



Interprofessional Education Guidelines on Opioid Use and Opioid Use Disorder



Association of Faculties
of Pharmacy of Canada
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de pharmacie du Canada

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CANADIAN ASSOCIATION FOR SOCIAL WORK EDUCATION
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Inclusion

CASN, AFPC, and CASWE-ACFTS are committed to developing inclusive policies and statements that challenge discrimination and cisnormative behaviour. A guiding objective, therefore in developing the guidelines is to ensure that they promote sensitivity, inclusion, and respect for all people including but not limited to Indigenous and racialized peoples, transgender, non-binary, intersex, and members of all marginalized communities.

Background

There is widespread recognition of the magnitude of the opioid-related harms in Canada, evidenced by the dramatic increase in the prevalence of opioid use disorder, opioid poisoning, and the numbers of opioid-related deaths.

- More than 13,900 apparent opioid-related deaths occurred between January 2016 and June 2019 – 1 life lost every 2 hours. The majority (75%) were males aged 30-39 years (Special Advisory Committee on the Epidemic of Opioid Overdoses, 2019).
- Between January 2016 and March 2019, 17,050 opioid-related poisoning hospitalizations occurred, with the majority (62%) being males aged 60 and over (Special Advisory Committee on the Epidemic of Opioid Overdoses, 2019).
- Opioid-related harms affect all age groups from all walks of life.
- Indigenous individuals have a higher rate of opioid overdose events – for example, findings from British Columbia indicate that First Nations people are 5 times more likely than non-First Nations to experience an overdose event (First Nations Health Authority, 2017) and 4.2 times more likely to die due to an overdose than non-First Nations (First Nations Health Authority, 2019).
- There are key gender differences regarding opioid use – 75% of opioid-related deaths in Canada between January 2016 and June 2019 were men (Special Advisory Committee on the Epidemic of Opioid Overdoses, 2019), although the gender proportion is more equal among First Nations (First Nations Health Authority, 2019).
- Characteristics more frequently observed among those who died from opioid and other drug-related overdoses include a history of mental health concerns, substance use disorder, trauma, and stigma (Special Advisory Committee on the Epidemic of Opioid Overdoses, 2019a).

Against this backdrop, there is an urgent need for collective interprofessional and intersectoral initiatives to address the gravity and complexity of opioid use and opioid use disorder in Canada (Government of Canada, 2018a).

In November 2016, the Honourable Jane Philpott, then Federal Minister of Health, and the Honourable Eric Hoskins, then Minister of Health, Ontario, engaged health care and social service professional organizations, national organizations and associations, regulators and decision makers, to commit to taking immediate and concrete actions to address it. In the *Joint Statement of Action to Address the Opioid Crisis*, Health Canada identified the following elements of a national action plan: informing Canadians about the risks of opioids, supporting better prescribing practices, reducing easy access to unnecessary opioids, supporting better treatment options for individuals, improving the evidence upon which policy decisions are made, and reducing the availability and harm of street drugs (Canadian Centre on Substance Abuse, 2017).

For the national plan to be actioned it is critical that health care and social service professionals enter the workforce well-equipped with the knowledge and skills needed to address this issue, and in collaboration with one another. New evidence-informed solutions and approaches, as well as guidelines and resources for practising professionals, are constantly being developed. There is a requisite need for educational programs

of entry-level health care and social service providers to have access to national, consensus-informed syntheses of this work to be able to incorporate interprofessional, evidence-informed knowledge, approaches, and skills into curricula.

Objective

The Canadian Association of Schools of Nursing (CASN) in partnership with the Association of Faculties of Pharmacy of Canada (AFPC) and the Canadian Association for Social Work Education – Association canadienne pour la formation en travail social (CASWE-ACFTS) committed to working together on a project to foster change in education programs for registered nurses, pharmacists, and social workers across Canada. The goal of the project is to ensure that health care and social service providers enter the workforce well-equipped with relevant, evidence-informed knowledge to address issues related to opioid use and opioid use disorder across the prevention, health promotion, harm reduction, treatment, and recovery continuums at primary, secondary, and tertiary care levels.

These interprofessional education guidelines are the first of three key deliverables and are supplemented with:

- ***interprofessional, consensus-based protocols*** to facilitate the integration of the education guidelines among the member schools of the three health care professions collaborating in this project;
- ***a series of online learning modules*** encompassing teaching and learning tools in a dynamic and easy-to-use format, for faculty and students in entry-level registered nursing, pharmacy, and social work programs.

CASN, AFPC, and CASWE-ACFTS acknowledge that although these interprofessional education guidelines are focused on opioid use and opioid use disorder, these are complex issues, and may be experienced along with other types of substance use, substance use disorder, trauma, stigma, and mental illness.

Methods

This comprehensive set of national, consensus-based interprofessional educational guidelines was developed using an evidence-informed, modified-Delphi approach. The project began with the creation of a Management Committee comprised of the three sponsoring organizations. Subsequently, a multidisciplinary, multistakeholder Advisory Committee of experts from across Canada was struck to guide the project. A subset of the Advisory Committee, an Education Working Group, was created, comprised of faculty from the three professions.

An environmental scan was conducted pertaining to the entry to practice competencies (knowledge, skills, and attitudes) required of registered nurses, pharmacists and social workers related to opioid use and opioid use disorder by Canadians, comprised of the following:

- Joanna Briggs Institute scoping review (peer review literature)
- grey literature review for existing profession specific or interprofessional resources, regulatory and/or educational competencies, as well as other relevant Canadian and international documents

- online survey of faculty
- online survey of persons using drugs/persons with lived experience

The results of these four activities were reviewed and synthesized to develop preliminary interprofessional education guidelines. The draft interprofessional education guidelines underwent a number of rounds of revisions by the Education Working Group and the Advisory Committee as a whole. Following these revisions, an in-person Stakeholder Engagement Forum was held in September 2019. The Forum was attended by a wide array of stakeholders from across Canada. The use of a world café format facilitated an in-depth review of each learning outcome and allowed the different voices in the room to be heard. The feedback provided was collated and reviewed by the Education Working Group, who revised the interprofessional educational guidelines based on this input from stakeholders.

The next step in the development process involved an online validation survey employing a snowball sampling method to obtain broad, multiprofessional, multistakeholder, pan-Canadian feedback. The Advisory Committee was invited to distribute the online validation survey to their members and networks. The survey was also sent to all nursing, pharmacy and social work entry-to-practice programs in Canada and to the Forum attendees. There were 490 responses to the survey, of which 25 were French. Respondents were asked to rate each learning outcome and indicator statement as one of the following: “essential,” “important,” “somewhat important,” “not important,” or to indicate if they did not know. Respondents were also given the opportunity to provide comments throughout the survey. Each learning outcome and indicator statement achieved over 88% overall on a combined “essential” and “important” ranking. Similar results emerged when the results were analyzed by profession. Given the level of agreement, the Management Committee met to review the comments and only minor revisions were made to the document based on respondents’ comments.

The interprofessional education guidelines then were analyzed using gender, race, and Indigenous lenses. These analyses were achieved through completion of a survey and/or telephone interview with experts in these areas, identified by the Advisory Committee. A review of this input was completed by the Education Working Group. Final approval for the interprofessional education guidelines was provided by the Management Committee and the Advisory Committee.

Key Considerations

- The respective scope of practice and jurisdictional standards of practice of registered nurses, pharmacists and social workers, will impact the depth of the learning related to some outcome indicators.
- An awareness, understanding, and respect for the role and scope of each other’s professions is foundational to these interprofessional education guidelines, and to the effective interprofessional management of opioid use and opioid use disorder.
- These learning outcomes were developed with the participation of representatives of a broad range of stakeholders including faculty, students, persons using drugs/persons with lived experience, professional regulatory bodies, professional associations, etc.
- A recognition of the intercultural reality of Canada and of the uniqueness of every individual underpins the guidelines.

- There is significant disproportionality in the prevalence of opioid-related harms in Canada and access to treatment. An understanding of age, racial, cultural, and sex/gender influences on opioid use and opioid use disorder demands critical analyses to address ongoing harms. An attempt has been made to bring such a lens to the learning outcomes in the guidelines. The need for ongoing enhancement of this, however, is recognized.
- An understanding of the differential impact of opioid use and opioid use disorder for racialized people and Indigenous Peoples is important in applying the guidelines' learning outcomes to curriculum development.
- The concepts of cultural humility, cultural safety and awareness, harm reduction, trauma- and violence-informed care, recovery, health equity, social, and structural determinants of health and intersectionality are prerequisite knowledge, and underpin all of these learning outcomes.
- The respectful acknowledgement of Indigenous Peoples and their respective territories, an understanding of their cultural strengths, and knowledge of the systemic historical and contemporary traumas unique to Indigenous Peoples, are crucial in working alongside Indigenous communities, families, and individuals.
- It is acknowledged that there are multiple ways of knowing: reason, sense perception, emotion, language, memory, intuition, faith, imagination (theoryofknowledge.net, n.d.), and Indigenous ways of knowing and being that see the whole person (physical, emotional, spiritual, and intellectual) as interconnected to land and in relation to others (family, communities, nations) (Cull, Hancock, McKeown, Pidgeon & Vedan, 2018).

Learning Outcomes

The document is organized into eight learning outcomes, each with associated indicators. A learning outcome “expresses the lasting changes that must arise in the learner during or following an educational experience” (Legendre, 2005). There are many benefits of well-defined learning outcomes. They clarify what must be learned in a course or program, offer direction for the selection of learning activities, and provide benchmarks for the assessment of learning. The learning outcomes identified in this document provide targets for graduates of entry-level baccalaureate nursing, pharmacy and social work programs related to opioid use and opioid use disorder across the prevention, health promotion, harm reduction, treatment, and recovery continuums at primary, secondary, and tertiary care levels.

In each of the learning outcome areas, seeking knowledge of factors that influence opioid use and affect treatment and support responses, is required. These factors include overall determinants of health such as sex and gender, and social and structural determinants of health such as racism. Researchers, practitioners, and people with lived/living experience may not yet have evidenced, identified, or voiced how these factors are in play. It is nonetheless important to search for, consider the impact of, and tailor responses to account for these factors in all educative and clinical work.

Learning Outcomes for Interprofessional Education on Opioid Use and Opioid Use Disorder

Learning Outcome 1

Demonstrate an understanding of the clinical and recreational use of opioids in Canada, and the impact of their use on the health and wellbeing of people in Canada.

Learning Outcome 2

Recognize the importance of a continuum of care, and know the available resources for people using opioids and opioid use disorder.

Learning Outcome 3

Demonstrate culturally safe/appropriate screening, assessment, intervention, structured follow-up, and support skills related to opioid use and opioid use disorder.

Learning Outcome 4

Establish a mutually trusting and therapeutic relationship with persons using opioids or persons with opioid use disorder, and their support networks.

Learning Outcome 5

Integrate trauma- and violence-informed practice and cultural safety principles in providing care or services to persons who use opioids or persons with opioid use disorder.

Learning Outcome 6

Educate persons, families, support persons, communities, decision makers, Elders, other health care and social service professionals, and the public regarding opioid use and opioid use disorder.

Learning Outcome 7

Explain pain and pain management, specific to opioid use and opioid use disorders.

Learning Outcome 8

Integrate knowledge of harm reduction in providing care or services to persons using opioids and persons with opioid use disorder.

Learning Outcome 1

Demonstrate an understanding of the clinical and recreational use of opioids in Canada, and the impact of their use on the health and wellbeing of people in Canada.

- a. Describe the epidemiology and consequences of opioid use and opioid use disorder in Canada;
- b. Summarize trends in the number of deaths and hospitalizations resulting from opioid use regionally and provincially/territorially across Canada in relation to age, gender, ethnicity, and culture, using evidence-informed sources;
- c. Describe the political, social, cultural, economic, and historical context that has contributed to the risks and harms related to opioids in Canada, including drug policies and the effects of stigma on opioid use;
- d. Describe the biological, cultural, spiritual, psychological, familial, environmental, and personal factors that can influence opioid use and the risk of opioid use disorder;
- e. Recognize there is no timeframe for the impact of various factors that can influence opioid use and the risk of opioid use disorder (e.g., impact of colonization, trauma);
- f. Identify risk factors for opioid poisoning and interventions to reduce the risk;
- g. Differentiate between the type and routes of administration of opioids being used clinically and recreationally in Canada;
- h. Describe the neuroscience of opioid use and opioid use disorder, recognizing that opioid use disorder is treatable and recovery is possible;
- i. Recognize the potential short- and long-term effects of opioid use and their impact on the person using opioids, significant others, family, community, and society;
- j. Describe the role of pharmacotherapies in reducing opioid-related harms, as well as emerging and evidence-informed treatments for opioid use disorder; and
- k. Recognize the person-specific and environmental factors that may influence the selection of a specific type of opioid agonist treatment for opioid use disorder.

Learning Outcome 2

Recognize the importance of a continuum of care, and know the available resources for people using opioids and opioid use disorder.

- a. Discuss the importance of assessing and responding to the needs of the person using opioids, their families, communities, and support networks;
- b. Identify how and why it is important to collaborate with persons using opioids, their families, and support networks, to determine the reasons for use, their goals (e.g., safer use, abstinence, opioid agonist therapy, obtaining specified outcomes), and the health care plan along their pathway;
- c. Collaborate with persons using opioids to formulate mutually agreed upon goals, and methods of monitoring progress and evaluating outcomes;
- d. Recognize potential barriers for persons using opioids to participate in their care including health literacy, cultural differences, language, logistics, stigma, self-stigma, lack of trust, and the intersectionalities among these, as well as potential facilitators;
- e. Listen, respect, and respond to the uniqueness of the individual's experience with opioid use and with the care plan;
- f. Recognize the importance and role of stepped care, in which the least intensive services are offered first, if appropriate;
- g. Describe the role of peer-engaged and peer-led services to establish trust and provide information and support for persons using opioids to sustain positive changes; and
- h. Recognize the multifactorial nature of opioid use, and the subsequent need for interprofessional and intersectoral collaboration throughout the continuum of care.

Learning Outcome 3

Demonstrate culturally safe/appropriate screening, assessment, intervention, structured follow-up, and support skills related to opioid use and opioid use disorder.

- a. Employ consistent screening procedures using appropriate and validated screening tools;
- b. Describe the importance of screening persons using opioids and persons with opioid use disorder for concurrent health conditions, and to identify available resources to support resilience;
- c. Demonstrate the ability to lead or collaborate in a multidimensional contextual assessment;
- d. Identify factors that may influence outcomes when conducting assessments related to opioid use, including physical and mental health challenges, stressors, criminalization, stigmatization, profiling, social determinants of health (e.g., housing, income, social support), and resources that support resilience;
- e. Incorporate the use of critical gender, race, and decolonial frameworks in screening, assessment, and intervention related to opioid use and opioid use disorder;
- f. Advocate for and collaborate to create low- or no-barrier spaces in which screening, assessment, and referrals can take place;
- g. Describe the role of supporting persons who use opioids for medical purposes to maximize benefit and minimize risk;
- h. Include an integrated intervention and supportive approach to meet the opioid use, physical and mental health, social and spiritual needs of the person; and
- i. Work collaboratively with other service providers across the continuum of care for persons using opioids and recognize when consultation and/or referral is necessary.

Learning Outcome 4

Establish a mutually trusting and therapeutic relationship with persons using opioids or persons with opioid use disorder, and their support networks.

- a. Describe the importance of reflecting on personal biases and assumptions as they relate to persons who are different from oneself, and in particular, those who use opioids;
- b. Demonstrate how to provide welcoming and culturally safe spaces when providing care or services to persons who use opioids;
- c. Develop mutually trusting relationships with persons using opioids;
- d. Employ an anti-stigma approach with persons using opioids that is gender and culturally informed, and advocate for non-stigmatizing behaviour;
- e. Recognize and incorporate cultural factors (e.g., fasting, sweat lodge) that affect opioid use, maintenance, abstinence, and relapse into the care plan;
- f. Help individuals identify supports in the community to make choices related to opioid use;
- g. Demonstrate knowledge of change and motivation theories (e.g., self-regulation theory, stages of change, theories of motivation), and of evidence-informed change strategies;
- h. Support persons to make informed decisions and set goals related to opioid use;
- i. Recognize barriers to receptiveness to treatment related to opioid use;
- j. Demonstrate skills to work with persons using opioids who are in a range of readiness states and receptiveness to treatment;
- k. Respect the stage, pace, and place of the person using opioids in the change process; and
- l. Recognize and promote strengths and resilience of the person using opioids.

Learning Outcome 5

Integrate trauma- and violence-informed practice and cultural safety principles in providing care or services to persons who use opioids or persons with opioid use disorder.

- a. Recognize multiple forms of trauma (e.g., physical, spiritual, emotional, sexual, mental/psychological, environmental, intergenerational);
- b. Describe the potential impact of past and current experiences of trauma, and social and structural violence on opioid use (e.g., colonialism, racism, sexual and sexual identity violence, gender bias, stigmatisation, interpersonal and intergenerational trauma);
- c. Recognize health inequities resulting from trauma and violence, marginalization and/or stigma that the person may have experienced and how systems (including health systems) can reinforce and/or reproduce these inequities;
- d. Apply an evidenced-informed awareness of the ongoing and potential health, emotional, behavioural, and relational impacts of trauma and violence including chronic pain, anger, dysfunctional coping strategies, and mental health issues;
- e. Provide welcoming processes, safe spaces, and culturally safe care to persons using opioids and those with opioid use disorder;
- f. Establish a relational connection when providing care or services to persons using opioids or experiencing an opioid use disorder;
- g. Provide care or services to persons using opioids or experiencing an opioid use disorder that support choice, voice, and empowerment;
- h. Provide opportunities to persons using opioids and with opioid use disorders that develop coping skills, promote resilience, and foster healing;
- i. Reflect on the position of power and privilege (cultural humility) of health care and social service professionals providing care or services to persons using opioids; and
- j. Collaborate interprofessionally and intersectorally in order for persons using opioids to receive ongoing support and treatment.

Learning Outcome 6

Educate persons, families, support persons, communities, decision makers, Elders, other health care and social service professionals, and the public regarding opioid use and opioid use disorder.

- a. Identify the spiritual, emotional, mental, and physical effects of opioids;
- b. Provide appropriate, relevant information to persons who are prescribed or using opioids, as well as to their families and significant others, including the purpose of the medication, how it is optimally used and its risks, benefits, consequences, and available community-specific harm reduction resources;
- c. Participate in the interprofessional development, implementation, and evaluation of public education, treatment, prevention, and health promotion programs related to opioid use;
- d. Educate persons, families, support persons, and communities on recognizing and responding to opioid harms including overdose, and on take-home naloxone;
- e. Challenge and eliminate stereotypes and harmful attitudes based in gender, sexual orientation, ability, race, culture, income, immigration, age, and stigma in health promotion and education materials about opioid use; and
- f. Engage in collaborative information-sharing with policy and decision makers to advocate for healthy public policy that is grounded in current evidence.

Learning Outcome 7

Explain pain and pain management, specific to opioid use and opioid use disorders.

- a. Compare different types of pain (e.g., acute, chronic, palliative, emotional, spiritual);
- b. Describe the pharmacological properties of opioids (e.g., how they interact with other medications, how they impact the person using them, how they can cause physical dependence and tolerance/withdrawal);
- c. Provide information on pharmacologic and non-pharmacologic management of pain to persons experiencing pain including the risks, benefits, and place in therapy of each alternative;
- d. Describe non-pharmacologic options to manage pain that help individuals relax, distract, or refocus such as acupuncture, Indigenous sweat lodge, massage therapy, and yoga;
- e. Recall the elements of a comprehensive and contextual person-centred pain assessment;
- f. Describe the impact of pain on the social, psychological, spiritual, and physical aspects of persons experiencing pain;
- g. Provide information to persons experiencing pain, their families, and other support persons regarding safe use, storage, and disposal of opioids;
- h. Describe the profession-specific and overlapping roles of the interprofessional team specific to pain management and identify opportunities for care collaboration; and
- i. Explore cultural considerations and approaches to pain and pain management with the person experiencing pain, such as the role of Indigenous ceremony and traditional healing.

Learning Outcome 8

Integrate knowledge of harm reduction in providing care or services to persons using opioids and persons with opioid use disorder.

- a. Describe how harm reduction fits with professional ethics and standards;
- b. Determine in collaboration with the person using opioids whether they are experiencing or are at risk of experiencing harm, and determine an appropriate course of action based on critical analysis;
- c. Describe harm reduction services (e.g., poverty reduction, supervised consumption services, needle distribution, pregnancy outreach, housing), and the role of health care and social service professionals in harm reduction services;
- d. Describe how to assess and manage overdose risks in consultation with person using opioids;
- e. Identify available emergency services and describe how to administer naloxone in response to an overdose; and
- f. Identify the signs and symptoms of withdrawal and describe appropriate action.

Glossary of Terms

Disclaimer: This glossary is a list of terms that are related to opioid use and opioid use disorder in the context of registered nursing, pharmacy and social work practice commonly used at the time of publication. It is not intended to provide an exhaustive list of terms related to opioid use and opioid use disorder.

Term	Definition
Bias	"...the negative evaluation of one group and its members relative to another" (Blair, Steiner & Havranek, 2011) .
Cultural humility	"...a process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience" (First Nations Health Authority, 2019a).
Cultural safety	An approach that moves beyond cultural sensitivity to explicitly address inequitable power relations, racism, discrimination, and ongoing impacts of historical and current inequities within health care encounters (Browne, Varcoe, Ford-Gilboe & Wathen, 2015).
Decolonial framework	"Decolonial approaches call for the examination of racism within educational, health care, justice and other systems, such as the lack of culturally appropriate curricula, racism among service providers, and links to residential school histories, as being related to low educational attainment, employment and health outcomes, and the impacts of these factors... In decolonial analyses, state systems are identified as the source of 'risk' rather than being inherent to Indigenous peoples" (Holmes & Hunt, 2017).
Evidence-informed	"The integration of the best research evidence with our clinical expertise and our patient's unique values and circumstances" (Stratus, Glasziou, Richardson & Haynes, 2011). In the Indigenous context, this includes Two-Eyed Seeing, which "considers the strengths of Western knowledge from one eye and Indigenous knowledge from the other, then bringing both eyes mindfully together for the benefit of all" (Bartlett, Marshall, Marshall & Iwama, 2015).
Gender informed	Sex-related factors (biology) affect how people respond to substances, and how fast they become intoxicated or dependent. Gender relations, norms and roles affect how people access and use substances, and gender identity and sexual orientation can affect patterns of use. A gender informed approach or a sex/gender informed approach considers these sex- and gender-related factors, and how they interact with equity issues when tailoring actions and policy for different groups of Canadians (Canadian Centre on Substance Use and Addiction, 2020).
Harm reduction	Harm reduction is a pragmatic and evidence-based approach that aims at reducing the potential harms associated with certain behaviours, contexts, and practices. It is a philosophy of care in which programs, policies and services are designed to meet the needs of individuals, groups, and communities in order to not only reduce harms but to promote health and safety, and prevent death and disability. Harm reduction is not limited to a physical space, a particular health problem or a specific population (Harm Reduction Nurses Association, 2019).
Health equity	The absence of avoidable or remediable differences in health among groups of people.
Health inequity	Unjust and avoidable differences in health between and within groups of people. For example, the health and wellbeing of Indigenous Peoples continues to lag behind that of the overall Canadian population on virtually every measure. This is not about <i>lifestyle</i> factors or the <i>culture</i> of a people, rather is reflects historical and ongoing constraints on the health and well-being of Indigenous Peoples.
Indigenous Peoples	The descendants of the original inhabitants of North America. Indigenous Peoples can be used to collectively describe three groups recognized in the Constitution Act, 1982: First Nations, Inuit, and Métis. These are separate peoples with unique histories, languages, cultural practices, spiritual beliefs, and political goals (Canadian Race Relations Foundations, 2015).

Interpersonal violence	"...violence between individuals, and is subdivided into family and community violence. Family violence includes child maltreatment; intimate partner violence; and elder abuse. Community violence includes acquaintance and stranger violence, youth violence; violence related to property crimes; and violence in workplaces and other institutions" (Health Canada, 2019).
Intersectionality	"...acknowledges the ways in which people's lives are shaped by their multiple and overlapping identities and social locations, which, together, can produce a unique and distinct experience for that individual or group, for example, creating additional barriers or opportunities. In the context of race, this means recognizing the ways in which peoples experiences of racism or privilege, including within any one racialized group, may differ and vary depending on the individual's or group's additional overlapping (or 'intersecting') social identities, such as ethnicity, Indigenous identification, experiences with colonialism, religion, gender, citizenship, socio-economic status or sexual orientation" (Government of Ontario, 2019).
Opioid Use Disorder	Defined in the <i>Diagnostic and Statistical Manual of Mental Disorders 5th Edition</i> (DSM-V) as "a problematic pattern of opioid use leading to clinically significant impairment or distress" (American Psychiatric Association, 2013). It was previously classified as Opioid Abuse or Opioid Dependence in DSM-IV.
Pharmacist	"Pharmacists are regarded as the medication management experts of the health care team and collaborate with patients, their families and other health care providers to benefit the health of Canadians. They are health care professionals who work in a variety of different settings, such as hospitals, community pharmacies, family health teams, the pharmaceutical industry, governments, associations, colleges and universities." "They deliver a range of innovative services, including medication reviews, chronic disease management, immunization services and wellness programs" (Canadian Pharmacists Association, 2019).
Racism	"...any individual action, or institutional practice which treats people differently because of their colour or ethnicity. This distinction is often used to justify discrimination" (Canadian Race Relations Foundations, 2015).
Registered Nurse (RN):	Registered Nurses "are self-regulated health-care professionals who work autonomously and in collaboration with others to enable individuals, families, groups, communities and populations to achieve their optimal levels of health. At all stages of life, in situations of health, illness, injury and disability, RNs deliver direct health-care services, coordinate care and support clients in managing their own health. RNs contribute to the health-care system through their leadership across a wide range of settings in practice, education, administration, research and policy" (Canadian Nurses Association, 2015).
Resilience	"...a dynamic process that enables an individual to develop, maintain, or regain their health and well-being despite experiences of significant adversity or trauma. Resilience is developed through a range of individual (i.e., psychological, biological) and environmental (i.e., social, political, and cultural) factors that can help people positively adapt to difficult life circumstances" (Health Canada, 2019).
Social Worker	"Social workers are regulated health professionals who work with individuals, families, groups and communities to enhance their individual and collective well-being. Social workers advocate for social justice, human rights, and equitable access to health and social services. They provide counselling, therapy and problem-solving interventions and help individuals gain access to information and resources (e.g., community support programs). In addition, they address broader social issues such as oppression, discrimination, domestic violence, unemployment and poverty" (Canadian Institute for Health Information, 2019).
Stigma	"...negative attitudes and beliefs about a group of people due to their circumstances in life. It includes discrimination, prejudice, judging, labeling, isolating and stereotyping" (Health Canada, 2019).
Systemic or structural violence	"...violence perpetrated against people through systems often as a result of widespread beliefs and socio-political systems, for example, ethnic-based genocide such as the Holocaust, the colonization of Indigenous peoples, or the normalization of gender-based sexual violence" (Government of Canada, 2018).
Systemic or structural racism	"...emerges when a dominant group is established and its power is reinforced through inequitable laws, policies, rules and regulations, as well as access to resources. Structural racism is perpetrated when policy makers and power brokers [re]produce or fail to redress structural inequities between racialized groups" (Reading, 2013).

Trauma	"...both the experience of, and a response to, an overwhelmingly negative event or series of events, such as interpersonal violence, personal loss, war or natural disaster. In the context of violence, trauma can be acute (resulting from a single event) or complex (resulting from repeated experiences of interpersonal and/or systemic violence)" (Government of Canada, 2018).
Trauma-informed care	"...seeks to create safety for clients/patients by understanding the effects of trauma, and its close links to health and behaviour. Unlike trauma-specific care, it is not about eliciting or treating people's trauma histories but about creating safe spaces that limit the potential for further harm for all people" (Varcoe, Wathen, Ford-Gilboe, Smye & Browne, 2016).
Trauma and violence-informed care (TVIC)	Recognizes the connections between violence, trauma, negative health outcomes and behaviours (Government of Canada, 2018). It expands on the concept of trauma-informed approaches to account for the broader systemic inequities that influence and contribute to interpersonal experiences of trauma and violence (Varcoe, Wathen, Ford-Gilboe, Smye & Browne, 2016).
Violence	The "intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation (Government of Canada, 2018).

References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.
- Bartlett, C., Marshall, M., Marshall, A., & Iwama, M. (2015). Integrative science and two-eyed seeing: Enriching the discussion framework for healthy communities. In L.K. Hallstrom, N. Guehlstorf, & M. Parkes (Eds.), *Ecosystems, society and health: Pathways through diversity, convergence and integration* (pp. 280-326). McGill-Queen's University Press.
- Blair, I. V., Steiner, J. F., & Havranek, E. P. (2011). Unconscious (implicit) bias and health disparities: where do we go from here?. *The Permanente journal*, 15(2), 71–78.
- Browne, A. J., Varcoe, C., Ford-Gilboe, M., Wathen, C. N., & EQUIP Research Team (2015). EQUIP Healthcare: An overview of a multi-component intervention to enhance equity-oriented care in primary health care settings. *International journal for equity in health*, 14, 152. <https://doi.org/10.1186/s12939-015-0271-y>
- Canadian Centre on Substance Use and Addiction. (2017). *Joint statement of action to address the opioid crisis: A collective response (annual report 2016-2017)*. <https://www.ccsa.ca/joint-statement-action-address-opioid-crisis-collective-response-annual-report-2016-2017>
- Canadian Centre on Substance Use and Addiction. (2020). *Sex, gender and equity analyses*. <https://www.ccsa.ca/sites/default/files/2020-01/CCSA-Sex-Gender-Equity-Analysis-Report-2020-en.pdf>
- Canadian Institute for Health Information. (2019). *About social workers*. <https://www.cihi.ca/en/social-workers>
- Canadian Nurses Association. (2015). *Framework for the practice of registered nurses in Canada*. https://www.cna-aic.ca/~/_media/cna/page-content/pdf-en/framework-for-the-practice-of-registered-nurses-in-canada.pdf?la=en
- Canadian Pharmacists Association. (2019). *What can pharmacists do in Canada?* <https://www.pharmacists.ca/pharmacy-in-canada/pharmacists-in-canada/>
- Canadian Race Relations Foundation. (2015). *CRRF glossary of terms*. <https://www.crrf-fcrr.ca/en/resources/glossary-a-terms-en-gb-1>
- Cull I., Hancock R.L.A., McKeown S., Pidgeon M., & Vedan A. (2018). Indigenous ways of knowing and being. In *Pulling together: A guide for front-Line staff, student services, and advisors*. Victoria, BC: BC Campus. <https://opentextbc.ca/>

- First Nations Health Authority. (2017). *Overdose data and First Nations in BC: Preliminary findings*. https://www.fnha.ca/AboutSite/NewsAndEventsSite/NewsSite/Documents/FNHA_OverdoseDataAndFirstNationsInBC_PreliminaryFindings_FinalWeb_July2017.pdf
- First Nations Health Authority. (2019). *First Nations opioid overdose deaths rise in 2018*. <https://www.fnha.ca/about/news-and-events/news/first-nations-opioid-overdose-deaths-rise-in-2018>
- First Nations Health Authority. (2019a). *Cultural humility*. <https://www.fnha.ca/wellness/cultural-humility>
- Government of Canada. (2018, February 2). *Trauma and violence-informed approaches to policy and practice*. <https://www.canada.ca/en/public-health/services/publications/health-risks-safety/trauma-violence-informed-approaches-policy-practice.html#s9>
- Government of Canada. (2018a, November 30). *Government of Canada actions on opioids: 2016 and 2017*. <https://www.canada.ca/en/health-canada/services/publications/healthy-living/actions-opioids-2016-2017.html>
- Government of Ontario. (2019, October 22). *A better way forward: Ontario's 3-year anti-racism strategic plan*. <https://www.ontario.ca/page/better-way-forward-ontarios-3-year-anti-racism-strategic-plan>
- Harm Reduction Nurses Association. (2019). *Position statement: Harm reduction education in baccalaureate nursing programs*. http://www.hrna-aiirm.ca/wp-content/uploads/2019/09/HRNA_PS_Baccalaureate_EN_190917.pdf
- Health Canada. (2019, February 6). *Stigma around substance use*. <https://www.canada.ca/en/health-canada/services/substance-use/problematic-prescription-drug-use/opioids/stigma.html>
- Holmes, C., & Hunt, S. (2017.) *Indigenous communities and family violence: Changing the conversation*. Prince George, BC: National Collaborating Centre for Aboriginal Health. <https://www.ccnsa-nccah.ca/docs/emerging/RPT-FamilyViolence-Holmes-Hunt-EN.pdf>
- Reading, C. (2013). *Understanding racism*. National Collaborating Centre for Aboriginal Health. http://www.nccah-ccnsa.ca/Publications/Lists/Publications/Attachments/103/understanding_racism_EN_web.pdf
- Richard, J-F. (2016). *Writing learning outcomes: Principles, considerations, and examples*. Fredericton, NB: Maritime Provinces Higher Education Commission. <http://www.mphec.ca/media/125744/Writing-Learning-Outcomes-Principles-Considerations-and-Examples-JF-Richard-EN.pdf>
- Special Advisory Committee on the Epidemic of Opioid Overdoses. (2019, December 11). *National report: Opioid-related harms in Canada web-based report*. <https://health-infobase.canada.ca/substance-related-harms/opioids>
- Special Advisory Committee on the Epidemic of Opioid Overdoses. (2019a). *Highlights from phase one of the national study on opioid- and other drug-related overdose deaths: insights from coroners and medical examiners*. <https://health-infobase.canada.ca/substance-related-harms/opioids>
- Straus S.E., Glasziou P., Richardson W.S., & Haynes R.B. (2011). *Evidence-based medicine: how to practice and teach it* (4th ed.). Churchill Livingstone Elsevier.
- theoryofknowledge.net. (n.d.). Ways of knowing. <https://www.theoryofknowledge.net/ways-of-knowing/>
- Varcoe, C.M., Wathen, CN, Ford-Gilboe, M, Smye, V, Browne, A. (2016). *VEGA briefing note on trauma- and violence-informed care*. VEGA Project and PreVAiL Research Network. <https://vegaproject.mcmaster.ca/docs/default-source/pdf/VEGA-TVIC-Briefing-Note-2016.pdf>



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