Supervised Consumption Services Needs Assessment

Northwestern Health Unit Region

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Prepared by LBCG Consulting for Impact
in partnership with the Ontario Public
Health Association

1 Foreword and Acknowledgments

The drug crisis has brought to light the devastating effects substance use is having on individuals, families, and communities across Canada. Potential harms resulting from higher-risk substance use can include impacts on an individual's mental health, schooling or work, and relationships. Harms can also include financial struggles, legal problems, and threats to health and safety including overdose.

Opioid-related emergency room visits, hospitalizations, and deaths in the Northwestern Health Unit (NWHU) catchment area saw considerable increases between 2019 and 2021. Opioid-related emergency department visits increased by 158%, opioid-related hospitalizations increased by 111%, and opioid-related deaths increased by 243% in the two-year period of 2019-2021. The opioid crisis is a serious concern for our region. In 2021, our region had higher rates than the rest of the province for all three opioid harms indicators (ER visits, hospitalizations, and deaths).

Substance use, and the related harms, are a community issue that requires community solutions. NWHU funded the Supervised Consumption Services Needs Assessment in 2022 to investigate one possible solution. NWHU hired *LBCG Consulting for Impact* to complete a supervised consumption services needs assessment in four communities - Dryden, Fort Frances, Kenora, and Sioux Lookout. An outside firm was chosen as they brought a wide range of expertise and dedicated time and resources to ensure a high quality and objective process and final product. This report provides substance use and supervised consumption services information relevant to the NWHU region. It breaks down the feedback provided by local partners, community members, and people who use drugs, and shares recommended next steps for the region and each of the four communities studied specifically.

We would like to acknowledge the community's participation in this needs assessment. The knowledge and experiences shared by people who use drugs, community partners, and community members has allowed this needs assessment to provide important data that can be used by our communities to move forward with community-based solutions. NWHU is pleased with the depth of information provided in this report and looks forward to seeing how communities come together to move this issue forward.

We would also like to thank LBCG and their research partners for the work they have done to complete this needs assessment and report over the last nine months.

Dr. Kit Young Hoon, Medical Officer of Health

Marilyn Herbacz, Chief Executive Officer

This needs assessment was funded and supported by NWHU and completed by LBCG Consulting for Impact and their research partners.

Executive Summary

The purpose of the needs assessment was to examine the substance use and related harms prevalence and patterns in the NWHU region and engage with local stakeholders and determine whether the NWHU region could benefit from supervised consumption services (SCS) in four communities in northwestern Ontario: Kenora, Dryden, Fort Frances, and Sioux Lookout.

The drug crisis has brought to light the devastating effects substance use is having on individuals, families, and communities across Canada. Observing the burden of the crisis in our region, the NWHU felt compelled to initiate a local assessment of SCS as a harm reduction strategy, as part of its mandate outlined in the Ontario Public Health Standards under the standards for Population Health Assessment and Substance Use and Injury Prevention. The NWHU is seeking solutions to address the following challenges:

- Reduce substance use related injuries, hospitalizations and deaths,
- Reduce the risk of infections from sharing or reusing drug-use equipment,
- Reduce public drug use and improperly discarded needles in our communities,
- Increase access to healthcare, treatment and supportive services for people who use drugs.

Examining the potential benefits of implementing SCS in the NWHU region was the focus of the needs assessment. Investigating the literature's evidence of SCS benefits or assessing the value of alternative harm reduction strategies or treatment services was not within the scope of this report. The undertaking for this needs assessment relies on the guidance and evidence base of Health Canada's *Canadian Drugs and Substances Strategy*[1], where SCS are recommended as an element of harm reduction within a comprehensive approach of prevention, treatment, harm reduction and enforcement.

SCS are being implemented across Canada as they offer a range of low-barrier services to PWUD such as:

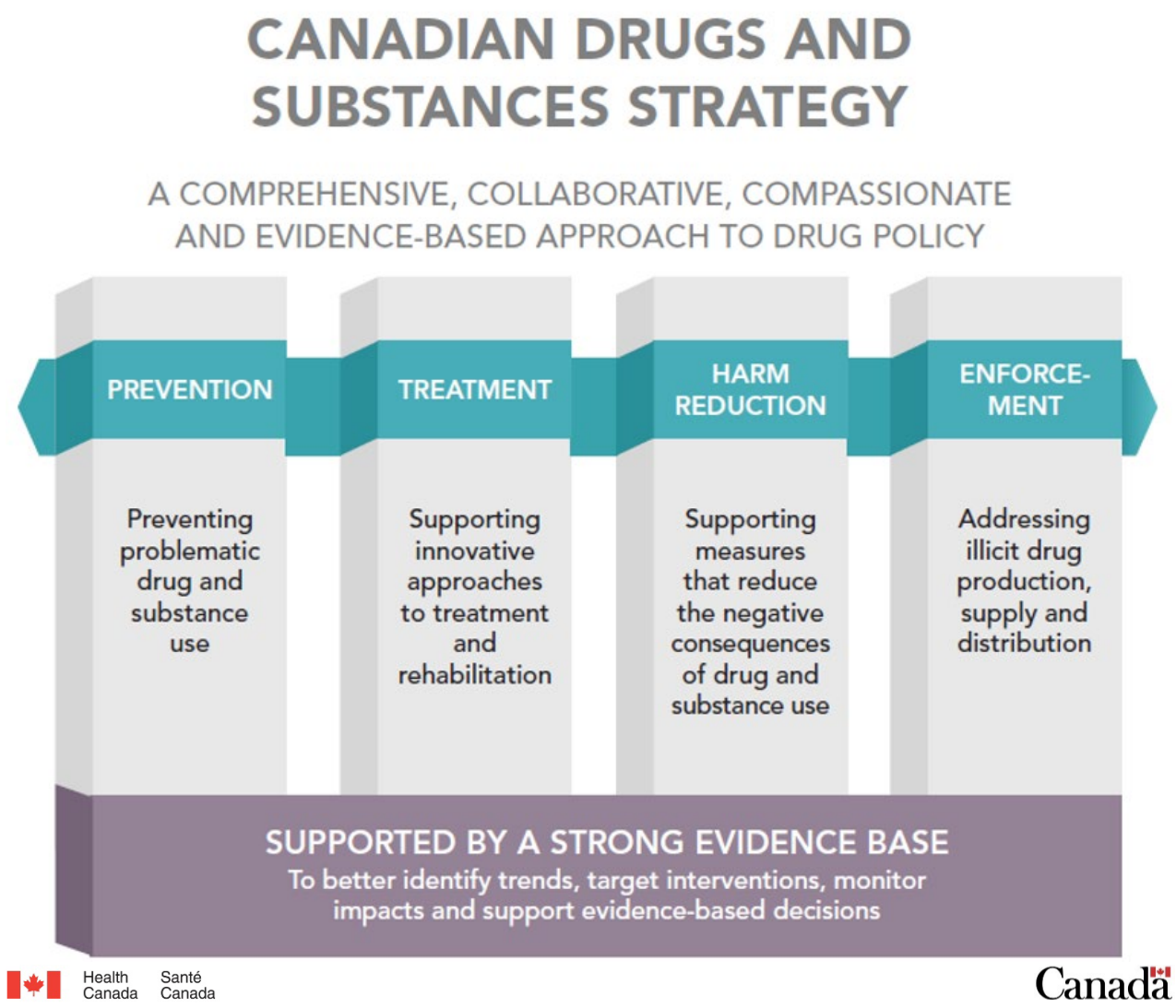
- hygienic and supportive spaces for drug consumption,
- sterile drug use equipment,
- peer support, and
- connections to supportive health and social services, including treatment.

Associated benefits to communities include the reduction of:

- overdoses and substance related harm
- harm to others and interactions of conflict,
- infections and spread of communicable diseases, and
- occurrence of discarded drug use supplies in public spaces.

Peer reviewed literature has found that SCS do not cause increases in crime or public nuisances[2]. SCS can also address gender equity and the disproportionate risk of experiencing gender-based power relations and/or violence for women who use drugs.

Currently, there are no SCS in the NWHU region, with the closest in Ontario being in Thunder Bay, yet the region has some of the highest rates of substance related harms.



Perspectives were heard from people who use drugs (PWUD), residents in the NWHU catchment area, community service providers and partners, municipal governments, and other key stakeholders. The needs assessment was sponsored and initiated by NWHU, which procured the services of a team of consultants to complete the needs assessment. The consultant team, LBCG Consulting for Impact in partnership with the Ontario Public Health Association, designed the needs assessment, collected the data, completed the analysis and wrote this report. NWHU owns the data and upon completion of the needs assessment, all data was transferred to NWHU, who has it on record and has access for future use.

This report outlines regional and then community-specific findings and recommendations for each of Sioux Lookout, Fort Frances, Dryden and Kenora.

Additional community-specific data of results outlined in this report may be made available upon request for community-specific SCS development purposes.

Research and Consultation

In all, over 1,850 stakeholders participated in the needs assessment engagement through three consultation methods:

a. An in-person survey of people who used drugs within the last six months,
b. A community online survey,
c. Interviews and focus groups with harm reduction and SCS key informants across the province and local community stakeholders, service providers and Indigenous partners; including those working in harm reduction, health promotion, treatment, enforcement and justice, local businesses, non-profit, municipal government, and other community organizations.

In addition to these primary sources of information, existing research and data were gathered on population health information, PWUD, harm reduction programming, drug use, opioid harms, and opioid overdoses.

Results

Learnings from PWUD, the public and the key stakeholders engaged are summarized in the report. There is a strong consensus amongst all consulted that there is a need for more supports for PWUD across in the NWHU region.

Higher rates of harm in relation to substance use, including higher rates of substance-related emergency visits, opioid overdose mortality and morbidity, and Hepatitis C rates in the NWHU region compared to the rest of the province illustrate a clear need for additional strategies and resources to address these trends.

There is strong agreement among PWUD surveyed that they would use SCS and would highly value SCS as a way to use under safer conditions, in addition to other benefits and quality of life improvements. Stigma and negative behaviour towards PWUD were identified as being one of the biggest challenges for PWUD in the region. These experiences can deter PWUD from accessing services they need.

Generally, the broader public varied substantially in their support for SCS and their perceptions of what may be the benefits and/or consequences of them. While some see SCS as a desperately needed initiative to prevent further overdose deaths and to provide help to vulnerable PWUD, others are concerned about the impacts that SCS will have in the region citing worries about its potential influence on crime, discarded drug use supplies, loitering, safety and other factors. These concerns are commonly raised and have been examined in some studies. Available peer reviewed research suggests that these negative outcomes do not happen following the introduction of SCS in communities[3]. There were some local stakeholders surveyed and interviewed as part of this needs assessment who believe that with sufficient planning and resources, foreseeable negative consequences can be adequately mitigated. The findings indicate that there is a need to continue sharing evidence-based information of the impacts of SCS openly and transparently with the general public and stakeholders.

The vast majority of key informants interviewed supported the introduction of SCS in light of the overwhelming drug use challenges they are facing in their communities and the inadequate resources available to address them. The key informants see the rise in both non-fatal and fatal

overdoses as having significant traumatic impacts on families and loved ones within their communities. Meanwhile, they also believe that there are rising tensions building within their community as a result of a high frequency of incidents (perhaps daily) involving substance use. This environment is attributed to increasing stigma towards PWUD in their communities.

Leadership will be critical to the success of SCS in the NWHU region. Pushback from some members of the community is common for SCS in any region, and organizations providing SCS have faced criticism in their communities for providing these services. Resources will be needed to maintain ongoing communication on the impact of SCS as demonstrated by research and evaluations, and effective implementation of such a site considering potential challenges and mitigation strategies.

Community-specific Findings and Recommendations

Individual chapters were prepared to outline the data related to drug use in each of the four communities of interest within this needs assessment – Sioux Lookout, Fort Frances, Dryden and Kenora - as well as community-specific results of the stakeholder engagement. The regional results apply to each of the four communities and should be taken into consideration alongside the community-specific findings.

Six recommendations were tailored to each of the four communities studied based on their specific findings. The foundation of the six recommendations are:

1. In each of the four communities studied, the rates of substance use harms are significant enough to indicate a need for greater harm reduction and treatment services and the addition of SCS are recommended as a means to reduce the risk of harm, overdose, and overdose deaths among PWUD.
2. Health, social and/or mental health service providers, including Indigenous service providers may be best positioned to lead future development planning of SCS as the local professionals on harm reduction.
3. Implementation plans need to be developed alongside of engagement with key stakeholder groups such as municipal governments, emergency services, Indigenous partners, and the broader community.
4. It is recommended that any SCS be positioned within the larger community level approach to mental health and addiction services, integrating them into the local treatment and service network. This can be done through the development of a Harm Reduction Strategy, should there not already be an existing analogous plan in place.
5. Educational activities for the public and partners regarding SCS is highly recommended alongside any SCS development. Raising awareness among and working alongside of community leaders will be critical to understanding community concerns, as well as help SCS to succeed and be sustainable. Stakeholders and the general public should be comprehensively informed of the research evidence of the impacts of SCS. Transparent and accurate information on SCS will ensure that decision makers understand the benefits and can mitigate any potential challenges.
6. Evaluation plans for any implemented SCS need to be developed to define, measure and report on the outcomes for transparency, reporting and improvement.

Introduction

This report is to convey the findings of the needs assessment for supervised consumption services and recommended actions for consideration. The purpose of the needs assessment was to examine the substance use and related harms prevalence and patterns in the NWHU region and engage with local stakeholders and determine whether the NWHU region could benefit from supervised consumption services (SCS) in four communities in northwestern Ontario; Kenora, Dryden, Fort Frances, and Sioux Lookout. Perspectives were heard from people who use drugs (PWUD), residents in the NWHU catchment area, community service providers and partners, municipal governments, and other key stakeholders.

Specifically, the needs assessment addressed the following objectives:

- Assess the need for supervised consumption services in Kenora, Dryden, Fort Frances, and Sioux Lookout through:
    - Determining the extent to which supervised consumption services are judged as suitable to intended users and other stakeholders.
    - Learning what the broader community's perspectives are on supervised consumption services – for instance, how they may be helpful and what questions there may be.
- Determine how supervised consumption services could be integrated with existing services in the community.
- Determine the extent to which services in communities can be enhanced to provide supervised consumption services.
- Determine potential locations that are accessible to the intended clients and ensure well-being for staff, clients, neighbourhood residents and business owners.

Examining the potential benefits of implementing SCS in the NWHU region was the focus of the needs assessment. Investigating the literature's evidence of SCS benefits or assessing the value of other alternative harm reduction strategics or treatment services was not the scope of this report. The undertaking for this needs assessment relies on the guidance and evidence base of Health Canada's *Canadian Drugs and Substances Strategy*[4], where SCS are recommended as an element of harm reduction within a comprehensive approach of prevention, treatment, harm reduction and enforcement.

Background

4a. Substance Use

Substance use occurs in Canada for a variety of reasons, including medical purposes, religious or ceremonial purposes, personal enjoyment, or for coping with stress, trauma, or pain[5]. Substance use occurs on a spectrum, with high-risk use being associated with harms or negative impacts, and addiction being associated with an inability to stop using substances despite a person's intention or desire to stop using drugs, tobacco or alcohol[5]. Potential harms resulting from higher-risk substance use can include impacts on an individual's mental health, schooling or work, and relationships. Harms can also include financial struggles, legal problems, and threats to health and safety[5].

There are a number of potential physical harms from higher risk substance use and increased risks for bacterial and viral infections, especially when people do not have access to sterile drug use equipment[5]. Fatality from unintentional overdose is also a significant consideration. In Ontario, illicit fentanyl (all types) was the most common opioid present at death being identified in 85.9% of deaths from opioids during the year 2020 and in 89.2% of all deaths in the year 2021[6]. For the Northwestern Health Unit (NWHU) catchment area population, fentanyl (all types) was present in 58.8% of deaths from opioids in 2020 and in 74.2% of all deaths in 2021[6]. The presence of fentanyl does not exclude the possibility of other drugs also being present as multiple drugs may have been present when the death occurred.

In Ontario, preliminary data tables from Public Health Ontario show that during the year of 2020 opioid-related emergency department visits occurred at a rate of 84.6 per 100,000 in the population and in the year 2021, this number rose to 114 per 100,000. In the catchment area for NWHU, the rate for opioid-related emergency visits in 2020 was 146.3 per 100,000 and in the year 2021 was 173.2 per 100,000[6]; demonstrating opioid-related emergency department visits that are 72.9% higher than that of the province for the year 2020 and 51.9% higher in 2021. The rate of increase for opioid-related emergency department visits from 2020 to 2021 was higher for Ontario overall at 34.8% compared to 18.4% for the NWHU catchment area.

Table 1: **Comparison of rates of opioid-related emergency department visits**

	Rate of opioid-related emergency department visits per 100,000		Percent increase from previous year
	Year		
	2020	2021	
Ontario	84.6	114	34.8%
NWHU	146.3	173.2	18.4%
Relative difference between NWHU and provincial rate	72.9%	51.9%	

Source: Based on data from the Public Health Ontario interactive opioid tool. Accessed Nov 25, 2022.

Changes during the pandemic

The COVID-19 pandemic has contributed to worsening the overdose crisis in Canada. While Ontario implemented public health restrictions in response to the pandemic, some factors that may have exacerbated the overdose crisis include more isolation and using drugs alone, stress and anxiety, changes in access to services for PWUD and the increasingly unpredictable illegal drug supply[7]. The State of Emergency was declared in Ontario on March 17, 2020, and in the year 2020 there were 60% more opioid-related deaths than in 2019[8].

Incentive for this Needs Assessment

The drug crisis has brought to light the devastating effects substance use is having on individuals, families, and communities across Canada. Observing the burden of the crisis in the region, the NWHU felt compelled to initiate a local assessment of SCS as a harm reduction strategy, as part of its mandate outlined in the Ontario Public Health Standards under the standards for Population Health Assessment and Substance Use and Injury Prevention. The NWHU is seeking solutions to address the following challenges:

- Reduce substance use related injuries, hospitalizations, and deaths,
- Reduce the risk of infections from sharing or reusing drug-use equipment,
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- Increase access to healthcare, treatment, and supportive services for people who use drugs.

4b. Needs Assessment Setting: Kenora, Dryden, Fort Frances, and Sioux Lookout

NWHU's catchment area spans 173,828 square kilometres and has a population density of approximately 0.5 people per square kilometre, which is much lower than the provincial average of 14.1 people per square kilometre[9]. Of the 19 municipalities, the four areas included in this needs assessment all differ substantially in terms of population density and geographical land area.

Table 2: **2021 Population demographics for the four primary communities of interest in the NWHU catchment area.**

Region	Population	Total Private Dwellings	Land Area in km^2	Population Density (per km^2)	Unemployment (%)	Average Age of the Population
Ontario	14,223,942	5,929,250	892,411.76	15.9	12.2	41.8
Kenora (City)	14,967	7,637	211.65	70.7	7.2	43.6
Dryden (City)	7,388	3,574	65.58	112.7	8.3	45.4
Fort Frances (Town)	7,466	3,779	25.55	292.2	8.1	44.6
Sioux Lookout (Municipality)	5,839	2,647	378.02	15.4	5.7	39.0

Source: 2021 Census Data

Opioid-related morbidity and mortality

Public Health Ontario released a report[10] noting that opioid-related deaths have varied from year to year in Ontario, however, a marked upwards trend is shown since the declaration of the COVID-19 related state of emergency in Ontario on March 17, 2020. The report also shows that about half of opioid-related deaths occurred in persons experiencing unemployment (this proportion also increased as the total number of unemployed persons increased during the pandemic)[10]. Of those employed, approximately one-third were employed in the construction industry[10]. While the largest portion of opioid-related deaths is consistently accidental in Ontario, the percentage of accidental deaths significantly increased during the pandemic cohort[10].

Table 3: **Rates of opioid-related morbidity and mortality per 100,000, for years 2020 and 2021.**

	Opioid-related emergency department visits per 100,000		Opioid-related hospitalizations per 100,000		Opioid-related deaths per 100,000	
	Year 2020	Year 2021	Year 2020	Year 2021	Year 2020	Year 2021
Ontario	84.6	114	13.9	16.3	16.6	19.2
NWHU	146.3	173.2	11	23.2	20.7	37.8

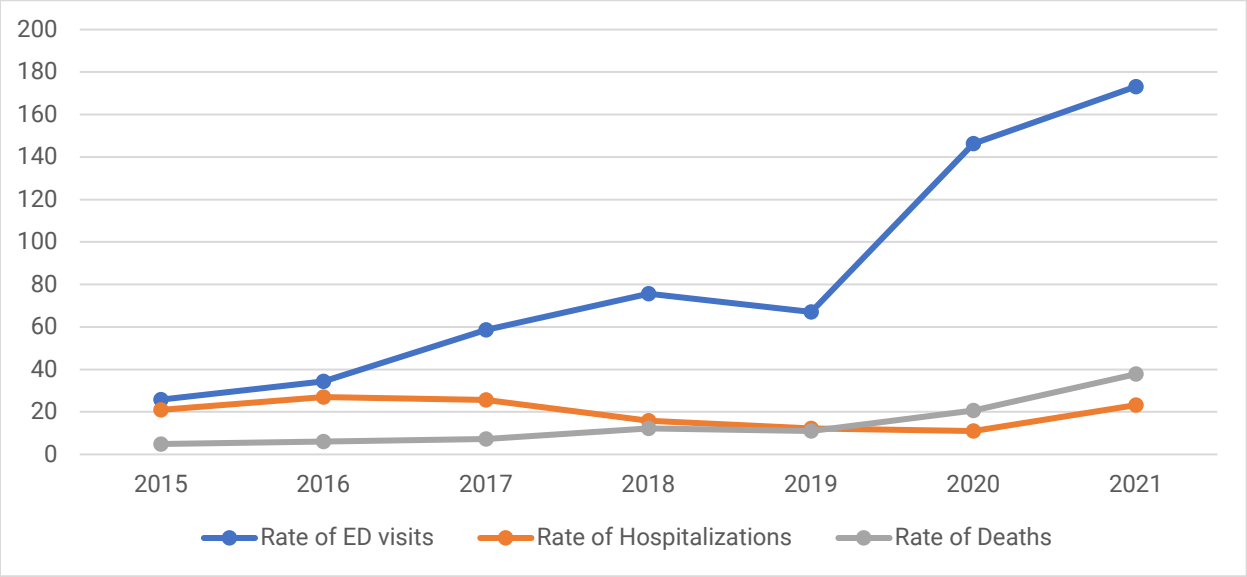
Source: Public Health Ontario interactive opioid tool. Accessed from: https://www.publichealthontario.ca/en/Data-and-Analysis/Substance-Use/Interactive-Opioid-Tool
Note: Municipality rates were not included due to concerns of privacy and confidentiality that arise when using very small values.

The NWHU catchment area demonstrates higher rates in 2021 than the rest of the province for all three indicators of opioid-related morbidity and mortality. This is consistent with the findings of other SCS needs assessments (Thunder Bay) that noted data from the Centre for Addiction and Mental Health and the Ontario Students Drugs Use and Health Survey also point to higher overall rates of substance use in northern Ontario compared to the rest of the province.

When looking at NWHU catchment area trends from 2015 to 2021, rates of emergency department visits have varied yet showed sharp increases of 118% in the year 2020 (compared to rates in the year 2019) and 18.4% in the year 2021 (compared to the rates in 2020). While rates of

hospitalization had been decreasing year over year since 2016 until 2021, the year 2021 saw a 110.9% increase in hospitalization rates compared to 2019. Opioid-related rates of death increased overall from 2015 to 2021 with a small decline occurring in 2019 (-9.8% from the previous year). However, this decline was followed by a sharp increase in the opioid mortality rate in the NWHU region, as it changed from 11 per 100,000 in 2019 to 37.8 per 100,000 in 2021 – an increase of 243% in that two-year period.

Figure 1: **Rate per 100,000 of opioid-related morbidity and mortality in the Northwestern Health Unit catchment area, 2015-2021.**



Source: See Appendix B:1. for the detailed values table.

When broadening to include wider substance-related reasons for Emergency Room (ER) visits, NWHU data[11] shows that rates are significantly higher than Ontario averages year over year. More information can be found in Appendix B:2. on ER visits by the (former) local health hubs.

Table 4: **Substance-related ER visits in NWHU catchment area from 2016-2020.**

Year	NWHU ER visits per 100,000	Ontario ER visits per 100,000
2016	4779.5	867.4
2017	5181.4	953.7
2018	5815.3	1010.4
2019	6253.0	1031.6
2020	5791.8	975.9

Source: Ambulatory Visits [2016-2020]. Ministry of Health and Long-Term Care. IntelliHEALTH Ontario. Date Extracted: May 12, 2022

As shown in Table 5, the burden of substance related ambulance calls in 2020 was much higher in communities such as Kenora and Sioux Lookout. In Sioux Lookout, the challenge of alcohol use is

seen to be proportionally larger than opioids as compared to the other communities, with local stakeholders stressing that anecdotally alcohol is considered the drug of choice within their community.

Table 5: **Substance use related ambulance calls for service, 2020.**

Primary Cited Problem	Kenora	Dryden	Fort Frances	Sioux Lookout	Total
Alcohol Intoxication (Rate per 100,000)	438 *(2,926)*	54 *(731)*	58 *(777)*	206 *(3,528)*	**756**
Non-Opioid Overdose (Rate per 100,000)	56 *(374)*	19 *(257)*	2 *(27)*	24 *(411)*	**101**
Opioid Overdose Suspected (Rate per 100,000)	18 *(120)*	12 *(162)*	24 *(321)*	3 *(51)*	**57**

Source: Calls for service data shared by KDSB and RRDSB. Rate per 100,000 calculated with 2021 Census data.

Risk of blood borne diseases

In addition to the risk of accidental death, persons who *inject* drugs in Canada also represent a group at increased risk of acquiring human immunodeficiency virus (HIV) and Hepatitis C[12]. It is estimated that in Canada, the proportion of new HIV infections attributable to injection drug use is around 11.3% (estimated from 2016). The prevalence of HIV and Hepatitis C antibodies was found to be high (11.2% and 68%, respectively) among people who inject drugs and were surveyed in Canada between 2010-2012 as highlighted in the findings from the *Tracks survey of people who inject drugs in Canada*[13].

Data from NWHU show that Hepatitis C rates in the catchment area have decreased per 100,000 from 2016-2018 and 2019-2021. Rates are 197.6 and 189.4 respectively, which is higher than the provincial average for Ontario of 34.5 from 2016-2018; and 24.1 in 2019-2021. Group A Streptococcus (GAS) for the NWHU catchment area is 45.4 per 100,000 from 2016-2021, which is also higher than the average for Ontario of 6.6. HIV prevalence in the catchment area is lower than the provincial average, with a rate of 4.0 per 100,000 from 2016-2021 versus the Ontario average of 5.5 per 100,000.

Table 6: **Hepatitis C incidence per 100,000 for three-year time periods between 2016-2021 for NWHU catchment area and Ontario.**

Data Period	NWHU (per 100,000)	Ontario (per 100,000)
2016-2018	197.6	34.5
2019-2021	189.4	24.1
Change from 2016-2018 to 2019-2021:	*4.15% decrease*	*30.14% decrease*

Source: iPHIS. Date Extracted: May 17, 2022

Table 7: **HIV incidence per 100,000, 10-year average from 2012-2021 for NWHU catchment area and Ontario.**

Data Period	NWHU (per 100,000)	Ontario (per 100,000)
2012-2021	4.0	5.5

Source: iPHIS. Date Extracted: May 17, 2022

4c. Harm Reduction and Supervised Consumption Services

Harm reduction

A public health approach to harm reduction looks to minimize negative outcomes of substance use in the population. Harm reduction is stated in the Ontario Public Health Standards and includes several different services. The harm reduction approach has the underpinning of health equity and social justice in that all should have an equal opportunity to strive for optimal health; and implies the understanding that the way our society is currently organized imparts many barriers to achieving health that are often disproportionately experienced by certain groups within the population[14]. A trauma-informed approach also recognizes the impact that trauma can have on individuals and communities which may become considerations when taking into account a driver of substance use can include coping with stress, trauma or pain[5]. Employing a trauma informed approach in harm reduction programming can be reflective of the changes that are needed at a cultural and organizational level[15].

Principles of harm reduction have the overarching goal of preventing negative consequences of substance use and focus on the well-being of PWUD. Harm reduction programs such as SCS present potential benefits to communities through the reduction of overdoses, harm to others, infections and spread of communicable diseases, and the occurrence of discarded drug use supplies in public spaces. SCS are one of many harm reduction services in a spectrum of services that a person should be able to access.

Supervised consumption services

SCS are a legally operated facility where people come to use their own drugs under the supervision of health workers. They offer a range of low-barrier services to PWUD, such as hygienic and supportive spaces for drug consumption, sterile drug use equipment, peer support, and supportive health and social services. In Canada, in order to ensure that clients of SCS cannot be charged for simple possession of illegal substances (under the *Controlled Drugs and Substances Act*), SCS must obtain an exemption to Section 56.1 of the Controlled Drugs and Substances Act (CDSA). Ontario is augmenting Health Canada's SCS program to include requirements for substance use treatment and support services. In order to receive provincial funding, applicants must demonstrate their proposed service meets federal requirements, as well as additional requirements under Ontario's Consumption and Treatment Services (CTS) program.

SCS can also be referred to by other names like Overdose Prevention Sites (OPS), Supervised Injection Site (SIS), and Drug Consumption Room (DCR).

SCS can be part of a harm reduction framework. More recently, an emphasis on using the language of "services" over "site" allows for greater inclusion of different supervised consumption models

that have been developed. In later sections of this report, various service models are discussed. Similarly, the shift from supervised '*injection'* services to supervised '*consumption'* services accommodates the inclusion of other methods of consumption (e.g., smoking, snorting or swallowing) that also pose risks of accidental death. As an example, in British Columbia, a recent coroner's report (and updated summary published in Feb 2022) demonstrated changing trends around consumption modes[16]. Up until 2016 in British Columbia, injection was most common, however as of 2017, smoking represents the most common mode of consumption with the highest rates in 2020 where 56% of illicit drug toxicity deaths are from smoking[16]. It should be noted that providing inhalation rooms in SCS require ensuring the space complies with the *Occupational Health and Safety Act*, requiring specific HVAC conditions.

Evaluations of existing supervised consumption services in Canada demonstrate positive effects on communities and health outcomes. As an example, *InSite* which has been operational since 2003 in Vancouver demonstrated multiple benefits including reducing risk behaviours, reducing the risk of overdose, increasing safety for women, and reducing injections in public places[17]. The *InSite* evaluation also showed that there was no increase in drug-related crime and no increase in drug use after the site opened[17]. Additionally, a systematic review of supervised consumption services, identified 22 studies that looked for a change in four outcomes of high interest that are associated with SCS[18]:

- A statistically "significant reduction in opioid overdose morbidity and mortality" was concluded in three of the five total research studies that investigated this outcome category;
- A statistically "significant improvements in injection behaviours and harm reduction" was concluded in five of the seven total research studies that investigated this outcome category;
- A statistically "significant improvements in access to addiction treatment programs" was concluded in six of the seven total research studies that investigated this outcome category; and
- A statistically "significant reduction in crime and public nuisance" was concluded in five of seven total research studies that investigated this outcome category.

None of the studies found unfavourable outcomes of SCS. Studies that did not conclude statistically significant favourable outcomes, either found favourable but not significant changes ($p \geq 0.05$), or the observed change was found to be not meaningfully different from the baseline. It should be noted that of the 22 studies, 16 of them looked at outcomes from the same supervised injection site in Vancouver.

Supervised Consumption Services Models

There are approximately 130 sanctioned SCS worldwide operating across as many as 12 countries[19]. The language around SCS has evolved to include multiple methods of drug use (i.e., 'consumption' to encapsulate more than 'injecting' as smoking among other methods have been increasingly popular and have resulting overdoses) and to encompass multiple different approaches to providing harm reduction practices ('services' as the model may differ and avoiding the use of 'site' as there may be multiple or mobile locations). For instance, some examples of SCS models operating today include stand-alone storefronts, injecting rooms integrated within existing community health services, hospital based SCS, and mobile vans[20]. Public health responses to the overdose emergency have primarily focused on large urban centres, while mid-sized and small

communities are contending with the same crisis, yet fewer resources. In Kelowna and Kamloops, two mobile SCS created from retrofitted recreational vehicles were used to serve the populations of the two rural, mid-sized cities. A review of the initiative concluded that while the mobile SCS were a viable alternative to a permanent site, they presented many challenges that undermined the continuity and quality of the service, and that their services are best suited as a temporary alternative[21].

An additional consideration is the aspect of gender equity and the disproportionate risk of experiencing gender-based power relations and/or violence for women who use drugs. Designated hours, services or portions of the facility that cater specifically to women can be additional aspects of the model to consider[22].

Below in Table 8 the key characteristics of various SCS models are outlined.

Table 8: Supervised Consumption Service Models.

Model	Characteristics	Contexts where the model might work well	Where to look for examples
Stand-alone	• Purpose of the facility is dedicated for providing SCS. • Facility might also provide other services (i.e., showers, food), or services like primary care, counselling, shelter etc.	• Better positioned to cater to the needs of PWUD. • Works best when there is a larger more concentrated population of PWUD. • May be more appealing to those who are hesitant to go to a healthcare facility.	• Insite (Vancouver, Canada)
Integrated	• SCS is part of a facility that offers many different services. • Often includes range of medical and social services. • Meant to be more of an "all-in-one" facility. • Tend to be smaller facilities. • Require thoughtful layout and signage to delineate where consumption can and cannot take place.	• Can serve to decrease barriers to service through the range being offered in one place and can more easily provide wrap-around services for clients with complex challenges. • Appropriate when PWUD are more dispersed.	• Dr. Peter Centre (Vancouver, Canada)

Model	Characteristics	Contexts where the model might work well	Where to look for examples
Embedded or hospital-based	• SCS are within other services or settings where PWUD might often attend, such as shelters, residential care, acute care etc. • SCS exemptions might be restricted to the person's suite or residence and not apply to the entire facility (i.e., SCS inside a hospital).	• Can work well when there are existing institutions or service settings that are commonly frequented by PWUD, and that PWUD are using drugs onsite against policies (i.e., stealthy, in washrooms or stairways etc.)	• Lariboisière Hospital (Paris, France)
Mobile	• Often modified van or bus that contains a space inside for consumption (i.e., a booth). • Space is small, permitting fewer clients per day. • Staffing required may be similar to other models despite having smaller capacity.	• Can work well to provide access to dispersed harder to reach populations across larger geographical areas. • Mobile site can go to scenes where drug use is known to occur. • Can work well combined with other models as an outreach element.	• Northreach Mobile Supervised Consumption Service (Grand Prairie, Alberta) • Anonyme Mobile Supervised Consumption Service (Montreal) • Interior Health Authority (Kamloops and Kelowna) • Spain (Barcelona) • Germany (Berlin) • Denmark (Copenhagen)

Source: Kerr T, Turje RB, Davis M, Johnson C, Lem M, Tupper K. Supervised Consumption Services Operational Guidance [Internet]. British Columbia: British Columbia Ministry of Health. [Cited 2022 Dec 4]. 95 p. Available from: https://www.bccsu.ca/wp-content/uploads/2017/07/BC-SCS-Operational-Guidance.pdf

5. Methods

The needs assessment was sponsored and initiated by NWHU, which procured the services of a team of consultants to complete the project. The consultant team, LBCG Consulting for Impact in partnership with the Ontario Public Health Association, designed the needs assessment, collected the data, completed the analysis and wrote this report. The members of the consultant team are provided in Appendix A. NWHU owns the data and upon completion of the needs assessment, all data was transferred to NWHU, who has it on record and has access for future use. Eight needs assessments/feasibility studies of SCS – Sudbury (2020), Peel (2019), Waterloo (2018), Thunder Bay (2017), Hamilton (2017) and London (2017), Toronto and Ottawa (2012), and Victoria (2007) – were reviewed in the scoping and development of this needs assessment.

The following primary data collection methods were used to address the research objectives:

a. An in-person survey of people who used drugs within the last six months,
b. A community online survey,
c. Interviews and focus groups with community stakeholders, service providers and Indigenous partners; including those working in harm reduction, health promotion, treatment, enforcement and justice, local businesses, non-profit, municipal government, and other community organizations.

In all, over 1,850 stakeholders participated in the needs assessment's engagement through the three consultation methods.

In addition to these primary sources of information, existing research and data were gathered on population health information, PWUD, harm reduction programming, drug use, opioid harms, and opioid overdoses.

People who use drugs survey

The in-person survey of PWUD was conducted throughout August 2022 at sites across the four municipalities. A total of 271 participants completed all or a portion of the survey; all participants had used drugs within the previous six months prior to the survey, were at least 18 years of age, spent on average at least seven days a month in the community where the survey took place, and gave informed consent to participate. Participants were recruited through co-locating surveyor teams at regular programming and services, in addition to peer outreach efforts and word-of-mouth. The survey consisted of 86 questions pertaining to personal and sensitive information, and typically took 20-40 minutes to complete. All participants received a $20 honorarium for their time and sharing knowledge and personal information. Providing honorariums for research participants is common and well researched and the honorarium provided in this needs assessment was inline with other SCS needs assessments and feasibility studies in Ontario.

The survey was facilitated by teams of volunteers from local agencies. The surveyors were community partners and volunteers where possible. Some NWHU staff participated, however, attempts were made where possible to not have front line harm reduction staff do surveys. The majority of surveyors were familiar with harm reduction and had knowledge of the PWUD in their community. The LBCG consultant team facilitated two 2-hour group surveyor trainings to allow for all surveyors to receive training and allow for consistency in the survey delivery through practicing

of the survey, providing supports for surveyors and emphasis of best practices of engaging with PWUD.

Community survey participants

The community survey was available online, in French and English, through NWHU's website for three weeks in July and August 2022. Public communications and recruitment were undertaken during the survey period, in which a total of 1,522 respondents completed all or a portion of the survey. The majority of respondents (77%) indicated that they were "a community member", with 17% selecting that they were "a staff member at a community agency or service provider", and 6% were "a business owner or operator". A quantitative coding analysis tool was used to gather themes and insights from the open-end survey responses in the community survey.

Interview and focus group participants

A total of 18 individual or small group interviews were set up with a select group of key stakeholders. These interviews were with five harm reduction and SCS key informants across the province, municipal leadership of each of the four northwestern Ontario communities (e.g., Mayors, Chief Administration Officers and/or Councillors), law enforcement (Ontario Provincial Police and Treaty Three Police Service), one organization that regularly interacts with local PWUD in each of the four communities (e.g., hospital, Friendship Centre and shelters), and NWHU Medical Officer of Health and Chief Executive Officer.

Over one hundred community stakeholders were invited to participate in a focus group. A total of 61 participated in eight focus groups held in July 2022, representing the following sectors and perspectives: health care (e.g., hospitals, Ontario Health Teams, primary care), mental health and addiction services, emergency services (e.g., District Social Services Administration Boards, Fire Marshalls, correctional services), community agencies (e.g., shelters, victim services, social services providers), Indigenous agencies (e.g., First Nation health authorities, Friendship Centres, Aboriginal Health Access Centres), business sector (e.g., Chamber of Commerce representatives), NWHU staff and NWHU Board of Health.

6. Results

Over 1,850 stakeholders participated in the needs assessment's engagement through three consultation methods:

a) An in-person survey of people who used drugs within the last six months,
b) A community online survey,
c) Interviews and focus groups with harm reduction and SCS key informants across the province, community stakeholders, service providers and Indigenous partners; including those working in harm reduction, health promotion, treatment, enforcement and justice, local businesses, non-profit, municipal government, and other community organizations.

The learnings from the stakeholders are presented in their respective sections below.

6a. What we heard from key informants with direct experiences with supervised consumption services

Before the commencement of engagement with PWUD, the broader community and key stakeholder groups in the region, the consultant team conducted four interviews with five health care professionals from NorWest Community Health Centres (Thunder Bay), Réseau Access Network (Sudbury), Bancroft Community Family Health Team, and the Dr. Peter Centre (Vancouver), who have experience providing or overseeing harm reduction services and/or who have helped develop and implement safe consumption site services in several communities in Ontario. These service providers also have experience conducting needs assessments for SCS, implementing peer programming, providing mobile outreach services, providing harm reduction supplies, and running naloxone programming. The perspectives and experiences of these service providers, while not representative of all safe consumption or harm reduction services in Ontario, can provide valuable insights for NWHU region. They shared a number of challenges and success factors from experiences setting up and providing supervised consumption and harm reduction services.

Finding sustainable funding was cited several times as a significant challenge. Funding for current health, social, mental health and addiction services is already limited, so re-directing existing resources is not possible. With provincial funding being limited and federal funding being short-term in nature, finding ongoing dedicated funding is difficult.

All respondents shared that community pushback and resistance to these services made providing services challenging. Organizations providing SCS have faced stigma and criticism in the community for providing these services. Many in the community, including service providers believe that treatment and sobriety should be the objective for PWUD, however, this is often not feasible. Interviewees shared that SCS meet people's needs and reduces harms where treatment is not feasible or desirable. In some communities when leaders, community organizations and other opponents learned more about SCS and harm reduction, SCS became more accepted and supported over time as both the benefits to PWUD and the broader community were observed.

For harm reduction and SCS to be successfully integrated into existing health and supportive care systems, understanding and support must be built among existing care providers.

Doing constant awareness-raising about why SCS are important or beneficial has been a key to their success within communities. Further, developing relationships and engaging with social services providers, public health, community members, Indigenous partners, municipal leaders, and other organizations prior to implementing new harm reduction services was seen to be important to these services meeting client needs and addressing broader community concerns. Further, working closely with emergency and police services is important to develop shared objectives and ways of working together. There is a general lack of understanding regarding substance use and the benefits of SCS including among health and support services providers, so education and training are needed for all. For harm reduction and SCS to be successfully integrated into existing health and supportive care systems, understanding and support must be built among existing care providers.

Developing trust and relationships with PWUD was cited as a success factor to not only ensure that harm reduction and SCS meet their needs, but also that the services get used. Suggestions included engaging PWUD as "experts" to advise the creation, monitoring and ongoing improvement of services over time, ensuring to engage with subsets of the population to understand needs and

getting PWUD to assist with outreach and delivery of services as paid employees. The use of peer outreach and support has increased overall engagement with PWUD and the use of services[23]. The service providers also talked about the importance of ensuring that services are accessible to clients including being available 7 days a week and outside of 'business hours' and shifting these hours depending on the season. In addition, there are several important location considerations, such as integrating SCS into a number of health and/or addiction services providers, having a central location that also provides privacy for clients, and using mobile services or outreach to meet PWUD "where they are". For rural areas, transportation and access are central issues meaning that outreach and mobile services that are consistently available are required. Incorporating the perspectives of PWUD from the outset can help to identify and mitigate barriers and ensure the services are meeting needs. Finally, interviewees cited that stigma can be a limiting factor for PWUD to access these services, so building trust and reducing stigma within the community is important.

Setting up harm reduction and SCS requires medical/clinical, outreach and supportive service providers, and peer PWUD workers. Interviewees shared that recruiting qualified and "passionate" staff to do this work is essential but also difficult. Further, they talked about burnout and fatigue being a challenge that needs to be proactively addressed in order to reduce turnover amongst staff. With many carefully crafted policies, protocols, and medical directives required to address health risks and harms and meet the medical needs of clients, adequate and qualified staffing is needed.

The service providers interviewed shared that it is essential to stay engaged with PWUD to monitor the changes in the types of drugs that are being used, the associated risks and the relevant supports that are needed. Drugs are often unsafe so providing safe supply at the same time as providing safe consumption options is important to consider.

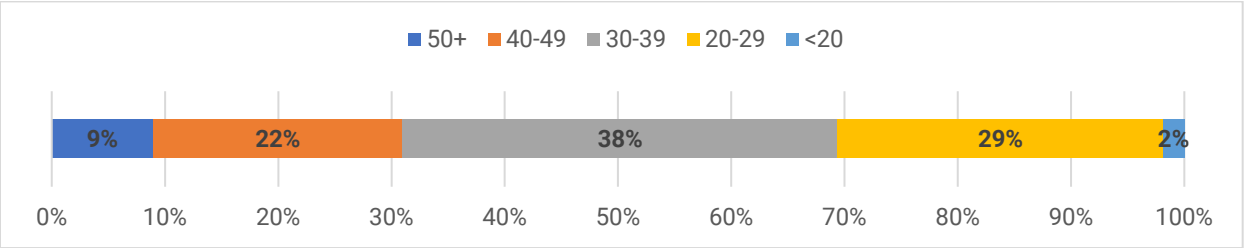
6b. What we heard from people who use drugs

The in-person survey of PWUD was conducted throughout August 2022 at sites across the four municipalities. A total of 271 participants completed all or a portion of the survey; all participants had used drugs within the previous six months prior to the survey, were at least 18 years of age, and spent on average at least seven days a month in the community where the survey took place. The survey methodology is detailed in the Methods section above. The following findings and observations were made based on the PWUD survey results.

PWUD Survey demographics

In total, 271 individuals participated in the survey with 101 from Kenora, 70 from Dryden, 50 from Fort Frances, and 50 from Sioux Lookout. There were individuals of all ages that participated in the PWUD survey, the oldest to participate being 67 years of age and an average age of 36 years. The largest demographic group was 30-39 years (38%), with roughly a third <30 years and the final third >39 years.

Figure 2: **PWUD Survey Respondents Age Distribution**



Source: NWHU Region PWUD Survey, August 2022

There was an even split in the gender distribution of the PWUD survey participants (49.4% female and 50.2% male). 2-Spirited, trans, and gender non-conforming individuals may have been underrepresented in the survey, given a very limited number of individuals voluntarily identified as such. As there is a high proportion of women who may access supervised consumption services based on the sample, and the anticipated likelihood of possibility for 2-Spirited, trans, and gender non-conforming individuals to attend the space, attention and resources should be directed to gender equity.

There was a large proportion of PWUD respondents who identified as First Nation (77.2%) and/or Métis (6.3%). Given that the majority of respondents are Indigenous, services must be geared towards supporting these populations. Hiring staff, including management, who are Indigenous will be important to ensure an understanding of the needs of the clients accessing services.

Places of residence

Nearly all PWUD respondents (97%) had somewhere that they considered their hometown(s) or home community(s). The majority of PWUD respondents identified the survey sites as their hometown, with 72% identifying as being from Kenora, Dryden, Fort Frances or Sioux Lookout. Only 4% having a hometown outside of the NWHU region. Twenty-six percent identified a First Nation community as a home community.

PWUD survey participants were asked about all of the types of places where they have spent multiple nights per month, in the last year. It was found that almost half (45%) have slept in public areas regularly. In comparison, only a third (33%) have stayed at a shelter, which can suggest difficulties or barriers to accessing services and/or limited availability. One in ten respondents had spent time in jail in the last year. The occurrence of recent incarceration amongst PWUD is significant especially as chances of overdose increase when a person leaves incarceration as their tolerance to drugs is often lower if they have not been able to use drugs while incarcerated[24].

Drug use

The most common drug amongst PWUD respondents is methamphetamine (77%), followed closely by opioids (71%). Over half (57%) used methamphetamine and opioids. Three out of four (75%) of PWUD respondents reported that they had injected drugs in the past year. Although it has historically been typical to think of opioids being injected and methamphetamine to be smoked, these trends seem to be shifting. For example, in 2020, 56% of illicit drug toxicity deaths in B.C. were from smoking[16]. Anecdotally, PWUD increasingly report smoking fentanyl. Through harm reduction education efforts, PWUD have been encouraged to smoke their opioids as the onset to action for the drug may be slowed, which can slow the onset of overdose[25]. Additionally, PWUD are

encouraged to swap methods of consumption as a means of giving their veins a rest since frequent injections can lead to injury or infection, which would also cause the rate at which PWUD smoke their drugs to rise. People may also choose to smoke drugs rather than inject them as there is less preparation involved. As well, in cold weather it can be difficult to "find a vein", so injection may not be possible.

Table 9: **Relationship between type of drug used and drug consumption of PWUD surveyed in the NHWU region.**

A drug used in the past year	*Percent that reported engaging in various consumption behaviour in last year when using ANY drug*			
	Inject	Smoke	Snort	Swallow
Crack cocaine	78%	85%	48%	18%
Cocaine powder	82%	72%	49%	15%
Crystal methamphetamine	83%	70%	37%	21%
Opioids	85%	61%	37%	26%
Methadone or suboxone	81%	65%	36%	32%
Tranquilizers or Benzodiazepines	83%	77%	50%	50%

Source: NWHU Region PWUD Survey, August 2022

Which drugs are consumed via which methods, can give insight into what supports and services are needed. For example, if there is a high number of individuals who inject methamphetamine, then onsite spaces may be needed to decompress in instances of overamping (stimulant "overdose") or psychosis. Individuals who use methamphetamine may need support around skin and wound care, and if they inject, could benefit from support around abscess prevention and safer injection techniques. If there is a high number of individuals who are smoking opioids, then there may need to be outreach services to distribute harm reduction supplies and naloxone, as well as ongoing efforts to provide training on overdose response and naloxone for PWUD and the broader community.

Which drugs are consumed via which methods, can give insight into what supports and services are needed.

One in 5 (20%) PWUD respondents identified using tranquilizers or benzodiazepines in the last year. However, as benzodiazepines and other unexpected drugs are being found in the drug supply, such as xylazine, many individuals may have been consuming these substances regularly without their knowledge[26,27,28]. Education around benzodiazepines, their effects on overdose, and the risks of benzodiazepine withdrawal should be provided to PWUD as well as staff who will be providing support. Efforts to send drug samples for testing should be explored to confirm what drugs are present in the local drug supply.

More than half (63%) of PWUD respondents acquired new equipment from another PWUD (i.e., not a distribution site or harm reduction service) in the past year. This shows that informal distribution is occurring. NWHU has a partnership for peer support workers, and there may be opportunities to enhance the support and/or compensation to community members for this work, which could expand the reach of sterile drug use supplies and reduce the rate at which individuals share or

reuse equipment. For instance, half (49%) of the PWUD respondents reported not being able to find any new drug use equipment at least once in the past year, and 37% have shared drug use equipment in the past year.

Almost 9 of 10 (87%) PWUD respondents injected drugs alone in the past year. Injecting alone increases the risk of a fatal overdose. If this behaviour can be reduced, it could have a significant impact on decreasing the number of fatal overdoses within communities.

Nine of ten (91%) obtained needles from a harm reduction program in the past year. However, many (36%) experienced being limited in the number of needles they could take and 1 in 5 (20%) shared injecting equipment (i.e., needles, versus more general drug use equipment) in the past year. Distribution of supplies without limits is considered a harm reduction best practice[29], and limiting the quantity of supplies given to PWUD should be avoided. The cause of these occurrences could be investigated further to determine whether policy, training, supply and/or physical space to store stock could play a role in this. Due to isolation or rural living, individuals in the NWHU region may need to stock up sufficiently when they have the opportunity to access harm reduction supplies.

Frequent drug use in public spaces was found through the survey, with 7 of 10 (73%) PWUD respondents reporting using drugs in outdoor public spaces in the past year.

More than half of PWUD (52%) used in indoor public spaces. Shelters (19%) and community-based organizations or service providers (12%) were identified as locations of use. Using in these places requires individuals to use stealthily and alone, isolating themselves from assistance in cases of overdose.

For those who use drugs in public spaces, the greatest reason for doing so was convenience (42%). Homelessness also plays a large role (34%). Multiple PWUD respondents specifically mentioned not wanting to use around others (e.g., people they are living with, particularly children). One in ten individuals stated a preference for using outside, with reasons including comfort, privacy, and fear of using in closed/isolated spaces due to the risk of overdose.

Many PWUD respondents indicated that they have used drugs in other cities or communities, including in various First Nation communities (22%). This highlights the importance of collaboration with Indigenous partners to engage and support First Nation community members who may use potential future SCS, so that this work may be done in culturally appropriate ways.
Overdoses are common with 1 in 2 (49%) of the PWUD respondents having experienced an overdose, with over half (68%) of those having overdosed more than once in the last year. Likewise, the majority (67%) have witnessed an overdose, with 47% having administered naloxone during an overdose. Over one in three PWUD respondents (37%) shared the presence of police or first responders as being a barrier to calling 911 during an overdose, creating a greater risk of fatalities.

Supervised consumption services

Just over half of the PWUD respondents (54%) had heard of supervised consumption services before the survey. This poses an opportunity for awareness and education for PWUD who are unaware of these services. The concept of SCS were well received by PWUD respondents, being deemed as Important or Very Important. The PWUD survey participants were asked to react to various SCS policies and services.

Table 10: **PWUD Survey responses on supervised consumption services programs.**

Survey Prompt	Very Important	Important	Somewhat Important	Not Important
New, sterile drug use equipment distribution	68.2%	29.2%	2.3%	0.4%
Distribution of naloxone/Narcan to people who use drugs	66.5%	30.1%	1.9%	1.5%
HIV and Hepatitis C testing	62.5%	34.5%	2.3%	0.8%
Overdose training for people who use drugs	62.0%	34.6%	1.9%	1.5%
Referrals to drug treatment, detox, and addiction recovery services	58.6%	35.7%	4.5%	1.1%
Wound care provided on site	54.7%	40.4%	4.2%	0.8%
Assistance with finding housing, employment and basic skills training	53.4%	35.6%	9.5%	1.5%
Trained staff present to supervise drug use for safety	52.9%	35.6%	9.2%	2.3%
Harm reduction counselling	49.2%	41.2%	6.9%	2.7%
Access to other healthcare services	48.1%	43.6%	7.6%	0.8%
Access to washrooms	42.3%	49.8%	6.4%	1.5%
Available food and beverages	39.2%	44.9%	10.9%	4.9%
Access to showers	37.7%	42.3%	14.0%	6.0%
Indigenous counsellors present	34.4%	40.6%	18.4%	6.6%
Access to drugs prescribed by a health professional	34.2%	46.3%	11.7%	7.8%
Peer support from other people who use drugs	30.4%	45.2%	16.7%	7.6%
A 'chill out' room to go after drug use	25.1%	41.4%	22.1%	11.4%
A place to charge your phone or other electronics	24.6%	40.9%	20.8%	13.6%

Source: NWHU Region Community Survey, August 2022

The vast majority of PWUD respondents (89%) rated trained staff present to supervise drug use for safety as Very Important or Important. Resources like: Access to washrooms, access to showers, available food and beverages, and a place to charge your phone or other electronics all rated Very Important or Important by most PWUD respondents, and this can be indicative of PWUD respondents experiencing homelessness and food insecurity.

A 'chill out' room to go after drug use was deemed the least important by PWUD respondents. A preference or need for this can depend on the type of drug used, as well as housing stability. Chill out spaces are also often utilized as spaces to sleep (e.g., for short periods during operating hours, not a substitute for overnight shelters) for those who cannot rest safely elsewhere, and this can include individuals who use opioids and benzodiazepines, as well as individuals who use stimulants during the times when they decide to sleep. The need for a space to rest has become even more pressing due to the presence of benzodiazepines in street supplies of opioids, which can cause long periods of sleep or unconsciousness.

Distribution of naloxone to PWUD, and overdose training for PWUD were both deemed Very Important or Important by 97% of PWUD respondents, however, only 52% of PWUD respondents indicated that they currently have a naloxone kit and 63% are trained to administer naloxone, signifying an unmet demand for these services.

Table 11: **PWUD Survey responses on policies that can apply to supervised consumption services.**

Survey Prompt	Very Acceptable	Acceptable	Neutral	Unacceptable	Very Unacceptable
That someone will administer naloxone when necessary	59.8%	36.8%	3.0%	0%	0.4%
That someone will administer oxygen when necessary	42.5%	49.6%	7.5%	0.4%	0%
That anyone who needs to be monitored for their safety will be asked to stay until they can leave under their own power	36.9%	50.4%	10.0%	2.7%	0%
Outdoor on-site video cameras for safety purposes	29.3%	44.5%	13.7%	10.3%	2.3%
That someone will monitor you using your drugs for safety	27.0%	47.9%	19.5%	5.2%	0.4%
Indoor on-site video cameras for safety purposes	27.0%	36.5%	17.1%	13.7%	5.7%
Being required to be a registered client and have an anonymous client number	22.5%	45.3%	22.1%	9.0%	1.1%
Having to sign using an anonymous client number each time you use	17.9%	50.8%	18.7%	10.3%	2.3%
A time limit for the drug consumption spaces	16.3%	43.6%	26.5%	11.0%	2.7%
Being allowed to smoke drugs on site	16.0%	38.5%	21.8%	18.3%	5.3%
That you may have to sit and wait until a consumption space is available for you to use	14.6%	62.1%	15.3%	5.4%	2.7%
Being allowed to assist others with injecting	12.5%	37.5%	22.3%	21.2%	6.4%
Being allowed to assist in preparing drugs for others	12.2%	32.8%	22.9%	23.7%	8.4%
Being allowed to share drugs during use	5.7%	29.7%	19.0%	36.5%	9.1%

Source: NWHU Region Community Survey, August 2022

Three quarters (75%) of PWUD respondents regarded that 'Someone will monitor you using your drugs for safety' was Very Acceptable or Acceptable. That 20% of the total respondents were neutral on this policy, could suggest that there is still hesitation for the policy that could be addressed by education of why the policy exists.

Most PWUD respondents rated a time limit for the drug consumption spaces as Acceptable (44%), but more chose Neutral (27%) than Very Acceptable (16%). It will be important for SCS staff to be communicative and flexible with time limits as a means of maintaining positive relationships with community members, and use discretion (e.g., if someone is having issues hitting their vein when injecting, they should be given extra time to finish instead of being told to leave once the time limit is up).

Likewise, for 'Being required to be a registered client and have an anonymous client number', the majority (68%) of PWUD respondents chose Acceptable or Very Acceptable, but 22% chose Neutral,

and 10% of PWUD respondents chose Unacceptable or Very Unacceptable. Care should be given to explaining the need for registration, how the process works - especially the anonymity - and exactly how this data is used and stored to dispel any concerns around surveillance.

There was a decline in support (i.e., Very Acceptable or Acceptable) for indoor cameras (64%) vs outdoor on-site video cameras (74%) for safety purposes. This indicates a need for transparency around the purpose of cameras, what the footage is and is not used for, who can have access and under what circumstances.

Though most PWUD respondents indicated 'Being allowed to smoke drugs on-site' as Acceptable (39%), the rate of support is lower than other policies, with more PWUD respondents choosing Neutral (22%) or Unacceptable/Very Unacceptable (24%) than Very Acceptable (16%). This warrants further investigation as to why there is hesitation around supervised smoking and an opportunity for education about what smoking facilities entail. Judgment among PWUD is common, typically between people who use opioids (historically more often injected) and people who use stimulants (historically more often smoked). Much of this stems from disparity in needs and perceived behaviours and the impacts of these perceptions.

Almost half (45%) of PWUD respondents were supportive (Acceptable or Very Acceptable) of being allowed to assist in preparing drugs for others at SCS and 50% were supportive of being allowed to assist others with injecting. This would be worth exploring further to understand the reasons for this. Some potential reasons may be that PWUD respondents are wary of theft or manipulation, and that a rule against handling other people's drugs may prevent such issues. For instance, more PWUD respondents chose Unacceptable/Very Unacceptable (46%) for a policy allowing the sharing of drugs during use at a SCS than Acceptable/Very Acceptable (35%), which can stem from the same concerns around theft or manipulation. However, for some, assisted injection is an accessibility need[30]. There is an opportunity for education around assisted injection and why it is a necessary practice for some. Furthermore, CTS/SCS operators can seek an exemption from Health Canada for assisted injection.

When asked, 77% of respondents said they would use Supervised Consumption Sites if they were available in their community.

When asked, 3 in 4 (77%) PWUD respondents said they would use SCS if they were available in their community, with more of the remaining stating they were Unsure (13%) than No (8%). One in two (55%) PWUD respondents suggested that they would use a SCS on a daily basis. This is a strong initial positive response from potential clients, being PWUD in the area, signalling a need or a willingness to try SCS. The top reasons given for wanting to use SCS were 'I would be using under safer conditions' (53%), 'Having a community space that is welcoming/safe/sense of belonging' (44%), 'Overdoses can be prevented and treated' (42%), and 'I would be able to get new, sterile drug equipment' (39%).

It was noted that while having a community space was the second most cited reason to use SCS, some of the lowest cited reason factors were those involving peers (e.g., 'I would be able to share my knowledge and skills with peers and professionals', and 'If there were peers on site'). Peer involvement is often integrated into SCS designs as PWUD are familiar with drug use practices, drug trends, often have to respond to overdoses, and are familiar with available services and supports and how to navigate systems.

Table 12: **What reasons would make you NOT want to use supervised consumption services?**

Reasons why would not use SCS	Percent
I do not want to be seen	33.3%
I do not want people to know I use drugs	26.7%
I fear being caught with drugs by police / the possibility of police outside the site	22.9%
I am afraid my name will not remain confidential	19.0%
Non-drug using people in the surrounding neighbourhood might harass me	11.0%
I already have a place to use drugs	9.5%
I need to avoid other people that would use the supervised consumption services	9.5%
I would rather use with my friends	8.6%
I'm worried about losing my kids to child welfare services	8.1%
I'm in too much of a hurry to wait to use the drug consumption room	8.1%
I feel it would not be convenient or have poor service and hours	7.1%
I feel there are too many rules and restrictions associated with using supervised consumption services	6.2%
I always use alone	5.7%
I can get new, sterile drug use equipment elsewhere	5.7%
I don't know enough about supervised consumption services	4.8%
I do not trust supervised consumption services or the agencies that deliver them	3.3%
I'm worried about sexual or gender harassment (transphobia) / sexism / misogyny	1.4%

Source: NWHU Region Community Survey, August 2022

The most common reasons why PWUD respondents indicated that they would not want to use SCS were; 'I do not want to be seen' (33%), and 'I do not want people to know I use drugs' (27%), highlighting concerns around loss of anonymity and other community members, friends, family or employers finding out they use drugs. Additionally, the 'Fear of being caught with drugs by police/the possibility of police outside the site' (23%), stresses the need for a cooperative relationship between SCS and police to ensure trust and safety. Only 1 in 10 (9.5%) indicated that they would not be interested in using SCS because they already have a place to use drugs.

Table 13: **Would you use supervised consumption services if it was located in these kinds of places? Please answer yes or no for each.**

Value	Percent "Yes"
Self-standing isolated service (not within another service building)	77.5%
Mobile clinic/site	63.4%
Shelter or housing agency	62.2%
Mental health and addictions agency	57.6%
Community health centre	56.5%
Walk-in clinic	45.8%
Hospital	42.7%
Social service agency	38.9%
Family doctor's clinic	30.2%
Declined	3.8%

Source: NWHU Region Community Survey, August 2022

The two most popular SCS models selected by PWUD respondents were a Stand-alone service (not Within another service's building) at 78%, and a Mobile clinic/site at 63%. The preference for these options may indicate a desire for independence, anonymity and autonomy, and freedom from surveillance. Other responses suggest SCS could be built into existing service settings. The next most popular response, Shelter or housing agency, followed close behind at 62%. Opening SCS within housing services would mean evaluating current policies and practices and incorporating harm reduction measures as many organizations are abstinence-based. There was moderate support for SCS being embedded in various medical facilities (Mental health and addictions agency 58%, Community health centre 57%, Walk-in clinic 46% and Hospitals 43%), where PWUD may already be attending for other needs. A benefit of multi-service sites is that they can offer some discretion since it is not obvious from the outside why a person is there, compared to single service models. Four of five PWUD respondents (83%) indicated that they would travel to SCS by walking or wheelchair/motorized scooter, highlighting the importance of a centralized and accessible location, where public transportation options are greatly limited in the NWHU region, and private transportation options are costly.

The importance of daily or 24/7 access to services was stressed, and if services were not available when PWUD choose to use them it would greatly undermine the interest, adoption, and access to services. Private cubicles were the most popular set up amongst PWUD respondents (52%). The type of substance being used can also impact preferences around the environment, as needs may differ. Cubicles would need to be large enough to accommodate staff during an overdose or to accommodate a person having an atypical overdose that involves dyskinesia or "flailing"[31].

Four of ten (43%) PWUD respondents at one point have tried but have been unable to get into a drug treatment or detox program. By being connected to services that they use daily, PWUD will be better connected to available drug treatment and detox programs, have greater support navigating the process (application, transportation, etc.), and stay engaged while waiting (can take weeks or months to get into a program). SCS can be instrumental in assisting PWUD in their recovery journey.

6c. What we heard from the broader public

The community survey was available online, in French and English, through the NWHU website for three weeks in July and August 2022. A total of 1,522 participants completed all or a portion of the survey. The majority of participants (77%) indicated that they were "a community member", with 17% selecting that they were "a staff member at a community agency or service provider", or 6% who were "a business owner or operator".

There was participation in the survey across the NWHU region and concentrated in the four largest municipalities. The majority of the community survey participants were from Kenora with 62.5% (949), 13% (198) from Dryden, 11% (168) from Fort Frances and 5.5% (83) from Sioux Lookout. The remaining 8% were scattered across other municipalities within the NWHU catchment area.

The distribution of participants by age roughly reflected the age distribution of the local population, with only individuals under the age of 20 significantly underrepresented. Fourteen percent of survey participants self-identified as First Nation, Inuit, or Métis. There was greater participation by women (55%) than men (21%), with 22% who did not answer the question and 2% who identified as non-binary.

Three quarters (74%) of the community survey respondents selected that they are familiar with what SCS are, with 7% selecting they were not familiar and the remaining 19% choosing to not answer.

Community survey participants were asked to indicate their level of agreement on a series of statements about SCS. The results are shown below.

Table 14: **PWUD Survey responses on statements about supervised consumption services.**

Survey Prompt	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
There is a need for drug consumption and treatment services in my community.[i]	50.1%	12.6%	5.3%	7.3%	24.8%

[i] The use of the language "drug consumption and treatment services" in the survey aligned with the language used by the Ontario government for SCS, however, it is acknowledged that by using this language it did create

Survey Prompt	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
I support the development of consumption and treatment services in my community.	38.5%	16.2%	8.5%	9.2%	27.6%
Supervised consumption services are important in preventing overdose deaths.	35.7%	23.2%	10.8%	10.7%	19.6%
There are negative consequences of supervised consumption services in communities.	31.5%	19.6%	22.3%	17.5%	9.1%
Supervised consumption services are important for providing an environment of dignity and safety for people who use drugs.	27.2%	22.3%	10.8%	14.3%	25.4%
Supervised consumption services help solve problems in the community.	25%	20.5%	12.4%	11.4%	30.7%
Supervised consumption services can save taxpayer money by reducing overall health and social services costs.	23.6%	18.9%	16.3%	15.5%	25.7%
Supervised consumption services will decrease public drug use.	19.2%	18.9%	14%	16.5%	31.3%

Source: NWHU Region Community Survey, August 2022

Nearly 63% of community survey respondents either Strongly Agreed or Agreed that there is a need for drug consumption or treatment services. Furthermore, 55% support the development of these services (Strongly Agreed or Agreed). In terms of overall perceptions of the benefits of SCS, 46% (Strongly Agree and Agree) feel that SCS can help to solve problems, 42% felt the opposite way (Strongly Disagree and Disagree). Further, while 59% believe that SCS will prevent overdose deaths, 52% feel that there will be negative consequences to their introduction. Also of note, is the 22% of community survey respondents who were undecided of whether there are negative consequences of SCS in communities. Additionally, about 40% of community survey respondents Strongly Disagreed or Disagreed that 'Supervised consumption services are important for providing an environment of dignity and safety for people who use drugs', while nearly 50% Strongly Agreed or Agreed.

The divide between community survey respondents on perceptions continued with whether 'SCS can result in reduced costs for municipalities by reducing health and social services costs'. Almost half (43%) Strongly Agreed or Agreed that this would happen, while nearly the same percentage (41%) either Disagreed or Strongly Disagreed. Some studies have quantified where cost savings are realized in relation to SCS. For instance, a cost analysis of a program in Calgary found that each overdose that is managed at the SCS produces approximately $1,600 CAD in cost savings by offsetting costs required for managing overdoses using emergency departments and pre-hospital ambulance services[32]. The *Insite* (Vancouver) evaluation found that among the cost-saving measures realized by Insite, the service prevents approximately 83.5 HIV infections per year and saves $17.6 million in HIV-related medical care[33]. While cost-effectiveness studies quantified HIV-

difficulty in determining whether respondents agreed with only consumption or treatment services, and is a limitation of the survey.

related costs, there are likely other savings being realized that have yet to be quantified[34]. This indicates a need for broader community education about the benefits of SCS.

Nearly half of respondents (47.8%) Strongly Disagreed or Disagreed that 'Supervised consumption services will decrease public drug use'. This is a common concern refuted by existing studies. An evidence brief conducted by researchers at the University of Victoria concluded that "there is little support for the assertion that supervised consumption sites contribute to social disorder. In fact, there is evidence to suggest that they reduce needle debris and public intoxication"[34].

Survey respondents were asked about their beliefs about how likely certain outcomes (e.g., Very Likely) would result from SCS being introduced into their community.

Table 15: PWUD Survey responses on their anticipated outcomes for if supervised consumption services were opened in their community.

Survey Prompt	Very Likely	Likely	Neutral	Unlikely	Very Unlikely	Unsure
More people who use drugs would come to the area.	28.1%	21.8%	19.1%	17.8%	6%	7.2%
Drug dealers would be attracted to the area.	25.6%	20.3%	18%	21%	6.9%	8.2%
Overdoses would be reduced.	25.2%	28.3%	10.7%	15.1%	18.5%	2.2%
The number of used syringes on the street would be reduced.	22.4%	26.4%	7.7%	17.1%	23.3%	3%
Injection with used needles would be reduced.	20.9%	28.3%	11.8%	16.3%	18.6%	4%
People would learn about drug treatment.	20%	31.7%	13.1%	15%	17.8%	2.5%
The number of people using drugs outdoors would be reduced.	15.5%	28.1%	8.8%	17.9%	26%	3.7%
People who use drugs would use the supervised consumption services.[ii]	10.5%	31.2%	17%	18.4%	17.2%	5.7%
Crime would be reduced in the area.	9.4%	16%	15.5%	17.4%	37%	4.7%
The supervised consumption services would be accepted by the broader community.	3.3%	15.1%	14.9%	29%	33.2%	4.5%

Source: NWHU Region Community Survey, August 2022

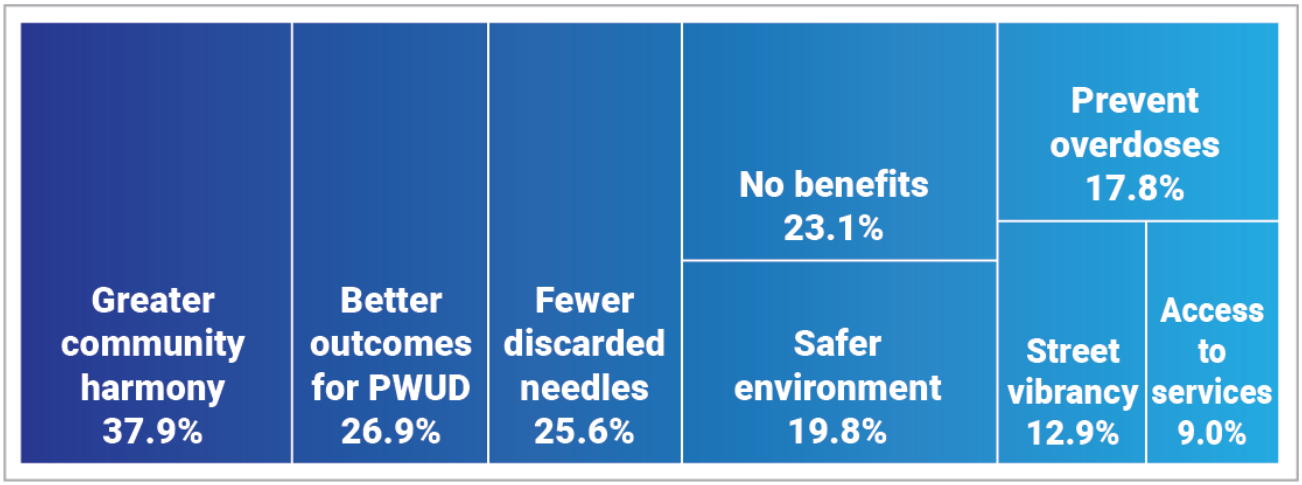
A large proportion (41.7%) of community survey respondents feel that SCS are likely to be used by PWUD, but the majority (62.2%) feel that the broader community are unlikely to accept them. The general public may make responses based on preconceived ideas, stereotypes and assumptions about PWUD and drug use culture. When PWUD were directly surveyed there was a largely positive response and interest in using SCS. More people (49%) thought there would be a reduction of needles on the street with the addition of SCS, than those who did not (40 %). Half (49%) of

[ii] The use of the language "drug consumption and treatment services" in the survey aligned with the language used by the Ontario government for SCS, however, it is acknowledged that by using this language it did create difficulty in determining whether respondents agreed with or not consumption versus treatment, and is a limitation of the survey.

community respondents believe that the sharing of used needles would be reduced with SCS introduced in their community. Over half of respondents (54%) Strongly Disagreed or Disagreed that 'Crime would be reduced in the area'. Related to crime, 45.9% Strongly Agreed or Agreed that 'Drug dealers would be attracted to the area'. This is believed to be a common assumption, whereas there is currently no evidence shows having SCS in a neighbourhood attracts more PWUD to that community[35].

Lastly, community survey participants were prompted to comment on what benefits, negatives and any thoughts or concerns they would like to share. A quantitative coding analysis tool was used to gather themes and insights from the open-end survey responses in the community survey.

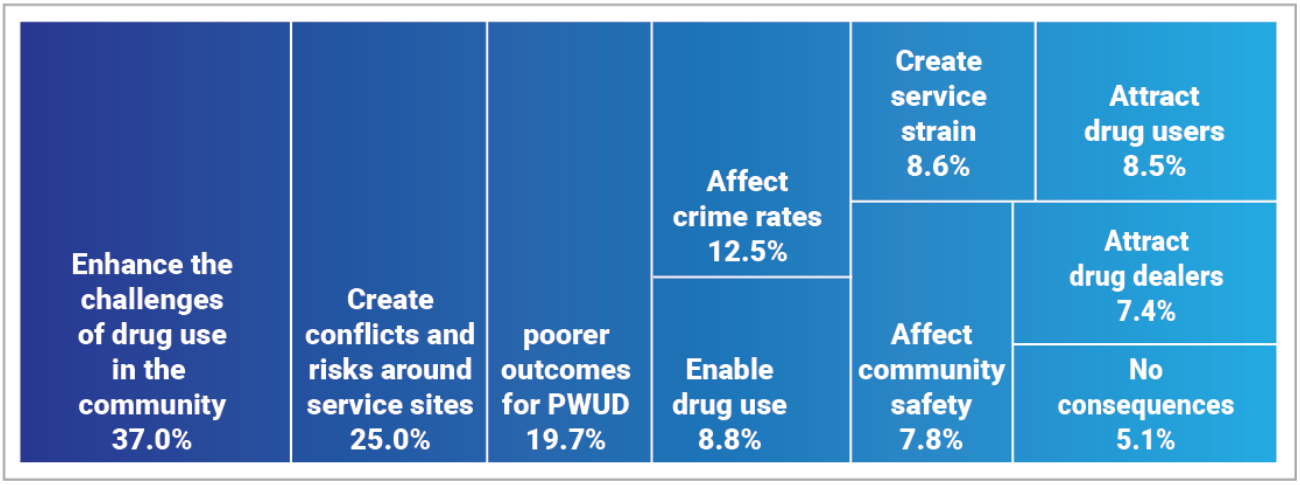
Figure 3: **Topic Tree Map of "What do you think might be the potential benefits of supervised consumption services in your community?"**



Source: Analysis of NWHU Region Community Survey (August 2022)

There were 1,041 responses from survey respondents, allowing members of the public to explain what they think may be the benefits of SCS in their community. The top themes are illustrated above. Respondents identified that through various anticipated benefits of SCS that there would be greater community harmony and better outcomes for PWUD. SCS would provide PWUD with trained supervision for the consumption of drugs, preventing overdose deaths in the communities and improving the overall well-being of PWUD by connecting them with various health and social services. Additionally, the improvement to streets and community areas was identified, as SCS could reduce the public consumption of drugs and discarded drug use materials, such as needles, across the community. There was a group of survey respondents (23%) who stated that they foresaw no benefits of SCS in their community.

Figure 6: **Topic Tree Map of "What do you think might be the negative consequences of supervised consumption services in your community?"**



Source: Analysis of NWHU Region Community Survey (August 2022)

There were 1,055 responses from survey respondents, allowing members of the public to explain what they think are the consequences of SCS in their community. The top themes are illustrated above. The greatest concern was for how SCS would fuel the substance use challenges already faced in their communities, affecting safety and community vibrancy for all. Many were concerned about the challenges that would present in proximity of SCS due to a concentration of drug use in the area. There are public concerns that SCS could enable PWUD by providing a space to consume drugs; increasing drug consumption, create health and safety risks for PWUD, increase rates of crime and attract dealers, which all could add strain on the emergency and health services within their communities. There is the concern that wherever a service site for SCS is placed will concentrate associated challenges to an area, being greatly detrimental to the immediate vicinity and neighbours. These concerns are commonly raised and have been examined in some studies. Results suggest that these negative outcomes do not happen following the introduction of SCS in communities[3]. This is an opportunity to provide education to address these perceptions held by members of the public. There was a group of respondents that believe that with sufficient planning and resources, all foreseeable negative consequences can be adequately mitigated.

Many of these topics of benefits and negative consequences overlapped with the detailed conversations had with stakeholders through interviews and focus groups that are discussed further in the following section: *Learnings from NWHU region key informants.*

6d. What we heard from key informants from the NWHU region

Interviews and focus groups were held with key informants comprising of health and social service providers, enforcement and justice, Indigenous partners, local businesses, non-profits, municipal government, and other community organizations. Abiding by the OCAP principles, specific findings from speaking with Indigenous partners has been shared directly with them and is not included in the body of the report.

Thirteen (13) individual or small group interviews were set up with a select group of key informants, plus an online survey was set up for those who could not attend the in-person sessions. These interviews were with municipal leadership of each of the four communities (e.g., Mayors, Chief Administration Officers and/or Councillors), law enforcement (Ontario Provincial Police and Treaty Three Police Service), and at least one organization in each community that regularly interacts with local PWUD (e.g., hospital, friendship centre and shelters).

Eight focus groups were held in July 2022, representing the following sectors and perspectives: health care (e.g., hospitals, Ontario Health Teams, primary care), mental health and addiction services, emergency services (e.g., District Social Services Administration Boards, Fire Marshalls, correctional services), community agencies (e.g., shelters, victim services, social services providers), Indigenous agencies (e.g., First Nation health authorities, Friendship Centres, Aboriginal Health Access Centres), business sector (e.g., Chamber of Commerce representatives), NWHU staff and NWHU Board of Health.

One hundred and three (103) key informants participated in a focus group, interview or the online survey including 29 participants from Kenora, 41 from Dryden, 13 from Sioux Lookout, and 20 from Fort Frances. The following section outlines the findings shared across the individual or small group interviews including common themes, issues, barriers, and enablers of developing SCS in the NWHU catchment area. The findings outline the common items raised and perspectives across the key informants from Kenora, Dryden, Sioux Lookout, and Fort Frances. Community-specific findings are highlighted at the end.

Drug use challenges in the community

All 103 key informants who participated in the interviews and focus groups agreed that there is a significant challenge responding to drug use across the NWHU region as well as in each of the four respective communities and surrounding communities. Anecdotally, key informants agree that drug use appears to be increasing with a rise in the use of methamphetamine (i.e., 'crystal meth'), opioids (e.g., fentanyl), and other drugs such as cocaine (to a lesser extent).

Key informants reported that the number of PWUD has steadily grown, as have the associated health harms. They are aware of the data that shows that there has been an increase in drug mortality and morbidity in their communities and equate the volume of drug related ambulance calls to a significant burden on local hospital emergency departments. The key informants see the rise in both non-fatal and fatal overdoses as having significant traumatic impacts on families and loved ones within their communities.

They shared that in addition to their drug use, many PWUD are experiencing mental health challenges, homelessness, and concurrent disorders and risk factors, among other health challenges that are not being properly addressed. The literature shows that many factors contribute to people using drugs and these factors need to be addressed to find sustainable solutions to high-

risk substance use. While a full analysis of the underpinnings of drug use in the NWHU region is beyond the scope of the needs assessment, it is important to acknowledge the significant systemic issues that PWUD face including poverty, homelessness, unemployment, racism, and discrimination. Issues such as mental health and illness often get overlooked while drug use becomes the focus. Key informants recognized the oppressive legacy of systemic racism and institutions like the residential school system, which has resulted in intergenerational trauma and substance use amongst members of Indigenous communities. The key informants also reported that the exploitation of women via human trafficking has increased. Human trafficking has a studied correlation with drug use as traffickers can exploit trafficking victims' existing drug use to coerce them into sex trafficking, or they may facilitate substance use to keep trafficking victims from exiting[36]. While there are many other factors that influence drug use, these are the main factors referred to by those who were interviewed.

Key informants reported that confrontations between people involving substance use and general tensions are rising within their communities. Many said that the symptoms of substance use are visible in their communities with PWUD often in the downtown areas, sometimes displaying 'erratic behaviour', and needles and other drug equipment are discarded in community areas such as playgrounds and sidewalks. Safety concerns were shared as there is the perception that theft and violent crime related to drug use is increasing in some communities. Many felt that there is general fatigue in the community for these conditions and there is an increasingly divided public discord on how to address it.

Stigma and negative behaviour towards PWUD were repeatedly cited as being one of the biggest challenges for PWUD in the region. With the history of drug use and repeated and growing frustrations in communities, key informants shared that they feel that stigma towards PWUD has increased. PWUD routinely experience stigmatization from all directions including from the broader public, business owners, service providers, community leaders, and law enforcement. This environment can be detrimental as experiences of being stigmatized and treated negatively affects PWUD comfort and willingness to seek help from the services they need[37].

People who use drugs acknowledged that available services are seen as helpful but are significantly underfunded and under resourced.

Across all communities, key informants shared that many organizations and service providers are making great efforts to help those who use drugs with the available capacity and resources. They acknowledged that available services are seen as helpful but are significantly underfunded and under resourced to meet the complex needs of the large number of PWUD in the community. Further, they stressed the need for drug treatment centres, beds for stabilization, withdrawal supports, detox services, rapid access to addictions medicine clinics, and other needed harm reduction services in each of their communities.

In all communities, key informants are concerned that it is difficult for PWUD to navigate and access services. The key informants recognized that services are sometimes disconnected, do not always coordinate well with one another, and in some communities, there is a lack of cooperation and collaborative planning. Some services have been said to be difficult to access due to rules, processes and forms that must be followed. Key informants have heard from PWUD that they don't know where to find the support they need or how to access these services. Across the region, a number of key informants shared that support services are often driven by organizations and

providers, and not by those who use drugs. Further, they felt that there needs to be a shift towards being more client-focused, where PWUD determine their support needs and to make decisions regarding these.

Municipal Officials

Municipal key informants stressed that substance use is increasing in their communities and not only reactive but proactive actions and initiatives are critical in order to save lives and improve outcomes for the entire broader community. The municipal key informants shared that they are hearing from residents that they are feeling increasingly uneasy in their communities due to erratic behaviour from PWUD and discarded drug use equipment in public spaces. Municipal key informants were concerned that the downtown areas of the municipalities are already a strained and fragile environment and feared that by adding SCS in their communities, it would introduce another challenge to their communities' vibrancy and downtown recovery.

Most municipal key informants expressed that their communities are quite progressive, and it would not be unreasonable to assume that there may be large levels of community support, even if it is quiet support from a silent majority. They believe that if the successes of SCS can be measured and communicated to the public in a timely fashion, then there will be support within the community. That said, it was stressed by municipal key informants that a fulsome dialogue of how SCS will impact the broad community (social, economic, safety, services) needs to be unpacked with clear communication of what measures will be put in place to ensure the well-being of everyone (e.g., mitigation strategies). It was particularly emphasised that they as municipal leaders, will need these resources to support them in justifying SCS to their constituents.

Many municipal key informants have a concern about introducing SCS while there is a continued gap in local drug treatment services. They don't see a foreseeable change in these circumstances as despite mental health and addiction being a top community priority across all the communities (e.g., highlighted in municipal Community Safety and Well-being Plans), there has been a longstanding gap in adequate government funding to support necessary initiatives and programs in the region.

Police Detachments

Key informants from police detachments in all four communities spoke about how overwhelmed they have been dealing with drug-related issues. They described how resources allocated to dealing with drugs and drug-related crime have increased significantly, however, there has been little improvement in the overall situation. The detachments reported that there has been an increase in violence-related and public safety calls involving drugs, instances of driving while impaired, theft, property damage, and an increase in children being brought into the drug trade.

Key informants from police detachments agreed that there is a severe lack of mental health and addictions services, especially for drug use treatment, available in their communities. In some communities, they commented on how relationships between community services organizations and law enforcement are positive, while in other communities they could be improved. The shortage or lack of availability of mental health and addictions services means that when individuals with a history of substance use are released from custody, there are none of the important supports while reintegrating into the community and thus, they are susceptible to relapsing.

Key informants from police detachments see that there are opportunities for improving connections between services for PWUD and the need to help them navigate the service networks in their communities. The key informants noted the importance of improving the safety of the environments where people use drugs so that they are less susceptible to victimization and human trafficking.

Harm reduction programs

Throughout many interviews and focus groups, the regional needle distribution program came up repeatedly. Many praised NWHU for their leadership in making this harm reduction program available in many parts of the region. However, many stakeholder groups have raised concerns with program's implementation and impact. Health, social, mental health and addiction service providers spoke about the benefits of this program in reducing harms, but also spoke about the challenges with needles being left around the communities. Likewise, many other key informants interviewed talked about some of the benefits of the program, but also spoke about the impact of both unused and used needles that are discarded and the constant need for cleanup.

Multiple key informants had concerns about the needle distribution program and the suboxone clinics. Some shared that the quantity of needles being given out is far greater than those that are 'exchanged' or returned, and several examples were shared where bags of unused (new) needles have been left on the ground along with used ones. Law enforcement gets many calls from the community regarding needles being left in places in the community, especially where children play. This is an ongoing issue in the community that causes concern and frustration among broader community members.

Perceived benefits of supervised consumption services

In general, many of the interviewed key informants felt that SCS could have benefits for communities in the region. For those who were unsure, they cited not knowing a lot about SCS, what kinds of impacts they could have or what research has been done to evaluate their impacts. Many key informants spoke about how they felt that gaps in treatment services should be addressed before SCS are considered. A small number of those interviewed expressed that there would be minimal benefits from SCS, specifically for PWUD, and not experienced by the broader public. Many shared they did not know very much about SCS and believe that there is a lot of work to be done to raise awareness and understanding of SCS amongst leaders, organizations, service providers and the broader community so that SCS benefits can be effectively communicated.

Benefits for people who use drugs

Many key informants see that a benefit of SCS for PWUD would be the opportunity to reduce hesitation and stigma around the use of community health services. They hope that SCS in their community would be accepted by PWUD as a safe place that maintains confidentiality and builds trust with them. When SCS achieve this, key informants understand that SCS can increase the safety of PWUD, save lives and decrease risks for communicable diseases. SCS users can build peer support networks and relationships with service providers which can greatly increase their adoption and utilization of health and social services, which can in turn help stabilize and assist individuals in their addictions management and recovery.

Key informants recognized the need for PWUD to have somewhere safe and non-judgemental. The potential of a "hub" could facilitate the development of a community for PWUD, by providing an environment where harm reduction practices can be promoted. There is the acknowledgement that

many of the communities do not have a shelter or drop-in centre where the PWUD community can gather, develop support networks and engage in harm reduction. Many key informants believe that SCS are important to address this gap.

Key informants acknowledged that PWUD are not receiving the care they need and that they have greater challenges navigating the health and social services system due to their circumstances. SCS were recognized by them as a tool in helping address service access for PWUD by strengthening the connections between services for PWUD. Health and social services could be delivered at SCS sites, effectively meeting PWUD where they are at, and service referrals could be made with greater opportunities for follow up given that PWUD may frequent a SCS and establish relationships with the SCS staff.

Potential benefits for organizations and businesses

In terms of some potential broad benefits that SCS could bring to businesses in communities, key informants noted reduced loitering, shoplifting, and drug equipment debris left around the community. They also speculated that SCS could result in fewer instances of people using drugs in public areas such as public or business washrooms, stairwells or spaces sheltered from the elements, as well as related drug supplies being left in these areas. They also hoped that if this occurred, that it would help decrease the number of confrontations between people regarding substance use, making all community and business areas more welcoming to all.

Community economic benefits and well-being for health care and emergency medical service workers were noted by key informants as possible benefits of SCS. Speculated SCS impacts for hospitals included savings through reduced ER visits and less money spent on the treatment of communicable diseases attributed to drug use. Paramedic services and ERs could see a reduced strain and experience less attrition of staff. It was noted that SCS could help to keep emergency medical service workers safe through a decrease in “risky calls”.

Key informants also acknowledged that in multiple communities, ‘ad hoc’ consumption sites are already occurring. These services are either unsupervised or volunteered-based, under-resourced, and operate without an exemption or government approval. Many stressed that these consumption sites are subject to great amounts of scrutiny by members of the public and are making the public discourse of harm reduction initiatives challenging. While the key informants recognized that these consumption sites may be mitigating some drug use harms, they are anxious to transition these sites to ones that have greater oversight, accountability and resources as soon as possible.

Potential benefits for the broader community

Key informants recognized how substance use is affecting their communities, either directly or indirectly, and that proactive actions and initiatives are critical in order to save lives and improve outcomes for all members of the public. They hope that the members of the public who are most concerned about drug consumption in public will recognize SCS as an opportunity to reduce these behaviours. They also shared that they believe that if the benefits and successes of SCS can be effective, measured and communicated in a timely fashion, that the level of support from the broader community will increase.

They also saw SCS contributing to general improved well-being for entire communities by:

- Helping to “clean up the community” with a decrease in improperly discarded drug equipment found across communities.

- Decreasing public exposure to drug use through the introduction of supervised, private spaces for drug consumption. SCS can provide alternative places for people who normally use drugs around their family, children and social networks.
- Reducing strain on community health care resources by reducing acute drug-related health incidents. With a potential decrease in overdoses and disorderly conduct, a resulting decrease may be experienced in calls for emergency or law enforcement services in communities.

Key informants recognized that a portion of drug use happens in households "behind closed doors". Some of them hope that the addition of SCS could help reduce the amount of overall drug use by PWUD by providing those in private residences to use SCS. They acknowledge that it cannot be expected that all PWUD would choose to use SCS over private residences that they have access to. However, there were many PWUD surveyed who expressed an interest in SCS in order to not use drugs around their families, specifically around children.

Potential negative consequences of supervised consumption services

Key informants were asked what risks or negative consequences they believe might result from SCS in the community. Most of them noted fewer concerns than the benefits shared in the previous section.

Potential negative consequences for people who use drugs

Some are concerned that without adequate education of SCS reaching the broader community, stigma for PWUD could get worse with SCS introduction. Concerns were also shared about ensuring that confidentiality of those using SCS is maintained. If PWUD are able to be identified by using SCS then they could be subject to increased judgement and scrutiny by others. Given that communities in the NWHU region are small, many people know one another and if confidentiality isn't assured, there could be negative consequences for PWUD.

Certain key informants noted that a dedicated space for drug consumption could pose risks to the safety of PWUD because others might seek them out at SCS. They were concerned that conflict could occur at the site with the possibility of people coming to the site to find individuals based on money owed or relationship issues. These concerns were noted as particularly relevant in the case where a SCS is operating within a single facility. The idea that the site could attract drug dealers or concentrate substance use in one area of the community was also a common concern.

Liability was raised as a risk by key informants, warranting consideration in a few areas. They wondered what the implications for liability would be for scenarios such as individuals leaving the site impaired and then driving a car. Should there be rules in place to prevent such scenarios, key informants wondered whether there may be challenges in enforcing certain rules. Some shared liability concerns pertaining to the safety of staff working in a facility where SCS are provided. They also raised questions of whether SCS could give PWUD a false sense of security, particularly when the safety of the drug supply outside SCS is unknown.

A few key informants were concerned that SCS could be seen as encouraging substance use for individuals, particularly with drugs being provided (i.e., safe supply distribution). This concern of SCS being interpreted as aiding or enabling substance use could have negative impacts within local

neighbourhoods where SCS are, especially without effective education about SCS and discussion with the broader public.

Potential negative consequences for organizations and businesses

With downtown areas already being 'strained' environments, key informants were concerned that adding SCS in their communities would impair the community's recovery, thus contributing to a further decline of these areas in the region. They anticipate that businesses will not want SCS to be near them as the frequency of PWUD in the vicinity and the potential for loitering could negatively impact their businesses. Concerns regarding SCS proximity to certain types of organizations like child or youth services were also flagged by key informants.

Some were concerned that SCS could contribute to increases in crime which could put further strain on local police forces. A similar concern from some key informants was that SCS could lead to increased homelessness due to an increase in PWUD coming in from out of town.

Key informants noted a shortage in health and allied health professionals across the NWHU region. Temporary closures of local Emergency Departments exemplify this struggle[38,39]. Given this challenge, some were concerned that existing talent from mental health and addiction organizations may leave to work at SCS.

Potential negative consequences for the broader community

The most common concern around negative impacts on the broader community raised by key informants related to where SCS could be located in their communities. Concerns ranged from fears that conflict might arise between neighbourhoods due to nimbyism, to worries that the location would increase the number of PWUD in the vicinity, thus increasing problems for neighbours. They shared concerns that community members would worry about SCS enabling users to use "more drugs", increased loitering around the service sites, and the potential for increased crime. Many were concerned that if locations for SCS are not the "right" locations and if steps are not put into place to reduce negative impact on neighbouring businesses, then pushback from certain members in the community will be strong.

Key informants noted how many members in the community obtain the majority of their information from social media. This has posed challenges in the past for harm reduction initiatives with the spreading of disinformation and negative commentary driving public dialogue. Many shared a concern that SCS would not be well positioned or resourced to lead an educational discussion across online community spaces to overcome this challenge.

Support for supervised consumption services implementation

Many key informants expressed concerns about introducing SCS when there is a continued gap or inadequacy in local drug treatment services. Within this group, some felt strongly that pursuing SCS is pre-emptive given the significant shortage of other needed treatment services. However, other key informants shared that they do not anticipate increases in funding for treatment services despite mental health and addiction being a top priority across all of the communities (e.g., highlighted in municipal Community Safety and Well-being Plans). There has been a longstanding gap in adequate government funding to support necessary initiatives and programs in the region. The concern is that waiting for additional funding to increase other treatment services will not prove fruitful, especially when harm reduction is needed now to save lives.

Some key informants expressed that many in their communities are quite progressive, and it would not be unreasonable to assume that there may be large levels of community support, even if it is quiet support from a silent majority. With this said, there were also some who shared concerns about significant community resistance and pushback against the introduction of SCS. Previous conflicts around harm reduction initiatives and programs have been described by key informants as "war zones" due to the frustration and anger between the service providers delivering the services and community members opposed to the harm reduction actions being taken in their community. While they acknowledged that this likely cannot be entirely avoided, they stressed how proactive public education on harm reduction and SCS is absolutely critical. Social media was noted as a place where there is a lot of negativity towards PWUD and harm reduction services, with a lot of misinformation shared. Several stakeholders wondered about whether the size of those who are resistant is quite small, yet vocal. It was noted that some of the previous opposition has at times been supported or championed by elected officials.

The majority of those interviewed were supportive of providing SCS, while acknowledging that there are gaps in current services and supports for PWUD. Given the size of the substance use challenge in the NWHU region, many felt that all possible tools available needed to be used. For those who do not know enough about SCS, they were open to their potential benefits. There were a small number of key informants who were opposed to SCS being introduced, largely due to the aforementioned lack of needed services and funding for current services, as well as concerns about potential increases in things such as drug use and crime. Some key informants questioned the extent of how many PWUD would access SCS given concerns about lack of anonymity/confidentiality or barriers like having to travel long distances to access the services.

It was stressed by some key informants that a plan with mitigation strategies for safety and other community concerns (e.g., social, economic, etc.) needs to be developed with clear communication for the broader public. This was particularly emphasised by municipal leaders who would need support to justify SCS to their constituents. It will also be important to articulate what the realistic outcomes of SCS are in order to set related expectations.

Considerations for how supervised consumption services could be organized

Key informants provided reflections on how SCS could be organized and what would need to be considered. For example, key informants shared what services should be offered, what partners should be involved, or what potential locations could look like. These considerations are summarised below.

Many key informants talked about accessibility, especially given that many live in areas and communities outside of the four municipal urban centres. While centralized services are advantageous for those who are in downtown areas, more rural residents are unlikely to travel to use SCS. Some key informants suggested mobile services or dispersed services across multiple providers as potential solutions. Despite the geographic challenges, most key informants agreed that best course of action is a centralized SCS that can be accessed by the majority of PWUD. In order to meet user needs and reduce harms and risks, services need to be available seven days a week with extended hours. Ontario Health Teams were identified by key informants as key potential supporters or even leaders for SCS development because of the scope required for SCS development, and the resources it will require. Otherwise, health, mental health and addiction, and/or social service providers were seen to be best positioned to lead the development of SCS.

In order to meet user needs and reduce harms and risks, services need to be available seven days a week with extended hours.

7. Community-specific Findings and Recommendations

The following section outlines data related to drug use in each of the four communities of interest within this needs assessment – Sioux Lookout, Fort Frances, Dryden and Kenora - as well as community-specific results from both the PWUD Survey and the Community Survey. It also summarizes the perspectives, opinions and feedback from key informants in each community. The regional results in the previous section applies to each of the four communities and should be taken into consideration alongside the community-specific findings. The number and kinds of organizations, individuals, as well as the levels of participation varied by community. While the data presented below contains robust insights and input from PWUD, the broader community and stakeholders, and key informants from a number of organizations in each community, these do not reflect the views of 'all' community members and stakeholders.

7a. Sioux Lookout

Demographics

With a population of 5,839 (2021 census data) the municipality of Sioux Lookout stretches over a geographical area of 378.02 km^2. The population density is 15.4 people per km^2. The average age of the population is 39.0 years old (2021 census data). Sioux Lookout is located in the District of Kenora. See Appendix C:1. for a map of Sioux Lookout.

Mortality and morbidity information

Mortality and morbidity data from provincial and regional sources demonstrates that the municipality of Sioux Lookout is exhibiting a disproportionate amount of morbidity and mortality across all indicators (not including naloxone distribution as a proxy indicator) when compared to provincial data. When compared to data for the NWHU catchment area, rates are higher in Sioux Lookout for all indicators except for ER visits related to opioid overdose. While each indicator is outlined in greater detail below, the findings are summarized in Table 16 in relation to the NWHU catchment area and across Ontario.

Table 16: **Summary of indicators demonstrating evidence of drug related harms in Sioux Lookout in comparison to the NWHU catchment area overall and Ontario.**

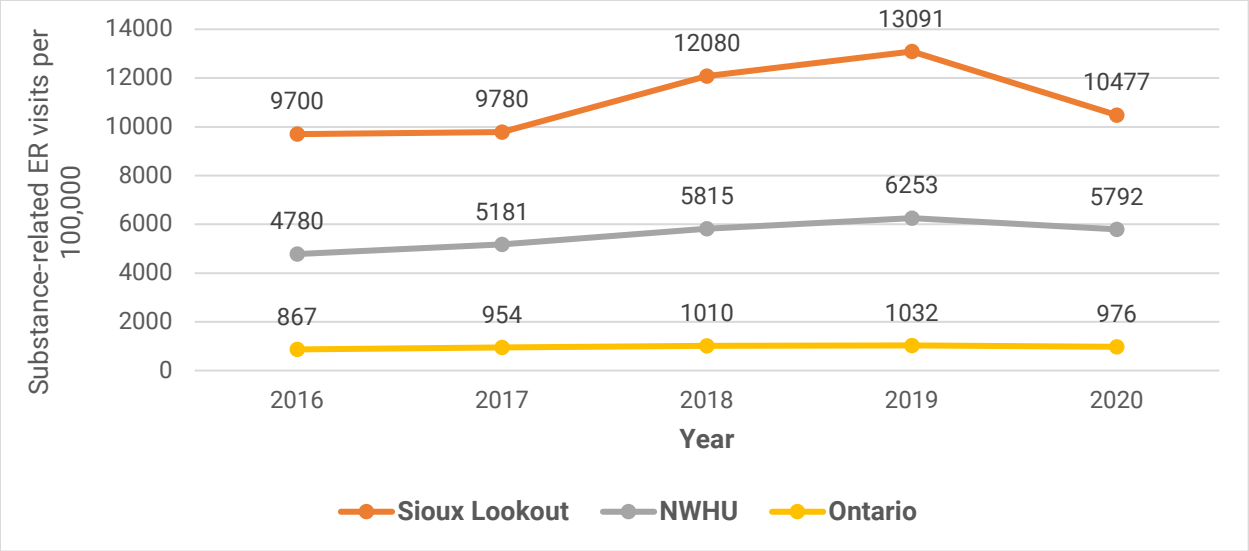
Morbidity/mortality indicator	How does this indicator for the municipality of Sioux Lookout compare to that of the NWHU catchment area?	How does this indicator for the municipality of Sioux Lookout compare to that of Ontario?
ER visits related to substance-related reasons ***(per 100,000 per year by local health hub 2016-2020)***	Rates in Sioux Lookout have been **higher** than across NWHU for each year between 2016 to 2020.	Rates in Sioux Lookout have been **much higher** than across Ontario for each year between 2016 to 2020.
ER visits related to opioid overdose ***(per 100,000 overall by local health hub for 2016-2020)***	Rates in Sioux Lookout have been **lower** than across NWHU for the overall time-period between 2016 to 2020.	Rates in Sioux Lookout have been **higher** than across Ontario for the overall time-period between 2016 to 2020.
Hepatitis C incidence ***(per 100,000 per year by local health hub 2016-2021)***	Rates in Sioux Lookout have been **higher** than across NWHU for each of the three-year time-periods captured (between 2016-2018 and 2019-2021).	Rates in Sioux Lookout have been **much higher** than across Ontario for each of the three-year time-periods captured (between 2016-2018 and 2019-2021).
HIV incidence ***(per 100,000 per year by local health hub 2012-2021)***	Rates in Sioux Lookout have been **higher** than across NWHU for the overall time-period captured (between 2012-2021).	Rates in Sioux Lookout have been **higher** than across Ontario for the overall time-period captured (between 2012-2021).
Proxy Indicator		
Naloxone kit distribution counts*	Naloxone kit distribution **did not** reflect the same increasing trends as were seen across NWHU catchment area between the years of 2018-2021.	Naloxone kit distribution **did not** reflect the same increasing trends as were seen across Ontario region between the years of 2018-2021.

* Note: the Sioux Lookout First Nation Health Authority operates their own naloxone distribution site which is not reflected in the available data.

Indicator: Substance-related ER visits

Between the years of 2016 to 2020, there was a higher rate of substance-related ER visits for Sioux Lookout than across the NWHU catchment area, both of which are higher than provincial rates. The five-year average of Sioux Lookout is 65.8% higher than the NWHU catchment area and 167.7% higher than the rest of Ontario.

Figure 7: **ER visits from 2016-2020 related to substance-related reasons per 100,000 per year for Sioux Lookout, NWHU catchment area and Ontario.**

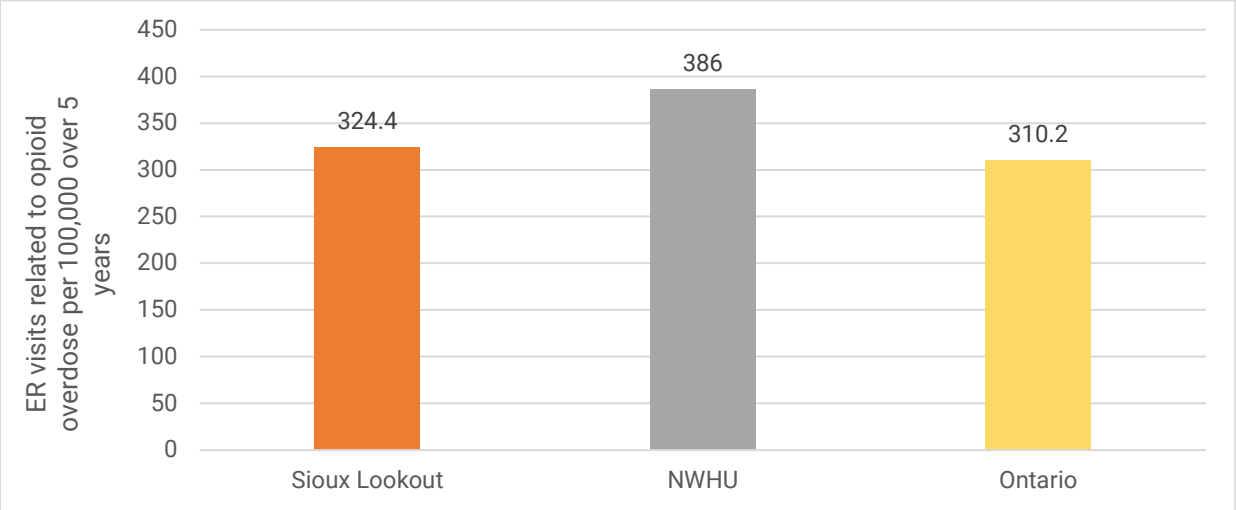


Source: Ambulatory Visits [2016 - 2020]. Ministry of Health and Long Term Care. IntelliHEALTH Ontario. Date Extracted: May 12, 2022

Indicator: Opioid-overdose related ER visits

When looking specifically at opioid-overdose related ER visits, rates in Sioux Lookout are 17.3% lower than those in the NWHU catchment area and 4.5% higher than those across the province.

Figure 8**: Total ER visits from 2016-2020 related to opioid overdose per 100,000 for Sioux Lookout, NWHU catchment area and Ontario.**



Source: Ambulatory Visits [2016-2020]. Ministry of Health and Long-Term Care. IntelliHEALTH Ontario. Date Extracted: May 12, 2022

Indicator: Hepatitis C

In the latest three-year period (2019-2021), the incidence rate per 100,000 of Hepatitis C in Sioux Lookout is 58.2% higher than that in the NWHU catchment area, however, both are much higher than the rates across Ontario for the same timeframe (173.9% and 154.8% respectively). Rates of Hepatitis C incidence per year in Sioux Lookout have decreased by 9.3% from one three-year period (2016-2018) to the next three-year period (2019-2021). Comparatively, rates decreased between each of the three-year periods for the NWHU catchment area (4.2%) and Ontario (30.1%).

Table 17: **Hepatitis C incidence per 100,000 for three-year time periods between 2016-2021 for Sioux Lookout, NWHU catchment area and Ontario.**

Years	Sioux Lookout	NWHU	Ontario
2016-2018	380	197.6	34.5
2019-2021	344.8	189.4	24.1
Change from 2016-2018 to 2019-2021:	*9.3 % decrease*	*4.2% decrease*	*30.1% decrease*

Source: iPHIS. Date Extracted: May 17, 2022

Indicator: HIV

Rates of HIV incidence per 100,000 averaged over the past 10 years in Sioux Lookout are 37.8% higher than the NWHU catchment area and 5.1% higher than HIV incidence across Ontario.

Table 18: **HIV incidence per 100,000, 10-year average from 2012-2021 for Sioux Lookout, NWHU catchment area and Ontario.**

Years	Sioux Lookout	NWHU	Ontario
2012-2021	5.8	4.0	5.5

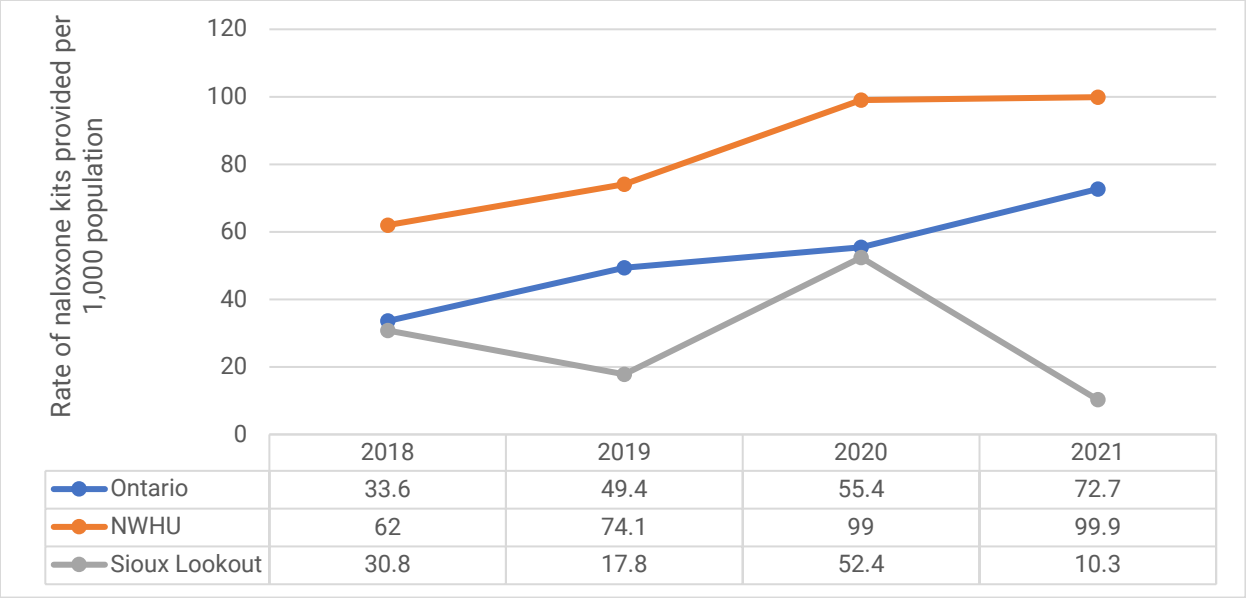
Source: iPHIS. Date Extracted: May 17, 2022

Proxy indicator: naloxone distribution

Rates of naloxone kit distribution has increased every year for the NWHU catchment area, with only a slight increase from 2020 to 2021. In Sioux Lookout, rates of naloxone kit distribution have varied from year to year decreasing from 2018 to 2019, then to increase in 2020, to then decrease again 2021. The pattern may warrant further investigation to understand why the rates vary to such a great extent from one year to the next.

It should be noted that the source of information at the regional and provincial levels were different than the source for the city-level data. There could be differences in how counts are recorded, and NWHU and Ontario data encompasses both community and pharmacy distributed counts.

Figure 9: **Rates per 1,000 of naloxone kit distribution by area by year for Sioux Lookout, NWHU catchment area, and Ontario.**



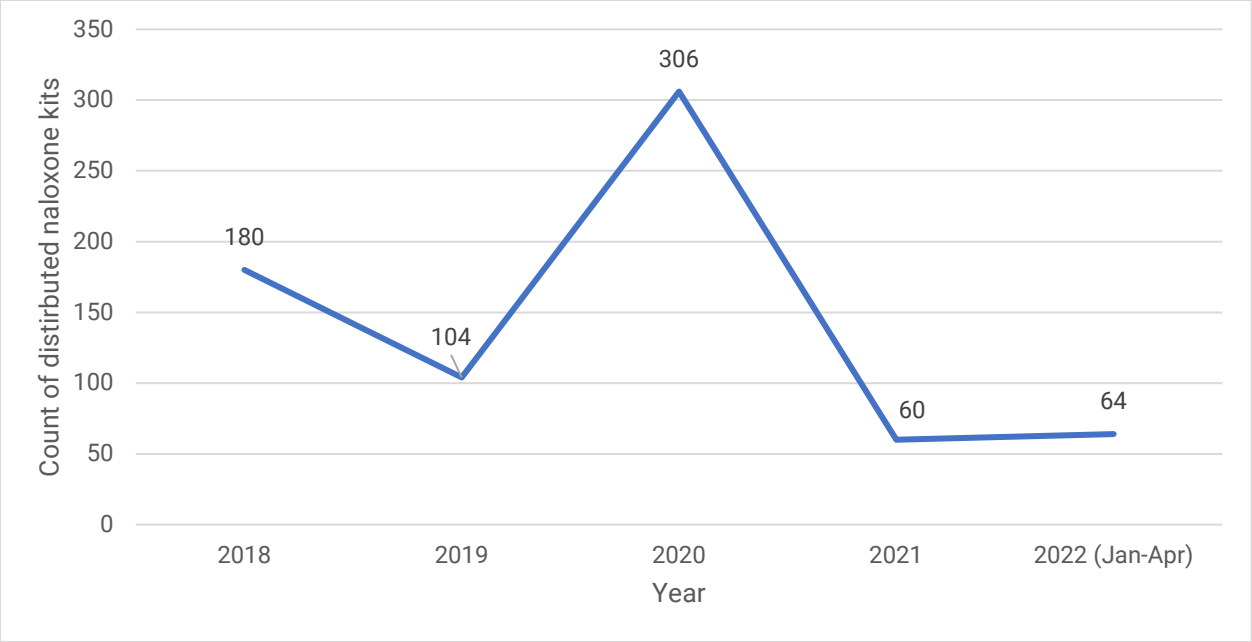
	2018	2019	2020	2021
Ontario	33.6	49.4	55.4	72.7
NWHU	62	74.1	99	99.9
Sioux Lookout	30.8	17.8	52.4	10.3

Source: Data provided from the Northwestern Health Unit (Sioux Lookout data series) and accessed from the ODPRN Ontario Opioid Data Tool (NWHU catchment area and Ontario data series)

When looking at the counts of naloxone distribution in Sioux Lookout in Figure 10, it is notable that the count of distributed kits for the year 2022 between Jan-April was 64, which may indicate an increasing trend in the year ahead.

Looking at data from the PWUD survey (discussed in greater detail in next section), 66% (n=50) of survey respondents in Sioux Lookout identified having been trained to administer naloxone, 29% (n=49) have administered naloxone to someone, and 37% (n=49) have a take-home naloxone kit to keep for an opioid overdose.

Figure 10: **Naloxone kit distribution count by year from 2018-2022 for Sioux Lookout.**



Source: Data provided by the Northwestern Health Unit

Demographics and preferences of people who use drugs

The in-person survey of PWUD was conducted throughout August 2022 at sites across the four Northwestern Ontario municipalities. A total of 271 participants completed all or a portion of the survey. All participants had used drugs within the previous six months prior to the survey, were at least 18 years of age, spent on average at least seven days a month in the community where the survey took place.

Of the 271 participants, 50 (18%) were completed in Sioux Lookout. Of the 50 respondents, 32% indicated Sioux Lookout as a place they consider to be their hometown or home community and 54% identify an 'other' place as their hometown or home community.

The following information is specific to those 50 respondents that completed the PWUD survey in Sioux Lookout.

A higher proportion (58%) of respondents from Sioux Lookout were women, while 42% were men.

A majority (94%) of respondents from Sioux Lookout identified as First Nation, in addition to 4% who identified as Métis. Two percent indicated that they were neither First Nation, Inuit and/or Métis.

Of the survey respondents, 92% reported spending multiple nights per month in the last year in a house or apartment. Sixty percent spent several nights per month in a shelter/transitional housing, 54% reported sleeping on the street multiple nights per month in the last year (including abandoned buildings, cars, parks), and 50% indicated no fixed address. Other answers included a hospital/rehab/medical facility (36%), hotel/motel room (34%), prison/detention centre (22%), a

place where people gather to do drugs (28%), and other (8%); which included in the bush, office building, and tents.

Drug use patterns and related behaviors

In the past year, the most frequently used drugs were crystal meth (82%), cocaine powder (80%), opioids (68%), crack (58%), methadone or suboxone (54%), tranquilizers or benzodiazepines (12%) or other (18%), including Gabapentin, Percocet, Oxycontin, Pregabalin, marijuana, mushrooms, Ritalin, Tylenol, and Xanax.

- The most common method of drug use was by injection (94%), smoking (54%), snorting (38%), swallowing (26%), and other (e.g., sublingual) (4%).
- 54% said that someone else had prepared their drugs for them in the last year (n=50).
- 22% said that they had at some point in the last year shared drug use equipment such as needles, cookers, or pipes (n=50).
- 64% indicated that they had at some point in the last year gotten new drug use equipment from a friend, dealer, or someone on the street (n=50).
- 54% said in the past year, they had not been able to find new drug use equipment when it was wanted (n=50).

Injecting-specific behaviours that respondents identified doing at any point in the last year:

- 94% have injected alone (n=47),
- 61% had help from someone to inject (n=46),
- 68% reused their own injecting equipment (n=47),
- 13% shared or reused someone else's injecting equipment (n=46),
- 48% used water from a puddle, public fountain, or other outside source to prepare drugs or rinse needles (n=46),
- 94% exchanged or obtained needles at a harm reduction program (n=47),
- 45% experienced a harm reduction program limiting the number of needles they could be given (n=47).

Using drugs in public spaces

- Location of drug use in the past year included:
    - Indoor residences (e.g., your own place, a relative's, a friend's or a stranger's place or a hotel or motel) (92%),
    - Outdoor public spaces (e.g., an abandoned building, a parking lot, or a park) (82%),
    - Indoor public spaces (e.g., in a stairwell/doorway/washroom of a store, coffee shop, public bathroom, office, or other building) (64%),
    - A shelter (32%),
    - A community-based organization or service provider (other than a shelter) (14%).

With the most common location among respondents for drug use being in public, the top reasons for using drugs outside included:

- It's where I am when I decide to use (50%),
- I'm homeless and don't have a place to use (45%),

- It’s convenient to where I hang out (33%),
- I need to use immediately after getting drugs (e.g., experiencing withdrawal) (26%),
- I don’t want the person I am staying with to know I use/am still using (24%),
- There is nowhere to use safely where I buy drugs (14%),
- I prefer to be outside (14%),
- I’m too far from home (12%),
- I need assistance from others to use (12%),
- Dealing/middleing (connecting sellers to purchasers) / steering (guiding potential buyers to selling) (10%),
- Guest fees at friend’s place, but I don’t want to pay/share (7%),
- Other (7%) – examples include: don't want to use around the children in the house/kids present in home, and having nowhere else to use,
- Declined to answer (5%).

Intention to use a SCS

- Four out of five (80%) respondents in Sioux Lookout said that they would use SCS if they were available, while 6% said they would not, and 14% were unsure.
- Two out of five (40%) of respondents said that they would use SCS (if they were in a convenient location) on a daily basis, of which 26% of the total respondents said they would go multiple times a day/night. Ten percent said they would go weekly, and 12% said a couple of times per month. Only 4% said they would go less than once per month, and 2% said rarely, and 4% said they would never use SCS.

Reasons that would make the respondent use SCS are displayed in Table 19.

Table 19: Reasons that PWUD respondents would use SCS in Sioux Lookout.

Reasons why would use SCS	Response Rate
I would be using under safer conditions	73.5%
Overdoses can be prevented and treated	61.2%
I would be able to use drugs indoors and not in a public space	55.1%
I would be able to get new, sterile drug use equipment	53.1%
I would be able to use facilities like washrooms, showers and electrical outlets	51.0%
Having a community space that is welcoming/safe/sense of belonging	46.9%
I would be safe from being seen by the police	44.9%
I could dispose of used drug use equipment more safely	44.9%
I would be able to see health professionals/access healthcare (e.g., wound care)	40.8%
Availability and convenience of the services (including hours of operation)	38.8%
I would be able to share my knowledge and skills with peers and professionals	34.7%
I would be safe from potentially threatening people	30.6%
That it is delivered by an agency I trust/receiving care/support from non-judgmental professionals	26.5%
I would be able to get a referral for health or social services	24.5%
If there were peers on site	22.4%
Other: including by using the facility they would be encouraging others to do so, and not using around family	10.2%
Declined	4.1%

Source: NWHU Region PWUD Survey, August 2022

Reasons that would render the respondent to not want to use SCS included those listed in Table 20.

***Table 20*: Reasons PWUD respondents would not want to use SCS in Sioux Lookout.**

Reasons why would not use SCS	Percent
I fear being caught with drugs by police / the possibility of police outside the site	51.4%
I am afraid my name will not remain confidential	42.9%
I do not want to be seen	37.1%
I do not want people to know I use drugs	37.1%
Non-drug using people in the surrounding neighbourhood might harass me	28.6%
I'm worried about losing my kids to child welfare services	28.6%
I would rather use with my friends	25.7%
I already have a place to use drugs	25.7%
I always use alone	20.0%
I'm in too much of a hurry to wait to use the drug consumption room	17.1%
I feel it would not be convenient or have poor service and hours	17.1%
I need to avoid other people that would use the supervised consumption services	14.3%
I feel there are too many rules and restrictions associated with using supervised consumption services	11.4%
I can get new, sterile drug use equipment elsewhere	11.4%
I'm worried about sexual or gender harassment (transphobia) / sexism / misogyny	5.7%
Other: including not wanting to 'fall into another category or fall through the cracks'	2.9%
I do not trust supervised consumption services or the agencies that deliver them	2.9%

Source: NWHU Region PWUD Survey, August 2022

What services PWUD are looking for

PWUD survey respondents identified the following as being most important when considering what services they would value. See Table 21, where rows are placed in descending order of being highly rated in importance.

Table 21: **Most important aspects of SCS for PWUD respondents in Sioux Lookout**

Survey Prompt	Very Important	Important	Somewhat Important	Not Important
Distribution of naloxone/Narcan to PWUD	54.2%	43.8%	2.1%	-
New, sterile drug use equipment distribution	51.1%	46.8%	2.1%	-
HIV and Hepatitis C testing	50.0%	50.0%	-	-
Overdose training for PWUD	48.9%	51.1%	-	-
Assistance with finding housing, employment and basic skills training	45.8%	52.1%	2.1%	-
Referrals to drug treatment, detox, and addiction recovery services	45.8%	52.1%	2.1%	-
Access to other healthcare services	41.7%	56.3%	2.1%	-
Harm reduction counselling	40.4%	48.9%	6.4%	4.3%
Wound care provided on site	39.6%	54.2%	4.2%	-
A place to charge your phone or other electronics	39.6%	47.9%	8.3%	4.2%
Access to washrooms	35.4%	60.4%	4.2%	-
Trained staff present to supervise drug use for safety	34.0%	51.1%	12.8%	2.1%
Access to showers	33.3%	50.0%	12.5%	4.2%
Peer support from other PWUD	33.3%	43.8%	14.6%	8.3%
Access to drugs prescribed by a health professional	32.6%	54.3%	8.7%	4.3%
Available food and beverages	29.8%	63.8%	4.3%	2.1%
Indigenous counsellors present	27.3%	54.5%	13.6%	4.5%
A 'chill out' room to go after drug use	20.8%	62.5%	12.5%	4.2%

Source: NWHU Region PWUD Survey, August 2022

SCS location and design preferences

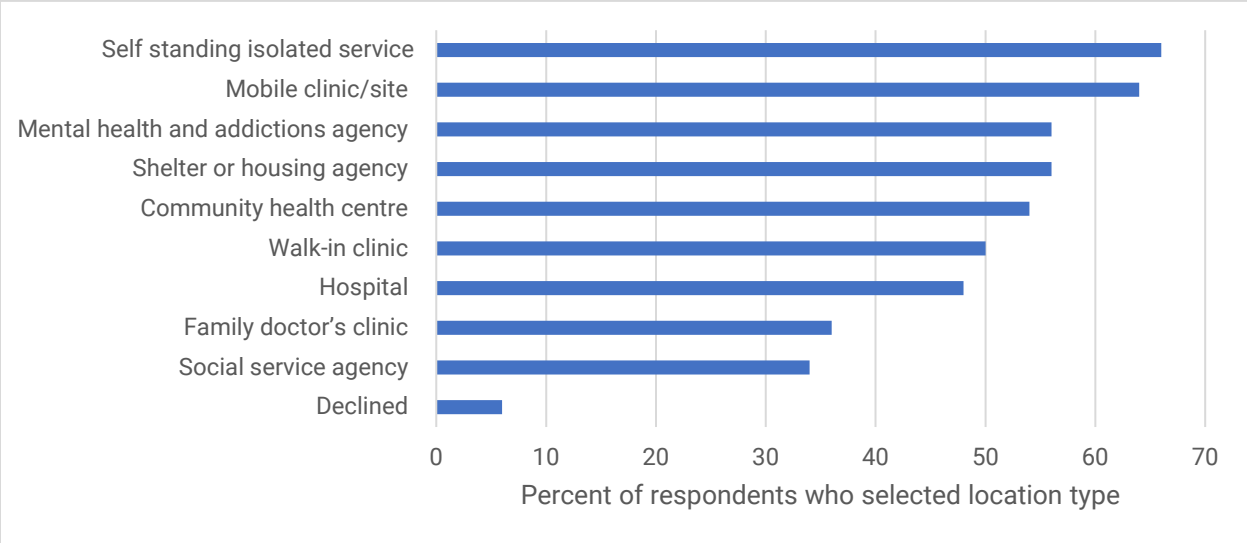
The location may affect the willingness for using a SCS. Below are the percent of respondents that indicated they would use SCS if it was in the following locations. Notably, most (66%) said they would use the service if it was in a self-standing building or if it was part of a mobile clinic/site (64%). Over half (56%) of respondents said that they would use SCS in a mental health and addictions agency, and 56% also said that they would access SCS if in a shelter or housing agency.

When asked what some of the ways are that respondents believed they would use to travel to SCS, 88% said they would walk or use a wheelchair/motorized scooter. Other modes of transportation included bike (32%), taxi (26%), buses (16%), private vehicle (14%), other (6%) and two percent declined.

With regards to what time of day would be most important for services to be offered, 82% said daytime (8am-4pm), 66% said evening (4pm-midnight), 56% said overnight (midnight-8am), and 2% declined to answer.

When shown pictures of different set-up spaces for SCS, 52% selected private cubicles, 40% selected a combination of the elements shown, 8% selected an open plan with table and chairs.

Figure 11: **Willingness of PWUD respondents to use SCS by types of in Sioux Lookout.**



Source: NWHU Region Community Survey, August 2022

Community readiness

Sociodemographic characteristics of community survey respondents

A community survey was implemented for the general public in order to seek community feedback around SCS.

A total of 83 surveys were initiated by individuals who identified as living in Sioux Lookout, with a completion rate of 90% (i.e., 75 fully completed).

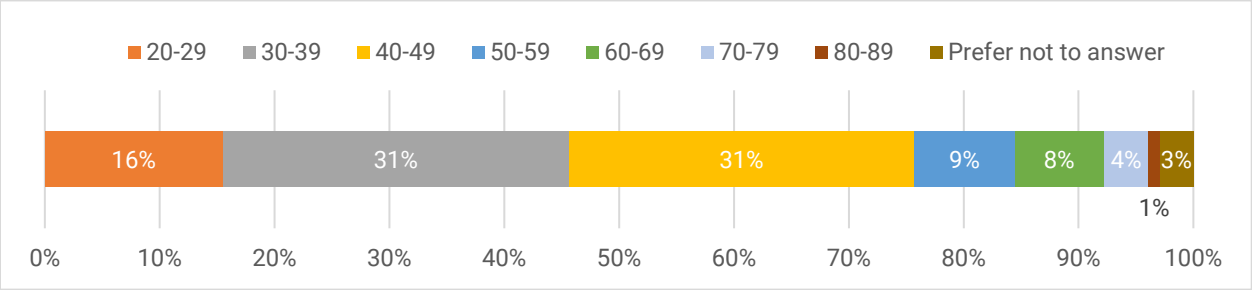
When asked if they identify as First Nations, Inuit or Métis, 76% said no, 15% said yes, and 10% preferred not to say (n=74).

Of the respondents, 31% identified as a staff member at a community agency of service provider and 5% identified as a business owner or operator.

Of those in Sioux Lookout that indicated their gender (n= 75) there was a higher proportion of respondents that identified as women (65%) compared to men (28%), non-binary (1%), prefer to self-describe (1%), and prefer not to answer (4%).

The age distribution for respondents in Sioux Lookout is outlined in Figure 12.

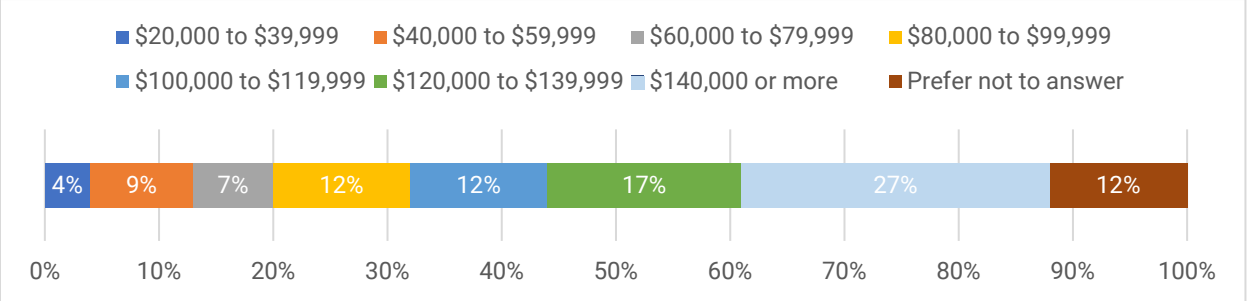
Figure 12: **Age distribution of community survey respondents from Sioux Lookout (n=75).**



Source: NWHU Region Community Survey, August 2022

The income distribution of respondents in Sioux Lookout when asked is illustrated in Figure 13.

Figure 13: **Approximate household income per year of community survey respondents from Sioux Lookout (n=75).**



Source: Nort NWHU Region Community Survey, August 2022

Community perceptions for the need of drug consumption and treatment services

Respondents from Sioux Lookout were generally familiar with what SCS are with 94% indicating 'yes' when asked (n=69).

When asked to indicate level of agreement around several statements about SCS, the following answers, listed in Table 22, were the respective responses from Sioux Lookout.

Table 22: **Level of agreement to SCS statements by community survey respondents in Sioux Lookout**

Survey Prompt	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree	Total Selections
There is a need for drug consumption and treatment services in my community	64.9%	11.7%	3.9%	7.8%	11.7%	77
Supervised consumption services are important in preventing overdose deaths	55.1%	23.1%	5.1%	7.7%	9%	78
I support the development of consumption and treatment services in my community	49.4%	19%	6.3%	10.1%	15.2%	79
Supervised consumption services are important for providing an environment of dignity and safety for drug users	46.8%	20.8%	7.8%	9.1%	15.6%	77
Supervised consumption services help solve problems in the community	37.7%	24.7%	11.7%	10.4%	15.6%	77
Supervised consumption services will decrease public drug use	37.7%	20.8%	11.7%	11.7%	18.2%	77
Supervised consumption services can save taxpayer money by reducing overall health and social services costs	35.9%	24.4%	14.1%	9%	16.7%	78
There are negative consequences of supervised consumption services in communities	17.3%	23.5%	19.8%	28.4%	11.1%	81

Source: NWHU Region Community Survey, August 2022

The majority (77%) of respondents strongly agree or agree that there is a need for drug consumption and treatment services in the community, with 4% who are undecided and 20% who disagree or strongly disagree. Of the statements surveyed, the need for drug consumption and treatment services in the community is one of the statements with the highest level of agreement, along with the statement that SCS are important in preventing overdose deaths (78% strongly agree or agree).

Respondents strongly agree or agree (62%) that SCS help to solve problems in the community and support the development of consumption and treatment services in their community (68% strongly agree or agree).

For all statements that indicated a potential benefit for SCS, the majority were in agreement with 59% or more of respondents indicating that they strongly agree or agree with the statements.

When stating if there are negative consequences of SCS in the community, the survey sample was divided, with 41% who strongly agree or agree, 40% who disagree or strongly disagree, and 20% who were undecided.

Respondents were also asked a series of questions about the possible impacts of SCS on the community. Their responses are outlined in Table 23.

Table 23: **Anticipated likelihoods of community impacts of SCS by community survey respondents in Sioux Lookout.**

Survey Prompt	Very Likely	Likely	Neutral	Unlikely	Very Unlikely	Unsure	Total Selections
Overdoses would be reduced	35.1%	33.8%	10.4%	9.1%	10.4%	1.3%	77
The number of used syringes on the street would be reduced	35.1%	31.2%	5.2%	16.9%	11.7%	0%	77
Injection with used needles would be reduced	32.9%	36.7%	5.1%	11.4%	11.4%	2.5%	79
People would learn about drug treatment	31.2%	33.8%	13%	7.8%	11.7%	2.6%	77
The number of people using drugs outdoors would be reduced	28.2%	30.8%	10.3%	15.4%	14.1%	1.3%	78
Crime would be reduced in the area	16.9%	29.9%	14.3%	15.6%	20.8%	2.6%	77
People who use drugs would use the supervised consumption services	13.9%	38%	19%	10.1%	13.9%	5.1%	79
More people who use drugs would come to the area	11.4%	25.3%	22.8%	22.8%	7.6%	10.1%	79
Drug dealers would be attracted to the area	10.4%	16.9%	16.9%	31.2%	10.4%	14.3%	77
The supervised consumption services would be accepted by the broader community	2.6%	20.5%	12.8%	38.5%	23.1%	2.6%	78

Source: NWHU Region Community Survey, August 2022

Responses to whether or not a SCS site would be accepted by the broader community in Sioux Lookout demonstrate that there is not a lot of confidence that the broad community would be accepting. The majority (62%) found this unlikely or very unlikely, and 13% were neutral. The perception that PWUD would use SCS was accepted by just over half of respondents with 52% finding this very likely or likely, and there was almost as many who were neutral (19%) as those who believed uptake would be unlikely or very unlikely (24%).

Overall, respondents found across all the statements that the proposed benefits would be more likely/very likely than not, including with the statement that crime rate would be reduced with 47% finding this likely/very likely compared to 36% who found this unlikely/very unlikely.

It does warrant some consideration however on how to ensure community concerns are addressed with regards to respondents either finding likely or very likely the statement that SCS could attract more PWUD to the area (45% very likely/likely) as well as drug dealers (48% very likely/likely).

With regards to statements around more PWUD coming to the area and drug dealers being attracted to the area, responses were a bit more spread out; with the highest level of uncertainty across the statements falling in those categories (10% and 14% respectively). Slightly more found the statement of more PWUD coming to the area likely/very likely (37%), and the opposite was true

for finding the statement that more drug dealers would be attracted to the area with 42% finding this unlikely/very unlikely.

Sioux Lookout Key Informant Findings

All key informants from Sioux Lookout acknowledged that drug use is a growing problem, especially over the past ten years. There has been an increasing number of those using opioids, with the use of crystal meth on the rise more recently. Injection drug use has become visible with people using in public and the number of discarded needles being found in the community is also increasing. The broader community in Sioux Lookout is becoming distressed about the drug use in the community and the safety issues that discarded needles present.

While drug use was seen by key informants as a significant concern, alcohol remains the dominant drug of choice with alcohol related harms being cited more often than illicit drugs. With this said, key informants recognized that drug use is likely to increase further over time, anticipating to see this particularly among the younger population.

Key informants shared that there is a lack of available addiction and support services, as well as a lack of harm reduction services for PWUD. Many PWUD do not have a safe place to use and often end up using outdoors and in public spaces. Current mental health and addiction services can be siloed and there is a need for an overarching plan to address addictions. While initiatives like needle distribution, access to naloxone kits, mobile outreach and wound care are helpful and beneficial, there is a need for more supportive services like a RAAM (Rapid Access to Addictions Medications) clinic, detox beds, and treatment services. The shortage of services results in individuals needing to leave the community to seek care elsewhere.

PWUD are heavily stigmatized in Sioux Lookout and in the surrounding Indigenous communities according to key informants. Likewise, harm reduction services also face scrutiny and distrust, especially amongst those who think that harm reduction practices enable people to use more drugs, and in First Nations communities where some view the suboxone initiatives as a failure. Key informants shared that community approaches have focused more on abstinence-based and crime prevention approaches, versus harm reduction services and addressing the underlying drivers of addiction. All key informants point to the effects of colonialism and historical trauma leading to addiction, particularly among Indigenous peoples, with high unemployment rates and poverty playing influencing roles in drug use.

Some key informants shared support for having SCS and that combining them with harm reduction alcohol consumption programming would be beneficial (i.e., managed alcohol program). They thought that these services/programs should be part of an overarching plan for the future, but SCS could be helpful to reduce harm and connect PWUD to vital health and supportive services. One key informant suggested the benefits of creating an addictions centre where SCS, treatment services, health care, mental health services and more could be housed in one central location.

Key informants shared that there is likely a lot of support for SCS from many in the broader community, with pushback potentially from some leaders, business owners, and Indigenous communities that are abstinence focused. They cited many other health and service providers who would support SCS and potentially be willing to coordinate services. Key informants stated that there is a need for lead agencies and funding to get this kind of initiative started. They shared that Sioux Lookout is a small community with a downtown that has many accessible services within

walking distance. This is why the downtown was thought to be the best location for SCS. The following were locations key informants suggested where SCS could be located:

- Front Street location as many of the organizations listed below are noted for having various distance barriers for PWUD dependent on how far they are away from natural gathering spaces for PWUD downtown,
- Consideration for any of the vacant commercial properties,
- Out of the Cold Shelter,
- Northwestern Health Unit site,
- Sioux Lookout First Nation Health Authority,
- Meno Ya Win Health Centre,
- Old Mayfair Theatre.

Finally, key informants in Sioux Lookout spoke about the importance of doing public education around harm reduction, what it is, the benefits, how it works, etc. in order to dispel myths and build support for how it can benefit both PWUD and the broader community.

Recommendations regarding the needs assessment of SCS in Sioux Lookout

Considering the key findings of the needs assessment, the following next steps are recommended. To support these recommended actions, community-specific datasets of results outlined in the report (e.g., PWUD Survey) may be made available upon request for further SCS development purposes.

1. ***The rates of substance use harms in Sioux Lookout are significant enough to indicate a need for greater harm reduction and treatment services and the addition of SCS are recommended as a means to reduce the risk of harm, overdose, and overdose deaths among PWUD.*** Sioux Lookout experiences higher rates of harm in relation to substance use, including overdose deaths which are higher across the NWHU catchment area than the provincial rates. Public health and community data illustrate a clear need for additional strategies and resources to decrease death and harms of substance use. ER visits related to substance use are higher than both NWHU and provincial rates, whereas rates for ER visits related to opioid overdose are lower than the NWHU catchment area but higher than rates for Ontario. While HIV incident rates are also higher in Sioux Lookout than across the NWHU catchment area and provincially, it is particularly alarming that the Hepatitis C incidence (per 100,000) in Sioux Lookout is 58.2% higher that for the NWHU catchment area and 173.9% higher than the provincial rate.

   There is strong intention among PWUD surveyed from Sioux Lookout that they would use SCS and would value them for numerous reasons, including the most frequently selected reason of using drugs under safer conditions. Additionally, key informants interviewed support the introduction of these services and the potential associated benefits to PWUD and the broader community. Given that alcohol use is a significant concern in Sioux Lookout, it is recommended that alcohol harm reduction practices be either integrated with other SCS services or developed in parallel to meet needs of those using alcohol.

2. ***Health, social and/or mental health service providers, including Indigenous service providers, in Sioux Lookout may be best positioned to lead future development planning of SCS as the local professionals on harm reduction.*** SCS should be shaped around the needs of local PWUD and alcohol (PWUDA), with the primary objectives of service provision being to reduce harms to users. PWUDA should be engaged to inform any development and ongoing implementation of services to ensure they are responsive. Should development planning of SCS be pursued in Sioux Lookout, lead health, social and/or mental health service providers should determine and complete the following, while consulting with other providers in Sioux Lookout:
    I. Agreement on a service model(s). A downtown SCS site is recommended given the proximity to other support services for PWUD. This location may help to meet the needs of those PWUD within the surrounding neighbourhoods. A mobile or hybrid model could be considered, allowing for greater outreach to those living further away from the downtown and immediate surrounding area. Lead health, social and/or mental health service providers should work with Indigenous service providers and communities to ensure that SCS are inclusive and responsive to the cultural needs of Indigenous community members.
    II. Given the limited number of available services for PWUD in Sioux Lookout, it will be extremely important to consider how SCS are integrated within the current system and how all service providers utilize SCS to support their service users. Therefore, it should be determined what the scope of harm reduction, health and social services should be delivered with, or linked to the SCS, and whether any specific Health Canada exemptions (e.g., for smoking or assisted-injected) are necessary. For instance, more than half of PWUD survey respondents indicated they have needed help from someone to inject in the past year. Smoking is also the second most common method of drug consumption among PWUD respondents in Sioux Lookout.
    III. Resources required and the necessary roles of the agencies involved for the development of SCS, including physical capital, human resources and partnerships.
    IV. The Sioux Lookout lead(s) should apply to Health Canada for a Section 56.1 Exemption for Medical Purposes under the Controlled Drugs and Substances Act for Activities at a Supervised Consumption Site. The application includes details about policies and procedures, personnel/staffing structure, a community consultation report, and a financial plan, which all will have been completed in the development of SCS.
    V. The Sioux Lookout lead(s) should strongly consider applying to the Ontario Ministry of Health for funding through the Consumption and Treatment Services (CTS) funding program. Other sources of funding, such as municipal, philanthropic, or private may also need to be considered. An organization can forego a funding application to Ontario Ministry of Health if they have secured an alternative source of funding. There are a number of organizations in Ontario who have taken this approach.

3. ***Implementation plans need to be developed alongside of engagement with key stakeholder groups such as municipal governments, emergency services, Indigenous partners, and the broader community.*** SCS will not provide a 'magic bullet' to solve all drug-related concerns in Sioux Lookout. Discussions regarding 'what are the realistic outcomes of SCS in our community?' will be important to have with results communicated widely, in order to manage expectations of the SCS. Implementation plans should consider how SCS could impact the broad community (social, economic, safety, and services), and risk-mitigation strategies for any

anticipated challenges. It is recommended that these be shared and explained with various stakeholders and the broader community.

4. ***Any SCS developed in Sioux Lookout needs to be positioned within the larger community level approach to mental health and addiction services, integrating them into the local treatment and service network.*** Sioux Lookout's Healthy Community Task Force and the Community Safety and Well-being Plan which could help oversee this. Specific considerations of the needs of PWUD from Sioux Lookout, community collaboration, geography, and existing and future harm reduction initiatives should all be considered. While a SCS/harm reduction approach tailored to Sioux Lookout is recommended, it is also recommended that regular communication with other northwestern communities regarding lessons learned, best practices, challenges, and tools will help to strengthen respective plans, reduce duplication, and amplify impact.

5. ***Educational activities for the public and partners, regarding SCS is highly recommended alongside any SCS development. Raising awareness among and working alongside of community leaders in Sioux Lookout will be critical to understanding community concerns, as well as help SCS to succeed and be sustainable. Stakeholders and the general public should be comprehensively informed of the research evidence of the impacts of SCS. Transparent and accurate information on SCS will ensure that decision makers understand the benefits and can mitigate any potential challenges.*** These educational activities should also aim to increase awareness and empathy regarding addiction in general and reduce stigma associated with PWUD. Notably 'Fear of being caught with drugs by police/the possibility of police outside the site' was the top reason cited that would stop PWUD from using SCS. Results from the community survey in Sioux Lookout showed mixed support for SCS among various stakeholder groups. While in the community survey there was majority support from Sioux Lookout respondents for the development of consumption and treatment services and agreement with the benefits that they provide, responses were less optimistic specifically about the broader community being accepting of SCS. Key informants spoke about current frustrations and tensions in broader community and how this could impact SCS implementation. The need for specific awareness, education and training activities tailored to the context of each stakeholder group will be important.

6. ***Evaluation plans for any implemented SCS need to be developed to define, measure and report on the outcomes for transparency, reporting and improvement.*** Evaluation plans should be able to assess client uptake and community impact and be aligned with the goal outcomes of the community's mental health, addiction and harm reduction strategies. Evaluation plans will be important in measuring the key impacts of SCS, which can then be communicated to stakeholders to illustrate the benefits and gains to the community and focus on improving where weaker results are being seen.

7b. Fort Frances

Demographics

With a population of 7,466 (2021 census data) the town of Fort Frances stretches over a geographical area of 25.55 km^2. The population density is 292.2 people per km^2. The average age of the population is 44.6 years old (2021 census data). Fort Frances is located in the District of Rainy River. See Appendix C:2. for a map of Fort Frances.

Mortality and morbidity information

Mortality and morbidity data from provincial and regional sources demonstrates that the town of Fort Frances is exhibiting a higher rate of substance-related emergency visits compared to the rest of Ontario, and a disproportionate rate of opioid-overdose related ER visits compared to both the NWHU catchment area and the province. Hepatitis C rates in Fort Frances are also much higher than those of Ontario. While each indicator is outlined in greater detail below, the findings are summarized in Table 24 in relation to the NWHU catchment area and across Ontario.

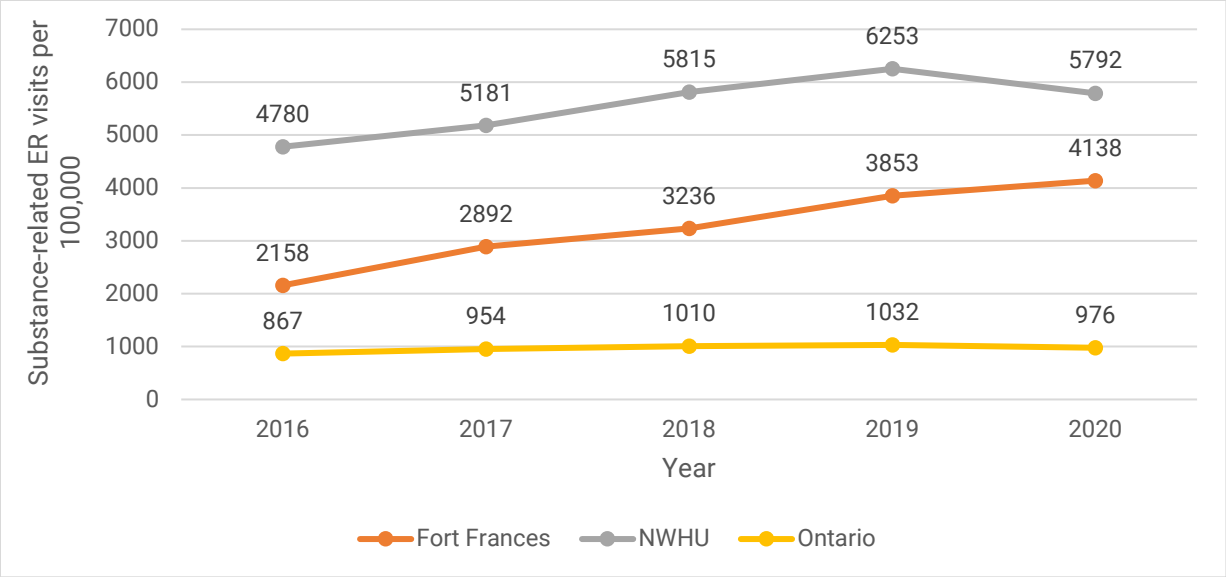
Table 24: Summary of indicators demonstrating evidence of drug related harms in Fort Frances in comparison to the NWHU catchment area and Ontario.

Morbidity/mortality indicator	How does this indicator for the town of Fort Frances compare to that of the NWHU catchment area?	How does this indicator for the town of Fort Frances compare to that of Ontario?
ER visits related to substance-related reasons ***(per 100,000 per year by local health hub 2016-2020)***	Rates in Fort Frances have been **lower** than across NWHU for each year between 2016 to 2020.	Rates in Fort Frances have been **higher** than across Ontario for each year between 2016 to 2020.
ER visits related to opioid overdose ***(per 100,000 overall by local health hub for 2016-2020)***	Rates in Fort Frances have been **higher** than across NWHU for the overall time-period between 2016 to 2020.	Rates in Fort Frances have been **much higher** than the rates across Ontario for the overall time-period between 2016 to 2020.
Hepatitis C incidence ***(per 100,000 per year by local health hub 2016-2021)***	Rates in Fort Frances have been **similar** to NWHU for each of the three-year time-periods captured (between 2016-2018 and 2019-2021).	Rates in Fort Frances have been **much higher** than across Ontario for each of the three-year time-periods captured (between 2016-2018 and 2019-2021).
HIV incidence ***(per 100,000 per year by local health hub 2012-2021)***	Rates in Fort Frances have been **lower** than across NWHU for the overall time-period captured (between 2012-2021).	Rates in Fort Frances have been **lower** than across Ontario for the overall time-period captured (between 2012-2021).
Proxy Indicator		
Naloxone kit distribution counts	Naloxone kit distribution **did not** reflect the same increasing trends as were seen across NWHU catchment area between the years of 2018-2021.	Naloxone kit distribution **did not** reflect the same increasing trends as were seen across Ontario region between the years of 2018-2021.

Indicator: Substance-related ER visits

Between the years of 2016 to 2020, there was a lower rate of substance-related ER visits for Fort Frances than across the NWHU catchment area, both of which are higher than provincial rates. The five-year average of Fort Frances is 52.4% lower than the NWHU catchment area and 108.3% higher than the rest of Ontario.

Figure 14: ER visits from 2016-2020 related to substance-related reasons per 100,000 per year for Fort Frances, NWHU Catchment area, and Ontario.

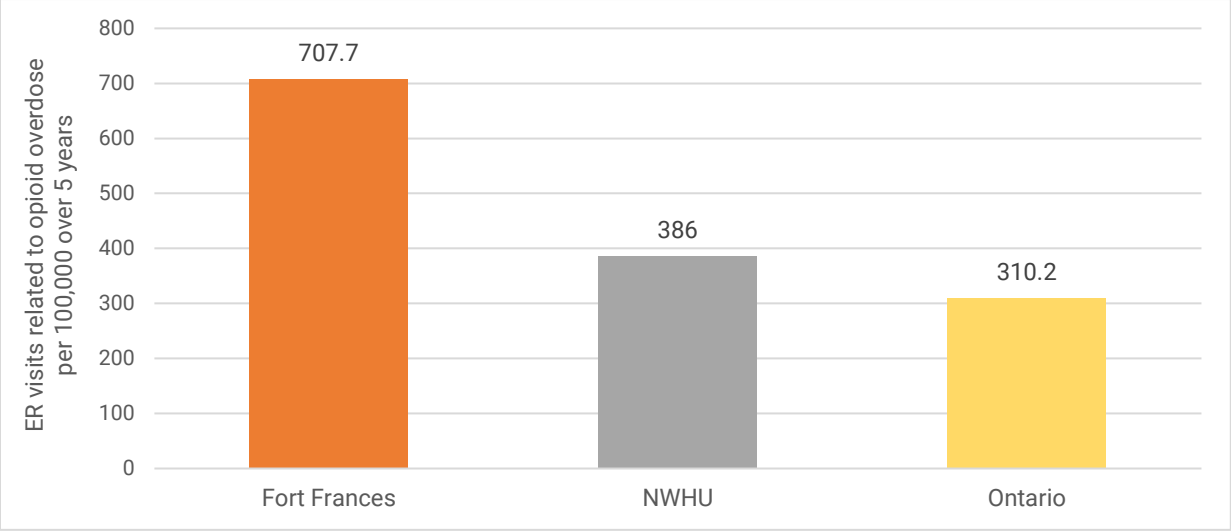


Source: Ambulatory Visits [2016 - 2020]. Ministry of Health and Long Term Care. IntelliHEALTH Ontario. Date Extracted: May 12, 2022

Indicator: Opioid-overdose related ER visits

When looking specifically at opioid-overdose related ER visits, rates in Fort Frances are 58.8% higher than the NWHU catchment area and 78.1% higher than the provincial average.

Figure 15: **Total ER visits from 2016-2020 related to opioid overdose per 100,000 for Fort Frances, NWHU catchment area and Ontario.**



Source: Ambulatory Visits [2016-2020]. Ministry of Health and Long-Term Care. IntelliHEALTH Ontario. Date Extracted: May 12, 2022

Indicator: Hepatitis C

In the latest three-year period (2019-2021), the incidence rate per 100,000 of Hepatitis C in Fort Frances is similar to the NWHU catchment area, however, both rates are much higher than those across Ontario (155.6% and 154.8% respectively). Incidence rates of Hepatitis C in Fort Frances have decreased by 1.5% from one three-year period (2016-2018) to the next three-year period (2019-2021). Comparatively, rates also decreased between each of the three-year periods for the NWHU catchment area (4.2%) and Ontario (30.1%).

Table 25: **Hepatitis C incidence per 100,000 for three-year time periods between 2016-2021 for Fort Frances, NWHU catchment area and Ontario.**

Years	Fort Frances	NWHU	Ontario
2016-2018	196.0	197.6	34.5
2019-2021	193.1	189.4	24.1
Change from 2016-2018 to 2019-2021:	*1.5 % decrease*	*4.2% decrease*	*30.1% decrease*

Source: iPHIS. Date Extracted: May 17, 2022

Indicator: HIV

Rates of HIV incidence per 100,000 averaged over the past 10 years in Fort Frances are 12.5% lower than those across the NWHU catchment area and 36.4% lower than HIV incidence across Ontario.

Table 26: **HIV incidence per 100,000, 10-year average from 2012-2021 for Fort Frances, NWHU catchment area and Ontario.**

Years	Fort Frances	NWHU	Ontario
2012-2021	3.5	4.0	5.5

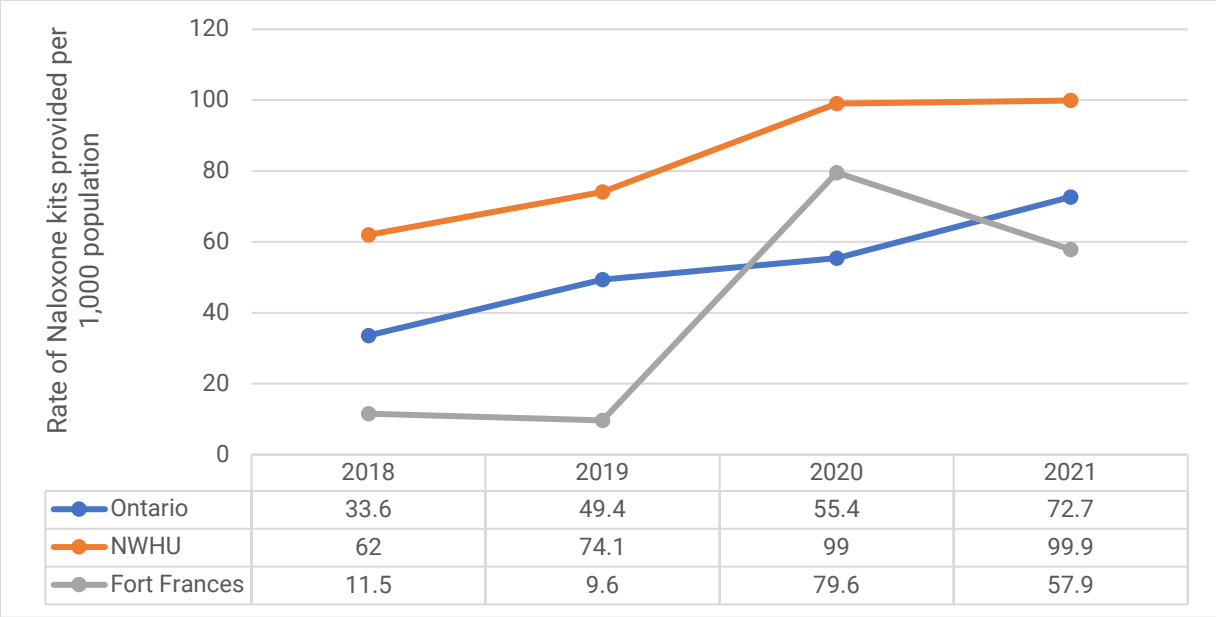
Source: iPHIS. Date Extracted: May 17, 2022

Proxy indicator: naloxone distribution

Rates of naloxone kit distribution has increased every year for the NWHU catchment area, with only a slight increase from 2020 to 2021. In Fort Frances, rates of naloxone kit distribution increased sharply in 2020.

It should be noted that the source of information at the regional and provincial level were different than the source for the city-level data. There could be differences in how counts are recorded, and NWHU and Ontario data encompasses both community and pharmacy distributed counts.

Figure 16: **Rates per 1,000 of naloxone kit distribution from 2018-2021 for Fort Frances, NWHU catchment area, and Ontario.**



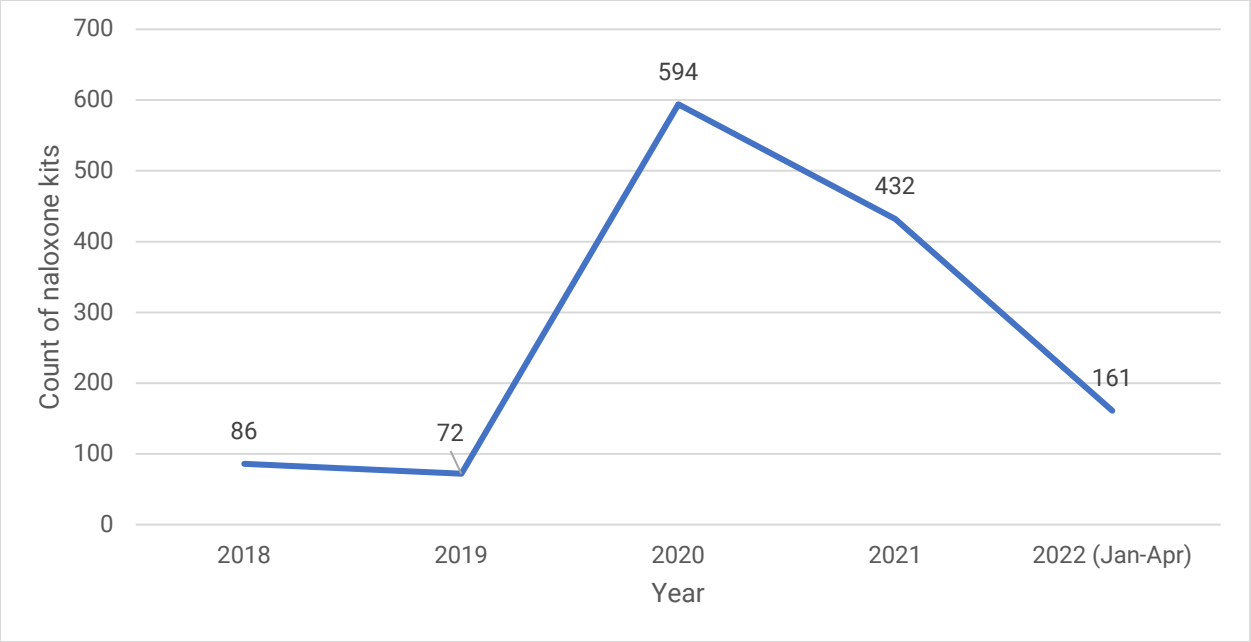
	2018	2019	2020	2021
Ontario	33.6	49.4	55.4	72.7
NWHU	62	74.1	99	99.9
Fort Frances	11.5	9.6	79.6	57.9

Source: Data provided from the Northwestern Health Unit (Fort Frances data series) and accessed from the ODPRN Ontario Opioid Data Tool (NWHU catchment area and Ontario data series)

When looking at the counts of naloxone distribution in Fort Frances in Figure 17, it is notable that the count of distributed kits for the year 2022 between Jan-April was 161, which may indicate a continued downward trend from 2020 onward.

Looking at data from the PWUD survey (discussed in greater detail in next section), 74% (n=49) of survey respondents in Fort Frances identified having been trained to administer naloxone, 69% (n=49) have administered naloxone to someone, and 70% (n=50) have a take-home naloxone kit to keep for an opioid overdose.

Figure 17: Naloxone kit distribution count by year from 2018-2022 for Fort Frances.



Source: Data provided by the Northwestern Health Unit

Demographics and preferences of people who use drugs

The in-person survey of PWUD was conducted throughout August 2022 at sites across the four northwestern Ontario municipalities. A total of 271 participants completed all or a portion of the survey. All participants had used drugs within the previous six months prior to the survey, were at least 18 years of age, spent on average at least seven days a month in the community where the survey took place.

Of the 271 participants, 50 (18%) were completed in Fort Frances. Of the 50 respondents, 94% indicated Fort Frances as a place they consider to be their hometown or home community.

The following information is specific to those 50 respondents that completed the PWUD survey in Fort Frances.

A higher proportion (55%) of respondents from Fort Frances were women, while 45% were men, and 2% identified as 2-Spirited.

A majority (70%) of respondents from Fort Frances identified as First Nation, in addition to 2% identified as Métis. Twenty eight percent indicated that they were neither First Nation, Inuit and/or Métis.

Of the survey respondents, 72% reported spending multiple nights per month in the last year in a house or apartment. Thirty eight percent spent several nights per month at no fixed address and 34% reported sleeping in a shelter/transitional housing. Thirty percent (30%) of answers included hotel/motel room and 24% reported sleeping on the street multiple nights per month in the last year (including abandoned buildings, cars, parks). Other answers included prison/detention centre (12%),

hospital/rehab/medical facility (12%), a place where people gather to do drugs (8%) and other (12%) which included family centre, camper, detox facility, and tent (2).

Drug use patterns and related behaviors

In the past year, the most frequently used drugs were crystal meth (76%), opioids (70%), cocaine powder (60%), crack (58%), methadone or suboxone (58%), tranquilizers or benzodiazepines (30%) or other (12%), including marijuana, fentanyl, hydromorphone, and mushrooms. Six percent declined to answer.

- The most common method of drug use was by smoking (78%), injection (62%), snorting (30%), swallowing (22%), and other (2%).
- 50% said that someone else had prepared their drugs for them in the last year (n=50).
- 47% said that they had at some point in the last year shared drug use equipment such as needles, cookers, or pipes (n=49).
- 64% indicated that they had at some point in the last year gotten new drug use equipment from a friend, dealer, or someone on the street (n=50).
- 48% said in the past year, it occurred that they had not been able to find new drug use equipment when it was wanted (n=50).

Injecting-specific behaviours that respondents identified doing at any point in the last year:

- 84% have injected alone (n=32),
- 50% had help from someone to inject (n=32),
- 93.8% reused their own injecting equipment (n=32),
- 42% shared or reused someone else's injecting equipment (n=31),
- 18% used water from a puddle, public fountain, or other outside source to prepare drugs or rinse needles (n=32),
- 94% exchanged or obtained needles at a harm reduction program (n=32),
- 9% experienced a harm reduction program limiting the number of needles they could be given (n=32).

Using drugs in public spaces

- Location of drug use in the past year included:
    - Indoor residences (e.g., your own place, a relative's, a friend's or a stranger's place or a hotel or motel) (86%),
    - Outdoor public spaces (e.g., an abandoned building, a parking lot, or a park) (65%),
    - Indoor public spaces (e.g., in a stairwell/doorway/washroom of a store, coffee shop, public bathroom, office, or other building) (45%),
    - A shelter (27%),
    - A community-based organization or service provider (other than a shelter) (18%),
    - Other (2%), including outside not public.

With the most common location among respondents for drug use being in public, the top reasons for using drugs outside included:

- It's convenient to where I hang out (67%),
- It's where I am when I decide to use (46%),
- I'm homeless and don't have a place to use (41%),
- I need to use immediately after getting drugs (e.g., experiencing withdrawal) (28%),
- I'm too far from home (21%),
- There is nowhere to use safely where I buy drugs (15%),
- I don't want the person I am staying with to know I use/am still using (10%),
- I need assistance from others to use (8%),
- Dealing/middleing (connecting sellers to purchasers) / steering (guiding potential buyers to selling) (8%),
- Guest fees at friend's place, but I don't want to pay/share (5%),
- Other (5%) – included: when was sick, and when couldn't find anywhere else to go,
- I prefer to be outside (3%),
- Declined to answer (3%).

Intention to use a SCS

- Three out of four (77%) respondents in Fort Frances said that they would use SCS if they were available, while 9% said they would not, 13% were unsure, and 2% declined to answer (n=47).
- Almost half (43%) of respondents said that they would use SCS (if they were in a convenient location) on a daily basis, of which 16% of the total respondents said they would use SCS multiple times a day/night. One in four (27%) said they would go weekly, and 10% said a couple of times per month. Only 4% said they would go less than once per month, and 6% said rarely. Six percent said they would never use SCS, and 4% declined to answer (n=49).

Reasons that would make the respondent use SCS are displayed in Table 27.

Table 27: **Reasons that PWUD respondents would use SCS in Fort Frances.**

Reasons why would use SCS	Response Rate
I would be using under safer conditions	58.3%
Overdoses can be prevented and treated	56.3%
I would be able to get new, sterile drug use equipment	56.3%
Having a community space that is welcoming/safe/sense of belonging	54.2%
I would be safe from being seen by the police	45.8%
I would be safe from potentially threatening people	43.8%
I would be able to use drugs indoors and not in a public space	43.8%
I could dispose of used drug use equipment more safely	43.8%
That it is delivered by an agency I trust/receiving care/support from non-judgmental professionals	35.4%
I would be able to see health professionals/access healthcare (e.g., wound care)	35.4%
I would be able to share my knowledge and skills with peers and professionals	31.3%
Availability and convenience of the services (including hours of operation)	31.3%
I would be able to use facilities like washrooms, showers and electrical outlets	29.2%
I would be able to get a referral for health or social services	29.2%
If there were peers on site	27.1%
Other: curiosity, no judgement, safer when trying new drugs, test drugs	8.3%
Declined	4.2%

Source: NWHU Region PWUD Survey, August 2022

Reasons that would render the respondent to not want to use SCS included those listed in Table 28.

Table 28: **Reasons PWUD respondents would not want to use SCS in Fort Frances.**

Reasons why would not use SCS	Response Rate
I do not want to be seen	43.2%
Other: None identified (4), "not relevant to their type of use", conflicts with others who use, too far to walk, cleanliness of the site, outstanding warrant, stigma/judgement	31.8%
I am afraid my name will not remain confidential	29.5%
I fear being caught with drugs by police / the possibility of police outside the site	27.3%
I do not want people to know I use drugs	27.3%
I need to avoid other people that would use the supervised consumption services	18.2%
I feel it would not be convenient or have poor service and hours	15.9%
Non-drug using people in the surrounding neighbourhood might harass me	13.6%
I can get new, sterile drug use equipment elsewhere	13.6%
I'm worried about losing my kids to child welfare services	9.1%
I would rather use with my friends	9.1%
I already have a place to use drugs	9.1%
I'm in too much of a hurry to wait to use the drug consumption room	6.8%
I always use alone	6.8%
I feel there are too many rules and restrictions associated with using supervised consumption services	4.5%
I'm worried about sexual or gender harassment (transphobia) / sexism / misogyny	2.3%
I don't know enough about supervised consumption services	2.3%
I do not trust supervised consumption services or the agencies that deliver them	2.3%

Source: NWHU Region PWUD Survey, August 2022

What services PWUD are looking for

PWUD survey respondents identified the following as being most important when considering what services they would value. See Table 29, where rows are placed in descending order of being highly rated in importance.

Table 29: Most important aspects of SCS for PWUD respondents in Fort Frances.

Survey Prompt	Very Important	Important	Somewhat Important	Not Important
New, sterile drug use equipment distribution	80.0%	18.0%	2.0%	-
Distribution of naloxone/Narcan to people who use drugs	68.0%	30.0%	-	2.0%
Referrals to drug treatment, detox, and addiction recovery services	64.0%	36.0%	-	-
Wound care provided on site	62.0%	36.0%	2.0%	-
Overdose training for people who use drugs	62.0%	32.0%	2.0%	4.0%
Trained staff present to supervise drug use for safety	59.2%	36.7%	4.1%	-
HIV and Hepatitis C testing	58.3%	35.4%	6.3%	-
Harm reduction counselling	50.0%	43.8%	4.2%	2.1%
Access to washrooms	46.0%	48.0%	4.0%	2.0%
Assistance with finding housing, employment and basic skills training	44.9%	36.7%	18.4%	-
Access to other healthcare services	44.7%	38.3%	14.9%	2.1%
Access to showers	43.8%	39.6%	14.6%	2.1%
Indigenous counsellors present	42.6%	36.2%	14.9%	6.4%
Access to drugs prescribed by a health professional	42.0%	42.0%	14.0%	2.0%
Peer support from other people who use drugs	33.3%	52.1%	8.3%	6.3%
Available food and beverages	32.7%	44.9%	18.4%	4.1%
A 'chill out' room to go after drug use	30.6%	49.0%	8.2%	12.2%
A place to charge your phone or other electronics	20.0%	58.0%	12.0%	10.0%

Source: NWHU Region PWUD Survey, August 2022

SCS location and design preferences

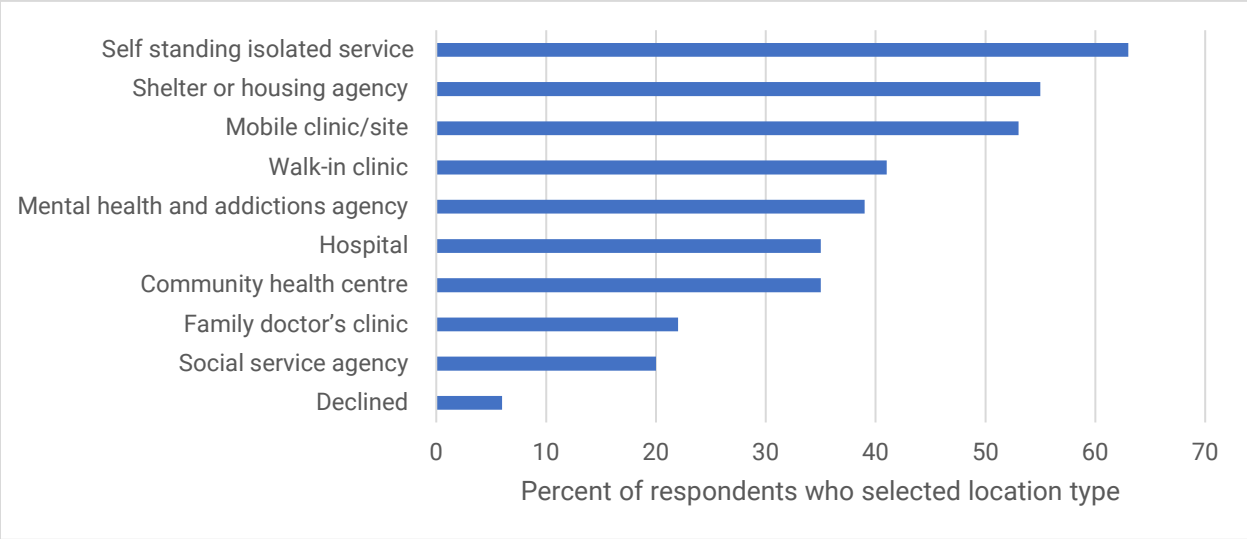
The location may affect the willingness for using the SCS. Below are the percent of respondents that indicated they would use the SCS if it was in the following locations. Notably, most (63%) said they would use the service if it was in a self-standing building. Fifty five percent said that they would use SCS in a shelter or housing agency, and 53% said they would use SCS as part of a mobile clinic/site.

When asked what some of the ways are that respondents believed they would use to travel to SCS, 82% said they would walk or use a wheelchair/motorized scooter. Other modes of transportation included bike (33%), private vehicle (22%), taxi (22%), other (6%) and 2% declined.

With regards to what time of day would be most important for services to be offered, 71% said daytime (8am-4pm), 82% said evening (4pm-midnight), 67% said overnight (midnight-8am), and 2% declined to answer.

When shown pictures of different set-up spaces for SCS, 65% selected private cubicles, 18% selected a combination of the elements shown, 10% selected an open plan with table and chairs. 2% selected other, and 4% declined to answer.

Figure 18: **Willingness of PWUD respondents to use SCS by types of in Fort Frances.**



Source: NWHU Region PWUD Survey, August 2022

Community readiness

Sociodemographic characteristics of community survey respondents

A community survey was implemented for the general public in order to seek community feedback around SCS.

A total of 168 surveys were initiated by individuals who identify as living in Fort Frances, with a completion rate of 82% (i.e., 138 surveys were fully completed).

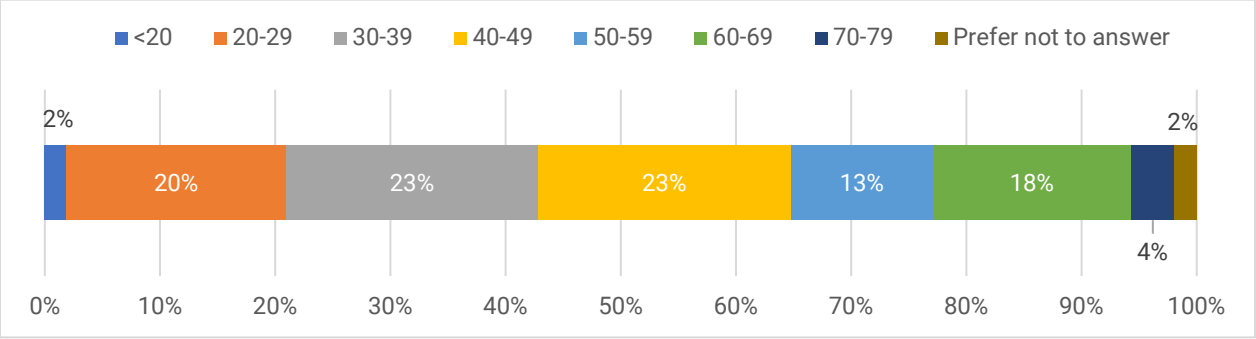
When asked if they identified as First Nations, Inuit or Métis, 65% said no, 26% said yes, and 10% preferred not to say (n=133).

Of the respondents, 20% identified as a staff member at a community agency of service provider and 4% identified as a business owner or operator (n=168).

Of the Fort Frances respondents that indicated their gender (n= 133) there was a higher proportion of respondents that identified as women (71%) compared to men (20%), non-binary (2%), agender (1%), prefer to self-describe (1%), and prefer not to answer (5%).

The age distribution for respondents in Fort Frances is outlined in Figure 19.

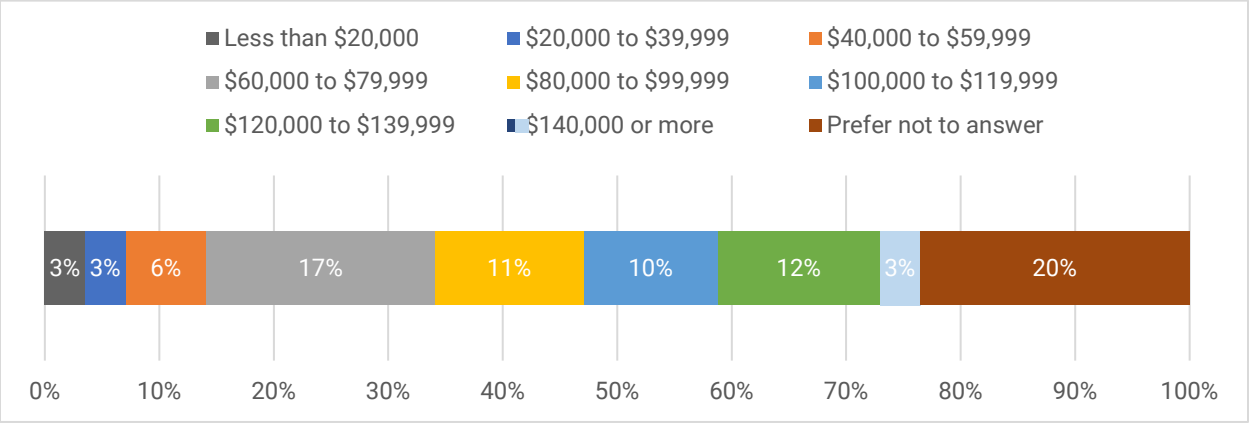
Figure 19: Age distribution of community survey respondents from Fort Frances (n=133).



Source: NWHU Region Community Survey, August 2022

The income distribution of respondents in Fort Frances when asked approximate household income per year is illustrated in Figure 20.

***Figure 20:* Approximate household income per year of community survey respondents from Fort Frances (n=133).**



Source: NWHU Region Community Survey, August 2022

Community perceptions for the need of drug consumption and treatment services

Respondents from Fort Frances were generally familiar with what SCS are with 89% indicating 'yes' when asked.

When asked to indicate level of agreement around several statements about SCS, the following answers, listed in Table 30, were the respective selections of respondents from Fort Frances.

Table 30: **Level of agreement to SCS statements by community survey respondents in Fort Frances.**

Survey Prompt	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree	Total Selections
There is a need for drug consumption and treatment services in my community	48.3%	19.3%	5.5%	8.3%	18.6%	145
Supervised consumption services are important in preventing overdose deaths	43.1%	18.8%	9%	14.6%	14.6%	144
I support the development of consumption and treatment services in my community	41.7%	16.7%	10.4%	9.7%	21.5%	144
Supervised consumption services are important for providing an environment of dignity and safety for drug users	28.9%	23.2%	9.9%	16.9%	21.1%	142
Supervised consumption services can save taxpayer money by reducing overall health and social services costs	26.4%	22.2%	16.7%	14.6%	20.1%	144
Supervised consumption services help solve problems in the community	25.7%	18.1%	17.4%	13.9%	25%	144
There are negative consequences of supervised consumption services in communities	22.2%	25%	27.8%	17.4%	7.6%	144
Supervised consumption services will decrease public drug use	18.9%	18.9%	13.3%	21%	28%	143

Source: NWHU Region Community Survey, August 2022

A majority (68%) strongly agree or agree that there is a need for drug consumption and treatment services in the community, with 6% who are undecided and 27% who disagree or strongly disagree. Of the statements surveyed, the need for drug consumption and treatment services in the community is the one with the highest level of agreement, followed by the statement that SCS are important in preventing deaths (62% strongly agree or agree).

A majority (58%) are also supportive of the development of consumption and treatment services in the community, and 52% of respondents strongly agree or agree that SCS are important for providing an environment of dignity and safety for drug users. There are also more respondents (49%) that strongly agree or agree with the benefit of potential tax savings from SCS through the social and health benefits they provide to the community versus 35% who disagree or strongly disagree, and 17% who are undecided.

Not everyone agrees about the benefit of SCS reducing public drug use, with more respondents (49%) that disagree or strongly disagree with the statement. Notably, 13% were undecided.

More respondents (47%) strongly agree or agree that SCS have negative consequences in communities, with roughly a quarter (28%) of respondents who were undecided and the remaining quarter (25%) that disagree or strongly disagree.

Respondents were also asked a series of questions about the possible impacts of SCS on the community. Their responses are outlined in Table 31.

Table 31: **Anticipated likelihoods of community impacts of SCS by community survey respondents in Fort Frances.**

Survey Prompt	Very Likely	Likely	Neutral	Unlikely	Very Unlikely	Unsure	Total Selections
Overdoses would be reduced	32%	22.4%	8.2%	16.3%	18.4%	2.7%	147
The number of used syringes on the street would be reduced	23.4%	26.2%	6.9%	23.4%	18.6%	1.4%	145
People would learn about drug treatment	22.9%	35.4%	8.3%	16.7%	13.2%	3.5%	144
More people who use drugs would come to the area	21.9%	15.1%	25.3%	23.3%	7.5%	6.8%	146
Injection with used needles would be reduced	21.5%	25%	13.2%	19.4%	18.8%	2.1%	144
Drug dealers would be attracted to the area	19.2%	17.8%	26%	23.3%	8.2%	5.5%	146
The number of people using drugs outdoors would be reduced	17.4%	25%	11.1%	24.3%	20.1%	2.1%	144
People who use drugs would use the supervised consumption services	11%	31.5%	19.9%	15.1%	18.5%	4.1%	146
Crime would be reduced in the area	6.3%	16.7%	14.6%	21.5%	35.4%	5.6%	144
The supervised consumption services would be accepted by the broader community	2.1%	11.2%	19.6%	25.2%	38.5%	3.5%	143

Source: NWHU Region Community Survey, August 2022

Responses to whether or not a SCS site would be accepted by the broader community in Fort Frances demonstrate that there may be more work that will be needed in order to gain the acceptance of community members, with only 13% indicating that this would be likely or very likely and 64% finding this unlikely or very unlikely. The perception that PWUD would use SCS was accepted by almost half of the respondents with 43% finding this likely or very likely. This aligns to respondent perspectives of those who indicated in the PWUD survey, in that most persons who used drugs responding to the survey have intent to use SCS if they were provided.

There was polarity around statements that suggest the number of people using drugs outdoors would be reduced, with 42% finding this likely or very likely, and 44% finding this unlikely or very unlikely. A similar polarity, with few unsure (1%) is observed around the likeliness of SCS reducing the number of used syringes on the streets, with 50% finding this likely or very likely, and 42% finding this unlikely or very unlikely.

Overall, with proposed benefits to the community around lowering injections with used needles, and more opportunities for people to learn about drug treatment, and the reduction of overdoses, the majority seem to find these outcomes either likely or very likely.

When it came to statements around potential negative impacts, a significant portion of respondents indicated being neutral around the subject, with 25% neutral about the statement that SCS could attract more PWUD to the area, and the statement of SCS attracting more drug dealers (26% neutral). For both of those statements, groups who either felt it was likely or very likely or unlikely or very unlikely were similar in terms of number of respondents selecting on either side being around 30%.

Fort Frances Key Informant Findings

Key informants from Fort Frances said that drug use is a significant problem in their community, with overdoses rising and hitting high levels recently. They stated that there is an opioid crisis in Fort Frances with high levels of fentanyl and heroine usage. Increases in demand for emergency, health and police services related to drugs and alcohol use are occurring and the number of drug-related deaths has increased. A contaminated drug supply and distance from services were cited anecdotally as contributing factors for why PWUD are dying.

Key informants identified that housing insecurity and homelessness, in addition to a shelter that is only open seasonally, is leading to people living in tents and using drugs in public. They explained that homelessness may be the greatest factor influencing drug use. They believe that PWUD are also suffering from hopelessness and marginalization. There are concerns that an unsafe drug supply is coming over the neighbouring border to Fort France from the United States, as well as from Winnipeg. Key informants also explained that there is victimization of PWUD. For example, human trafficking is occurring, where women with addictions are being exploited.

Key informants suggested that stigma is a problem for PWUD in Fort Frances. It makes things difficult for those who wish to access services, for they fear that they will be judged and treated differently. They also shared that stigma is a significant problem for PWUD living in neighbouring communities. This has led to many leaving their communities and moving to the town.

According to key informants, some in the broader community are frustrated and angry, especially with the large number of discarded needles left in the community. Conversely, they shared that some in the community do not believe there is a crisis. The key informants shared that with deaths

related to overdoses occurring in the community, discarded needles being found in numerous places and the number of those who are homeless in Fort Frances, the issues around substance use are very public and plain to see.

Key informants spoke about the benefits of current support services available, including the RAAM clinic, mental health crisis workers, the Ontario Addiction Treatment Centre, the detox facility, and the needle distribution program among others, but they do not meet the growing needs of the opioid crisis. Existing services are hard for PWUD to access according to key informants, whether it be the number of barriers before accessing services (e.g., long wait times, forms, extent of information collected, need to have a health card, etc.) or the rules that need to be followed once they are accessing the services. For instance, there is a safe beds program, but those who are actively using drugs cannot access it. Another service does not provide support to those in crisis, limiting access to those who need the service most. Another barrier cited was the large geographic region around Fort Frances where people have to travel up to 1-2.5 hours to access services.

Key informants stated that there is currently no safe place for people to use drugs or get harm reduction support while using. The Family Centre was cited as being a place where PWUD can seek shelter and gather with others, however several key informants shared concerns about the lack of safety and supervision from trained professionals. Several key informants referred to issues with the justice system releasing individuals from jail or custody and because there are no services available to support these folks, they end of relapsing and often becoming homeless again. They shared that there are a number of services that are needed including safe testing for existing drugs, a shelter, safe supply programs, more detox beds, counselling, primary care, housing, and food among others.

When it comes to the potential role of SCS in Fort Frances, key informants all felt that there is a significant need, and a number of potential benefits from these harm reduction services. They also think that SCS would be frequently used by many PWUD. They saw SCS as being able to save lives, increase general safety, connect users with other services, reduce burden on emergency and health care services, reduce stigma, decrease communicable diseases, reduce discarded needles, and reduce trauma among other benefits. With all of this said, they explained that these services would need to be fully accessible, 24 hours a day, 7 days a week and be staffed by the 'right' people who can build relationships and trust with the clientele.

Key informants pointed to the location of SCS being extremely important to ensure it is central, accessible, but also maintains anonymity and confidentiality. While a central downtown location makes a lot of sense, there needs to be consideration of how to support those who live far from Fort Frances. Mobile services were suggested to be a potential way of reaching the surrounding communities. The following is a list of potential locations for SCS according to the key informants:

- Near other services (e.g., safe bed program, hospital, counselling support, RAAM clinic)
- Downtown on a side street off of Scott Street
- Nelson House
- The Family Centre
- Northwest Health Unit site
- Canadian Mental Health Association
- Mobile services

There is a lot of tension within the broader community regarding drug use and key informants say that there is a need for education and empathy. The need for education about addiction and harm reduction is not limited to the broader public, but also for all organizations and helping professionals (e.g., healthcare professionals, mental health workers, etc.). With SCS potentially being seen as a way that encourages people to use drugs, education would not only help reduce the stigma that exists for PWUD, but it will also raise awareness and support for SCS in Fort Frances.

Recommendations regarding the needs assessment of SCS in Fort Frances

Considering the key findings of the needs assessment, the following next steps are recommended. To support these recommended actions, community-specific datasets of results outlined in the report (e.g., PWUD survey) may be made available upon request for further SCS development purposes.

1. ***The rates of substance use harms in Fort Frances are significant enough to indicate a need for greater harm reduction and treatment services and the addition of SCS are recommended as a means to reduce the risk of harm, overdose, and overdose deaths among PWUD.*** Fort Frances experiences higher rates of harm in relation to substance use, including a higher rate of substance-related emergency visits compared to the rest of Ontario, and a disproportionate rate of opioid-overdose related ER visits compared to both the NWHU catchment area and the province (opioid overdose related ER visits are more than double rates for Ontario). Public health and community data illustrate a clear need for additional strategies and resources to decrease death and harms of substance use. There is intention among PWUD surveyed to utilise SCS. The top reason PWUD surveyed in Fort Frances said they would value SCS for was to use under safer conditions. Additionally, key informants interviewed support the introduction of these services and the potential associated benefits to PWUD and the broader community.

2. ***Health, social and/or mental health service providers, including Indigenous service providers, in Fort Frances may be best positioned to lead future development planning of SCS as the local professionals on harm reduction.*** SCS should be shaped around the needs of local PWUD, with the primary objectives of service provision being to reduce harms to users. PWUD should be engaged to inform any development and ongoing implementation of services to ensure they are responsive. Should development planning of SCS be pursued in Fort Francis, lead health, social and/or mental health service providers should determine and complete the following, while consulting with other providers in Fort Frances.

    I. Agreement on a service model(s). A central, downtown SCS site is recommended and may help to meet the needs of those PWUD within the surrounding neighbourhoods. A mobile or hybrid model could be considered, allowing for greater outreach to those living further away from the downtown and immediate surrounding area. Lead health, social and/or mental health service providers should work with Indigenous service providers and communities to ensure that SCS services are inclusive and responsive to the cultural needs of Indigenous community members.
    II. Given the limited capacity of current services and stated barriers to accessing services for PWUD, it will be extremely important to consider how SCS are integrated within the current system and how all service providers utilize SCS to support their service users.

Additionally, it will be important for the network of service providers to discuss ways of increasing accessibility to supports for PWUD and their challenges with addiction and relapse. Therefore, it should be determined what the scope of harm reduction, health and social services that will be delivered with, or linked to the SCS, and whether any specific Health Canada exemptions (e.g., for smoking or assisted-injected) are necessary. In Fort Frances, smoking was cited as the most common method of drug consumption.

III. Resources required and the necessary roles of the agencies involved for the development of SCS, including physical capital, human resources and partnerships.
IV. The Fort Frances lead(s) should apply to Health Canada for a Section 56.1 Exemption for Medical Purposes under the Controlled Drugs and Substances Act for Activities at a Supervised Consumption Site. The application includes details about policies and procedures, personnel/staffing structure, a community consultation report, and a financial plan, which all will have been completed in the development of SCS.
V. The Fort Frances lead(s) should strongly consider applying to the Ontario Ministry of Health for funding through the Consumption and Treatment Services (CTS) funding program. Other sources of funding, such as municipal, philanthropic, or private may also need to be considered. An organization can forego a funding application to Ontario Ministry of Health if they have secured an alternative source of funding. There are a number of organizations in Ontario who have taken this approach.

3. ***Implementation plans need to be developed alongside of engagement with key stakeholder groups such as municipal governments, emergency services, Indigenous partners, and the broader community.*** SCS will not provide a 'magic bullet' to solve all drug-related concerns in Fort Frances. Discussions regarding 'what are the realistic outcomes of SCS in our community?' will be important to have with results communicated widely, in order to manage expectations of the SCS. Implementation plans should consider how SCS could impact the broad community (social, economic, safety, and services), and risk-mitigation strategies for any anticipated challenges. It is recommended that these be shared and explained with various stakeholders and the broader community.

4. ***Any SCS developed in Fort France needs to be positioned within the larger community level approach to mental health and addiction services, integrating them into the local treatment and service network.*** Specific considerations of the needs of PWUD from Fort Frances, community collaboration, geography, and existing and future harm reduction initiatives should all be considered. While a SCS/harm reduction approach tailored to Fort Frances is recommended, it is also recommended that regular communication with other northwestern Ontario communities regarding lessons learned, best practices, challenges, and tools will help to strengthen respective plans, reduce duplication, and amplify impact.

5. ***Educational activities for the public and partners, regarding SCS is highly recommended alongside any SCS development. Raising awareness among and working alongside of community leaders in Fort Frances will be critical to understanding community concerns, as well as help SCS to succeed and be sustainable. Stakeholders and the general public should be comprehensively informed of the research evidence of the impacts of SCS. Transparent and accurate information on SCS will ensure that decision makers understand the benefits and can mitigate any potential challenges.*** These educational activities should also aim to increase awareness and empathy regarding addiction in general, and reduce stigma associated with PWUD. Results from the community survey in Fort Frances showed a majority of support for supervised consumption and treatment services among various stakeholder groups. However, there was not consensus around the benefits of SCS and there was very little agreement around the likelihood of the community accepting SCS. Key informants spoke about current frustrations and tensions in the broader community and how this could impact SCS implementation. The need for specific awareness, education and training activities tailored to the context of each stakeholder group will be important.

6. ***Evaluation plans for any implemented SCS need to be developed to define, measure and report on the outcomes for transparency, reporting and improvement.*** Evaluation plans should be able to assess client uptake and community impact and be aligned with the goal outcomes of the community's mental health, addiction and harm reduction strategies. Evaluation plans will be important in measuring the key impacts of SCS, which can then be communicated to stakeholders to illustrate the benefits and gains to the community and focus on improving where weaker results are being seen.

7c. Dryden

Demographics

With a population of 7,388 (2021 census data) the city of Dryden stretches over a geographical area of 65.58 km2. The population density is 112.7 people per km^2. The average age of the population is 45.4 years old (2021 census data). Dryden is located in the District of Kenora. See Appendix C:3. For a map of Dryden.

Mortality and morbidity information

Mortality and morbidity data from provincial and regional sources demonstrates that Dryden is exhibiting higher rates of substance-related emergency visits compared to the rest of Ontario, and Hepatitis C rates that are much higher than those of Ontario. While most indicators are showing slightly lower than those of the NWHU catchment area, rates for HIV incidence are higher, but still lower than the provincial rates. While each indicator is outlined in greater detail below, the findings are summarized in Table 32 in relation to the NWHU catchment area and across Ontario.

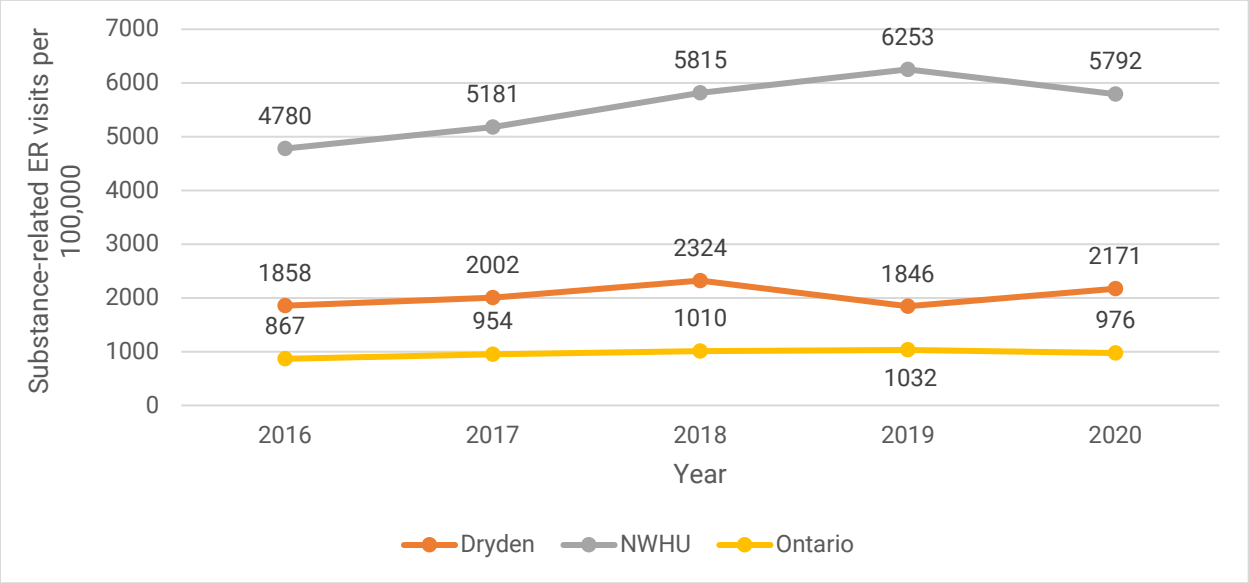
Table 32: **Summary of indicators demonstrating evidence of drug related harms in Dryden in comparison to across the NWHU catchment area and Ontario.**

Morbidity/mortality indicator	How does this indicator for the city of Dryden compare to that of the NWHU catchment area?	How does this indicator for the city of Dryden compare to that of Ontario?
ER visits related to substance-related reasons ***(per 100,000 per year by local health hub 2016-2020)***	Rates in Dryden have been **lower** than across NWHU for each year between 2016 to 2020.	Rates in Dryden have been **higher** than across Ontario for each year between 2016 to 2020.
ER visits related to opioid overdose ***(per 100,000 overall by local health hub for 2016-2020)***	Rates in Dryden have been **lower** than across NWHU for the overall time-period between 2016 to 2020.	Rates in Dryden have been **similar** to Ontario for the overall time-period between 2016 to 2020.
Hepatitis C incidence ***(per 100,000 per year by local health hub 2016-2021)***	Rates in Dryden have been **lower** than across NWHU for each of the three-year time-periods captured (between 2016-2018 and 2019-2021).	Rates in Dryden have been **much higher** than across Ontario for each of the three-year time-periods captured (between 2016-2018 and 2019-2021).
HIV incidence ***(per 100,000 per year by local health hub 2012-2021)***	Rates in Dryden have been **similar** to NWHU for the overall time-period captured (between 2012-2021).	Rates in Dryden have been **lower** than across Ontario for the overall time-period captured (between 2012-2021).
Proxy Indicator		
Naloxone kit distribution counts	Naloxone kit distribution somewhat reflected the same **increasing trends** as were seen across NWHU catchment area between the years of 2018-2021, however, with a sharper increase by more than doubling counts in Dryden year over year in most years, with the year 2021 as an exception.	Naloxone kit distribution somewhat reflected the same **increasing trends** as were seen in Ontario between the years of 2018-2021, however, with a sharper increase in Dryden.

Indicator: Substance-related ER visits

Between the years of 2016 to 2020, there was a lower rate of substance-related ER visits for Dryden than across the NWHU catchment area, both of which are higher than provincial rates. The five-year average of Dryden is 92.7% lower than the NWHU catchment area and 71.3% higher than the rest of Ontario.

Figure 21: **ER visits from 2016-2020 related to substance-related reasons per 100,000 per year for Dryden, NWHU catchment area and Ontario.**

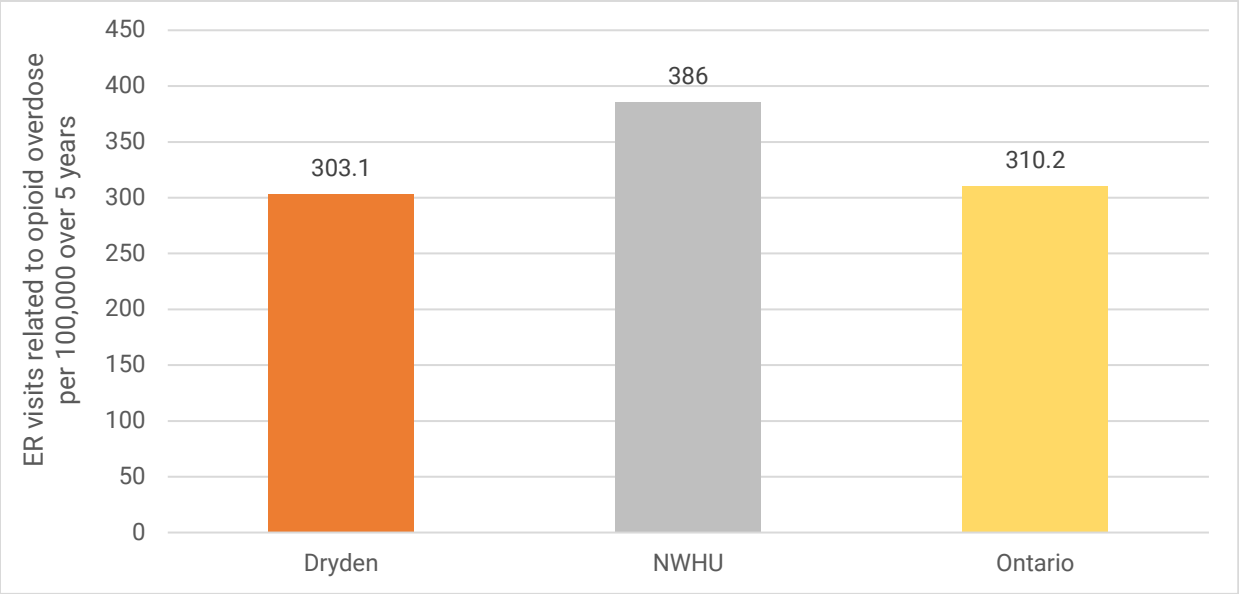


Source: Ambulatory Visits [2016 – 2020]. Ministry of Health and Long Term Care. IntelliHEALTH Ontario. Date Extracted: May 12, 2022

Indicator: Opioid-overdose related ER visits

When looking specifically at opioid-overdose related ER visits, rates in Dryden are 24.1% lower than the NWHU catchment area and 2.3% lower than the provincial average.

Figure 22: Total ER visits from 2016-2020 related to opioid overdose per 100,000 for Dryden, NWHU catchment area and Ontario.



Source: Ambulatory Visits [2016-2020]. Ministry of Health and Long-Term Care. IntelliHEALTH Ontario. Date Extracted: May 12, 2022.

Indicator: Hepatitis C

In the latest three-year period (2019-2021), the incidence rate per 100,000 of Hepatitis C in Dryden is 44.5% lower than the rate across the NWHU catchment area, however, is 133.3% higher than the incidence rate across Ontario. Rates of Hepatitis C incidence per year in Dryden have decreased by 2% from one three-year period (2016-2018) to the next three-year period (2019-2021). Comparatively, rates decreased between each of the three-year periods for the NWHU catchment area (4.2%) and Ontario (30.1%).

Table 33: Hepatitis C incidence per 100,000 for three-year time periods between 2016-2021 for Dryden, NWHU catchment area and Ontario.

Years	Dryden	NWHU	Ontario
2016-2018	123	197.6	34.5
2019-2021	120.5	189.4	24.1
Change from 2016-2018 to 2019-2021:	*2.0 % decrease*	*4.2% decrease*	*30.1% decrease*

Source: iPHIS. Date Extracted: May 17, 2022

Indicator: HIV

Rates of HIV incidence per 100,000 averaged over the past 10 years in Dryden are 7.5% higher than those across the NWHU catchment area and 21.8% lower than HIV incidence across Ontario.

Table 34: **HIV incidence per 100,000, 10-year average from 2012-2021 for Dryden, NWHU catchment area and Ontario.**

Years	Dryden	NWHU	Ontario
2012-2021	4.3	4.0	5.5

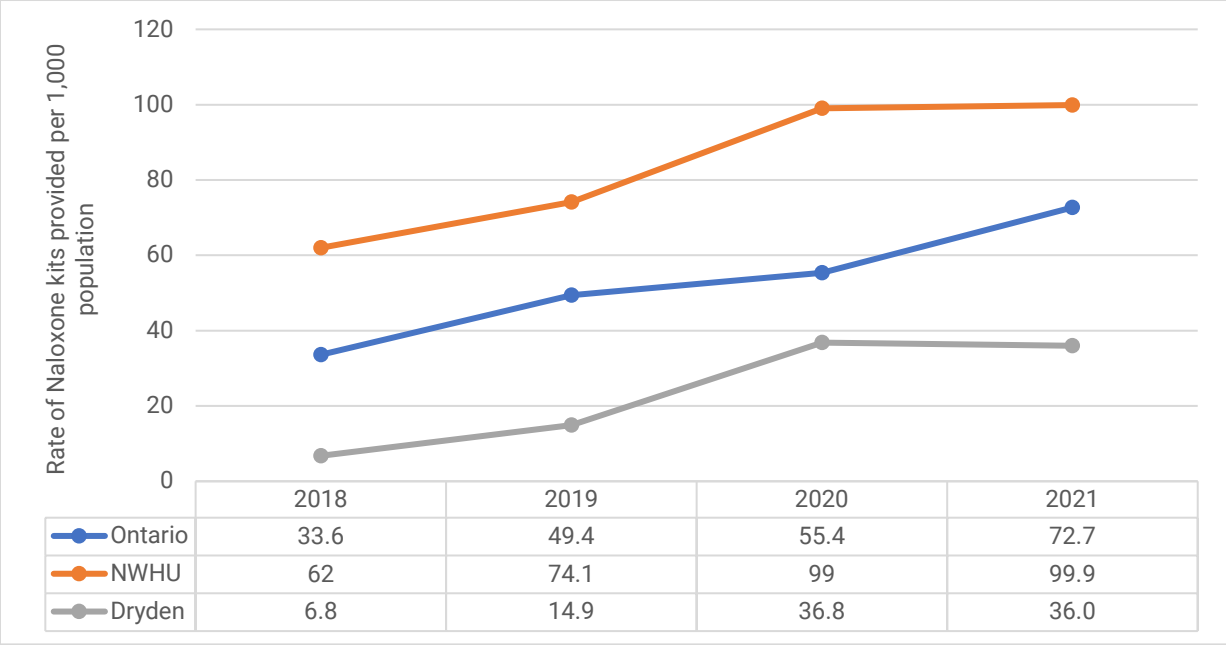
Source: iPHIS. Date Extracted: May 17, 2022

Proxy indicator: naloxone distribution

Rates of naloxone kit distribution has increased every year for the NWHU catchment area, with only a slight increase from 2020 to 2021. In Dryden, naloxone kit distribution has also increased, more than doubling the previous year's total from one year to the next between 2018 to 2020.

It should be noted that the source of information at the regional and provincial level were different than the source for the city-level data. There could be differences in how counts are recorded, and NWHU and Ontario data encompasses both community and pharmacy distributed counts.

Figure 23: **Rates per 1,000 of naloxone kit distribution from 2018-2021 for Dryden, NWHU catchment area, and Ontario.**



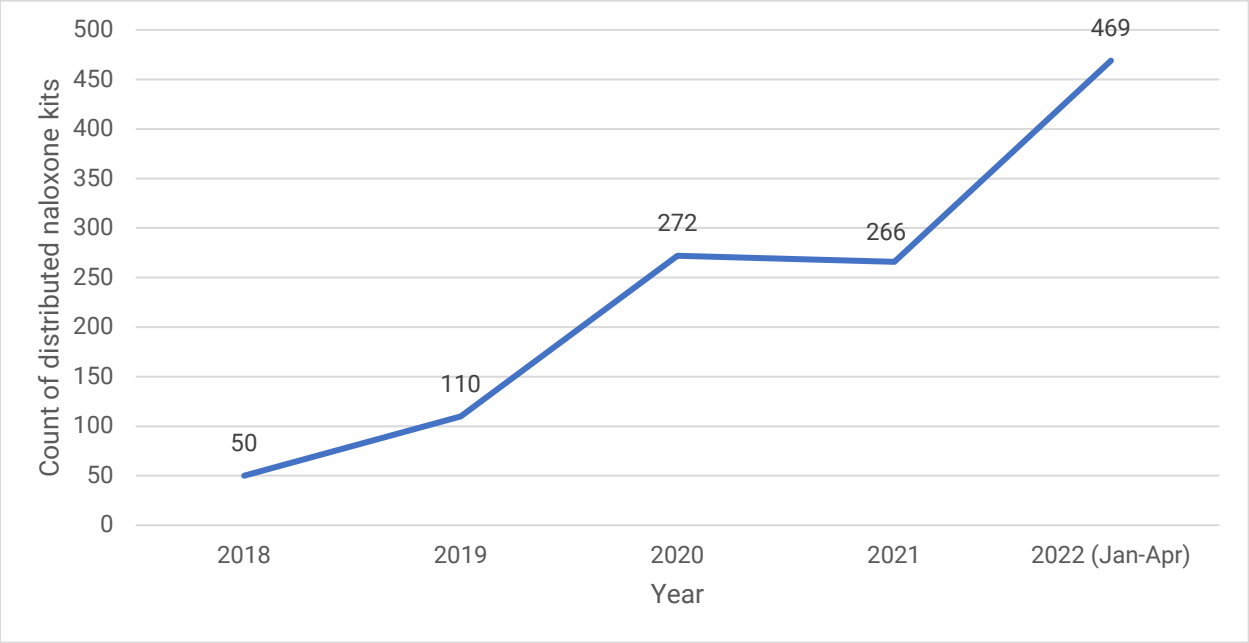
	2018	2019	2020	2021
Ontario	33.6	49.4	55.4	72.7
NWHU	62	74.1	99	99.9
Dryden	6.8	14.9	36.8	36.0

Source: Data provided from the Northwestern Health Unit (Dryden data series) and accessed from the ODPRN Ontario Opioid Data Tool (NWHU catchment area and Ontario data series)

When looking at the counts of naloxone distribution in Dryden in Figure 24, it is notable that the count of distributed kits for the year 2022 between just Jan-April have surpassed the totals for the previous years, with 469 kits distributed already.

Looking at data from the PWUD survey (discussed in greater detail in next section), 61% (n=70) of survey respondents in Dryden identified having been trained to administer naloxone, 41% (n=70) have administered naloxone to someone, and 54% (n=70) have a take-home naloxone kit to keep for an opioid overdose.

Figure 24: **Naloxone kit distribution count by year from 2018-2022 for Dryden.**



Source: Data provided by the Northwestern Health Unit

Demographics and preferences of people who use drugs

The in-person survey of PWUD was conducted throughout August 2022 at sites across the four northwestern Ontario municipalities. A total of 271 participants completed all or a portion of the survey. All participants had used drugs within the previous six months prior to the survey, were at least 18 years of age, and spent on average at least seven days a month in the community where the survey took place.

Of the 271 participants, 70 (26%) were completed in Dryden. Of the 70 respondents, 74% indicated Dryden as a place they consider to be their hometown or home community.

The following information is specific to those 70 respondents that completed the PWUD survey in Dryden.

A higher proportion (61%) of respondents (n=69) from Dryden were women, while 39% were men.

A majority (64%) of respondents from Dryden identified as First Nation, in addition to 15% who identified as Métis. Twenty three percent indicated that they were neither First Nation, Inuit and/or Métis.

Of the survey respondents, 82% reported spending multiple nights per month in the last year in a house or apartment. Twenty two percent reported sleeping on the street multiple nights per month in the last year (including abandoned buildings, cars, parks). Other answers included hotel/motel room (22%), no fixed address (18%), shelter/transitional housing (7%), hospital/rehab/medical facility (6%), prison/detention centre (4%), a place where people gather to do drugs (3%), and other (7%) which included outdoors, hostel/lodge at hospital, in a tent, and skywalk.

Drug use patterns and related behaviors

In the past year, the most frequently used drugs were opioids (67%), crystal meth (60%), methadone or suboxone (50%), cocaine powder (47%), crack (36%), tranquilizers or benzodiazepines (17%) or other (20%) which included marijuana, acid, alcohol, 'all on card', Percocet, psychedelics, and 'whatever is out there', and 1.4% declined to answer.

- The most common method of drug use was by injection (64%), smoking (59%), snorting (35%), swallowing (30%), and other (e.g., sublingual) (1%).
- 49% said that someone else had prepared their drugs for them in the last year (n=69).
- 36% said that they had at some point in the last year shared drug use equipment such as needles, cookers, or pipes (n=69).
- 63% indicated that they had at some point in the last year gotten new drug use equipment from a friend, dealer, or someone on the street (n=69).
- 54% said in the past year, it occurred that they had not been able to find new drug use equipment when it was wanted (n=69).

Injecting-specific behaviours that respondents identified doing at any point in the last year:

- 80% have injected alone (n=44),
- 67% had help from someone to inject (n=45),
- 75% reused their own injecting equipment (n=44),
- 13% shared or reused someone else's injecting equipment (n=45),
- 40% used water from a puddle, public fountain, or other outside source to prepare drugs or rinse needles (n=45),
- 91% exchanged or obtained needles at a harm reduction program (n=45),
- 24% experienced a harm reduction program limiting the number of needles they could be given (n=45).

Using drugs in public spaces

- Location of drug use in the past year included:
    - Indoor residences (e.g., your own place, a relative's, a friend's or a stranger's place or a hotel or motel) (96%),
    - Indoor public spaces (e.g., in a stairwell/doorway/washroom of a store, coffee shop, public bathroom, office, or other building) (49%)
    - Outdoor public spaces (e.g., an abandoned building, a parking lot, or a park) (46%),
    - A shelter (7%),
    - A community-based organization or service provider (other than a shelter) (7%),
    - Other (13%), including OATC, alley, car, hospital, hotel, private outdoors, waterfront.

With the most common location among respondents for drug use being in public, the top reasons for using drugs outside included:

- It's convenient to where I hang out (39%),
- I need to use immediately after getting drugs (e.g., experiencing withdrawal) (34%),
- It's where I am when I decide to use (27%),
- I'm homeless and don't have a place to use (22%),
- Other (22%) – included: nowhere else to go, lack of caring where they use drugs, really needed to/felt like it, offered in public under the influence of alcohol, residence too far, withdrawal, and sharps container present,
- There is nowhere to use safely where I buy drugs (20%),
- I'm too far from home (15%),
- I don't want the person I am staying with to know I use/am still using (7%),
- I prefer to be outside (5%),
- I need assistance from others to use (2%),
- Guest fees at friend's place, but I don't want to pay/share (2%),
- Dealing/middleing (connecting sellers to purchasers) / steering (guiding potential buyers to selling) (2%).

Intention to use a SCS

- Sixty eight percent of respondents (n=69) in Dryden said that they would use SCS if they were available, while 12% said they would not, 19% were unsure and 1% declined to answer.
- Thirty seven percent of respondents (n=65) said that they would use SCS (if they were in a convenient location) on a daily basis, of which 8% of the total respondents said they would go multiple times a day/night. More than one in four (29%) said they would go weekly, and 12% said a couple of times per month. Only 3% said they would go less than once per month, 6% said rarely, and 3% said they would never use SCS, with 2% who declined to answer.

Reasons that would make the respondent use SCS are displayed in Table 35.

Table 35: Reasons that PWUD respondents would use SCS in Dryden.

Reasons why would use SCS	Response Rate
Having a community space that is welcoming/safe/sense of belonging	40.6%
I would be using under safer conditions	39.1%
Other – included: not sure, safety/safe from others/safe place to go/safe space supervision/safe space to get help, fewer needles in the community, clean, discrete, safe space, food/beverages, not using at home in front of kids, harm reduction, having a place to go, if not able to get home, it's there/available, fewer overdoses and cleaner space, never thought of it, only if starting injections, overdose prevention, takes burden off emergency responders	31.9%
Overdoses can be prevented and treated	30.4%
I would be able to get new, sterile drug use equipment	29.0%
I would be safe from potentially threatening people	23.2%
I would be able to see health professionals / access healthcare (e.g., wound care)	18.8%
I could dispose of used drug use equipment more safely	18.8%
I would be able to use drugs indoors and not in a public space	15.9%
Availability and convenience of the services (including hours of operation)	11.6%
I would be able to get a referral for health or social services	10.1%
I would be able to share my knowledge and skills with peers and professionals	8.7%
I would be safe from being seen by the police	7.2%
I would be able to use facilities like washrooms, showers and electrical outlets	5.8%
That it is delivered by an agency I trust/receiving care/support from non-judgmental professionals	5.8%
If there were peers on site	4.3%
Declined	1.4%

Source: NWHU Region PWUD Survey, August 2022

Reasons that would render the respondent to not want to use SCS included those listed in Table 36.

Table 36: Reasons PWUD respondents would not want to use SCS in Dryden.

Reasons why would not use SCS	Response Rate
Other: Answers ranged along the themes of needing to build trust (2), not wanting to be videotaped (3) or need for privacy (2), being on OATC, trying to go to treatment, worry about police (2), no reason (6), no answer (1), fear of judgement/being uncomfortable around others (11), fear of seeing someone OD, legal conditions prohibiting use, not feeling safe (2)	50.7%
I do not want to be seen	38.8%
I do not want people to know I use drugs	26.9%
I am afraid my name will not remain confidential	10.4%
I feel there are too many rules and restrictions associated with using supervised consumption services	6.0%
I fear being caught with drugs by police / the possibility of police outside the site	6.0%
I don't know enough about supervised consumption services	6.0%
I do not trust supervised consumption services or the agencies that deliver them	6.0%
I already have a place to use drugs	6.0%
Non-drug using people in the surrounding neighbourhood might harass me	4.5%
I'm in too much of a hurry to wait to use the drug consumption room	4.5%
I would rather use with my friends	1.5%
I need to avoid other people that would use the supervised consumption services	1.5%
I feel it would not be convenient or have poor service and hours	1.5%
I always use alone	1.5%

Source: NWHU Region PWUD Survey, August 2022

What services PWUD are looking for

PWUD survey respondents identified the following as being most important when considering what services they would value. See Table 37, where rows are placed in descending order of being highly rated in importance.

Table 37: Most important aspects of SCS for PWUD respondents in Dryden.

Survey Prompt	Very Important	Important	Somewhat Important	Not Important
New, sterile drug use equipment distribution	79.7%	20.3%	-	-
Referrals to drug treatment, detox, and addiction recovery services	75.4%	18.8%	8.7%	1.4%
Distribution of naloxone/Narcan to people who use drugs	71.4%	25.7%	10.3%	1.4%
Overdose training for people who use drugs	69.6%	30.4%	1.4%	-
HIV and Hepatitis C testing	68.1%	29.0%	-	1.4%
Trained staff present to supervise drug use for safety	60.9%	26.1%	8.7%	4.3%
Wound care provided on site	60.3%	33.8%	1.4%	-
Assistance with finding housing, employment and basic skills training	58.0%	33.3%	11.4%	-
Access to other healthcare services	52.9%	35.7%	5.9%	-
Harm reduction counselling	52.2%	39.1%	18.6%	2.9%
Access to washrooms	44.1%	45.6%	8.7%	%
Available food and beverages	42.9%	42.9%	15.7%	4.3%
Indigenous counsellors present	38.2%	36.8%	5.8%	7.4%
Access to showers	35.7%	41.4%	10.3%	7.1%
Access to drugs prescribed by a health professional	33.8%	48.5%	17.6%	7.4%
Peer support from other people who use drugs	25.7%	45.7%	29.0%	10.0%
A 'chill out' room to go after drug use	21.7%	36.2%	31.9%	13.0%
A place to charge your phone or other electronics	17.4%	34.8%	10.0%	15.9%

Source: NWHU Region PWUD Survey, August 2022

SCS location and design preferences

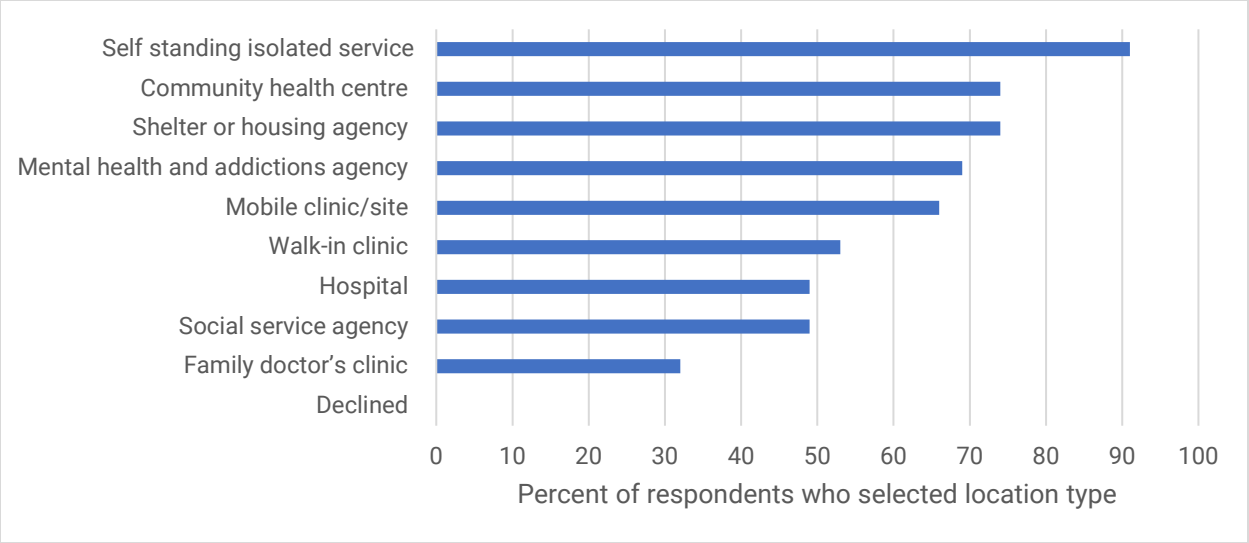
The location may affect the willingness for using the SCS. Below are the percent of respondents that indicated they would use the SCS if it was in the following locations. Notably, most (91%) said they would use the service if it was in a self-standing building. Shelter or housing agency and community health centre were each selected by 74% of respondents.

When asked what some of the ways are that respondents believed they would use to travel to SCS, 81% said they would walk or use a wheelchair/motorized scooter. Other modes of transportation included bike (30%), private vehicle (13%), taxi (23%), 10% said other.

With regards to what time of day would be most important for services to be offered, 71.4% said daytime (8am-4pm), 83% said evening (4pm-midnight), 61% said overnight (midnight-8am), and 6% declined to answer.

When shown pictures of different set-up spaces for SCS, 64% selected private cubicles, 30% selected a combination of the elements shown, 3% selected an open plan with table and chairs. 3% selected other, and 2% declined to answer.

Figure 25: **Willingness of PWUD respondents to use SCS by types of locations in Dryden.**



Source: NWHU Region PWUD Survey, August 2022

Community readiness

Sociodemographic characteristics of community survey respondents

A community survey was implemented for the general public in order to seek community feedback around SCS.

A total of 198 surveys were initiated by individuals who identified as living in Dryden with a completion rate of 88% (i.e., 174 completed the full survey).

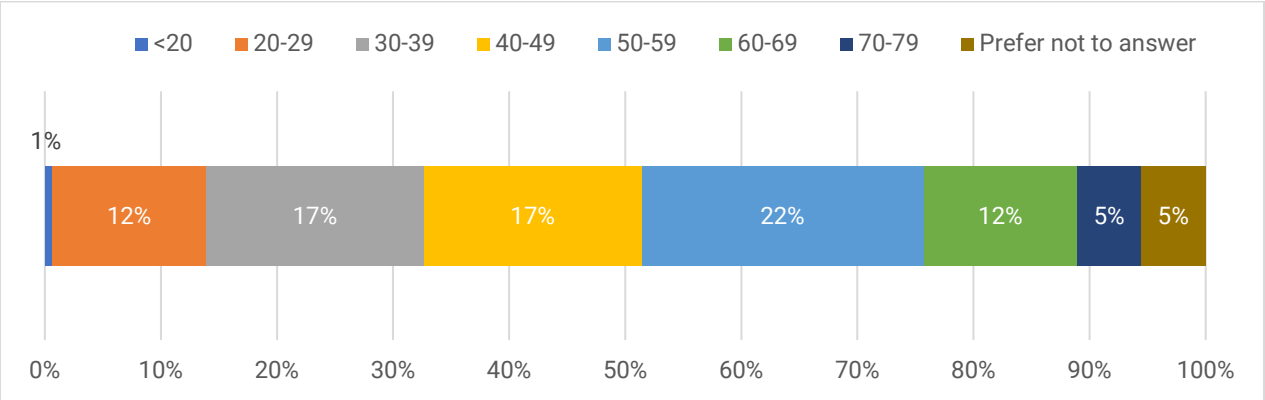
When asked if they identified as First Nations, Inuit or Métis, 72% said no, 15% said yes, and 13% preferred not to say (n=170).

Of the respondents, 23% identified as a staff member at a community agency of service provider and 5% identified as a business owner or operator.

The Dryden respondents that indicated their gender (n= 170) there was a higher proportion (73%) of respondents that identified as women compared to men (15%), prefer to self-describe (2%), and prefer not to answer (10%).

The age distribution for respondents in Dryden is outlined in Figure 26.

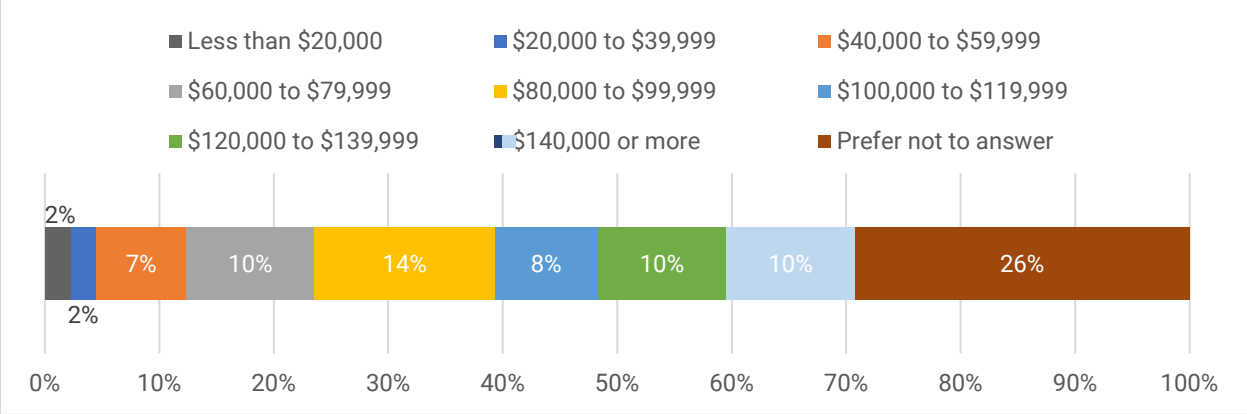
Figure 26: **Age distribution of community survey respondents from Dryden (n=170).**



Source: NWHU Region Community Survey, August 2022

The income distribution of respondents in Dryden when asked approximate household income per year is illustrated in Figure 27.

Figure 27: **Approximate household income per year of community survey respondents from Dryden (n=168)**.



Source: NWHU Region Community Survey, August 2022

Community perceptions for the need of drug consumption and treatment services

Respondents from Dryden were generally familiar with what SCS are with 93% indicating 'yes' when asked.

When asked to indicate level of agreement around several statements about SCS, the following answers, listed in Table 38, were the respective selections of respondents from Dryden.

Table 38: **Level of agreement to SCS statements by community survey respondents in Dryden.**

Survey Prompt	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree	Total Selections
There is a need for drug consumption and treatment services in my community	42.5%	15.5%	6.1%	8.8%	27.1%	181
There are negative consequences of supervised consumption services in communities	35.4%	19.3%	21.5%	15.5%	8.3%	181
Supervised consumption services are important in preventing overdose deaths	33.9%	23%	8.7%	8.7%	25.7%	183
I support the development of consumption and treatment services in my community	30.1%	19.1%	7.7%	9.8%	33.3%	183
Supervised consumption services are important for providing an environment of dignity and safety for drug users	26%	19.3%	14.4%	11.6%	28.7%	181
Supervised consumption services can save taxpayer money by reducing overall health and social services costs	22.5%	17.6%	12.1%	20.3%	27.5%	182
Supervised consumption services help solve problems in the community	20.3%	22%	12.1%	9.3%	36.3%	182
Supervised consumption services will decrease public drug use	15.4%	19.2%	12.6%	17.6%	35.2%	182

Source: NWHU Region Community Survey, August 2022

Just over half (58%) strongly agree or agree that there is a need for drug consumption and treatment services in the community, with 6% who are undecided and 36% who disagree or strongly disagree. Of the statements surveyed, the need for drug consumption and treatment services in the community is the one with the highest level of agreement, followed by the statement that SCS are important in preventing deaths (57% strongly agree or agree), and that there are negative consequences to SCS in communities, with that 55% strongly agree or agree with this last statement. Notably, there are almost as many respondents who were undecided around the statement of negative impacts for the community (22%) as there are who disagree (24%). Fewer people strongly agree or agree than disagree or strongly disagree that SCS can help solve problems in the community.

Overall, despite some polarity around perceived negative consequences and/or the ability of SCS to solve problems in the community, there was half (49%) of the respondents who strongly agree or agree with the development of consumption and treatment services in the community. It should be noted that in this phrasing used, a limitation is that there is not a distinction between consumption and treatment services.

More people disagree or strongly disagree than agree or strongly agree with the potential for SCS to decrease public drug use. Other benefits listed, such as providing PWUD with dignity and safety and saving taxpayer money also appear to have garnered responses that demonstrate there is some polarity between those who see benefits and those who do not.

Respondents were also asked a series of questions about the possible impacts of SCS on the community. Their responses are outlined in Table 39.

Table 39: **Anticipated likelihoods of community impacts of SCS by community survey respondents in Dryden.**

Survey Prompt	Very Likely	Likely	Neutral	Unlikely	Very Unlikely	Unsure	Total Selections
Drug dealers would be attracted to the area	24.2%	20.9%	15.9%	21.4%	7.7%	9.9%	182
Overdoses would be reduced	22.5%	25.3%	10.4%	19.2%	20.3%	2.2%	182
People would learn about drug treatment	22.2%	27%	13.5%	16.8%	17.8%	2.7%	185
More people who use drugs would come to the area	21.5%	26.5%	16.6%	22.1%	7.7%	5.5%	181
Injection with used needles would be reduced	19.8%	28%	9.9%	22%	15.4%	4.9%	182
The number of used syringes on the street would be reduced	19.7%	27.9%	7.7%	18.6%	23%	3.3%	183
The number of people using drugs outdoors would be reduced	12.6%	27.3%	9.3%	17.5%	29%	4.4%	183
People who use drugs would use the supervised consumption services	10.5%	28.7%	19.3%	20.4%	13.3%	7.7%	181
Crime would be reduced in the area	9.8%	14.8%	15.3%	15.8%	38.8%	5.5%	183
The supervised consumption services would be accepted by the broader community	2.2%	8.8%	14.8%	28.6%	39.6%	6%	182

Source: NWHU Region Community Survey, August 2022

Responses to whether or not a SCS site would be accepted by the broader community in Dryden demonstrate that there may be more work that will be needed in order to gain the acceptance of community members, with only 11% indicating that this would be likely or very likely and 68% finding this unlikely or very unlikely. The perception that PWUD would use SCS seemed more probable to almost half of respondents with 39% finding this likely or very likely. This aligns to

respondent perspectives of those who responded to the PWUD survey indicating a high level of intent to use SCS if they were provided.

Overall, with proposed benefits to the community around lowering needle debris in the streets, lowering injections with used needles, and more opportunities for people to learn about drug treatment, and the reduction of overdoses, the majority seem to find these outcomes either likely or very likely.

It does warrant some consideration however on how to ensure community concerns are addressed with regards to respondents either finding likely or very likely the statement that SCS could attract more PWUD to the area (45% very likely or likely) as well as drug dealers (48% very likely or likely).

Dryden Key Informant Findings

The key informants interviewed from Dryden all agree that drug use is a problem and has been on the rise in their community, being further exacerbated by the COVID-19 pandemic. They explained that drug use was not as visible as compared to other communities in the NWHU region, but more recently there are now constant visible signs that appear such as ambulances, discarded drug supplies, drug use in public places, and PWUD experiencing homelessness. Overdoses and overdose deaths are occurring in Dryden, but key informants feel that the general public awareness of the issues remains low. Key informants shared that safety is becoming a concern with a greater awareness of violence and property damage occurring in the broader community. With Highway 17 passing nearby, it is reported by key informants that there are people who stop in Dryden who use or sell drugs and this contributes to an increase in overall drug use.

While other communities may not have enough mental health, addiction, health and other social services, many from Dryden have to travel if they want to access supports. Key informants pointed to the severe lack of any significant services such as the absence of a treatment centre, safe beds or stabilization program, and detox or withdrawal supports. There is also a lack of mental health and addiction support in surrounding communities, making accessibility to services difficult for their community members. While a suboxone program runs with crisis-related supports, there are no ongoing counselling supports available with suboxone distribution. They explained that often the only place to deal with drug-related health concerns is the emergency department of the hospital, which has seen a huge increase in these visits. Key informants report that the ER has become a central place were PWUD go for detox, overdoses, referrals and treatment programs.

Some key informants explained that it can also be difficult for PWUD to seek help given that Dryden is such a small community and that everyone knows each other. It is difficult for individuals to feel that their confidentiality is protected. A couple of recent positive developments were mentioned by key informants including the launching of a RAAM clinic in the regional health centre and integrating mental health and addiction services into family health teams. Others pointed to the positive roles that peer and outreach workers, the Dryden Native Friendship Centre and the Waasegiizhig Nanaandawe'iyewigamig Health Access Centre play in supporting PWUD.

Key informants shared that PWUD face other issues including housing insecurity, poverty and mental health issues. Discrimination and anti-Indigenous racism contribute to the further marginalization of these community members. They state that unemployment, lack of affordable housing and intergenerational trauma are all big contributors to addiction.

While there wasn't a lot of awareness among key informants about SCS, they were very supportive of SCS and felt that they could reduce overdoses and death. There are currently no safe places for people to use drugs and SCS could provide that and intervene before harms occur. Additionally, the drug supply in Dryden was anecdotally reported to be contaminated so there is a need for safe supply of drugs in addition to consumption services. Key informants felt that SCS could have community-wide benefits such as reducing public use of drugs in washrooms and communal areas, as well as help to reduce stigma for PWUD. Other perceived benefits included increased safety for all, decreases in communicable diseases, less discarded drug debris in community, reduced strain on hospital resources, and a reduction in suicides related to trauma. Concerns regarding safety of SCS for clients, staff and the surrounding community were expressed and that it would be important to identify risk mitigation strategies as a part of the assessment and planning and processes.

Many key informants believe that sufficient mental health and addiction services is the highest priority for Dryden and should be addressed before SCS is introduced. Comprehensive services that support individuals in terms of their housing, employment, health care, mental health and addiction treatment are all needed. Otherwise, services will continue to be reactionary and will not help improve the overall quality of life of those in Dryden.

All key informants pointed to their perception that there would be significant push back in Dryden to the introduction of SCS. They shared that there has been resistance and opposition to the needle distribution program, and they believe that many including the broader community, town council, and other organizations will speak out against SCS. A lot of education is needed both to broadly address a lack of awareness about addiction to reduce stigmatization and discrimination, but also to raise awareness about harm reduction and its role in addressing drug addiction. Without this education, key informants shared that it will be difficult to get decision-makers to support new harm reduction initiatives.

While the need for other services was repeated by all key informants, they provided input on how SCS could be implemented in Dryden given previous benefits cited. While they shared that it makes sense to locate SCS in the downtown due to proximity to other services and PWUD, there are many who live in rural areas around Dryden who would benefit from access to mobile harm reduction services. Key informants recognized that a downtown location does present issues around confidentiality, so it was recommended that SCS be integrated into other organizations and/or services. It was recommended that services ensure cultural relevancy so that Indigenous community members feel comfortable accessing them.

When it comes to the location of SCS, key informants noted that having a centralized location would be best, especially given the lack of available transportation. Further, getting the input of PWUD was also thought to be key. In order to reduce worries about confidentiality/anonymity, key informants suggested that SCS be physically located with other services. Some suggested locations include:

- Location in and around Queen Street area (this area is accessible by foot, "quieter", there are vacant locations, and it is close to downtown services, including the foodbank)

- Northwestern Health Unit site
- Dryden Native Friendship Centre
- Ontario Addiction Treatment Centre
- Dryden Regional Health Centre's Mental Health and Addiction clinics
- Dryden Hospital

Recommendations regarding the needs assessment of SCS in Dryden

Considering the key findings of the needs assessment, the following next steps are recommended. To support these recommended actions, community-specific datasets of results outlined in the report (e.g., PWUD Survey) may be made available upon request for further SCS development purposes.

1. ***The rates of substance use harms in Dryden are significant enough to indicate a need for greater harm reduction and treatment services and the addition of SCS are recommended as a means to reduce the risk of harm, overdose, and overdose deaths among PWUD.*** Dryden experiences higher rates of harm in relation to substance use, including higher rates of substance-related emergency visits compared to the rest of Ontario, and Hepatitis C rates that are much higher than those of Ontario. Public health and community data illustrate a clear need for additional strategies and resources to decrease death and harms of substance use. There is strong intention among PWUD surveyed that they would use SCS and would highly value the aspect of SCS that create a sense of belonging, safety, and feel like a welcoming community space. Additionally, key informants interviewed support the introduction of these services and the potential associated benefits to PWUD and the broader community.

2. ***Health, social and/or mental health service providers, including Indigenous service providers, in Dryden may be best positioned to lead future development planning of SCS as the local professionals on harm reduction.*** SCS should be shaped around the needs of local PWUD, with the primary objectives of service provision being to reduce harms to users. PWUD should be engaged to inform any development and ongoing implementation of services to ensure they are responsive. Should development planning of SCS be pursued in Dryden, lead health, social and/or mental health service providers should determine and complete the following, while consulting with other providers in Dryden.

    I. Agreement on a service model(s). A downtown Dryden SCS site that is close to other services is recommended and may help to meet the needs of those PWUD within the surrounding neighbourhoods. A mobile or hybrid model could be considered, allowing for greater outreach to those living further away from the downtown and immediate surrounding area. Lead health, social and/or mental health service providers should work with Indigenous service providers and communities to ensure that SCS services are inclusive and responsive to the cultural needs of Indigenous community members.
    II. Given the lack of mental health and addiction services in Dryden, it will be extremely important to consider how SCS are integrated within the current system and how all servicer providers leverage SCS to support their service users. Therefore, it should be determined what the scope of harm reduction, health and social services will be delivered with, or linked to the SCS, and whether any specific Health Canada exemptions (e.g., for smoking or assisted-injected) are necessary. Almost half of

PWUD survey respondents cited needing help with injection last year, and smoking is the second most common method of drug use among those surveyed in Dryden.

III. Resources required and the necessary roles of the agencies involved for the development of SCS, including physical capital, human resources and partnerships.
IV. The Dryden lead(s) should apply to Health Canada for a Section 56.1 Exemption for Medical Purposes under the Controlled Drugs and Substances Act for Activities at a Supervised Consumption Site. The application includes details about policies and procedures, personnel/staffing structure, a community consultation report, and a financial plan, which all will have been completed in the development of SCS.
V. The Dryden lead(s) should strongly consider applying to the Ontario Ministry of Health for funding through the Consumption and Treatment Services (CTS) funding program. Other sources of funding, such as municipal, philanthropic, or private may also need to be considered. An organization can forego a funding application to Ontario Ministry of Health if they have secured an alternative source of funding. There are a number of organizations in Ontario who have taken this approach.

3. ***Implementation plans need to be developed alongside of engagement with key stakeholder groups such as municipal governments, emergency services, Indigenous partners, and the broader community.*** It needs to be understood, among leaders, providers and the broader community, that these services will not provide a 'magic bullet' to solve all drug-related concerns in Dryden, however they can play a complementary role to other solutions. Discussions regarding 'what are the realistic outcomes of SCS in our community?' will be important to have the results communicated widely, in order to manage expectations of the SCS. Implementation plans should consider how SCS could impact the broad community (social, economic, safety, and services), and risk-mitigation strategies for any anticipated challenges. It is recommended that these be shared and explained with various stakeholders and the broader community.

4. ***Any SCS developed in Dryden needs to be positioned within the larger community level approach to mental health and addiction services, integrating them into the local treatment and service network.*** Specific considerations of the needs of PWUD from Dryden, community collaboration, geography, and existing and future harm reduction initiatives should all be considered. While a SCS/harm reduction approach tailored to Dryden is recommended, it is also recommended that regular communication with other northwestern Ontario communities regarding lessons learned, best practices, challenges, and tools will help to strengthen respective plans, reduce duplication, and amplify impact.

5. ***Educational activities for the public and partners, regarding SCS is highly recommended alongside any SCS development. Raising awareness among and working alongside of community leaders in Dryden will be critical to understanding community concerns, as well as help SCS to succeed and be sustainable. Stakeholders and the general public should be comprehensively informed of the research evidence of the impacts of SCS. Transparent and accurate information on SCS will ensure that decision makers understand the benefits and can mitigate any potential challenges.*** These educational activities should also aim to increase awareness and empathy regarding addiction in general, and reduce stigma associated with PWUD. They should begin with leaders and seek to involve them in the implementation of community-wide education. Results from the community survey in Dryden showed mixed support for SCS among various stakeholder groups, and there was some polarity around the potential for benefits that SCS could provide. Survey respondents in Dryden also by majority felt that acceptance of SCS by the community would be unlikely/very unlikely. Key informants spoke about likely resistance and opposition from the broader community due to existing tensions as well as concerns and fears regarding SCS implementation. The need for specific awareness, education and training activities tailored to the context of each stakeholder group will be important.

6. ***Evaluation plans for any implemented SCS need to be developed to define, measure and report on the outcomes for transparency, reporting and improvement.*** Evaluation plans should be able to assess client uptake and community impact and be aligned with the goal outcomes of the community's mental health, addiction and harm reduction strategies. Evaluation plans will be important in measuring the key impacts of SCS, which can then be communicated to stakeholders to illustrate the benefits and gains to the community.

7d. Kenora

Demographics

With a population of 14,967 (2021 census data) the city of Kenora stretches over a geographical area of 211.65 km^2. The population density is 70.7 people per km^2. The average age of the population is 43.6 years old (2021 census data). Kenora is located in the District of Kenora. See Appendix C:4. for a map of Kenora.

Mortality and morbidity information

Mortality and morbidity data from provincial and regional sources demonstrates that the city of Kenora is exhibiting a disproportionate amount of substance-related emergency visits compared to the NWHU catchment area and the rest of Ontario. Hepatitis C rates are much higher than those of Ontario. While each indicator is outlined in greater detail below, the findings are summarized in Table 40 in relation to the NWHU catchment area and across Ontario.

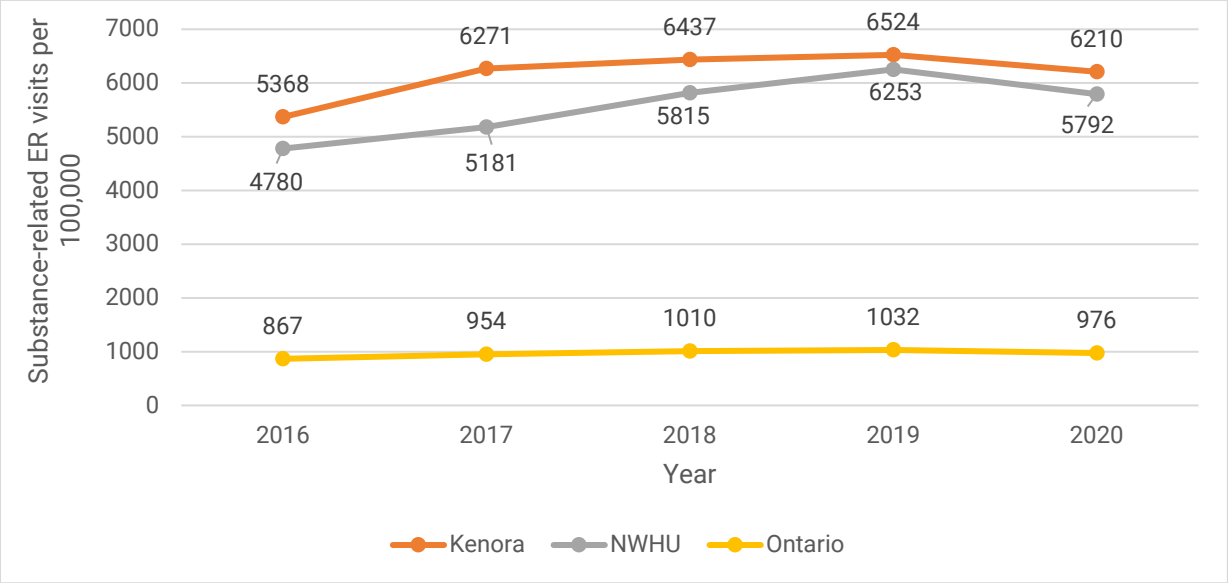
Table 40: **Summary of indicators demonstrating evidence of drug related harms in Kenora in comparison to across the NWHU catchment area and Ontario.**

Morbidity/mortality indicator	How does this indicator for the city of Kenora compare to that of the NWHU catchment area?	How does this indicator for the city of Kenora compare to that of Ontario?
ER visits related to substance-related reasons ***(per 100,000 per year by local health hub 2016-2020)***	Rates in Kenora have been **higher** than across NWHU for each year between 2016 to 2020.	Rates in Kenora have been **much higher** than across Ontario for each year between 2016 to 2020.
ER visits related to opioid overdose ***(per 100,000 overall by local health hub for 2016-2020)***	Rates in Kenora have been **lower** than across NWHU for the overall time-period between 2016 to 2020.	Rates in Kenora have been **similar** to Ontario for the overall time-period between 2016 to 2020.
Hepatitis C incidence ***(per 100,000 per year by local health hub 2016-2021)***	Rates in Kenora have been **lower** than across NWHU for each of the three-year time-periods captured (between 2016-2018 and 2019-2021).	Rates in Kenora have been **much higher** than across Ontario for each of the three-year time-periods captured (between 2016-2018 and 2019-2021).
HIV incidence ***(per 100,000 per year by local health hub 2012-2021)***	Rates in Kenora have been **similar** to NWHU for the overall time-period captured (between 2012-2021).	Rates in Kenora have been **lower** than across Ontario for the overall time-period captured (between 2012-2021).
Proxy Indicator		
Naloxone kit distribution counts	Naloxone kit distribution **did not** reflect the same increasing trends as were seen across NWHU catchment area between the years of 2018-2021. From 2020-2021, the trends differed as NWHU overall increased naloxone kit distribution while in Kenora there was a **decrease.**	Naloxone kit distribution **did not** reflect the same increasing trends as were seen across Ontario region between the years of 2018-2021. From 2020-2021, the trends differed as Ontario overall increased naloxone kit distribution while in Kenora there was a **decrease.**

Indicator: Substance-related ER visits

Between the years of 2016 to 2020, there was a higher rate of substance-related ER visits for Kenora than across the NWHU catchment area, both of which are higher than provincial rates. The five-year average of Kenora is 10.2% higher than the NWHU catchment area and 145.7% higher than the rest of Ontario.

Figure 28: **ER visits from 2016-2020 related to substance-related reasons per 100,000 per year for Kenora, NWHU catchment area and Ontario.**

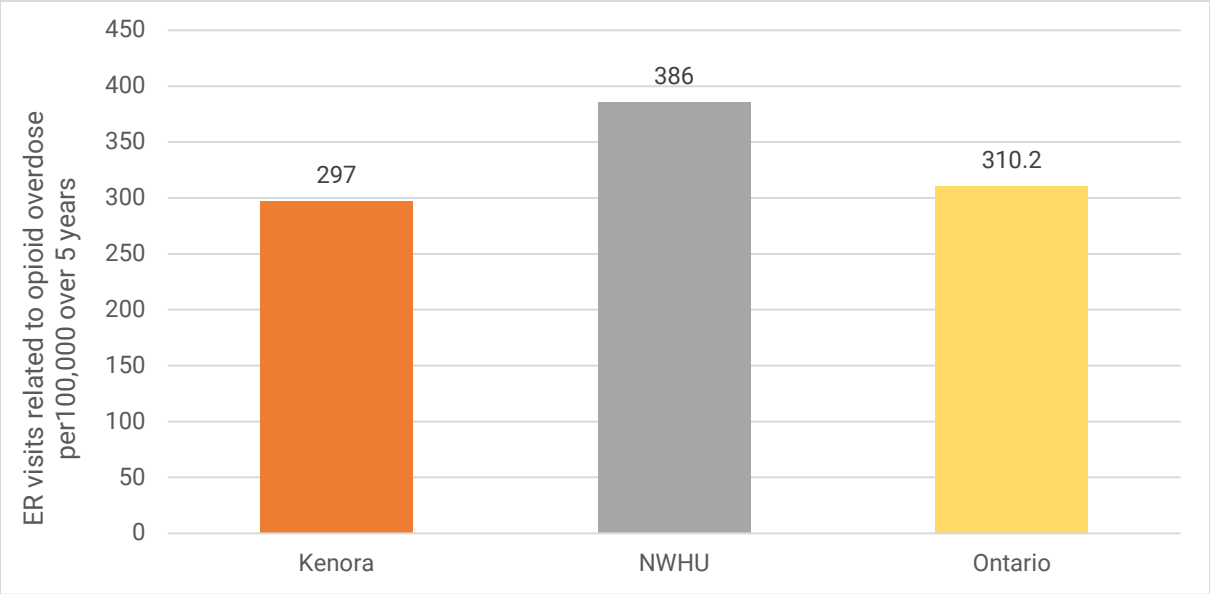


Source: Ambulatory Visits [2016 – 2020]. Ministry of Health and Long Term Care. IntelliHEALTH Ontario. Date Extracted: May 12, 2022

Indicator: Opioid-overdose related ER visits

When looking specifically at opioid-overdose related ER visits, rates in Kenora are 26% lower than the NWHU catchment area and 4.3% lower than the provincial average.

Figure 29: Total ER visits from 2016-2020 related to opioid overdose per 100,000 for Kenora, NWHU catchment area and Ontario.



Source: Ambulatory Visits [2016-2020]. Ministry of Health and Long-Term Care. IntelliHEALTH Ontario. Date Extracted: May 12, 2022

Indicator: Hepatitis C

In the latest three-year period (2019-2021), the incidence rate per 100,000 of Hepatitis C in Kenora is 4.3% lower than that in the NWHU catchment area, however, 153.1% higher than the incidence rate across Ontario. Rates of Hepatitis C incidence per year (per 100,000) in Kenora have increased by 7.5% from one three-year period (2016-2018) to the next three-year period (2019-2021). Comparatively, rates decreased between each of the three-year periods for the NWHU catchment area (4.2%) and Ontario (30.1%).

Table 41: Hepatitis C incidence per 100,000 for three-year time periods between 2016-2021 for Kenora, NWHU catchment area and Ontario

Years	Kenora	NWHU	Ontario
2016-2018	168.9	197.6	34.5
2019-2021	181.5	189.4	24.1
Change from 2016-2018 to 2019-2021	*7.5 % increase*	*4.2% decrease*	*30.1% decrease*

Source: iPHIS. Date Extracted: May 17, 2022

Indicator: HIV

Rates of HIV incidence per 100,000 averaged over the past 10 years in Kenora are 4.9% lower than those across the NWHU catchment area and 37.6% lower than HIV incidence across Ontario.

Table 42: **HIV incidence per 100,000, 10-year average from 2012-2021 for Kenora, NWHU catchment area and Ontario.**

Years	Kenora	NWHU	Ontario
2012-2021	3.8	4.0	5.5

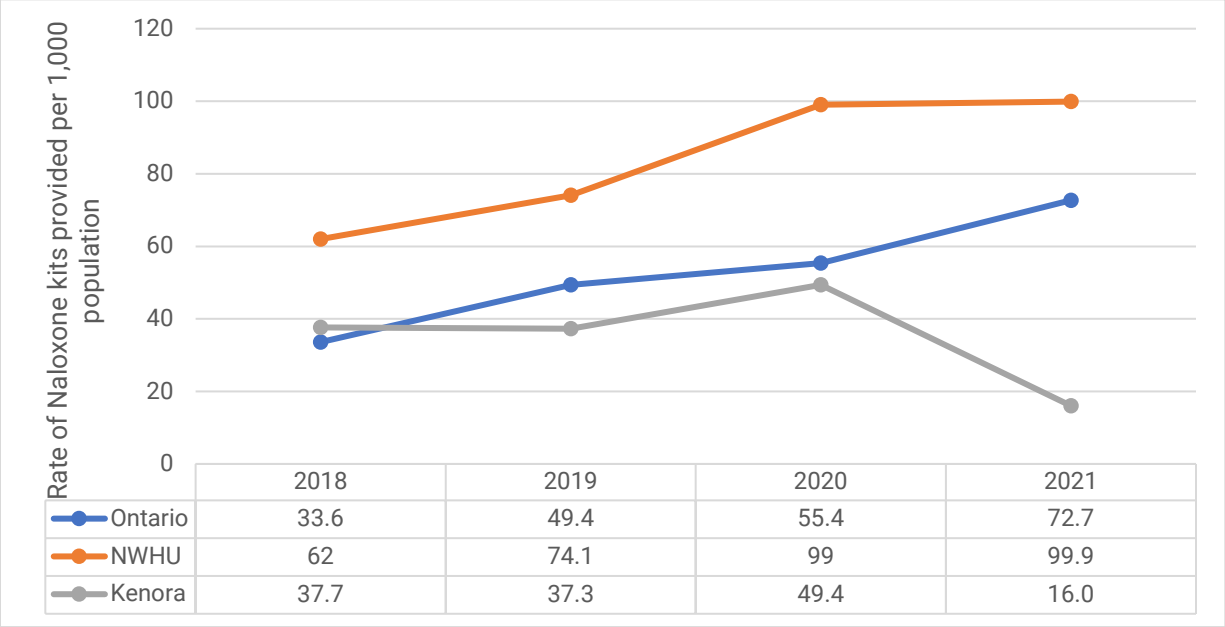
Source: iPHIS. Date Extracted: May 17, 2022

Proxy indicator: naloxone distribution

Rates of naloxone kit distribution has increased every year for the NWHU catchment area, with only a slight increase from 2020 to 2021. In Kenora, there was an observed significant decrease in naloxone kit distribution from 2020 to 2021.

It should be noted that the source of information at the regional and provincial level were different than the source for the city-level data. There could be differences in how counts are recorded, and NWHU and Ontario data encompasses both community and pharmacy distributed counts.

Figure 30: Rates per 1,000 of naloxone kit distribution from 2018-2021 for Kenora, NWHU catchment area, and Ontario.



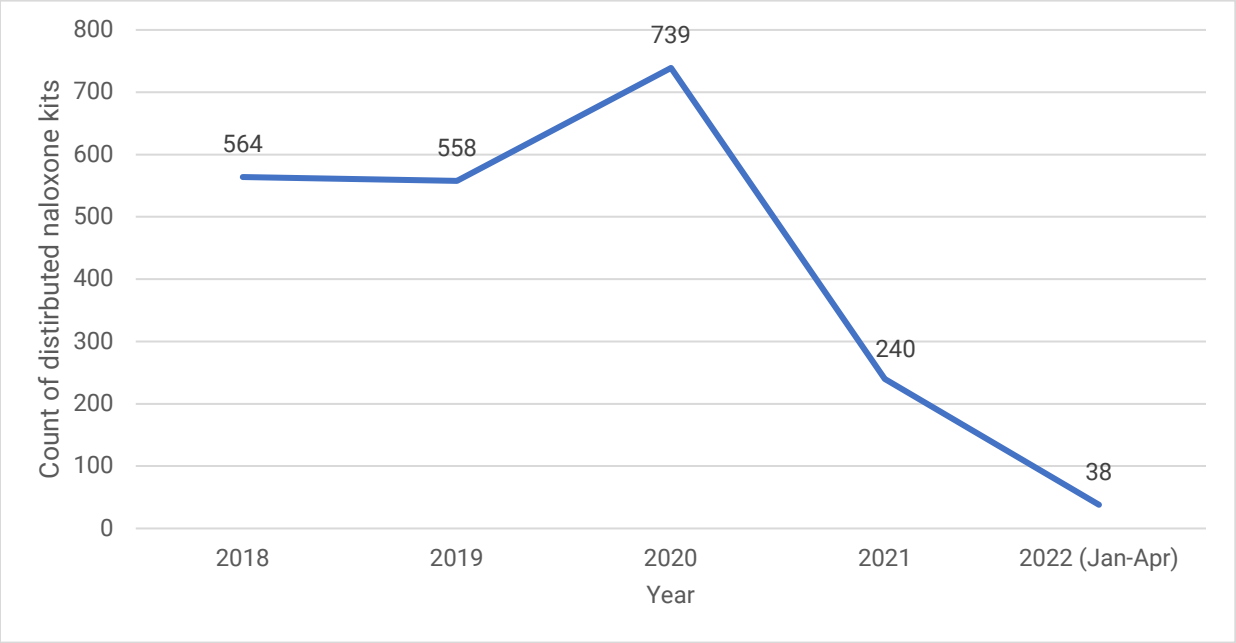
	2018	2019	2020	2021
Ontario	33.6	49.4	55.4	72.7
NWHU	62	74.1	99	99.9
Kenora	37.7	37.3	49.4	16.0

Source: Data provided from the Northwestern Health Unit (Kenora data series) and accessed from the ODPRN Ontario Opioid Data Tool (NWHU catchment area and Ontario data series).

When looking at the counts of naloxone distribution in Kenora in Figure 31, it is notable that the count of distributed kits for the year 2022 between Jan-April was 38 kits, which may indicate a continued downward trend.

Looking at data from the PWUD survey (discussed in greater detail in next section), 59% (n=93) of survey respondents in Kenora identified having been trained to administer naloxone, 50% (n=96) have administered naloxone to someone, and 52% (n=97) have a take-home naloxone kit to keep for an opioid overdose.

Figure 31: **Naloxone kit distribution count by year from 2018-2022 for Kenora.**



Source: Data provided by the Northwestern Health Unit

Demographics and preferences of people who use drugs

The in-person survey of PWUD was conducted throughout August 2022 at sites across the four northwestern Ontario municipalities. A total of 271 participants completed all or a portion of the survey. All participants had used drugs within the previous six months prior to the survey, were at least 18 years of age, spent on average at least seven days a month in the community where the survey took place.

Of the 271 participants, 101 (37%) were completed in Kenora. Of the 101 respondents, 71% indicated Kenora as a place they consider to be their hometown or home community.

The following information is specific to those 101 respondents that completed the PWUD survey in Kenora.

A higher proportion (63%) of respondents from Kenora were men, while 36% were women, and 1.0% identified as non-binary.

A majority (81%) of respondents from Kenora identified as First Nation, in addition to 4% who identified as Métis. Fifteen percent indicated that they were neither First Nation, Inuit and/or Métis.

Of the survey respondents, 67% reported sleeping on the street multiple nights per month in the last year (including abandoned buildings, cars, parks). Half (50%) also reported spending multiple nights per month in the last year in a house or apartment. Other answers included shelter/transitional housing (35%), hotel/motel room (17%), no fixed address (16%), prison/detention centre (6%), hospital/rehab/medical facility (5%), a place where people gather to do drugs (4%) and other (5%) which included trap house, bail residency, group home, warming space, and working overnight.

Drug use patterns and related behaviors

In the past year, the most frequently used drugs were crystal meth (88%), opioids (75%), cocaine powder (44%), crack (26%), methadone or suboxone (25%), tranquilizers or benzodiazepines (20%) or other (14%).

- The most common method of drug use was by injection (81%), smoking (62%), snorting (37%), swallowing (21%), and other (1%).
- 53% said that someone else had prepared their drugs for them in the last year (n=97).
- 41% said that they had at some point in the last year shared drug use equipment such as needles, cookers, or pipes (n=96).
- 62% indicated that they had at some point in the last year gotten new drug use equipment from a friend, dealer, or someone on the street (n=97).
- 45% said in the past year, it occurred that they had not been able to find new drug use equipment when it was wanted (n=96).

Injecting-specific behaviours that respondents identified doing at any point in the last year:

- 89% have injected alone (n=81),
- 63% had help from someone to inject (n=81),
- 70% reused their own injecting equipment (n=80),
- 19% shared or reused someone else's injecting equipment (n=80),
- 48% used water from a puddle, public fountain, or other outside source to prepare drugs or rinse needles (n=81),
- 89% exchanged or obtained needles at a harm reduction program (n=81),
- 47% experienced a harm reduction program limiting the number of needles they could be given (n=79).

Using drugs in public spaces

- Location of drug use in the past year included:
    - Outdoor public spaces (e.g., an abandoned building, a parking lot, or a park) (91%),
    - Indoor residences (e.g., your own place, a relative's, a friend's or a stranger's place or a hotel or motel) (68%),
    - Indoor public spaces (e.g., in a stairwell/doorway/washroom of a store, coffee shop, public bathroom, office, or other building) (52%),
    - A shelter (18%),
    - A community-based organization or service provider (other than a shelter) (11%),
    - Other (5%).

With the most common location among respondents for drug use being in public, the top reasons for using drugs outside included:

- It's convenient to where I hang out (36%),
- Other (32%) – included: nowhere else to go (specified 9 times), addiction, because of past experiences and traumas, couldn't do at home, afraid wouldn't have a chance to do it if there was a warrant, etc., avoid children or police, for pain/most comfortable, like to be alone with one other person and to use privately away from public eye, need to use quickly so police don't take it away, only if absolutely necessary, quiet shady spot outside, relief of current situation, respect, rushed, so people would know what happened to them if they died, uses where they are at, and visiting the public,
- I'm homeless and don't have a place to use (31%),
- It's where I am when I decide to use (30%),
- I need to use immediately after getting drugs (e.g., experiencing withdrawal) (26%),
- There is nowhere to use safely where I buy drugs (17%),
- I prefer to be outside (12%),
- I don't want the person I am staying with to know I use/am still using (7%),
- I'm too far from home (6%),
- I need assistance from others to use (2%),
- Declined to answer (1%).

Intention to use a SCS

- Four out of five (83%) of respondents in Kenora said that they would use SCS if they were available, while 8% said they would not, and 10% were unsure (n=93).
- A third (33%) of respondents said that they would use SCS (if they were in a convenient location) on a daily basis (33%), of which 26% of the total respondents said they would go multiple times a day/night. Twenty one percent said they would go weekly, and 7% said a couple of times per month. Only 3% said they would go less than once per month, 6% said rarely, and 3% said they would never use SCS (n=96).

Reasons that would make the respondent use SCS are displayed in Table 43.

***Table 43*: Reasons that PWUD respondents would use SCS in Kenora.**

Reasons why would use SCS	Response Rate
I would be using under safer conditions	50.0%
Having a community space that is welcoming/safe/sense of belonging	39.4%
Overdoses can be prevented and treated	34.0%
I would be able to get new, sterile drug use equipment	30.9%
Other: better life, need help injecting, safety, restock, be with friends, clean space, counselling, don't get arrested, don't have to hide, kids wouldn't see needles, more privacy, warm and safe	29.8%
I would be able to use drugs indoors and not in a public space	24.5%
I would be able to see health professionals / access healthcare (e.g., wound care)	23.4%
I would be able to use facilities like washrooms, showers and electrical outlets	19.1%
I would be safe from being seen by the police	17.0%
Availability and convenience of the services (including hours of operation)	16.0%
I could dispose of used drug use equipment more safely	14.9%
I would be able to get a referral for health or social services	14.9%
I would be safe from potentially threatening people	12.8%
I would be able to share my knowledge and skills with peers and professionals	11.7%
If there were peers on site	11.7%
That it is delivered by an agency I trust/receiving care/support from non-judgmental professionals	10.6%
Declined	5.3%

Source: NWHU Region PWUD Survey, August 2022

Reasons that would render the respondent to not want to use SCS included those listed in Table 44.

Table 44: **Reasons PWUD respondents would not want to use SCS in Kenora.**

Reasons why would not use SCS	Response Rate
Other - including: people would know you are using, shy/unsure/nervous, avoiding someone, people fighting, feeling unsafe, unwanted, no privacy from other clients, and if they minimize access	54.0%
I fear being caught with drugs by police / the possibility of police outside the site	22.2%
I do not want people to know I use drugs	20.6%
I do not want to be seen	19.0%
I need to avoid other people that would use the supervised consumption services	9.5%
I am afraid my name will not remain confidential	7.9%
I'm in too much of a hurry to wait to use the drug consumption room	7.9%
I would rather use with my friends	6.3%
Non-drug using people in the surrounding neighbourhood might harass me	6.3%
I don't know enough about supervised consumption services	6.3%
I'm worried about losing my kids to child welfare services	4.8%
I already have a place to use drugs	4.8%
I feel there are too many rules and restrictions associated with using supervised consumption services	4.8%
I can get new, sterile drug use equipment elsewhere	3.2%
I always use alone	1.6%
I feel it would not be convenient or have poor service and hours	1.6%
I do not trust supervised consumption services or the agencies that deliver them	1.6%

Source: NWHU Region PWUD Survey, August 2022

What services PWUD are looking for

PWUD survey respondents identified the following as being most important when considering what services they would value. See Table 45, where rows are placed in descending order of being highly rated in importance.

Table 45: **Most important aspects of SCS for PWUD respondents in Kenora.**

Survey Prompt	Very Important	Important	Somewhat Important	Not Important
Distribution of naloxone/Narcan to people who use drugs	68.4%	26.3%	3.2%	2.1%
HIV and Hepatitis C testing	66.7%	31.3%	2.1%	-
Overdose training for people who use drugs	64.9%	30.9%	4.3%	-
New, sterile drug use equipment distribution	63.2%	32.6%	4.2%	-
Assistance with finding housing, employment and basic skills training	57.9%	29.5%	9.5%	3.2%
Wound care provided on site	55.2%	40.6%	4.2%	-
Trained staff present to supervise drug use for safety	53.8%	34.4%	10.8%	1.1%
Harm reduction counselling	51.6%	36.6%	9.7%	2.2%
Referrals to drug treatment, detox, and addiction recovery services	51.0%	39.6%	8.3%	1.0%
Access to other healthcare services	49.0%	46.9%	4.2%	-
Available food and beverages	45.8%	37.5%	11.5%	5.2%
Access to washrooms	42.7%	49.0%	6.3%	2.1%
Access to showers	39.6%	40.6%	13.5%	6.3%
Peer support from other people who use drugs	31.9%	41.5%	20.2%	6.4%
Access to drugs prescribed by a health professional	31.1%	43.3%	13.3%	12.2%
Indigenous counsellors present	30.9%	39.4%	23.4%	6.4%
A place to charge your phone or other electronics	25.5%	33.0%	24.5%	17.0%
A 'chill out' room to go after drug use	25.5%	30.9%	29.8%	13.8%

Source: NWHU Region PWUD Survey, August 2022

SCS location and design preferences

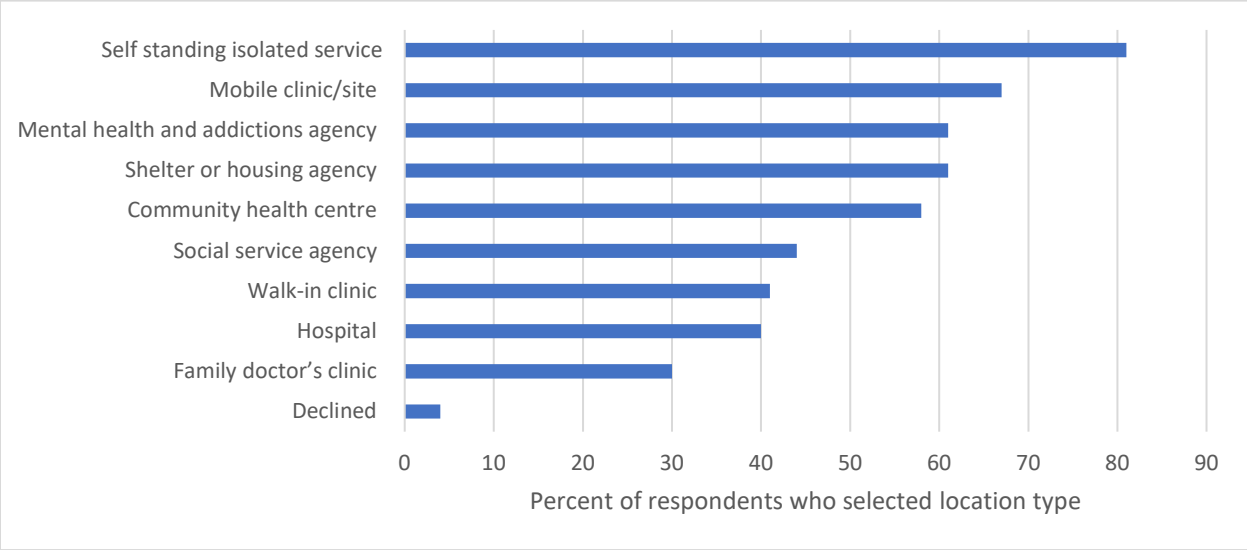
The location may affect the willingness for using the SCS. Below are the percent of respondents that indicated they would use the SCS if it was in the following locations. Notably, most (81%) said they would use the service if it was in a self-standing building. Mobile sites were selected by 67% of respondents.

When asked what some of the ways are that respondents believed they would use to travel to SCS, 81% said they would walk or use a wheelchair/motorized scooter. Other modes of transportation included bike (34%), bus (26%), private vehicle (18%), taxi (16%), other (10%), and 1% declined to answer.

With regards to what time of day would be most important for services to be offered, 85% said daytime (8am-4pm), 77% said evening (4pm-midnight), 79% said overnight (midnight-8am), and 1% declined to answer (n=96).

When shown pictures of different set-up spaces for SCS, 38% selected private cubicles, 37% selected a combination of the elements shown, 19% selected an open plan with table and chairs. Four percent selected other, and 2% declined to answer (n=97).

Figure 32: **Willingness of PWUD respondents to use SCS by types of in Kenora.**



Source: NWHU Region PWUD Survey, August 2022

Community readiness

Sociodemographic characteristics of community survey respondents

A community survey was implemented for the general public in order to seek community feedback around SCS.

A total of 949 surveys were initiated by individuals who identified as living in Kenora, with a completion rate of 85% (i.e., 808 surveys were fully completed).

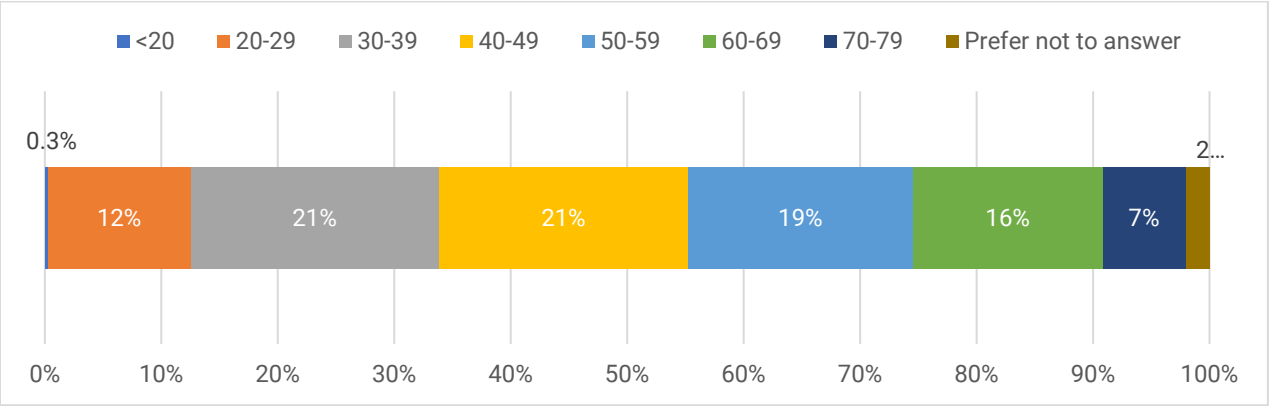
When asked if they identified as First Nations, Inuit or Métis, 73% said no, 16% said yes, and 11% preferred not to say (n=796).

Of the respondents, 15% identified as a staff member at a community agency of service provider and 7% identified as a business owner or operator.

Of the Kenora respondents that indicated their gender (n= 797) there was a higher proportion of respondents that identified as women (67%) compared to men (27%), non-binary (2%), prefer to self-describe (0.3%), 2-spirited (0.1%), and prefer not to answer (6%).

The age distribution for respondents in Kenora is outlined in Figure 33.

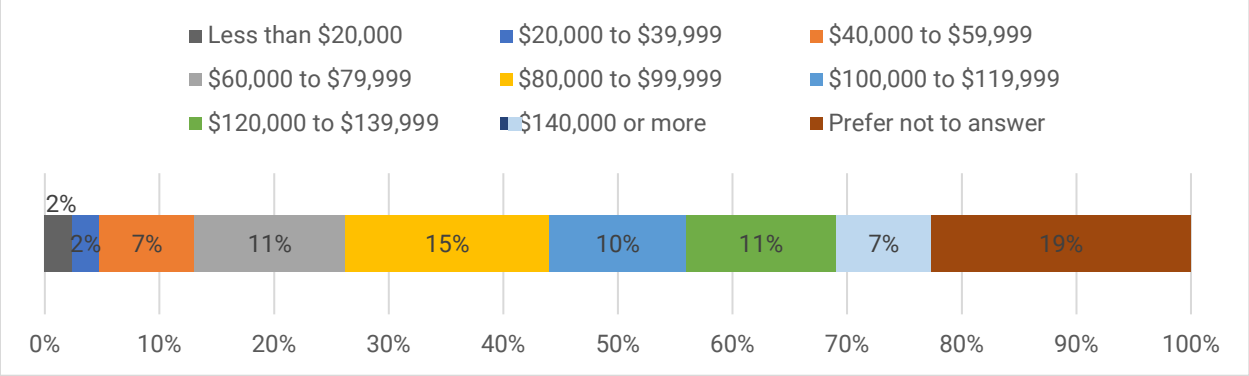
Figure 33: Age distribution of community survey respondents from Kenora (n=797).



Source: NWHU Region Community Survey, August 2022

The income distribution of respondents in Kenora when asked approximate household income per year is illustrated in Figure 34.

***Figure 34:* Approximate household income per year of community survey respondents from Kenora (n=792).**



Source: NWHU Region Community Survey, August 2022

Community perceptions for the need of drug consumption and treatment services

Respondents from Kenora were generally familiar with what SCS are with 94% indicating 'yes' when asked.

When asked to indicate level of agreement around several statements about SCS, the following answers, listed in Table 46, were the respective selections of participants from Kenora.

Table 46: Level of agreement to SCS statements by community survey respondents in Kenora.

Survey Prompt	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree	Total Selections
There is a need for drug consumption and treatment services in my community	51.8%	10.2%	4.9%	6.4%	26.6%	841
I support the development of consumption and treatment services in my community	39.1%	15.3%	8.1%	8.2%	29.2%	838
There are negative consequences of supervised consumption services in communities	33.7%	18.4%	21.7%	17.1%	9.1%	843
Supervised consumption services are important in preventing overdose deaths	32.7%	25.1%	12.2%	10.6%	19.5%	842
Supervised consumption services are important for providing an environment of dignity and safety for drug users	25.1%	23.6%	10.0%	15.3%	26.0%	838
Supervised consumption services help solve problems in the community	24.9%	20.4%	11.8%	11.1%	31.8%	844
Supervised consumption services can save taxpayer money by reducing overall health and social services costs	22.0%	18.5%	17.5%	15.2%	26.8%	844
Supervised consumption services will decrease public drug use	18.7%	18.9%	14.6%	15.8%	32.0%	841

Source: NWHU Region Community Survey, August 2022

There seems to be a strong amount of awareness around community needs pertaining to substance use, with 62% strongly agreeing or agreeing that there is a need for drug consumption and treatment services in the community. Of the statements surveyed, the strongest support seems to be for the statement that SCS are important in preventing overdose deaths (57.8% strongly agree or agree). However, when it comes to the statement of the potential for SCS to solve broader problems in the community, support is less consistent with 45% who strongly agree or agree and

43% that strongly disagree or disagree. It is also of note that the majority are not convinced that SCS do not have negative consequences for the community, with 52% who strongly agree or agree that there are negative consequences, and another 21% were undecided.

Despite this, over half of respondents (54%) strongly agree or agree with providing their support for the development of treatment and consumption services, however a limitation of the survey is that there was no distinction made between consumption and treatment services, potentially raising the favourable responses by grouping together the support for the two.

More people disagree or strongly disagree than agree or strongly agree with the potential for SCS to decrease public drug use. Other benefits listed, such as providing PWUD with dignity and safety and saving taxpayer money also appear to have garnered responses that demonstrate there is some polarity between those who see benefits and those who do not.

Respondents were also asked a series of questions about the possible impacts of SCS on the community. Their responses are outlined in Table 47.

Table 47: **Anticipated likelihoods of community impacts of SCS by community survey respondents in Kenora.**

Survey Prompt	Very Likely	Likely	Neutral	Unlikely	Very Unlikely	Unsure	Total Selections
More people who use drugs would come to the area	33.0%	21.1%	18.2%	15.8%	5.0%	7.0%	848
Drug dealers would be attracted to the area	28.2%	20.6%	17.5%	20.3%	6.0%	7.3%	844
Overdoses would be reduced	23.5%	30.0%	11.0%	14.7%	18.6%	2.0%	842
The number of used syringes on the street would be reduced	21.7%	26.4%	7.5%	15.8%	25.4%	3.3%	844
Injection with used needles would be reduced	19.8%	28.6%	12.7%	15.1%	20.4%	3.4%	843
People would learn about drug treatment	18.0%	32.1%	13.1%	14.9%	19.4%	2.5%	839
The number of people using drugs outdoors would be reduced.	14.5%	29.0%	8.2%	16.9%	27.6%	3.8%	844
People who use drugs would use the supervised consumption services	9.7%	31.4%	15.9%	19.6%	18.0%	5.4%	849
Crime would be reduced in the area	8.6%	15.7%	16.1%	17.0%	38.4%	4.2%	849
The supervised consumption services would be accepted by the broader community	3.9%	16.4%	14.3%	29.0%	32.0%	4.4%	847

Source: NWHU Region Community Survey, August 2022

Responses to whether or not a SCS site would be accepted by the broader community in Kenora demonstrate that there may be more work needed in order to gain the acceptance of community members, with only 20% indicating that this would be likely or very likely. Whether or not PWUD would use the SCS also garners some polarity among the responses with 41% finding this likely or very likely, and 38% unlikely or very unlikely. Notably, the respondent perspectives in the broader public survey around the potential uptake of SCS by PWUD is starkly different than the majority who responded to the PWUD survey indicating intent to use SCS if they were provided indicating there may be an opportunity to raise awareness around the perspectives of persons who use drugs in the community. A similar polarity was observed with regards to lowering the number of people using drugs outdoors.

Overall, with proposed benefits to the community around lowering needle debris in the streets, lowering injections with used needles, and more opportunities for people to learn about drug treatment, and the reduction of overdoses, the majority seem to find this either likely or very likely.

It does warrant some consideration however on how to ensure community concerns are addressed in that the majority of respondents either find the statement that SCS could attract more PWUD to the area as well as drug dealers likely or very likely.

Kenora Key Informant Findings

Key informants in Kenora shared that drug use in Kenora is a significant problem and that it has grown over time. PWUD do not have a safe place to use, so in turn many use in public settings, private homes or in local businesses (e.g., in the bathrooms). The effects of drug use are also visible with PWUD being homeless or with large quantities of discarded needles scattered across the community, including in places like parks and school yards. According to key informants, there has been an increase in methamphetamine use in recent years as well as other drugs like cocaine (to a lesser extent). They report that there has also been an increase in property and violent crimes. Key informants also shared that it is observed that people come from other communities to Kenora to join the community of PWUD in residence, as well as to access support services because Kenora is perceived to have more services available.

Key informants spoke about overdoses, overdose deaths and the resulting trauma this causes for family and friends of those who have died. They discussed how both non-fatal and fatal overdoses have increased. They spoke about the toll that drug addiction has on PWUD in terms of the severe mental health issues and their overall reduced quality of life. The reported stigma that PWUD face is significant in Kenora; PWUD feel judged and are often treated badly by other community members. Stigma affects the mental health of PWUD and causes them to be hesitant to seek help or support. PWUD also experience victimization such as human trafficking and violence. Additionally, informants shared that criminal networks and drug dealers often follow people during and after treatment or being given housing, further victimizing them as they try to improve their lives. Ongoing mental health challenges and illness resulting from trauma, intergenerational drug use, and a host of other issues, plus a large network of peers who use drugs, make it very difficult for individuals to break free from addiction.

Key informants shared that large unsanctioned injection sites exist, which present additional safety risks for PWUD. The prospect of SCS in Kenora was highly supported amongst the majority of those who were interviewed from Kenora. A couple of key informants talked about the need for providing

healthcare in ways that are different from the formal approach, that PWUD need to have involvement in the process, and about the need for harm reduction-based services.

It was shared by the key informants that while a lot of mental health and addiction services exist in Kenora, current services are at, or over capacity, and there is an overall shortage of treatment services. Hospital ER visits have increased substantially, and the hospital is often overwhelmed responding to mental health and drug-related issues. Key informants also shared that the demands on law enforcement and emergency services have been significant; while they believe that a lot is being invested into policing and emergency services who are responding to the drug problem in Kenora, the community is not seeing any improvements in response to these expenditures. Key informant report that wait times for treatment and detox services are long. A shortage of available services is resulting in PWUD seeking treatment having to travel outside of Kenora to Winnipeg, Thunder Bay and southern Ontario. Key informants identified that if services aren't available in Kenora that help people address their addictions and remain sober, they can quickly relapse, and a repeated cycle continues. They also reported that there is a limited number of places that distribute medications like methadone. Currently, there is only one pharmacy that is dispensing these kinds of medications. Key informants report that other pharmacies have stopped doing so due to security and safety issues, as well as concerns about losing customers.

The needle distribution program in Kenora is highly utilized, with key informants reporting that PWUD are accessing clean needle supplies "around the clock". While there are benefits to the needle distribution program, it is also a source of conflict and challenges with the broader community. For instance, some key informants spoke about staff being confronted, accosted and video taped when they go to empty sharps containers. There was a perception among some key informants that the way the clean needles are distributed in Kenora is different and that there are greater numbers of used needles left on the ground than in other communities in the NWHU region. SCS was mentioned by key informants as a way to help reduce improperly discarded needles.

Key informants talked about burnout and how it is difficult for service providers not to feel completely overwhelmed by the endless burden of drug addiction and loss; it feels never-ending and that it is hard to remain optimistic that the community can get ahead of it. Housing services were also mentioned as being limited and that some organizations are very risk averse meaning that those who use drugs may get immediately evicted. Key informants shared that these policies must change so that people aren't punished for relapsing.

Despite the challenges with existing services not able to meet the demand of those who need them, key informants spoke about some positive services in Kenora that can be built upon. For instance, partnerships between some organizations (e.g., RAAM, Morningstar, mobile outreach unit) were mentioned to be very strong. They also spoke about innovative approaches like some physicians being able to secure funding for patient support (when Ontario Health funding is unavailable), while others spoke about needing more approaches like the one being taken by a large group of providers through the All Nations Health Partners and the former Waterview residence. They shared that the Waterview provided a home to those who needed one, and also allowed them to continue to engage in substance use while ensuring their safety. Other service programs like the RAAM clinic, the mobile crisis team, and previous harm reductions services, are all examples of positive practices that key informants identified that could be replicated or expanded.

Overall, more services are needed in Kenora including safety testing for drugs, safer supply, wrap around services for PWUD (e.g., counselling, nursing, etc.), more detox beds, and greater resources for EMS. In addition to more services and resources, it was shared that there are territorial issues amongst health and service organizations and there needs to be greater collaboration between agencies. In terms of introducing SCS in Kenora, it was pointed out by key informants that getting buy-in and a commitment to collaborate among EMS, health care, mental health and addiction services, and law enforcement would be critical to ensure the success of SCS.

Key informants recognized that the broader community does not feel safe and are unhappy about the impacts that drug use has had in Kenora. For instance, key informants pointed out how drug use has negatively impacted local businesses and tourism, with many going out of business or moving away due to the associated challenges. They shared that one of the biggest areas of contention within the broader community is the drug debris and needles found in town.

As mentioned, there was a lot of support by those interviewed for SCS and the provision of a safe place for those using drugs that can reduce harms, overdose and death. Many key informants mentioned that PWUD in the community have been asking for SCS for some time. Key informants shared that the status quo is working to address the overall the drug problem and SCS need to be seen as part of the solution. In addition to safer consumption, they mentioned how there needs to be safe supply of drugs provided to reduce toxicity and contamination that can cause harm.

Key informants spoke about the importance of starting to empower PWUD to advocate for themselves and for service providers and leaders to begin listening. It was shared that PWUD should be engaged in an ongoing dialogue (e.g., via a user action group) and they be compensated for their participation. While they felt that it would take some time to establish SCS and build trust among potential clientele, there is the sense from key informants that the use of SCS would grow over time to be significant. They also shared that they thought not only could SCS be for supervised drug use, but it also could be used for treatment of supervised injectables such as Kadian. An SCS was also identified by key informants as a potential place for safer supply distribution. Key informants see SCS as a way to engage with PWUD, connect them with other health and social services and their providers. If those connections are made and trust is developed, if or when PWUD are ready, providers can more readily connect them with treatment supports at the time they want them.

There were concerns expressed about the ability to recruit the 'right' kind of staff to work at SCS given current shortages in staffing in the area. The staff need to be able to engage and build trust with the clients while supporting and educating them on how to reduce harm. Some spoke about the concerns with the broader community pushing back against SCS because of a fear that more people will come to Kenora to use SCS. It was felt that some community or elected leaders may be opposed and undermine SCS directly or influence how the broader community views it. Others felt that there would be good support for SCS in broader community, but the location would be the biggest area of contention. Some key informants shared concerns about the potential for deterioration of the downtown area and increases in crime.

Other concerns included worries about PWUD being negatively targeted when using SCS, loitering outside of the facility, community concerns about the location being close to residential areas, schools, etc., and worry of increased crime. With these concerns stated, many other community benefits were shared as well. These included decreased burden on EMS and the hospital, increased

safety for health care and social service professionals, greater retention of helping professionals, greater community safety, a cleaner and safer outside environment, providing a sense of community to PWUD who are currently very marginalized, reduction of stigma for PWUD and Indigenous community members as well, reduced trauma and grief, decreased communicable diseases, decreased suicides, and improved conditions for businesses.

In terms of how SCS could be implemented in Kenora, some informants spoke about the value of engaging PWUD to work as peers to do outreach and support others around safer consumption. Accessibility is seen to be a key issue and while a downtown or urban-based SCS will serve those who are nearer to those areas, many live in the surrounding communities including First Nations will not be able to access this kind of location. Some felt that it would be ideal to locate SCS with other services; a "hub" model of sorts. Others felt that locating it near other services would be beneficial. Finally, a couple of key informants spoke about the importance of avoiding buildings associated with the legacy of residential schools. A number of potential locations in Kenora were suggested for SCS. These included:

- In the downtown area but not on the main street, although there were concerns cited regarding businesses and residents' resistance
- Integrate into an existing facility
- Near or in the Northwestern Health Unit site (e.g., the basement area)
- Morningstar (detox centre) as it was noted that it is the busiest needle distribution site, is downtown but a bit out of the way, and is a combined treatment centre.
- Waasegiizhig Nanaandawe'iyewigamig Health Access Centre (WNHAC)
- Canadian Mental Health and Addictions site
- Kenora Association for Community Living
- Kenora Fellowship Centre
- Ne-Chee Friendship Centre
- Minto area (secondary site)
- Tiny home community (secondary site) – not yet built
- Mobile service could be an option through the mobile outreach

Finally, the role of education was reiterated many times during focus groups and interviews as being essential to reduce stigma of PWUD and increase the understanding regarding SCS. They shared with us the power of social media to negatively influence the broader community regarding PWUD. While it was thought to be difficult, key informants said it would be essential to use social media to dispel myths, share information and promote a greater understanding of addiction and the benefits of SCS. It was stated that there needs to be greater compassion in the broader community and education is the only way to help address this.

Recommendations regarding the needs assessment of SCS in Kenora

Considering the key findings of the needs assessment, the following next steps are recommended. To support these recommended actions, community-specific datasets of results outlined in the report (e.g., PWUD Survey) may be made available upon request for further SCS development purposes.

1. ***The rates of substance use harms in Kenora are significant enough to indicate a need for greater harm reduction and treatment services and the addition of SCS are recommended as a means to reduce the risk of harm, overdose, and overdose deaths among PWUD.*** Kenora experiences higher rates of harm in relation to substance use, including higher rates of substance-related emergency visits compared to the NWHU catchment area and the rest of Ontario. Hepatitis C rates are also much higher than those of Ontario. Public health and community data illustrate a clear need for additional strategies and resources to decrease death and harms of substance use. There is strong agreement among PWUD surveyed that they would use SCS and would highly value SCS as a way to use under safer conditions. Additionally, key informants interviewed overwhelmingly support the introduction of these services and the potential associated benefits to PWUD and the broader community.

2. ***Health, social, and/or mental health service providers, including Indigenous service providers, in Kenora may be best positioned to lead future development planning of SCS as the local professionals on harm reduction.*** SCS should be shaped around the needs of local PWUD, with the primary objectives of service provision being to reduce harms to users. PWUD should be engaged to inform any development and ongoing implementation of services to ensure they are responsive. Should development planning of SCS be pursued in Kenora, lead health, social and/or mental health service providers should determine and complete the following, while consulting with other providers in Kenora.
    I. Agreement on a service model(s). While a downtown Kenora SCS site is recommended and may help to meet the needs of those PWUD within the surrounding neighbourhoods, many live in rural communities around Kenora. A mobile or hybrid model could be considered, allowing for greater outreach to those living further away from the downtown and immediate surrounding area. Lead health, social and/or mental health service providers should work with Indigenous service providers and communities to ensure that SCS services are inclusive and responsive to the cultural needs of Indigenous community members.
    II. The scope of harm reduction, health and social services will be delivered with or linked to the SCS, and whether any specific Health Canada exemptions (e.g., for smoking or assisted-injected) are necessary. In the past year more than half of PWUD survey respondents in Kenora identified needing help with injecting. Smoking is the second most common method of drug use according to survey respondents in Kenora.
    III. Resources required and the necessary roles of the agencies involved for the development of SCS, including physical capital, human resources and partnerships.
    IV. The Kenora lead(s) should apply to Health Canada for a Section 56.1 Exemption for Medical Purposes under the Controlled Drugs and Substances Act for Activities at a Supervised Consumption Site. The application includes details about policies and procedures, personnel/staffing structure, a community consultation report, and a financial plan, which all will have been completed in the development of SCS.

V. The Kenora lead(s) should strongly consider applying to the Ontario Ministry of Health for funding through the Consumption and Treatment Services (CTS) funding program. Other sources of funding, such as municipal, philanthropic, or private may also need to be considered. An organization can forego a funding application to Ontario Ministry of Health if they have secured an alternative source of funding. There are a number of organizations in Ontario who have taken this approach.

3. ***Implementation plans need to be developed alongside of engagement with key stakeholder groups such as municipal governments, emergency services, Indigenous partners, and the broader community.*** SCS will not provide a 'magic bullet' to solve all drug-related concerns in Kenora. Discussions regarding 'what are the realistic outcomes of SCS in our community?' will be important to have with results communicated widely, in order to manage expectations of the SCS. Implementation plans should consider how SCS could impact the broad community (social, economic, safety, and services), and risk-mitigation strategies for any anticipated challenges. It is recommended that these be shared and explained with various stakeholders and the broader community.

4. ***Any SCS developed in Kenora needs to be positioned within the larger community level approach to mental health and addiction services, integrating them into the local treatment and service network.*** Specific considerations of the needs of PWUD from Kenora, community collaboration, geography, and existing and future harm reduction initiatives should all be considered. While a SCS/harm reduction approach tailored to Kenora is recommended, it is also recommended that regular communication with other northwestern Ontario communities regarding lessons learned, best practices, challenges, and tools will help to strengthen respective plans, reduce duplication, and amplify impact.

5. ***Educational activities for the public and partners, regarding SCS is highly recommended alongside any SCS development. Raising awareness among and working alongside of community leaders in Kenora will be critical to understanding community concerns, as well as help SCS to succeed and be sustainable. Stakeholders and the general public should be comprehensively informed of the research evidence of the impacts of SCS. Transparent and accurate information on SCS will ensure that decision makers understand the benefits and can mitigate any potential challenges.*** These educational activities should also aim to increase awareness and empathy regarding addiction in general, and reduce stigma associated with PWUD. Results from the community survey in Kenora showed mixed support, with just over half of respondents providing support for the development of treatment and consumption services. There is some polarity among responses around the potential for SCS to either benefit or present negative consequences for the community. Respondents also found it unlikely that SCS would be accepted among various community stakeholder groups. Key informants spoke about the potential for broader community concerns and fears regarding their implementation. The need for specific awareness, education and training activities tailored to the context of each stakeholder group will be important.

6. ***Evaluation plans for any implemented SCS need to be developed to define, measure and report on the outcomes for transparency, reporting and improvement.*** Evaluation plans should be able to assess client uptake and community impact and be aligned with the goal outcomes of the

community's mental health, addiction and harm reduction strategies. Evaluation plans will be important in measuring the key impacts of SCS, which can then be communicated to stakeholders to illustrate the benefits and gains to the community and focus on improving where weaker results are being seen.

8. Appendices

Appendix A: Needs Assessment Consultant Team

The needs assessment was sponsored and initiated by NWHU, which procured the services of a team of consultants to complete the needs assessment . The consultant team, LBCG Consulting for Impact in partnership with the Ontario Public Health Association, designed the needs assessment, collected the data, completed the analysis and wrote this report. NWHU owns the data and upon completion of the needs assessment, all data was transferred to NWHU, who has it on record and has access for future use.

The consultant team was comprised of the following members:

Steve Lough, LBCG Consulting for Impact – Project Director

Nick Chauvin, LBGC Consulting for Impact – Project Lead

John Atkinson, Ontario Public Health Association – Sr. Consultant

Melanie Sanderson, Ontario Public Health Association – Sr. Consultant

Marissa Lustri, Ontario Public Health Association – Researcher

Carol Strike, Independent – Harm Reduction Subject Matter Expert

Nick Boyce, Independent – Harm Reduction Subject Matter Expert

Em Carl, Independent – Harm Reduction Research Advisor

Appendix B: NWHU Catchment Data

B:1. Rate per 100,000 of opioid-related morbidity and mortality in the Northwestern Health Unit catchment area, 2015-2021.

Year	Population	Rate of ED Visits	Change of ED Visits	Rate of Hospitalizations	Change of Hospitalizations	Rate of Deaths	Change of Deaths
2015	81,349	25.8	-19.1%	20.9	143.0%	4.9	-33.8%
2016	81,554	34.3	32.9%	27	29.2%	6.1	24.5%
2017	81,752	58.7	71.1%	25.7	-4.8%	7.3	19.7%
2018	81,886	75.7	29.0%	15.9	-38.1%	12.2	67.1%
2019	81,963	67.1	-11.4%	12.2	-23.3%	11	-9.8%
2020	81,997	146.3	118.0%	11	-9.8%	20.7	88.2%
2021	81,967	173.2	18.4%	23.2	110.9%	-	-

Source: Ontario Drug Policy Research Network. Ontario Opioid Indicator Tool. Accessed from: https://www.publichealthontario.ca/en/Data-and-Analysis/Substance-Use/Interactive-Opioid-Tool

B:2. ER visits due to substance-related reasons per 100,000, 2016-2020, by local health hub.

	ER visits per 100,000				
Local Health Hub	**2016**	**2017**	**2018**	**2019**	**2020**
Atikokan	2,083.9	1,966.2	2,430.1	2,187.8	2,769.3
Dryden	1,857.5	2,002.2	2,323.5	1,845.6	2,170.7
Emo	976.9	1,228.1	883.9	1,749.2	1,302.6
Fort Frances	2,157.8	2,891.5	3,235.7	3,852.5	4,138.2
Kenora	5,367.7	6,271.4	6,436.7	6,523.6	6,210.1
Rainy River	4,036.3	3,020.5	3,838.5	3,847.5	4,315.0
Red Lake	3,631.0	3,942.8	3,264.3	5,831.7	6,785.3
Sioux Lookout	9,699.6	9,780.1	12,079.8	13,090.5	10,477.1
NWHU	**4,779.5**	**5,181.4**	**5,815.3**	**6,253.0**	**5,791.8**
Ontario	**867.4**	**953.7**	**1,010.4**	**1,031.6**	**975.9**

Source: Ambulatory Visits [2016-2020]. Ministry of Health and Long-Term Care. IntelliHEALTH Ontario. Date Extracted: May 12, 2022

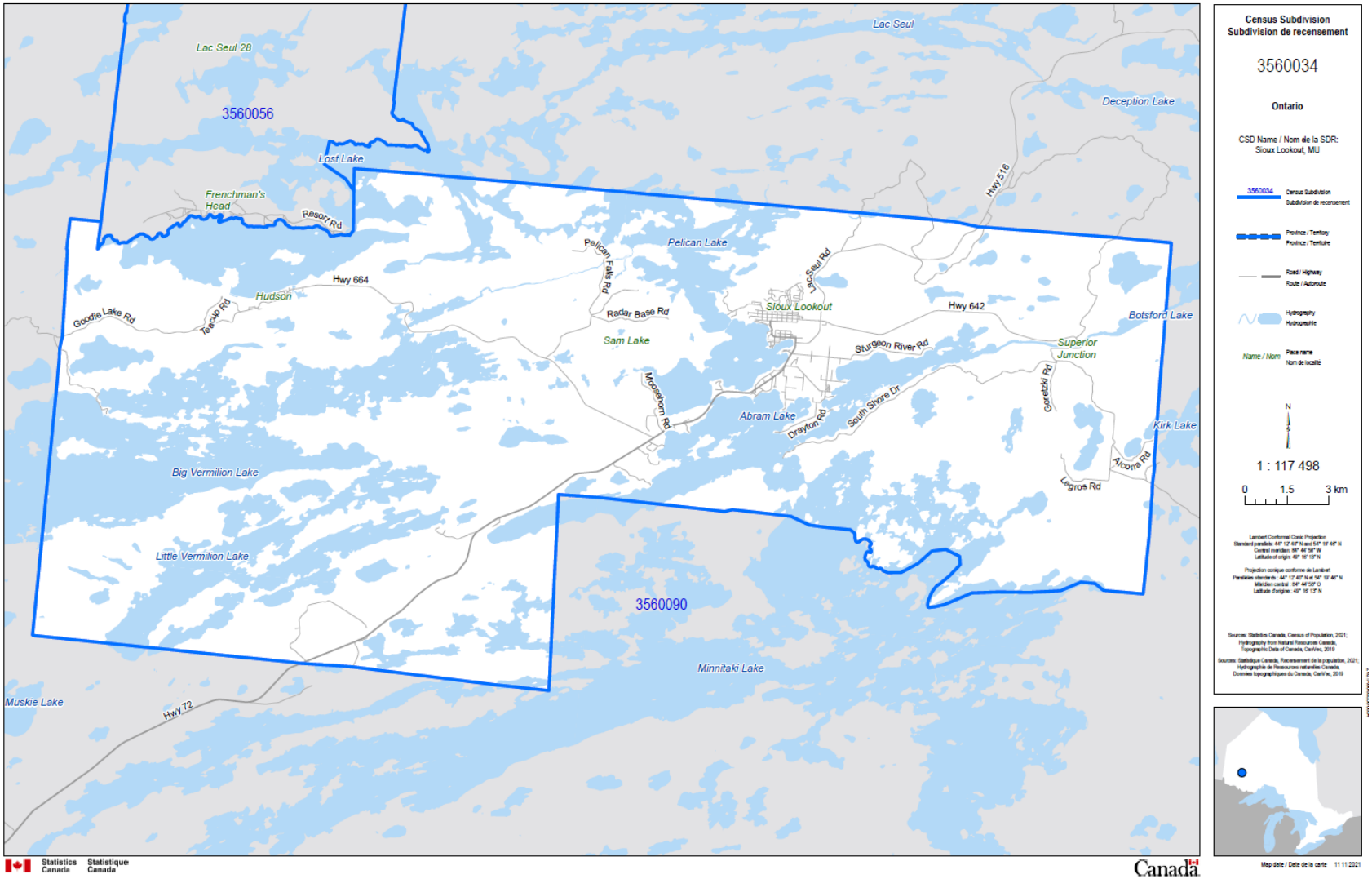
B:3. Naloxone distribution by area.

Year	Kenora	Dryden	Fort Frances	Sioux Lookout	Red Lake
2018	564	50	86	180	5
2019	558	110	72	104	0
2020	739	272	594	306	21
2021	240	266	432	60	3
2022 (Jan-Apr)	38	469	161	64	0

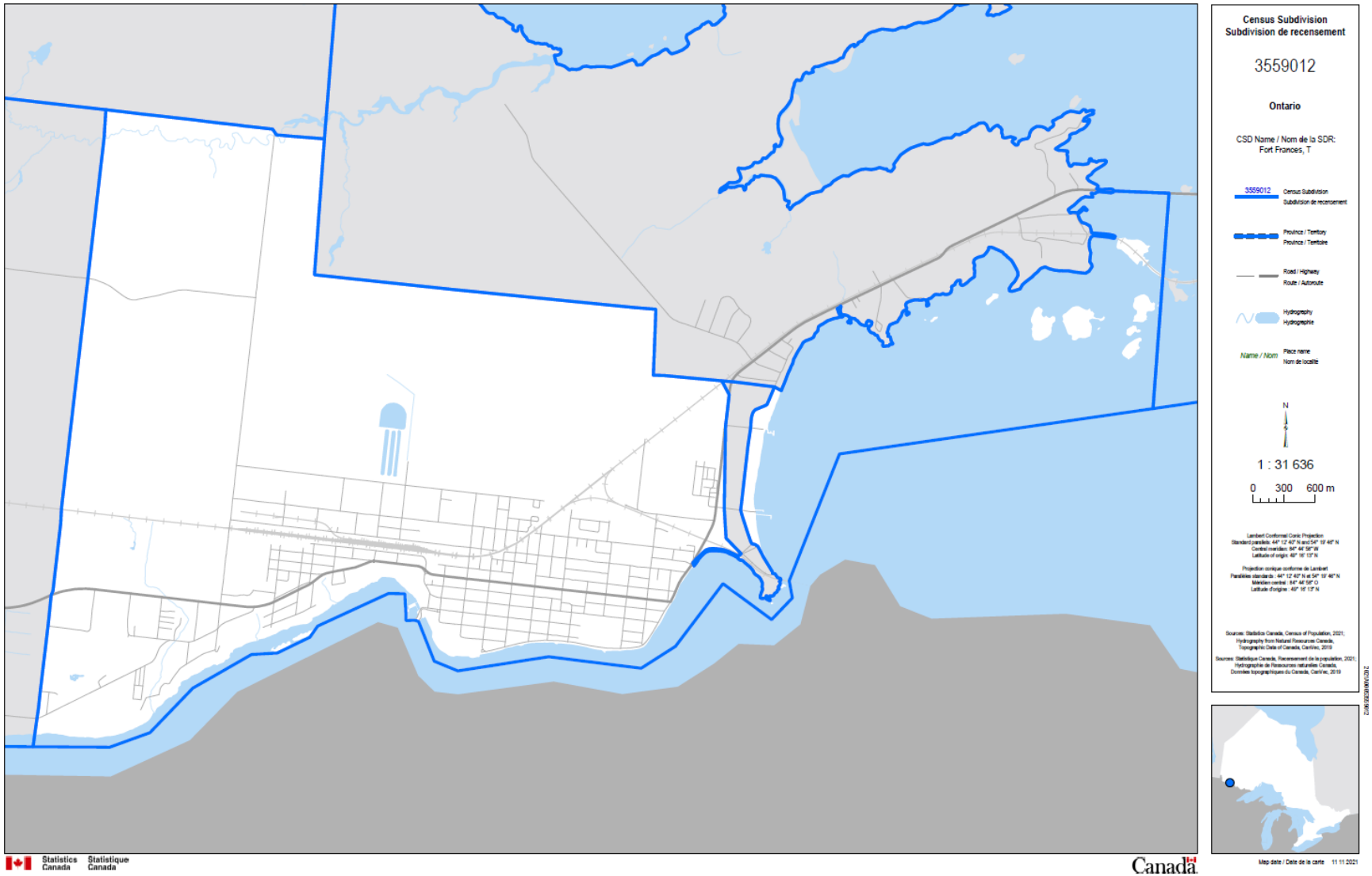
Source: Data provided by Northwestern Health Unit

Appendix C: Municipal Maps

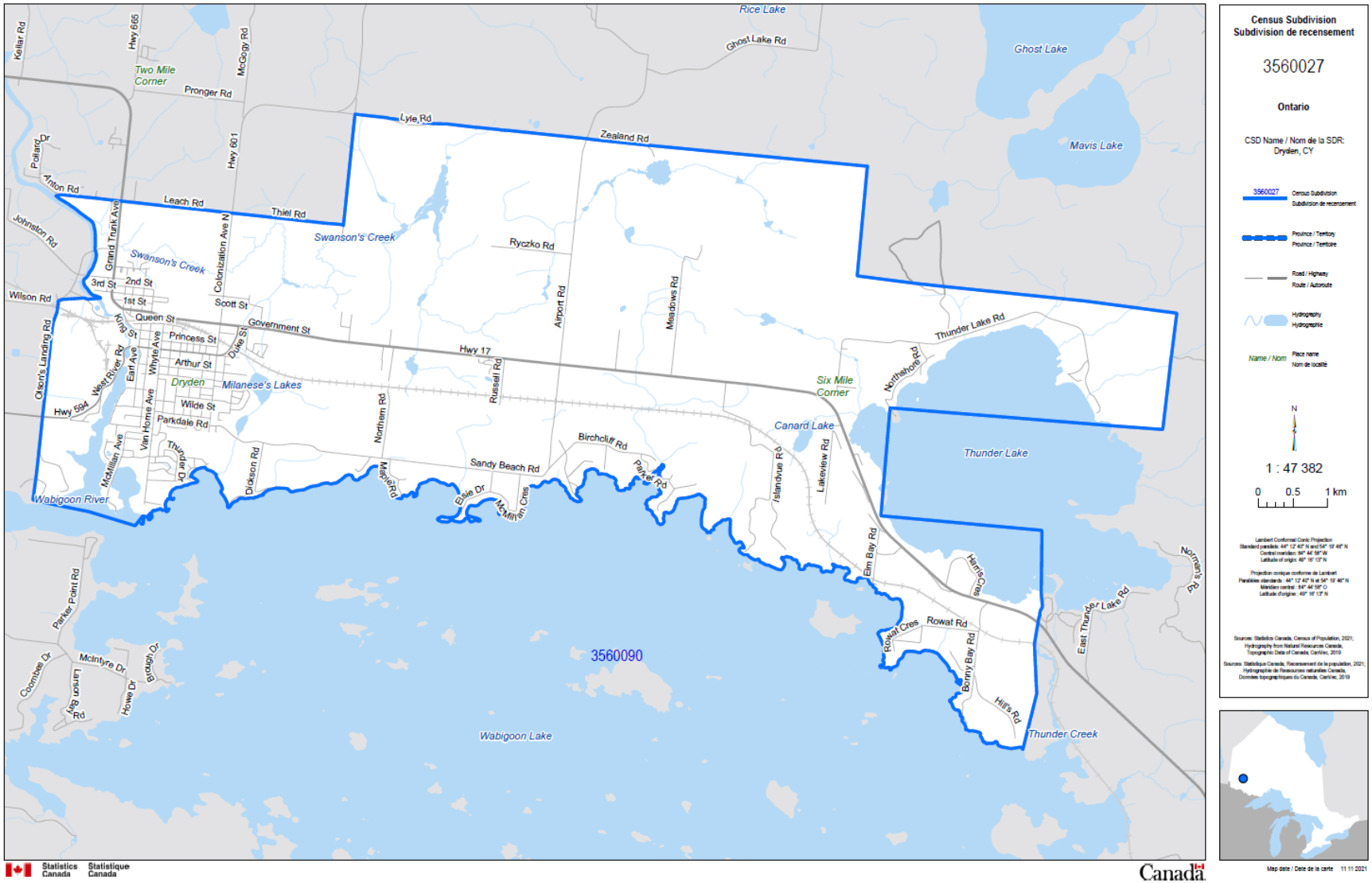
F:1. Map of the Municipality of Sioux Lookout



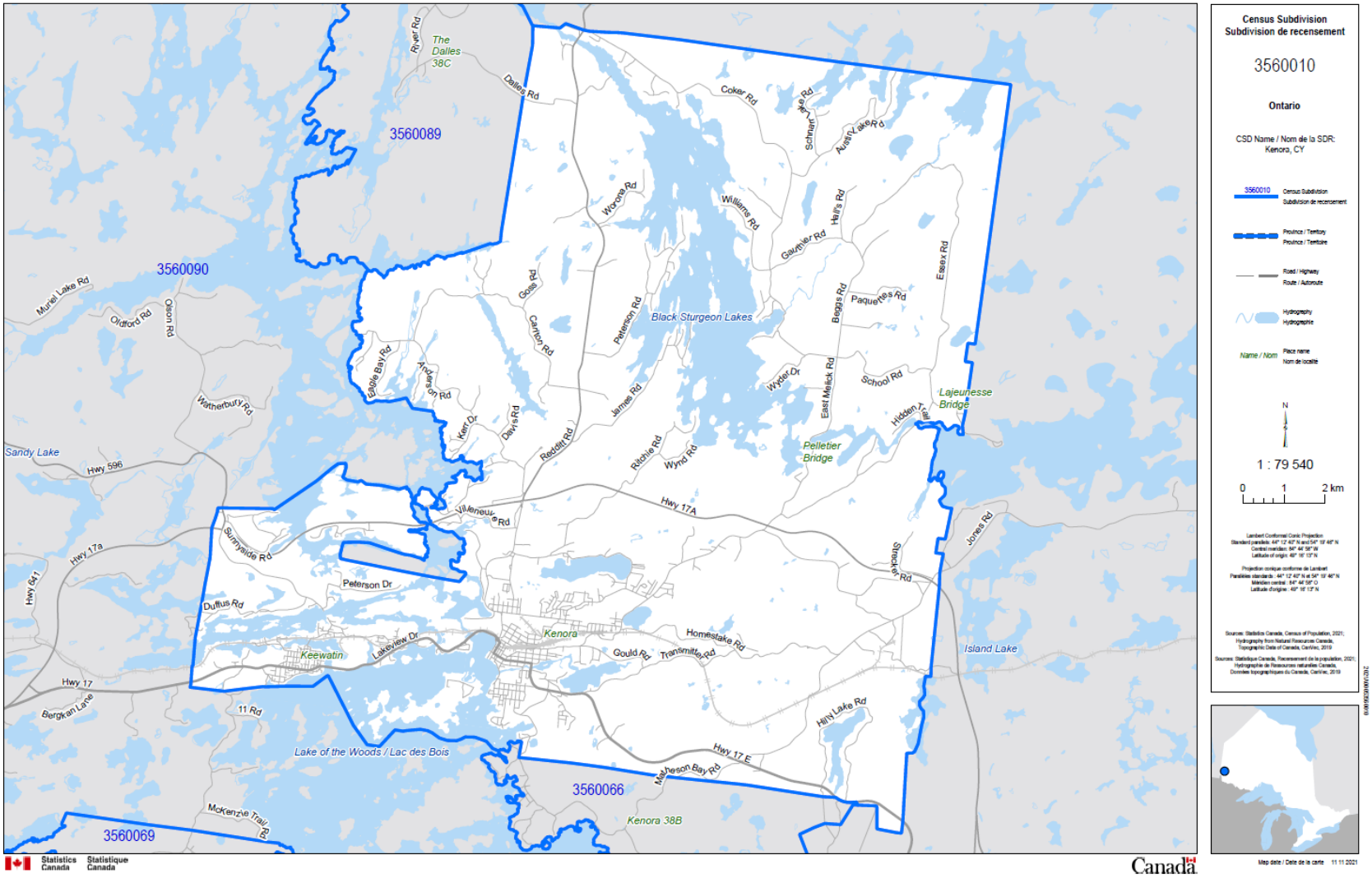
F:2. Map of the Town of Fort Frances



F:3. Map of the City of Dryden



F:4. Map of the City of Kenora



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