# ELGIN COMMUNITY
# DRUG & ALCOHOL STRATEGY


## Summary Report 2022

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# Acknowledgements

The Elgin Community Drug and Alcohol Strategy (ECDAS) Steering Committee would like to acknowledge the contributions of everyone who participated in the community consultation process that shaped this strategy. They would like to express appreciation and gratitude to the individuals with lived or living experience with substance use who provided insight, perspectives, and ideas for action. People who have past or present experience with substance use are experts in this field. Their involvement in this work is essential to implement initiatives that will improve the lives of people in our community who use substances.

A special thanks to The Homeless Coalition of ST Thomas for providing unique ideas that were brought forward for consideration. This Coalition has a mission to advocate for non-traditional, no-fail, supportive housing for people surviving long-term homelessness.

The Steering Committee consists of community members with lived experience of substance use and representation from key partner agencies who work in this field. The members of this group include:

## Active Membership

| | |
|---|---|
| Alicia Malcolm | Central Community Health Centre |
| Bobby Wiens | Member with Lived Experience, and co-founder of STASH |
| Brendan Kelliher | Member with Lived Experience |
| Cindy Bratt | East Elgin Family Health Team |
| Dan Bolton | Member with Lived Experience, and secretary of The Homeless Coalition of St.Thomas |
| Ellen Hickey | St. Thomas-Elgin Housing Stability Services |
| John D'Oria | St. Thomas-Elgin Social Services |
| Marcia Van Wylie | Southwestern Public Health |
| Sgt. Frank Boyes | St. Thomas Police Services |
| Sandra McCabe | CMHA Thames Valley Addiction & Mental Health Services |
| Tina Oliveira | St. Thomas Elgin General Hospital |
| Megan Van Boheemen | Regional HIV/AIDS Connection |

## Past Members

| | |
|---|---|
| Andy Kroeker | West Egin Community Health Centre |
| Danielle Neilson | St. Thomas-Elgin Housing Stability Services |
| Heather Stilitano | Central Community Health Centre |
| Jody Berkelmans | St. Thomas-Elgin Social Services |
| Kate Reid | Family and Children's Services |
| Kyle Johnstone | St. Thomas Police Service |
| Linda Sibley | CMHA Thames Valley Addiction & Mental Health Services |
| Sonja Burke | Regional HIV/AIDS Connection |
| Troy Carlson | Ontario Provincial Police |
| Jackie Harris | Central Community Health Centre |
| Nancy Lawrence | Southwestern Public Health |
| Michelle Michael-Murray | St. Leonard Community Services |
| Shaun Wright | Member with Lived Experience |
| Craig Watkin | St. Thomas Elgin General Hospital |

Finally, the Steering Committee would also like to thank the members of the four pillar working groups representing Prevention, Harm Reduction, Justice, and Treatment for their participation and valuable contributions.

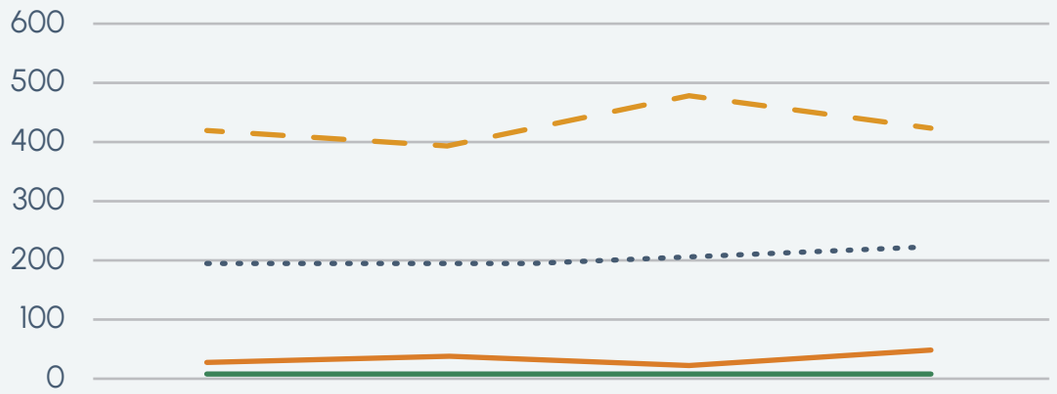
# Background

The opioid crisis is a significant public health issue impacting many communities across Canada, including those in St. Thomas and Elgin County. Over the past several years, the rate of opioid-related hospitalizations has been concerning, reaching a high during the COVID-19 pandemic of 53.1 per 100,000 in 2021.[1] This was more than three times the provincial rate in the same year.

Similarly, the rate of hospitalizations due to conditions entirely caused by alcohol (excluding mental health conditions) rose sharply from 403.7 per 100,000 in 2019 to 481.8 per 100,000 in 2020.[1] Although the rate slightly decreased in 2021, it remained higher than pre-pandemic rates. In comparison to the province, hospitalizations due to conditions entirely caused by alcohol, Elgin and St. Thomas has had a rate two times higher than Ontario nearly every year since 2018, with the sharp increase in 2020 not being observed in the provincial rate.[1] In addition to opioids and alcohol, other substances such as cannabis and illicit drugs, present significant harms and challenges in our communities. These worrying trends indicate an ongoing elevated risk of substance-related harms and the need for further action.[1]

## Figure 1 : Elgin St. Thomas Alcohol and Opioid Hospitalization Data 2018-2021

(Inpatient Discharges (2018-2021), Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: July 2023)




| | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|
| EST Opiod Hosp | 37.4 | 45.2 | 35.2 | 53.1 |
| ON Opiod Hosp | 14.6 | 13.6 | 13.9 | 16.3 |
| EST Alcohol Hosp | 418.6 | 403.7 | 481.8 | 430.0 |
| ON Alcohol Hosp | 205.0 | 202.2 | 215.7 | 228.2 |

Problematic substance use is a complex issue that requires a multi-pronged, whole-community response. The use of substances, whether legal or illegal, tends to arouse strong feelings and opinions because it strikes at the heart of our personal values.  Many different strategies have been implemented to address problematic substance use and related harms over the years. However, a comprehensive approach is needed, including good public policy and a range of interventions that have the potential to benefit everyone in the community.

# Establishment of the Elgin Community Drug and Alcohol Strategy

The Elgin Situation Table identified the need for a comprehensive drug and alcohol strategy in 2018. In response, a Steering Committee was established with a vision of 'A safe and healthy community in Elgin without the negative impacts of drugs and alcohol.'

The Steering Committee led the formation of four pillar workgroups in prevention, harm reduction, treatment, and justice. This four-pillar approach was taken because it was recognized that all are needed to reduce the harms of alcohol and other drug use effectively. The members of those workgroups used their experience and expertise to draft recommendations and work plans for the strategy specific to their knowledge area. Following that, the Steering Committee reached out to local community groups and coalitions for additional input into the draft recommendations. Overall, a total of 121 recommendations were created.

In 2021, the Steering Committee had an opportunity to work with the consulting firm, Collective Results, to conduct community consultations to refine and finalize the Elgin Community Drug and Alcohol Strategy (ECDAS). The consultations were completed between December 2021 and April 2022. This report will review the consultation process, summarize the findings, and outline the recommendations to reduce substance related harms in the communities of Elgin and St. Thomas.


# Summary of Consultations

In the fall of 2021, a plan was created to collect valuable input from the communities of Elgin and St. Thomas. The objectives of the community consultations were:

## 1. Conduct Consultation

To conduct consultations with members of the community, partners, and individuals with lived and living experience of substance use to:

- Affirm that the draft work plans are comprehensive, well situated in the current context, and meet the anticipated future needs of the Elgin and St. Thomas communities;
- Identify gaps in the draft work plans;
- Identify duplications of already existing community activities in the draft work plans; and
- Identify new or innovative strategies that should be considered for inclusion in the draft work plans.

## 2. Confirm Consultation

To confirm interest and commitment to support the ongoing implementation of the ECDAS among:

- Individuals and organizations that participate in the Steering Committee or the Pillar Workgroups; and
- Other individuals and organizations that are not currently represented on the Steering Committee or the Pillar Workgroups.

## 3. Prioritize

To prioritize activities for implementation in consultation with the Steering Committee and the Pillar Workgroups.

The consultations included a Community Survey, Partner Survey, Partner Interviews, Peer-Led Lived/Living Experience Interviews, and Pillar Workgroup Facilitated Sessions.

The Community Survey assessed the perspectives of community members on the local issues related to drug and alcohol consumption and the actionable items that could be used to address these issues. Data was reported by geographical status (rural vs. urban) and for participants who reported having had personal (self or friend/family member) or professional (paid or volunteer) involvement with people using drugs and alcohol (abbreviated as “with involvement”), and participants without personal or work experience with alcohol and/or drug use (abbreviated as “without involvement”). Please see Appendix A for a summary of the study design, participant demographics, findings specific to this survey, and the limitations.

A Partner Survey was conducted to begin prioritizing ECDAS recommendations based on the criteria of need and capacity. Community partners were selected by the Steering Committee and participation was voluntary. For a summary of the study design, participant demographics, findings specific to this survey, and the limitations, please see Appendix B.

The Partner Interviews were conducted to understand perspectives on drug and alcohol use in St. Thomas and Elgin County. The Steering Committee selected twenty-four (24) participants, with the majority working in healthcare and social services. For a summary of the interview questions, participant demographics, findings specific to these interviews, and the limitations, please see Appendix C.


The Peer-Led Lived/Living Experience Interviews were conducted with over 30 People with Lived/ Living Experience (PWLE) in St. Thomas and Elgin County. Recruitment was completed by health and social service partners and peer interviewers. For a summary of the interview questions, participant demographics, findings specific to these interviews, and the limitations, please see Appendix D.

Finally, Pillar Workgroup Facilitated Sessions were done to establish a shared understanding of the findings collected from the Community Survey, Partner Survey, Partner Interviews, and Peer-Led Lived/Living Experience Interviews. Collective Results facilitated the sessions with each of the four pillar groups. Recommendations were given scores created from prioritization tools and by using information from the Partner Survey, Community Survey alignment, Partner Interviews alignment, and Peer-Led Lived/Living Experience Interviews alignment. For a summary of the sessions and the recommendations' scores, please see Appendix E.

In total, 350 participants were reached through the consultations including 166 community survey participants, 88 partner survey participants, 24 partner interview participants, 32 lived/living experience interview participants, and 40 pillar workgroup session participants. There is the possibility that some individuals participated in more than one consultation method.

Following the consultations, the prioritized recommendations remained in the 4 pillars and were organized by the ECDAS theme areas of service enhancement, building community capacity, community coordination, and advocacy. To fully understand the consultations and the resulting recommendations within this report, readers can review the Summary of Consultations Report prepared for the ECDAS Steering Committee.

# Summary of Findings & Recommendations

## The main themes that came through all consultations include:

### Community Strengths

Elgin and St. Thomas is a supportive community that provides many needed and appreciated services.

### Stigma

This has been described as manifesting in a variety of ways including a lack of knowledge in the community, particularly in the healthcare system and in the business community.

### Substance Related Harms are Increasing

There is a general sense that the harms related to substance use are worsening. The need for comprehensive, integrated, and flexible supports and services in our community is growing.

### Accessibility of Programs & Services

Increasing the accessibility of programs and services in urban and rural settings was identified as a top recommendation that spans the four pillars.

The following section will summarize the key issues identified through the consultations by pillar area and outline the corresponding recommendations. Note, the consultations found recommendations that were aligned across all pillars, these common recommendations are included in the outline of each pillar area.

# Summary of Issues under the Prevention Pillar

Issues and recommendations related to prevention surfaced across consultations. Strong agreement was noted in the Community Survey with respect to the recommendations of studying new ways to help prevent substance use, sharing local substance use statistics with the community, and investing more money to prevent and address substance use concerns.

The recommendation to provide opportunities for people to build relationships and find connections within their community through school/community groups or leisure activities was rated high for need and impact in the Partner Survey. This sentiment was also expressed in the Peer-Led Lived/Living Experience Interviews, whereby participants noted boredom/too much idle time as a trigger for drug use and alluded to the fact that having a purpose and something to occupy time can help prevent relapse and provide motivation for continued recovery.

Recommendations around boosting community awareness also surfaced across consultations. In the Partner Survey, developing a community education plan regarding the harms of substance use and challenging the promotion of drugs and alcohol in the media was noted.

In the Partner and Peer-Led Lived/Living Experience Interviews, it was also recommended that public speaking events be used to communicate with the public to reduce stigma and celebrate wins. This is also consistent with what was heard in the Community Survey, where there was strong agreement to share substance use stories of real local people with the community.

Another idea related to prevention that surfaced through the consultation process is the Icelandic Model, which is an initiative to reduce alcohol and drug use in young people by using parenting, parental supervision, organized leisure time, curfew hours, and encouragement of joint family dinners. While some of the prevention pillar recommendations are connected to elements of the Icelandic Model (e.g., leisure activities for youth), individually the recommendations do not form the Icelandic Model. As a result of the facilitated sessions, the Icelandic Model has been adopted as a recommendation.

# Prevention Recommendations

## Service Enhancement

- **Alignment Across Pillars:** Reduce barriers for people accessing services with an equity-centred and trauma informed approach, and offer support to increase the accessibility of programs and services in both urban and rural settings (e.g., transportation, child minding, free services, mobile outreach etc.)
- **Short Term Priority:** Assess access to leisure activities and other preventive factors such as safe places to socialize, make meaningful relationships and opportunities for employment and academic achievement.
- **Long Term Priority:** Increase access to leisure activities and other preventive factors such as safe places to socialize, make meaningful relationships and opportunities for employment and academic achievement.

## Community Coordination

- **Alignment Across Pillars:** Improve coordination between community partners that work across all four pillars.
- **Short Term Priority:** Provide evidence based resources to schools and school boards to inform school-based interventions.
- **Long Term Priority:** Enhance school and community group partnerships to build a sense of community connection.

## Building Community Capacity

- **Alignment Across Pillars:** Identify and prioritize annual evidence-informed training for ECDAS members and partners, and provide evidence-informed anti stigma training and promotion of respectful language and dialogue with all community partners that work across all four pillars.
- **Short Term Priorities:** Develop a local education campaign in consultation with the local community and priority groups about the harms of substance use, and implement an awareness campaign on the social determinants of health to increase community awareness of preventive factors and their role in preventing substance use.
- **Long Term Priority:** Icelandic Model

## Advocacy

- **Alignment Across Pillars:** Develop an advocacy strategy outlining advocacy efforts at the local, provincial and federal levels that is aligned with drug and alcohol advocacy efforts in other regions.
- **Short Term Priorities:** Advocate for service that is inclusive, accessible, coordinated and responsive, and challenge the continuum of service providers and media not to perpetuate stigma.
- **Long Term Priority:** Advocate for service that is coordinated and responsive.

# Summary of issues under the Harm Reduction Pillar

Issues related to harm reduction services emerged as a major theme across consultations. A top issue noted in the Community Survey is difficulty accessing services. A top action that emerged is more accessible services. This is congruent with what was seen in the Partner Survey where almost every top recommendation had to do with the accessibility of support services.

Strong agreement was seen in the Community Survey with the recommendation to make harm reduction services easier to access and more available. This is also consistent with what was heard in the Peer-Led Lived/Living Experience Interviews whereby participants felt that the following harm reduction services and supports were needed: a methadone clinic in rural areas, a safe consumption site, improvements to outreach services/awareness of services, and crisis services.

A top recommendation that surfaced in the Partner Survey among PWLE only was regarding advocating for drug checking services; this was also mentioned in the Peer-Led Lived/Living Experience Interviews when the need for a safe consumption site was also expressed.

The lack of access to housing was a strong theme throughout the consultations. There was strong disagreement in the Community Survey that people who use substances are well supported in the community when finding a stable place to live. A lack of supportive housing was also indicated in the Partner Interviews and the recommendation of improving access to housing was rated high for impact and need in the Partner Surveys. A lack of access to housing/shelter was commonly noted during the Peer-Led Lived/Living Experience Interviews, including a lack of supportive housing, a transition house, and affordability, as well as shelters being full, and discrimination by owners not wanting to rent to them.

# Harm Reduction Recommendations

## Service Enhancement

- **Alignment Across Pillars:** Reduce barriers for people accessing services with an equity-centred and trauma informed approach, and offer support to increase the accessibility of programs and services in both urban and rural settings (e.g., transportation, child minding, free services, mobile outreach etc.).
- **Short Term Priorities:** Explore the possibility of a comprehensive withdrawal management program in Elgin-St. Thomas (identified as a quick win), and expand access to opioid substitution programs and counselling services.
- **Long Term Priority:** Enhance capacity and availability of crisis support services.

## Community Coordination

- **Alignment Across Pillars:** Improve coordination between community partners that work across all four pillars.
- **Long Term Priorities:** Improve access to healthcare, housing and coordinate referral services for people with Lived and Living experience, and collaborate with social, treatment, justice services to improve discharge planning, aftercare and continued community support upon release.

## Building Community Capacity

- **Alignment Across Pillars:** Identify and prioritize annual evidence-informed training for ECDAS members and partners, and provide evidence-informed anti stigma training and promotion of respectful language and dialogue with all community partners that work across all four pillars.
- **Short Term Priority:** Build community capacity by engaging people with Lived and Living experience at public speaking events. Conduct a community needs assessment to determine the acceptance and feasibility of Consumption and Treatment Services.
- **Long Term Priority:** Provide education and training for healthcare providers to reduce healthcare stigma, particularly in regards to prescribing naltrexone and suboxone and offering alternative options for treatment.

## Advocacy

- **Alignment Across Pillars:** Develop an advocacy strategy outlining advocacy efforts at the local, provincial and federal levels that is aligned with drug and alcohol advocacy efforts in other regions.
- **Long Term Priorities:** Advocate to reduce experiences of stigma when accessing naloxone, including not limiting the number of naloxone kits distributed and equitable treatment of clients, and advocate for policy and legal change within the provincial and federal correctional systems that supports both harm reduction and treatment.

# Summary of issues under the Treatment Pillar

One of the major themes noted across all consultations was concerns around access to treatment services. Participants in the Community Survey very strongly agreed that there is an overall lack of treatment options and that efforts are needed to make more treatment services available and to make them easier to access. This did not appear as an overall top recommendation in the Partner Survey, however, expanding existing outreach services and access to professional pre-treatment services was noted as having a high impact and high need by community partners. This is related to discussions during the treatment pillar facilitated session whereby the need to improve coordination of existing services was expressed. A lack of awareness of available services was noted in the Peer-Led Lived/Living Experience Interviews, disproportionately mentioned by the rural subpopulation. The need for improved outreach services and to create awareness of the available services was noted. A lack of awareness may also contribute to the lack of access to treatment services.

Differences were noted between participants with vs without involvement with respect to opinions related to treatment in St. Thomas and Elgin County. In the Community Survey, issue statements regarding treatment and treatment support had the most significant differences between those *with involvement* and those *without involvement* in terms of their degree of congruence on strength of agreement. In the Partner Survey, treatment was the pillar that had no overlap in top recommendations between those with and without involvement, indicating potential differences in priorities between the groups as they relate to treatment.

The lack of a local treatment centre and lack of timely access to treatment were top issues across consultations. Improving access to treatment/ withdrawal service in the St. Thomas and Elgin Community was by far the most recommended action item from the Partner Interviews and was also a top recommendation from the Community Survey.

This was also highlighted as a key missing service in Peer-Led Lived/Living Experience Interviews, whereby interviewees noted concerns with needing services that are available immediately and services that are available over a long span of time to cover the entire duration of recovery. Those with lived experience underscored the need for more timely services and indicated that long wait times are a significant barrier to support. A treatment centre in the St Thomas and Elgin community was deemed by partners as a critical way to provide timely treatment support with less wait time.

The concern of physicians not being open to new treatment methods was touched on across consultations. In the Partner Interviews, it was noted that physicians are not using up-to-date treatment options and may not currently be open to using different methods potentially due to financial incentives. A concern regarding doctors prescribing methadone as opposed to suboxone, with the presumption that this is due to financial incentive was noted in the Peer-Led Lived/Living Experience Interviews.

# Treatment Recommendations

## Service Enhancement

- **Alignment Across Pillars:** Reduce barriers for people accessing services with an equity-centred and trauma informed approach, and offer support to increase the accessibility of programs and services in both urban and rural settings (e.g, transportation, chi minding, free services, mobile outreach etc.).
- **Short Term Priorities:** Enhance access to services through 24-hr drop-in centres, support clients with access to a variety of professional "Pre-treatment" services that meet them where they are at prior to entering services, and support establishing an anonymous opioid clinic.
- **Long Term Priority:** Expand existing mobile outreach team models providing basic medical services and harm reduction strategies.

## Community Coordination

- **Alignment Across Pillars:** Improve coordination between community partners that work across all four pillars.
- **Short Term Priority:** Recruit outreach workers/peers for transitions of care who will create a roadmap for system navigation. Support Sanctuary and Support micro or small group professionally supported safe sites designed by people currently experiencing harm from substance use and homelessness thus aiding those ineligible for supportive housing.
- **Long Term Priority:** Enhance the coordination and warm transfers between agencies as well as referrals between STEGH, CMHA TVAMHS, CCHC, 217, Grace Café and other diverse service organizations.

## Building Community Capacity

- **Alignment Across Pillars:** identify and prioritize annual evidence-informed training for ECDAS members and partners, and provide evidence-informed anti stigma training and promotion of respectful language and dialogue with all community partners that work across ail four pillars.
- **Short Term Priorities:** Provide training to peers/volunteers on de-escalation techniques, and educate service providers and community on support programs and options such as Community Withdrawal Support Program, CMHA Thames Valley Addiction and Mental Health Services, Clinic 217. Conduct a community needs assessment to determine the acceptance and feasibility of Consumption and Treatment Services.

# Summary of issues under the Justice Pillar

Issues with the justice system were noted across consultations, including a need to enhance collaboration between the justice system and other services. Partners strongly felt that the justice system was not working for anyone. Partners noted a missing connection between the justice sector and support services including treatment services, wrap-around support, and mental health services.

One of the top recommendations from the Partner Survey was to reduce barriers to employment for people with criminal records by exploring collaborations with groups such as the Downtown Development Board and Employment Services. This need was also expressed in the Peer-Led Lived/Living Experience Interviews where challenges with obtaining employment for those with criminal records were noted. In the Community Survey there was strong disagreement that people who use substances are well supported in the community when looking for a job.

Providing treatment as an alternative to incarceration was also a theme mentioned across consultations. This theme was mentioned in both the Community Survey and Partner Survey; however, this was not related to a specific action in the ECDAS recommendations. Jail being used as a place for access to treatment/detox (intentional or not) was mentioned in the Partner Interviews. The need for rehabilitative services that do not involve the criminal justice system was expressed in the Peer-Led Lived/Living Experience Interviews. A novel idea presented in the Partner Interviews was a reference to the Seattle is Dying documentary which depicts a facility that is both a jail and a treatment centre where treatment/withdrawal services are provided including medication and counselling, and people are connected to services upon release.

Fear of police was noted as a barrier to support in the Peer-Led Lived/Living Experience Interviews, which may relate to the top recommendation from the Partner Survey, which calls for crisis intervention, de-escalation, and compassion fatigue for all front-line workers. It was also noted in the Partner Interviews that people are not getting the proper support in crises when there is a need for mental health support, which may also play into the reluctance to call the police in crises such as an overdose. Calls to decriminalize/legalize drugs were also mentioned in the Peer-Led Lived/Living Experience Interviews.

# Justice Recommendations

## Service Enhancement

- **Alignment Across Pillar:** Reduce barriers for people accessing services with an equity-centred and trauma Informed approach, and offer support to increase the accessibility of programs and services in both urban and rural settings (e.g., transportation, child minding, free services, mobile outreach etc.).
- **Long Term Priority:** Enhance withdrawal management services provided to individuals while in custody.

## Community Coordination

- **Alignment Across Pillar:** Improve coordination between community partners that work across all four pillars.
- **Short Term Priorities:** Enhance discharge planning through coordination with multiple services (e.g., the provision of complimentary transportation, clothing and housing options); advocate for a peer support worker at the courthouse and a CMHA office in the courthouse to support service navigation, crisis intervention and assist with de-escalation; and aid in navigating services in the community through system navigators and peer support systems.
- **Long Term Priority:** Enhance communication and collaboration between justice, treatment, social services and outreach services.

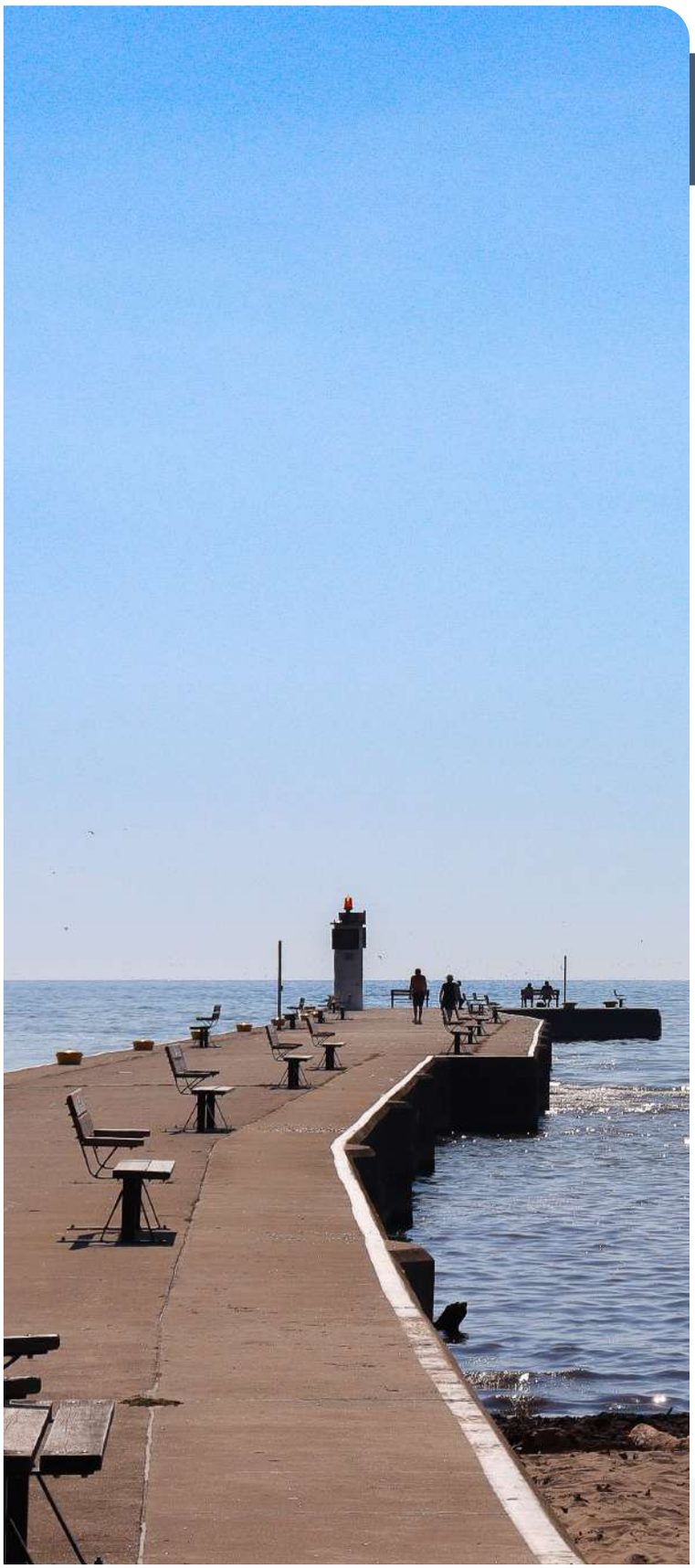
## Building Community Capacity

- **Alignment Across Pillars:** Identity and prioritize annual evidence-informed training for ECDAS members and partners, and provide evidence informed anti stigma training and promotion of respectful language and dialogue with all community partners that work across all four pillars.
- **Short Term Priorities:** Decrease stigma associated with people in breach of probation by disabling commenting on social media posts, and provide harm reduction training to police and enforcement services in the community.

## Advocacy

- **Alignment Across Pillars:** Develop an advocacy strategy outlining advocacy efforts at the local, provincial and federal levels that aligned with drug and alcohol advocacy efforts in other regions.
- **Short Term Priority:** Advocate for compassion fatigue training for all front-line workers.
- **Long Term Priority:** Assess the needs of people with lived/living experience and their interactions with the justice system.

The community consultations undertaken for the Elgin Community Drug and Alcohol Strategy provide insight into strengths, barriers, and recommendations from the general public, community partners, and those with lived/living experience with drug and alcohol use in St. Thomas and Elgin County. The above recommendations summarize of all the data collected and show the underlying themes across the consultations, including unique perspectives, new ideas and suggestions for addressing the complex issue of substance use.



# Conclusion

The ECDAS was formed in response to worrying trends of substance-related harms in Elgin and St. Thomas.[1] The strategy uses a four-pillar approach addressing problematic substance use. The recommendations outlined in this report result from extensive consultation with a wide range of community stakeholders, including PWLE, community partners, decision-makers, and community members. These recommendations will guide the future activities of the ECDAS and our partners.

## Report Contributions

- Collective Results Consulting
- Meagan Lichti, Southwestern Public Health
- Alicia Malcolm, Central Community Health Centre
- Dan Bolton, Steering Committee Member with Lived Experience & Secretary of The Homeless Coalition of ST Thomas,
- Sandra McCabe, CMHA Thames Valley Addiction & Mental Health Services
- Abigail Dzur, Southwestern Public Health
- Marcia Van Wylie, Southwestern Public Health
- Local images photographed by Vanessa Gould

# Appendix A

# Community Survey

A descriptive, cross sectional study design was used to assess the perspective of community members on local issues related to drug and alcohol consumption as well as their perspective on actionable items that could be used to address these issues. Residents were invited to complete the community survey electronically, on paper, or over the telephone. Participation in the survey was both voluntary and anonymous.

The survey consisted of a total of 34 statements; 22 statements related to factors affecting the impact of substance use prevention, harm reduction, treatment, and justice and 12 statements were used to assess ways to create a safe and healthy community without the negative impacts of drug and alcohol. Each statement was assessed using a 4-point scale ranging from “Strongly Disagree” to “Strongly Agree.”

Data was stratified according to both geographical status (rural vs. urban) and for participants who reported having had personal (self or friend/family member) or professional (paid or volunteer) involvement with people using drugs and alcohol (abbreviated throughout as *“with involvement”*), to identify any significant differences from participants without personal or work experience with alcohol and/or drug use (abbreviated throughout as *“without involvement”*).

# Appendix A:
# Community Survey

## Participant Demographics

A total of 166 community members participated in the survey, ranging in age from 21-81 years. The sample was mostly female (86%) and there was heavy representation from those who had completed post-secondary education (70%). There was high representation from participants who were working in full-time employment or were considered retired (69%).

55% of the responses indicated that they live in St. Thomas and 45% indicated living in a rural area of Elgin County. When compared to population data, two potential areas of underrepresentation were the Township of Malahide and the Municipality of Bayham.

The majority of the sample identified themselves as "with involvement" (75%). 81% of the sample had not heard of the ECDAS.

## Findings

Strongly Agreed  Strongly Disagreed

The top 10 issues identified, in order of strength of agreement/disagreement from participants include:

| | | |
|---|---|---|
| 1 | 👍 | Substances are becoming more dangerous. |
| 2 | 👍 | The opioid crisis is getting worse. |
| 3 | 👎 | There are enough substance use treatment options. |
| 4 | 👍 | Substances are becoming easier to get. |
| 5 | 👍 | Drug use has increased in Elgin County during the COVID-19 pandemic. |
| 6 | 👎 | It is easy for people who need substance use treatment support to access the help they need. |
| 7 | 👎 | People who use substances are treated with respect in our community. |
| 8 | 👍 | Some barriers such as cost and transportation, make it hard for people to get treatment for substance use. |
| 9 | 👎 | People who use substances are well supported in the community when finding a stable place to live. |
| 10 | 👎 | People who use substances are well supported in the community when looking for a job. |

# Appendix A: Community Survey

The top themes that emerged were:

1. **The issue is getting worse in the community;**

2. **There is a lack of treatment options; and**

3. **There is a lack of support** (e.g., stable living arrangements, assistance obtaining employment or accessing treatment).

Significant differences with respect to agreement/disagreement on issue statements were not observed between urban and rural participants nor between those with involvement compared to those without involvement. The only issue statement that did not have consensus was participants with involvement generally disagreed with the statement, "health care workers are aware of services that can help people that need support for substance use", whereas participants without involvement agreed.

While the two samples were generally in agreement about the most pressing issues, participants *with involvement* tended to feel more strongly about the issues in comparison to participants *without involvement*.

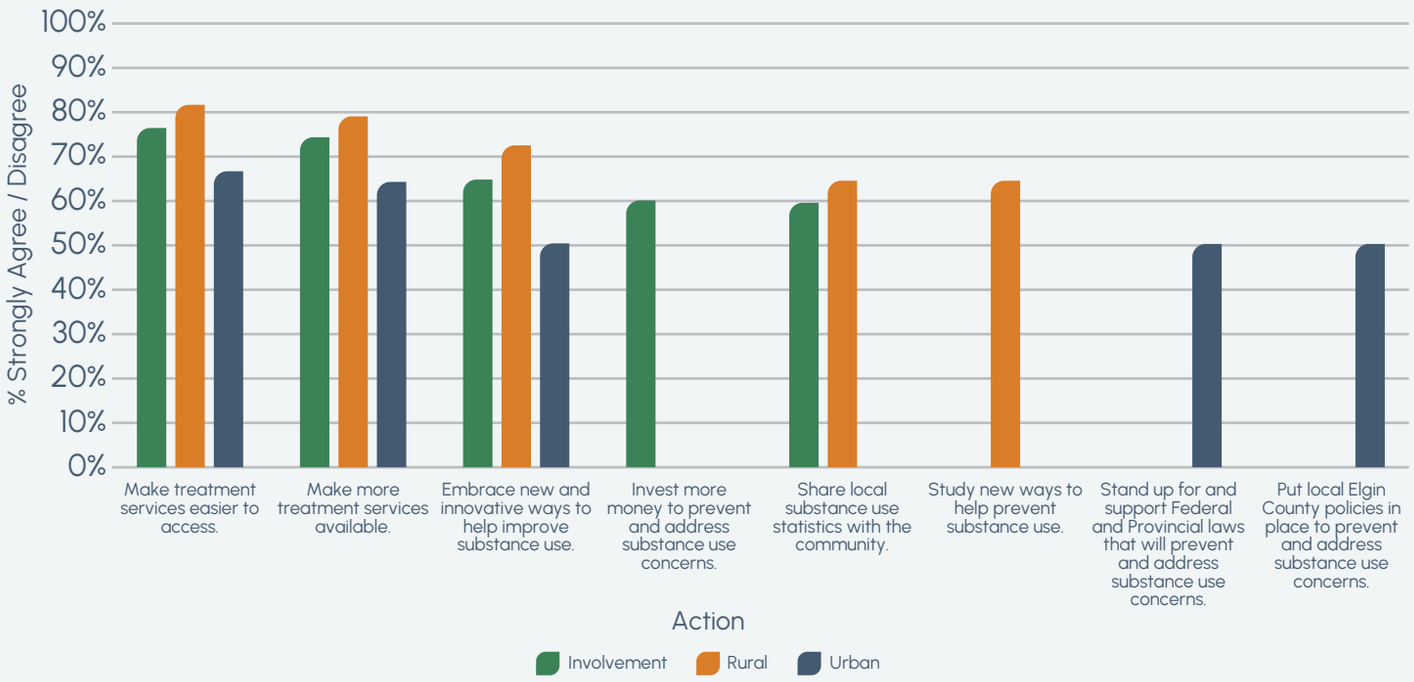
## Action Statements Most Important to the Community

The following 12 action statements assessed in the survey are presented below in the order of how strongly participants "strongly agreed" with each statement:

1. Make treatment services easier to access.
2. Make more treatment services available.
3. As a community, embrace new and innovative ways to help improve substance use concerns.
4. Make it easier for organizations to work together to help people who need substance use support.
5. Study new ways to help prevent substance use.
6. Share local substance use statistics with the community.
7. Make harm reduction services easier to access.
8. Invest more money to prevent and address substance use concerns.
9. Stand up for and support Federal and Provincial laws that will prevent and address substance use concerns.
10. Put local Elgin County policies in place to prevent and address substance use concerns.
11. Make more harm reduction services available.
12. Share substance use stories of real local people with the community.

# Appendix A: Community Survey

## Figure 1 : Top five actions for rural and urban participants and participants with involvement




The above chart depicts the top five actions for rural and urban participants and participants with involvement.[1] Please note that an action's absence from the 'top 5 actions' does not imply that it was not important to a given demographic.[1] All three demographics highly rated actions regarding increased access to treatment as well as finding new and innovative solutions.

## Some differences that have emerged:

1. Participants with involvement felt stronger about investing more money to address substance use concerns.

2. Participants from St. Thomas (urban) felt stronger about actions related to municipal policies and leveraging government support.

3. Participants from rural Elgin County felt stronger about prioritizing new ways to help prevent substance use and sharing local statistics with the community.

# Appendix A:
# Community Survey

## Limitations

Limitations of this survey include a potential lack of generalizability to the population of the St. Thomas and Elgin Community, as the sample had an over-representation of the female, full-time employed or retired populations, as well as those that have a post-secondary education. A relatively small sample size (n=166) also contributes to limitations of results as it is only representative of 0.25% of the adult population of St. Thomas and Elgin County.

There may also be a response bias as individuals *with involvement* may be more likely to complete the survey due to personal relevance. The majority of the sample (75%) was individuals with involvement, therefore any general data trends mentioned may be biased to more heavily reflect the opinions of those *with involvement* as opposed to a more balanced sample.

# Appendix B

# Partner Survey

A Partner Survey was conducted to begin prioritizing ECDAS recommendations based on the criteria of need and capacity. Community partners were selected by the Steering Committee and participation was voluntary. The identified stakeholders represented diverse sectors and roles including organizational leaders, frontline employees, and volunteers.

# Appendix B:
# Partner Survey

The survey consisted of the 121 recommendations divided into four pillars of Prevention, Treatment, Justice, and Harm reduction.

Each pillars' recommendations where further divided into 5 categories:

1. Community coordination: To create collective impacts that better the community through collaboration, coordination and leadership of citizens, community groups, service providers, and government.

2. Service enhancement: To enhance services, create new programs, and provide better access, availability, and capacity, leading to people having access to the right programs or services when they are ready.

3. Building public capacity: To help increase community awareness and acceptance, while decreasing stigma through knowledge sharing, engagement, and innovative training opportunities.

4. Research and development: To examine and evaluate evidence-informed and innovative solutions to prevent and address current concerns, including changes on key local policy issues. To stay informed of the local context and measure progress and impact of actions via indicator monitoring, research, policy implementation, and evaluation mechanisms.

5. Advocacy: To advocate with different levels of government to create change that will have an impact on local, provincial, and federal laws and funding.

Participants rated each recommendation on a 5-point Likert scale for both need and impact in the community to give each recommendation a total score out of 10.

## Participant Demographics

88 survey responses were collected from community partners. Most respondents were from healthcare and social service sectors (64%). Half of respondents were in a direct client or customer service role (50%) including nurse, social worker, police officer, etc. Participants who identified as a Person with Lived/Living Experience (PWLE) of substance use accounted for 23% of the sample (n=21).

# Appendix B:
# Partner Survey

## Findings

The recommendations that were rated most highly by community partners are listed in Table 1, along with the corresponding pillar.

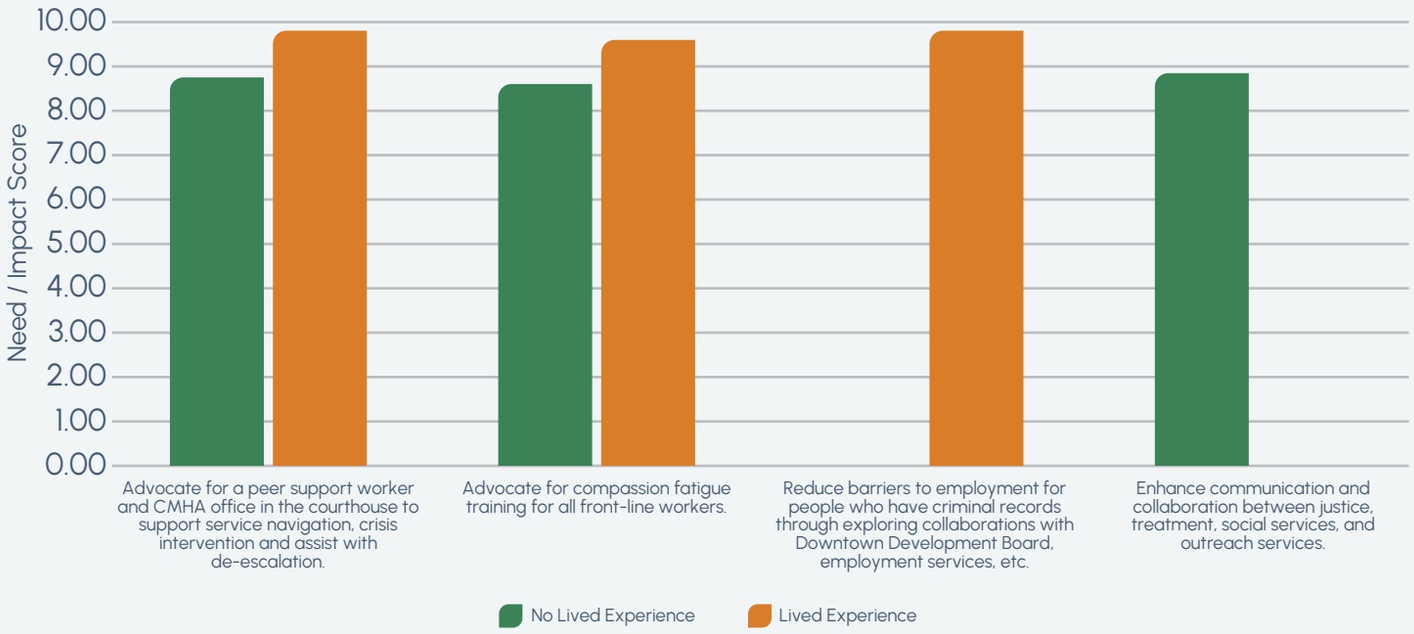
### Table 1 : Top 5 Recommendations from Community Partners

| | |
|---|---|
| **Alignment Across Pillars** | Reduce barriers for people accessing services with an equity-centered and trauma-informed approach. |
| **Justice** | Enhance communication and collaboration between justice, treatment, social services, and outreach services. |
| **Justice** | Advocate for a peer support worker in the courthouse to support service navigation, crisis intervention, and assist with de-escalation. |
| **Alignment Across Pillars** | Offer supports to increase the accessibility of programs and services in both urban and rural settings (e.g., transportation, child minding, free services, mobile outreach, etc.). |
| **Harm Reduction** | Improve access to healthcare, housing, and coordinate referral services for people with lived/living experience. |

The top responses for each pillar were analyzed for all data, and then compared the responses of PWLE and those without lived experience. Pillars are listed in order of highest to lowest mean scores for all data.

# Appendix B:
# Partner Survey

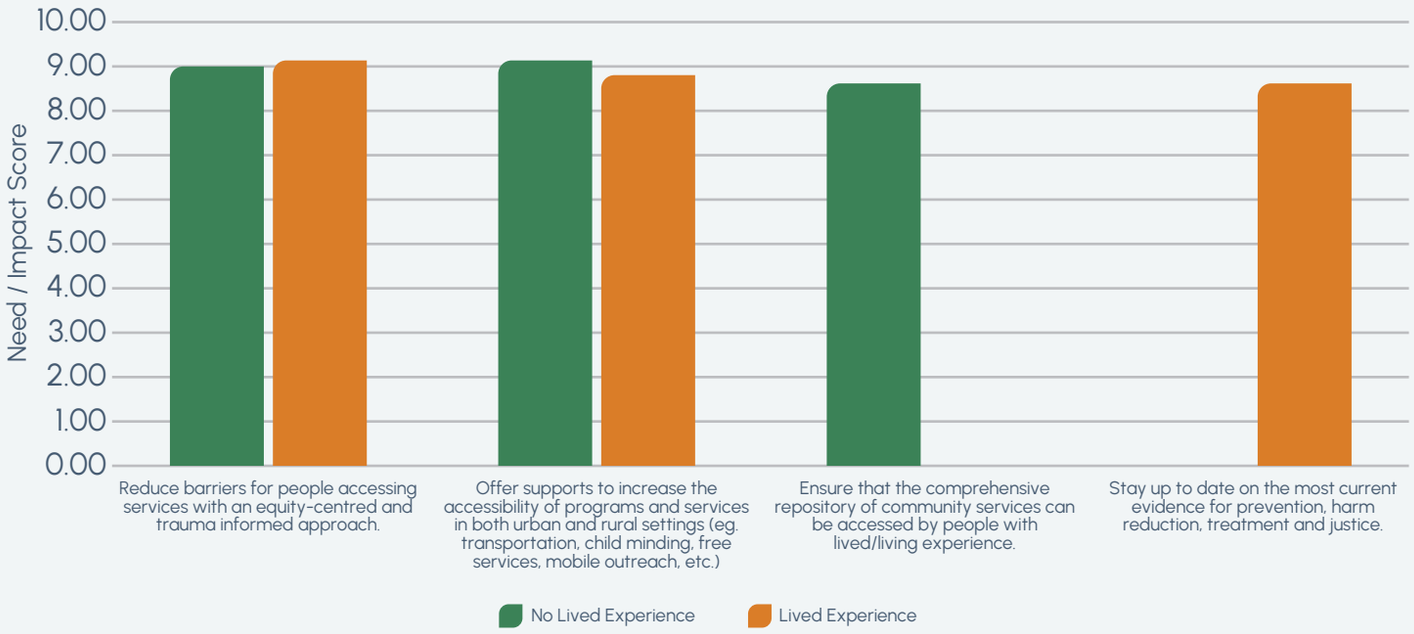
## Figure 1 : Top 3 recommendations from the justice pillar




The justice pillar includes some of the highest ranked recommendations.[1] Trends include hiring a peer support worker and incorporating a CMHA office in the courthouse to support service navigation, crisis intervention and de-escalation, advocate for compassion fatigue training for all front-line workers, reduce barriers to employment for people with a criminal record, and an emphasis on communication and collaboration between sectors.

# Appendix B:
# Partner Survey

## Figure 2 : Top 3 recommendations from the alignment across pillars

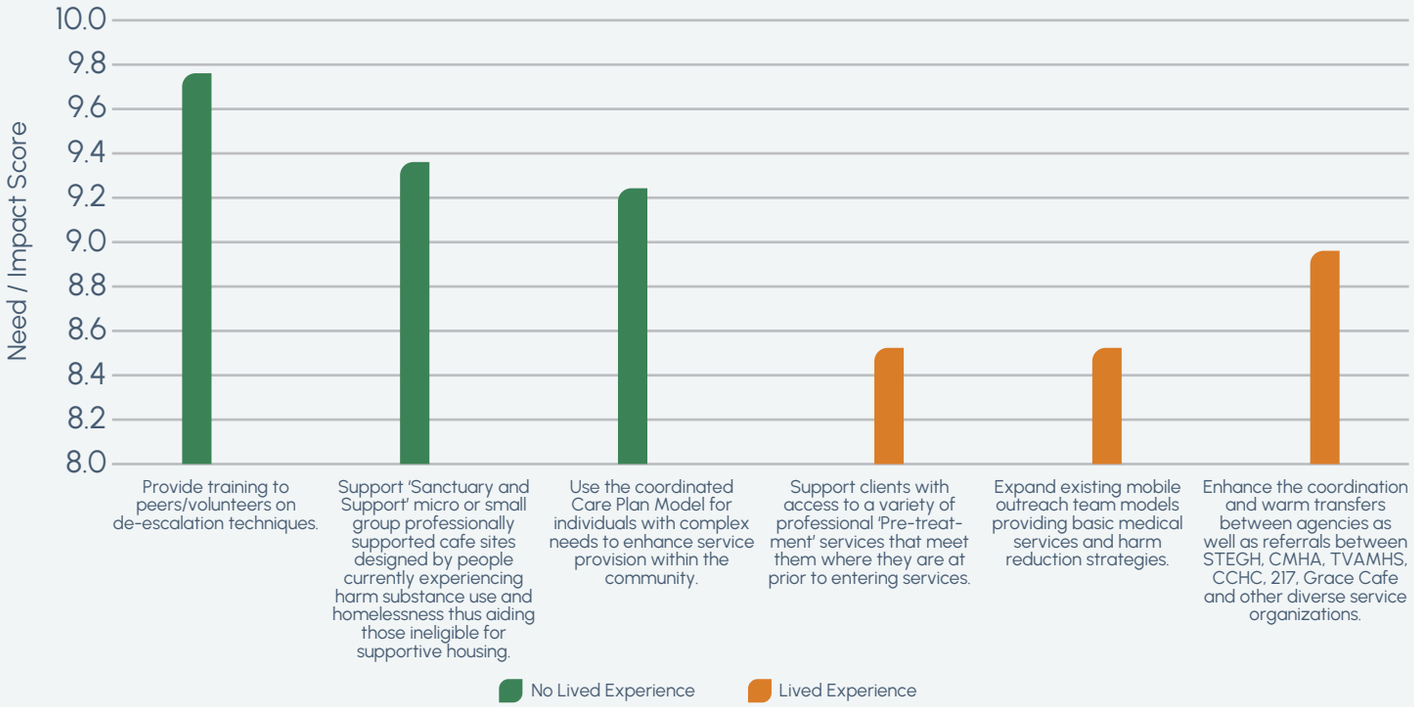



Alignment across pillars recommendations generally rated high for impact and need.[2] The four recommendations that were rated highest by participants are detailed below.

1. Reducing barriers to services.
2. Increasing accessibility to programs for both urban and rural settings.
3. Staying up to date on current evidence for prevention, treatment, harm reduction, and justice (top response only for PWLE).
4. Ensuring that PWLE have access to a comprehensive repository of community services (top response only for those without lived experience).

# Appendix B:
# Partner Survey

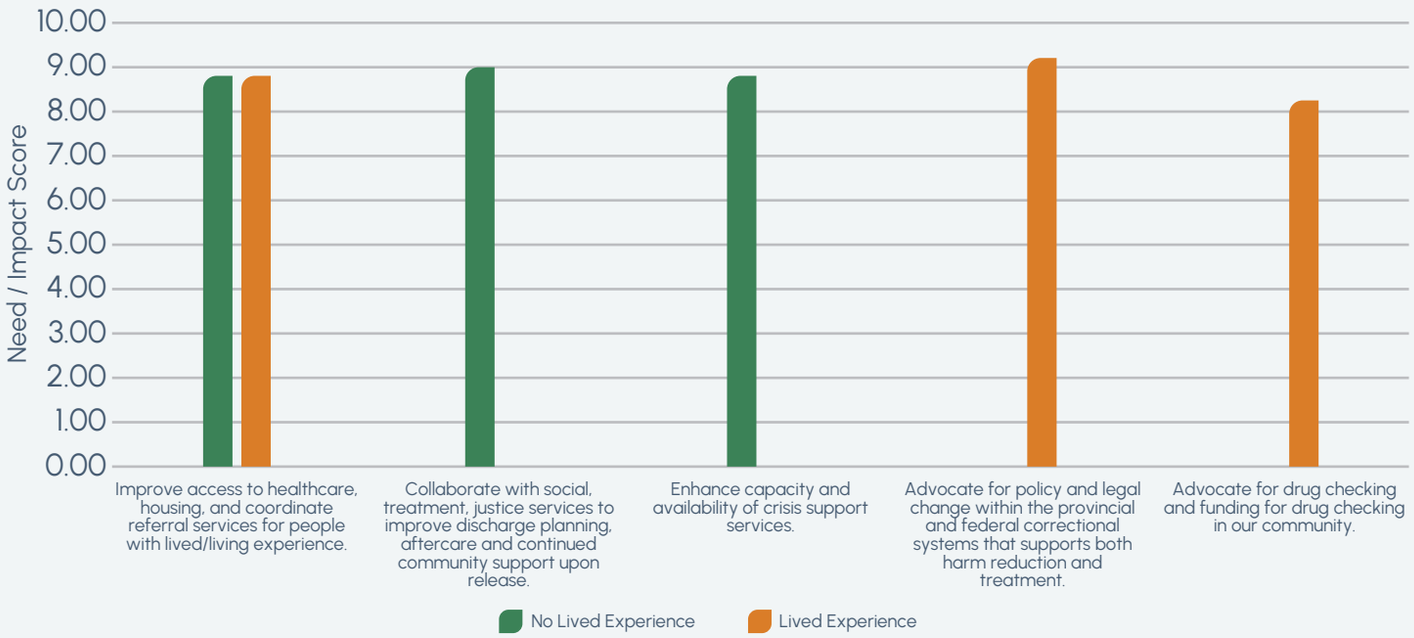
## Figure 3 : Top 3 recommendations from the treatment pillar




The treatment pillar was the most inconsistent between those with and without lived experience.[3] PWLE's top 3 recommendations included de-escalation training for peers, non-traditional housing designed by people currently experiencing harm as a means of supporting people ineligible for supportive housing, and use of a coordinated Care Plan Model for people with complex needs. Top rated recommendations from people without experience include coordination between organizations, expanding existing outreach services, and access to professional pre-treatment services.

# Appendix B:
# Partner Survey

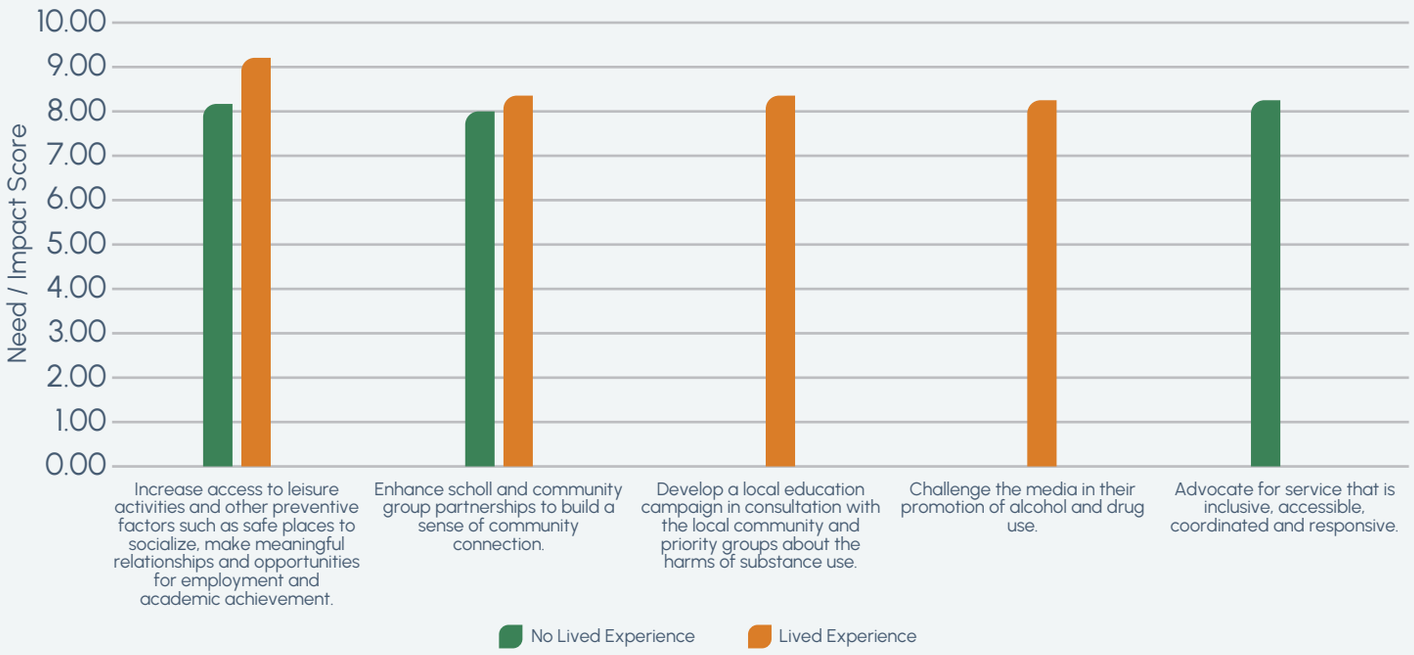
Figure 4 : Top 3 Recommendations from the harm reduction pillar




Top responses in the harm reduction pillar included themes related to increasing access to services including healthcare, housing, referral services, and crisis support services, providing continued support upon release and collaboration between social, treatment, and justice services.[4] Top recommendations for PWLE that did not appear in the data for those without lived experience include advocating for drug checking services, and legal and policy changes in the correctional system to support harm reduction and treatment.

# Appendix B:
# Partner Survey

Figure 5 : Top 3 Recommendations from the prevention pillar




In general, prevention strategies rated lower than the other pillars. Some themes that emerged from the prevention pillar recommendations include access to safe and inclusive environments and activities, as well as providing opportunities for people to build relationships and find connection with their community by means of school/ community groups or leisure activities.[5] PWLE rated challenging the promotion of drugs and alcohol in the media and developing a community education plan regarding the harms of substance use as top priorities.

## Limitations

Survey participants were selected by the ECDAS steering committee and therefore their perspectives may be biased. The relatively small sample size also poses limitations with respect to the generalizability of the results, whereby the sample of partners may not be representative of the broader community of partners and there is greater potential for outliers to affect mean scores.

Appendix C

# Partner Interviews

Partner interviews were conducted to gain insight into perspectives on drug and alcohol use in St. Thomas and Elgin County. The interview consisted of 6 questions related to top issues, barriers, strengths, and actions to develop a full understanding of individual perspectives. After all interviews were completed, a thematic analysis was used to identify themes that developed from the raw data.

## Participant Demographics

There were 24 participants interviewed. Participants were selected by the Steering Committee with the intention to bring a wide perspective on topics related to drug and alcohol use in St. Thomas and Elgin County. The majority of participants were from healthcare and social service sectors and there was also representation from all levels of government.

# Appendix C:
# Partner Interviews

## Findings

### Top Strength

When people were asked about strengths that should be leveraged for support it is very clear that the community itself is a main asset. People often named the amazing work of many community organizations including:

- Grace Café opening the Annex in the spring to hire two full time counsellors.
- One of the most discussed success stories was the work of Indwell creating supportive housing.
- Nameless providing much needed peer support.
- Police support downtown including helping people take medications and accompanying people to get cheques from Ontario Works if they are banned.

### Top Barriers Identified

Participants in the partner survey were asked to identify barriers that would prevent the St. Thomas and Elgin Community in advancing the efforts of ECDAS. There were four main barriers identified:

#### Stigma

Stigma in the community was identified as a major barrier, particularly noted in the following areas:

- Social media (i.e., Facebook groups/posts).
- Lack of community support for harm reduction methods.
- Locations for services that serve individuals that use drugs and alcohol and individuals that are homeless.

#### Knowledge

Lack of knowledge was discussed as a barrier in the following ways:

- A contributor to stigma in the community, particularly in service sectors like the healthcare system as well as the downtown business community.
- For prevention, especially lack of education resources for youth and parents.

#### Service Sector Buy-in

It was identified that providing education and awareness is not always enough to generate buy-in and support. Partners noted a lack of buy-in in the following sectors:

- The business community to support community initiatives.
- Local physicians to update their treatment/ harm reduction strategies.

#### Government Support

This looked different depending on the level of government:

- The need for more funding from the provincial government to support community initiatives, as they control funding for items related to healthcare.
- With municipal government there are logistical issues such as approving locations for the community centre bus, and general gatekeeping around getting support.

# Appendix C:
# Partner Interviews

## Top Issues and Actions

Issues and recommended actions were noted by partners that were relevant to the pillars.

## Alignment Across Pillars

### Top Issues

1. Lack of coordination between service providers/community organizations.
   - This theme also showed up as competition for funding or overlapping services between community organizations like The Nameless, Grace Café, and Inn Out of the Cold.

2. Difficulty navigating the support pathway.

3. Transportation is a barrier to accessing services.
   - This barrier came up in general, however, it was specifically important for the rural population.

4. Stigma in community worsened by social media.

### Top Actions

1. Improve collaboration between community service sectors like healthcare, the justice system, mental health services, grassroot organizations, housing support, etc.
   - This may be a key area to incorporate peer support.
   - This may include promoting services such as “no wrong door” or “one number to call”.

2. Integrate peer support work into the boots on the ground support.
   - This was mentioned consistently as important actionable items to help improve service enhancement in the community.
   - Related to bringing services to people, rather than expecting people to seek out support in the community.

3. Improve access to transportation to help people access support services in the community.
   - This was identified as another area for peer support, connecting people to support services that may not be available in the street, bringing people to supportive housing, treatment, or harm reduction support.

4. Control stigma promoted on social media, use social media to promote good stories.

# Appendix C:
# Partner Interviews

## Treatment Pillar

### Top Issues

1. No local treatment centre.

2. Treatment takes too long to access.

3. Physicians are not open to new treatment methods and are not using up to date treatment options.
- This may be due to stigma or potentially due to financial incentive to continue using their current methods.
- There was specific concern with the Rapid Access to Addictions Medicine (RAAM) clinic, which provides medical treatment for opiate and alcohol use disorder.

4. Re-integration upon release from treatment, the hospital, or jail.
- Individuals can receive treatment support when they are removed from their environment, but if they return to the same place with the same friends upon release, it increases the likelihood of relapse.

### Top Actions

1. Improve access to treatment/withdrawal services available in St. Thomas and Elgin County.
- This was by far the most recommended action item from the Partner interviews.
- A treatment centre in the St. Thomas and Elgin Community was seen as a critical way to provide timely treatment support, with less wait time.

2. Education for the healthcare sector to improve treatment methods and reduce stigma.
- Buy-in will become significantly important so physicians and healthcare workers are open to receiving education.
- May include anti-stigma training or information about different types of treatment.

3. Hiring a practitioner that specializes in addictions at the hospital.
- This was reported to have been implemented at other hospitals and has been successful. This is accompanied by beds specifically for detox or additional treatment.

4. Supporting grassroots organizations (Grace Café) that are increasing access to treatment.

# Appendix C:
# Partner Interviews

## Justice Pillar

### Top Issues

The overall sentiment from partners is that the current justice system framework is not working for anyone. Frustration is felt by all parties.

1. The need for long-term solutions. *"We can't arrest ourselves out of the problem"*.

2. People are not getting the right support in crisis situations when there is a need for mental health support.

3. Mental health support services do not have the resources and are overwhelmed quickly when police reach out for support.

4. Missing connection between justice sector and support services including treatment services, wrap around support, and mental health services.

### Top Actions

1. Treatment as an alternative to incarceration.

2. Jail as a place where people can access treatment/detox (medication, therapy).

- Jail is currently being used as a detox center, whether that is intentional or not. There was reference to the Seattle is Dying documentary which depicts a specific type of facility that is both a jail and a treatment center where services are provided including medication, counselling, and connections to services upon release.

3. Improved collaboration between police and support services/mental health support.

- One recommendation was to adopt the Mobile Response Crisis Team Framework (MRCT) that is currently being used in other municipalities, including London.

# Appendix C:
# Partner Interviews

## Prevention Pillar

### Top Issues

1. Youth learning about drugs and alcohol too late in school.
- Increase education in grades 6-8 because once kids are in high school they are already experimenting.

2. Parents do not know the signs to look for and are not aware of issues regarding opioids.

### Top Actions

1. Public events to celebrate community wins, share success stories, and reduce stigma.
- In London, September is “recovery month” and they raise awareness and share stories of success from PWLE.

2. Provide education and support to youth and families/parents.
- Educating parents on signs that may identify issues with drug and alcohol use. People felt that information coming from PWLE would be more powerful, especially for youth.

3. Icelandic Model/Planet Youth
- Iceland went from having one of the worst rates of substance use in teens to one of the best in the world. The Icelandic model is an initiative to reduce alcohol and drug use in young people by using parenting, parental supervision, organized leisure time, curfew hours, and encouragement of joint family dinners.
- Planet Youth Framework was developed to help communities replicate the Icelandic Model, but curates it to be community specific. It is based on evidence-based decision making, data collection, and implementing changes in the built environment of communities.

# Appendix C:
# Partner Interviews

## Harm Reduction

### Top Issues

1. Community concern over harm reduction methods: needle exchange, supervised consumption, and location of services.
- Conflicting opinions for almost every method of harm reduction.
- Concern for whether or not harm reduction methods are consistent with best practice.
- Concern over how harm reduction methods are impacting safety in the community, especially the needle exchange program due to presence of needles found in the community.
- Discrepancies in opinions regarding the use of safe consumption sites were noted, and concern over the location being in the downtown area.

2. Current harm reduction methods are not meeting the needs in the community.
- Specific reference to methods used by the RAAM clinic.
- The need for more supportive housing such as Indwell was identified.

### Top Actions

1. Use best practices/evidence-informed harm reduction methods.

2. Support for organizations who are developing supportive housing.
- Includes Indwell and the tiny houses project being proposed by the YWCA.

## Limitations

Partner interview participants were selected by the Steering Committee and therefore their perspectives may be biased. The relatively small sample size also poses limitations with respect to the generalizability of the results, whereby the sample of partners may not be representative of the broader community of partners.

Appendix D

# Peer-Led Interviews for Individuals with Lived Experience

Peer-led Lived/Living Experience interviews were conducted to gain insights directly from PWLE in St. Thomas and Elgin County, to understand their perspectives. Each interview was conducted by one of three peer interviewers who self-identified as having personal experience with substance use.  A member of the Collective Results team was also present to record notes. Recruitment was completed by health and social service partners and the peer interviewers; participation was voluntary.

The interview consisted of four demographic questions and five content questions pertaining to what works well in the community, what barriers there are to getting support, what is missing to support people, and what other programs or services are needed to help reduce the harms from drugs and/or alcohol in the community.

# Appendix D:
# Peer-Led Interviews for Individuals with Lived Experience

## Participant Demographics

There was a total of 32 participants; 31 participants were interviewed in-person and one participant provided a written response. Interview locations included rural and urban settings. 25 participants lived in St Thomas and the remainder (7) lived in rural areas of Elgin County. 21 participants were male, 9 were female, 1 identified as transgender, and 1 declined to respond. Ages ranged from 23 years to 66 years of age, with the average age of participants being 43.6 years old. Participants lived in the community for an average of 22 years, ranging from 3 to 59 years.

## Findings

### Helpful Services

Participants noted that there are some existing services in the community that they find to be helpful. Notably, a greater variety of services were highlighted by participants from St. Thomas as compared to those from rural communities.

There were many services noted as being helpful to the urban participants of St Thomas.

- The Nameless was the highest (N=12).
- The CCHC Primary Care Outreach (PCO) (N=6). The PCO offers medical care from a physician and nurse for physical, mental health, and addictions concerns for vulnerable community members.
- The Grace Café (N=6).
- Some participants noted that they looked forward to the Annex opening and the addition of computers to this establishment was also noted as a positive.
- Other services mentioned as being helpful include Indwell, CCHC's Opioid Treatment and Harm Reduction Program, Employment Centre, The Inn, the needle exchange, methadone, first responders, hospital services, OW/ODSP, Giving Back, Addiction Services (Thames Valley), Teen Challenge, and peer support.

The services and treatment options noted as being helpful to rural participants include Family Central, Needle Exchange, Ontario Addiction Treatment Centre, Rural Pop-Ups, and Methadone and Suboxone.

Some individuals felt that 'nothing' was going well (8 participants, 25.0%).

# Appendix D:
# Peer-Led Interviews for Individuals with Lived Experience

## Barriers to Getting Support

Participants provided insights on barriers and challenges to getting support in the communities of St. Thomas and Elgin County. Barriers were noted by all participants. The top themes related to barriers to getting support are listed below.

Lack of Accessible and Available Programs and Services Mentioned by 53.1% of participants (n=17; 6 rural, 11 urban). Issues identified include:

- Lack of awareness of services was mentioned by a disproportionate number of rural participants (n = 4 rural, 2 urban).

- Inconsistent access that is not timely/long wait times.
  - *"… for addiction services to be available only 2 days a month, it's ridiculous."*
  - "We need resources that second, if you give us 5 seconds to chew on it, we will use again."

- Specific features of programs that hinder access, such as needing an appointment.
  - *"When you want help, it's hard to get help – it takes too long – you have to have an appointment and the times you need to go are when you are sleeping."*
  - *"if you miss your time/appointment you can't come back until the next week or the next time that they can take you."*

- The lack of co-located services.
  - *"Need to have one place for all the support they need – how many meetings and places is someone going to go to in a week? All the different spots you have to go to how many addicts are going to wake up and go to 6 appointments?"*

- The requirement to have identification to access services.

- Lack of services in rural areas.
  - *"Every day someone says that they can't get to St. Thomas for help at the methadone clinic so they use Fentanyl to get by that day – they can't get a ride to St. Thomas to get their methadone. Why is St. Thomas the keeper of the Methadone treatment? Why do they have to go to St. Thomas?"*

- Fear of law enforcement.
  - *"… It would be better if just paramedics came to a 911 call rather than police too."*

# Appendix D:
# Peer-Led Interviews for Individuals with Lived Experience

## Stigma

Mentioned by 46.8% of participants (n=15; 4 rural, 11 urban).
Issues identified include:

- Negative perceptions of establishments/organizations that serve people with addictions.
    - *"Bus drivers judge you coming out of Grace Café and make comments."*

- Participants expressed feeling judged, disrespected, and looked down upon which makes it difficult to ask for help.

- Lack of awareness/understanding of why people turn to drugs
    - *"It's unfair that we're looked down upon, we are not all bad people."*

- Avoiding using public transit due to embarrassment.
    - *"A lot of people don't want to use the bus because they are embarrassed because they are high."*

- Stigma associated with being homeless.
    - *"Being homeless – nobody ever wants to deal with you – it's like you have a disease"*

- Businesses treating people poorly.
    - *"Businesses treat you really bad – someone said you are a cockroach and should get out."*

- Differential treatment in healthcare.
    - *"Sometimes doctors are great but others see you as a druggie and they treat you poorly – if you are using it over and above maybe there is a reason for it."*

## Issues at Shelters - The Inn and Indwell

Negative comments regarding the Inn were made by 6 participants and negative comments regarding Indwell were made by 3 participants (*note: some participants made comments about both establishments). Issues identified include:

- Restrictive rules/policies.
    - *"The rules at the shelter and Indwell are hard and don't make any sense… it creates isolation."*

- People are getting banned.
    - *"The Indwell and the shelters – having some issues right now – fights breaking out and people getting kicked out for this and banned. They will kick people out of the shelter for trying to save people and not calling 911."*

- Unsupportive staff/staff who lack understanding.
    - *"The staff (at the shelter) are not supportive – they say we are not your counsellor."*

# Appendix D:
# Peer-Led Interviews for Individuals with Lived Experience

## Missing Services / Initiatives and Service Enhancements

90.6% of participants provided insight on what they feel is missing or needs improvement in the St. Thomas and Elgin Community to support people who use drugs or alcohol which are included below.

## Lack of Peer Support

A resounding theme noted by participants is a lack of caring, respectful peer support/someone to talk to (56.3% of participants, 4 rural, 14 urban). Many noted frustrations interacting with providers who lack understanding and have no lived experience. Some participants noted that there is a lack of available counselling.

- *"The programs should put more thought into what they are doing – who are they putting in as workers – need people with lived experience – some people seem like they don't want the job."*

- *"Support is a very big thing, don't have any sort of AA or NA groups in town. Nobody to go to or call if you need to talk..."* (Aylmer)

## Lack of Harm Reduction and Treatment Services

The following services were noted as being needed in the St. Thomas and Elgin Community.

- A comprehensive withdrawal management option in the Community.
    - *"We need programs for the entire duration of someone with addictions. It can't last 19 days and that's it. Need to have longer term support".*

- A methadone clinic in rural areas.
    - *"Why is St. Thomas the keeper of the methadone treatment? Why do they have to go to St. Thomas?"*
    - *"There is nothing for us here (West Lorne) – I have to go to Strathroy to get my methadone."*

- Safe consumption site
    - *"Safe injection sites so people who do use have a safe place to go – not in some alleyway – they will at least have the care they need – there should be one in every city."*

- Improvements to outreach services/awareness of services.

- Rehabilitative services that do not involve the criminal justice system.
    - *"There needs to be a place where you can go that is not jail – you will be forced to stop but then when you leave you are back at it again."*

- Crisis Services.
    - *"We need resources that second, if you give us 5 seconds to chew on it, we will use again... they have eliminated the crisis centre."*

- A suggestion to add a counselling component to the D8 program and concerns that people sell their D8 for other drugs.

# Appendix D:
# Peer-Led Interviews for Individuals with Lived Experience

## Lack of Work and Activity Opportunities

Both rural and urban participants noted that boredom/too much idle time can be a trigger for drug use and alluded to the fact that having a purpose and something to occupy time can help prevent relapse and provide motivation for getting clean (25%; 5 urban, 3 rural). The need for more employment support services for those with criminal records or with lived/living experience was expressed. It was noted that having an income would allow people to afford hobbies.

- *"...the boredom is the worst part, it's the trigger. So need more things to keep occupied. Help people get a job would be the best thing."*
- *"Wants to open a big farm house, there would be animals to care for, it helps to have something to occupy your time".*
- *"Most factories won't hire because of background checks and past drug use."*

## Lack of Access to Housing / Shelter

The lack of housing was noted by 21.9% of participants (n=7, all urban). A variety of challenges were noted including lack of supportive housing, lack of a transition house, lack of affordability, shelters being full, and discrimination experienced with owners not wanting to rent to them.

- *"If I could find housing I could get myself on track – affordable housing – but you can't even get in the door because you have a criminal record or bad credit..."*

## More Public Awareness/Efforts to Reduce Stigma

15.6% of participants expressed that more public knowledge/awareness of addiction issues are needed to help reduce the stigma associated with using drugs and alcohol (1 rural, 4 urban).

- *"I think you need to change social attitudes and quit calling people addicts – people have problems and that is why they use the drug."*

## Accessibility of Drugs and Concerns for Friends

A challenge noted by 18.8% of participants was easy access to drugs, with Fentanyl noted as a particular concern. This was due to being around others who are using and the low price of drugs.

- *"The closer I get to getting clean – prices get cut in half – and it becomes harder to escape."*
- *"The Inn rests between three drinking establishments."*

# Appendix D:
# Peer-Led Interviews for Individuals with Lived Experience

71.9% of participants expressed concerns for their friends, particularly due to the prevalence of Fentanyl use, the fear of them overdosing/dying, and the persistence of unsafe practices including using alone and being unskilled in CPR (4 rural, 19 urban). One individual made a comment that it is difficult for those living in rural areas to get to St. Thomas to visit the methadone clinic, so they do Fentanyl instead. Many shared that they had lost friends.

- *"The type of drugs they are doing is deadly - you never know what you are going to take - concerned about friends dying."*

- *"Lost 18 friends last year."*

- *"Concerned because friends have died, using by themselves, uneducated on how to save people's lives, scared to call 911 because of police coming. Fentanyl use. It would be better if just paramedics came to a 911 call rather than police too."*

Struggles dealing with the trauma of these situations was also expressed.

- *"I have saved five people – I have experienced trauma because of that and I am not receiving help for that – I'm still feeling traumatized by that – I don't think there is anything for us."*

Some noted concerns that friends do not seem to care for their own wellbeing.

- *"I'm slowly watching the next phase [of friends] go, that's hard. I can see them fading, I try to give them advice but they don't care. It is getting a lot harder 10X harder."*

## Other Themes / Items Noted

- A general expression that the fentanyl crisis is a major problem is a theme across many participants.
    - *"Drug use is bad here – fentanyl – it's an epidemic out there – impossible to stop."*

- A preference for suboxone as opposed to methadone was noted.

- Decriminalization/legalization of drugs was mentioned by several individuals as something that would make a positive difference.
    - *"… it promotes the decriminalization of drugs which I think is good - I think our attitude towards drugs needs to change…"*

One individual mentioned the need for more discrete services when accessing medication at pharmacies to avoid getting harassed on the street.

# Appendix D:
# Peer-Led Interviews for Individuals with Lived Experience

### Urban and Rural Similarities / Differences

Overall, those living in St. Thomas seem to have greater access to services than rural participants as there was a greater variety of helpful services noted by participants from St. Thomas compared to participants from rural Elgin County. It was also noted by some rural participants that there is frustration with having to travel to receive services.

Both rural and urban participants noted barriers to support with respect to lack of access to harm reduction and treatment services and stigma. Trends indicate that rural participants may have less access to services than urban participants.

## Limitations

A small sample size (n=32) poses limitations with respect to the ability to generalize results to the broader population of individuals who use alcohol or drugs in Elgin County. The relatively small rural sample size (n=7) also makes it particularly difficult to generalize results to the broader rural population who use drugs and alcohol. This also poses limitations with respect to assessing differences between the urban and rural sub-groups within the sample.

There is also a high likelihood of non-response bias, where the most vulnerable individuals in Elgin County are less likely to have had the opportunity to participate in the interviews. Furthermore, since the interviews were conducted at social service agencies, the results may be biased towards individuals who have better access to services and supports.

Appendix E

# Facilitated Sessions with Pillar Workgroups

# Appendix E:
# Facilitated Sessions with Pillar Workgroups

Collective Results led a half day facilitated session with each of the four Pillar Workgroups with a purpose to:

- Establish a shared understanding of the consultation findings collected to date from the Community Survey, Partner Survey, Partner Interviews, and Peer-Led Lived/Living Experience Interviews.

- Prioritize Pillar Workgroup recommendations based on consultation findings collected to date and in consideration of the following criteria:
    - Need and impact scores from the Partner Survey;
    - Community Survey alignment;
    - Partner Interviews alignment;
    - Peer-Led Lived/Living Experience Interviews alignment;
    - Payoff/difficulty matrix completed during the facilitated session (PICK chart); and
    - If required: Urgency/importance matrix completed during the facilitated session (Covey matrix).

- Explore Pillar Workgroup member involvement in implementing prioritized activities.

Prior to each session, the Pillar Workgroups received a document summarizing the consultation findings and their alignment with the Pillar Workgroup recommendations. Within this document, each recommendation received a total score out of 13 based on:

- Need Score from Partner Survey (Score range 1 to 5).

- Impact Score from Partner Survey (Score range 1 to 5).

- Community Survey Alignment (0 = no alignment, 1 = alignment).

- Partner Interview Alignment (0 = no alignment, 1 = alignment).

- Peer-led Lived/Living Experience Interviews Alignment (0 = no alignment, 1 = alignment).

The top recommendations were summarized for each Pillar Workgroup. The top recommendations included:

- The overall top 5 highest scoring recommendations.
- The top 2 highest scoring recommendations from each category:
    - Community Coordination;
    - Service Enhancement;
    - Building Community Capacity;
    - Research and Development; and
    - Advocacy:
        - Note: some categories only had one recommendation and some pillars did not have recommendations in each category.

# Appendix E:
# Facilitated Sessions with Pillar Workgroups

Recommendations spanned across all 4 pillars; the common recommendations were not explored through the facilitated sessions with the pillar workgroups but did receive a score out of 13. The top 6 rated common recommendations include:

- Offer supports to increase the accessibility of programs and services in both urban and rural settings (e.g., transportation, child minding, free services, mobile outreach etc.).
- Improve coordination between community partners across the continuum from prevention to harm reduction to treatment and justice.
- Provide opportunities for community members and organizations to learn about the impact of substance use, addiction, harm reduction, and stigma.
- Reduce barriers for people accessing services with an equity-centred and trauma informed approach.
- Promote “no wrong door” service within the community.
- Provide evidence-informed anti stigma training and promotion of respectful language and dialogue with all community organizations that work across the continuum from prevention to harm reduction to treatment and justice.
- Stay up to date on the most current evidence for prevention, harm reduction, treatment and justice.
- Use a data driven, decision making process to apply local drug and alcohol data in planning and decision making for the Drug and Alcohol Strategy.

In total, 40 members across the Pillar Workgroups participated in the sessions; some members participated in multiple sessions. Overall, the sessions were well attended by a diverse group of individuals from various organizations including PWLE. Based on facilitator observations and participant comments, groups were engaged during the sessions and appreciated the opportunity to connect and collaborate.

# Appendix E:
# Facilitated Sessions with Pillar Workgroups

## Findings

### Harm Reduction

During the harm reduction group session, the group did not change, add, or withdraw any of the recommendations. The group completed the PICK chart activity and prioritized most of the recommendations in the “implement” and “long term projects” category. There was also one recommendation that was categorized as a “quick win”. During the prioritization activity, it was noted that some of the recommendations may be easier or harder to implement based on geography (e.g., in St. Thomas or the rural areas of the County), or there may be more of a need in one area or another.

Following the PICK chart activity, the group completed the Covey matrix activity in an attempt to further prioritize the identified long-term projects. During this activity, the group placed all long-term projects in the same category - high urgency and high importance. As such, the Covey matrix activity did not change the prioritization of the recommendations.

### Justice

During the justice group session, the group worked with the recommendations that were provided to them and did not change, remove, or add any recommendations. They completed the PICK chart activity and prioritized all the recommendations in either the “implement” or “long term projects” categories. It was clear from the discussion that the group agreed that all recommendations should be implemented, but with limited community capacity it would be challenging. The growth of communication and collaboration between justice, treatment, social services, and outreach services was identified as an ongoing priority to focus on in the long term, but one that would yield immediate benefits.

Following the PICK chart activity, the group completed the Covey matrix activity to further prioritize the five identified long-term projects. Following the Covey matrix activity, three of the recommendations remained as long-term project priorities and two of the recommendations were moved to the “monitor” category meaning that the group would revisit implementing these projects once the other projects had started to build momentum.

# Appendix E:
# Facilitated Sessions with Pillar Workgroups

## Prevention

During the prevention group session there were four changes/modifications to the initial prioritized recommendations that were made. These changes were:

1. The group recommended adding a new recommendation building from the initial recommendation that read, "Increase access to leisure activities and other preventive factors such as safe places to socialize, make meaningful relationships, and opportunities for employment and academic achievement." The new complementary recommendation that the group added was, "Assess access to leisure activities and other preventive factors such as safe places to socialize, make meaningful relationships, and provide opportunities for employment and academic achievement." The group indicated that this change would allow this work to be divided into two phases with the "assessment of preventive factors" occurring first followed by the "increased access to preventive factors" representing the second longer term phase of this work.

2. The group saw a difference between advocacy for "inclusive, accessible, coordinated, and responsive services" and advocacy for "coordinated and responsive services". The group felt that advocacy pertaining to "coordinated and responsive services" would be a long-term project that is highly difficult to do.

3. The group identified that there was overlap between the following recommendations: "Advocate for service that is inclusive, accessible, coordinated, and responsive services", "Implement an awareness campaign on the social determinants of health to increase community awareness of preventive factors and their role in preventing substance use", and "Challenge the continuum of service providers and media not to perpetuate stigma". The group wanted to keep the recommendations separate but intentionally bundled them together in Mural to visually indicate the linkages between these recommendations.

4. Through the community consultations, the Icelandic Model arose as a comprehensive prevention model for substance use in youth that was not initially included as a prevention pillar recommendation. The group acknowledged that while some of the prevention pillar recommendations were connected to elements of the Icelandic model (e.g., leisure activities for youth), the recommendations individually do not form the Icelandic Model. The group decided to adopt the Icelandic Model as a recommendation and incorporated it into the prioritization activities during the facilitated session.

For the prevention pillar, the PICK chart activity did not result in any of the recommendations being removed from the priority list. The prevention group did not have enough time to complete the Covey matrix activity. For the prevention pillar, it was decided that all recommendations falling within the "Long Term Projects" quadrant of the PICK chart were assumed to be long term priorities for prevention.

# Appendix E:
# Facilitated Sessions with Pillar Workgroups

## Treatment

During the treatment group session there were two additions to the initial prioritized recommendations. These changes were:

1. The group decided to add the following recommendation to the list of top treatment pillar recommendations, "Support Sanctuary and Support micro or small group professionally supported safe sites designed by people currently experiencing harm from substance use and homelessness thus aiding those ineligible for supportive housing." This recommendation had a high overall score and was one of the top treatment pillar recommendations identified by PWLE.

2. The group decided to add the following recommendation to the list of top treatment pillar recommendations, "Support establishing an anonymous "Opioid Clinic". This no exclusions, safe relationship clinic, is a new concept and is unlike anything currently offered in the community. The move from addiction to dependency idea was conceived by people experiencing homelessness and addiction with the support of a medical specialist."

During the treatment pillar session, there was group validation that the top ranked treatment recommendation focusing on coordination, warm transfers, and referrals between agencies was in alignment with the work already underway within their agencies and in the community. The group acknowledged that solutions to treatment challenges are not always about creating new services and recognized that there is potential to make improvements by improving service integration, working better across agencies, and "connecting the dots". The group also identified that the rural needs are unique and must always be considered as recommendations are prioritized and implemented. The importance of continuing to engage with PWLE was central to the treatment pillar discussion recognizing that the top needs of PWLE do not always align with those without lived experience.

For the treatment pillar, the PICK chart activity did not result in any of the recommendations being removed from the priority list. However, the group had difficulty placing the sanctuary and support recommendation within the PICK chart. Following group discussion, there was a decision to re-word this recommendation to support group understanding and placement of it within the priorities. This will be identified as an early implementation planning step for the treatment pillar.

Following the PICK chart activity, the treatment group did not have enough time to complete the Covey matrix activity. For the treatment pillar, it was decided that all recommendations falling within the "Long Term Projects" quadrant of the PICK chart were assumed to be long term priorities for treatment. This decision may need to be revisited by the treatment group later if it is deemed that there are too many long-term projects to manage.

# Appendix E:
# Facilitated Sessions with Pillar Workgroups

## Limitations

The facilitated sessions allowed an opportunity for group discussion to inform the prioritization of recommendations. Due to the extensive discussion during some sessions, there was limited time to complete all the activities as outlined in the pillar workgroup facilitated session guide. Two of the four pillars did not have enough time to complete the Covey matrix and, as a result, assumptions were made about the prioritization of long-term projects. Three of the four pillars did not have enough time to complete the implementation planning activities during the session. For these groups, the Mural link was circulated by email for individuals to indicate their level of involvement in implementing prioritized recommendations. A limitation of this approach was low response to this task outside of the session. Overall, the sessions provided a starting point for prioritization planning.

Another limitation of the facilitated sessions was the group thinking that everything is a priority. Across all four sessions, the groups were unable to move any of the recommendations into the “don’t prioritize” quadrant of the PICK chart.

# References

1. Inpatient Discharges (2018-2021), Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: July 2023.

ELGIN COMMUNITY
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## Contact Us

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