Harm Reduction for People Who Use(d) Drugs

The role of Nova Scotia physicians in delivering care

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Background

What is harm reduction?

Harm reduction is an evidence-based, gold-standard approach that tries to reduce the harmful effects of substance use.[1] The seven key attributes of harm reduction are: a focus on harms, the participation of people who use(d) drugs (PWUD), the promotion of human rights, a public health approach, value neutrality and nonjudgment, practicality and pragmatism, and innovation and adaptability.[2] Harm reduction involves working with the person using substances so that they use more safely, without expecting them to stop using. Harm reduction is a spectrum of care options that recognizes that some people may not want to, be ready for or be able to stop completely. At its core, harm reduction is a practice of patient-centred care that offers physicians multiple tools for supporting better health outcomes.

Why does it matter for Nova Scotia physicians?

The drug poisoning crisis in Canada is prevalent and continues to escalate. There were 32,632 apparent opioid toxicity deaths between 2016 and 2022, driven by the unregulated street supply of drugs.[3] The crisis is most prevalent in Alberta, British Columbia and Ontario; historically the Atlantic provinces have not been impacted on the same scale. However, in 2022 alone, 63 Nova Scotians died due to accidental opioid poisoning – an increase from 45 deaths in 2021.[4] Waves of substance supply and related health outcomes from Western provinces may continue to move eastward. This crisis has spurred action among government and health-care actors to promote harm reduction programming, but the issue remains stigmatized and there are still significant gaps in services,[5] including in Nova Scotia specifically.[6]

Physicians are also increasingly called to understand harm reduction and substance use outside the parameters of the drug poisoning crisis. In January 2023, the Canadian Centre on Substance Use and Addiction recommended a significant reduction in alcohol consumption among Canadians.[7] These recommendations are timely, as substance use disorders (including use of alcohol and cannabis) have become the fifth most likely reason for hospitalization in Canada.[8] Substance use health is a pressing concern for all patients and all physicians, as the health-care system seeks upstream approaches to preventing and mitigating associated harms. This position paper focuses on opioid use and accidental

[1] Centre for Addiction and Mental Health. (2018). *Harm reduction: Where to go when you're looking for help.* Retrieved from https://www.camh.ca/-/media/files/community-resource-sheets/harm-reduction-resources-pdf.pdf?la=en&hash=A175EF581BD43ACE51D964DEEBD09DD2738CB7D7

[2] Denis-Lalonde, D., Lind, C., and Estefan, A. (2019). Beyond the buzzword: A concept analysis of harm reduction. *Research and Theory for Nursing Practice, 33*(4).

[3] Federal, provincial, and territorial Special Advisory Committee on the Epidemic of Opioid Overdoses. Opioid- and Stimulant-related Harms in Canada. Ottawa: Public Health Agency of Canada; December 2022. https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants/

[4] Government of Nova Scotia. (2017). *Nova Scotia's Opioid Use and Overdose Framework*. Retrieved from https://novascotia.ca/opioid/

[5] Hyshka, E., Anderson-Baron, J., Pugh, A., Belle-Isle, L., Hathaway, A., Pauly, B., Strike, C., Asbridge, M., Dell, C., McBride, K., Tupper, K., & Wild, T. C. (2019). Principles, practice, and policy vacuums: Policy actor views on provincial/territorial harm reduction policy in Canada. *The International journal on drug policy*, *71*, 142–149.

[6] Lois A. Jackson, Holly Mathias, Fiona Martin, Jane A. Buxton, Anik Dubé, Niki Kiepek, Jo-Ann MacDonald & Carol Strike (2022) Accessing drug treatment programs in Atlantic Canada: the experiences of people who use substances, Drugs: Education, Prevention and Policy.

[7] Canadian Centre on Substance Use and Addiction. (2023). *Canada's guidance on alcohol and health: Final report.* Retrieved from https://ccsa.ca/sites/default/files/2023-01/CCSA_Canadas_Guidance_on_Alcohol_and_Health_Final_Report_en.pdf

[8] Canadian Institute for Health Information. (2023). *Hospital stays in Canada [release summary].* Retrieved from https://www.cihi.ca/en/hospital-stays-in-canada

drug poisonings through opioid use, but recommendations on harm reduction practice and governance are also applicable for substance use health more broadly.

Provincial and territorial medical association positions on harm reduction

The Canadian Medical Association (CMA) has played an important role in the development of harm reduction policy in Canada. In 2010, the CMA took a strong stance in support of supervised injection sites and medical care based in harm reduction, after the establishment of the first supervised injection site (INSITE) in Vancouver led to Supreme Court of Canada challenges by the federal government at the time.[9] Since then, CMA advocacy to the federal government has continued with statements that position substance use and addiction as health issues, not moral or criminal offences. The CMA has advocated for the integration of harm reduction principles – including the full spectrum from abstinence to safe consumption – into health-system supports for PWUD, as well as the decriminalization of drugs for personal use.

Individual provincial and territorial medical associations (PTMAs) have also addressed harm reduction, particularly in the context of the drug poisoning crisis. The associations are largely working in provincial political environments that feature rapidly increasing interest in tackling mental health and addictions care through government policy. However, there is limited evidence of plans to expand and support harm reduction programs and services through government funds.[10] In response, several PTMAs (in British Columbia, Alberta and Ontario) have taken positions that advocate for expanded community harm reduction programs, including a broad spectrums of care options. There is also support for the need to reduce stigma and barriers to care for PWUD, and for enhanced physician education and supports. In particular, the Ontario Medical Association advocated in 2020 for role clarity on physicians' work in harm reduction, as well as for the implementation of standards for mental health care as delivered across the health-care system. British Columbia also noted physician hesitancy to prescribe for opioid agonist treatment (OAT), due to concerns about discipline by the provincial college of physicians.

Policies on harm reduction and opioid use in Nova Scotia

Despite challenges, Nova Scotia has seen recent policy action on substance use health. In 2017, the provincial government published the Opioid Use and Overdose Framework,[11] which recommended a harm reduction approach to substance use health. The framework also identified the need for increased health-care provider training and capacity building, focused on management of opioid use in patients, and the establishment of appropriate prescribing thresholds for opioids in pain management. As of April 2023, progress has been made toward these goals through new Nova Scotia Health (NSH) policies on care of patients receiving OAT.[12] Based on the 2017 framework, opportunities still exist to enhance primary care and community supports for PWUD, as well as the expansion of non-pharmacological approaches to harm reduction in NSH facilities.

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[9] Canadian Medical Association. (2011). *Insite: CMA submission regarding Insite supervised injection site and program.* CMA Policybase. Retrieved from: https://policybase.cma.ca/link/policy14129

[10] Hyshka, E., Anderson-Baron, J., Karekezi, K., Belle-Isale, L., Elliott, R., Pauly, B., Ashbridge, M., Dell, C., McBride, K., Hathaway, A., and Wild, T.C. (2017). Harm reduction in name, but not substance: a comparative analysis of current Canadian provincial and territorial policy frameworks. *Harm Reduction Journal, 14*(50), 1-14.

[11] Government of Nova Scotia. (2017). *Nova Scotia's Opioid Use and Overdose Framework*. Retrieved from https://novascotia.ca/opioid/

[12] Nova Scotia Health and IWK Health. (2022). *Care of patients on Opioid Agonist Treatment (OAT) [methadone, buPRENorphine/ naloxone (Suboxone®)] for Opioid Use Disorder.* Retrieved from: https://policy.nshealth.ca/Site_Published/IWK/document_render.aspx?documentRender.IdType=6&documentRender.GenericField=&documentRender.Id=96491

Health professions in Nova Scotia have begun to create policies on caring for patients who use substances. The College of Physicians and Surgeons of Nova Scotia (CPSNS) has guidelines on the initiation of opioid therapy for acute pain, care of legacy patients (i.e., patients previously prescribed inappropriate dosages of opioids by another physician), and the prescribing and management of benzodiazepines and Z-drugs. The Nova Scotia Prescription Monitoring Program (PMP) also operates as a regulator of physician prescribing patterns for substances including opioids, benzodiazepines and cannabinoids.[13]

Other health professions in Nova Scotia have issued standards on expected levels of care and competency in harm reduction practice. The Nova Scotia College of Nursing expects that entry-level nurses will "incorporate principles of harm reduction with respect to substance use and misuse into plans of care,"[14] and the Nova Scotia College of Pharmacists has published a comprehensive policy on harm reduction care provided by pharmacists.[15] This policy outlines expectations for registered pharmacists, including avoiding stigmatization through appropriate language and respect for PWUD, and the provision of care on a spectrum that does not require abstinence. The official standard of care for pharmacists practicing harm reduction requires that they maintain professional competence in harm reduction care within their scope, and ensure pharmacies are equipped for patient-centred care of PWUD.[16]

[13] Nova Scotia Prescription Monitoring Program. (2023). *Nova Scotia Prescription Monitoring Program List*. Retrieved from https://www.nspmp.ca/about-nspmp/monitored-drugs

[14] Nova Scotia College of Nursing. (2020). *Entry-Level Competencies for the Practice of Registered Nurses*. Retrieved from: https://www.nscn.ca/sites/default/files/documents/resources/EntryLevelCompetenciesRN.pdf

[15] Nova Scotia College of Pharmacists. (2021). *Pharmacy practice policy: Harm reduction.* Retrieved from: https://www.nspharmacists.ca/wp-content/uploads/2021/04/Policy_HarmReduction.pdf

[16] Nova Scotia College of Pharmacists. (2021). *Professional responsibilities to meet patient needs related to compounding, Opioid Agonist Therapy, and prescribing.* Retrieved from: https://www.nspharmacists.ca/wpcontent/uploads/2021/09/Position_ProfessionalResponsibilitiestoMeetPatientNeeds.pdf

Position statements

Addressing stigma and bias against people who use drugs and harm reduction care

Both federal and provincial Canadian governments have developed policies on addressing the opioid crisis and meeting mental health and substance use health needs, but there is limited recognition of the barriers impacting access to services, including the stigma that permeates health-care systems.[17] Doctors Nova Scotia takes the position that reducing stigma against PWUD is essential to improving access to and outcomes of care. Perceiving substance use through a morality lens rather than a health care lens can create negative attitudes toward both the patients seeking harm reduction care and the providers delivering it. Stigmatization in health-care settings can lead to patients avoiding future health-care interactions, thereby delaying needed treatments.[18,19]

Currently, stigma is coded into health-care structures and institutions and reinforced by connections to the legal and justice systems. In December 2021, DNS officially endorsed the Canadian Society of Addiction Medicine (CSAM) position on the decriminalization of drug use and possession for personal use.[20] Decriminalization will support reduced stigmatization of drug use and increase access to needed health services. Decriminalization of drug use is also an emerging federal priority, as governments look to increase investment in mental health and addictions care.[21] Recent research from Nova Scotia suggests that decriminalization of drug use could enhance community support for harm reduction programming.[22]

The impact of stigma in health-care institutions is also felt by physicians, who may be perceived to make riskier practice choices when caring for PWUD. This perception is due in part to the medical profession's complicated history with opioid prescribing, but also speaks to the lingering stigma surrounding addictions medicine. Doctors Nova Scotia supports the full spectrum of harm reduction, from abstinence to safe supply, to be practised by Nova Scotia physicians where and when they and their patients deem these approaches to be safe and appropriate.

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[17] Hyshka, E., Anderson-Baron, J., Karekezi, K., Belle-Isale, L., Elliott, R., Pauly, B., Ashbridge, M., Dell, C., McBride, K., Hathaway, A., and Wild, T.C. (2017). Harm reduction in name, but not substance: a comparative analysis of current Canadian provincial and territorial policy frameworks. *Harm Reduction Journal, 14*(50), 1-14.

[18] Muncan, B., Walters, S.M., Ezell, J., and Ompad, D.C. (2020). "They look at us like junkies": influences of drug use stigma on the healthcare engagement of people who inject drugs in New York City. *Harm Reduction Journal, 17*(53), 1-9.

[19] Government of Canada. (2022). *Stigma around drug use.* https://www.canada.ca/en/health-canada/services/opioids/stigma.html

[20] Canadian Society for Addictions Medicine. (2021). *Policy brief: CSAM-SMCA in support of the decriminalization of drug use and possession for personal use.* Retrieved from: https://policybase.cma.ca/media/PolicyPDF/PD21-12.pdf

[21] Reeder, M. (2023, February 24). "Trudeau taps student energy and ideas at health-care town hall." *Dal News.* Retrieved from: https://www.dal.ca/news/2023/02/24/prime-minister-canada-dalhousie-town-hall-health.html

[22] Jackson, L., Dechman, M., Mathias, H., Gahagan, J., & Morrison, K. (2022). Safety and danger: Perceptions of the implementation of harm reduction programs in two communities in Nova Scotia, Canada. *Health & Social Care in the Community*, *30*(1), 360–371.

Supporting physicians to practise harm reduction in substance use health

The following recommendations are based on community and physician stakeholder interviews in Nova Scotia, a scan of policy positions taken by Canadian medical associations (provincial and territorial), and peer-reviewed, scientific evidence.

Support physicians to deliver harm reduction care

Harm reduction is a spectrum – some physicians will provide care at only one end of the spectrum, while others may work across its full breadth. All physicians should be aware of the spectrum and supportive of patients accessing the services that best meet their needs. Many physicians and community programs offer more intensive harm reduction options, and patients may be referred if needed.

Physicians in all medical specialties should be aware of how substance use health impacts their practice, such as appropriate, collaborative prescribing of medications for pain management in PWUD, who may experience barriers to accessing prescribed pharmacological pain relief.[23] All physicians may benefit from accessing supports and educational resources on providing care within substance use health, and those providing harm reduction care across the full spectrum should be especially engaged in ongoing education. Resources include continuing professional development, peer support networks (formal and informal), and an ongoing dialogue with communities and patients. Physicians must be supported through payment and accountability mechanisms to integrate these activities into their practice. Included in this position paper are resources on best practices for clinical management of opioid use disorder, Nova Scotia resources for physician learning on harm reduction and a list of Nova Scotia community-based harm reduction services.

Provide flexibility to meet patient needs across the spectrum

Harm reduction practice requires access to a full range of care options for patient-centred care. This type of care necessitates distinct parameters, within which physicians can be flexible to meet patient and community need alongside established medical practices and guidelines. For example, physicians are required to balance collaborative prescribing of opioids for pain management in PWUD with official guidelines on recommendations for prescribing.[24] Physicians require clear parameters for evaluating all forms of evidence (including, but not limited to, scientific literature, peer and expert consultation, and patient engagement) used to make clinical judgements within harm reduction practice.

In Nova Scotia, physicians have previously noted that potentially punitive structures governing methadone prescribing were a deterrent that kept them from including harm reduction care in their practice.[25] Physicians should be actively supported and enabled to appropriately care for patients who use substances, with a focus on enabling best practices rather than retroactively correcting practice choices.

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[23] Voon, P., Greer, A.M., Amlani, A., Newman, C., Burmeister, C., Buxton, J.A. (2018). Pain as a risk factor for substance use: a qualitative study of people who use drugs in British Columbia, Canada. *Harm Reduction Journal*, *15*(35), 1-9.

[24] College of Physicians and Surgeons of Nova Scotia. (2020). *Initiation of opioid therapy for acute pain: Professional standards regarding initiation of opioid therapy for acute pain*. Retrieved from https://cpsns.ns.ca/resource/initiation-of-opioid-therapy-for-acute-pain/

[25] Livingston, J.D., Adams, E., Jordan, M., MacMillan, Z., and Hering, R. (2018). Primary care physicians' views about prescribing methadone to treat opioid use disorder. *Substance use & misuse, 53*(2), 344-353.

Integrate harm reduction into all care settings

Integration of care across the full health-care system is essential to delivering health and well-being for patients and providers alike. Collaborative approaches that put patients in the care of the right provider at the right time must be actively facilitated to optimize health outcomes. This includes substance use health and harm reduction care.

Harm reduction care in Nova Scotia needs to be cohesively integrated into both primary care and hospital services, and not siloed within mental health and addictions care. Substance use health should not be limited to specialized care settings – it is relevant for a wide variety of patients and should be understood by all health-care providers. For example, accounting for the needs of PWUD in settings such as hospitals means providing space and equipment to use drugs and ensuring patients and physicians engage in shared decision-making about treatment plans, to avoid premature patient-initiated discharge.[26]

[26] Brothers, T., Fraser, J., and Webster, D. (2021). Caring for people who inject drugs when they are admitted to hospital. *Canadian Medical Association Journal, 193*(12), E423-E424.

Harm reduction resources for Nova Scotia physicians

Glossary of key terms

1. **Accidental drug poisonings:** When an individual experiences signs and/or symptoms of substance toxicity, without the intention of inflicting harm on themselves.[27] For instance, the ingestion of an illicit opioid supply that contains fentanyl may lead to overdose or death.[28]

2. **Addiction:** A complex process with a variety of definitions. The Canadian Mental Health Association,[29] describes addiction as "a condition that leads to a compulsive engagement with a stimuli, despite negative consequences. This can lead to physical and/or psychological dependence."[30]

3. **Decriminalization (vs. legalization):** Within the scope of this report, decriminalization refers to the exemption of criminal offenses for possession and usage of substances.[31] Legalization refers to making something legal that was previously illegal, such as the licensed sale and use of cannabis.[32]

4. **Opioid agonist therapy (OAT):** Routine administration of medications that reduce withdrawal symptoms associated with opioids. Common opioid agonists include methadone, suboxone and long-acting buprenorphine.[33]

    a. **Methadone:** A full opioid agonist that is typically administered orally, mixed with a beverage.[34]

    b. **Suboxone:** A combination of buprenorphine and naloxone, typically administered sublingually.[35]

        i. **Buprenorphine:** A partial opioid agonist that works to reduce withdrawal symptoms.

        ii. **Naloxone:** An opioid receptor antagonist that works to reduce the therapeutic effects of buprenorphine.

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[27] Australian Institute of Health and Welfare. (2015). *Leading cause of premature mortality in Australia fact sheet: accidental poisoning*. Cat. no. PHE 201. Canberra: AIHW.

[28] Government of Canada. (2022, March 17). *Prescribed medications as a safer alternative to toxic illegal drugs*. Retrieved from https://www.canada.ca/en/health-canada/services/opioids/responding-canada-opioid-crisis/safer-supply.html

[29] Canadian Mental Health Association. (n.d.). *Substance use and addiction*. Retrieved from https://ontario.cmha.ca/addiction-and-substance-use-and-addiction/#_edn1

[30] European Monitoring Centre for Drugs and Drug Addiction. (2013). *Models of Addiction.* Retrieved from http://www.emcdda.europa.eu/attachements.cfm/att_213861_EN_TDXD13014ENN.pdf

[31] Canadian Centre on Substance Use. (2018, June). *Decriminalization: Options and evidence (policy brief).* Retrieved from https://www.ccsa.ca/sites/default/files/2019-04/CCSA-Decriminalization-Controlled-Substances-Policy-Brief-2018-en.pdf

[32] Government of British Columbia. (2023, February 1). *Decriminalizing people who use drugs in B.C. Province of British Columbia*. Retrieved from https://www2.gov.bc.ca/gov/content/overdose/decriminalization#:~:text=Adults%20in%20B.C.%20are%20not,2023%20until%20January%2031%2C%202026.

[33] World Health Organization. (2009). *Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence*. Retrieved from https://www.who.int/publications-detail-redirect/9789241547543

[34] UpToDate. *Methadone: Drug Information*. Published by UpToDate. 2022. Reviewed 06-Nov-2022.

[35] UpToDate. *Buprenorphine and Naloxone: Drug Information*. Published by UpToDate. 2022. Reviewed 06-Nov-2022.

5. **People who use(d) drugs/substances (PWUD):** Preferred terminology for denoting individuals who consume(d) substances.
6. **Safer supply:** A method of harm reduction involving the provision of substances to PWUD through the health-care system, as an alternative to an illicit supply.[28]
7. **Substance use health:** "A continuum that encompasses beneficial uses, recreational uses, and harmful uses and consequences, and encompasses harm reduction to promote health in relation to using substances."[36] Similar to how physical health and mental health are understood as a continuum without presumed illness, "substance use health" refers to this continuum without the presumption of substance use disorder.[37]

[36] Ottawa Public Health & CAPSA. (2021). *Spectrum of Substance Use*. Retrieved from: https://www.ottawapublichealth.ca/en/public-health-services/have-that-talk-about-substance-use-health.aspx

[37] CAPSA. *Substance use health* (n.d.). Retrieved from https://capsa.ca/wp-content/uploads/2022/10/CAPSA-Substance-Use-Health-EN-1.pdf

Literature review

Best practices for harm reduction in substance use health for opioid use disorder

This review is focused on current physician best practices in harm reduction related to opioid use disorder (OUD). Emphasis has been placed on family physicians in the Canadian health-care system. Please note that this review is not an exhaustive list of all modes of treatment for OUD, nor should it be interpreted as clinical advice to physicians. Rather, it serves as a starting point to educate readers about current key approaches and provide resources for further education on managing OUD.

There are six key objectives:

1. Define the continuum of care for managing OUD, including non-pharmacologic and pharmacologic approaches.
2. Explore options for opioid agonist therapy (OAT).
3. Describe an approach to making OAT a sustainable and patient-centred regimen.
4. Conduct a scan on the current state of providing safer opioid supply in Canada.
5. Review the barriers and facilitators relevant to OUD treatment services.
6. Emphasize the social determinants of health by discussing an approach optimizing delivery in equity-deserving populations.

Objective 1 – Define the continuum of care for managing OUD, including non-pharmacologic and pharmacologic approaches: The Canadian Centre on Substance Use and Addiction[1] outlined a framework to define the continuum of care for the management of OUD. It demonstrates how screening, assessment and various modes of intervention all play a key role in the approach to OUD.

Continuum of Care									
Harm Reduction									
Screening	Assess-ment	Brief Interven-tions	*Rapid Access Clinics	*Community Outreach	Withdrawal Manage-ment	Pharmaco-logical Interven-tions	Psychosocial Interven-tions	Recovery, Sustaining Wellness & Ongoing Care

Figure 1: The continuum of care for the management of OUD, from the Canadian Centre on Substance Use and Addiction (2018).[38]

Various screening tools are available, and currently, there is no consensus on one being the best practice. Popular tools include CAGE-AID (taught in the Dalhousie Medicine curriculum; four questions where two or more "yes" answers yield a positive screen)[39] and ASSIST (an eight-question tool commonly used in primary care).[40] Thereafter, assessment should be undertaken if the patient screens

[38] Taha, S. (2018). Best Practices across the Continuum of Care for the Treatment of OUD. Canadian Centre on Substance Use and Addiction. Retrieved from https://www.ccsa.ca/sites/default/files/2019-04/CCSA-Best-Practices-Treatment-Opioid-Use-Disorder-2018-en.pdf.

[39] Brown, R. L., & Rounds, L. A. (1995). Conjoint screening questionnaires for alcohol and other drug abuse: Criterion validity in primary care practice. Wisconsin Medical Journal, 94(3), 135-140.

40 Humeniuk, R., Ali, R., Babor, T. F., Farrell, M., Formigoni, M. L., Jittiwutikarn, J., de Lacerda, R. B., … Simon, S. (2008). Validation of the alcohol, smoking and substance involvement screening test (ASSIST). Addiction, 103(6), 1039-1047.

positively – which includes the Addiction Severity Index (ASI)[41] and gauging their readiness for change through motivational interviewing (the "5A's" model, also taught in the Dalhousie Medicine curriculum).[42] Regarding management, a combination of non-pharmacologic and pharmacologic therapy is an effective treatment strategy for OUD.[43] Non-pharmacologic interventions may include community-based resources (e.g., interprofessional addiction services, social work and peer support services)[44,45] and specific interventions including psychosocial therapy (e.g., cognitive behavioral therapy, couples-based therapy or supportive counselling).[45] Pharmacologic therapy, including opioid agonist therapy (OAT) and safer supply, can be effective in supporting recovery.[46] Various approaches have proven successful for OAT initiation; including provision solely through a specialized OAT clinic, through a primary care provider, or a hybrid approach where the specialized OAT clinic initiates the program and it is subsequently followed by the primary care provider.[47,48] Several Canadian treatment guidelines for OUD have been developed, notably by the Canadian Research Initiative in Substance Misuse (CRISM),[49] and the Centre for Addiction and Mental Health (CAMH).[44] Additional methods of harm reduction, including naloxone kits and public education, are also important components of the continuum of care for the management of OUD.[50]

Ultimately, the elements of managing OUD should be tailored to each patient's values, beliefs and individualized treatment goals. Health-care providers should be aware of services and providers in their communities that are equipped to administer non-pharmacologic and pharmacologic modes of therapy for OUD, such that they can refer patients to services that they are not trained to provide themselves.

Objectives 2 and 3 – Explore options for opioid agonist therapy (OAT); 1. Describe an approach to making OAT a sustainable and patient-centred regimen: Methadone, buprenorphine/naloxone ("suboxone") and long-acting buprenorphine are some common opioid agonist medications noted in the literature.[51] There are other OAT options available, as well as safer supply, which will be discussed in the

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41 Kosten, T. R., Rounsaville, B. J., & Kleber, H. D. (1983). Concurrent validity of the addiction severity index. Journal of Nervous and Mental Disease, 171(10), 606-610.

42 Jay, M., Gillespie, C., Schlair, S., Sherman, S., & Kalet, A. (2010). Physicians' use of the 5As in counseling obese patients: is the quality of counseling associated with patients' motivation and intention to lose weight?. BMC health services research, 10(1), 1-10.

43 National Institute on Drug Abuse. (2018). Principles of drug addiction treatment: A research-based guide (Third Edition). Retrieved from https://www.drugabuse.gov/publications/principles-drugaddiction-treatment-research-based-guide-third-edition/principles-effective-treatment.

44 National Institute on Drug Abuse. (2018). Principles of drug addiction treatment: A research-based guide (Third Edition). Retrieved from https://www.drugabuse.gov/publications/principles-drugaddiction-treatment-research-based-guide-third-edition/principles-effective-treatment.

45 McHugh, R. K., Hearon, B. A., & Otto, M. W. (2010). Cognitive behavioral therapy for substance use disorders. The Psychiatric clinics of North America, 33(3), 511–525. https://doi.org/10.1016/j.psc.2010.04.012

46 Substance Abuse and Mental Health Services Administration. (2018). Medications for OUD for healthcare and addiction professionals, policymakers, patients and families. Treatment improvement protocol 63. Retrieved from https://www.drugabuse.gov/publications/principles-drugaddiction-treatment-research-based-guide-third-edition/principles-effective-treatment.

47 Lois A. Jackson, Holly Mathias, Fiona Martin, Jane A. Buxton, Anik Dubé, Niki Kiepek, Jo-Ann MacDonald & Carol Strike (2022) Accessing drug treatment programs in Atlantic Canada: the experiences of people who use substances, Drugs: Education, Prevention and Policy. https://doi.org/10.1080/09687637.2022.2102461

48 Livingston, J. D., Adams, E., Jordan, M., MacMillan, Z., & Hering, R. (2018). Primary care physicians' views about prescribing methadone to treat OUD. Substance Use & Misuse, 53(2), 344–353. https://doi.org/10.1080/10826084.2017.1325376

49 CRISM National Guideline Committee. (2018, March). CRISM National Guideline for the Clinical Management of Opioid Use Disorder. Canadian Research Initiative in Substance Misuse. Retrieved March 10, 2023, from https://crism.ca/wp-content/uploads/2018/03/CRISM_NationalGuideline_OUD-ENG.pdf

50 Wermeling D. P. (2015). Review of naloxone safety for opioid overdose: practical considerations for new technology and expanded public access. Therapeutic advances in drug safety, 6(1), 20–31. https://doi.org/10.1177/2042098614564776

51 World Health Organization. (2009). Guidelines for the psychosocially assisted pharmacologic treatment of opioid dependence. Geneva, Switzerland: World Health Organization Press. Available from: https://www.who.int/publications-detail-redirect/9789241547543

following section. For the scope of this review, focus will be placed on methadone, buprenorphine/ naloxone ("suboxone") and long-acting buprenorphine.

Methadone is a full opioid agonist, typically mixed with a beverage and administered orally.[52] Suboxone is typically administered sublingually.[53] Suboxone's components include buprenorphine (a partial opioid agonist) and naloxone (opioid receptor antagonist, to mitigate buprenorphine's effects from activating the opioid receptor),[53] which work together to control withdrawal symptoms while reducing the therapeutic effects of pain relief and euphoria due to the antagonistic activity of naloxone.[53] As such, it has a lower risk of physiologic dependence compared to methadone, but lacks the full agonistic activity at the opioid receptor compared to methadone.[54,55]

Methadone's relative contraindications include cardiac arrhythmias and taking concurrent medications that cause QT interval prolongation (e.g., antidepressants, antipsychotics, antiarrhythmics and antimicrobials),[56] which would require further monitoring.[57] Further, patients and providers should be aware of the hormonal impacts noted predominantly with methadone.[58] Specifically, it interferes with the hypothalamic pituitary gonadal axis. In turn, this may induce hypogonadal activity, hence reports of sexual disorders for certain individuals taking methadone.[59] The endocrine impacts of OAT and opioids, particularly among females, are still not fully understood and are currently under research.[58] Another OAT option is an injectable administration of long-acting buprenorphine.[44,60] This subcutaneous injection sustains the physiologic effect of buprenorphine for about one month, thereby it is administered by a health-care provider on a monthly basis.[44,60] This convenience and reduced frequency of facility access may be ideal for certain individuals and communities, particularly in rural and underserviced areas.[44,60] Weighing these benefits with the patient is paramount in selecting the ideal OAT medication choice for each patient.

Patients are more likely to maintain a long-term regimen if they play a key role in deciding which treatment option they undertake, no matter which OAT option is chosen.[55,61] As such, health-care providers should apply a patient-centred approach by presenting these evidence-based treatment options and their relative advantages, and empowering the patient to decide which option is best for them in sustaining a long-term routine that achieves their goals. Irrespective of the pharmacologic

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[52] UpToDate. Methadone: Drug Information. Published by UpToDate. 2022. Reviewed 06-Nov-2022.

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[61] Connock M, Juarez-Garcia A, Jowett S, Frew E, Liu Z, Taylor RJ, et al. Methadone and buprenorphine for the management of opioid dependence: a systematic review and economic evaluation. Health Technol Assess 2007;11(9):1-171.

option, slowly tapering down the dose over several months is important for successful discontinuation and sustainable recovery from OUD.[62]

Objective 4 – Conduct a scan on the current state of providing safer opioid supply in Canada: Safer supply involves the provision of opioid medications to PWUD through the health-care system, as an alternative to unregulated supplies of opioids.[63] This is a notable harm reduction approach to OUD, as safer supply is a known potency and dose, compared to that of an illegal supply.[63,64] For instance, an unregulated opioid supply is more likely to contain an unknown dose of fentanyl – a synthetic opioid that is 100x more potent than morphine.[63,65] As such, safer supply significantly reduces the risk of accidental drug poisoning and death when compared to an unregulated opioid supply.[63,65] The flexibility of safer supply has been demonstrated – as safer supply has been prescribed as a sole treatment, adjunct to OAT, and transitional adjunct to OAT during the early course of OUD management (i.e., a "treatment bridge").[63-66] Hydromorphone or morphine are often utilized as the opiates of choice for safer supply, due to their relatively lower potency and risk of toxicity.[67,68] As well, tightly-controlled doses of higher-potency opiates including fentanyl have also been utilized in safer supply for cases of high tolerance.[69]

The positive impacts of safer supply have been demonstrated in various jurisdictions, notably British Columbia and Ontario,[70,71] and it has been shown to lead to reductions in accidental drug poisoning rates, emergency department visits, infections, criminal activity, necessity-based sex work and death.[63,72] Health Canada's interactive map details the sites available,[73] demonstrating that safer supply services may be integrated with various health-care settings – including primary care services, pharmacies, clinics and supervised consumption sites.[73,74] As outlined in the following section, various facilitators and barriers help shape the accessibility of safer supply services.[47] Further studies, as well as the development of a Canada-wide framework, are currently in progress to help guide the approach to safer supply programs.[73,74]

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Objective 5 – Review the barriers and facilitators relevant to OUD treatment services: Published in August 2022, the report “Accessing drug treatment programs in Atlantic Canada: the experiences of people who use substances” focuses on public/government-funded programs aimed at treating substance use disorders; namely OAT and withdrawal management programs.[47] This report serves as Phase 1 of the Atlantic Community Addictions Treatment (COAST) study, a multi-year study funded by the Canadian Institute of Health Research (learn more online at https://www.dal.ca/sites/atlantic-coast.html).[47] This report outlines the key facilitators (i.e., factors that promoted access and satisfaction) as well as barriers (i.e., factors that may contribute to avoidance, program withdrawal and dissatisfaction) for treatment programs, summarized in the table below.[47] Tangible measures aligned with this table include (but are not limited to): streamlined access to treatment programs, services in a private/confidential setting, supportive staff that embrace a non-judgmental approach to harm reduction, consistent hours of operation and clinics that are centrally located/accessible via bus routes.

Type of environment	Facilitators to access and retention (or what was helpful)	Barriers to access and retention (or what was not helpful)
1: Policy and practice environment	• *Quick and easy intake* • *Accommodations for/acceptance of substance use and specific health needs*	• *Requirements to 'get in' to treatment* • *Rigid policies and practices* • *Hours of operation of pharmacies/clinics*
2: Physical environment	• *Ready physical availability* • *Physical layout of pharmacy*	• *Distance to facilities and limited spaces* • *Physical layout of treatment/testing spaces*
3: Social environment	• *Supportive and understanding staff & structured and protective social environment*	• *Judgmental attitudes and negative conversations/social interactions*
4: Resource environment	• *Meetings, 'good' food and other amenities*	• *Boredom and poor–quality food*

Figure 2: Facilitators and barriers to treatment programs for substance use disorder, as outlined in “Accessing drug treatment programs in Atlantic Canada: the experiences of people who use substances” (2022).[47]

Objective 6 – Emphasize the social determinants of health by discussing an approach optimizing delivery in equity-deserving populations: There are tangible measures to consider for harm reduction care amongst certain equity-deserving groups.[38,75] Recognizing that this list of groups is not exhaustive and an intersectional approach for all patients is paramount, identified groups include youth, Indigenous Peoples, pregnant people, individuals convicted of an offense, and those living in remote or rural areas.[38,75] Several takeaways are noted for these groups. Per the youth's preference, additional factors should be strongly considered as a supplement to their OAT, including family engagement and cognitive behavioural therapy focused on building resilience, problem-solving skills and interpersonal connections.[38,76] With respect to Indigenous Peoples undergoing OAT, culturally safe supports including community resources and additional psychosocial therapy that focuses on the patient's spiritual, emotional and mental health should be considered.[38,75,77] Opioid agonist therapy is safe prepartum, antepartum and postpartum.[38,78] Lastly, OAT and psychosocial interventions for OUD should be (at least) equally accessible to individuals convicted of an offense compared to those who have not.[38,51]

This review has outlined the key components and best practices of OUD management. The topics discussed are non-exhaustive of the full spectrum of OUD management and continue to evolve in the Canadian landscape.

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[78] British Columbia Centre on Substance Use, B.C. Ministry of Health, B.C. Ministry of Mental Health and Addictions, & Perinatal Services BC. A Guideline for the Clinical Management of OUD – Pregnancy Supplement. Published June 1, 2018. Available from: http://www.bccsu.ca/care-guidance-publications/

Programs to support physicians delivering harm reduction care

Physician support and education programs for harm reduction (February 2023)	
Program	**Information**
Atlantic Mentorship Network – Pain & Addiction	The AMN – P&A started life as a pilot project in the South Shore District Health Authority. It was conceived bring pain and addiction care from the ivory tower to the community. Programs include the first interprovincial mentorship launched in 2010, a monthly discussion series via GoToMeeting, annual workshops on key pain and addiction topics, monthly online discussions, mentor training workshops and a safe opioid prescribing course. Their website features upcoming educational sessions. https://www.atlanticmentorship.com/
NSH Practice Support Program	To support primary health care providers and teams in Nova Scotia, the Primary Health Care and Chronic Disease Management Network offers a range of practice support tools, resources and initiatives aimed at supporting primary health care providers and teams in your practice, fostering a culture of shared learning, quality and safety, and ultimately enabling quality care for patients and families. https://physicians.nshealth.ca/topics/primary-health-care/practice-support-program
Opioid Use Disorder Practice Support Program (NSH)	The Opioid Use Disorder Practice Support Program provides training and support for primary care providers and teams to build competencies for the care of patients with opioid use disorder (OUD). The program is aimed at building competencies for providers with limited or no experience in OUD treatment; however, those who presently care for patients with OUD will also benefit. https://physicians.nshealth.ca/topics/primary-health-care/supporting-patients-mild-moderate-mental-health-concerns-and-substance-0
Free Online Comprehensive Training (NSH)	https://physicians.nshealth.ca/resources/free-comprehensive-online-training
Safer Opioid Prescribing Course (University of Toronto)	https://www.cpd.utoronto.ca/opioidprescribing/

National Safer Supply Community of Practice	The National Safer Supply Community of Practice (NSS-CoP) is a knowledge exchange initiative whose goal is to scale up safer supply programs across Canada. The NSS-CoP brings together physicians, people who use(d) drugs, researchers, pharmacists and other health-care providers to share emerging evidence, practices and experiences of safer supply. The NSS-CoP has resources specific to health-care providers, including a prescriber consult line and clinician-only Zoom meetings in which physicians can consult with their peers on specific patient cases of safer supply prescribing. These resources are only open to members of the NSS-CoP. It is free to register to become a member and you can do so here: https://www.nss-aps.ca/user/register. Please note, although the NSS-CoP does have resources specific to OAT in its Resource Library, this community practice is focused on safer supply prescribing. If looking for guidance on OAT prescribing, please consider calling the Addictions Medicine Consult Service (below).
Addictions Medicine Consult Service (AMCS)	The AMCS provides rapid addictions medicine consultant advice to physicians and nurse practitioners working in primary care, mental health and addictions (including offender health), emergency departments and acute care in Nova Scotia. The AMCS provides verbal evidence-informed clinical advice and guidance to diagnose and manage substance use disorders in adults, adolescents and children, as well as the management of medications related to substance use. The AMCS is available Monday to Friday from 8:30 a.m. to 4:30 p.m., toll free, at: 1-855-970-0234.

Community harm reduction programs in Nova Scotia

<table>
<tr><th colspan="2">Nova Scotia Community Harm Reduction Services (February 2023)</th></tr>
<tr><th>Organization:</th><th>Offerings</th></tr>
<tr><td>Direction 180
(Halifax)</td><td>Health services
Addiction medical assessment and follow-up medical care
Hepatitis C care and treatment
Wound care
Hepatitis A and B immunizations
Flu vaccines
Programs & support
One-on-one peer support
Recovery support programs
Recreational activities
Skills building and peer development programs
Overdose prevention training and take-away naloxone
Harm reduction education on safer drug using practices
Advocacy and links to other ancillary support services
Treatment options
Direction 180 offers a variety of opioid agonist treatment options such as: buprenorphine, methadone, kadian, sublocade and probuphine.
The following tasks will be completed as part of the admission process:
Psychosocial assessment (to identify emotional, behavioral, mental, environmental, spiritual well-being)
Urine drug test
MSI information gathered
Confirming drug coverage or financial ability to cover cost of medication
Blood work (non-mandatory testing to identify HIV, Hepatitis A, B, or C, and/or pregnancy status)
Complete medical examination
Policy review
Client treatment contract/rights/responsibilities</td></tr>
</table>

Mainline (Halifax)	• Grounded in the principles of harm reduction and a "nothing about us without us" philosophy • Needles, syringes, sterile water, cookers, matches, filters, ties, condoms, stems, meth pipes • Safe disposal of used needles • Fentanyl test strips and naloxone kits • Awareness and education related to harm reduction, particularly safer injection, and safer practices • Peer support, including assistance with exploring and accessing detox, treatment and/or methadone • Assistance in locating and navigating resources for legal, social services, employment and housing issues • Over-the-counter nutrition counselling as available
Ally Centre Cape Breton (Sydney)	• Sharp Advice Needle Exchange (S.A.N.E): safe injection equipment (clean needles, alcohol swabs, filters, ties) and sharps containers for safe disposal of used needles to Cape Bretoners in need. The needle exchange also provides outreach services as required • Anonymous HIV testing and non-nominal testing for Hepatitis B and C and syphilis (completed by a nurse) • Opioid overdose prevention training and free naloxone kits • Primary health care services for people from vulnerable populations (care is given by two part-time physicians and one part-time nurse practitioner) • Housing first program • Sex workers peer group for connection and safe supplies

North End Community Health Centre (Halifax)	• Mobile Outreach Street Health: Provides primary care services to people who are experiencing homelessness or are insecurely housed, street involved and underserved in the community (funded by Primary Care at Capital Health)
	• Nursing/medical
	  ○ Blood work
	  ○ Vein care
	  ○ HIV and Hepatitis C testing
	  ○ Harm reduction supplies
	  ○ Birth control and condoms
	  ○ Pregnancy tests with results right away
	  ○ Emergency contraception/morning after pill
	  ○ Sexually transmitted infection (STI) testing
	  ○ PAP tests
	  ○ Check-ups
	  ○ Vaccinations
	  ○ Wound care
	  ○ Addiction-related support
	  ○ Help managing chronic diseases, (e.g., diabetes, heart diseases)
	  ○ Help with medication

<table>
<tr>
<td>North End Community Health Centre (Halifax), cont.</td>
<td>

<li style="list-style-type:circle">Health education
<li style="list-style-type:circle">Help with special needs requests for income assistance
<li style="list-style-type:circle">Help getting a health card
<li style="list-style-type:circle">Help organizing dental and eye exams/referrals to other health professionals

Housing First (Coordinated with Nova Scotia Health): supports around 100 individuals a month on the various caseloads to secure and maintain their housing. They prioritize individuals and couples with multiple barriers (struggles with substance use, chronic health and mental health) who are African Nova Scotian, Indigenous and/or transgender and gender diverse
The Overlook: harm reduction, peer-supported housing project

<li style="list-style-type:circle">Houses 65 individuals who struggle with active and problematic drug and/or alcohol use, as well as have chronic health conditions, have lengthy experience with homelessness, and/or are actively engaged in sex work. The North End Community Health Centre is partnering with the Affordable Housing Association of Nova Scotia (AHANS) (the landlord) to offer 24/7 on-site, on-demand harm reduction supports to tenants
<li style="list-style-type:circle">Once fully operational, the Overlook team will consist of six full-time and five or six part-time harm reduction housing workers and a nurse-led clinical team that includes RNs, a harm reduction counsellor, PCW/CCAs and an OT. The Overlook will also support individuals in units who meet our eligibility criteria and require additional supports because they are dying, are chronically palliative or need respite care. Their care will be coordinated by an End-of-Life Care Coordinator and a small team of CCAs and peer volunteers.

Managed Alcohol Program (MAP): A medicalized harm reduction and nurse-led program that began in June 2020 and does essential outreach across the HRM. A consistent, safe supply of alcohol is prescribed by a physician through a permit provided by the provincial government of Nova Scotia to allow the team to distribute alcohol provided by the NSLC.
Safe Supply Project: A harm reduction program that aims to provide registered participants with a pharmaceutical supply of opioids dispensed from community pharmacies

<li style="list-style-type:circle">Initial program capacity will be set at 50 participants and once the program has reached capacity, a waitlist will be created (2022)

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Spryfield Medical (Spryfield)	The Spryfield Medical Clinic provides:
	• addiction medicine (as of February 2023)
	  ○ Dr. David Saunders provides care at Direction 180, CDHA Inpatient program and Crosbie House Rehabilitation centre
	  ○ Accepts referrals of patients in whom substance or process dependence or addiction is suspected by the patient or their care givers/employers/family physician.
	  ○ Dr. Saunders will provide a comprehensive assessment and recommendations for follow-up and treatment. The consultation includes a one-hour visit and follow-up consult letter.
	  ○ Services are covered by MSI. There is a fee for corporate referrals
	  ○ Mental health counselling and treatment, lifestyle counselling, general medical care

Northern Healthy Connections Society (Truro)	The Northern Healthy Connections Society provides:
	• Needle distribution and disposal
	• Mobile outreach delivery – delivering sterile drug use equipment, fentanyl testing strips and naloxone kits to the Northern Zone, including Amherst, Pictou, Springhill and New Glasgow.
	• “Better Off in the Box” program provides safe, secure needle disposal boxes in discreet locations throughout the Northern Zone.
	  ○ Two of these boxes are in Truro, one in Amherst and eight are located throughout the Millbrook First Nations Community. The Truro and Amherst disposal boxes were funded by community health board grants.
	  ○ The eight disposal boxes in Millbrook First Nations Community were provided through funding received from the First Nations Inuit Health Branch of Health Canada, as well as two large boxes in Sipekne’Katik First Nation Community.
	• Support coordinator, who also provides:
	  ○ Supervised access to a laptop for the purpose of finding housing, completing online job applications, doing online banking
	  ○ Information on how to find an apartment/housing
	  ○ Information on applying for income assistance

ReFix (Halifax)	ReFix is the first overdose prevention site in Atlantic Canada operating under an exemption pursuant to s. 56 (1) of the *Controlled Drugs and Substances Act* in relation to an urgent public health need. ReFix offers a non-judgmental and supportive space for people to use substances under the supervision of trained people with living and lived experience of drug use. Sterile drug use equipment is also available on site, as are naloxone training and take-home kits. There is also peer support on offer and direct linkage to health and social services. ReFix is located at the lower level of the Brunswick Street Mission, 2107 Brunswick Street in Halifax, N.S., operating seven days per week, from 9:30 a.m. to 4:30 p.m.
Peer Six **(Sydney)**	An overdose prevention site where people can use substances in a stigma-free environment under the supervision of trained peers. Peer Six currently has two semi-private drug use booths and sterile drug use equipment is also available. Peer Six is located at 75 Prince Street in Sydney, N.S., open seven days a week from 10 a.m. until 5 p.m.
National Overdose Response Service (www.nors.ca)	The National Overdose Response Service (NORS) is a supervised consumption hotline for Canadians that provides confidential and nonjudgmental support. Operators are available year-round, 24/7 at 1-888-688-6677. Callers provide their current location and safety plan in the event of a toxic drug poisoning, then they use drugs while on the phone. If the caller becomes unresponsive after doing so, the NORS operator will refer to the caller's safety plan; be it calling 911 or someone known to the caller nearby who can respond with naloxone. National Overdose Response Service operators are also happy to speak to people with lived or living experience of drug use who are not looking for supervised consumption, but just need some peer support and someone to talk to. Lastly, NORS can provide callers with a list of services and programs in their community related to substance use treatment and/or harm reduction if they are seeking other supports.