Renfrew County & District
Drug Strategy

Phase 1: A Focus on Opioids

April 2025

Land Acknowledgement

We wish to acknowledge that the drug strategy was developed on the unceded territory of the Algonquin Anishinaabe People.

We honour the land and peoples of the Algonquin Anishinaabe, whose ancestors have lived in this territory since time immemorial, and whose culture and presence have nurtured and continue to nurture this land.

We honour all First Nations, Inuit and Metis peoples, their elders, their ancestors and their valuable past and present contributions to this land.

Dedication

The Renfrew County and District Drug Strategy (RCDDS) is dedicated to the members of our communities who we have lost due to the harmful effects of substances. It's also dedicated to their families, friends and to the first responders, health care agencies, social services, public health and other providers working so passionately and tirelessly in the fields of substance use prevention, treatment, harm reduction, and community safety.

Table of Contents

Message from the Renfrew County and District Drug Strategy Co-Chairs

The 25 priorities for action and associated implementation recommendations that make up the Renfrew County and District Drug Strategy: A Focus on Opioids, were methodically designed to provide an organized and thoughtful local response to opioids.

This comprehensive and evidence-based strategy provides a roadmap for how partnering organizations and the community can act collectively to urgently address substance use.

The dedication and collaboration of all members of the steering committee and pillar working groups must be recognized for their instrumental role in shaping this strategy. I encourage the continued cooperation and meaningful dialogue between partners and the community as we work together on the implementation of this strategy.

I am pleased to share with you the Renfrew County and District Drug Strategy, Phase 1: A Focus on Opioids.

Substance use harms present an urgent public health issue, and one that requires a collaborative multi-sectoral response to reduce harms and improve health and well-being for all of society.

This evidence-based strategy applies a person-centred, non-stigmatizing approach based on the pillars of prevention, treatment, harm reduction, and community safety.

I would like to express my appreciation to all the Renfrew County and District partners, and particularly people with lived and living experience, who have contributed their expertise in developing this strategy and continue to work so diligently to address substance use and harms.

Jama Watt
Strategic Implementation Lead
Ottawa Valley Ontario Health Team

Dr. Jason Morgenstern
Medical Officer or Health
Renfrew County and District Health Unit

Acknowledgements

The Renfrew County and District Drug Strategy would not be possible without the collaboration between communities, municipal and provincial governments, health and social services, people with lived and living experience and residents. We express sincere gratitude to the organizations listed below who participated in the steering committee by providing their expertise and guidance to shape this strategy.

Addiction Treatment Services
Algonquins of Pikwàkanagàn
City of Pembroke
County of Renfrew, Community Services
County of Renfrew, Paramedics
Harvest House
Mackay Manor
Ontario Addiction Treatment Centre
Ottawa West Four Rivers Health Team
Ottawa Valley Ontario Health Team
Pathways Alcohol and Drug Treatment Services
Pembroke Regional Hospital
Phoenix Centre for Children and Families
Renfrew County and District Health Unit
Renfrew County Catholic District School Board
Renfrew County District School Board
Renfrew County Youth Wellness Hub
The Grind
The Town of Laurentian Hills (County of Renfrew County Council Representative)
Township of Admaston Bromley (County of Renfrew County Council Representative)
Township of South Algonquin
Upper Ottawa Valley OPP

Executive Summary

In recent years Renfrew County and District (RCD), like many areas of the province and the country has been experiencing an unprecedented rate of overdose deaths, emergency department visits and other harms related to the contaminated and highly unpredictable illegal drug supply. The overdose crisis is incredibly complex, making it an issue that one organization or sector cannot solve on its own. As a strategic and intersectoral response to this challenge, more than 30 RCD organizations, community members and leaders have united to dedicate their time, energy, and expertise to develop, implement and evaluate an evidence-based strategy to reduce substance use harms.

The Renfrew County and District Drug Strategy (RCDDS) recommends **25** priorities, **5** at the strategy level and **20** across the four pillars of prevention, treatment, harm reduction, and community safety.

Renfrew County and District Drug Strategy Priorities

- Increase services and support in the client's language of choice
- Reduce stigma for people who use substances
- Provide culturally safe and appropriate services and care for Indigenous people and people from equity-deserving groups
- Increase communication across all pillars of the strategy
- Conduct ongoing surveillance and monitoring

Prevention Priorities

- Improve early and equitable access to screening, assessment, diagnoses and pathways to care
- Re-envision services that are family-centered, focusing on building trust and improving family engagement
- Expand and integrate the community-based approach for youth care and intensive case management including mobile crisis response services
- Recognize adult mental health and access to care as integral to child and youth well-being
- Build a comprehensive, collaborative, interdisciplinary community approach to focus on meeting the needs of families, children and youth

Treatment Priorities

Increase and expand existing high demand outpatient services

Explore possibility of establishing medical withdrawal management and stabilization beds in Renfrew County

Increase short and long-term housing including availability and breadth of integrated services for people who use opioids

Identify and reduce barriers to access MHASUH treatment and services

Decrease stigma with training for health care partners and embedding peer support

Harm Reduction Priorities

Implement remote spotting services

Implement drug checking services

Centralize and automate drug toxicity alerts

Increase naloxone distribution

Determine feasibility of an Urgent Public Health Needs site

Maintain the Renfrew County and District Drug Toxicity Response Plan

Community Safety Priorities

Implement a comprehensive complaint reporting mechanism

Foster social order

Ensure the safe disposal of substance use supplies

Integrate enforcement by balancing proactive and reactive measures

Vision

Renfrew County and District is a community that is compassionate and inclusive that works collaboratively to reduce and eliminate the harms associated with substance use, which will improve the safety, health, and well-being of all individuals.

Mission

Develop, implement and evaluate an evidence-based comprehensive drug strategy to reduce substance use and harm using a person centred, non-stigmatizing and equity focused approach based on the pillars of prevention, harm reduction, treatment, and community safety.

Guiding Principles

1. Respects the autonomy and right to self-determination of people who use substances.
2. Approaches substance use through a health and human rights framework, not a criminal justice framework, while acknowledging the historic and current harms of drug policy.
3. Recognizes and collaborates with lived and living experience of substance use as experts and fairly compensates them for their work.
4. Supports the underlying determinants of and addresses health inequities.
5. Works to protect and promote the freedom, health, wellness, and safety of people who use substances.
6. Is collaborative and comprehensive and ensures a continuum of programs and services are available to meet most people where they are at.
7. Is trauma and violence-informed, gender transformative, anti-racist, anti-oppressive and culturally safe.
8. Works to end stigma and discrimination.
9. Is pragmatic and evidence informed.

Source: Framework for a Public Health Approach to Substance Use. Canadian Public Health Association, January 2024

Measuring Substance Use Harms in Renfrew County and District

Like many communities across Ontario and Canada, Renfrew County and District (RCD) residents are experiencing significant harms related to substance use. Confirmed opioid toxicity deaths have continued to rise in RCD since 2019, reaching 25 in 2023, which is the highest ever recorded locally. Overall suspect drug related deaths also reached their highest level locally in 2023, at 41 deaths. Suspect drug related deaths are higher than confirmed opioid toxicity deaths, as they are related to preliminary investigations, may include deaths from drugs other than opioids, and are reported more rapidly. See Renfrew County and District Health Unit's Substance Use-Related Harms Dashboard for more information.

Mortality

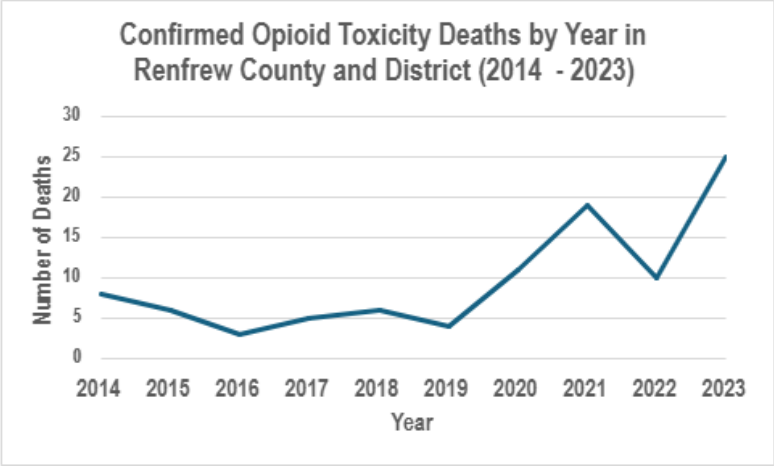


Figure 1: Opioid Toxicity Deaths by Year in Renfrew County and District
Source: Office of Chief Coroner (OCC) - Data effective January 21, 2025

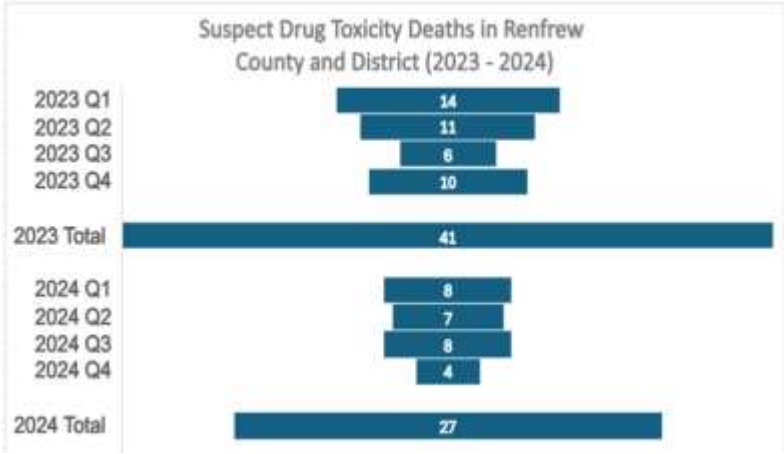


Figure 2: Suspect Toxicity Deaths in Renfrew County and District by Quarter (2023-2024)
Source: Office of Chief Coroner (OCC) - Data effective January 21, 2025

Mortality by Sex

There are considerable differences in drug-toxicity deaths between men and women. In 2023 and 2024, approximately 4 in 5 deaths were male.

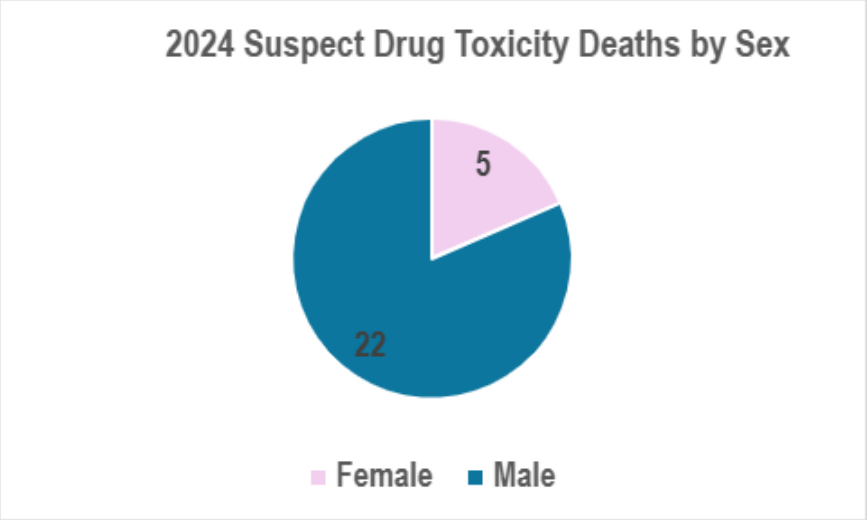


Figure 3: 2024 Suspect Drug Toxicity Deaths in Renfrew County and District by Sex
Source: Office of Chief Coroner (OCC) - Data effective January 21, 2025

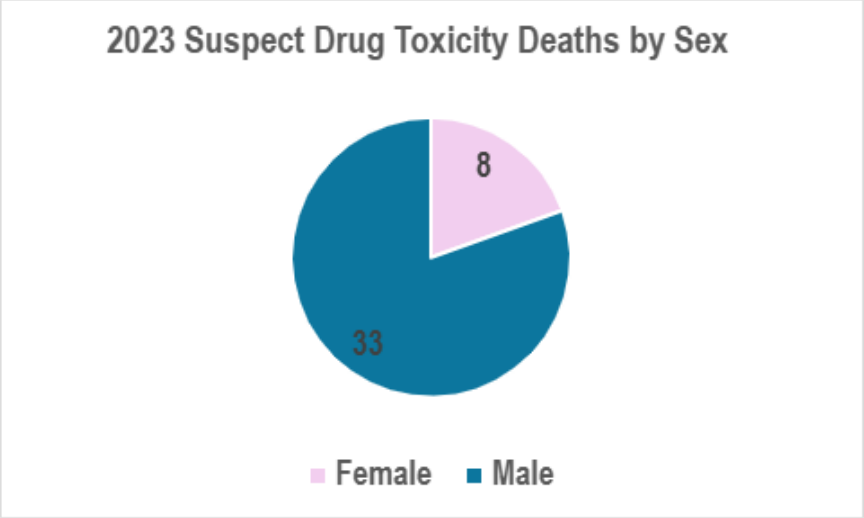


Figure 4: 2023 Suspect Drug Toxicity Deaths in Renfrew County and District by Sex
Source: Office of Chief Coroner (OCC) - Data effective January 21, 2025

Mortality by Age

When age is considered, more than half of deaths occur in the 30-59 age group. It is important to note that there were not any suspect drug toxicity deaths among people younger than 20 years of age in both 2023 and 2024.

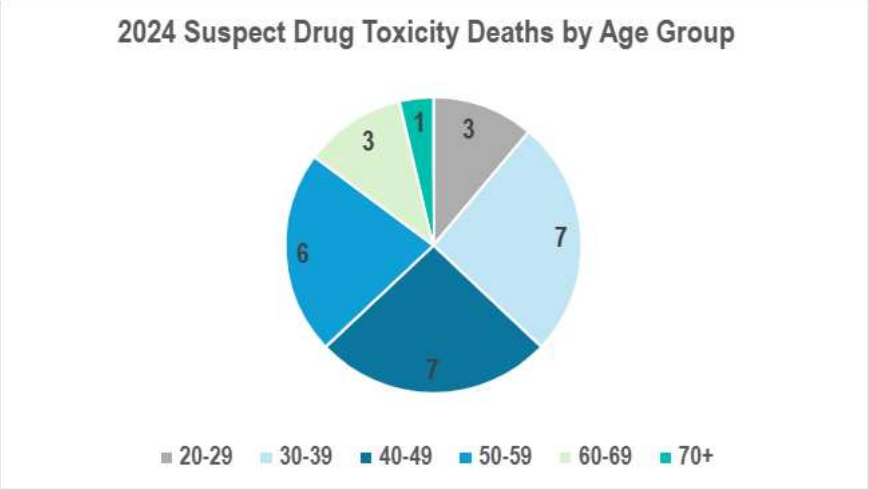


Figure 5: 2024 Suspect Drug Toxicity Deaths in Renfrew County and District by Age Group
Source: Office of Chief Coroner (OCC) - Data effective January 21, 2025

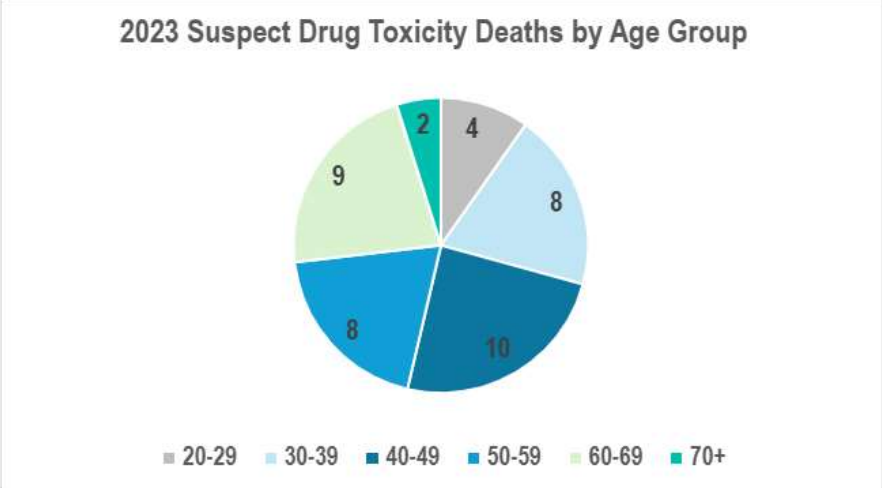


Figure 6: 2023 Suspect Drug Toxicity Deaths in Renfrew County and District by Age Group
Source: Office of Chief Coroner (OCC) - Data effective January 21, 2025

Mortality by Postal Code

In both 2023 and 2024, the greatest number of Suspect Drug Toxicity Deaths occurred in the K8A postal code area of RCD. However, a significant decrease of 50 percent can be seen in the most recent year. There is less change in the number of deaths from 2023 to 2024 in other geographical areas.

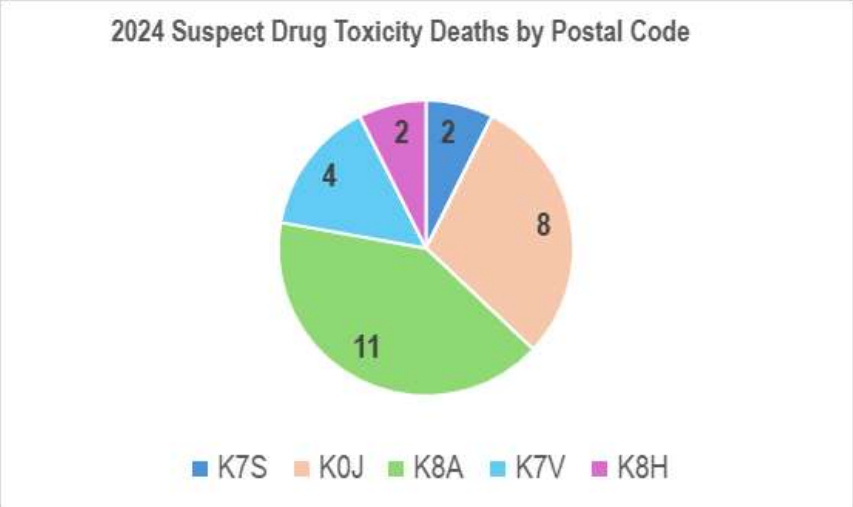


Figure 7: 2024 Suspect Drug Toxicity Deaths in Renfrew County and District by Postal Code
Source: Office of Chief Coroner (OCC) - Data effective January 21, 2025

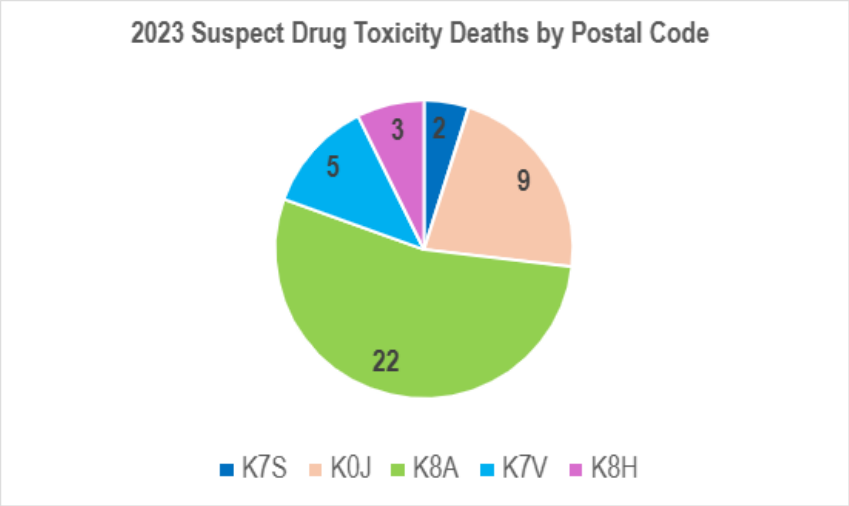


Figure 8: 2023 Suspect Drug Toxicity Deaths in Renfrew County and District by Postal Code
Source: Office of Chief Coroner (OCC) - Data effective January 21, 2025

Emergency Department Visits

There is quarter-to-quarter variability in opioid-related emergency department (ED) visits, as seen in Figure 9. There were approximately 70 ED visits to local hospitals in 2023. This is 1.5-2 times higher than the annual number of visits observed in 2018-2019. In 2024 the number of ED visits continued to increase to a total of 78. Figure 9 shows the reduction in ED visits that was experienced in the second half of 2024.

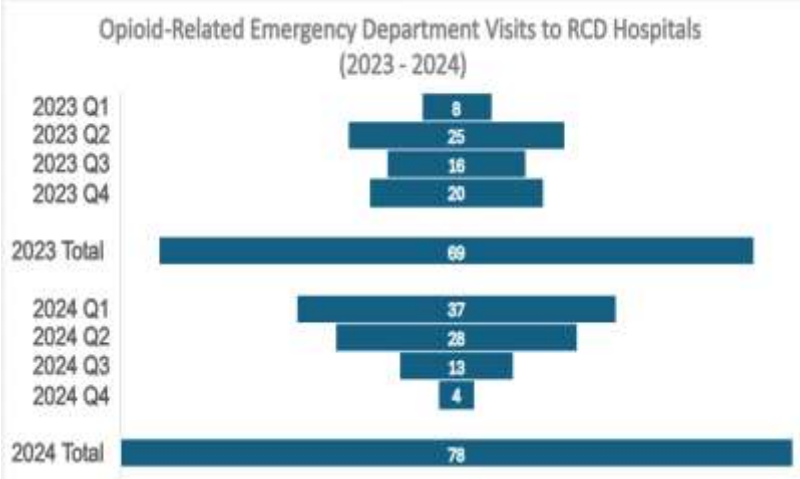


Figure 9: Opioid-Related Emergency Department Visits to Renfrew County and District Hospitals
Source: National Ambulatory Care Reporting System (NACRS), Canadian Institute for Health (CIHI)
Data Effective January 6, 2025

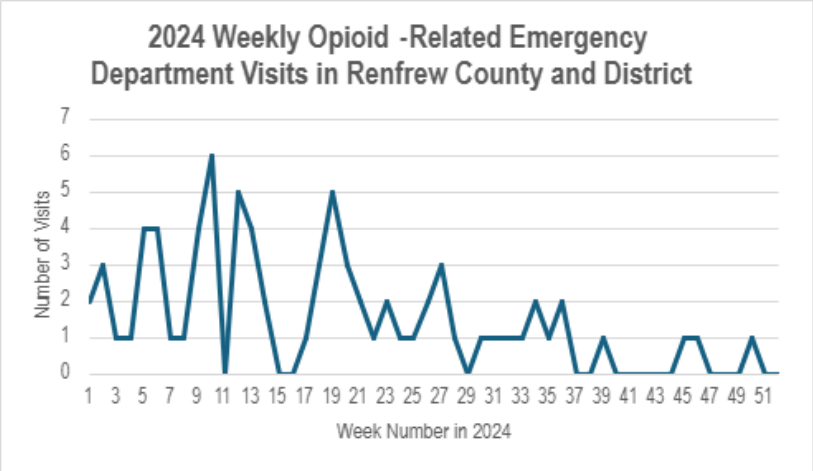


Figure 10: 2024 Weekly Opioid-Related Emergency Department Visits to Renfrew County and District Hospitals
Source: National Ambulatory Care Reporting System (NACRS), Canadian Institute for Health (CIHI)
Data Effective January 6, 2025

Four Pillar Strategy

The Canadian Drugs and Substances Strategy uses public health principles to take a comprehensive approach to substance use across four pillars. The integrated pillars of prevention, treatment, harm reduction, and community safety address the societal issues associated with substance use. The collaborative approach includes foundational principles of trauma-informed care, anti-stigma, anti-oppression, and is inclusive of evidence-based methods and health equity.

Prevention

Initiatives aimed at reducing risk factors for substance use harm across the lifespan, particularly those related to adverse childhood experiences, social determinants of health, and social inequity; while increasing protective factors that promote child and youth development, family well-being, and community connection.

Harm Reduction

Programs that mitigate the negative health and social impacts associated with drug use.

Treatment

Accessible and effective treatment options for those struggling with addiction and substance use disorders.

Community Safety

Efforts to reduce drug-related crime and community harm while supporting individuals in need of treatment and recovery services.

Implementation Recommendations

Prevention Priority 1

Improve **early and equitable access to screening, assessment and diagnoses, and pathways to care** for child and youth mental health, substance use health and neurodevelopment.

- Working with local and regional partners, including 1Call1Click, Children's Hospital of Eastern Ontario (CHEO) and Kids Come First, **review and improve equity informed pathways to screening, assessment, diagnostics and services.**
- Support RCD primary care providers to **increase and expand local capacity for child and youth mental health and neurodevelopmental screening, assessment and diagnostic services with training, consultation and exploration of opportunities to co-deliver services.**
    - **Explore role of nurse practitioners to meet need**
- **Explore common practices for screening, assessment and care coordination for mental health, addictions, substance use health and neurodevelopmental needs.**
    - **Ensure youth receive the appropriate diagnoses to access the care and services they need through transitions,** such as dual diagnoses critical to continuity of funded services from youth to adulthood.
- Review and advocate for the **removal of barriers to equitable access to care and services due to unnecessary diagnostic or referral requirements.**
    - **Improve clear communication for public on where to access services and support.**

Prevention Priority 2

Re-envision services that are family-centred, focusing on building trust and improving family engagement with the supports and services that matter most to them.

- With coordinated access as a foundation, **explore a one-team, multi-disciplinary family-driven approach to wrap-around complex care delivery for children, youth and adult family members.**
    - Increase **consent to share information, assign cross service case management, co-develop care plans and consult regularly**.

- Leverage the **role of schools to build on established relationships with families.**
- **More effectively promote and offer existing family-centred services,** such as the Strengthening Families Program.
- **Invest in building the capacity of local providers** to meet increasing level of need with shared training opportunities and professional development.

Prevention Priority 3

Expand and integrate the community-based approach for youth care coordination and intensive case management including mobile crisis response services to better reach and support young people with complex needs.

- **Review, expand and optimize community-based, mobile response services** including Renfrew County Youth Wellness Hub Ontario (RCYWHO), Mesa, school-based partnerships, Pembroke Regional Hospital Mental Health Services of Renfrew County (PRH-MHSRC), **for outreach and connection to services for youth and adults with children**.
  - **Review case studies** to determine the gaps in service and opportunities for improvement in interventions.
  - Seek funding and partnerships to **expand intensive youth mental health case management**.
  - Adopt a **community-based approach to reach youth where they are.**
  - **Improve coordination of care and navigation of all health and social services**.
    - Leverage **RCYWHO navigation, care coordination and integrated pathways** to wrap-around services and care.
    - Leverage **Coordinated Access to triage and quickly mobilize integrated services** with comprehensive, individualized care plans for the highest need youth and families.
  - Meet the needs of youth experiencing homelessness or who are vulnerably housed with **youth crisis-beds** and coordinated, wrap around services.

Prevention Priority 4

Recognize adult mental health and access to care as integral to child and youth wellbeing, development and long-term health outcomes.

- **Adopt common practices to identify family needs, including mental health needs of parents and caregivers, and connect family members to their own care and services.**
  - **Review case studies** to determine the gaps in service and opportunities for improvement in interventions.

    - **Review, scale and scope successful initiatives identifying and connecting parents** to Mental Health, Addictions and Substance Use Health (Mental Health, Addictions and Substance Use Health) and social services.
    - Support primary care providers in **adoption of best practice pain management, opioid dispensing,** and to **increase and expand local capacity for adult mental health screening, assessment, diagnostic and referral services.**
- **Explore more coordination and integration** of mental health services.
    - Based on need and client choice, **offer coordinated family-centred care** and/ or **parallel child/youth and adult services.**
    - Support child, youth and family workers with **resources, pathways and connections to adult mental health care and social services.**

Prevention Priority 5

Build a comprehensive, collaborative, interdisciplinary community approach to focus on meeting the needs of families, children and youth that includes health, safety, housing, food security, opportunities, sense of belonging, community and purpose.

- Improve **equitable access to after-school programs and extra-curricular activities** for all children, youth and families in Renfrew County.
    - **Build and maintain spaces for children and youth to connect**, play sports and engage in other meaningful activities, both organized and informal.
        - **Seek and distribute funding to remove equity barriers such as fees and transportation barriers for child and youth sports and other activities.**
        - **With a youth and family-led approach, improve communications strategies with parents and youth to increase participation.**
    - **Create and promote volunteer opportunities** with local organizations that support and include children, youth, and families, foster positive community connections, and promote harm reduction and treatment efforts.
- **Explore implementation of a broad community-based strategy for prevention,** such as the Icelandic model.
- **Investigate local implementation of the Nurse-Family Partnership**, a program with a strong evidence base that reduces risk factors for substance use.
- **Increase awareness, education and health promotion related to wellness, mental health, addictions and substance use health,** such as drug and alcohol education for youth and for pregnant and parenting adults.

Implementation Recommendations

Treatment Priority 1

Increase and expand existing high demand outpatient services currently exceeding service capacity.

- **Collaboratively seek, plan and allocate resources to meet local need for Mental Health, Addictions and Substance Use Health by** considering the full complement of community services within the continuum of care.
- Continue to **advocate for additional funding** for Mental Health, Addictions and Substance Use Health services.
- Adopt and adapt **innovative provider recruitment and retention strategies** and minimize staff vacancies.
- **Adopt a data-driven, system level approach** to planning and allocating new and available resources.
- Optimize and integrate **mobile outreach services**.
- **Coordinate case-management across the continuum** of services to support continuity in care.
    - **Increase coordination and offer of wrap around services,** including Opioid Agonist Treatment (OAT).
    - **Explore opportunities to improve flexible & responsive access throughout the continuum of care** to meet individual needs and re-entry/ engagement following recurrence (relapse).
    - **Explore opportunities to improve care transition processes** that better support continuity and mitigate risk of disengagement.

Treatment Priority 2

Explore the possibility of establishing **medical withdrawal management** and stabilization beds in RCD.

- **Seek funding and share resources to collaboratively build and deliver bed-based medical and non-medical withdrawal management and stabilization services.**
    - **Collaboratively co-deliver bed-based services with comprehensive wrap around care** in a hub and spoke model.
    - **Develop a sustainability plan for ongoing** local supportive/relapse prevention housing beds, medical withdrawal beds and supportive bridge housing spaces.

Treatment Priority 3

Continue to increase **short and long-term supportive housing** including availability and breadth of associated integrated services and specific services for people who use opioids.

- Regional partners **seek funding and share resources to collaboratively build and deliver more supportive housing**.
    - **Collaboratively co-deliver supportive housing services** including holistic, wrap around care and case management.
    - **Include opioid specific treatment** in current and future supportive housing services.
- Continue to **advocate for additional funding for supportive housing**.

Treatment Priority 4

Continue to **identify and reduce barriers to access Mental Health Addictions and Substance Use Health treatment and services**.

- **Commit to continuing to identify and breaking down barriers to treatment and services.**
    - **Embed Indigenous specific care navigation and coordination with Indigenous specific services** throughout Mental Health, Addictions and Substance Use Health care**.**
    - Regional partners, including childcare providers and Family and Children's Services, develop and implement a plan **to coordinate childcare options with Mental Health, Addictions and Substance Use Health services.**
    - **Explore opportunities to optimize fee for service options with advocacy or other avenues to improve equity.**
- Develop a **communications and navigation strategy** to ensure clients and providers have current information on services, including inclusion/ exclusion criteria.
- **Identify, scope, and scale successful one-team approach to share and integrate care plans** among care and service providers.
- Improve **equitable access with flexible transportation**.
    - Develop a plan to **contract transportation services to and from local Mental Health, Addictions and Substance Use Health services.**
    - Explore possibility of hiring **peer support** drivers as part of transportation plan.

Treatment Priority 5

Decrease stigma with training and support for health care providers in addiction treatment, trauma informed and culturally safe practices, and by expanding and **embedding peer support** throughout the continuum of services.

- Offer cross-training to all health and social service providers in **anti-stigma, trauma informed care, privacy and confidentiality, Equity Diversity, Inclusion and Anti-Racism, addictions and substance use health, and Indigenous cultural safety and history.**
    - **Implement coaching and communities of practice** to support ongoing, required professional development and quality improvement.
- Offer and promote **training in Opioid Agonist Treatment for primary care and Emergency Department staff.**
- **Seek funding and share resources to increase and expand peer support and Indigenous specific service navigation, care coordination and culturally relevant services.**
- Identify, scope, and scale successful **peer support delivery models and consultation**.

Implementation Recommendations

Harm Reduction Priority 1

Implement **Remote Spotting** Services

- Endorse and promote the use of the **National Overdose Response Service** (NORS). The virtual safe consumption service is available for all Canadians 24 hours a day, 365 days a year.
- Collaborate with partners to **identify and promote other spotting services,** such as cell phone applications that are operable in RCD.

Harm Reduction Priority 2

Implement **Drug Checking**

- Pilot the **distribution and training** of Renfrew County and District Health Unit (RCDHU) Harm Reduction Program clients with **drug test strips** to detect the presence of fentanyl, xylazine and benzodiazepine.
    - **Collect input from clients** who used the test strips to determine their effectiveness, ease of use, and the likelihood of the results **changing their behaviour related to substance use**.
- Participate in the **Ontario Drug Checking Community of Practice** to monitor trends in the composition of the unregulated drug supply as determined through testing conducted by the Toronto Drug Checking Service.
- Explore the **possibility of providing a drug checking service** that uses a model and technology that can collect local statistics on the drug supply for sharing with people who use drugs and community partners.

Harm Reduction Priority 3

Centralize and **Automate** Drug Toxicity Alerts

- Identify a **web-based system to provide drug toxicity and health alerts**.
    - It must provide a free, real-time text messaging service for anyone to receive alerts about toxic drugs in their community.
- Continue to **share drug toxicity alerts** with local media, on social media channels, and with partners to ensure timely and widespread communication reaches PWUD.

Harm Reduction Priority 4

Increase **Naloxone** Distribution

- **Recruit, train and onboard additional partners** to the Ontario Naloxone Program.
- Promote the **effectiveness of Naloxone** in temporarily reversing opioid overdoses to the community, clients, and partners.
- Ensure maximum **geographic and demographic access** to Naloxone through mobile outreach programs.

Harm Reduction Priority 5

Determine Feasibility of an **Urgent Public Health Needs Site**

- Consult with Health Canada and the Ontario Minister of Health regarding a **subsection 56(1) class exemption from the *Controlled Drugs and Substances Act*** in relation to urgent public health needs site.
- Engage with community members and partners to **identify the most appropriate location** for an Urgent Public Health Needs Site should the need arise.

Harm Reduction Priority 6

Maintain the **Drug Toxicity Response** Plan

- Meet quarterly and more frequently, if necessary, with the partners of the RCD **Drug Toxicity Response Plan** to share information regarding suspect opioid-related deaths, opioid overdose emergency department visits, and/or the presence of high-potency or contaminated opioid formulations in the community.
- Complete **daily surveillance** of the RCDHU Suspect Overdose and Drug Toxicity reports.
- Complete **weekly surveillance** of the reports received from the Office of Chief Coroner of Ontario related to emergency department visits for opioid overdose and suspect, probable, and confirmed deaths.

Implementation Recommendations

Community Safety Priority 1

Implement a comprehensive complaint reporting mechanism by providing the community with a clear, accessible system to report safety concerns.

- Extend the capabilities of the City of Pembroke's **AccessE11, Citizen Issue and Relationship Management** platform to collect and action community safety-related reports from residents.
- Collect, analyze, and report **community safety data** to identify trends that can be proactively addressed.

Community Safety Priority 2

Promote a cohesive and inclusive community by addressing the factors that impact safety while **fostering social order** that values respect, belonging and accessibility for all.

- Implement a **"Good Neighbour Contract Program"** that outlines expectations related to environmental, operational, and procedural standards to mitigate any potential negative impacts on the neighbourhood.
- Collect data with AccessE11and from partners to **identify recurring patterns** to uncover gaps and inform areas for improvement.
- Explore the possibility of implementing a **peer delivered program** that offers assertive outreach to increase access to health promotion services among high-risk, isolated people who use drugs.
    - Use the peer-led program to reinforce the social order norms and expectations of the Good Neighbour Contracts.

Community Safety Priority 3

Ensure the safe disposal of substance use supplies by expanding education and training and supporting harm reduction through increased awareness.

- Provide opportunities for **education and training regarding the safe handling and disposal of substance use supplies** to municipal staff, business owners and staff, community members, and people who use drugs.
- **Increase opportunities** for the **safe disposal** of substance use supplies by providing additional options and locations for return and disposal.

Community Safety Priority 4

Integrate **enforcement** by balancing proactive and reactive measures, utilizing data and feedback, and ensure effective, adaptive responses to substance use related challenges.

- **Coordinate the efforts** of the Ontario Provincial Police (OPP), bylaw enforcement, and other partners such as Mobile Crisis Response Teams and Mesa **to respond to complex situations where drug use is involved**.
- Review by-laws to identify **opportunities to align with and support enforcement** efforts.
- Support **proactive public and policing measures** such as the Community Watch Program and CamSafe.
- Collect, analyze, and disseminate **data from local enforcement agencies to assess the effectiveness** and influence on community safety.

Prevention Report

Background

The prevention pillar of a community drug strategy prioritizes initiatives aimed at reducing risk factors for substance use harms across the lifespan and increasing protective factors. Risk factors commonly include adverse childhood experiences (ACEs), social determinants of health, and social inequity.[1] Protective factors promote child and youth development, family and individual well-being, and community connection. Access and early interventions for children, youth and families to services and health care, including mental health care, are central to a long-term community strategy to prevent and mitigate lifelong harms that can result from problematic substance use. In addition to a focus on children, youth and families, prevention can happen at any age, for example access to best practice pain management following injury or illness. A comprehensive prevention plan reflects the intersection of risk and protective factors, mitigating risk when possible but recognizing that protective strengths significantly improve outcomes when people do live with or survive adversity.[2]

Prevention of harm related to substance use informed by a socioecological model, recognizes the complex interactions of individual, family, community and societal factors that increase or decrease risk. Furthermore, prevention may be framed within three levels:

1. primary prevention, to prevent a condition from occurring.
2. secondary prevention, for early identification and intervention; and,
3. tertiary prevention, to mitigate harm, promote recovery, prevent recurrence and support long-term well-being.[3]

A public health approach to prevention incorporates many of these aspects, considering the social determinants of health and focusing on interventions with the greatest population level benefit and reduction of health inequities. Some additional examples of the public health approach may include lower-risk guidelines and warnings to promote informed individual decision making and regulation to delay and restrict age of use and exposure.[4]

Lastly, the earlier the intervention, the better the outcomes. A comprehensive prevention plan should address both the long-term, sustainable opportunities to prevent risk and harm from occurring and improve the protective care, services and interventions for individuals, families and communities who are already at risk. The Public

Health Agency of Canada (PHAC) advises that "**[i]ntervening early to counteract the risk factors** of problematic use offers the best chance of having a positive influence on a young person's development and reducing long-term harms to them and to society as a whole."[4]

Local Prevention Context

Children, youth and families in RCD are supported by natural and professional support systems working to promote healthy communities, families and individual development. These supports work across the continuum of need, from health promotion and development beginning with communities, Renfrew County District Health Unit, schools and community-based organizations, such as The Boys and Girls Club, to health care providers mitigating risk with provision of services when needed, such as Pembroke Regional Hospital, Mental Health Services Renfrew County, Phoenix Centre, Renfrew County Youth Wellness Hub Ontario, Family and Children Services, and Developmental Services, Robbie Dean Centre and family health teams and community health centres across RCD. To best meet the needs of the community, health and service providers work towards more collaborative and innovative approaches.

Right Time, Right Care

Regional child and youth care providers and school boards are working collaboratively to implement the 'Right Time, Right Care' strategy developed by School Mental Health Ontario, the Knowledge Institute on Child and Youth Mental Health and Addictions, Lead Agency Consortium, Youth Wellness Hubs Ontario and Children's Mental Health Ontario. Right Time, Right Care envisions schools and community-based child and youth mental health and addiction organizations providing 'the right service, at the right time, in the right modality and in the right place to meet the unique needs of each child and young person.'[5] Aligned with this effort, regional partners are working to clarify roles and responsibilities, build better and clearer pathways to care, and jointly monitor outcomes.

In alignment with the Right Time, Right Care implementation in the 2024/25 school year, School Mental Health Ontario is supporting school boards, including RCD, with common training on Mental Health, Addictions and Substance Use Health screening and assessment, prevention and brief intervention.

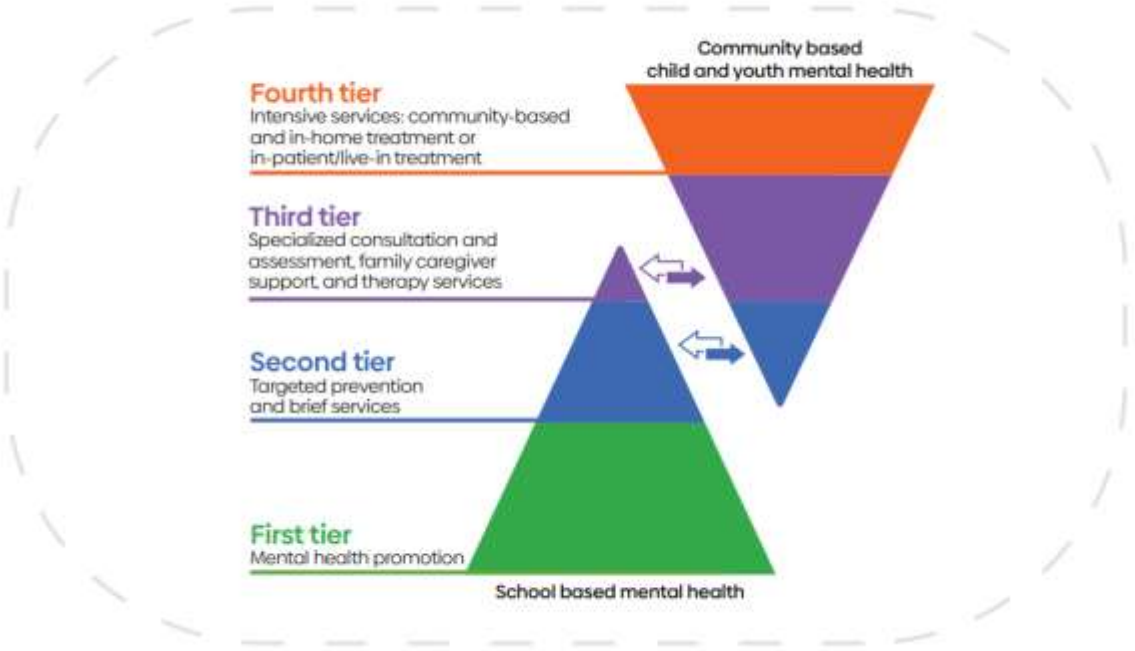


Figure 11: Multi-tiered System of Care

Source: School and Community System of Care Collaborative. (2022). Right time, right care: Strengthening Ontario's mental health and addictions system of care for children and young people

Renfrew County Youth Wellness Hubs Ontario (RCYWHO) (Renfrew and Pembroke)

The RCYWHO has two locations within RCD, Pembroke and Renfrew. The youth hubs integrate the services of intersectoral partners to support children and youth, aged 12 to 25, and their families, in relation to a breadth of needs. Together partners are guided by a commitment to the youth wellness hub of Ontario model of youth and family engagement in decision making, safe spaces, integrated and collaborative care, working within multidisciplinary and agency networks, low and no barrier service, culturally appropriate care, equity-based principles and inclusivity of access, anti-oppressive and anti-racist informed care and practice, integrated and coordinated service pathways, harm reduction, trauma informed care and measurement based care.

Since 2021, the numbers of youth served by the hubs has more than doubled in each year since opening. The youth hubs have also achieved year over year increases in the number of partners delivering service, the types of support provided and referrals. Partner organizations have also seen evidence of the impact, with youth over the age of 17 now able to access more appropriate services for their transitional age.

PreVenture

The PreVenture program, adopted by Youth Wellness Hubs Ontario, is a strength based, evidence informed prevention program for youth 12-18 of "personality-targeted interventions to promote mental health and delay substance use". The program is comprised of workshops "designed to help students learn useful coping skills, set long-term goals, and channel their personality towards achieving those goals."[6] RCYWHO is currently leading the implementation of PreVenture in the region.

School-based Partnerships

Partnerships between the five school boards in RCD and prevention and addiction treatment services are critical to offering school-based programs for children and youth. Due to the rural and isolated nature of many of the RCD communities, offering accessible and equitable services in school settings is a key strategy to alleviate transportation barriers for families. Organizations such as Addiction Treatment Services, Phoenix Centre for Children and Families, Renfrew County and District Health Unit, police services, RCYWHO, and others collaborate to offer preventative and educational programming to students. The addition of mental health and addiction treatment counsellors has broadened the scope of the programs and services being offered.

HEADS-ED Pathway

Close to 400 children and youth under the age of 19 who are residents of the Ottawa Valley accessed an emergency department (ED) for Mental Health, Addictions and Substance Use Health needs in 2022/23. In response to these rates and to connect children, youth and families to the mental health care they need, partners worked together to implement the HEADS-ED pathway to provide care before they may need to access the emergency department. Conducted by PRH-MHSRC Mobile Crisis Team in collaboration with the EDs, the HEADS-ED pathway supports referrals from RCD EDs to community care at all regional hospitals. In an ongoing, collaborative effort to use the information from this pathway to improve the system and access, partners share HEADS-ED data.

The Indigenous Health Circle

The Algonquins of Pikwakanagan First Nation, in partnership with the Ottawa Valley Ontario Health Team (OVOHT), are working to create an Indigenous Health Circle (the Circle). The Circle will help to fill gaps that exist for Indigenous people accessing health services and aims to enhance healthcare services for the First Nations, Metis, and Inuit communities in RCD. Indigenous leaders and care providers are working with community partners to increase and expand Indigenous specific service navigation and care coordination as a key priority for equitable access and outcomes.

Strengthening Families Program

The Strengthening Families Program (SFP) is an evidence-based family skills training program for high-risk and general population families that is recognized both nationally and internationally. Parents and youth aged 12-17 attend weekly SFP skills classes together, learning parenting skills and youth life and refusal skills. They have separate class training for parents and youth the first hour, followed by a joint family practice session the second hour.

Healthy Babies Healthy Children

Healthy Babies Healthy Children is a free and voluntary home-visiting program that supports families in:

- having a healthy pregnancy and birth
- connecting with their baby
- how they can help their child grow and develop
- breastfeeding, food and healthy nutrition
- taking care of themselves and their family
- connecting families and their children with services in the community

The Healthy Babies Healthy Children program is funded by the government of Ontario and delivered by RCDHU.

Consultation with Youth, Parents and Caregivers

In late 2023, as a part of Renfrew County Child and Youth Mental Health Lead Agency System planning, consultations were held with youth at the RCYWHO advisory in Pembroke on areas of needs, gaps and priorities. At this time, key themes emerged emphasising early education, promotion and prevention related to mental health, coordinated care and client-centred approach, focusing on trust building and client choice in care and service navigation. In 2024, follow-up consultations were held at the Renfrew and Pembroke RCWYHO in support of the RCDDS development. This time, youth focused on perceived opportunities for improved services and approaches to achieve those with the greatest needs and complexity in the community.
Youth felt that the mental health mobile crisis response teams were working well and appreciated this significant improvement. However, they noted that work was still needed to increase and improve training and de-escalation tactics among non-specialised responders, such as police and security personnel, including security at health care facilities. In addition to training related to mental health response and de-escalation, youth noted that some responders and health care professionals require further training in anti-stigma and anti-oppression, including experiences of transphobia. Youth reported that these experiences resulted in missed opportunities to build trust and connections to services. Youth also noted times when bias and rejection from services, due to severe mental health and behaviour issues, left them without care options in their community, as no providers had the capacity to support them.

Youth also noted that adult MHSUH and services were not meeting family and community needs. Youth spoke to the need for better interventions for adults, particularly those with children, to break cycles of intergenerational trauma.

Lastly, youth noted that knowing where to turn for help remains a gap. Youth mentioned a need for a non-crisis line to offer an earlier opportunity for youth to connect with services and care before a crisis.

Parents in 2023 saw gaps in the services for children and youth, particularly those with severe mental health needs, those in crisis, those who are Indigenous, and those with housing and rural living challenges. Parents recommended that more be done to unify the system of care and services and optimize the potential of the youth hubs, a model parents valued for wrap around, holistic services and programming, positive connections, and a focus on wellness and strength-building.

Building on key initiatives, system strengths, and identified needs, the following priorities were developed.

Prevention Pillar Priorities

1. Improve **early and equitable access to screening, assessment and diagnoses and pathways to care** for child and youth mental health, substance use health and neurodevelopment.
2. **Re-envision services that are family-centred, focusing on building trust and improving family engagement** with the supports and services that matter most to them.
3. **Expand and integrate the community-based approach for youth care coordination and intensive case management including mobile crisis response services** to better reach and support young people with complex needs.
4. **Recognize adult mental health and access to care** as integral to child and youth wellbeing, development and long-term health outcomes.
5. **Build a comprehensive, collaborative, interdisciplinary community approach to focus on meeting the needs of families, children and youth** that includes health, safety, housing, food security, opportunities, sense of belonging, community and purpose.

Priority 1: Improve **early and equitable access to screening, assessment, diagnoses and pathways to care** for child and youth mental health, substance use health and neurodevelopment.

At times, a diagnosis is required to access health services, such as specialized mental health or neurodevelopmental care. For example, before a family can access funds to support a child with autism spectrum disorder (ASD) with critical and time sensitive interventions, a formal diagnosis must be obtained from a limited number of qualified

sources. A diagnosis can help providers to determine the best course of action and types of services needed. However, a requirement for diagnosis or other screening requirements adds a layer of complexity that can be a barrier to equitable access to care. If everyone does not have the same opportunity, they do not have equitable access to the services and care they need. Inequity in opportunity to receive services may correspond to a variety of factors, such as location, if services are too far away; cost, if some people are able to pay for private assessments and services while others wait longer to access public pathways; and, attachment to primary care, if people without a primary care doctor are less likely to receive a referral.

Access to health care and social services is a protective factor for long-term wellbeing. Children, youth and adults with undiagnosed and untreated mental health needs are at greater risk for harm related to substance use throughout their life. Identifying mental health needs as early as possible and connecting to the right services significantly improves health outcomes. Continuity in care and services is equally important. Funding available for services and support tied to specific diagnoses changes as people age. Complex funding models can result in inequitable access and outcomes. Before periods of transition, such as from child and youth to adult services, it is vital that people have the diagnoses they need to access services at every stage of life. Reducing and eliminating barriers to services increases the likelihood that children and youth will be connected to the care they need and remain engaged with the services. The PHAC notes that "[p]reventing or reducing problematic substance use among youth in Canada can only be achieved through **a range of coordinated actions** that serve to **promote wellness, reduce risks and harms, strengthen protective factors, and improve access to quality mental health and support services**."[4]

Evidence

Providers of child, youth, adult and family mental health, substance use health, and social services are facing demand that exceeds capacity as the severity and complexity of needs continue to rise. The most recent Early Development Instrument data for RCD, which includes the first report capturing the impact of the COVID-19 pandemic, shows significant increases in vulnerability rates in 4 out of 5 domains. Vulnerability rates for physical health and well-being, social competence, emotional maturity, and language and cognitive development in RCD also exceed the provincial average.[7] Similar to Ontario as a whole, the percentage of children and youth under the age of 19 with a mental health and/or addiction related concern(s) is 8.3%. The proportion of mental health related emergency department visits in RCD by people aged 18 to 39 represents about half of all visits.[8]

HEADS-ED data from April to September 2024, shows that 59% of children and youth accessing the ED were already connected to community resources for mental health, and 9% had visited the ED previously for mental health within the past 30 days. In addition to being evident of a system struggling to meet demand, this data also suggests that there may be missed opportunities to support children and families with the care they need before they need to access the ED. Providers and families report that access to a diagnosis, a requirement for some services, is a significant barrier to

care. The demand on diagnostic services due to high levels of need is exacerbated in rural and remote regions where few local providers may be able to diagnose child and youth mental health, and access to diagnostic services in neighbouring regions such as Ottawa is inequitably burdensome and unattainable for some families. Inequity in access is worsened by private access to assessments available only to families with the means to pay.

Implementation Recommendations

- Working with local and regional partners, including 1Call1Click, CHEO and Kids Come First, **review and improve equity informed pathways to screening, assessment, diagnostics and services.**
- Support RCD primary care providers to **increase and expand local capacity for child and youth mental health and neurodevelopmental screening, assessment and diagnostic services with training, consultation and exploration of opportunities to co-deliver services.**
    - **Explore role of nurse practitioners to meet need**
- **Explore common practices for screening, assessment and care coordination for mental health, addictions, substance use health and neurodevelopmental needs.**
    - **Ensure youth receive the appropriate diagnoses to access the care and services they need through transitions,** such as dual diagnoses critical to continuity of funded services from youth to adulthood.
- Review and advocate for the **removal of barriers to equitable access to care and services due to unnecessary diagnostic or referral requirements.**
    - **Improve clear communication for public on where to access services and support**

Priority 2: Re-envision services that are family-centred, focusing on building trust and improving family engagement with the supports and services that matter most to them**.**

Child and youth development, mental health and life-long health and wellbeing outcomes are significantly improved when families are supported to be well and be able to stay together. Wellness for a family corresponds to the individual health of each member and the relationships between members of a family. Families with the most complex needs may struggle to engage with services for many reasons, such as ill health, including mental or physical illness, lack of time from over work or overburden by caregiving, or lack of trust from a personal or intergenerational history of trauma, stigma or discrimination. To overcome barriers to engagement, some families may need complementary services, such as childcare, or accommodations, such as evening or weekend service hours, to be able to engage. Some families may need significant efforts from service providers to build trust. These efforts may include a flexible, family-driven approach, where service providers prioritize what is most important to the family and co-develop plans of care without judgement.

Evidence

Aligned with a strengths-based approach to health promotion, prevention, and wellness, the PHAC[9], developed the positive mental health framework. The framework identifies strengths and risks defined under an individual, family, community and society structure. An associated dashboard (Positive Mental Health Surveillance Indicator Framework (PMHSIF) (canada.ca)) defines indicators for each section with national data presented where available. Positive mental health is integrally tied to prevention of harm related to substance use, including indicators such as life satisfaction, coping, nurturing childhood environment, health status, family health and needs, social support, environments, inequality and stigma.

ACEs are negative conditions and events that significantly and cumulatively impact an individual's development, health and long-term outcomes.[10] ACEs may include a wide variety of experiences, most often corresponding to neglect, emotional, physical or sexual abuse, other traumatic events, such as war, natural disaster or illness, or unmet basic needs, including poverty. Toxic stress, stress over which an individual has no control or escape, is a defining characteristic of ACEs. The more ACEs and experience of toxic stress an individual has, the greater the risk to their short and long-term health and wellbeing, including significantly greater risk of experiencing harm related to substance use throughout their life. Preventing ACEs from occurring is the best way to prevent the associated risks and harm. When ACEs have occurred, protective factors and interventions can significantly mitigate the associated harm and risks, such as supportive, nurturing and responsive caregivers, connection to community and development of coping skills.[11] A family-centred, strengths-based approach can mitigate risk and promote improved, life-long wellbeing outcomes.

Regional providers identify a lack of family engagement with services for children and youth with complex needs as a significant barrier to care. Partners note that service delivery and engagement with families must be flexible and responsive, recognizing that each family journey is unique and there is no 'one-size-fits-all' approach.

Implementation Recommendations

- With coordinated access as a foundation, **explore a one-team, multi-disciplinary family-driven approach to wrap-around complex care delivery for children, youth and adult family members.**
    - Increase **consent to share information, assign cross service case management, co-develop care plans and consult regularly**.
    - Leverage the **role of schools to build on established relationships with families.**
    - **More effectively promote and offer existing family-centred services,** such as Strengthening Families Program and the Nurse-Family Partnership home visiting program.

- **Invest in building the capacity of local providers** to meet increasing level of need with shared training opportunities and professional development.

Priority 3: Expand and integrate the community-based approach for youth care coordination and intensive case management including mobile crisis response services to better reach and support young people with complex needs.

Mobile services are a proven approach to reach people in a community who may be most vulnerable and least supported. Youth with the most complex needs may not be able to access services through traditional routes, such as school if they are not attending, or family, if they are not living at home. Youth who are not attached to school, family or community-based services will face many barriers to care and are highly vulnerable to traumatic experiences that correspond to worsening mental health and poorer outcomes, including increased life-long risk of harm related substance use. Youth-specific care coordination as a part of mobile mental health outreach and crisis response is an opportunity to connect, build trust, and intervene when someone may need it most. Furthermore, mobile teams are also best positioned to reach adults with children and connect them to the services and support they need, both as an individual and as a family.

Mobile teams are uniquely able to support complex and vulnerable clients as they take the services to the individual rather than requiring an individual to find the services. Mobile teams can build trust and engagement over time with repeated visits and an individualized approach, an approach that is critical for youth and adults who are disconnected from support systems and may have a history of disengagement from services and supports that have not been successful in meeting their needs in the past.

Evidence

Gaps in access and a lack of coordinated, integrated services for children and youth with complex and co-occurring needs is a significant challenge across the province of Ontario.[12] Front line mental health mobile staff in RCD recognize youth as a priority and as particularly vulnerable to risks associated with being unhoused. The teams report that needs related to housing for youth, complex trauma, and complex or broken family dynamics are increasingly identified among clients. These are examples of the unmet basic and mental health needs that put children and young people at risk of harm related to substance use throughout their life.[4]

PRH-MHSRC youth dedicated case workers (age 18-35) and the 'You-It' program (age 16-24) have seen an increase in referrals, with 'You-It' up 53% in 2024, reporting that youth are waiting to be served. Providers serving children, youth and families in RCD have prioritized coordinated efforts to offer no and low barrier, integrated services and seamlessly connect young people to appropriate care pathways. Experience shows that the most effective engagement strategies involve meeting youth where they are whether in the community, at school, or in their homes. Child and youth service and

care providers have identified gaps where the system is failing to reach those at greatest need and with the greatest vulnerability, including youth who are not living at home and not attending school.

Youth, when consulted at the RCYHWO, expressed appreciation for the mental health specific response of the mobile crisis and outreach teams. They valued this approach and reported significant improvements when compared to non-specialized response to mental health crises. Youth reported that the mental health crisis and outreach teams represented opportunities to build trust and connect youth to care and services. Without this approach, youth reported escalations and a cycle of worsening mental health and reduction of service options, as increased complexity left them ineligible for many services. Youth also spoke about family and inter-generational needs, sharing their thoughts about how outreach and other services could have broken familial cycles of unmet need by connecting a parent to services and supports. This local experience speaks to a need to connect youth and family members to a holistic system as their needs cannot and have not been met by any one agency and instead must be a "shared responsibility" among intersectoral partners offering "integrated solutions".[11]

Implementation Recommendations

- **Review, expand and optimize community-based, mobile response services** including RCYWHO, Mesa, school-based partnerships, and PRH-MHSRC, **for outreach and connection to services for youth and adults with children**.
    - **Review case studies** to determine the gaps in service and opportunities for improvement in interventions.
    - Seek funding and partnerships to **expand intensive youth mental health case management**.
    - Adopt a **community-based approach to reach youth where they are.**
    - **Improve coordination of care and navigation of all health and social services**.
        - Leverage **RCYWHO navigation, care coordination and integrated pathways** to wrap-around services and care.
        - Leverage **Coordinated Access to triage and quickly mobilize integrated services** with comprehensive, individualized care plans for the highest need youth and families.
    - Meet the needs of youth experiencing homelessness or who are vulnerably housed with **youth crisis-beds** and coordinated, wrap around services.

Priority 4: Recognize adult mental health and access to care as integral to child and youth wellbeing, development and health outcomes.

Unmet mental health and substance use health needs of a parent, caregiver or other adult in a child or youth's life can increase the risk that the child or youth will in turn experience harm from substance use in their lifetime. This risk may be elevated because of modelling, a child or youth may be more likely to emulate substance use that can be harmful if they have witnessed this type of use by someone close to them, for example heavy drinking. The risk may also be elevated if the unmet needs of the adult cause disruptions to the stability or safety of the family and child.[4] The latter is an example of the intergenerational or cyclical risk that may disproportionately impact some families if needs continue to go unmet. However, the removal of a child from their family, home and/or community is traumatic and associated with long-term health and developmental risk, including harm from substance use. Removal of a child from a home should be a last resort. If and whenever possible, outcomes for children and youth are best when a family has the services and supports they need to live together. Unmet and increasingly severe needs identified among children and youth are likely to reflect unmet needs among adults, parents, and caregivers. If these needs continue to go unmet, patterns are predictive of future harm associated with substance use and increasing demand for mental health, addiction, substance use health, and social services.

Evidence

Among Ontario Health Teams in the Eastern Region, the OVOHT ranks as the most remote, with the lowest population density, highest rate of "uncertainly attached" patients,[13] the highest rate of emergency department visits per capita, and the longest average wait time for home care services.[14] Regional adult service providers have reported significant strain due to rising demand for services. Adult mental health services have seen an 88% increase in demand since pre-pandemic levels, 2018/19 to 2023/24. The PRH-MHSRC Mobile Crisis team has responded to increased demand of 173% and the Upper Ottawa Valley OPP Mobile Crisis Response Team (MCRT) reports a 45% increase in calls when compared to pre-pandemic levels. Addiction Treatment Services are supporting 1,100 additional clients beyond funded targets. Pathways Alcohol and Drug Treatment Services are currently functioning 25% beyond capacity. With demand exceeding capacity, waitlists for mental health and substance use services are lengthy. For individuals ready to access treatment, wait times often exceed 20 days, while mental health case management has a backlog of 120 days. This creates barriers to recovery and increases the risk of disengagement from care, worsening outcomes for adults seeking mental health and substance use health care.

Front line staff in RCD report more complex situations, and individuals who require multiple supports, including basic needs, food, shelter, finances, substance use care, complex trauma, and complex/broken family dynamics. Providers identified a critical need for increased housing support, particularly for individuals preparing to begin withdrawal management or intensive case management.

In December 2023, The Algonquins of Pikwakanagan First Nation declared a state of emergency due to opioid overdoses. Pikwakanagan identifies homelessness and

inadequate or insufficient supportive housing, services for women, and intensive services as unmet priorities for their community.

On March 31, 2023, following an inquest into the murders of three women in 2015, Renfrew County declared intimate partner violence an epidemic. Since the onset of the COVID-19 pandemic, wait times for accessing assessment and services for survivors of intimate partner violence within RCD have increased substantially. Women, particularly survivors of intimate partner violence, face unique and significant barriers to accessing healthcare and treatment, including mental health and substance use services. Increased stigma, the inequitable burden of caregiving, and concerns about safety all contribute to these challenges.

This regional context paints a picture of a community that is struggling to meet the needs of adults, whose health and wellbeing may have direct and indirect impacts on the health and wellbeing of the next generations.

Implementation Recommendations

- **Adopt common practices to identify family needs, including mental health needs of parents and caregivers, and connect family members to their own care and services.**
    - **Review case studies** to determine the gaps in service and opportunities for improvement in interventions.
    - **Review, scale and scope successful initiatives identifying and connecting parents** to Mental Health, Addictions and Substance Use Health and social services.
    - Support primary care providers in **adoption of best practice pain management, opioid dispensing,** and to **increase and expand local capacity for adult mental health screening, assessment, diagnostic and referral services.**
- **Explore more coordination and integration** of mental health services.
    - Based on need and client choice, **offer coordinated family-centred care** and/ or **parallel child/youth and adult services.**
    - Support child, youth and family workers with **resources, pathways and connections to adult mental health care and social services.**

Priority 5: Build a comprehensive, collaborative, interdisciplinary community approach to focus on meeting the needs of families, children and youth that includes health, safety, housing, food security, opportunities, sense of belonging, community and purpose.

Strong and supportive community connection is protective against harm related to substance use.[15] In seeking to prevent harm related to substance use, an 'upstream' vision can illustrate the many points along an individual journey when something or someone may have changed the course of that person's life. These upstream factors

may be risks, such as poverty, abuse or disconnection, or protective, such as positive peer relationships, a close and responsive parent, or strong sense of purpose. The PHAC recommends that "[w]ithin the context of prevention, we will only succeed by **acknowledging and acting on risks, while at the same time strengthening protective factors so that youth are engaged, resilient, and empowered**."[4]

The Icelandic model, an evidence based, multi-sectoral, collaborative community approach to prevention, follows five guiding principles: apply a primary prevention approach; engage community action and public-school involvement; engage stakeholders in decision making and use high quality evidence; integrate researchers, policy makers, practitioners, and community members; and align the scope of the solution with the scope of the problem.

The Canadian Nurse-Family Partnership (NFB) Program is an evidence-based community health program that pairs young pregnant women and first-time mothers experiencing social and economic disadvantage with a Public Health Nurse to receive ongoing home visitation throughout pregnancy, infancy and into toddlerhood. The goals of the program are to improve pregnancy outcomes, improve child health and development, and improve families' economic self-sufficiency.

Evidence

Specifically designed child and youth substance use prevention programs and interventions have been implemented in and out of school for many decades, in many jurisdictions and evolved over time. Methodology for review of these programs has varied widely making comparisons challenging. Life skills training programs, delivered by teachers or trained facilitators and covering misconceptions about substances, resistance skills, self-concept, decision-making, problem-solving, stress and anxiety management, social skills, communication, and media literacy, are among those most studied and with the most robust reduction in use of substances and improvement in emotional and social outcomes.[16]

Implementation Recommendations

- Improve **equitable access to after-school programs and extra-curricular activities** for all children, youth and families in RCD.
    - **Build and maintain spaces for children and youth to connect**, play sports and engage in other meaningful activities, both organized and informal.
        - **Seek and distribute funding to remove equity barriers such as fees for child and youth sports and other activities.**
        - **With a youth and family-led approach, improve communications strategies with parents and youth to increase uptake.**
    - **Create and promote volunteer opportunities** with local organizations that support and include children, youth, and families, foster positive

community connections, and promote harm reduction and treatment efforts.

- **Explore implementation of a broad community-based strategy for prevention,** such as the Icelandic model.
- **Investigate local implementation of the Nurse-Family Partnership**, a program with a strong evidence base that reduces risk factors for substance use.
- **Increase awareness, education and health promotion related to wellness, mental health, addictions and substance use health,** such as youth drug and alcohol education and for pregnant and parenting adults.

Prevention Pillar Indicators

1. Sociodemographic analysis of equitable access to diagnosis and connection to services, including culturally appropriate services.
2. Wait time to diagnosis and services for child, youth and family, and for adults with children.
3. Coordinated access engagement and retention rates.
4. Referral and engagement rates for youth not attending school and/or unhoused.
5. Referral and engagement rates of parents and caregivers with adult mental health services.
6. RCD indicators of child, youth, family and community wellbeing.
    a. Rates of Mental Health Addictions and Substance Use Health ED and hospital visits by age.
    b. Early development indicators.
    c. Self-reported mental health and wellbeing by age.
    d. Families, children and youth living in poverty.
    e. Youth unemployment.

Treatment Report

Background

The treatment pillar of a community drug strategy seeks to define and prioritize accessible and effective treatment for those who want to reduce or stop using alcohol and/or drugs.[17] To meet the unique needs of individuals experiencing harm related to addictions and substance use across the spectrum of need, communities work to plan and provide equitable access to a continuum of quality care and services. Every recovery journey is complex and unique. The best care and outcomes in substance use health care occur when services are individualised, client-centred, holistic, and integrated, including concurrent care for mental health, wrap-around social services and harm reduction.

Addiction and substance use disorders are chronic medical conditions.[18] A continuum of services (figure 1) supports individuals with different levels of need and at different stages of recovery. However, recovery is not linear, and services work most effectively when each person can access the different types of care according to their own need, choice and co-develop a care plan with an integrated team that is flexible and responsive to recurrence (relapse).[19] Addictions and substance use health needs may be concurrent with mental health and social service needs. A cohesive and integrated system considers the levels of Mental Health, Addictions and Substance Use Health (figure 2) and social service needs of each client and connects people to all the services they need to pursue their recovery goals. The Canadian Centre on Substance Use and Addiction summarizes the best practices for a continuum of services[20] to include:

- Harm reduction
- Assessment
- Brief Interventions
- Rapid Access Clinics
- Community Outreach
- Withdrawal management
- Pharmacological interventions
- Psychosocial interventions
- Recovery Sustaining Wellness & Ongoing Care

Furthermore, peer support, particularly at first points of contact, builds trust and mitigates barriers due to stigma, resulting in improved rates of engagement and retention in treatment.[20] No and low-barrier access and engagement with treatment is also established with provider training and practice in compassionate, trauma and culturally informed care and anti-stigma, including anti-systemic racism and oppression. Both peer support and ongoing professional development should be embedded throughout the health care system.[21]

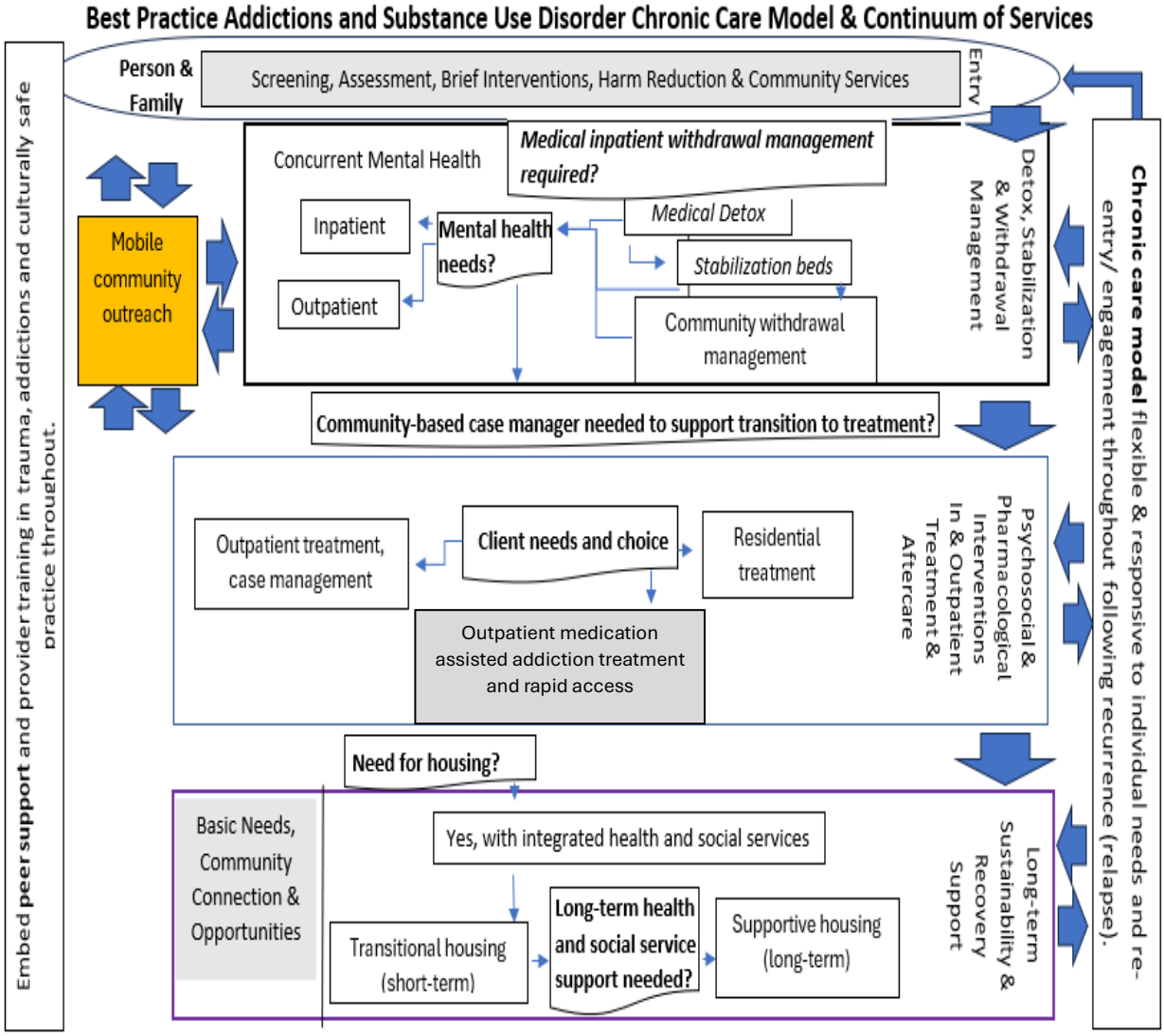


Figure 12: Example of how the continuum of services may be mapped. Note that this is not a linear model and that re-entry, and engagement should be open throughout the continuum in a chronic care model responsive to recurrence (relapse).

Exhibit 1. The Four Quadrants Model			
		Mental Disorder	
		Low	High
Substance Use Disorder	High	III—Less severe mental disorder/ more severe SUD	IV—More severe mental disorder/ more severe SUD
	Low	I—Less severe mental disorder/ less severe SUD	II—More severe mental disorder/ less severe SUD

Figure 13: The four-quadrant model[22] can inform the most appropriate level of care within the continuum of mental health, addictions and substance use health service.

Local Treatment Context

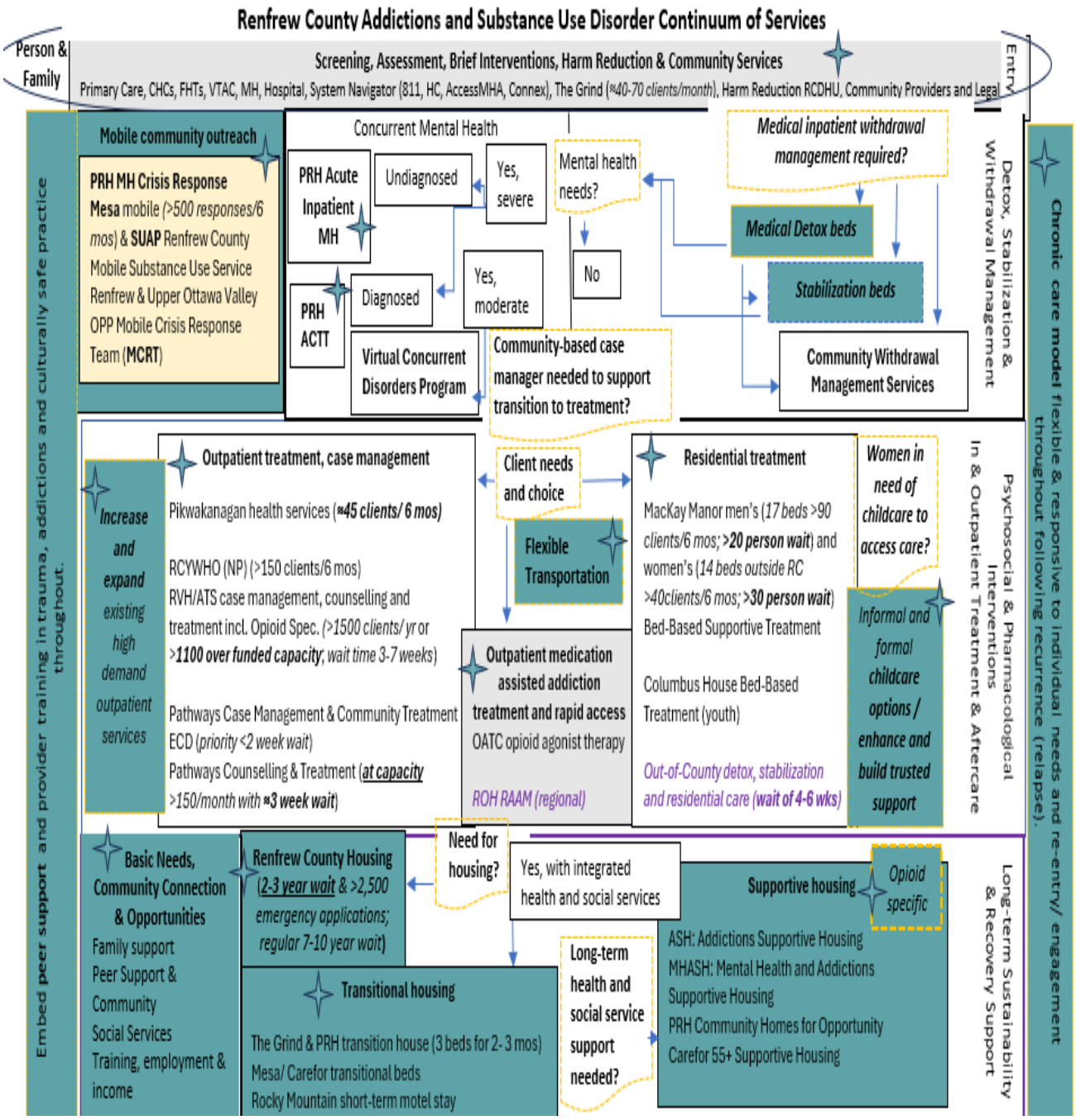
RCD is supported by a range of mental health, substance use health, housing, and social services across the continuum of care. To address the complex needs of individuals experiencing harm related to substance use disorders, partners and persons with lived and living experience have worked to create a more integrated and collaborative system of care.

A Renfrew County Addictions and Substance Use Disorder Continuum was developed during the planning of the RCDDS to demonstrate the pathway that currently exists and that could be supplemented with additional proposed programs and services.

The following definitions that will assist with interpretation od the continuum:

CHCs: Community Health Centres
FHTs: Family Health Teams
MCRT: Mobile Crisis Response Team
MH: Mental Health
OATC: Ontario Addictions Treatment Centre
PRH: Pembroke Regional Hospital
RCDHU: Renfrew County and District Health Unit
SUAP: Substance Use and Addictions Program
VTAC: Virtual Triage and Assessment Centre

Disclaimer: Please note the Renfrew County Addictions and Substance Use Disorder Continuum of Services was developed at the time of RCDDS planning and is subject to change.



Legend: white boxes are existing resources, grey provided for information, but out of scope for treatment recommendations, purple out-of-county, yellow related to preliminary recommendations and blue related to preliminary and aligned with HART Hub planning.

Indicates possible HART Hub pathway.

Figure 14: An example of how local current and proposed treatment services in Renfrew County map in a continuum with identified needs.

Mesa Approach

In RCD, innovation and joint commitment among inter-sectoral partners is exemplified by Mesa, a collaborative, multi-sector approach to providing compassionate care. Mesa seeks to break down silos, remove barriers, and improve client engagement, experience and access to a diverse range of supports. Central to Mesa's philosophy is the recognition that housing is a foundation for stability and recovery. Without safe and secure housing, recovery from substance use disorders and co-occurring needs, such as trauma, mental health, unemployment, family breakdowns, or poverty is undermined.

Mesa's approach tailors support to the individual's level of need. The Attainable Housing philosophy helps individuals achieve stable housing through rent supplements and access to treatment. Medium- and high-acuity individuals may require temporary emergency services and more intensive wraparound supports, including residential treatment. Through this flexible and collaborative model, Mesa supports access to housing, healthcare, and social supports across the full spectrum of need.

Mobile Services

As a primarily rural region, RCD mobile services are essential for access to care, particularly for individuals who live in remote areas or do not have means of transportation to health and social services. Currently, mobile services are facilitated by the PRH-MHSRC Mobile Crisis team, Mesa Mobile Response teams, MacKay Manor's Community Withdrawal Management Services, Community Paramedics, and Renfrew and the Upper Ottawa Valley OPP MCRT.

All the mobile services are working collaboratively and towards integration. In 2024, a partnership of service providers, led by MacKay Manor—a provincial residential substance use disorder treatment provider—successfully secured Health Canada Substance Use and Addictions Program funding to expand mobile response services in the County. This partnership is part of the Mesa approach and focused on integrating and expanding existing services. Funding will allow the mobile units to offer additional services, including peer support, immunizations, wound care, chronic disease monitoring, opioid agonist treatment initiation, Elder support and access to traditional medicines, distribution of essential items, system navigation and referrals, and case management.

Supportive Housing

Several organizations in RCD provide housing supports for individuals with complex needs, including PRH-MHSRC, MacKay Manor and the County of Renfrew. Several programs are operated under these organizations including Addictions Supportive Housing (ASH), Carefor's 55+ Supportive Housing, and Mental Health and Addictions Supportive Housing (MHASH).

In August 2024, The County of Renfrew published its Framework for a 10 Year Homelessness and Housing Plan[23], a framework addressing urgent and growing gaps in housing, services, and supports due to rising homelessness, substance use disorder challenges, and health issues. The plan focuses on prevention, expanding supportive housing, and improving the homelessness response system. A key priority is establishing a year-round, low-barrier Service Hub to provide immediate shelter and essential services. In October 2024, regional partners once again came together to seek funding under the provincial HART Hub call for proposals. The proposed Hub-and-Spoke model would enhance access to care in rural communities by distributing services around a centralized Hub. In regions with limited healthcare resources, this model enhances care coordination, reduces access barriers, and ensures that individuals receive the appropriate level of care closer to home. This system is particularly beneficial for individuals with complex needs who require varying levels of care throughout their recovery journey.

Services for Women

RCD does not have a local women's-only residential treatment program. MacKay Manor operates a women's-only inpatient treatment program in Ottawa and works diligently to ensure clients stay connected to their service providers and support systems within RCD, maintaining critical relationships throughout their care journey. Pathways Alcohol and Drug Treatment Services often operates at or above capacity but remains able to prioritize and quickly respond to the needs of pregnant and parenting women under the MotherSafe Treatment and Case Management Programs.

To improve access for women and in partnership with Renfrew County Family and Children's Services, local substance use treatment providers are working to build trust and provide equitable access to childcare, better supporting women with children to seek residential treatment without fear of losing custody. Furthermore, under the leadership of Algonquins of Pikwàkanagàn First Nation, child and family services for First Nation residents will now be operated by the community. This significant shift will help reduce stigma and the harms associated with children being removed from their community, culture, and families. Pathways' MotherSafe Programs are also available bi-weekly at the Health Centre of Algonquins of Pikwakanagan.

Pathways, Peer Support and Engagement of People with Lived and Living Experience

With the leadership of MacKay Manor and PRH, OVOHT partners have prioritized anti-stigma initiatives to address barriers to substance use disorder treatment. Partners have improved pathways to treatment for those accessing EDs, resulting in faster and improved connection with warm referrals. These partners have also begun a phased approach to embedding peer support into Emergency Departments. In 2024, peer support workers were welcomed to PRH to support staff with consultation services related to addiction and substance use health cases. Partners are actively working to

expand this approach and establish a role for peer support in direct service as a first point of contact for patients with substance use health needs when they visit the ED.

Grounded in principles of co-design, people with lived and living experience were involved in the development of the community strategy. Indicative of the ever-present partnership among regional providers with people with lived and living experience, many of the recommendations of people with lived and living experience aligned with those of providers, including peer support embedded throughout care, particularly at intake, provision of basic needs, detox beds close to home and housing for those ready for treatment while they wait for a treatment bed. One of the most notable and unique elements from consultation with people with lived and living experience was 'Creating a Circular Economy to Support Recovery'. 'Creating a Circular Economy to Support Recovery' was recommended by people with lived and living experience as a unique opportunity to serve and support long-term recovery goals and sustainable wellness for people in recovery seeking opportunities to 'give-back', train, build work experience, and attain meaningful employment. people with lived and living experience identified an opportunity for people in recovery to be employed in various roles in service delivery, the result having a two-fold impact (1) people accessing services would be supported by peers and (2) people in long-term recovery would have more opportunities for training, meaningful employment and a sense of purpose, all significant protective factors in maintaining wellness and mitigating risk of recurrence.

The Grind

The Grind offers a wide breadth of no-barrier services and supports. First and foremost, as a place for people to gather and eat, the Grind provides breakfasts, lunches, dinners, coffee and a community pantry. On-site people can also access showers, laundry, phones, mail, clothing and footwear, winter coats, hygiene kits, blankets emergency food boxes, and haircuts. In addition to meeting basic needs and in partnership with community members, providers and groups, the Grind offers: community outreach and wellness checks, community mental health, care coordination (Ontario Health at Home), Ontario Works, public health services including harm reduction services, recovery group, women's sexual assault services, victims services, ID clinics and follow-up support, dental services and the homelessness committee.

Mesa Warming Centre

The Mesa Warming Centre located within the Ontario Addictions Treatment Centre (OATC) Pembroke clinic location offers a space for people in need 24 hours a day, seven days a week for a five-month (Winter) period, with staffing by MacKay Manor. The Warming Centre provides integrated washroom facilities, along with amenities such as a kitchenette, cleaning facilities, storage facilities and program space. This service is a vital part of the continuum of services and fills a need for a safe, warm space for people who are unhoused or vulnerably housed.

In 2023 the Warming Centre provided services to 101 total guests, 89 of whom were from Renfrew County and 12 from outside the County. Of those 12, 10 were transient stays. This reinforces the need for housing and addiction services to support RCD residents and that large numbers of people are not migrating to RCD to access these services.

The Renfrew County Mesa HART Hub

As the RCDDS recommendations were being developed, partners were simultaneously working on solutions to known gaps. Two key priorities for the region included establishing **medical withdrawal management** and **stabilization beds** in RCD and continuing to increase **short and long-term supportive housing** including availability and breadth of associated integrated services such as specific services for people who use opioids. Local service providers, community leaders and community members, including people with lived and living experience of substance use and homelessness, developed a successful bid for a Homelessness and Addiction Recovery Treatment (HART) Hub. The Hub-and-Spoke model centralizes specialized services at a "hub" while extending outreach and less intensive services through "spokes," making comprehensive care accessible throughout the region. Partnerships with key service providers and people with lived and living experience will ensure both onsite and proximal access to a range of treatment and preventative services, including:

- Primary care
- Mental health services
- Substance use care and support
- Social services and employment support
- Temporary respite and supportive bridge housing beds
- Supportive housing
- Essential supplies and services including showers, food, clothing, cultural supports, and peer support
- Culturally safe services and pathways for Indigenous clients

Hub: The Mesa Hub is a specialized 24/7 wellness centre offering immediate access to intensive supports such as stabilization services, bed-based care and onsite care for individuals with complex needs. The centre will lead comprehensive care planning by conducting physical and mental health assessments and delivering treatments based on those assessments.

Spokes: The Spokes are pre-existing community-based access points that will serve as local entry points for those outside Pembroke, particularly individuals who cannot easily access the Mesa Hub or are unsure where to go. These community locations will provide immediate support and referrals, including transportation to the Mesa Hub if needed, for individuals requiring intensive care. They also offer ongoing assistance to clients transitioning from the Mesa Hub. When and where necessary, mobile services will act as additional spokes, bringing services directly to clients who cannot access the Mesa Hub or when accessing the Mesa Hub would not be suitable. The spokes focus on intensive case management, systems navigation, and life skills training, helping clients

stay engaged in care within their own communities. This approach ensures continuity as client needs evolve.

Building on key initiatives, system strengths and identified needs, the following priorities were developed:

Treatment Pillar Priorities

1. **Increase and expand existing high demand outpatient services** currently exceeding service capacity.
2. Explore the possibility of establishing **medical withdrawal management** and stabilization beds in RCD.
3. Continue to increase **short and long-term supportive housing** including availability and breadth of associated integrated services and specific services for people who use opioids.
4. Continue to **identify and reduce barriers to access Mental Health, Addictions and Substance Use Health treatment and services**.
5. **Decrease stigma with training and support for health care providers** in addiction treatment, trauma informed and culturally safe practices and by expanding and **embedding peer support** throughout the continuum of services.

Priority 1: Increase and expand existing high demand outpatient services currently exceeding service capacity.

Substance use disorders are chronic medical conditions. As such, a chronic care model, flexible and responsive to individual needs and to re-entry or re-engagement with services, should be established throughout the continuum, including following recurrence (relapse). The chronic care model decreases risk of disengagement with services and improves outcomes as care is individualized rather than artificially and rigidly imposed with one-size-fits-all requirements, expectations, and responses. The continuum of services in a community work most effectively when each person can access the different types of care according to their own need, choice and with a co-developed integrated-team care plan that is flexible and responsive to recurrence (relapse).[24] As addiction and substance use disorder are best addressed by a chronic care model,[25,26] any need to re-enter or engage with services should be without barriers, stigma, or loss of other supports and services.

A continuum of services supports individuals with different levels of need and at different stages of recovery. While the continuum of Mental Health, Addictions and Substance Use Health services is not linear and each individual recovery journey will be unique, it is critical that access to all the services within the continuum be considered as a whole. Bottlenecks, wherein some services in the continuum may be at or over capacity, prevent and delay access and continuity in care. As individuals move through their recovery journey, they may be at risk of disengagement and recurrence (relapse) if they experience gaps in their treatment. Gaps, because of full or waitlisted services, may reflect a 'siloed' or isolated approach rather than an integrated and

cohesive system of care. A flexible, holistic and data-driven approach can assess areas of need and inform collaborative planning and resource allocation. For example, a collaborative system might identify and fill missing pieces in the continuum, such as with the addition of withdrawal management beds in RCD. A collaborative system may also anticipate and augment existing services that are under pressure, such as with additional resources for community-based treatment services functioning at or over capacity. Successful treatment outcomes and long-term recovery can be achieved and sustained when the system of care works as a cohesive whole and clients seamlessly receive the care and services they need when they need them.

Mobile services are a part of the Mental Health Addictions and Substance Use Health continuum, bringing care directly to individuals and often serving as a first point of contact, building trust and connections to the wider system of social and health services. Mobile teams engage individuals with complex challenges in their homes or community settings, helping them access treatment, services, and support more quickly than traditional models. Integrated mobile outreach services are an important part of any continuum of care for substance use health, particularly for rural and remote regions. Mobile services increase accessibility for underserved populations such as those who are unhoused or face other constraints that make it difficult to access health care and social services. Mobile services ensure care reaches clients where and when it is needed, enhancing the system's flexibility and responsiveness to diverse and individual needs, including those with complex needs who require varying levels of care throughout their recovery journey.

Evidence

Like other chronic illnesses, such as diabetes, treatment of substance use disorder with a chronic care model, including proactive, team-based clinical management and primary care, can improve outcomes.[27] The chronic medical model emphasizes the need for continuity between services to mitigate risk of recurrence.[18] Furthermore, when recurrence does occur, harms are best mitigated and outcomes improved, when individuals can quickly access the services they need and choose.

Regional service providers have reported significant strain due to rising demand for services. Mental Health Services of Renfrew County have seen an 88% increase in demand since pre-pandemic levels. The Algonquins of Pikwakanagan First Nation identify a lack of Indigenous intensive services to provide culturally appropriate care close to home for Indigenous residents. From 2018/19 to 2023/24, MacKay Manor's residential treatment programs have seen a 45% increase in clients and service days for men, and an 81% increase in service days for women. Pathways Alcohol and Drug Treatment Services often operates at 25% above capacity. Addiction Treatment Services has implemented innovative solutions and partnerships to address a surge in demand that exceeds their funded targets by 1,100 clients annually.

Waitlists for mental health and substance use services are lengthy. For individuals ready to access treatment, wait times often exceed 20 days with substantial waitlists for Ministry funded services at 8-12 weeks for most programs, while mental health case

management has a backlog of 120 days. Furthermore, the Mental Health Services of Renfrew County Crisis Management Team, intended as short-term navigation connecting individuals to services within 14 days, is currently averaging 24 days to be able to connect people to services. When compared with the previous year (2023), the team has seen a 26% increase in average length of stay, 42% increase in the average number of encounters, and 22% increase in the average number of unique individuals served per month. This creates barriers to recovery and increases the risk of disengagement from care.

A systematic review of mobile health services found they effectively reached high-risk, stigmatized populations, increasing engagement in health services, including screening for mental health.[28] These findings underscore the importance of mobile services in reaching underserved populations and improving access, engagement, and retention in care, particularly in rural and remote regions.[29] From 2018/19 to 2023/24, the PRH-MHSRC Mobile Crisis team has responded to increased demand of 173% in individuals served, 256% in face-to-face visits, and 91% in non-face-to-face visits. Front line staff report more complex situations, and individuals who require multiple supports, including basic needs, food, shelter, finances, substance use care, complex trauma, and complex or broken family dynamics. Additionally, individuals are increasingly being connected to the crisis team multiple times and by multiple referral sources. The Upper Ottawa Valley OPP MCRT reports a 45% increase in calls in 2024. In 6 short months, Mesa mobile response has engaged with people in need with over 3,200 mental health services, community-based supports, Addiction Treatment Services, and outreach-based encounters. These reports reflect the importance of outreach efforts and the demand for intensive support.

Implementation Recommendations

- **Collaboratively seek, plan and allocate resources to meet local need for Mental Health, Addictions and Substance Use Health** by considering the full complement of community services within the continuum of care.
- Continue to **advocate for additional funding** for Mental Health, Addictions and Substance Use Health services.
- Adopt and adapt **innovative provider recruitment and retention strategies** and minimize staff vacancies.
- **Adopt a data-driven, system level approach** to planning and allocating new and available resources.
- Optimize and integrate **mobile outreach services**.
- **Coordinate case-management across the continuum** of services to support continuity in care.
    - **Increase coordination and offer of wrap around services,** including Opioid Agonist Treatment (OAT).
    - **Explore opportunities to improve flexible & responsive access throughout the continuum of care** to meet individual needs and re-entry/ engagement following recurrence (relapse).
    - **Explore opportunities to improve care transition processes** that better support continuity and mitigate risk of disengagement.

Priority 2: Explore the possibility of establishing **medical withdrawal management** and stabilization beds in RCD.

Medication for alcohol and drug withdrawal is a well-established best practice that greatly improves withdrawal outcomes and is often necessary prior to accessing treatment. With medical withdrawal management, client health is continuously monitored by nurses and substance use workers alongside other medical professionals. As a part of the continuum of services, clients co-develop individualized treatment plans and are connected to services following medical withdrawal management.

Following the acute withdrawal stage, non-medical withdrawal management services or stabilization beds offer one option when transitioning to treatment, either because further stabilization is needed or when treatment services are not immediately available. The availability of ongoing care, including bed-base care, is a critical aspect in continuity and to mitigate risk of disengagement. Following bed-based stabilization, clients may be connected to residential treatment or community-based services and outpatient programs, this may include Community Withdrawal Management Services, outpatient treatment programs, case management, systems navigation, community mental health services, and/or peer support. Long-term recovery goals and client outcomes depend on community services throughout the continuum being available close to home and being available when they are needed.

Evidence

From 2018 to 2023, yearly toxic drug deaths in RCD tripled, with opioid-specific deaths increasing four-fold in the region. As of October 2024, opioid overdose-related ED visits already surpassed the total for all of 2023. Beyond opioids, alcohol use continues to heavily impact EDs, ranking as the fourth most frequent cause of mental health-related emergency department visits in 2022-2023.[30]

Despite innovation and collaboration among health care providers in the region, demand is exceeding capacity and pivotal supports in the continuum of care, such as bed-based withdrawal management, are missing. Currently, there are not any medically or non-medically supervised withdrawal beds available within RCD. The only withdrawal management services available within the community is MacKay Manor's Community Withdrawal Management service, which is home-based. Residents requiring bed-based, supervised withdrawal are referred to facilities outside the County and away from their home, community, and essential supports, such as childcare. While some individuals may choose to seek services outside their community, for many this is a significant barrier. Access to out-of-county in-patient care is further hindered by restrictive timelines, requiring clients to present for services within 1-2 hours of a bed becoming available - an inequitable standard for a County as geographically vast as ours, where travel times can exceed two hours within the County alone. Recently, local partners were able to negotiate an extended window of time for County residents to present for withdrawal management services. Regardless of this improvement, there

remains a wait of 4 to 6 weeks for out-of-county detox, stabilization, and residential care, delaying access to critical supports. In 2023, data from Connex Ontario, a provincial system navigator, indicated that over 35 residents were referred outside the County for bed-based withdrawal services. However, this figure only captures a fraction of the total need, as it does not account for the many people who disengage from care due to the prolonged wait times. Additionally, there is no centralized system to track referrals from hospitals, care providers, other system navigators, or individuals seeking care directly. For example, Pathways Alcohol and Durg Treatment Services alone has already referred 32 people to treatment outside of RCD (April 1-November 2024). Without local stabilization beds or supervised withdrawal management, individuals with substance use disorders and mental health challenges often miss the window of opportunity for treatment. The absence of comprehensive in-county bed-based withdrawal management services, compounded by long waitlists and a lack of supportive bridge housing, severely limits the potential for sustained recovery and treatment engagement.

Implementation Recommendations

- **Seek funding and share resources to collaboratively build and deliver bed-based medical and non-medical withdrawal management and stabilization services.**
    - **Collaboratively co-deliver bed-based services with comprehensive wrap around care** in a hub and spoke model.
    - **Develop a sustainability plan for ongoing** local supportive/relapse prevention housing beds, medical withdrawal beds and supportive bridge housing spaces.

Priority 3: Continue to increase **short and long-term supportive housing** including availability and breadth of associated integrated services and specific services for people who use opioids.

The housing first model emphasizes housing as a human right and fundamental to health equity and health outcomes, including for people with substance use disorders. Access to adequate, safe and affordable housing improves outcomes for clients in substance use treatment and supports long-term recovery and wellness.[31] For people who are experiencing harms related to substance use and other needs such as mental health, it is essential that health care and services be provided as a part of an individualized housing plan. A failure to adequately support people with complex needs significantly elevates risk of harm, including recurrence of substance use, homelessness and trauma. Supportive housing is recognized as a part of the continuum of care for substance use treatment. As with other chronic medical needs, for some people, sustainable, long-term recovery from substance use disorder may require ongoing connection to some level of care and services. Services may be specific to treatment of substance use, including opioid specific care, or to other health and social service needs such as personal care, food delivery, and income supports. Without

supportive services, some clients may not be able to live independently and be at risk of chronic homelessness, mental and physical illness and harm related to substance use.

Evidence

The 2023 Point in Time Count[32] identified at least 55 households experiencing homelessness, with 65% located in Pembroke and 53% experiencing chronic homelessness. The most common factors contributing to homelessness were mental illness (56%), medical conditions (49%), and challenges with substance use (42%). The 2024 County of Renfrew: Framework for a 10 Year Homelessness and Housing Plan found that the system is currently unable to meet demand for housing, with a net increase in homelessness each month. A survey found that 77% of respondents believe more housing with rent geared to monthly income is needed, and 70% support supportive housing for people with complex needs in their neighbourhood.

The supportive housing system is significantly under-resourced and operating beyond capacity. Between 2018/19 and 2023/24, the Addictions Supportive Housing program experienced a 113% increase in clients served and a 98% rise in service days. The Algonquins of Pikwakanagan First Nation have reported that residents who are unhoused are often temporarily placed in motel rooms—an inadequate and unsustainable solution. The Renfrew County community housing program has waitlists exceeding 1,600 households for rent-geared-to-income housing, with wait times ranging from 2 to 3 years for Special Priority Placement, and 7 to 10 years for those on the regular waitlist. Without stable housing, individuals are less likely to access treatment and recovery services, less likely to remain engaged and at greater risk for recurrence and poorer health outcomes.

Implementation Recommendations

- Regional partners **seek funding and share resources to collaboratively build and deliver more supportive housing**.
    - **Collaboratively co-deliver supportive housing services** including holistic, wrap around care and case management.
    - **Include opioid specific treatment** in current and future supportive housing services.
- Continue to **advocate for additional funding for supportive housing**.

Priority 4: Continue to **identify and reduce barriers to access Mental Health Addictions and Substance Use Health treatment and services**.

People in need of substance use treatment may face barriers to care because the services they need are not accessible or because service navigation is not connecting people to the right services. Identifying and breaking down barriers to care, such as unnecessary and harmful exclusionary criteria, is a necessary, continuous quality improvement process of any efficient and effective health care system. Whether or not

an individual in need of substance use health services can get to treatment is an issue of equity in access and outcomes. Readiness for treatment is integral to the stages of change model[33] and emphasizes the importance of no and low barrier access when someone is ready.

In a large, rural and remote County without public transportation, getting to treatment and services is a significant equity issue. Flexible and responsive transportation, including both professional drivers and compensation for natural systems of support, such as family and friends, is one way to ensure that individuals in need of substance use health services can connect with care. Furthermore, leveraging the advantages of peer support transportation may further reduce barriers such as stigma, and thereby increase the likelihood of an individual connecting with services. Peer support driver positions would also align with the recommendation of people with lived and living experience to create ways for people in recovery to support peers, gain work experience, and have opportunities for meaningful employment.

Women face unique and significant barriers to accessing healthcare and treatment, including mental health and substance use services. Increased stigma, the inequitable burden of caregiving, and concerns about safety represent greater challenges and barriers for women seeking treatment. The Centre for Excellence for Women's Health has noted a system level lack of services for women in Canada and recommends a four-element strategy: addressing physical health and recovery needs; responsive to trauma, violence and mental health concerns; supportive of mothers, children and the mother-child unit; and supportive of connections among women and individual and collective agency.[34]

As barriers to services are removed and access to care improved, it is equally vital that individuals and service providers are made aware of what is available. In a complex healthcare system, clearly communicating up to date information and dispelling sometimes long held but no longer relevant information is a significant challenge. For no and low barrier, equitable access, it is important that accurate information about treatment services be easily available to all formal and informal points of contact, including the individual themselves, their friends and family, and all levels and types of service delivery staff and navigators.

Evidence

Inequitable access to care, such as that faced by individuals and groups related to social determinants of health, is a widespread challenge that is first addressed by identifying and acknowledging the contributing factors.[35] In RCD, the prevalence of low income varies widely with some regions experiencing much higher rates of basic need.[36] Consistent with general trends, income and level of education in the County are directly correlated with self-reported well-being, while people with the greatest socioeconomic need and less formal education are the least likely to report their mental health is excellent or very good.[37] The rates of uncertain attachment to primary care were significantly higher in economically deprived (21.6%) and residentially unstable neighborhoods (25.2%).

people with lived and living experience and providers in RCD report barriers to services which negatively impact recovery and long-term wellness. At times, barriers to care correspond to a system that is over capacity and struggles to flexibly accommodate re-entry without wait times. Other barriers exist due to outdated system and program processes and polices. For example, some clients report that they have been banned from some health services because of past behaviour, but such bans are contrary to a chronic care medical approach and leave high need individuals without alternatives for care. Additionally, some service providers report difficulty connecting clients to the services they need because of rigid entry requirements, such as the need for non-medical, supervised withdrawal in a County without such services. Clients who do not receive the right care at the right time are at greater individual risk of harm and more likely to require increasingly intensive, costly, and less efficient resources from health and social services.

Providers and people with lived and living experience have identified issues with transportation and equitable access as a significant challenge. Renfrew County is Ontario's largest County by land area, consisting of 17 municipalities, the City of Pembroke, and the Algonquins of Pikwakanagan First Nation but with no public transportation system. The rurality of the region hinders access to essential health services. Fifteen of the seventeen municipalities have a Rurality Index of Ontario score over 40, which indicates significant resource and infrastructural needs. Among Ontario Health Teams in the Eastern Region, the OVOHT is the most remote, with the lowest population density, highest rate of "uncertainly attached" patients,[38] the highest rate of ED visits per capita, and the longest average wait time for home care services.[39]

Both Indigenous and non-Indigenous people and providers have identified a lack of gender-based services for women in RCD and barriers for women to non-gender-based care, such as lack of childcare for women with children.

While efforts are underway to develop coordinated access for mental health and addictions services, the navigation system remains fractured and uncoordinated. People accessing services via different points of entry may receive inconsistent information about services available, undermining equitable access to services and choice in care.

Implementation Recommendations

- **Commit to continuing to identify and breaking down barriers to treatment and services.**
    - **Embed Indigenous specific care navigation and coordination with Indigenous specific services** throughout Mental Health Addictions and Substance Use Health care.
    - Regional partners, including childcare providers and Family and Children's Services, develop and implement a plan **to coordinate childcare options with Mental Health Addictions and Substance Use Health services**.

    - **Explore opportunities to optimize fee for service options with advocacy or other avenues to improve equity.**
- Develop a **communications and navigation strategy** to ensure clients and providers have current information on services, including inclusion/exclusion criteria.
- **Identify, scope and scale successful one-team approach to share and integrate care plans** among care and service providers.
- Improve **equitable access with flexible transportation**.
    - Develop a plan to **contract transportation services to and from local Mental Health, Addictions and Substance Use Health services**.
    - Explore possibility of hiring **peer suppor**t drivers as part of transportation plan.

Priority 5: **Decrease stigma with training and support for health care providers in addiction treatment, trauma informed and culturally safe practices** and by expanding and **embedding peer support** throughout the continuum of services.

Stigma is a barrier to services, care and recovery for people with addiction or substance use health needs.[40] Given the complexity of needs often faced by people with substance use disorder, individuals may interact with various health and social services prior to accessing treatment. It is vital that all health and social services work towards addictions and substance use disorder competent, anti-stigma, trauma-informed and culturally safe practice. Training, in addictions and substance use health, trauma, Indigenous cultural safety and Equity, Diversity, Inclusion and Anti-Racism should be embedded into onboarding processes and ongoing professional development opportunities.

Training areas may include:

- Trauma-Informed Care
- Non-Violent Crisis Intervention and De-escalation Training
- Algonquins of Pikwakanagan First Nation Cultural Safety Training
- Concurrent Disorders Treatment Approaches and Applications
- Opioid Poisoning Response Training
- Anti-Stigma Training
- Peer Support Training for peer support workers
- Motivational Interviewing
- Collaborative Care and Interprofessional Teams
- Substance Use Care and Treatment Best Practices
- Mental Health First Aid
- Applied Suicide Intervention Skills Training (ASIST)

In addition to training, staff must be supported by processes that review and rectify systemic and organizational biases and inequities in care delivery. Equity in access and outcomes includes increasing the number of culturally specific programs and services

that offer culturally competent, safe care, particularly for Indigenous clients and other equity-deserving groups.

Peer support and the involvement of people with lived and living experience play a significant role in reducing stigma, both by improving access to treatment and supporting health care professionals to develop their practice and confidence when working with people who have addictions and substance use health needs. Peer support may be embedded within services in any number of ways, including one-on-one and group support, and throughout the continuum, from trust building in outreach to sustainable wellness in aftercare and supportive housing.

Evidence

RCD has larger Indigenous population proportion (9%) than the province, including greater proportions of Indigenous children and youth.[42] Effects of colonialization, inter-generational trauma, and systemic racism are associated with disproportionate health harms for Indigenous people. In December 2023, the Algonquins of Pikwakanagan First Nation declared a state of emergency due to opioid overdoses. Compounding the toxic drug crisis, Pikwakanagan also identifies homelessness, inadequate or insufficient supportive housing, services for women, and intensive services as unmet priorities for their community. Pikwakanagan emphasizes the need to identify Indigenous clients and offer Indigenous specific services, including Indigenous navigation of culturally relevant resources and a care coordinator.

The population of racialized people in RCD is relatively small but increased by 75% from 2011 to 2021.[41] Due in part to the small population, racialized people in the region are less likely to see themselves reflected in their service providers and the services available to them. Health services must work actively to develop equity and anti-racism informed processes and programs, including addressing systemic, organizational, community and interpersonal biases.[42]

The Mental Health Commission of Canada[43] emphasizes the following foundational principles:

- **Person-centered** focus on the lived and living experience of service users. people with lived and living experience involved in both service design (via advisory committees) and service delivery (via peer support roles).
- **Trauma-informed** care policies and procedures and all staff trained to provide care that acknowledges and addresses trauma histories.
- **Recovery-oriented** support for individuals in defining their own treatment and recovery goals and acknowledging that recovery looks different for each person.
- **Cultural safety commitment** to decolonizing care and embedding traditional healing practices into navigation and services.

In 2019, the Chief Public Health Officer of Canada released the *Addressing stigma towards a more inclusive health system: The Chief Public Health Officer's Report on the State of Public Health in Canada 2019*[44] drawing attention to the ongoing issue of

stigma in the health system and the health inequities that result. Providers and people with lived and living experience report that stigma remains an issue for people with substance use disorder when accessing health and social services. When consulted, youth with lived experience emphasized the need for more and better training for staff who encounter people with mental health and substance use needs, ranging from security personnel and police officers to doctors and other health professionals.

Peer support has been identified as a core service across the spectrum of need, with benefits to clients and service providers, and to the mental health system and 'communities as a whole'.[45] Peer support strengthens therapeutic alliances by building trust and credibility; building hope; supporting informal approaches; and offering long-term accessibility."[46] When consulted, people with lived and living experience strongly recommended that a range of peer support roles be incorporated into the community strategy, emphasizing the unique impact peers can have in bridging gaps in access, mitigating stigma barriers, and exemplifying hope and resilience.

Implementation Recommendations

- Offer cross-training to all health and social service providers in **anti-stigma, trauma informed care, privacy and confidentiality, Equity Diversity, Inclusion and Anti-Racism, addictions and substance use health, and Indigenous cultural safety and history.**
    - **Implement coaching and communities of practice** to support ongoing, required professional development and quality improvement.
- Offer and promote **training in Opioid Agonist Treatment for primary care and ED staff**.
- **Seek funding and share resources to increase and expand peer support and Indigenous specific service navigation, care coordination and culturally relevant services**.
- Identify, scope and scale successful **peer support delivery models and consultation.**

Treatment Pillar Indicators

1. Wait times for addictions and substance use health (ASUH) services.
2. Number of people served in and out of County with withdrawal management bed-based services.
3. Number and types of transportation services offered related to ASUH care and services.
4. Number of people supported by mobile services.
5. Wait times and number of people in supportive housing.
6. Equity in access to ASUH services (sociodemographic analysis).
7. Number of trainings, number of staff trained, and types of training.
8. Number of peer support workers and number and types of services offering peer support.
9. Number/percentage of clients engaged with Peer Support Workers.

10. Average time to client stabilization and client outcomes related to retention in services, completion, long-term recovery, health, employment, and satisfaction with services.
11. Client perception of care.

Harm Reduction Report

Background

Harm reduction is a key pillar for supporting the health and rights of people who use drugs (PWUD). Its goal is to prevent deaths and reduce harms for PWUD, while working to support PWUD to stay alive, improve their health and make positive change in their life. Each client interaction is an opportunity to build rapport, provide information, education and referrals to other health and social services. It is community-based, client driven, non-judgemental, non-coercive, and addresses systems and inequities that isolate, stigmatize and marginalize people.

Drug-related harms can include drug poisoning deaths, blood-borne infections such as hepatitis C and HIV, bacterial and soft tissue infections, and other harms. Beyond the direct impacts of drug use, harms are driven by social systems, laws and policies that marginalize PWUD and shape the contexts in which people use drugs.[47]

Local Harm Reduction Context

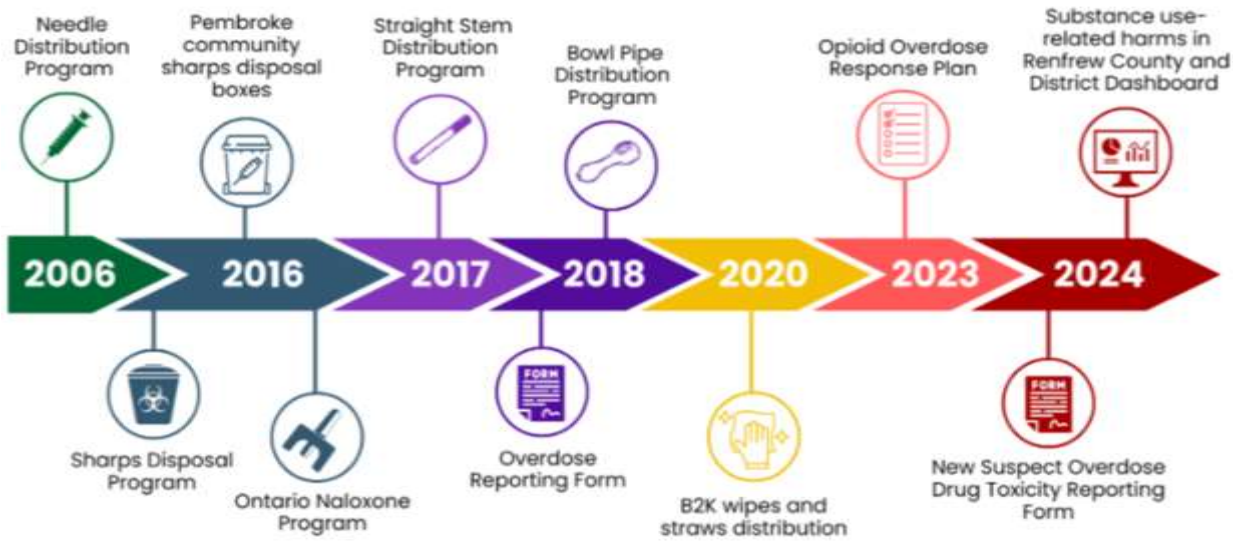


Figure 15: Timeline of Harm Reduction Services at Renfrew County and District Health Unit

Substance Use-Related Harms in Renfrew County and District Dashboard

In 2024, Renfrew County and District Health Unit (RCDHU) launched an interactive Substance Use-Related Harms in Renfrew County and District Dashboard to provide individuals and community partners with an overview of current substance use-related trends in RCD, such as opioid overdose-related ED visits to local hospitals, opioid-related deaths, and suspect drug poisoning deaths.

Drug Toxicity Response Plan

Drug Toxicity Response Plan partners approved the final plan in 2023 to share data, improve communication on drug use, identify increases in overdoses, and collaborate on initiatives to prevent or mitigate risks among people who use substances. The plan is used as a guide when responding to an increase in drug toxicity events and/or the detection of high potency formulations in the unregulated drug supply. Partners and community members can report suspect overdoses or communicate concerns about the unregulated drug supply through the new Suspect Overdose Drug Toxicity Reporting Form.

Safe Supplies Distribution and Disposal

RCDHU and partners provide access to new sterile equipment and proper disposal methods to help reduce the risk of bloodborne infections among individuals who use

substances, their peers, and the public through the Pembroke Office core needle syringe program site, satellite sites, and needle drop boxes. It's also a safe, non-judgmental way of engaging with clients using a trauma and violence-informed approach to share information for other programs, services and resources.

In 2024, there were 2,493 interactions with clients for harm reduction services across all sites. Satellite sites include Ontario Addiction Treatment Centres in Pembroke and Renfrew, Arnprior Shoppers Drug Mart, and Algonquins of Pikwakanagan First Nation Health Services. This is an increase from the 1,723 interactions in 2023.

Since 2018, the number of needles being distributed has been decreasing in both RCD and Ontario, which is most likely due to changes in modes of drug use from injection to inhalation. In 2023, 21,343 stem pipes were distributed, increasing from 11,505 in 2022. There were also 9,315 bowl pipes distributed, a slight increase from the 8,572 in 2022.

Ontario Naloxone Program

The Ontario Naloxone Program (ONP) distributes injectable and nasal spray naloxone kits through participating community-based organizations and pharmacies to individuals at risk of opioid overdose and the individual's friends and family. Through participating pharmacies, the Ontario Naloxone Program for Pharmacies (ONPP) distributes injectable and nasal spray naloxone kits to individuals at risk of an opioid overdose, the individual's family and friends and people in a position to care for at risk individuals.

Naloxone distribution has continued to increase across RCD since 2016. In 2024, RCDHU harm reduction staff and 14 partnering organizations distributed 4,452 doses to eligible clients through the ONP and more than 6,500 doses were distributed by pharmacies through the ONPP. This is a notable increase from 2023, when 2,796 doses were distributed through the ONP and the ONPP distributed 5,784.

Drug Test Strip Program

In 2024, RCDHU began offering fentanyl, xylazine, and benzodiazepine drug test strip kits to interested clients of their Harm Reduction Program. This pilot initiative supported by the Ontario Harm Reduction Program is intended to reduce the risk of overdoses by allowing individuals to test their substances for the presence of these potentially fatal contaminants in their drug supply.

Outreach Team

In 2024, RCDHU Harm Reduction Public Health Nurses formed an Outreach Team to provide Harm Reduction and other Public Health Services to individuals in high need and underserved areas of RCD. Locations included within the outreach model are

foodbanks, community libraries, community housing locations, the warming centre, youth wellness hubs, and others.

Harm Reduction Pillar Priorities

1. Implement Remote Spotting Services
2. Implement Drug Checking Services
3. Centralize and Automate Drug Toxicity Alerts
4. Increase Naloxone Distribution
5. Determine Feasibility of Urgent Public Health Needs Site
6. Maintain the Drug Toxicity Response Plan

Priority 1: Implement Remote Spotting Services

Spotting services refer to a practice among PWUD of supervising or observing someone who is using drugs to provide help in case an overdose occurs. People who use drugs typically connect with trusted family and friends in person and remotely for spotting.[48] Remote spotting can be done at all hours, including when other services are closed, and provides access to supervised consumption for people who cannot access a Supervised Consumption Site.[48]

The National Overdose Response Service (NORS) has begun to provide remote spotting for people across Canada and an evaluation is underway.[49] It's an overdose prevention hotline that provides compassionate, non-judgemental support for PWUD whenever and wherever they are. It can be accessed by calling or texting 1-888-688-NORS (6677). During the first 14 months of operations, NORS monitored 2,172 substance use events; 53 adverse events required emergency response, and no fatalities were reported.[50]

Evidence

Evidence on remote spotting continues to emerge in Canada. People who use drugs report that remote spotting provides access to overdose response when and where they need it, and some find it more comfortable to use spotting than to access other traditional services.[48]

One primary study conducted in British Columbia, found that 68% of individuals who used substances and had a cellphone stated that they were willing to use technology-based solutions to mitigate the risks of overdose.[51]

Virtual overdose monitoring services are novel public health interventions capable of providing timely and accessible harm reduction and overdose prevention services for people who use substances. Evidence, including pilot data from the NORS, suggests that virtual overdose monitoring services have promise as an adjunct to supervised consumption services in the continuum of care for people who use substances.[52]

Implementation Recommendations

- Implement **Remote Spotting** Services
- Endorse and promote the use of the **National Overdose Response Service** (NORS). The virtual safe consumption service is available for all Canadians, 24 hours a day, 365 days a year.
- Collaborate with partners **to identify and promote other spotting services** such as cell phone applications that are operable in RCD.

Priority 2: Implement Drug Checking

Drug checking refers to services that provide people with more information about the composition of their drugs to allow them to make informed decisions on use of the drug. These services can also be used to monitor the unregulated market and inform broader policy and program initiatives including informing public health alerts, harm reduction interventions, and safer supply initiatives.[53] Monitoring the drug supply includes identifying expected and unexpected substances, detecting new substances, and detecting drugs of concern.[54] Some common approaches to drug checking include providing people with test strips to check their drugs for specific substances (e.g., fentanyl, benzodiazepines) or using advanced technologies to analyze the full chemical composition of drug samples.[55]

Evidence

Drug checking services have expanded in recent years in community settings and studies have presented evidence that drug checking can lead to more informed decision-making and to changes in behaviour. It allows people to submit drug samples or used supplies for chemical analysis and receive feedback about the sample and harm reduction advice. A systematic review found that drug checking services can influence peoples' intentions and actions by analyzing their drug samples.[54] This influence appears to vary depending on the setting and the population.[54] For example, for people who use opioids, information from drug checking (e.g., detecting fentanyl) has been found to change behaviour in ways that can reduce the chance of overdose (e.g., doing a test shot, reducing the dose, not using alone).[54]

The integration of drug checking within existing services can reportedly facilitate improved relationships between service users and staff across services, and aid in the provision of a more holistic approach and wrap-around care.[56] This is particularly key for individuals who have become 'disconnected' from care and services, or who have never been in contact with services.[56]

A recent report from Toronto's Drug Checking Service summarizes 10 key findings related to the impact of drug checking, which are consistent with learnings from the implementation and evaluation of similar programs in British Columbia and elsewhere.[57] They are:

1. Drug checking provides potentially life-saving information to those at highest risk of overdose.
2. Drug checking facilitates behaviour change.
3. Drug checking provides a gateway to accessing harm reduction services.
4. Drug checking services enable monitoring of the unregulated drug market and public dissemination of drug market trends in real time.
5. Drug checking informs clinicians and care.
6. Drug checking findings improve health and social services.
7. Drug checking empowers people who use drugs to advocate for themselves and help develop solutions that impact them.
8. Drug checking generates evidence to support advocacy for services and safer alternatives for people who use drugs.
9. Toronto's Drug Checking Service has created turnkey solutions for other organizations and jurisdictions to establish local drug checking programs, increasing system efficiencies and limiting redundancy.
10. Drug checking is valuable to PWUD.

Implementation Recommendations

- Pilot the **distribution and training** of RCDHU Harm Reduction Program clients with **drug test strips** to detect the presence of fentanyl, xylazine, and benzodiazepine.
    - Collect input from clients who used the test strips to **determine their effectiveness, ease of use, and the likelihood of the results changing their behaviour related to substance use**.
- Participate in the **Ontario Drug Checking Community of Practice** to monitor trends in the composition of the unregulated drug supply as determined through testing conducted by the Toronto Drug Checking Service.
- **Explore the possibility of providing a drug checking service** that uses a model and technology that can be integrated with existing programs.

Priority 3: Centralize and Automate Drug Toxicity Alerts

The Drug Toxicity Response Plan for RCD provides guidance on how community partners will respond to a surge in opioid overdoses and/or the detection of high-potency opioid formulations in RCD to prevent harm to residents. Once the plan is activated, there are a series of response operations that can be mobilized, with one critical intervention being the issuing of an overdose alert. Drug alerts are distributed through different forms of media, harm reduction service websites, social networks, posters, and through outreach interactions. These alerts provide an opportunity to

provide life-saving information quickly and efficiently. A cross-sectional survey found that of the 261 participants who responded to a question asking if they took steps to be safer when using substances after seeing/hearing a drug alert, 176 (67.4%) reported they did subsequently take safer steps.[58]

The centralization and automation of the RCD alert system will allow for an almost instant distribution of alerts while ensuring it reaches PWUD with timely and targeted information about the local drug supply to enable them to use more safely and reduce the impact.

Evidence

An effective way to reduce the impact of emergencies on communities is for governments to issue alerts and warnings to the public before, during, and after emergencies. Public alerts and warnings provide the necessary information to warn the public and effect the necessary actions that will lead to their safety. Public alerts and warnings deliver messages to populations at risk of imminent hazards, with the goal of maximizing the probability that people take protective actions and minimize the delay in taking those actions.[59]

A literature review of public alerts and warning systems examined the relationship between location and the sources individuals receive warnings from. The results indicated that the preferred warning source for individuals away from home and those at home for authority-based media sources were automated texts and television, respectively. Additionally, it examined students' perceptions of emergency alert communications and found that students considered warning messages via text messages to be more serious than warning messages from social media.[60]

Implementation Recommendations

- Identify a **web-based system to provide drug toxicity and health alerts**.
    - It must provide a free, real-time text messaging service for anyone to receive alerts about toxic drugs in their community.
- Continue to **share drug toxicity alerts** with local media, on social media channels, and with partners to ensure timely and widespread communication reaches PWUD.

Priority 4: Increase Naloxone Distribution

The Ministry of Health distributes naloxone kits through the ONP to RCDHU and other Public Health Units. Naloxone is an opioid antagonist, which means it is a fast-acting medication that can temporarily reverse the effects of an opioid overdose and prevent deaths. Naloxone can be administered in two ways, through an injection or nasal spray, and can restore breathing in 2 to 5 minutes. The program distributes naloxone to

organizations and programs that interact with people at risk of an overdose, or family and friends of people at risk of an overdose.[61]

The rural nature of RCD poses challenges related to naloxone transportation and distribution, and stigma continues to limit access in some regions. This makes it crucial to make naloxone as accessible as possible by continuing to expand access through partner organizations.

Evidence

Overdose education and naloxone distribution programs are effective at preventing opioid overdose deaths. Systematic reviews of these programs have found that they provide long-term improvement in knowledge about opioid overdose, they reduce opioid-related mortality and there is a strong association between naloxone distribution and overdose survival.[62,63]

Implementation Recommendations

- **Recruit, train and onboard additional partners** to the Ontario Naloxone Program.
- **Promote the effectiveness of Naloxone** in temporarily reversing opioid overdoses to the community, clients, and partners.
- Ensure maximum **geographic and demographic access to Naloxone** through mobile outreach programs.

Priority 5: Determine the Feasibility of an Urgent Public Health Needs Site

Urgent public health need sites are similar to supervised consumption sites and provide services to reduce the harms related to drug use and infectious diseases. They are established on a temporary basis to respond to urgent needs (e.g., a significant increase in overdoses or drug-related deaths) in a specific region or community. They are also known as overdose prevention sites and can be established quickly.

Urgent public health need sites, when established under the authority of the class exemption issued to a provincial or territorial government, are the responsibility of that government. The government to which the exemption is issued is responsible for the oversight of sites set up under the exemption. Should the province or territory not use the class exemption, Health Canada would consider any applications to set up urgent public health need sites.

Evidence

Research has shown that supervised consumptions sites reduce overdose deaths, improve access to other forms of health care, and reduce unsafe drug use behaviours.[64] They also reduce the burden on emergency services.[65]

The benefits of supervised consumption sites are recognized by numerous expert bodies both in Canada and internationally. Supervised consumption sites have been endorsed by multiple professional associations in Canada, including the Canadian Nurses Association, Registered Nurses Association of Ontario, Canadian Medical Association, Canadian Association of Family Physicians, Canadian Public Health Association, and more.[64]

Contrary to critics' concerns, supervised consumption sites do not appear to increase or encourage harmful use of drugs.[66] Most people who use these services report long term, high frequency use of injection drugs and are already at elevated risk for the outcomes that supervised consumption sites aim to address.[67] Additionally, supervised consumption sites have been linked to improved public order.[66]

Implementation Recommendations

- Consult with Health Canada regarding a **subsection 56(1) class exemption from the *Controlled Drugs and Substances Act*** in relation to urgent public health needs site.
- Engage with community members and partners to **identify the most appropriate location for an Urgent Public Health Needs Site** should the need arise.

Priority 6: Maintain the Drug Toxicity Response Plan

In Ontario, overdose response strategies have been implemented that reflect the comprehensive approach of the Canadian Drugs and Substances Strategy.

The Drug Toxicity Response Plan (formerly Opioid Overdose Response Plan) for RCD identifies how the community can respond to drug toxicity events that have the potential to tax first responders, hospitals, resources, and/or cause harm in the community.

RCDHU and/or partners will respond to a surge in drug toxicity events and/or the detection of high potency formulations in the unregulated drug supply. Partners will convene meetings as appropriate and begin an investigation to collect more information and identify a cause. Depending on the results, the RCDDS may issue a drug alert to the community. Additional roles and responsibilities of partnering organizations are defined in the plan and could include enhancing surveillance, additional knowledge exchange, increasing focused naloxone distribution, activating an Incident Management System and establishing an Urgent Public Health Needs Site.

Evidence

Public health surveillance is the foundation for public health response, including policy and practice.[68]

Surveillance data from multiple partners (medical examiners/coroners, EDs, first responders, etc.) can provide a more complete picture of the nature of the substance use and overdose problem, facilitating a multisector systems response. However, challenges exist in sharing and translating these surveillance data. Cross-sector partnerships can help turn data into action to inform the development of prevention and intervention strategies that can lead to improved community outcomes. Collaboration between public health and public safety is a critical step to saving lives and responding to the drug overdose crisis.[69]

Implementation Recommendations

- Meet quarterly and more frequently, if necessary, with the partners of the RCD **Drug Toxicity Response Plan** to share information regarding suspect opioid-related deaths, opioid overdose ED visits, and/or the presence of high-potency or contaminated opioid formulations in the community.
- Complete **daily surveillance** of the RCDHU Suspect Overdose and Drug Toxicity reports.
- Complete **weekly surveillance** of the reports received from the Office of Chief Coroner of Ontario related to ED visits for opioid overdose and suspect, probable, and confirmed deaths.

Harm Reduction Pillar Indicators

1. Number of communications promoting the spotting services.
2. Number of drug samples checked or submitted for checking.
3. Number of members enrolled in automated drug toxicity alert system.
4. Number of naloxone kits distributed through the Ontario Naloxone Program.
5. Number of partners distributing naloxone.
6. Plan created to enable rapid deployment of an Urgent Public Health Needs Site.
7. Number of Drug Toxicity Alerts issued.
8. Number of partners participating in the Harm Reduction Working Group.
9. Number of partners participating in the Drug Toxicity Response Plan.
10. Number of harm reduction interactions by RCDHU and partners.

Community Safety Report

Background

The Community Safety pillar of the RCDDS aims to enhance public safety through proactive measures that address the interconnected challenges of substance use and community safety. Community safety is a critical element in fostering resilient and healthy communities. In recent years, there has been an increasing recognition of the prevalence of substance use challenges and the impact on the overall feeling of safety in communities. The frequency of substance use has been linked to various forms of criminal activity, anti-social behaviour, and the presence of discarded substance use supplies, all of which can impact the feeling of safety and quality of life for community members. Canada is currently facing a severe public health crisis, largely driven by the increasing risks associated with the unregulated drug supply.[70] In this context, strengthening community safety is crucial for supporting safer communities while also aiming to address the challenges associated with substance use.

By addressing community safety as a distinct but interrelated component of this larger strategy, we seek to explore how substance-related challenges influence safety

concerns, and how community initiatives can be strengthened to mitigate the effects of substance use. An essential component of this work is in collaboration with a wide range of agencies, organizations and community groups building on existing efforts that have contributed to a strong sense of safety and well-being. By working across sectors, the group aims to leverage local expertise and resources, creating a coordinated and effective approach. The main goal of this group is to establish a mechanism for gathering and compiling data to build comprehensive statistics as it relates to substance use in our communities. This data will be shared transparently, with an honest reflection of both successes and challenges, ensuring that all aspects of the situation are accurately represented. By providing clear and open access to this information, we aim to achieve trust and accountability within the community. In addition, efforts will be made to standardize datasets, minimizing the risk of conflicting information and facilitating more accurate comparisons and analyses. Ultimately, this will enable the identification of key areas where safety initiatives can be promoted and enhanced, while also placing a strong emphasis on gaps in services that may hinder effective support.

Understanding the factors that contribute to community safety is essential to developing effective strategies that not only address immediate concerns related to substance use but also nurture lasting resilience and the feeling of community wellness. Substance use is often linked to non-violent offenses such as disorderly behavior and public intoxication, which can impact community safety and perceptions of security.[71] Recognizing the work already underway within communities, this group aims to strengthen these efforts through collaboration and coordination. By building on these successes and working together, the Community Safety pillar seeks to maximize the impact of available resources, ensuring that communities are safe, resilient and better supported.

Community Safety Pillar Priorities

1. **Implement a comprehensive complaint reporting mechanism** by providing the community with a clear, accessible system to report safety concerns.
2. Promote a cohesive and inclusive community by addressing the factors that impact safety while **fostering social order** that values respect, belonging and accessibility for all.
3. **Ensure the safe disposal of substance use supplies** by expanding education and training and supporting harm reduction through increased awareness.
4. Integrate **enforcement** by balancing proactive and reactive measures, utilizing data and feedback, and ensure effective, adaptive responses to substance use related challenges.

Priority 1: Develop a Complaint Reporting Mechanism

The development of a formalized complaint reporting mechanism plays a crucial role in improving community safety. Currently, no such system exists to consistently capture and address community safety concerns, making it a missing but vital component in the effort to foster safer communities. This will not only help address concerns but will act as a central mechanism for gathering data and ultimately initiating actions. A well-structured and efficient system will provide residents with a clear channel to report concerns, helping to ensure that matters are identified. The cornerstone of this initiative will be the implementation of Access E11 software, a platform that allows for seamless communication between community members and local government. This system will give residents the ability to submit reports on a variety of community safety concerns, ensuring that it is captured and tracked effectively.

In addition to the direct reports made through Access E11, complaints received by other agencies will also be incorporated into the system. These concerns will be documented on complaint reporting data sheets, which will be distributed during Community Safety Working Group meetings. The data sheets will be collected at the following meeting and manually entered into the Access E11 platform, ensuring that all complaints, regardless of their source, are systematically tracked and addressed.

One of the key benefits of Access E11 is its ability to generate detailed dashboards and statistical reports. These tools provide real-time insights into the types, frequency and location of issues raised by the community, making it easier to spot trends and identify areas that require attention.

The complaint mechanism will not only improve the responsiveness of the local agencies but also provide a structured way to gather data that can inform and refine broader community safety strategies. By continuously analyzing the information collected, the system will allow for targeted and data-driven interventions, ensuring that the community's most pressing safety concerns are addressed in an effective manner.

Evidence

A well-structured and streamlined system allows for the collection and analysis of data related to complaints, helping communities and authorities prioritize resources effectively and address concerns. This mechanism is particularly significant for identifying patterns or recurring issues that may not be immediately apparent without an organized data collection process.[72]

Key to the success of the systems is the standardization of data. Efforts will be made to eliminate conflicting data and ensure that information across various sources is accurate and comparable. This process will allow for more effective analysis while acknowledging that data may evolve over time as trends shift within the community. Standardized data enhances the reliability of insights, making it easier for authorities and organizations to assess community safety needs and distribute or establish resources accordingly.

In addition to tracking statistical data from complaints, emphasis will also be placed on collecting information related to the "actions taken" and "outcomes" resulting from responses to complaints and interventions. This will provide insight into the effectiveness of the response to resolve issues, helping to assess whether safety strategies and interventions are working as intended. By tracking the outcomes of each complaint and response, stakeholders can better understand what measures are most effective in reducing safety concerns within the communities.

Efficient data analysis is paramount in gaining valuable understanding. Without the ability to efficiently analyze collected data, municipalities may find it challenging to identify underlying trends and draw actionable conclusions.[73] The Access E11 platform, for example, is designed with data capture and consolidation integrated into the service request process. The software is equipped with customizable dashboards that make it easy to visualize data and generate comprehensive reports at any time.[74] This feature can significantly enhance transparency and ensure that community safety concerns are being received.

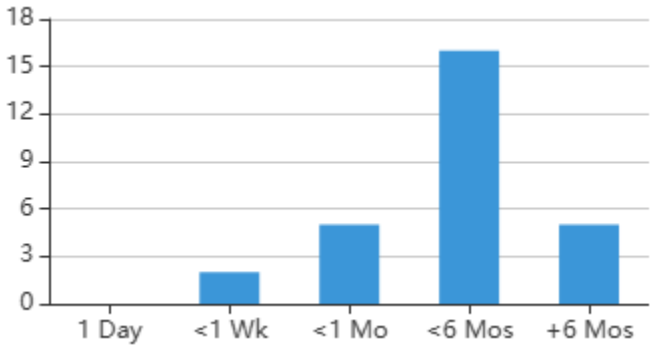


Figure 16: Example graphic from Access E11 software dashboard showing the approximate age of cases/reports received.

Figure 17: Example graphic from Access E11 software dashboard showing the approximate location of cases/reports received.

The use of a digital complaint reporting mechanism also contributes to increasing citizen participation and organizational transparency. A survey involving 169 local government leaders highlights this trend, revealing a substantial 51% increase in constituent participation due to the implementation of digital tools for citizen engagement.[75] These tools not only foster better engagement but also improve the transparency of the process, which is essential for maintaining community trust.

Despite the automated features of Access E11, certain data will still require manual input by staff, which introduces the potential for human error in the data entry process. The simple act of manually inputting data into a spreadsheet has the probability of human error as high as 40%.[76] This reinforces the value of using automated data systems, like Access E11, which reduce the chances of such errors and enhance the accuracy and reliability of the data collected. Effectively communicating and promoting Access E11 will be crucial to ensuring its successful implementation and reduction in manual data entry error.

The combination of standardized data collection, real-time reporting, and detailed outcome tracking will provide a robust evidence base for improving community safety. These tools will also facilitate the ongoing refinement of strategies, helping to adapt approaches as new trends and challenges emerge in the community.

Implementation Recommendations

- Extend the capabilities of the City of Pembroke's **AccessE11, Citizen Issue and Relationship Management** platform to collect and action community safety-related reports from residents.
- Collect, analyze, and report **community safety data** to identify trends that can be proactively addressed.

Priority 2: Fostering Social Order

Cultivating social order is essential for forming a cohesive and inclusive community where all individuals feel respected, valued, and safe. Social order refers to the structured arrangement of norms, values, roles, and institutions within a society that guides individuals' behavior, maintains stability, and regulates interactions.[77] It is vital in shaping how individuals interact with one another and influences the broader scope of social dynamics within the community. This priority focuses on understanding and addressing the underlying social factors that contribute to community safety, including substance use and access to resources.

Efforts to promote social order aim to strengthen existing systems by ensuring that current services and actions are not only effective but also equitable and accessible to

all members of the community. Social order provides individuals with a sense of security, belonging, and predictability, contributing to their emotional and psychological well-being.[78] Ensuring services are aligned with these needs helps create a more stable and unvarying environment, contributing to an overall social cohesion and improved feeling of safety. One significant challenge in achieving social order is combatting the stigma that individuals who use substances often face. This stigma can impact the community structure of social order by creating divisions and amplifying exclusion. The negative perceptions of people who use substances can create barriers to both accessing services and receiving fair treatment. A national Canadian survey revealed that nearly half of individuals who have used substances reported experiencing stigma or discrimination during their period of substance use.[79] This societal stigma can lead to a sense of isolation and reluctance to seek help, which undermines efforts to promote safety and cohesion in the community. Furthermore, stigma impacts how services are structured and delivered. When stigma is present, services may be less welcoming, and the quality of care may be compromised. For those affected by substance use, these inequalities are often amplified, creating a cycle where individuals are deterred from seeking the care they need.

Figure 18: Infographic showing the cycle of stigma as it relates to substance-use.

A fundamental component of social order involves the concept of "societal norms" and behavioral expectations in public spaces. "Societal norms" are the shared rules and standards that help shape how individuals engage and interact in various social contexts. These norms help regulate behavior by establishing expectations for how people should act in public, from maintaining order in communal areas to following health and safety regulations. However, when these norms become rigid or exclusionary, they can inadvertently create divisions within the community. For example, the expectation that people in public spaces should conform to certain standards of behavior, cleanliness, and conduct can alienate individuals who are struggling with substance use. As a result, spaces such as public washrooms, shelters, and other communal facilities may close their doors or restrict access. This exclusionary tendency can create a cycle where marginalized individuals are pushed further into isolation, making it more difficult for them to access basic services. These closures, while perhaps intended to maintain order, ultimately reduce the overall accessibility and inclusivity of public spaces, undermining the social order's goal of ensuring safety and well-being for all community members.

Social order and cohesion are fundamental to creating a safe community. Social order is shaped by societal norms, behavioral expectations, and the ability of institutions to provide accessible services to all. When stigma, exclusions, and limited access to services take hold, these elements can divide communities. Stigma associated with substance use can hinder one's ability to seek help and receive fair treatment. Moreover, societal norms and behavioral expectations about public conduct can further the feeling of isolation. Promoting a more inclusive, equitable, and accessible social order requires addressing these barriers and ensuring that the systems in place foster collective well-being for all members of the community.

Evidence

To measure the effectiveness of efforts to promote social order, it is essential to capture social order-related complaints and reports through **Access E11** and additional data and reports from other agencies. By documenting complaints and identifying recurring patterns, we can uncover gaps in services and support. This helps inform the areas where improvements are needed, ensuring that social order strategies are addressing the challenges present within the community. The development of social order relies on careful planning and the establishment of partnerships across multiple sectors.

For these efforts to be successful, it is essential that all involved sectors share plans and data, ensuring there is a common understanding of local and systemic issues.[80] A shared understanding is critical in making informed decisions about enhancing community safety measures and resource allocation.

Additionally, monitoring the number of "Good Neighbor" contracts that are signed serves as an important metric for evaluating social order efforts. A "Good Neighbor" contract is an agreement signed by establishments that wish to operate as emergency care facilities in communities. The terms of the contracts aim to ensure that establishments are maintaining standards that include environmental, operational, and procedural considerations to minimize negative impacts on the surrounding neighborhood. In signing these contracts, establishments commit to fostering positive, supportive and safe environments for all individuals, promoting community well-being. Using this data as an indicator of the social order surrounding services helps track how well the community is responding to initiatives that encourage positive engagement. "Widespread participation in community and social life is fundamental to social cohesion. Full participation requires access to economic, political, and cultural opportunities and involves active engagement with other members of the community and society."[81]

This approach helps to inform strategies to reduce stigma, improve social cohesion, and ensure that social order efforts align with the needs of all community members. All societies regulate human behaviour, which involves enforcing norms. It can be broadly defined as "organized efforts aimed at influencing and changing people's

behaviour."[82] When used to enhance inclusivity, maintaining social order can act as a tool for promoting stability without reinforcing exclusion. As such, maintaining social order ensures that norms and expectations support the well-being of all community members. The underlying goal is to uphold social order, which consists of practices and behaviours that guide the daily lives of members in communities.[83]

The integration of data-driven approaches, such as tracking social order-related complaints, monitoring "Good Neighbor" contracts, and fostering multi-sectoral collaboration for maintaining social order, plays a vital role in refining community social order strategies. These efforts ensure that services are accessible, effective, and responsive to the needs of the community. By addressing stigma, reinforcing inclusivity, and actively involving all community members, we can create a more cohesive and resilient social environment. Ultimately, promoting social order is not just about maintaining rules and regulations but about fostering environments where all individuals feel supported, respected, and valued. This creates a community where safety, well-being, and social cohesion can thrive for everyone.

Implementation Recommendations

- Implement a **"Good Neighbour Contract Program"** that outlines expectations related to environmental, operational, and procedural standards to mitigate any potential negative impacts on the neighbourhood.
- Collect data with AccessE11and from partners to **identify recurring patterns** to uncover gaps and inform areas for improvement.
- Explore the possibility of implementing a **peer delivered program** that offers assertive outreach to increase access to health promotion services among high-risk, isolated PWUD.
    - Use the peer-led program to reinforce the social order norms and expectations of the Good Neighbour Contracts.

Priority 3: Ensuring the Safe Disposal of Substance Use Supplies

Improperly disposing of sharps in public places is a safety risk that many communities need to address. A sharp is a biomedical waste product that has edges that can lacerate or puncture the skin. Sharps may contain blood, body fluids or hazardous substances and must be treated as a health hazard and disposed of properly. Common harm reduction materials that would be considered sharps are needles and glass pipes, as well as anything attached to them such as syringes.

RCD residents can obtain an approved sharps disposal container and access disposal services at RCDHU, local pharmacies and community agencies throughout the County free of charge. The Ottawa Valley Waste Recovery Centre accepts sharps at their Hazardous Waste Depot or at one of their Environmental Days. The City of Pembroke

also offers Community Disposal Bins locations as depicted below (Figure 20). Additionally, many public washrooms contain wall-mounted sharps disposal boxes.

Figure 19: Location of Community Disposal Bins in Pembroke, ON.

Despite these evidence-based interventions, sharps are sometimes still disposed of improperly in the community. To mitigate this risk, RCDHU offers education and training to municipal staff, business owners and staff, and community members on the safe handling and disposal of sharps.

Needle distribution and disposal programs play an important role in improving community safety by reducing improper syringe disposal in addition to mitigating risks associated with needlestick injuries. Research has shown a 49% decrease in improperly discarded syringes following the implementation of a syringe disposal program. As such, continued access to increased disposal options encourages safer syringe handling practices and improves community safety while supporting harm reduction efforts.

Evidence

When needles are discarded improperly in a community, it is often due to a lack of knowledge regarding proper disposal practices and/or not having accessible places to properly dispose of sharps. Most people will dispose of needles safely if disposal options are available. For people experiencing homelessness who also inject drugs, this issue is made even more difficult due to limited hours of operation for programs and agencies that accept sharps for disposal.[84]

To increase proper disposal, several evidence-based strategies have been shown to reduce the risk of sharps in the community. This includes: adopting needle/syringe

distribution policies instead of strict exchange policies;[85] providing multiple options and locations for return and disposal of equipment;[85] conducting visits to retrieve biohazard bins and syringes from homes, social housing and communal drug use spaces;[85] conducting community clean-ups to collect needles;[85] lengthening the hours of operation of NSPs and other harm reduction programs;[86] installing public disposal boxes[87]; promoting pharmacy disposal[88];; and providing safer spaces such as supervised consumption sites for PWUD[89].

Implementation Recommendations

- Provide opportunities for **education and training regarding the safe handling and disposal of substance use supplies** to municipal staff, business owners and staff, community members, and PWUD.
- **Increase opportunities** for the **safe disposal** of substance use supplies by providing multiple options for and locations for return and disposal.

Priority 4: Enforcement

Community safety involves a broad range of approaches that collaborate to promote the well-being and safety of communities. While the working group recognizes that enforcement plays an important role in this broader framework, it is acknowledged that it is not the primary focus when addressing substance use-related harms. Enforcement is viewed as a critical component but not the most important priority within the broader scope of community safety efforts. A comprehensive approach is taken, with enforcement as one component of the broader strategy. By collaborating, these efforts can create an improved response to substance-use challenges, balancing short-term enforcement actions with long-term goals for community safety.

Enforcement efforts aimed at addressing challenges related to substance use are essential in maintaining public safety and order. These efforts focus on proactive measures, such as drug seizures and foot patrols, as well as reactive measures, such as responding to calls for service. By actively disrupting illegal activities, law enforcement plays a key role in reducing the availability of substances and curbing related criminal activity. These actions contribute not only to public safety but also to fostering a sense of security and trust within the community.

Data collected from local agencies, including the OPP and Bylaw Enforcement Services, will provide valuable insights into the scope and effectiveness of enforcement activities. Information will help assess enforcement efforts and inform ongoing strategies. By tracking this data, the community can better understand enforcement needs, identify any gaps, and recognize successes. Additionally, tracking trends over time allows for a more informed approach to resource allocation, ensuring that enforcement actions are both efficient and aligned with emerging challenges.

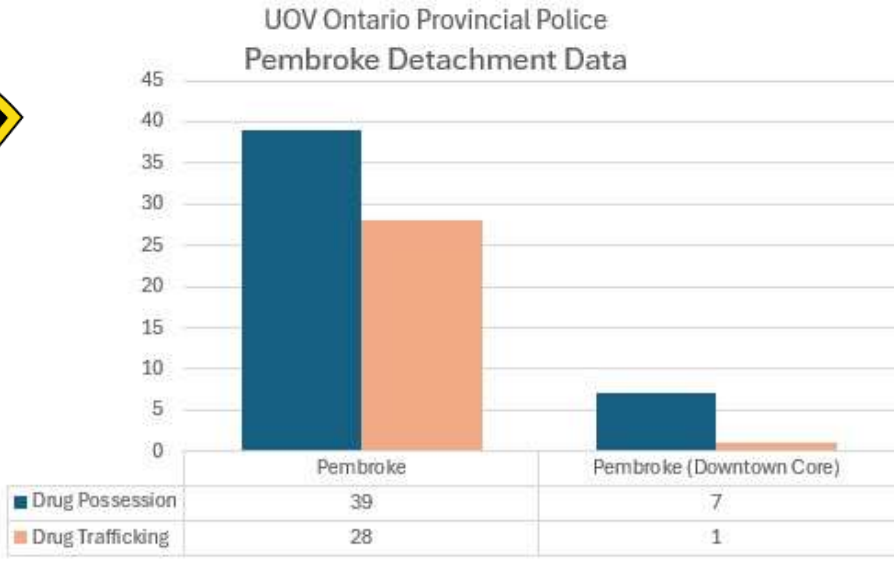
In addition to quantitative data, qualitative information will also be crucial in assessing the impact of enforcement actions. This will help gauge how well enforcement activities reassure and protect the community, while also identifying areas for improvement. Qualitative feedback from residents, community leaders, and local organizations will provide a deeper understanding of the social and emotional effects of enforcement on the community.

Ongoing data collection and analysis will be key in refining enforcement strategies over time. As the landscape of substance use in the community evolves, so too should enforcement responses. Continuous feedback and collaboration will ensure that enforcement strategies remain adaptive, focused on enhancing safety, and responding effectively to emerging challenges. This continuous process ensures that enforcement remains dynamic and responsive to shifts in substance use patterns, ensuring that public safety measures evolve with the community's needs.

Evidence

To understand the impact of enforcement efforts on community safety, it is essential to gather and analyze data from various local agencies involved in addressing substance use-related issues. Data from police, bylaw enforcement, and other agencies and organizations provide valuable insights into the scope of substance use and the effectiveness of enforcement activities.

The OPP, Pembroke detachment has recorded a significant number of calls for service, highlighting ongoing substance use challenges. In 2024, there were 39 drug possession-related calls in Pembroke, with 7 occurring in the Downtown Core. Drug trafficking calls totaled 28 in Pembroke, with 1 in the Downtown Core.



number of charges related to drug crimes and their approximate location.

Additionally, City of Pembroke Bylaw Enforcement data shows a small but increasing number of calls for issues related to substance use. In 2023, there were 2 loitering calls, and 3 calls about improperly disposed substance use supplies. In 2024, loitering calls increased to 7, while calls regarding substance use supplies remained steady at 3. Notably, in 2024, there were no supplies found in responding to these calls, though the issue of improperly disposed substance use supplies continues to be a concern.

Despite the currently available data, there is a recognition that more data collection and dissemination is necessary to assess the entire reach of enforcement efforts and their influence on community safety. As policing in Ontario shifts towards more strategic approaches that focus on diversion and health,[90] it is crucial to continue gathering data that accurately reflects these evolving strategies. This shift emphasizes the need for continuous and comprehensive data to guide law enforcement responses to substance use issues, particularly as the focus moves from purely punitive measures to those that address underlying causes. This evidence supports the growing importance of accurate and reliable data collection.

Reviews of proven policing practices suggest that visible patrols, if strategically focused on crime hotspots, can reduce crime more effectively.[91] By further integrating data collection into these efforts, law enforcement agencies can develop a better understanding of where interventions are most needed and whether they are successful. This coordination ensures timely, effective responses to both immediate enforcement needs and long-term community safety goals. Additionally, Mobile Crisis Response Teams, which combine police officers with crisis workers, have been shown to be effective in responding to complex situations where addictions are a factor. These teams help connect individuals with the appropriate community supports,[92] rather than putting the emphasis on enforcement measures.

Finally, it is important to highlight that as agencies continue to collect data, efforts will be made to ensure that the data is consistent, comparable, and repeatable across various organizations. This approach will be crucial in creating reliable evidence for future strategies and allowing enforcement practices to evolve based on real-world outcomes. By continuously improving data collection and maintaining alignment between agencies, we can ensure that enforcement strategies remain adaptable and responsive to the community's changing needs.

Implementation Recommendations

- **Coordinate the efforts** of the OPP, bylaw enforcement, and other partners such as Mobile Crisis Response Teams and Mesa **to respond to complex situations where drug use is involved**.
- Review by-laws to identify **opportunities to align with and support enforcement** efforts.

- Support **proactive public and policing measures** such as the Community Watch Program and CamSafe.
- Collect, analyze, and disseminate **data from local enforcement agencies to assess the effectiveness** and influence on community safety.

Community Safety Pillar Indicators

1. Number of entries into Access E11 across agencies and organizations
2. Number of "Good Neighbor" contracts signed
3. Number of "Social Order" related complaints received
4. Number of substance use supplies disposed of by community members/downtown business owners
5. Number of complaints related to improperly disposed of substance use supplies
6. Number of calls for service related to substance use issues
7. Number of drug possession charges
8. Number of drug trafficking charges
9. Number of large-scale drug seizures
10. Number of foot patrol hours

Community Engagement Report

In January and February 2025, residents of RCD were invited to participate in a Community Engagement Survey (CES) to share their feedback and insight about substance use-related harms in their community. 180 people took part in the survey, which asked 15 questions that were designed to assist with identifying the priorities for action within each of the four pillars of the strategy. The survey also included one open-ended question that allowed participants to share any additional thoughts on prevention, treatment, harm reduction, or community safety. A thematic summary of those responses can be found in Appendix A.

The results of the CES were shared with the RCDDS steering committee and the pillar working groups to inform and validate the priorities and create the implementation recommendations.

The following figures depict the results of the survey.

Question 1: What municipality do you live in?

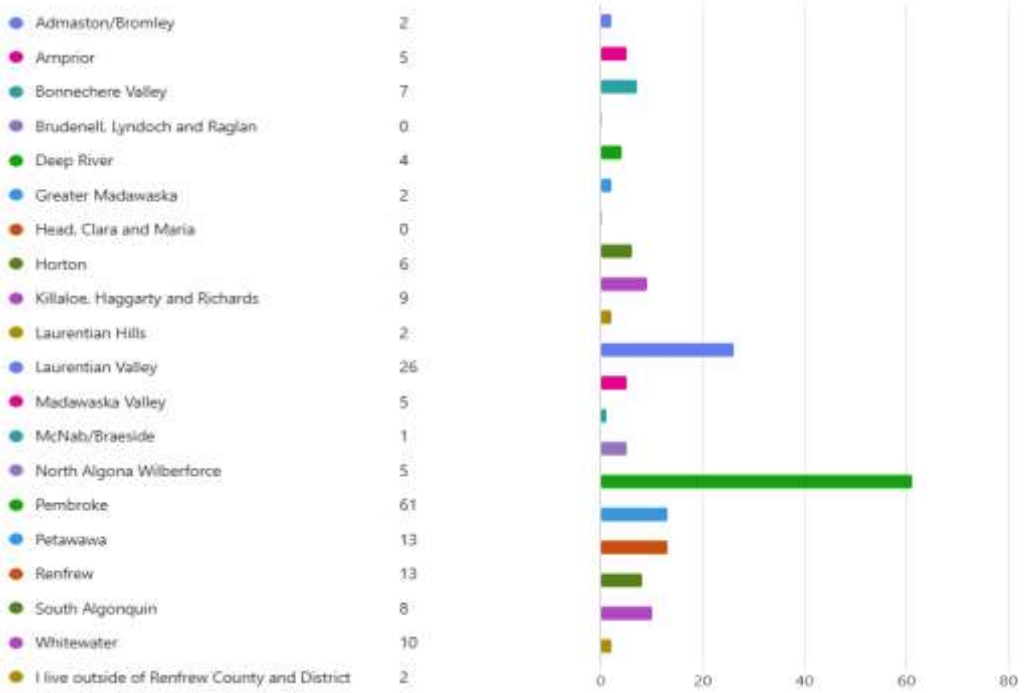


Figure 21: Community Engagement Survey respondent's municipality of residence.

There was participation from all but two municipalities in RCD with the most responses (34%) submitted by Pembroke residents.

Question 2: What is your age?

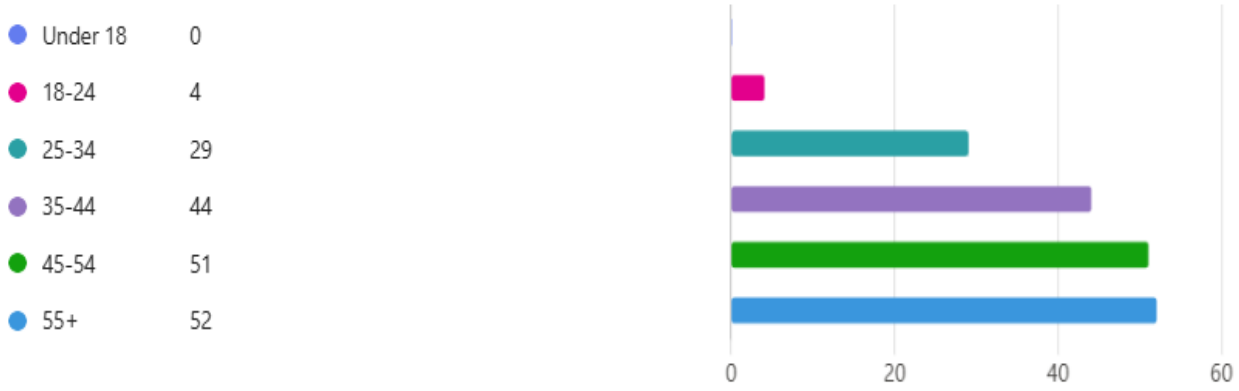


Figure 22: Community Engagement Survey respondent's age.

Most respondents were over the age of 45, with 28% in the 45-54 and 29% in the 55+ age groupings.

Question 3: What is your main connection with substance use or drug policy?

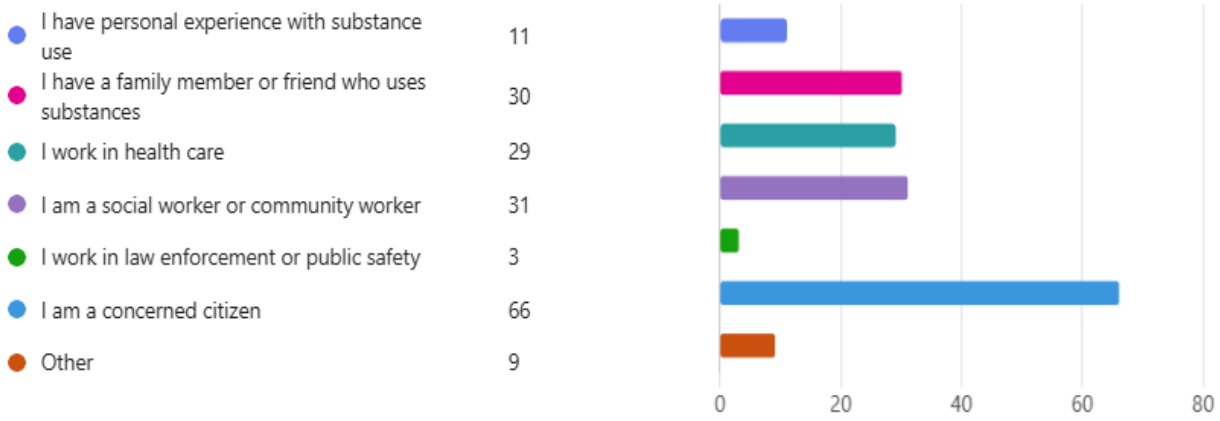


Figure 23: Community Engagement Survey respondent's main connection to substance use or drug policy.

Being a concerned citizen was the main connection respondents had to substance use or drug policy (37%) with near equal participation by family members or friends of someone who use substances, health care workers, and social or community workers (16-17%).

Question 4: Which of the four areas do you think needs the most attention?

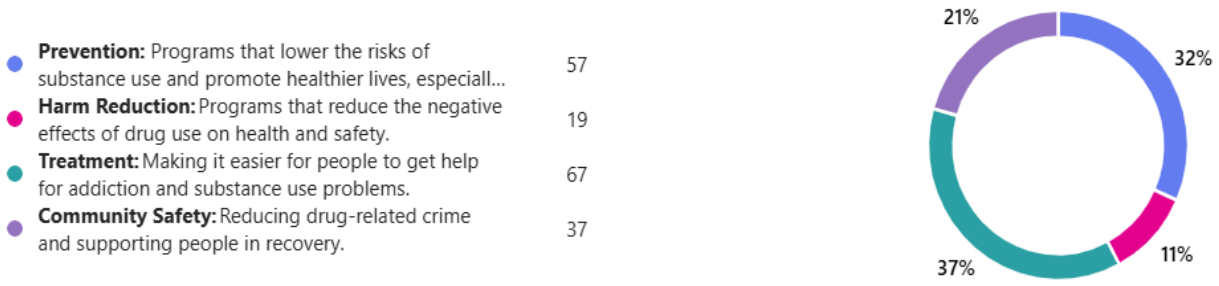


Figure 24: Community Engagement Survey respondent's desired main area for attention.

There was a similar distribution of respondents that would like the most attention given to the priorities in the prevention and treatment areas. Community safety and harm reduction programs received fewer responses.

Question 5: Select all the Prevention services that you think need attention

Figure 25: Community Engagement Survey respondent's desired Prevention priorities.

Mental health services were selected most frequently (89% of respondents; 31% of all options selected in response to the question) as the prevention area service that respondents would like to see given attention. That was followed by prevention programs in schools (69% of respondents; 24% of all options selected in response to the question) and prevention programs in the community (66% of respondents; 23% of all options selected in response to the question).

Question 6: Select all the Harm Reduction services that you think need attention

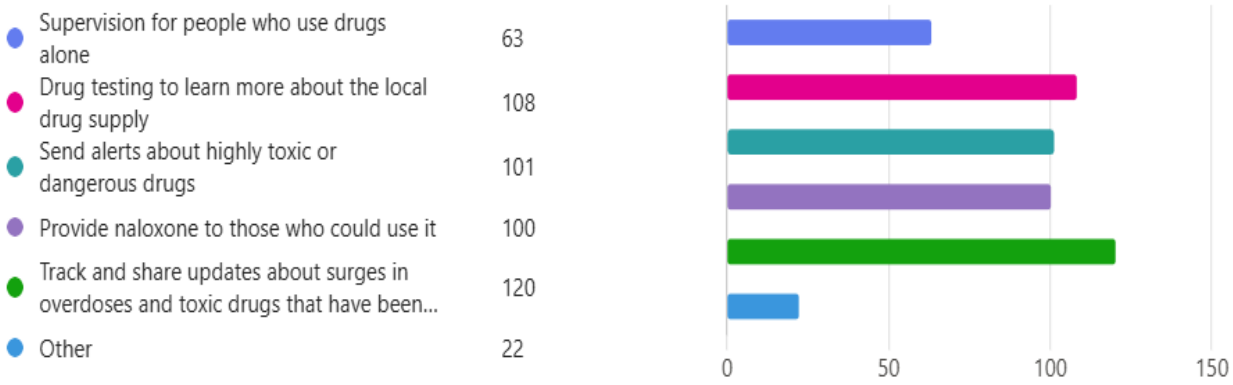


Figure 26: Community Engagement Survey respondent's desired Harm Reduction priorities.

Tracking and sharing updates about toxic drugs that have been detected in the community was selected most frequently (67%) as the harm reduction service that respondents would like to see given attention. That was followed by drug testing (60%) and sending alerts about highly toxic or dangerous drugs (56%).

Question 7: Select all the Treatment services that you think need attention

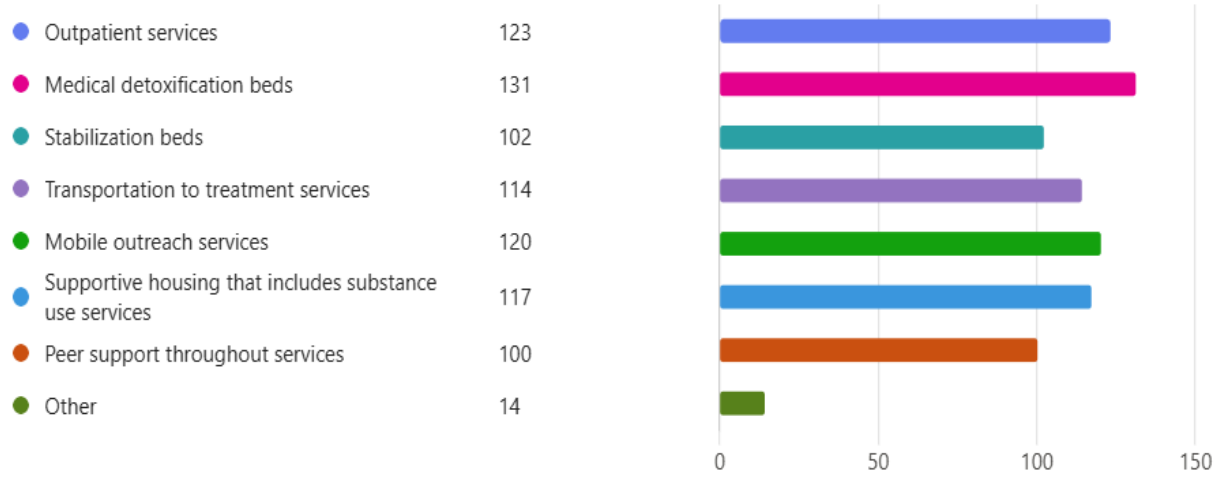


Figure 27: Community Engagement Survey respondent's desired Treatment priorities.

The response rate for treatment services needing attention showed little variation (55%-73%). The Medical detoxification beds option was selected most frequently (73%).

Question 8: Select all the Community Safety services that you think need attention

Figure 28: Community Engagement Survey respondent's desired Community Safety priorities.

Enforcement was selected most frequently (72% of respondents; 32% of all options selected in response to the question) as the Community Safety service that respondents would like to see given attention. The remaining priorities of social order, disposal of sharps, and a non-emergency reporting system received a similar number of responses.

Question 9: Do you think people who use substances face stigma that stops them from getting help?

Figure 29: Community Engagement Survey respondent's perception of stigma preventing seeking assistance.

Almost three quarters of respondents (74%) indicated that they think stigma stops people who use substances from getting help.

Question 10: Which of the following substances should the Renfrew County and District Drug Strategy prioritize? (select all that apply)

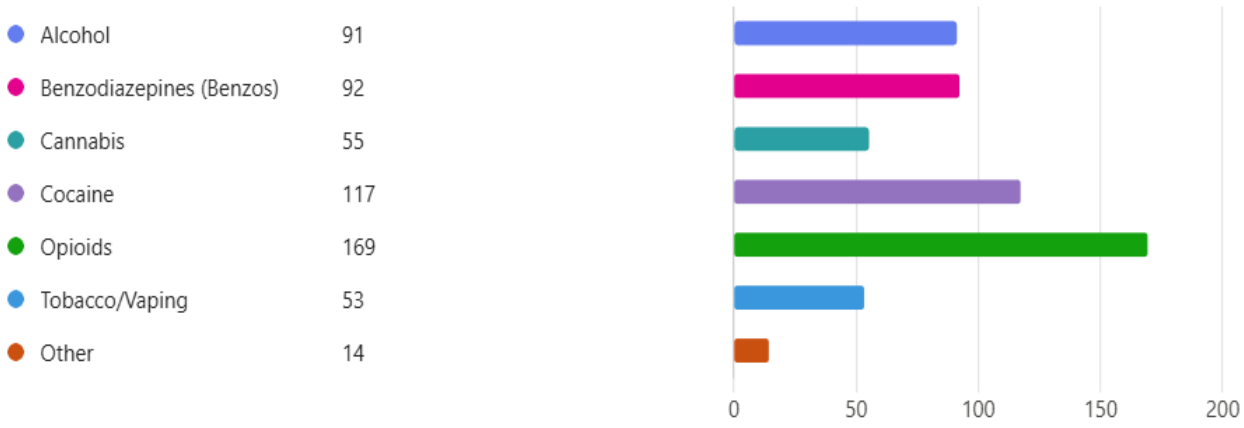


Figure 30: Community Engagement Survey respondent's substances to prioritize.

Opioids were selected most frequently by 94% of respondents as the substance the RCDDS should prioritize. Cocaine was selected second most frequently (65%) followed by benzodiazepines (51%) and alcohol (51%).

Question 11: How would you rate the current level of public education and prevention programs in your area?

Figure 31: Community Engagement Survey respondent's rating of public education and prevention programs.

70% of respondents rated public education and prevention programs as poor or very poor compared to the 30% who rated them as adequate, good or excellent.

Question 12: How effective do you think harm reduction services are at improving public health and reducing harms from substance use?

Figure 32: Community Engagement Survey respondent's rating of harm reduction services.

Half of the respondents (50%) rated harm reduction services as poor or very poor, and the 50% rate them as adequate, good or excellent at improving public health and reducing harms from substance use.

Question 13: What type of treatment services do you think are most needed in your area? (select all that apply)

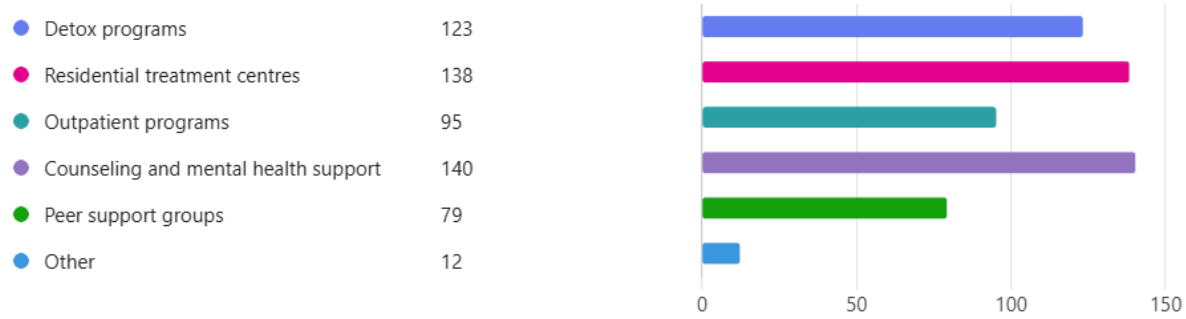


Figure 33: Community Engagement Survey respondent's identified treatment services of need in their area.

Most respondents (78%) thought that counseling and mental health support and residential treatment services were most needed in their area. Ranking third (68%) were detox programs.

Question 14: Do you think substance use affects safety in your community?

Figure 34: Community Engagement Survey respondent's thoughts on if substance use affects community safety.

Most respondents (87%) strongly agreed or agreed that substance use affects safety in their community.

Question 15: Is there anything else you would like to share about your thoughts on prevention, harm reduction, treatment, or community safety?

Note: Below is a thematic summary of the 65 responses to this question. The responses were shared in their entirety with the members of the Steering Committee.

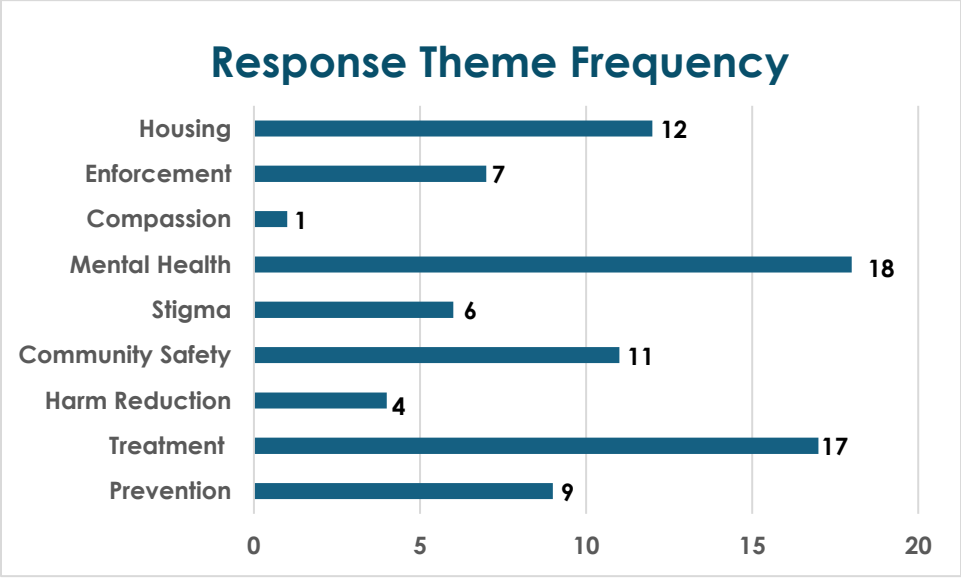


Figure 35: Thematic Summary results of Community Engagement Survey respondent's additional thoughts on prevention, harm reduction, treatment and community safety.

Evaluation Summary and Progress Indicators

To measure levels of collaboration and the impact of the RCDDS, tools from the Municipal Drug Strategy Coordinators Network of Ontario (MDSCNO) Evaluation Framework (Taylor & Schwartz, 2018) were used to inform and guide the evaluation process. The MDSCNO Evaluation Framework was a project led by the Strategy Design and Evaluation Initiative at the University of Toronto to support local and regional drug strategies in measuring their impact in the community.

Purpose

1. Demonstrate value
2. Identify areas for improvement
3. Contribute to evidence
4. Build trust
5. Measure effectiveness

Process[93]

1. Clarify what is to be evaluated
2. Engage stakeholders
3. Assess resources and evaluability
4. Determine evaluation indicators
5. Determine appropriate methods of measurement and procedures
6. Develop evaluation plan
7. Collect data
8. Process data and analyze results
9. Interpret and disseminate the results
10. Apply evaluation findings

Evaluation Options[94]

Type of Evaluation	Description	Implementation Possibilities
Performance Measurement and Process Evaluation	Performance measurement is the systematic collection of monitoring data (e.g. # of participants, # presentations, # media requests). Ongoing performance measurement is useful for	Systems can be put in place for continuously monitoring activities, outputs and potentially some outcomes. Monitoring data should be shared regularly with Strategy partners.

	tracking activities, outputs and potentially some outcomes and monitoring changes over time. Similarly, process evaluation is about whether program activities have been implemented as intended.	Process evaluation may be integrated into activity roll out (e.g. end of presentation surveys). Another process that strategies may be interested in evaluating is how well partners are collaborating. Most funders and stakeholders will expect strategies to be able to speak to the achievement of outputs.
Population Level Surveillance	Population level surveillance is the measurement of changes in population indicators (e.g. health, community safety) that are relevant to the work of the strategy (e.g. the # of non-fatal overdoses, # fatal overdoses, type of overdoses (i.e. drug vs. opioid), # self-reported overdoses, # of overdoses requiring health care intervention, # of youth using substances, # of deaths related to substance use).	While observed changes in population health indicators cannot be solely attributed to the work of the strategy, they should be measured and tracked over time to provide contextual information. Changes in population indicators (e.g. health, community safety) can be part of the contribution analysis, whereby changes in population indicators can be theoretically linked to strategy activities and outcomes. The case can be made that the strategy activities achieved measured outcomes, which in turn influenced (amongst many other factors) the achievement of population level impacts. Population health indicators can be found in published surveys and administrative data. Each strategy should familiarize themselves with the data available for their jurisdiction and review this regularly.
Thematic Evaluation	A thematic evaluation is the purposeful evaluation of specific topics that crosscut the work of a strategy such as equity, gender, and inclusion. For	A thematic evaluation may be implemented if there is a particular theme of interest. Thematic evaluations should be completed if there is an intended

	example, a strategy may conduct a strategic evaluation of the challenges and enablers to providing access to rural and remote service users, or how the strategy is addressing social isolation.	use for the evaluation findings to improve work around that theme.
Project Evaluation	Evaluations of projects can improve learning and ensure accountability related to specific interventions. These should be carried out strategically (rather than universally). Project evaluations are likely to be most valuable when the findings will have a direct use (i.e. to decide whether to scale -up, or to learn about how the project could be improved in the future).	It will be important to make purposeful decisions about which interventions to evaluate (and which not to). In some cases, project evaluations may be required by funders. Otherwise, projects should be evaluated selectively. Generally, it is a good idea to evaluate projects if they are highly innovative, promising and/or there is a weak evidence base for the intervention.
Comprehensive Strategy Evaluation (Outcomes, Strategy, Surveillance)	A comprehensive strategy evaluation may consist of three components: outcomes evaluation, population level surveillance, and strategy evaluation. (It may also be informed by performance measurement, process evaluation, project evaluation and thematic evaluation). **Outcomes Evaluation:** A comprehensive strategy evaluation will measure short and long-term outcomes related to the drug strategy's work. Because of the complexity of drug strategies and the	Comprehensive strategy evaluation should ideally take place every **3-5 years** as resources and time allow. Ideally, they should include three components: outcomes evaluation, strategy evaluation, and population level surveillance. Strategy evaluations could be conducted by program staff and/or by an external evaluator. It may be beneficial to conduct a comprehensive strategy evaluation before preparing major funding applications, and for making major planning decisions. Where resources are limited, much of this work could be done by staff, and an external

	environment in which drug strategies work, it may be helpful to characterize outcomes as attitude, capacity and behaviour changes amongst strategy partners, or those individuals, organizations, or groups that a strategy intends to influence. A contribution analysis can be utilized to gather evidence to make a case (or tell a story) that the strategy's achievement of these outcomes contributed towards (rather than caused) population level changes observed through surveillance data. **Population Level Surveillance:** Comprehensive strategy evaluation should include population level surveillance. Changes at the population level (e.g. health outcomes, health behaviours, health service use, community safety) inform understanding of the context. Once outcomes have been measured, a theoretical case can be built to tell the story that outcomes influenced changes at the population level. **Strategy Evaluation:** Comprehensive evaluation should also include strategy design evaluation. This will	evaluator could be contracted to verify the findings. Strategy design evaluations should be conducted when questions arise about the paradigm, how to prioritize interventions, and adapting to shifting goals.

	evaluate the appropriateness of the overarching paradigm, how well interventions are selected, how they work together, and how they are sequenced. Strategy evaluation assesses the set of goals and principles that guide the work of the strategy. Strategy evaluations also look at "enablers" that support the implementation of this set of interventions including a learning system.	

Evaluation Recommendation

Hybrid Model

1. Evaluative thinking, population level surveillance (Strategy Level)
2. Selective priority and thematic evaluations as needed (Pillar Level)
3. Comprehensive Strategy Evaluation (every 3-5 years) (Strategy Level)

Governance Recommendations

1. Identify an evaluation lead for each pillar/working group.
2. Identify an evaluation lead or co-leads for the RCDDS.

RCDDS Outcome Indicators

1. Decreased number of opioid overdose-related ED visits.
2. Decreased number of opioid toxicity deaths.
3. Decreased number of suspect drug toxicity deaths.

RCDDS Output Indicators

1. Number of municipalities engaged in the Strategy
2. Number of multi-stakeholder meetings
3. Number and type of training sessions
4. Number of community leaders engaged (Steering Committee Members)
5. Number of people with lived and living experience engaged
6. Number of resources leveraged (in kind and direct amount)

7. Number of presentations and number of participants
8. Number of grant applications and/or funding opportunities explored
9. Number of destigmatization efforts
10. Number of media releases

Pillar Indicators

Prevention

1. Sociodemographic analysis of equitable access to diagnosis and connection to services, including culturally appropriate services.
2. Wait time to diagnosis and services for child, youth and family and for adults with children.
3. Coordinated access engagement and retention rates.
4. Referral and engagement rates for youth not attending school and/or unhoused.
5. Referral and engagement rates of parents and caregivers with adult mental health services.
6. RCD indicators of child, youth, family and community wellbeing.
    a. Rates of Mental Health, Addictions and Substance Use Health ED and hospital visits by age.
    b. Early development indicators.
    c. Self-reported mental health and wellbeing by age.
    d. Families, children and youth living in poverty.
    e. Youth unemployment.

Treatment

1. Wait times for ASUH services.
2. Number of people served in and out of County with withdrawal management bed-based services.
3. Number and types of transportation services offered related to ASUH care and services.
4. Number of people supported by mobile services.
5. Wait times and number of people in supportive housing.
6. Equity in access to ASUH services (sociodemographic analysis).
7. Number of trainings, number of staff trained and types of training.
8. Number of peer support workers and number and types of services offering peer support.
9. Number/percentage of clients engaged with Peer Support Workers.
10. Average time to client stabilization and client outcomes related to retention in services, completion, long-term recovery, health, employment, and satisfaction with services.
11. Client perception of care.

Harm Reduction

1. Number of communications promoting the NORS spotting services.
2. Number of drug samples checked or submitted for checking.
3. Number of members enrolled in automated drug toxicity alert system.
4. Number of naloxone kits distributed through the Ontario Naloxone Program.
5. Number of partners distributing naloxone.
6. Plan created to enable rapid deployment of an Urgent Public Health Needs Site.
7. Number of Drug Toxicity Alerts issued.
8. Number of partners participating in the Harm Reduction Working Group.
9. Number of partners participating in the Drug Toxicity Response Plan.
10. Number of harm reduction interactions by RCDHU and partners.

Community Safety

1. Number of entries into Access E11 across agencies and organizations.
2. Number of "Good Neighbor" contracts signed.
3. Number of "Social Order" related complaints received.
4. Number of substance use supplies disposed of by community members/downtown business owners.
5. Number of complaints related to improperly disposed of substance use supplies.
6. Number of calls for service related to substance use issues.
7. Number of drug possession charges.
8. Number of drug trafficking charges.
9. Number of large-scale drug seizures.
10. Number of foot patrol hours.

Methods

Self-Assessment and Interviews

Evaluation questions can be included in steering committee and working group meetings to encourage reflection by partners. This information should be recorded in meeting notes and used to improve the strategy.

Monitoring

Shared data entry mechanism such as excel spreadsheet or online form to record number of presentations, training sessions, and participants.

Surveys

Surveys can be used for closed ended questions (e.g., yes/no, multiple choice). If primarily online, paper versions should be available for those without access to internet.

Population Health Data

Surveillance to determine any trends over time such as ED visits, suspect, and confirmed opioid-toxicity deaths.

References

1. World Health Organization: WHO. (2019, May 30). *Social determinants of health*. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1
2. Health Canada. (2024, April 11). *Canadian Drugs and Substances Strategy: Substance use services and supports*. Canada.ca. https://www.canada.ca/en/health-canada/services/substance-use/canadian-drugs-substances-strategy/substance-use-services-supports.html
3. Latimore, A. D., E. Salisbury-Afshar, N. Duff, E. Freiling, B. Kellett, R. D. Sullenger, A. Salman, and the Prevention, Treatment, and Recovery Services Working Group of the National Academy of Medicine's Action Collaborative on Countering the U.S. Opioid Epidemic. 2023. Primary, secondary, and tertiary prevention of substance use disorder through sociological strategies. *NAM Perspectives.* Discussion Paper, National Academy of Medicine, Washington, DC. https://doi.org/10.31478/202309b.
4. Public Health Agency of Canada. THE CHIEF PUBLIC HEALTH OFFICER'S REPORT ON THE STATE OF PUBLIC HEALTH IN CANADA 2018: Preventing Problematic Substance Use in Youth. 2018; available from 2018-preventing-problematic-substance-use-youth.pdf (canada.ca)
5. School and Community System of Care Collaborative. (2022). Right time, right care: Strengthening Ontario's mental health and addictions system of care for children and young people. https://cmho.org/wp-content/uploads/Right-time-right-care_EN-Final-with-WCAG_2022-04-06.pdf
6. PreVenture Program @ YWHO | Youth Wellness Hubs Ontario (youthhubs.ca)
7. EDI Over Time Report, Ontario, County of Renfrew: A snapshot of children's developmental health at school entry, 2024
8. Renfrew County and District Health Unit. Status of Mental Health in Renfrew County and District. July 2020. Pembroke (ON): Renfrew County and District Health Unit; 2020. Available from: https://www.rcdhu.com/reports
9. Orpana, H., Vachon, J., Dykxhoorn, J., McRae, L., & Jayaraman, G. (2016). Monitoring positive mental health and its determinants in Canada: the development of the Positive Mental Health Surveillance Indicator Framework. Health Promotion and Chronic Disease Prevention in Canada: Research, Policy and Practice, 36(1), 1-10.
10. Preventing Adverse Childhood Experiences | Adverse Childhood Experiences (ACEs) | CDC
11. What Are ACEs? And How Do They Relate to Toxic Stress? (harvard.edu)
12. Sansone, G., Williams, C.C., Crowe, A., Kartusch, M., Vandermorris, A., Fallon, B., D'Angiulli, A. & Maxie, J. (2024). *Supports and Systems to Respond to Complex Needs Among Children and Youth in Ontario.* Toronto, Ontario: Policy Bench, Fraser Mustard Institute of Human Development, University of Toronto.
13. Inspire-PHC Primary Care Data Reports for OHTs, 2022.
14. OH OHT dashboard, accessed June 2024.

15. Orpana, H., Vachon, J., Dykxhoorn, J., McRae, L., & Jayaraman, G. (2016). Monitoring positive mental health and its determinants in Canada: the development of the Positive Mental Health Surveillance Indicator Framework. Health Promotion and Chronic Disease Prevention in Canada: Research, Policy and Practice, 36(1), 1-10.
16. Griffin KW, Botvin GJ. Evidence-based interventions for preventing substance use disorders in adolescents. Child Adolesc Psychiatr Clin N Am. 2010 Jul;19(3):505-26. doi: 10.1016/j.chc.2010.03.005. PMID: 20682218; PMCID: PMC2916744.
17. Health Canada. (2024, April 11). *Canadian Drugs and Substances Strategy: Substance use services and supports*. Canada.ca. https://www.canada.ca/en/health-canada/services/substance-use/canadian-drugs-substances-strategy/substance-use-services-supports.html
18. *Substance use treatment*. (2024, April 3). Canada.ca. https://www.canada.ca/en/health-canada/services/substance-use/treatment.html
19. Centre for Addiction and Mental Health. Opioid Agonist Therapy: A Synthesis of Canadian Guidelines for Treating Opioid Use Disorder. Published May 2021. Available at www.camh.ca
20. Taha, S. (2018). Best Practices across the Continuum of Care for Treatment of Opioid Use Disorder. Ottawa, Ont.: Canadian Centre on Substance Use and Addiction.
21. Public Health Agency of Canada. (2020, February 6). *A primer to reduce substance use stigma in the Canadian health system*. Canada.ca. https://www.canada.ca/en/public-health/services/publications/healthy-living/primer-reduce-substance-use-stigma-health-system.html
22. Substance Abuse and Mental Health Services Administration. (2020). *Substance Use Disorder Treatment for People with Co-Occurring Disorders*. https://store.samhsa.gov/sites/default/files/pep20-06-04-006.pdf
23. *COUNTY OF RENFREW 10 YEAR HOMELESSNESS AND HOUSING PLAN*. (2024). https://www.countyofrenfrew.on.ca/en/community-services/resources/Community-Housing/Renfrew-County-10-Year-Housing-and-Homelessness-Report-Final.pdf
24. Centre for Addiction and Mental Health. Opioid Agonist Therapy: A Synthesis of Canadian Guidelines for Treating Opioid Use Disorder. Published May 2021. Available at www.camh.ca
25. Christy K. Scott, Mark A. Foss, Michael L. Dennis, Pathways in the relapse—treatment—recovery cycle over 3 years, Journal of Substance Abuse Treatment, Volume 28, Issue 2, Supplement, 2005, Pages S63-S72,ISSN 0740-5472,https://doi.org/10.1016/j.jsat.2004.09.006.
26. McLellan, A.T., Starrels, J.L., Tai, B. *et al.* Can Substance Use Disorders be Managed Using the Chronic Care Model? Review and Recommendations from a NIDA Consensus Group. *Public Health Rev* 35, 8 (2013). https://doi.org/10.1007/BF03391707
27. McLellan AT, Starrels JL, Tai B, Gordon AJ, Brown R, Ghitza U, Gourevitch M, Stein J, Oros M, Horton T, Lindblad R, McNeely J. Can Substance Use Disorders be Managed Using the Chronic Care Model? Review and Recommendations from

a NIDA Consensus Group. Public Health Rev. 2014 Jan;35(2):http://www.journalindex.net/visit.php?j=6676. doi: 10.1007/BF03391707. PMID: 26568649; PMCID: PMC4643942.
28. Yu, S.W.Y., Hill, C., Ricks, M.L. *et al.* The scope and impact of mobile health clinics in the United States: a literature review. *Int J Equity Health* 16, 178 (2017). https://doi.org/10.1186/s12939-017-0671-2
29. https://www.ccsa.ca/sites/default/files/2020-10/CCSA-Rapid-Access-Models-Substance-Use-Services-Rapid-Review-Report-2020-en.pdf
30. National Ambulatory Care Reporting System, Ministry of Health, Intellihealth Ontario, extracted Jan 2024
31. Canadian Mental Health Association. (n.d.). *HOUSING FIRST: THE PATH TO RECOVERY*. https://ontario.cmha.ca/wp-content/uploads/2021/07/CMHAOn_Housing_First_2020_FINAL.pdf
32. *County of Renfrew releases results of Point-in-Time Count on homelessness*. (2023, November 23). https://www.countyofrenfrew.on.ca/en/news/county-of-renfrew-releases-results-of-point-in-time-count-on-homelessness.aspx. Accessed November 11, 2024.
33. *Fundamentals of Addiction: Motivation and change*. (n.d.). CAMH. https://www.camh.ca/en/professionals/treating-conditions-and-disorders/fundamentals-of-addiction/f-of-addiction---motivation-and-change
34. Women's Substance Use Treatment and Recovery. (2024). In Canadian Institutes of Health Research (CIHR), *Women's Substance Use Treatment and Recovery*. https://cewh.ca/wp-content/uploads/2024/10/Final-Womens-Substance-Use-Treatment-and-Recovery.pdf
35. *Social determinants of health framework*. (n.d.). Ontario Health. https://www.ontariohealth.ca/system-planning/social-determinants-of-health-framework
36. Statistics Canada. 2022. Focus on Geography Series. 2021 Census
37. Renfrew County and District Health Unit. Status of Mental Health in Renfrew County and District. July 2020. Pembroke (ON): Renfrew County and District Health Unit; 2020. Available from: https://www/rcdhu.com/reports/
38. Inspire-PHC Primary Care Data Reports for OHTs, 2022.
39. OH OHT dashboard, accessed June 2024.
40. Stigma | Canadian Centre on Substance Use and Addiction
41. Statistics Canada. 2022. Focus on Geography Series. 2021 Census
42. Black Health Alliance. (2023). *Mental Health Services and Programs with, and for, Black Communities*. https://www.publichealthontario.ca/-/media/Documents/M/2023/mental-health-services-programs-black-communities.pdf?rev=61e1c90b8fb542bdb886e455dc2ebf07&sc_lang=en
43. Canadian Centre on Substance Use and Addiction & Mental Health Commission of Canada. (2023e). Toward Substance Use Health and Mental Health Service Integration: Findings from a Scoping Review. In *Toward Substance Use Health and Mental Health Service Integration: Findings From a Scoping Review*. https://mentalhealthcommission.ca/wp-content/uploads/2023/11/Toward-Substance-Use-Health-and-Mental-Health-Executive-Summary.pdf

44. Tam, T. (2019). *Addressing stigma towards a more inclusive health system: The Chief Public Health Officer's Report on the State of Public Health in Canada 2019* [Report]. https://www.canada.ca/content/dam/phac-aspc/documents/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/addressing-stigma-what-we-heard/stigma-eng.pdf
45. Mental Health Commission of Canada. (2021, September 8). *Making the case for peer support - Mental Health Commission of Canada*. https://mentalhealthcommission.ca/resource/making-the-case-for-peer-support/
46. Francia, L., Berg, A., Lam, T., Morgan, K., & Nielsen, S. (2022). "The peer workers, they get it" – how lived experience expertise strengthens therapeutic alliances and alcohol and other drug treatment-seeking in the hospital setting. *Addiction Research & Theory*, *31*(2), 106–113. https://doi.org/10.1080/16066359.2022.2124245
47. Collins AB, Boyd J, Cooper HLF et al. The intersectional risk environment of people who use drugs. *Social Science & Medicine*. 2019;234:112384. Available from: https://doi.org/10.1016/j.socscimed.2019.112384
48. Perri M, Kaminski N, Bonn M et al. A qualitative study on overdose response in the era of COVID-19 and beyond: how to spot someone so they never have to use alone. *Harm Reduction Journal*. 2021;18(1):1-9. Available from: https://doi.org/10.1186/s12954-021-00530-3
49. Crossland M. UCalgary researcher is part of team receiving $2 million grant from Health Canada to fight overdose epidemic. 2021. Available from: https://cumming.ucalgary.ca/news/ucalgary-researcher-part-team-receiving-2-million-grant-health-canada-fight-overdose-epidemic
50. Matskiv G, Marshall T, Krieg O, Viste D, Ghosh SM. Virtual overdose monitoring services: a novel adjunctive harm reduction approach for addressing the overdose crisis. CMAJ. 2022 Nov 28;194(46): E1568-E1572. doi: 10.1503/cmaj.220579. PMID: 36442886; PMCID: PMC9828965.
51. Tsang VWL, Papamihali K, Crabtree A, et al.. Acceptability of technological solutions for overdose monitoring: perspectives of people who use drugs. Subst Abus 2021;42:284–93.
52. Matskiv G, Marshall T, Krieg O, Viste D, Ghosh SM. Virtual overdose monitoring services: a novel adjunctive harm reduction approach for addressing the overdose crisis. CMAJ. 2022 Nov 28;194(46):E1568-E1572. doi: 10.1503/cmaj.220579. PMID: 36442886; PMCID: PMC9828965.
53. Wallace B, van Roode T, Pagan F et al. The potential impacts of community drug checking within the overdose crisis: qualitative study exploring the perspective of prospective service users. *BMC Public Health*. 2021;21(1):1-12. https://doi.org/10.1186/s12889-021-11243-4
54. Maghsoudi N, Tanguay J, Scarfone K et al. Drug checking services for people wo use drugs: a systematic review. *Addiction*. 2021. Available from: https://doi.org/10.1111/add.15734
55. McCrae K, Tobias S, Stunden C. *Drug Checking Operational Technician Manual*. Vancouver (BC): BC Centre on Substance Use; 2019. Available from: https://www.bccsu.ca/wp-content/uploads/2019/03/BCCSU-Technician-Manual-March-2019.pdf

56. Carroll J.J., Mackin S., Schmidt C., McKenzie M., Green T.C. The Bronze Age of drug checking: Barriers and facilitators to implementing advanced drug checking amidst police violence and COVID-19. *Harm Reduct. J.* 2022;19:9. doi: 10.1186/s12954-022-00590-z.
57. McDonald K, Thompson H, Werb D. 10 key findings related to the impact of Toronto's Drug Checking Service. Toronto: Centre on Drug Policy Evaluation. May 31, 2023.
58. Daowd K, Ferguson M, Liu L, Loyal J, Lock K, Graham B, Lamb J, McDougall J, Buxton JA. Awareness, predictors and outcomes of drug alerts among people who access harm reduction services in British Columbia, Canada: findings from a 2021 cross-sectional survey. BMJ Open. 2023 May 9;13(5):e071379. doi: 10.1136/bmjopen-2022-071379. PMID: 37160395; PMCID: PMC10174008.
59. National Academies of Sciences, Engineering, and Medicine (2018) Emergency alert and warning systems: current knowledge and future research directions. The National Academies Press. 10.17226/24935
60. Sadiq AA, Okhai R, Tyler J, Entress R. Public alert and warning system literature review in the USA: identifying research gaps and lessons for practice. Nat Hazards (Dordr). 2023;117(2):1711-1744. doi: 10.1007/s11069-023-05926-x. Epub 2023 Apr 11. PMID: 37251347; PMCID: PMC10098234.
61. Tadrous M, Shearer D, Martins D, Campbell T, Gomes T. Naloxone Distribution Across Ontario. Toronto: Ontario Drug Policy Research Network; June 2019. DOI: 10.31027/ ODPRN.2019.01.
62. McDonald R, Strang J. Are take-home naloxone programmes effective? Systematic review utilizing application of the Bradford Hill criteria. *Addiction.* 2016;111(7):1177-87.
63. Razaghizad A, Windle SB, Filion KB et al. The effect of overdose education and naloxone distribution: an umbrella review of systematic reviews. *American Journal of Public Health.* 2021;111(8):1516-17.
64. KG. Card, K. Urbanoski, B. Pauly. (2020) "Supervised Consumption Sites Are Necessary Public Health Services." Canadian Institute for Substance Use Research.
65. Madah-Amiri D, Skulberg AK, Braarud A-C, Dale O, Heyerdahl F, Lobmaier P, et al. Ambulanceattended opioid overdoses: An examination into overdose locations and the role of a safe injection facility. Substance Abuse. 2019;40(3):383–8.
66. Potier C, Laprévote V, Dubois-Arber F, Cottencin O, Rolland B. Supervised injection services: what has been demonstrated? A systematic literature review. Drug Alcohol Depend. 2014 Dec 1;145:48–68.
67. Kerr T, Tyndall MW, Zhang R, Lai C, Montaner JSG, Wood E. Circumstances of first injection among illicit drug users accessing a medically supervised safer injection facility. Am J Public Health. 2007 Jul;97(7):1228–30.
68. Office of Public Health Scientific Services. Centers for Disease Control and Prevention. Public health surveillance: preparing for the future. https://www.cdc.gov/surveillance/pdfs/Surveillance-Series-Bookleth.pdf. September 2018.
69. Wolff J, Gitukui S, O'Brien M, Mital S, Noonan RK. The Overdose Response Strategy: Reducing Drug Overdose Deaths Through Strategic Partnership

Between Public Health and Public Safety. J Public Health Manag Pract. 2022 Nov-Dec
70. Government of Canada. (2024, December 23). Opioid- and stimulant-related harms in Canada: Key findings. *Canada.ca*. https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants/
71. Greene, B. T. (2009). An examination of the relationship between crime and substance use in a drug/alcohol treatment population. *International Journal of the Addictions, 16*(4), 389–404.
72. Wainscott, A. M. (2024). *Complaints to resolutions: Building a robust process* (Publication No. [ProQuest Number]). [Master's thesis, California State University, Sacramento]. ProQuest Dissertations & Theses Global.
73. AccessE11. (n.d.). *Simplify municipal data analytics & reporting*.
74. AccessE11. https://accesse11.com/simplify-municipal-data-analytics/
75. AccessE11. (n.d.). *Town manager*. AccessE11. https://accesse11.com/town-manager/
76. Facini, A. (2021, August 19). *Local government's role in citizen engagement: It's now digital*. *American City & County*. https://www.americancityandcounty.com/government-technology/local-government-s-role-in-citizen-engagement-it-s-now-digital
77. Panko, R. R. (2008). Thinking is bad: Implications of human error research for spreadsheet research and practice. *Journal of Organizational and End User Computing, 16*(4), 25-46. https://doi.org/10.1907590
78. Editorial Office, E. (2024, February 2). *Social order*. In *Encyclopedia*. https://encyclopedia.pub/entry/54688
79. Health Canada. (2024, April 22). *Stigma around drug use*. Government of Canada. https://www.canada.ca/en/health-canada/services/opioids/stigma.html
80. Ontario Ministry of the Solicitor General. (n.d.). *Section 2 - The Community Safety and Well-being planning framework*. Government of Ontario. https://www.ontario.ca/document/community-safety-and-well-being-planning-framework-booklet-3-shared-commitment-ontario/section-2-community-safety-and-well-being-planning
81. Department of Justice Canada. (n.d.). *Inclusion for all: A Canadian roadmap to social cohesion: Insights from structured conversations*. Government of Canada. https://www.justice.gc.ca/eng/rp-pr/csj-sjc/jsp-sjp/tr01-rt01/p0.html
82. Innes, Martin. 2003. *Understanding Social Control: Deviance, Crime and Social Order*. Maidenhead, UK: Open University Press.
83. McGivern, R. (2024). *Chapter 7: Deviance, crime, and social control*. In *Introduction to Sociology - 1st Canadian Edition*. BCcampus. https://opentextbc.ca/introductiontosociology/chapter/chapter7-deviance-crime-and-social-control/
84. Interior Health Harm Reduction Program, Population Health. (2020, June 8). *Safe sharps disposal toolkit*. Interior Health. https://www.interiorhealth.ca/sites/default/files/PDFS/safe-sharps-disposal-toolkit.pdf
85. Small D, Glickman A, Rigter G, Walter T. The Washington Needle Depot: fitting healthcare to injection drug users rather than injection drug users to healthcare:

moving from a syringe exchange to syringe distribution model. Harm Reduction Journal, 2010;7(1).
86. Wenger LD, Martinez AN, Carpenter L, Geckeler D, Colfax G, Kral AH. Syringe disposal among injection drug users in San Francisco. American Journal of Public Health, 2011;101(3):484- 486.
87. de Montigny L, Vernez Moudon A, Leigh B, Kim SY. Assessing a drop box programme: a spatial analysis of discarded needles. International Journal of Drug Policy, 2010 May;21(3):208-214.
88. Golub ET, Bareta JC, Mehta SH, McCall LD, Vlahov D, Strathdee SA. Correlates of unsafe syringe acquisition and disposal among injection drug users in Baltimore, Maryland. Substance Use and Misuse, 2005;40(12):1751–1764
89. Wood E, Kerr T, Small W, Li K, Marsh DC, Montaner JS, Tyndall MW. Changes in public order after the opening of a medically supervised safer injecting facility for illicit injection drug users. Canadian Medical Association Journal, 2004;171(7):731-734
90. Bacon, (2021); Crofts, P., & Patterson, S. (2016); Kammersgaard, A. (2019). Desistance from criminalisation: Police culture and new directions in drug policing.
91. Sherman, L. and Eck, J. (2002) Police for Crime Prevention, in: Sherman, L., Farrington, D., Welsh, B. and Layton MacKenzie, D. (eds) Evidence-Based Crime Prevention. London: Routledge.
92. Government of Ontario. (2024, February 17). *Ontario expanding mobile crisis response teams*. Ontario Newsroom. https://news.ontario.ca/en/release/1001758/ontario-expanding-mobile-crisis-response-teams
93. Ontario Agency for Health Protection and Promotion (Public Health Ontario), Snelling S, Meserve A. Evaluating health promotion programs: introductory workbook. Toronto, ON: Queen's Printer for Ontario; 2016
94. Taylor, E., & Schwartz, R. (2018). MDSCNO Evaluation Framework. Toronto, ON: Strategy Design and Evaluation Initiative.