APRIL 2021

PEEL INTEGRATED DRUG STRATEGY

COMMUNITY CONSULTATION AND RECOMMENDATIONS

moyo

LAND ACKNOWLEDGMENT

The Peel Integrated Drug Strategy is located on the territories of the Anishnabek, Huron-Wendat, Haudenosaunee, Ojibway, and Mississaugas of the Credit First Nation. We also recognize the past and present contributions of Métis, Inuit and First Nations peoples that continue to have a hand in shaping and strengthening these communities in our province and country as a whole.

03

ACKNOWLEDGMENTS

Primary Authors: Shradha Pandey, Erika Kouzoukas, and Adam Chalcraft from Moyo Health and Community Services

We would like to express our gratitude towards the Peel Integrated Drug Strategy collaborative members for their kind co-operation and contribution to this report.

Members of the Peel Integrated Drug Strategy:

Canadian Mental Health Association Peel Dufferin
John Howard Society
Moyo Health and Community Services
Peel Addiction Assessment and Referral Centre
Peel Alliance to End Homelessness
Peel Drug Users Advisory Panel
Peel Public Health
Punjabi Community Health Services
Safe City Mississauga
Services and Housing in the Provinces
WellFort Community Health Services
YMCA of Greater Toronto

APRIL 2021

TABLE OF CONTENTS

05

BACKGROUND OF THE PEEL INTEGRATED DRUG STRATEGY

The story of the Peel Integrated Drug Strategy (PIDS) and this report began in 2012 with the creation of the Peel Harm Reduction Committee (PHRC). The PHRC sought to bring together stakeholders to share information and resources and identify gaps and challenges to expand harm reduction knowledge and initiatives throughout Peel. The PHRC hosted trainings and a forum every year during Drug Awareness Week to bring greater attention to substance use-related issues in the Region. One gap identified by the PHRC early on was the need for Peel to have a comprehensive drug strategy to better address the needs of the community. One forum brought in Drug Strategy Coordinators from different regions to present on the importance of the work of their respective strategies in the hopes that this would spark greater discussion for the need for a strategy of our own.

The PHRC formed a working group to begin looking at how we might develop a drug strategy and what steps would need to be taken to do so. We applied for, received funding, and in 2018 a coordinator was hired and the Peel Integrated Drug Strategy collaborative was formed. Various stakeholders were brought together to form a steering committee, literature reviews were conducted and other strategies were looked at to develop a framework for PIDS. From the beginning it was recognized that no strategy would be successful without the meaningful engagement of people who use drugs (PWUD) at every stage, therefore the Peel Drug Users Advisory Panel (PDAP) was formed. PDAP has been made up of 12 people who have lived/living experience with substance use who represent the diversity of communities of PWUD in the Region. They were trained in group dynamics, along with policy formation and advocacy as well as harm reduction, overdose prevention and response, anti-oppression/anti-racism, 2SLGBTQ+ inclusion, mental health first aid and CPR training. PIDS, along with rotating members of PDAP, joined and contributed to the Region's Opioid Strategy Steering Committee. During the 2018 forum, we were able to conduct our first round of service provider consultations around substance use-related issues faced by specific priority populations.

06

During year two, PIDS and PDAP conducted an environmental scan (to take stock of existing relevant services, data and reports and to identify priority populations), and developed the community consultation tools and engagement strategies that guided the creation of this report. All fixed-site needle exchange programs were brought together for the first time and services were reviewed by PDAP through their development of evaluation tools and recommendations along with the revision of harm reduction kits for Peel Public Health. PDAP also helped with the Safe Consumption Site (SCS) Feasibility Study conducted by Peel Public Health whereby PDAP was able to recruit and conduct the surveys for 150 people who use drugs across the Region. PDAP addressed Regional Council with Peel Public Health to present the findings of the study and present the need for SCS in Peel, which Council endorsed. Bad Drug Reporting mechanisms were also put in place to be able to inform the community and service providers of tainted substances that were being seen in the local drug supply. The forum in 2019 provided the opportunity to conduct our second round of consultations with service providers and other key stakeholders based on the four pillars approach of harm reduction, prevention, treatment and enforcement.

During 2020, PIDS finalized the community consultation tools and began the community consultation process through the creation and distribution of surveys for people who use drugs as well as general community members. Data analysis and recommendations were developed based on the findings along with other evidence-informed best practices identified in the literature. All of this culminated into the completion of the final report, of which the key findings were presented at the 2020 forum. The PIDS and the Opioid Strategy groups also hosted a facilitated meeting with members of both strategies to look at how these two strategies could be eventually merged into one larger strategy.

The Peel Integrated Drug Strategy would like to thank all of the organizations, stakeholders and individuals who made this possible through years of collaborative work and consultation. We would like to thank the two PIDS Coordinators and the placement students for their leadership and coordination at every stage of this process along with the analysis and writing of this report. We would like to thank the Region of Peel for having the vision to fund this important work, as well as Peel Public Health for your continued support and guidance through this process.

07

We want to thank everyone from the Peel Drug Users Advisory Panel for the invaluable guidance and work that you provided at every stage of the development of this strategy without which this report along with all other PIDS initiatives would not have been possible. Lastly, we would like to give our gratitude to the members of drug-using communities across Peel who were willing to share their valuable insights and experiences with us during our community consultation process, this report is dedicated to you and the many people we have lost along the way. It is our hope that this report can help contribute to the greater health and wellbeing of people who use drugs and by extension the Region as a whole.

With love and solidarity,

The Peel Integrated Drug Strategy Steering Committee

08

EXECUTIVE SUMMARY

Introduction

Substance use is a reality within society and is part of the social culture. People from all walks of life engage in the use of legal or illegal substances for different reasons. This report recognizes that substance use is not always problematic and that people have a variety of relationships with substances.

Peel, as with many communities across Canada, is experiencing significant harms related to problematic substance use including illegal drugs, non-medical use of over-the-counter and prescription drugs and a steady increase in opioid-related overdoses and death. The root causes for harms related to substance use are largely derived from systemic structures such as restrictive laws and policies, institutional biases, inequities and discrimination. Therefore, in 2018 community organizations in Peel came together to address the growing impact that substance use has on the collective safety and wellbeing of the diverse communities of the region and developed the Peel Integrated Drug Strategy (PIDS).

The PIDS aims to unite stakeholders in Peel to develop collaborative solutions to minimize the harms related to substance use, and strive for policies, laws and programs that reflect the values of public health and human rights.

The purpose of the drug strategy is not to be the only authority in Peel designing services, programs or policies for substance users. Rather, recommendations will be made to agencies and systems aimed at reducing service delivery fragmentation, limiting the duplication of services and ensuring that policies and programs in Peel are well informed by actual needs on the ground.

Objectives

The community consultation was conducted to explore the perspectives of people who use drugs, service providers and general community members in Peel. The objective of the consultation was to better understand the perspectives of people who use drugs in Peel, including demographics and drug use practices, identify needs and gaps in services and supports, determine the priorities of the drug strategy and develop informed recommendations.

Methods

The PIDS collaborative engaged people who use drugs, general community members as well as service providers for data collection. It included collecting quantitative and qualitative survey responses from people who use drugs and general community members through survey, analyzed separately and merged together. We also included available health data from regional and provincial sources such as overdoses, drug-related emergency department visits and hospitalizations. The qualitative component involved focus groups with service providers in Peel and ongoing consultation with the Peel Drug Users Advisory Panel.

Findings

1. Characteristics of consultation participants

- The consultation was done with 790 people who use drugs, 155 general community members and more than 100 service providers in Peel.
- Among the 790 participants, 93.5% of respondents used substances in the past three months.
- The top three age groups that completed the survey were 25 to 30 years (49%), 31 to 40 years (24.9%) and 16 to 24 years (17.5%).
- Fifty-eight and a half percent of survey participants identified as male and 36.8% of participants identified as female.
- Twenty-five percent of individuals who completed the survey made less than $30,000 before taxes in 2019.
- One in five survey participants did not have stable housing or were currently homeless.
- Sixty-three percent of study participants who completed the survey identified as heterosexual whereas 36% identified as being members of the 2SLGBTQ+ communities.

2. Drug and substance use in Peel

- Forty-one percent of respondents identified themselves as using substances occasionally. Fourteen percent of individuals identified being dependent on substances and 14.3% of individuals expressed their substance use was problematic and led to negative health and social outcomes for them.
- The top three preferred substances used by respondents were alcohol (42.8%) , prescription (24.7%) and non-prescription (20.7%) marijuana/cannabis and methamphetamines (23.4%)
- Coping with unpleasant feelings (34%), pleasure and enjoyment (28.4%) and life stressors (22.8%) as their top three reasons for initiation of substance use.
- Among general community survey respondents, 82.4% felt that substance use was a problem in Peel and identified health issues (42.14%), drug-related litter (33.6%), criminalization of drug users (33.6%), driving under the influence (32.1%) and community safety/crimes (30.7%) as the primary issues related to substance use.

- Three in four general community survey respondents indicated that they did know someone who had a previous or existing issue with substance use and 69.2% expressed that this person's substance use negatively impacted those around them.

3. Barriers and enablers for accessing services and supports

- Addiction services including withdrawal management and replacement therapy were accessed by 45% of the individuals. Thirty-six percent of respondents accessed a general practitioner and 29.5% of respondents accessed harm reduction services such as needle exchange programs in the last two years.
- Fear of other people finding out (community/family/cultural shame) (28.1%), fear of arrest/criminalization/incarceration (18.3%), personal shame/embarrassment (17.3%), and fear of child welfare services involvement (17.1%) were identified as the top individual-level barriers to accessing services.
- Confidentiality concerns (28.1%), lack of relevant services for youth, seniors, women, or persons of color (28.1%), long waiting lists (19.1%), and high cost of service (17.3%) were the top service provider related reasons for not accessing services.

4. Prevention of problematic substance use

The top five supports identified to prevent problematic substance use:

- housing supports including access and availability of affordable and suitable housing options (53.1%).
- social supports including supportive spaces and places and social opportunities for substance users (49.7%).
- income supports (47%).
- mental health supports including programs that help with mental health issues and promote mental health (39.6%).
- greater education and awareness related to effects of drug use and drug use safety (36.2%).

5. Priorities for drug strategy in Peel

- The respondents identified access to treatment services (54.7%) as the number one priority for the drug strategy.
- Education and awareness regarding substance use including stigma reduction (50.3%) were also identified as a major priority.
- Harm reduction services (47.5%) were identified as a priority by respondents.
- The top five priority groups for receiving substance use-related services and supports include youth and homeless youth (41%), members of the 2SLGBTQ+ community (34%), individuals living in poverty (32.6%), women (26.8%), and members of the African, Caribbean and Black community (21.7%).

Recommendations

Overall, the Peel Integrated Drug Strategy consists of 7 priorities and 78 recommendations. The priorities and recommendations for the drug strategy were identified based on the community consultation findings, a review of academic and grey literature and the work done by other drug strategies in Ontario. The PIDS also developed some guiding principles based on the community consultation process, which are the core values to move forward the work of the drug strategy.

1. Reducing stigma
2. Enhancing housing
3. Decriminalizing drugs
4. Increasing access to programs and services
5. Enhancing existing programs and services
6. Developing supervised consumption sites and safe supply
7. Facilitating leadership, collaboration and implementation

Next steps

1. Continue the work of the drug strategy.
2. Identify priorities for the implementation phase of the drug strategy.
3. Develop working groups for COVID-19 and substance use.
4. Coordinate with the Opioid Strategy to develop a comprehensive strategy in Peel.

A NOTE ON LANGUAGE USE

The Peel Integrated Drug Strategy has a responsibility to be thoughtful and respectful with our language choices (Figure 1). We recognize that the words used to discuss substance use and the people that use substances can impact the types of conversations we have with the people around us. Using language that excludes a person or group impacts people's health and ability to access services and supports. We use person-first language to maintain and prioritize the integrity of individuals. We avoid using negative, stigmatizing language that reflects prejudiced or discriminatory views as it discredits people who use substances.

Within this report, our aim is to be inclusive with our language choices and avoid words that inadvertently exclude a person or group, however, there is the potential for harm regardless of our intention. As a collaborative, we understand that inclusive language should reflect societal views and must continue to evolve based on how people and communities choose to redefine their own identities. PIDS acknowledges that inclusive language helps promote equal opportunity and is committed to creating an inclusive environment for all people.

TOPIC	INSTEAD OF	USE
People who use drugs	Addicts Junkies Users Drug abusers Recreational drug users	People who use drugs People with a substance use disorder People with lived/living experience People who occasionally use drugs
People who have used drugs	Former drug addicts Referring to a person as being "clean"	People who have used drugs People with lived/living experience People in recovery
Drug use	Substance/drug abuse Substance/drug misuse	Substance/drug use Substance use disorder/opioid use disorder Problematic [drug] use [Drug] dependence

Figure 1. Government of Canada language chart on "Changing How We Talk About Substance Use". https://www.canada.ca/en/health-canada/services/substance-use/problematic-prescription-drug-use/opioids/stigma/stigmatips-talk-substance-use.html

INTRODUCTION

Substance use is a reality within society and is part of the social culture. People from all walks of life engage in the use of legal or illegal substances for different reasons. This report recognizes that substance use is not always problematic and that people have a variety of relationships with substances. Moreover, substance use occurs along a spectrum that ranges from no use to problematic with varying personal and social effects (Figure 2).[1] For some people, substance use may remain non-problematic while for others, it may pose significant harm. Problematic substance use can lead to a variety of health and social consequences including blood-borne infections, overdose, dependence, psychological harm, trauma, precarious housing, crime, family instability and economic and emotional burden.[2,3]

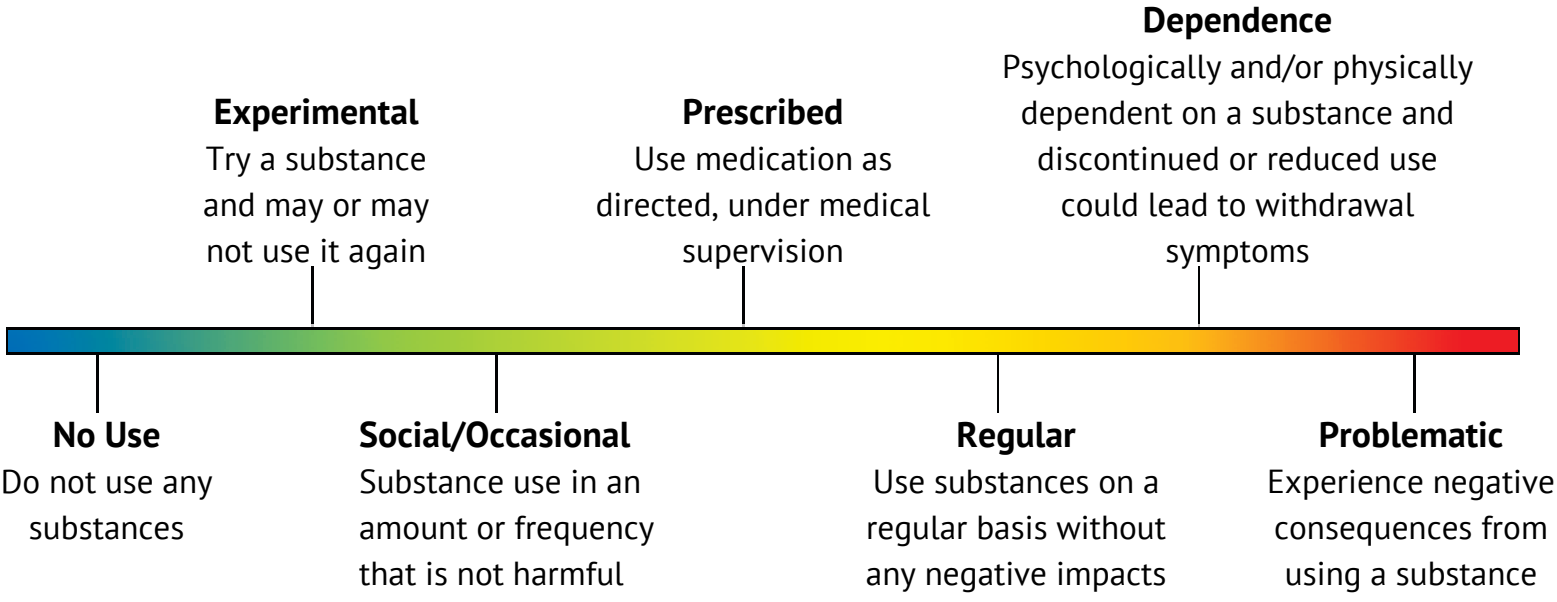

Figure 2. The spectrum of substance use.

15

NEED FOR A DRUG STRATEGY IN PEEL

Peel, as with many communities across Canada, is experiencing significant harms related to problematic substance use including illegal drugs, non-medical use of over-the-counter and prescription drugs and a steady increase in opioid-related overdoses and death.[2,4] The impact of problematic substance use is far-reaching and has direct and indirect effects on the individual and the community. The punitive approach to drug laws and policies in Canada promotes the stigmatization of people who use substances as it dehumanizes people by labeling them as criminals. Their effects exacerbate existing inequalities and threaten the well-being of people who use substances. In addition, the presence of stigma, discrimination and cultural incompetency act as barriers and they serve to perpetuate and exacerbate the negative effects of substances on people who use drugs.

The root causes for harms related to substance use are largely derived from systemic structures such as restrictive laws and policies, institutional biases, inequities and discrimination. Therefore, in 2018 community organizations in Peel came together to address the growing impact that substance use has on the collective safety and wellbeing of the diverse communities of the region and developed the Peel Integrated Drug Strategy. The drug strategy in Peel aims to provide a coordinated, nonjudgmental and innovative roadmap of policy and program recommendations through cross-sectoral collaboration, and coordination of priorities, policies and interventions to reduce harms related to substance use.

MISSION OF THE PIDS

The PIDS aims to unite stakeholders in Peel to develop collaborative solutions to minimize the harms related to substance use, and strive for policies, laws and programs that reflect the values of public health and human rights.

The purpose of the drug strategy is not to be the only authority in Peel designing services, programs, or policies for substance users. Rather, recommendations will be made to agencies and systems aimed at reducing service delivery fragmentation, limiting the duplication of services and ensuring that policies and programs in Peel are well informed by actual needs on the ground. Most importantly, with alarming overdose rates, a strategy that is rooted in collaboration, continuous communication and a common agenda is needed to save lives. The work of the Peel Integrated Drug Strategy is in alignment with the Opioid Strategy to reduce opioid-related harms in Peel (https://www.peelregion.ca/opioids/pdf/Peel-opioid-strategy.pdf).

SUBSTANCE USE IN PEEL

In 2019, the Region of Peel released a comprehensive report on the health status of Peel residents. This population health assessment outlined the state of health and risk factors within the community.

Alcohol consumption is a risk factor for chronic diseases and injuries. Overall, the proportion of Peel residents that regularly consume alcohol (47%) is significantly lower compared to Ontario (56%); however, males (56%) and those in the highest household income category (72%) drink more alcohol compared to females (38%) and other income categories (low-middle income: 47% and middle income: 49%).[2] Harms associated with alcohol use have steadily increased over the last 20 years in Peel with a rate of 429.5 emergency department visits related to alcohol per 100,000 in 2018.[5] In addition, in 2017, 7% of students (grades 9 to 12) engaged in hazardous and harmful drinking, including binge drinking.[2]

Cannabis, which includes marijuana, hashish and extracts, was legalized in Canada in October 2018. Evidence is emerging regarding the health risks associated with recreational cannabis use, however, due to the novelty of the legalization, further research is needed to ascertain the health implication of cannabis use.[6] In Peel, harms associated with cannabis use have increased annually with 58.4 emergency department visits for cannabis-related harms per 100,000 in 2018 compared to 10.4 per 100,000 in 2008.[7]

Opioids are a class of drugs that includes both natural and synthetic varieties and vary greatly in strength. Currently, opioid-related morbidity and mortality is a national public health emergency. Evidence published by the Public Health Agency of Canada indicates that opioids are the leading cause of overdose and overdose-related death in Canada. In Peel, the average number of annual opioid-related deaths have increased sharply from 26 deaths in 2013 to 112 deaths in 2019.[8] Between January 2019 and June 2020, there have been 306 opioid-related deaths with 80% involving fentanyl (up from 13% prior to 2014).[8] In addition, in 2017, 12% of students in Peel (grades 7 to grade 12) reported using opioid pain relief pills for non-medical use without a prescription over a 12-month period.[2]

17

COVID-19 AND PEOPLE WHO USE DRUGS

In the absence of supervised consumption sites and safe supply, Peel is experiencing a drug crisis with increasing overdose deaths over the past few years. The crisis has worsened with COVID-19, as the pandemic measures have inadvertently increased access-related barriers and aggravated health vulnerabilities for people who use substances. Compared to 2018 and 2019, fewer individuals were able to access harm reduction supports in Peel in the first six months of 2020, due to COVID-19 public health measures (e.g., physical distancing, service closures, reduced working hours or alternative delivery of services). During the same period, the number of opioid-related deaths in Peel increased between March 2020 and October 2020 (Figure 3). [8]

Figure 3. The number of opioid-related deaths in Peel between January 2020 and October 2020. At the time of writing this report (March 2021), the number of opioid-related deaths beyond October 2020 was not available.

The COVID-19 pandemic also had a significant negative impact on the physical, mental, and social well-being of people who use substances.[9] The physical distancing guidelines disrupted social and healthcare supports that people who use substances rely on. Reduced or altered services and supports have led to anxiety, fear, and social isolation. Community spaces such as libraries and malls where people could congregate are closed, making people feel alone and vulnerable.[9] Inequities in availability and access to harm reduction education and services existed before, however, the pandemic has exposed these inequities and the impacts they have had on various groups in our societies. As ethno-culturally diverse and economically disadvantaged neighborhoods, particularly in medium and large urban centers, such as Peel, are disproportionality experiencing an increase in opioid-related deaths [10], the physical distancing guidelines mean that people are mourning the loss of their family and friends alone [9]. In comparing pre-pandemic opioid-related deaths to pandemic opioid-related deaths, Peel is one the hardest-hit regions, with the second-largest change of absolute deaths in Ontario [10]. The pandemic more than ever has brought to the forefront the need for a comprehensive and collaborative drug strategy in Peel.

OBJECTIVES

The community consultation was conducted to explore the perspectives of people who use drugs, service providers and general community members in the Peel, identify needs and gaps in services and supports, determine the priorities of the drug strategy and develop informed recommendations.

1. Better understand the community of people who use drugs in Peel, including demographics and drug use practices.
2. Document the community's understanding of the issues/biases related to drug/substance use.
3. Identify how does drug/substance use affects Peel's communities.
4. Recognize the community's survey respondents' priorities to help address drug/substance-use related issues

- Understanding the use of drugs and substances in Peel
- Familiarity with supports and services for people who use drugs
- Identifying needs and gaps in services provided to people who use drugs

20

METHODS

Steering committee formation → **Environmental scan and evidence review** → **Community consultations** → **PIDS report**

ENVIRONMENTAL SCAN AND EVIDENCE REVIEW

To better understand the local context of problematic substance use in Peel, an environmental scan of all available programs and services in the region was conducted and relevant literature and local data were reviewed. This included collecting and analyzing available resources from academic journals, community organizations as well as from regional, provincial and federal agencies related to Peel demographics, housing, drug use, immigration and population health assessment. Priority populations were identified for targeted engagement based on need or lack of available information (Appendix C).[11]

SERVICE PROVIDER CONSULTATION

Service providers were consulted during the Drug Awareness Week forum in 2018 and 2019 through focus groups. The questions and themes for the focus groups were developed by PIDS in consultation with the Peel Harm Reduction Committee and the Peel Drug Users Advisory Panel. More than 100 service providers from different organizations (healthcare, social services, government and municipal services, and police and emergency services) were consulted over the two years. The focus of the 2018 forum was on priority populations including women, racialized individuals, 2SLGBTQ+ persons and youth from 12-24 years of age. The 2019 forum focused on the four-pillar approach to problematic substance use - prevention, treatment, harm reduction and justice and enforcement.

21

PEOPLE WHO USE DRUGS SURVEY

The Peel Integrated Drug Strategy in consultation with the Peel Drug Users Advisory Panel developed a survey to better understand the community of people who use drugs in Peel, including demographics, drug use practices and needs and gaps in services provided. The questions were developed based on the environmental scan, consultation with service providers in Peel, surveys conducted in other regions and equity data collection tools such as “We ask because we care”.[12] The questions were tailored to the local context, and a pilot survey was conducted before releasing the final survey.

The survey was made available to people who self-identified as having used substances in the past two years in Peel. The survey was divided into four sections: demographic information, current drug use practices, existing services and supports in Peel, and priorities for the drug strategy in Peel.

The eligibility criteria for the survey were as follows:

1. The participant should be over 16 years of age,
2. The participant should be able to give informed consent,
3. The participant should have used drugs/substances in the past two years and
4. Participants should live/work/use substances in Peel.

Recruitment of participants:

Participants for the people who use drugs survey were recruited differently for online and paper surveys. Originally, the plan was only to conduct paper surveys. Organizations serving priority populations were identified and engaged for survey distribution. Leads were identified in each organization that would be able to administer the survey to the population of interest. Similarly, the Peel Drug Users Advisory Panel was also involved in the recruitment and distribution process of the survey. After completion of the survey, the leads brought the survey back to the Drug Strategy Coordinator who inputted the survey to a secure online survey tool (Survey Monkey).

Following the COVID-19 restriction in March 2020, the paper survey distribution was paused to follow provincial government guidelines. The survey was released online between 2nd and 8th September and 22nd October and 2nd November 2020. The survey was promoted through the following means:

- Social media – The survey was promoted on social media through different community organizations and grassroots groups on Facebook, Twitter and Instagram.
- Networks – Survey and contact information was distributed through emails to different community organization networks such as Peel Harm Reduction Committee, Peel Integrated Drug Strategy steering committee and Peel Drug Users Network.
- Word of mouth – The Peel Drug Users Advisory Panel promoted the survey to hard-to-reach members of the community. Initially, the link to the survey was shared with all organizations.

To avoid multiple responses from each respondent, participants interested in completing the survey were asked to reach out to the Drug Strategy Coordinator to receive the survey link and code. The respondents completed their survey on a secure online survey tool (Survey Monkey). Once the responses were validated for authenticity, survey participants received a $15 honorarium.

GENERAL COMMUNITY MEMBERS SURVEYS

An online survey was made available to general community members in Peel. This survey was divided into four sections: drug/substance use in Peel, personal experience with someone who uses drugs, priorities for drug strategy in Peel and demographic information. Participants who were eligible for the People who use drugs survey were redirected to the other survey. Similar to the other survey, the completed responses were inputted directly to a secure online survey tool.

The eligibility criteria for the survey were as follows:

1. The participant should be over 16 years of age,
2. The participant should be able to give informed consent and
3. Participants should live/work in Peel.

Recruitment of participants:

The survey was released online between October 22nd and November 9th, 2020. The survey was promoted through the following means:

- Social media – The survey was promoted on social media through different community organizations and grassroots groups on Facebook, Twitter and Instagram.
- Networks – Survey and contact information were distributed through emails to different community organization networks such as Peel Harm Reduction Committee, Peel Integrated Drug Strategy steering committee and Peel Drug Users Network.

We recognize the importance of involving the perspectives of people with lived/living experiences in the development of the drug strategy. The PIDS developed the Peel Drug Users Advisory Panel (PDAP), a panel of 12 members to support the work of the drug strategy and to provide a lived
experience perspective in the development of the drug strategy. The members provided input in all parts of the strategy and community consultation process, including the formation, distribution and analysis of surveys and the development of recommendations for the drug strategy documents.

FINDINGS

The analysis of the community consultation data led to the development of the following themes:

1. Characteristics of consultation participants
2. Drug/substance use in Peel
3. Barriers and enablers for accessing services in Peel
4. Prevention of problematic substance use
5. Priorities for the drug strategy in Peel

25

THEME 1: CHARACTERSITCIS OF CONSULTATION PARTICIPANTS

The survey for people who use drugs was administered physically between March 9th and 12th 2020, and then virtually between 2nd and 8th September and 22nd October and 2nd November 2020. A total of 790 participants completed the survey and self-identified living, working, or using in Peel and using substances in the past two years. Among the 790 participants, 93.5% of respondents used substances in the last three months.

Age and gender

The age of survey respondents ranged from 16 years to more than 65 years (Figure 4). The top three age groups that completed the survey were 25 to 30 years (49%), 31 to 40 years (24.9%) and 16 to 24 years (17.5%). This corresponds with the opioid-related emergency department (ED) visits, hospitalizations and deaths in Peel where persons 25 years to 44 years of age represented 53.4% of ED visits, 40.2% of hospitalizations and 49.4% of deaths in 2019.[4] Additionally, 58.5% of survey respondents identified as male and 36.8% of respondents identified as female (Figure 5). This corresponds to recent data trends that show that men make up a larger proportion of opioid-related ED visits, hospitalizations and deaths in Peel (Figure 6).

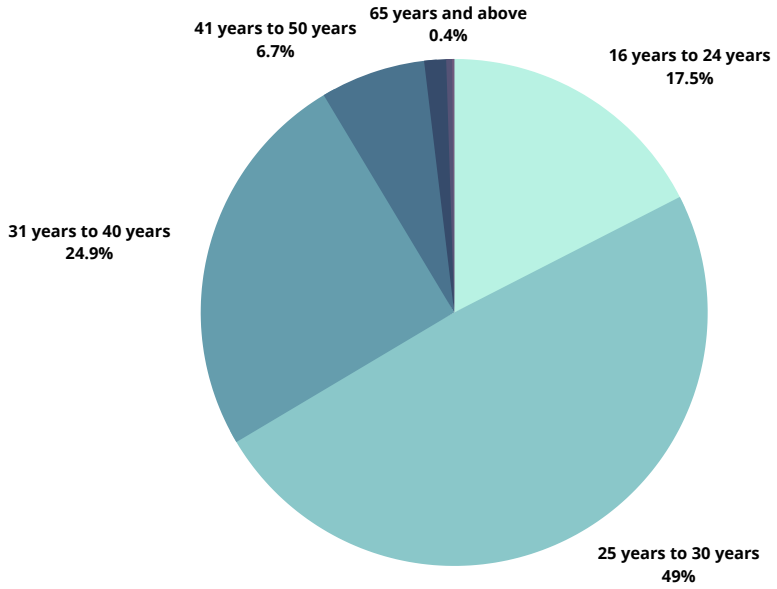

Figure 4. The distribution of survey respondents by age.

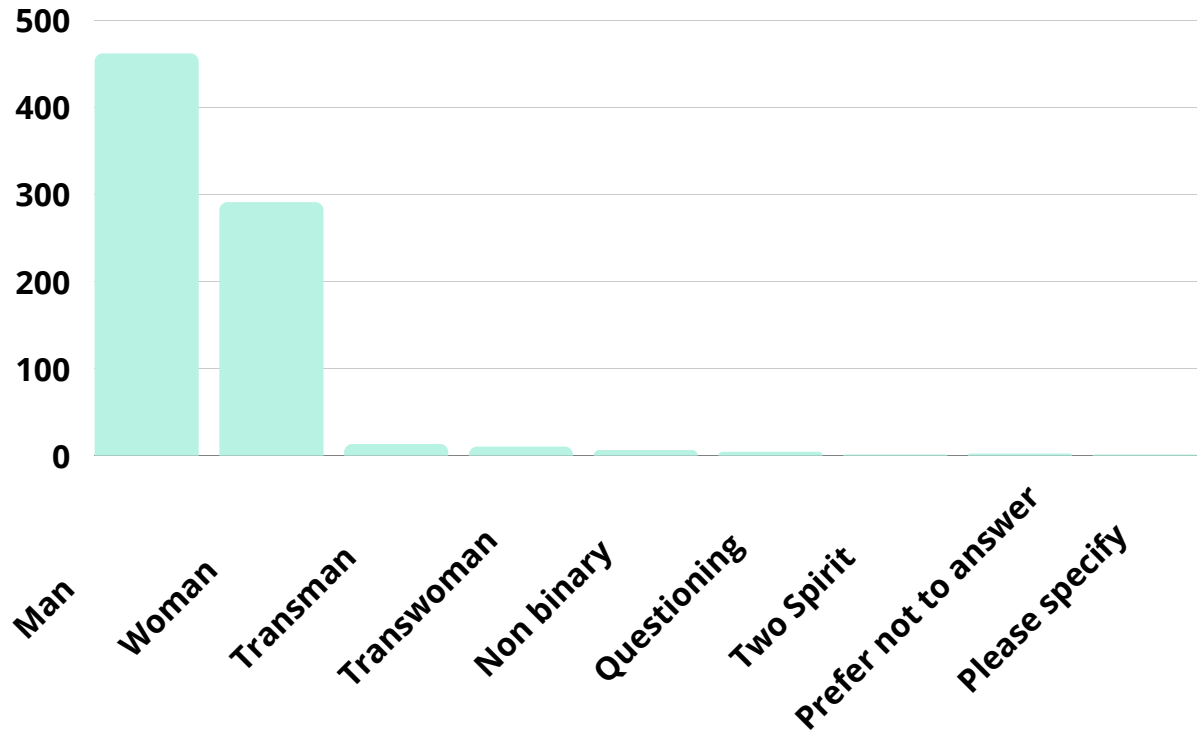

Figure 5. The distribution of survey respondents by self identified gender identity

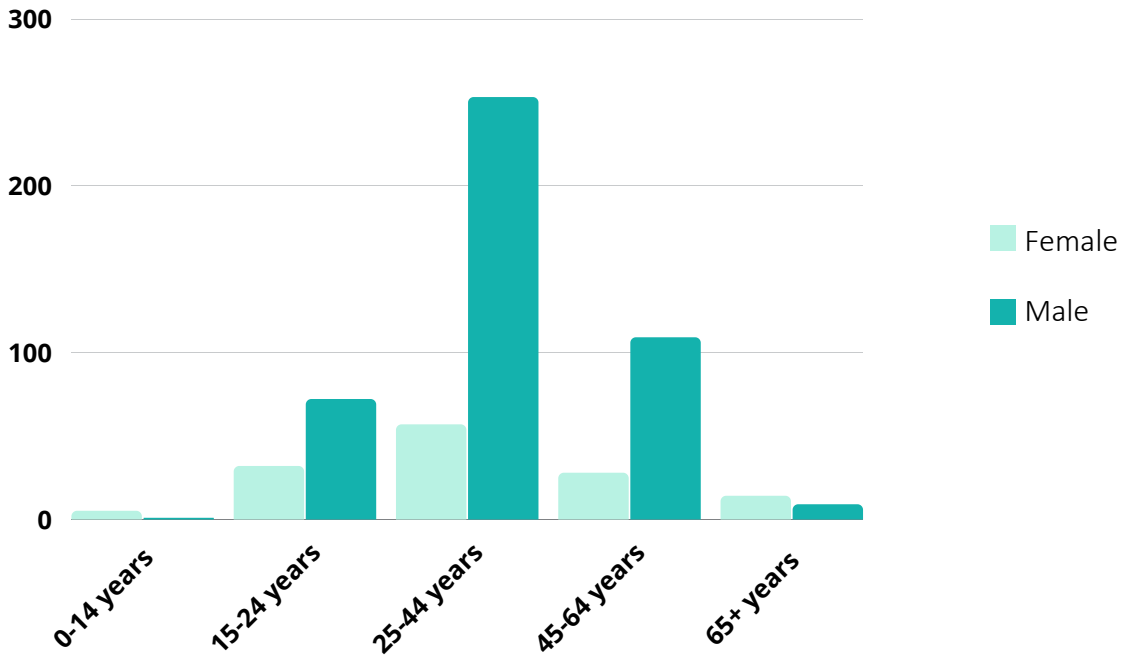

Figure 6. The number of cases of opioid-related emergency department visits by age group in Peel Public Health in 2019

Income and housing

Twenty-five percent of individuals who completed the survey made less than $30,000 before taxes in 2019 (Figure 7). This is lower than the 2016 average income after taxes in Peel of $35,665 and considerably lower than the average income after taxes in Ontario of $39,318.[13] When asked about the source of income, 64.3% of survey responders had a full-time job and 21.4% worked part-time jobs in 2019. Twenty-two percent of respondents relied on government support such as GST, HST, Ontario Disability Support Program, Ontario Works or Canadian Pension Plan and 16.7% of responders were involved in activities such as sex for money, selling drugs, selling needles, panhandling, theft and other illegal activities ***(n=790)***.

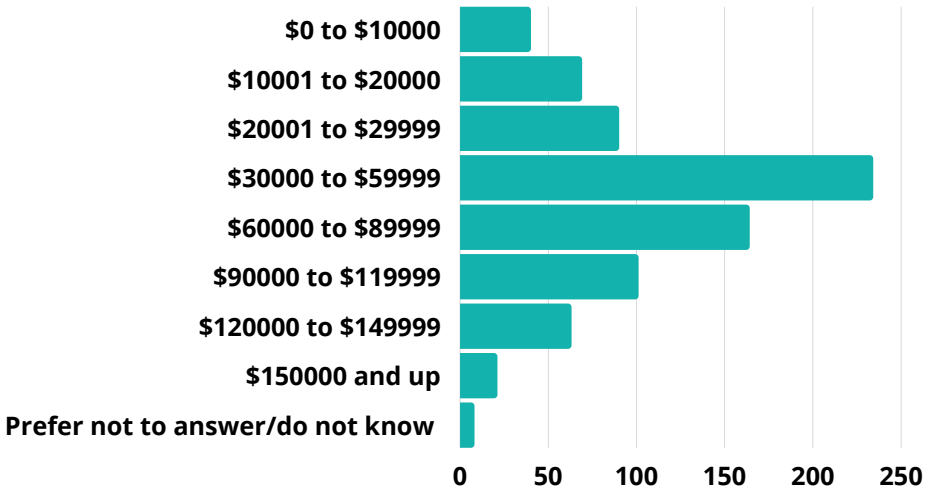

Figure 7. The distribution of survey respondents by total personal income in 2019 (before taxes)

Twenty-one percent of survey respondents did not have stable housing or were currently homeless. Several factors have made housing less affordable and have contributed to the growing rate of homelessness and precarious housing in Peel including an increase in homeownership prices, lower vacancy rates, and a significant increase in rental prices ($10,000/year more compared to five years ago for a two-bedroom apartment in Peel).[14]

Other demographic information

Sixty-three percent of study respondents who completed the survey identified as heterosexual whereas 36% identified as being members of the 2SLGBTQ+ communities. There is a lack of data related to substance use based on sexual orientations and gender identities in Peel. Additionally, 90% of survey respondents lived in Canada for more than three years and 93% of survey respondents prefer English as their language of choice while connecting with service providers in the region.

The White-North American ethnic group represented the majority of survey respondents (53.2%) followed by Black-North American (12.5%) and White European (11.3%) (Table 1). This corresponds with opioid-related death data between May 2017 and December 2018, where 71% of individuals with accidental opioid-related deaths were of white ethnicity.[15]

Racial or ethnic group	Number	Percent
White - North American (e.g., Canadian, American)	420	(53.2)
Black - North American (e.g., Canadian, American)	99	(12.5)
White - European (e.g., English, Italian, Portuguese, Russian)	89	(11.3)
Asian - South (e.g., Indian, Pakistani, Sri Lankan)	28	(3.5)
Black - African (e.g., Ghanaian, Kenyan, Somali)	27	(3.4)
Black - Caribbean (e.g., Barbadian, Jamaican)	25	(3.2)
Mixed heritage (e.g., Black - African and White - North American)	23	(2.9)
Asian - East (e.g., Chinese, Japanese, Korean)	14	(1.8)
Indian - Caribbean (e.g., Guyanese with origins in India)	12	(1.5)
Asian - South East (e.g., Malaysian, Filipino, Vietnamese)	11	(1.4)
Middle Eastern (e.g., Egyptian, Iranian, Lebanese)	10	(1.3)
First Nations - Non-status	10	(1.3)
Latin American (e.g., Argentinean, Chilean, Salvadorian)	9	(1.1)
Metis	4	(.5)
First Nations - Status	4	(.5)
Prefer not to answer	3	(.4)
Indigenous/Aboriginal not included elsewhere	1	(.1)
Other (please specify)	1	(.1)
Do not know		
Inuit		
Total	790	(100.0)

Table 1. The distribution of survey respondents by racial or ethnic group.

GENERAL COMMUNITY SURVEY

The general community survey was completed by 155 respondents. Respondents ranged in age from 16 years to 65 years, 61% of the respondents were between the ages of 25-30 years. The survey overrepresented the residents of Brampton (63.9%) and Caledon (29.7%) and underrepresented the residents of Mississauga (6.5%) (Figure 8). Thirty-three percent of the general community survey respondents made less than $30,000 per year.

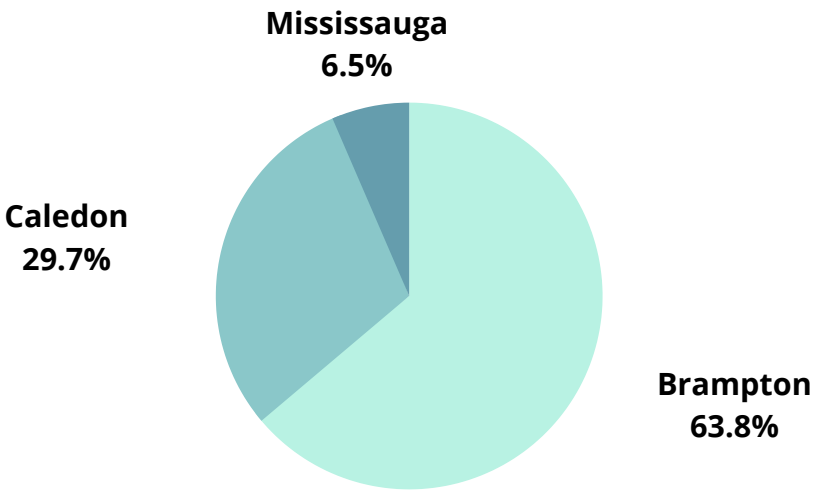

Figure 8. The distribution of survey respondents by region of residence

CONSULTATION WITH SERVICE PROVIDERS

More than 100 service providers from different community and regional organizations took part in the consultation over the two years including health care organizations, settlement services, mental health and social service organizations along with members from the Peel Regional Police, Peel paramedic services, and Region of Peel – Public Health.

THEME 2: DRUG AND SUBSTANCE USE IN PEEL

PEOPLE WHO USE DRUGS SURVEY

Survey respondents were asked to self-identify their current position on the spectrum of substance use from no use to dependence (definition can be found in the appendix) (Figure 9). Forty-one percent of respondents identified themselves as using substances occasionally. Fourteen percent of individuals identified being dependent on substances and 14.3% individuals expressed their substance use was problematic and led to negative health and social outcomes for them (***n=782***)

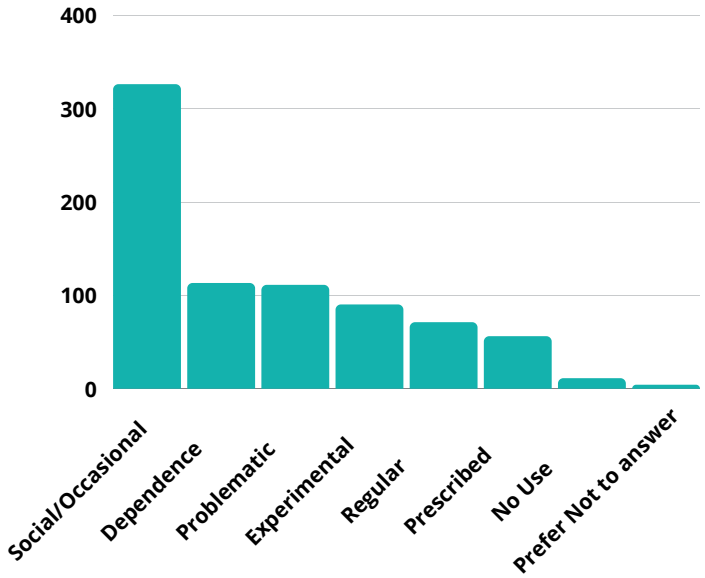

Figure 9. The distribution of survey respondents by self-identified position on the spectrum of substance use.

The top three preferred substances used by respondents were alcohol (41.7%), prescription (24.7%) and non-prescription (20.7%) marijuana/cannabis and methamphetamines (23.4%) (Table 2). The majority of respondents indicated that their preferred method for administering substances was smoking (62.5%). Fifty-one percent of individuals administered drugs orally, 36.2% administered via injection and 28.8% administered via snorting.

Preferred Substances	Number	(%)
Alcohol	335	(42.8)
Prescription marijuana/cannabis	193	(24.7)
Methamphetamine (crystal, ice, glass, tina, meth, speed) or other forms of amphetamines	183	(23.4)
Non-prescription Marijuana/cannabis	162	(20.7)
Sleeping pills, barbiturates or other sedatives	127	(16.2)
Prescription painkillers from other sources (codeine, morphine, hydromorphone)	123	(15.7)
MDMA (molly/ecstasy)	114	(14.6)
Heroin (alone or mixed)	101	(12.9)
Prescription fentanyl prescribed by health care providers	100	(12.8)
Hashish	91	(11.6)
Crack	89	(11.4)
Prescription fentanyl from other sources	85	(10.9)
Other forms of cocaine	80	(10.2)
Inhalants or huffed	75	(9.6)
Benzodiazepines (benzos, xanax)	63	(8.1)
Other OTC (Over the counter) drugs	63	(8.1)
Prescription methadone/suboxone	60	(7.7)
PCP/angel dust (phencyclidine)	56	(7.2)
Edibles or concentrates	54	(6.9)
Prescription painkillers prescribed by health care providers (codeine, morphine, hydromorphone)	47	(6.0)
GHB gamma hydroxybutyrate (G)	43	(5.5)
Non-prescription or street methadone	36	(4.6)
I am currently not using any substances	34	(4.3)
Mushrooms or other hallucinogens	29	(3.7)
Shatter	28	(3.6)
LSD (acid, blotter)	23	(2.9)
Ketamine (special K)	16	(2.0)
Used any other drug/substance (please specify)	6	(.8)
Prefer not to answer	3	(.4)
Do not know	0	0
Total	782	(100.0)

Table 2. The distribution of survey respondents by preferred substances.

When asked what led to substance initiation, respondents cited coping with unpleasant feelings (34%), pleasure and enjoyment (28.4%) and life stressors (22.8%) as their top three reasons (Table 3). Similar responses were given when asked why people who use substances continue to engage in substance use. Individuals noted coping with unpleasant feelings (34.5%), pleasure or enjoyment (22.5%) and dependency (21.2%) as the top 3 reasons for current substance use.

Reason respondent began using substances	Number	(%)
Cope with unpleasant feelings (e.g., situational nervousness, sadness, fear etc.)	266	(34.0)
Pleasure/enjoyment/having fun	222	(28.4)
Life stressors (e.g., work/school stress)	178	(22.8)
Mental health/illness	172	(22.0)
Peer pressure	171	(21.9)
Enhanced sexual pleasure	170	(21.7)
Easy access to drugs	167	(21.4)
Family exposure	137	(17.5)
Boredom	133	(17.0)
Experimenting	120	(15.3)
Medical prescription/pain management	111	(14.2)
Homelessness	88	(11.3)
traumatic experiences, abuse or neglect	78	(10.0)
Poverty	75	(9.6)
Forced (by other individuals)	69	(8.8)
Religion/cultural practice	57	(7.3)
Systemic oppression (e.g., racism, homophobia etc.)	50	(6.4)
Living with a disability	21	(2.7)
Other (please specify)	5	(.6)
Prefer not to answer	3	(.4)
Do not know	0	0

Table 3. The distribution of survey respondents by reason of substance use initiation

GENERAL COMMUNITY SURVEY

Among general community survey respondents, 82.4% felt that substance use was a problem in Peel (Figure 10) and identified health issues (42.14%), drug-related litter (33.6%), criminalization of drug users (33.6%), driving under the influence (32.1%) and community safety/crimes (30.7%) as the primary issues related to substance use. When the general community respondents were asked what they thought the main reasons were for engaging in substance use, survey respondents expressed that substance users likely used drugs/substances as a coping mechanism (42.5%), as a means to enhance sexual pleasure (31.7%), as a result of media-related influences (30.2%) and due to the easily accessible nature of drugs (30.2%).

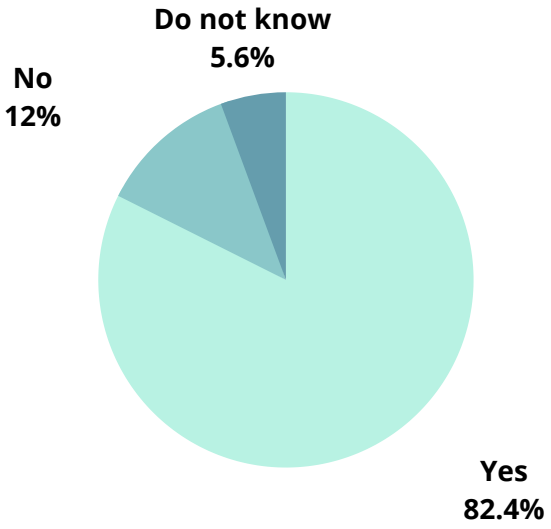

Figure 10. The proportion of survey respondents who feel that substance use is an issue in Peel.

Seven in ten respondents knew someone who had previous or existing issue with substance use

Participants of the general community survey were also asked if they knew someone that had an issue with substance use. Seventy-four percent of survey respondents indicated that they did know someone who had a previous or existing issue with substance use and 69.2% expressed that this person's substance use negatively impacted those around them. When asked if this person was able to access the necessary supports, 57% of respondents selected 'yes' and 20.3% of respondents selected 'no'.

34

THEME 3: BARRIERS AND ENABLERS FOR ACCESSING SERVICES AND SUPPORTS

PEOPLE WHO USE DRUGS SURVEY

> *That part of confidentially for example, if someone found out I was using I would not be able to see my baby and I would be terrified of that.*
>
> -Peel Drug Users Advisory Panel member

Respondents were asked the types of services and supports they had accessed in Peel in the last two years. Addiction services including withdrawal management and replacement therapy were accessed by 45% of the individuals. Thirty-six percent of respondents accessed a general practitioner and 29.5% of respondents accessed harm reduction services such as needle exchange programs in the last two years. Sixty-three percent of respondents felt very familiar and very comfortable accessing services for substance use in Peel and 20% of individuals felt not at all familiar and not at all comfortable accessing services.

Fear of other people finding out (community/family/cultural shame) (28.1%), fear of arrest/criminalization/incarceration (18.3%), personal shame/embarrassment (17.3%), and fear of child welfare services involvement (17.1%) were identified as the top individual-level barriers to accessing services. Additionally, confidentiality concerns (28.1%), lack of relevant services for youth, seniors, women or persons of colour (28.1%), long waiting lists (19.1%), and high cost of service (17.3%) were the top service provider related reasons for not accessing services (Table 4).

Main Barriers faced	Number	(%)
Confidentiality concerns	219	(28.1)
Lack of services relevant for me as a youth/senior/woman/person of colour/2SLGBTQ+	219	(28.1)
Fear of other people finding out (community/family/cultural shame)	212	(27.2)
Inhibiting rules/policies (e.g., have to be abstinent)	179	(22.9)
Lack of availability of services	163	(20.9)
Service provider lacked knowledge/I was never referred to services I needed	152	(19.5)
Long wait lists	149	(19.1)
Fear of arrest/criminalization/incarceration	143	(18.3)
High cost of service	135	(17.3)
Personal shame/embarrassment	135	(17.3)
Fear of child welfare services involvement	133	(17.1)
Work/school responsibilities (e.g., not being able to take time off work)	132	(16.9)
Insufficient opening hours	127	(16.3)
Stigma/discrimination by service provider	113	(14.5)
Family responsibilities (e.g., not being able to find alternative childcare options)	106	(13.6)
Agency was not physically accessible (e.g., not wheelchair accessible)	84	(10.8)
Transportation issues (e.g., service not on bus route, no money for transportation)	81	(10.4)
Cultural barriers (e.g., service not delivered in my language)	76	(9.7)
No access to communication device(s) (e.g., mobile phone, email, postal address)	65	(8.3)
Bad past experiences with service(s)	50	(6.4)
Did not know of service(s)	33	(4.2)
Family/partner influences	11	(1.4)
Other (please specify)	9	(1.2)
Total	780	(100.0)

Table 4. The distribution of survey respondents by the main barriers faced when accessing substance use services in Peel.

GENERAL COMMUNITY SURVEY

Three in four individuals who completed the general community survey identified they had someone close to them that had an issue with substance use. Sixty-six percent of individuals also mentioned that they were negatively impacted by their loved one's substance use. Only 57% of individuals were able to get the support needed for substance use and 50% of respondents felt there were adequate supports for family members and friends affected by their loved one's substance use. The top three supports that survey responders were able to access to cope with the negative impacts of their loved one's substance use were counselling (42%), education and training (63.1%) and mental health supports (49.6%).

SERVICE PROVIDERS CONSULTATION

The service providers consultation revealed several barriers, gaps, and ways to improve access to services and programs in Peel.

> *"Barrier in accessing services is stigma and discrimination – part of prevention is to look at how we can prevent people from feeling this way."*
>
> -Service Proivder Consultation

Stigma - Service providers agreed that stigma related to substance use was one of the main barriers for individuals to access supports and services in Peel. Stigma related to drug use and fear of being judged was brought up by service providers. In addition, the inability of people to secure stable housing due to their drug use was a prominent theme.

> *Every person has past trauma that they have been treating on their own. If we have the opportunity to treat at an earlier stage in journey/screen for trauma earlier on – we can educate on triggers and support them sooner.*

-Service Proivder Consultation

Training of service providers - Service providers mentioned the lack of understanding from medical professionals on human service needs and the lack of training of front-line workers as key barriers to accessing services. There is a need to build capacity among service providers in order to move away from the one-size-fits-all approach to care. Evidence-based practices that utilize an anti-racist, anti-oppressive framework such as trauma-informed care should become a common practice among service providers. Similarly, we need to provide more education and training to officials in the enforcement and justice sector to identify the needs of people who use substances that interact with the justice system.

Mental health and substance use – Service providers brought up the relationship between mental health and substance use. Mental health problems and problematic substance use can co-exist, or one can trigger the other. The stigma associated with mental health problems and substance use can delay or prevent individuals from accessing the supports they need. Mental health problems and substance use can also lead to severed ties with loved ones and social isolation. The burden of loss carried by people who use substances, and their family members is enormous as more people die of overdose every day.

Improved service delivery - Service providers discussed the importance of providing wrap-around services, increasing the availability and training for naloxone administration and developing a centralized community network to provide better service coordination to clients. Additionally, to reduce access-related barriers, service providers discussed reducing the wait times to access services and providing more home-based services.

Meaningful engagement of people with lived/living experience – Service providers expressed the importance of engaging people with lived/living experience of substance use in the design, development, delivery and evaluation of programs and services in order to reduce the harms related to substance use in Peel.

39

THEME 4: PREVENTION OF PROBLEMATIC SUBSTANCE USE

PEOPLE WHO USE DRUGS SURVEY

Survey respondents were asked what types of supports are required to prevent problematic substance use. The five primary supports identified by substance users were:

1. Housing supports including access and availability of affordable and suitable housing options (53.1%).
2. Social supports including supportive spaces and places and social opportunities for substance users (49.7%).
3. Income supports (47%).
4. Mental health supports including programs that help with mental health issues and promote mental health (39.6%) and;
5. Greater education and awareness related to effects of drug use and drug use safety (36.2%) (Table 5).

Support to prevent problematic substance use	Number	(%)
Housing supports (e.g., access and availability of affordable and suitable housing options)	415	(53.1)
Social supports (e.g., Ensure communities have supportive places, spaces and social opportunities and support a sense of	389	(49.7)
Income supports (e.g., financial help to pay for living expenses)	369	(47.2)
Mental health supports (e.g., programs to help with mental illness and promote mental health)	310	(39.6)
Education and Awareness (related to effects of drug use and drug use safety)	283	(36.2)
Parenting supports (e.g., programs that enhance positive parenting skills and parent-child relationships)	264	(33.8)
Youth supports (e.g., Ensure children/youth have low cost or free access to recreational activities)	179	(22.9)
Other (please specify)	14	(1.8)

Table 5. The distribution of survey respondents by type of support required to prevent problematic substance use.

When it comes to basic living, the amount of stress that comes from [figuring out] where are you going to live and if you need a connection to different services. There needs to be a team that supports you, connects you to services that you need, not just housing because then what? Wrap-around services are needed. If you don't have these supports in 6 months, I have seen people ending up back in shelters or in the streets.

-Peel Drug Users Advisory Panel member

GENERAL COMMUNITY SURVEY

The general community survey responses aligned with the responses given in the people who use drugs survey. The five primary supports identified by respondents are housing supports including access and availability of affordable and suitable housing options (52.2%), greater education and awareness related to effects of drug use and drug use safety (50%), social supports including supportive spaces and places and social opportunities for substance users (44%), income supports (39.1%), and mental health supports including programs that help with mental illness and promote mental health (34%).

SERVICE PROVIDERS CONSULTATION

In consulting with service providers on preventing problematic substance use, several recommendations were made.

> *"It is important that we start talking about the cause of the cause, the underlying cause of problematic substance use."*

Dismantling of siloed services – Within healthcare and public health, silos disrupt the continuum of care and can act as barriers to progress and positive reform. Service providers noted that a more holistic approach is needed to bridge existing service gaps and support a higher quality of continuous care.

More expansive Needle Exchange Programs – Service providers expressed the need for a greater supply of drug kits and greater awareness of these kits. In addition, as part of needle exchange programs, the safe disposal of used kits should be addressed, and sharps containers should be distributed.

Counseling – Service providers identified that the accessibility and breadth of counseling services needed to be expanded in Peel. In recognition of the growing population of substance users in Peel, service providers highlighted areas where focused counseling supports are needed including mental health, problematic substance use, grief and family instability.

Peer supports – Service providers focused on the importance of peer supports in facilitating interactions between people who identify their substance use as problematic and people with lived or living experience with substance use to provide supportive environments free of judgment and stigma.

Education – Service providers expressed the need for the development of educational initiatives to prevent problematic substance use. Key areas of focus for these initiatives include developing public awareness campaigns to address substance use safety, substance-related harms and stigma reduction; supporting capacity building training for healthcare providers; and utilizing a non-judgmental approach to prevent additional harms.

Supporting family engagement – Service providers highlighted the need for strong family support systems, especially among youth or young parents.

Housing – Adequate and affordable housing was a big topic of discussion, mentioned in all priority population and drug strategy pillar discussions. Service providers discussed the lack of available shelter beds, individuals being discharged from shelters for substance use, lack of women-specific and youth-specific shelters in Peel, the difficulty of maintaining stable housing for their clients, lack of housing workers and long waiting times to secure stable and affordable housing in Peel.

THEME 5: PRIORITIES FOR DRUG STRATEGY IN PEEL

PEOPLE WHO USE DRUGS SURVEY

The respondents identified access to treatment services (54.7%) as the number one priority for the drug strategy (Table 6). Similarly, education and awareness regarding substance use including stigma reduction (50.3%) was also identified as a major priority. Another priority for the drug strategy identified by responders was access to harm reduction services (47.5%).

> *"When someone comes out to someone saying that they have issues with using drugs – addiction services is the one that comes to mind first."*
>
> -Peel Drug Users Advisory Panel member

Priorities for drug strategy	Number	(%)
Access to treatment services	423	(54.7)
Education and awareness regarding substance use, including reducing stigma	389	(50.3)
Access to harm reduction services	367	(47.5)
Addressing production, importation, and distribution of drugs	306	(39.6)
Advocacy to all levels of government to address housing challenges	276	(35.7)
Advocacy to all levels of government to improve access to education and employment opportunities	194	(25.1)
Other (please specify)	18	(2.3)
Total	773	(100.0)

Table 6. The distribution of survey respondents by drug strategy priority

Participants of the people who use drugs survey were asked to identify priority groups for receiving substance use-related services and supports. Among all the groups identified, there were 5 priority populations (Table 7). Forty-one percent of respondents prioritized youth and homeless youth, 34% prioritized members of the 2SLGBTQ+ community, 32.6% prioritized individuals living in poverty, 26.8% prioritized women and 21.7% prioritized members of the African, Caribbean and Black community.

Priorities for drug strategy	Number	(%)
Homeless youth (16-24 years)	320	(41.4)
Youth (12-24 years)	317	(41.0)
2SLGBTQ+ (youth and adults)	263	(34.0)
Individuals living in poverty	252	(32.6)
Women	207	(26.8)
African, Caribbean and Black	168	(21.7)
Individuals experiencing the justice system	142	(18.4)
Hidden users (those who are housed/and or not accessing services)	141	(18.2)
Individuals experiencing a mental health problem/illness	138	(17.9)
Indigenous	89	(11.5)
East/South East Asians	87	(11.3)
South Asians	74	(9.6)
Other (please specify)	13	(1.7)
Total	773	(100.0)

Table 7. The distribution of survey respondents by priority group for receiving substance use-related services and programs.

GENERAL COMMUNITY SURVEY

General community survey participants were asked to identify priorities for the Peel drug strategy. Among all the priorities listed, access to treatment services (54.3%), access to harm reduction services (48%), addressing production, importation and distribution of drugs (46.5%) and greater education and awareness regarding substance use and stigma (45.7%) were identified as key priorities by respondents.

Participants were also asked to identify priority groups for receiving substance use-related services and supports. Among all the groups identified, there were three main priority populations. Thirty-two percent of respondents prioritized youth, 17.2% prioritized members of the 2SLGBTQ+ community and 15% prioritized homeless youth.

46

DISCUSSION

This report provides a snapshot of the demographics of people who use substances in Peel. Most individuals who completed the survey were younger, identified as a man, and were of white ethnicity. This demographic is consistent with the increasing trend of emergency department visits, hospitalizations, and deaths in the Peel Region over the past eight years. One in five individuals who completed the survey were precariously housed or experiencing homelessness. Housing insecurity has been directly associated with the perceived increase in drug use due to housing status[16] and homelessness has been associated with the initiation of injection drug use.[17] Unsurprisingly, housing, social and income supports were the top recommendations to prevent problematic substance use among people who use substances as well as service providers.

There is a lack of data on gender, race, and sexuality for people who use substances. In a region as diverse as Peel where more than 62% of individuals identify as visible minorities,[18] this data can help in developing policies, programs and services targeted to specific populations. This is particularly important as survey respondents identified one of the major barriers for not accessing services is services not being relevant to them as women, people of color, youth or members of the 2SLGBTQ+ communities.

Smoking was the most preferred method of using drugs, followed by oral, injectable and snorting. Alcohol was the most consumed substance which is consistent with Peel data showing 47% of Peel residents regularly consume alcohol. There has been a recent increase in uptake of methamphetamine in Peel among people who use substances, which is reflected in this consultation. The total number of individuals who use opioids is not in the top three in this consultation because opioids were categorized into different types such as prescription fentanyl, non-prescription fentanyl, prescription painkillers, heroin, etc.

The number of deaths in Peel due to opioid-related overdoses has increased at an alarming rate, especially over the eight years.[4] Most opioid-related deaths in Peel are accidental, associated with fentanyl and occurred when individuals were home alone [15].

Peel has witnessed a statistically significant increase in the rate of opioid-related deaths during the COVID-19 pandemic compared to the pre-pandemic rates.[10] A study in Peel of 150 people who use substances showed that 86.5% would consider using a supervised consumption site.[15] Supervised consumption sites have been shown to decrease the number of overdose-related deaths and the incidence of bloodborne infections such as HIV and Hepatitis C.[19] The presence of a supervised consumption site in Peel is essential in tackling the opioid crisis.

Stigma and discrimination against people who use substances were major themes in the report. The major barriers for accessing services and supports in Peel were fear of other people finding out, fear of child welfare services getting involved, personal shame and embarrassment. These barriers are evident with the low percentage of people accessing harm reduction services in Peel. It takes time for service providers to build trust with people who have been marginalized and stigmatized repeatedly for their substance use. Therefore, the capacity building of service providers to deliver judgment-free, trauma-informed care is important. Further, providing job opportunities to people with lived/living experiences of substance use also has a significant role in building trust and acceptance among communities impacted by inequitable policies and programs.

Barriers related to service provision such as long waiting times, lack of service availability, high cost of services and confidentiality concerns also emerged from the consultation. Additionally, eligibility rules and services such as providing services only to individuals who are not actively using substances further marginalize this population. It is essential that organizational policies and mandates reflect the needs of people who use substances.

LIMITATIONS

PEOPLE WHO USE DRUGS SURVEY

People who use substances are considered a hard-to-reach population and various strategies were employed to capture their data. Community organizations in Peel, as well as the Peel Drug Users Advisory Panel, were involved in survey distribution. Originally, the survey was released in hard copy, and responses were collected in person from individuals recruited by community organizations. This method did not provide equal opportunity for all people who use substances to access the survey, as those who did not attend these organizations or were not in contact with the PDAP members would not have access to the survey. Due to COVID-19, the survey was released online in September. Only people with access to a computer or phone and internet connection were able to complete the survey. Additionally, the survey was only available in English, so only individuals who could read and write in English could be recruited. All these factors introduced sampling bias where not all individuals who use substances had an equal opportunity to complete the survey.

Social desirability bias where individuals frame their responses in the best possible light specifically for socially sensitive questions (e.g., income and employment) may be present. Further, recall bias where individuals did not completely remember the details or omitted certain details while responding to survey questions (e.g., reasons for starting to use substances) may bias the data. The survey was released online as an open link and a $15 honorarium was offered to individuals who completed the survey and provided consent to be contacted via email to receive their honorarium. All precautions were taken so that anonymity was maintained, any identifying information such as email address was removed from the analysis, and the survey responses could not be linked back to an individual. A large number of surveys were completed in a single day which prompted the survey closure and further analysis of data. All individual responses were analyzed, any discrepancy in responses were noted, and survey respondents were contacted individually before providing the honorarium to determine if the responses were completed by humans. Only responses that could be verified were included in the analysis and surveys that were speculated to be completed by online bots were removed. Although each completed survey was checked for validity, there is still a possibility of any individual completing more than one survey.

GENERAL COMMUNITY SURVEY

The general community survey was released online and promoted through social media channels. Similar to the people who use drugs survey, this may have introduced sampling bias. The survey was completed by more individuals in the younger demographics compared to the older demographics. Similarly, the survey was completed by more individuals in Brampton and Caledon, compared to Mississauga. Based on the number of surveys completed and the geographical distribution of respondents, our sample may not be generalizable to the general population of Peel.

SERVICE PROVIDERS CONSULTATION

Service providers were consulted during the 2018 and 2019 Drug Awareness Week forum. This could have led to sampling bias as not all service providers would have attended the consultation sessions. Individuals can feel restricted and uncomfortable to give their honest opinion in group settings. Hence, social desirability bias can be present in focus group situations where individuals may agree with the most vocal person or the majority response. Some service providers shared more compared to others and some discussions were longer compared to other discussions, based on the knowledge of the service providers.

50

RECOMMENDATIONS

PIDS GOALS/OBJECTIVES

Overall, the Peel Integrated Drug Strategy report consists of 7 priorities and 78 recommendations. The priority areas include reducing stigma, enhancing housing, decriminalizing drugs, increasing access to programs and services, enhancing existing programs and services, developing supervised consumption sites and safe supply and facilitating leadership, collaboration and implementation. The recommendations are organized by stream of work – education and awareness building, advocacy, programs/services and evidence-informed research and evaluation.

The priorities and recommendation for the drug strategy were identified based on the community consultation findings, review of academic and grey literature and work done by other drug strategies in Ontario. The PIDS also developed some guiding principles based on the community consultation process, that are the core values to move forward the work of the drug strategy. All recommendations are based on the following guiding principles and will be considered as much as possible in developing initiatives pertaining to the strategies

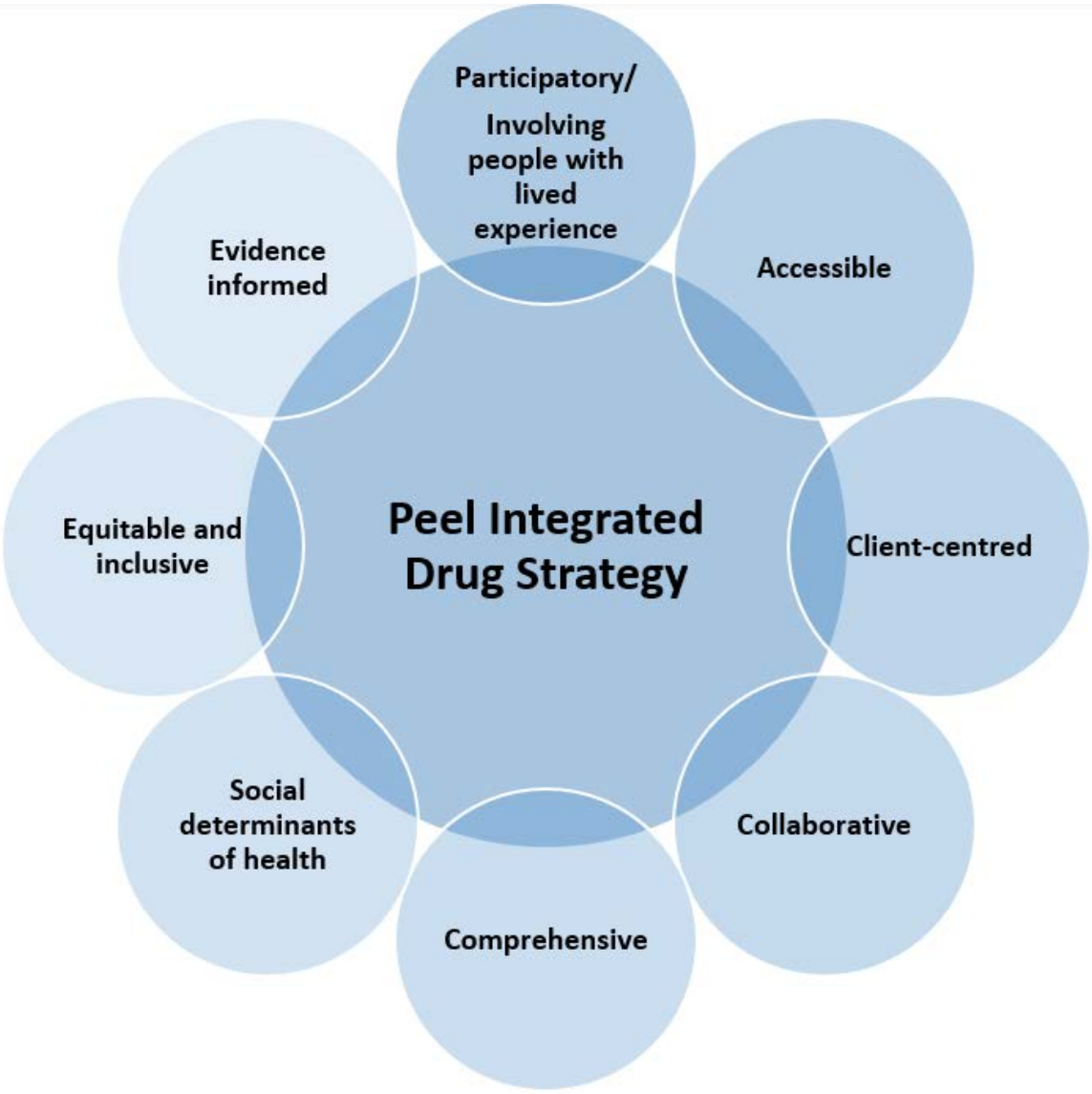

Figure 11. The guiding principles of the Peel Integrated Drug Strategy

The recommendations focus on promoting collaboration and engagement with community partners, organizations and stakeholders to create solutions that address substance-use-related harms and to advocate for health and health equity in Peel. In acknowledging that certain populations are at a greater risk of problematic substance use due to risk factors and inequities, these recommendations focus on five priority populations including children and youth, women, members of the 2SLGBTQ+ communities, black, indigenous and people of color, and individuals living in poverty. In addition, this report aims to center the voices of people with lived and living experiences of substance use to ensure solutions are inclusive, diverse and equitable.

Reduce Stigma

Stigma often involves the negative stereotyping of people's characteristics, identities, health conditions, behaviors and practices.[20] It is used to perpetuate unequal power dynamics by separating people into "us" and "them". These social norms continue to persist within the healthcare, social and justice systems and create barriers for people who use drugs when accessing health services, housing supports and employment.[20] For example, the criminalization of drugs and the people who use substances is a stigmatizing process that exacerbates inequalities, deters individuals from seeking support and threatens well-being.[21]

To reduce and prevent the harms associated with substance use, stigmatizing practices that prevent individuals from accessing protective services must be eliminated. This means designing services that are equity-driven and safe for diverse populations.[20] The 2019 Chief Public Health Officer's Report on the State of Public Health in Canada provided some key interventions that can be used to target stigma drivers and influence systemic-level change.[20] Population-level education campaigns that target stereotypes have been shown to have a positive impact on public attitudes.[20] In addition, evidence-based policy interventions that challenge stereotypes and health inequities have the potential for a large population effect.[20] For example, the Undetectable=Untransmissible (U=U) campaign has been successful in influencing public opinion regarding HIV prevention, testing and treatment.[20] The Public Health Agency of Canada has signed onto the global campaign to help dismantle stigma and improve the lives of people with HIV.[20] The development of evidence-based policies and programs related to substance use should be explored.

1. Education and awareness building

- Provide presentations within the community in partnership with other health and social service providers.
- Explore producing videos, social media and other relevant resources and messaging to engage and educate the general public about the stigma associated with substance use.
- Disseminate resources related to substance use and stigma reduction such as fact sheets for schools, partners and teachers.

2. Advocacy

- Advocate for the provision of education intervention focused on capacity building and improving behavioral skills for all service providers working with people who use substances.

3. Program/services

- Explore what existing anti-stigma programs are currently in place and adapt or develop messaging as appropriate.
- Conduct the Drug Awareness Week forum annually to increase awareness among service providers, people who use substances and general community members.

4. Evidence-informed research and evaluation

- Assess and evaluate gaps in training related to substance use, harm reduction and stigma reduction that may exist for those working in the healthcare, social service, government and municipal services, the justice system and local businesses.

Enhance Housing

Current trends in the literature have shown an increase in injection drug initiation among individuals experiencing homelessness. One Canadian study found that among youth, injection drug initiation was independently associated with homelessness.[17] These findings suggest that addressing the housing needs of those who are homeless or precariously housed may help to prevent injection drug initiation as this method of use has the greatest number of health risks associated with it including bloodborne infections and a higher risk of overdose.[17]

Housing programs have shown a significant improvement in housing stability among individuals who were previously homeless or precariously housed.[22,23] In the context of Canada, the Housing First initiative has been implemented in various cities across the country and has been found to increase housing stability while reducing emergency department visits, hospitalizations and time spent hospitalized.[23] The Housing First model is grounded in harm reduction and aims to provide stable housing and health supports to current substance

users without requiring sobriety or abstinence.[23,24] For example, a study exploring the outcomes of a 2-year Housing First program for adults who are homeless and use substances in Ottawa reported that clients showed improvements in community functioning and safety-related quality of life and spent a greater proportion of time housed.[25] The feasibility and implementation of evidence-informed housing programs such as Housing First in Peel should be explored.

1. Education and awareness building

- Increase awareness of existing supportive housing and homelessness prevention programs available in Peel.[26]

2. Advocacy

- Advocate expanding housing services to include shelter specializations (ie. youth shelters, women shelters, 2SLGBTQ+ shelters).[27]
- Advocate increasing access and availability to affordable and appropriate housing that meets the needs of people who use substances.[27]
- Advocate for housing policies and programs that address poverty and homelessness.

3. Programs/services

- Further, explore and expand harm reduction services within existing emergency shelter programs.
- Identify youth as a priority population for programs and services related to housing and homelessness.
- Explore supportive housing approaches to assist people who are homeless or precariously housed in finding permanent housing (e.g., Housing First).[27]

4. Evidence-informed research and evaluation

- Promote evidence-informed supportive housing models such as Housing First when working with people who use substances.[27]
- Evaluate the effectiveness of housing policies and programs in addressing poverty and homelessness.

Decriminalize Drugs

The criminalization of drugs is a punitive approach to drugs that has created serious health and social harms for people that use substances. Research has shown that criminalization has resulted in the perpetuation of negative stereotypes, increased rates of blood-borne infections, increased unsafe injection practices[28] and led to the creation of an illegal, unregulated drug market with a toxic drug supply.[29] Additionally, the incarceration of people who use substances is often overrepresented by people of color and those living in poverty which prevents individuals from seeking help.[30] For example, Toronto Police Service's marijuana, possession and charge data shows that people of color with no history of criminal convictions are three times more likely to be arrested for simple possession compared to white people with similar backgrounds.[31]

The decriminalization of drugs is a public health approach to drug policy that serves to prevent and reduce the potential harms associated with drug use. Health and drug policy organizations such as the Canadian Public Health Association, Canadian Drug Policy Coalition, the World Health Organization and the Global Commission on Drug Policy recommend the adoption of decriminalization as best-practice for public health.[28,29,32] Several countries including Portugal, the Czech Republic and the Netherlands have implemented decriminalization models with a number of positive health outcomes. Since decriminalizing drugs in 2001, Portugal has seen: a reduction in drug use among certain vulnerable populations;[33] a decrease in HIV transmission rates[34] and drug-related deaths;[35] and an increase in persons accessing treatment services.[33] Note that a non-punitive approach to drug policy such as decriminalization must be implemented in combination with the delivery of harm reduction, health promotion and treatment services to mitigate the harms associated with substance use.

1. Education and awareness building

- Support training on substance use and harm reduction for service providers working within the justice system.[27]
- Increase awareness of new laws and policies regarding substance use to reduce barriers to accessing services.[26]

2. Advocacy

- Advocate for the decriminalization of illegal substances for personal use.[28]
- Advocate for amnesty for those previously convicted of possession of small quantities of illegal substances.[28]

3. Program/services

- Support the justice system in developing and implementing diversion programs.

4. Evidence-informed research and evaluation

- Further, examine research around health and social outcomes of decriminalization and associated policies and programs from statewide efforts to smaller size examples such as safe consumption sites and safe supply programs.
- Further, examine research around the impacts of the war on drugs and criminalization.

Increase Access to Programs and Services

Fundamental to health equity is the distribution and accessibility of supports and services for populations experiencing problematic substance use.[26] In Peel, there is a need for greater transportation to programs and events for children, youth and individuals who do not have access to a vehicle. Greater efforts are also required to enhance the continuum of care for people who seek access to services in different systems in order to move towards an integrated model of care.

1. Education and awareness building

- Increase awareness of existing treatment information and pathways to treatment services in Peel, including awareness of existing sources of information.
- Increase awareness of youth-specific services and supports.[27]
- Facilitate opportunities for capacity building for families and friends of people who use substances.[26]
- Increase awareness of programs and supports available to families and friends of people who use substances.[27]

2. Advocacy

- Advocate for the provision of affordable transportation services within and outside Peel.[26]
- Support cultural-competency training and trauma-informed care training at agencies, organizations and institutions (e.g., hospitals).[26,27]

3. Program/services

- Improve service coordination by providing transitional supports between key service areas.[26]
- Expand current substance use supports and services.[26]
- Enhance existing services to promote a continuum of care and ensure programs are meeting the needs of people who use substances.
- Improve access to family supports and community programs available for families and friends of people who use substances.[26]
- Increase access and decrease barriers to mental health supports and treatment services (e.g., reduce the cost of treatment or program, reduce waiting time).
- Explore different methods to increase access to supports and services for women (e.g., harm reduction training, affordable childcare, private and safe spaces).
- Enhance organization and agency policies, programs and services to ensure cultural safety.[27]
- Implement culturally appropriate programming and treatment options for priority populations (e.g., women, 2SLGBTQ+ folks, individuals living in poverty and youth).[26]
- Provide harm reduction and naloxone training to youth.[26]
- Engage youth in the development of youth-specific programs and services.
- Identify and increase supports for pregnant women or women planning a pregnancy who use substances.

4. Evidence-informed research and evaluation

- Evaluate the effectiveness of local interventions in prevention, harm reduction, treatment, enforcement and justice services.

Enhance Existing Programs and Services

Peer support initiatives are designed to complement traditional clinical care and improve a person's overall quality of life.[36] Nationwide leaders devoted to wellness and resiliency such as the Canadian Mental Health Association (CMHA) acknowledge that peer support workers are a critical component of substance use treatment and recovery.[37] Evidence suggests that integrating peer support workers into substance use programs can have a positive impact on client outcomes[38] including a decrease in problematic substance use (alcohol and drugs) and risky behaviors (sharing of needles) and an increase in treatment engagement[39] and sense of control.[40] There is a need for greater representation of people with lived or living experiences of substance use in all sectors in Peel. It is critical that people with lived or living experience be involved in the development and implementation of substance use programming and services in a variety of roles as their expertise will greatly enhance the capacity of service providers to develop supports that truly fits the needs of the population.[41]

Additionally, the intersectionality of inequity, risk factors and the social determinants of health puts certain populations at greater risk for problematic substance use. Currently, the needs of priority populations in the community, including children and youth, women, members of the 2SLGBTQ+ communities, people of color and individuals living in poverty, are not being met. Greater efforts are required to decrease barriers and enhance the range of services available to people seeking support for problematic substance use. By promoting collaboration between organizations and agencies and inclusivity within the community, Peel can create supportive built and social environments that promote health and wellbeing.

1. Education and awareness building

- Develop a comprehensive communication plan to disseminate harm reduction information through community agencies, social media and healthcare practitioners.
- Collaborate with partners within and outside the community on awareness and education initiatives.

2. Advocacy

- Advocate for more resources being made available to fund peer programs and population-specific services and for the development of safer recreational spaces.

3. Program/services

- Increase the hiring and training of peer outreach workers.[26]
- Work with organizations and agencies that have established successful peer support training programs.
- Develop training programs tailored to people with lived or living experiences of substance use.[27]
- Continue the Peel Drug Users Advisory Panel with members representing diverse communities of Peel.
- Increase the involvement of people with lived or living experience of substance use at important strategy tables.
- Enhance collaboration between harm reduction and mental health services. [27]
- Explore a "one-stop-shop" approach for clients that offers a range of services including mental health supports, harm reduction services, detox facilities and counseling.[26]
- Increase availability, accessibility and breadth of treatment programs.
- Explore strategies to integrate substance use and mental health services to promote a holistic model of care.[26]
- Provide mental health and treatment supports tailored to the needs of the clients (e.g., racialized communities, newcomers, women, youth, 2SLGBTQ+ communities).
- Develop programs that engage and target youth in schools and the community.[26]
- Create opportunities within the community for recreation and safe spaces. [26]

4. Evidence-informed research and evaluation

- Evaluate existing peer support programs.[26]
- Monitor and utilize research, peer reviews and evaluation findings to promote existing programs, policies, and services with demonstrated success.

60

Develop Supervised Consumption Sites and Safe Supply

Supervised consumption sites (SCS) and safe supply services are public health strategies rooted in harm reduction and are designed to reduce the risk of overdose events and death.[42] More specifically, SCS benefit communities and provide a safe space for people to use pre-obtained substances under the supervision of trained professionals who can intervene in the case of an overdose. There is clear evidence that shows SCS reduce adverse health events including accidental overdoses and the transmission of blood-borne infections and reduce strain on the healthcare system.[19] However, there is a wide range of drug use patterns among people who use drugs and the ability of SCS to directly address them in addition to the contaminated drug supply is limited.[30] Safe supply programming may help to address this gap.

Safe supply refers to the use of prescribed legal, pharmaceutical-grade drugs under the guidance of a physician as an alternative to the toxic illicit drug market. [30] By integrating safe supply into existing harm reduction supports and services for people who use substances, a more holistic public health model centered around safety and stigma reduction is created. There is good evidence in the Canadian context that suggests that safe supply interventions have a considerable impact on health outcomes. Reported results from these interventions include a reduction in illicit drug use, improvements in overall health (mental and physical), a sustained engagement with healthcare and a decrease in overdoses.[30,43,44] Furthermore, safe supply programs in Ontario have reported several health benefits including zero fatal overdoses, improved health and social outcomes, decreased homelessness and decreased criminal activity among participants.[45]

1. Education and awareness building

- Provide presentations and seminars within the community in partnership with other health and social service providers.
- Disseminate resources related to supervised consumption sites and safe supplies such as fact sheets for schools, partners and teachers.
- Collaborate with partners within and outside the community on awareness and education initiatives.

2. Advocacy

- Advocate for the development and implementation of supervised consumption sites and safe supply In Peel.

3. Program/services

- Support efforts to implement a Supervised Consumption Site in Peel.
- Develop partnerships with local physicians to facilitate the implementation of safe supply programs.

4. Evidence-informed research and evaluation

- Build upon the work of the Supervised Consumption Sites Needs Assessment and Feasibility study for the Region of Peel.

Leadership, Collaboration and Implementation

The successful implementation of a comprehensive drug strategy in Peel requires fostering collaborative partnerships within and across agencies and organizations. This report is a call to action to community leaders, decision-makers, politicians, public health officials and staff, healthcare workers and law enforcement officers to come together and develop a coordinated approach to address the harms associated with substance use in Peel.

1. Education and awareness building

- Coordinate the meaningful engagement of health and social service agencies, PWUD and other stakeholders with police services to increase collective capacity to better implement public health-based approaches and solutions to substance use.
- Greater engagement and involvement of organizations that serve diverse communities at the collaborative table (e.g., Indigenous, women, black communities).

2. Advocacy

- Advocate for greater representation of people with lived or living experience of substance use in employment and leadership positions.
- Advocate for the adoption of the Health-in-All-Policies approach among community organizations and agencies in Peel.

3. Program/services

- Increase coordination of activities among community partners including researchers, non-profit organizations, businesses and institutions.[26]
- Collaborate with school boards to include evidence-informed prevention and harm reduction programs on substance use.[26]
- Continue to collaborate with existing systems and partners to create opportunities for community involvement.[27]
- The PIDS steering committee facilitates the working groups based on areas of expertise to support recommendation implementation.
- Develop an implementation plan for the PIDS that directly addresses the funding of strategy initiatives.
- Work towards combining the Opioid Strategy and PIDS for the development of a comprehensive drug strategy in Peel.

4. Evidence-informed research and evaluation

- Continue to evaluate prevention, harm reduction and treatment services.[27]
- Enhance surveillance and monitoring of substance use risk factors and health indicators in Peel.[27]
- Build on the existing surveillance data available from emergency department visits and the Coroner's Office to enhance local evidence on suspected/confirmed drug overdose-related incidents, injuries and fatalities.

FUTURE STEPS

The recommendations in this document are the initial steps to develop a comprehensive drug strategy in Peel. This document was developed in consultation with people who use drugs and service providers in Peel. The next phase of the strategy will involve the PIDS collaborative guiding the implementation of the strategy and the development of working groups to address and support the implementation of the recommendations. These groups will include representatives from different sectors, as well as people with lived/living experience of drug use who will determine when and how each recommendation can be implemented based on available resources, community needs and required approvals. These recommendations act as a guiding document and serve as a roadmap to prioritize interventions and initiatives based on community needs. This is a living document, and the recommendations may be updated based on the changing needs of the diverse communities in Peel.

PIDS recognizes the significant negative impact of COVID-19 on people who use drugs and will be developing a working group to address the dual health crisis. Peel Public Health is leading the opioid-specific work in the region through the Opioid Strategy. PIDS is a member of the Opioid Strategy work and will continue to work with them to advance common objectives of reduced substance-related harms and deaths in Peel and to develop a comprehensive drug strategy in Peel.

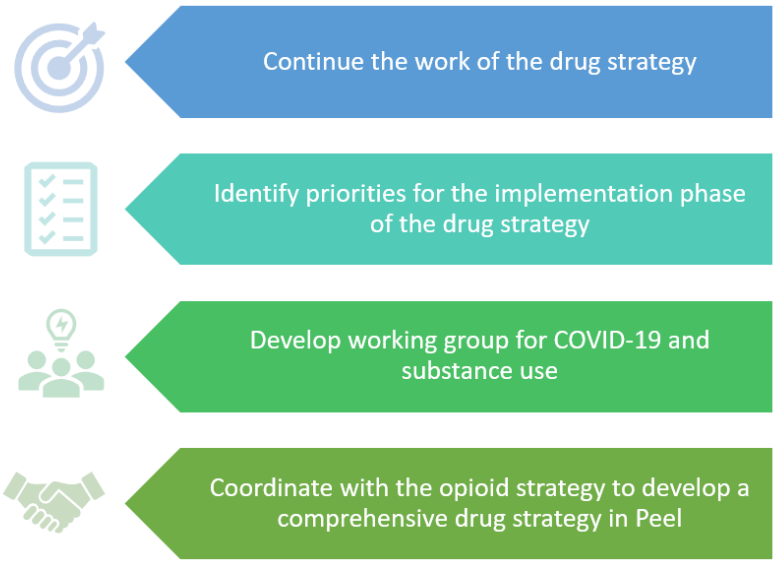

Figure 12. A pictoral outline detailing the next phase of the strategy.

APPENDIX A

DEFINITIONS

Dependence: Psychologically and/or physically dependent on a substance and discontinued or reduced use could lead to withdrawal symptoms.

Experimental substance use: Try a substance and may or may not use it again.

No substance use: Do not use any substances.

Prescribed substance use: Use the medication as directed, under medical supervision.

Problematic substance use: Experience negative consequences from using a substance.

Regular substance use: Use substances on a regular basis without any negative impacts.

Social/occasional substance use: Use substances in an amount or frequency that is not harmful.

APPENDIX B

SURVEY RESPONSES FOR PEOPLE WHO USE DRUGS

Survey responses for people who use drugs

Table 0.1 Screening Questions - Live or work or use substances in Peel or in last 2 years			
Live/Work or use substances in Peel	Have you personally used substances within the last 2 years?		
	Yes	No	Total
	Number	Number	Number
Yes	790	0	790
No	0	0	0
Total	790	0	790

Table 1.1: Distribution of respondents by language feel most comfortable speaking when accessing services

Language	Number	Percent
English	738	93.4
French	13	1.6
Punjabi	6	0.8
Chinese (Cantonese)	6	0.8
Amharic	4	0.5
Spanish	3	0.4
Chinese (Mandarin)	3	0.4
Bengali	3	0.4
Portuguese	2	0.3
Czech	2	0.3
Arabic	2	0.3
ASL	2	0.3
Prefer not to answer	1	0.1
Russian	1	0.1
Italian	1	0.1
Hindi	1	0.1
Greek	1	0.1
Dari	1	0.1
Total	790	100.0

Table 1.2: Distribution of respondents by racial or ethnic group		
Racial or ethnic group	Number	Percent
White - North American (e.g., Canadian, American)	420	(53.2)
Black - North American (e.g., Canadian, American)	99	(12.5)
White - European (e.g., English, Italian, Portuguese, Russian)	89	(11.3)
Asian - South (e.g., Indian, Pakistani, Sri Lankan)	28	(3.5)
Black - African (e.g., Ghanaian, Kenyan, Somali)	27	(3.4)
Black - Caribbean (e.g., Barbadian, Jamaican)	25	(3.2)
Mixed heritage (e.g., Black - African and White - North American)	23	(2.9)
Asian - East (e.g., Chinese, Japanese, Korean)	14	(1.8)
Indian - Caribbean (e.g., Guyanese with origins in India)	12	(1.5)
Asian - South East (e.g., Malaysian, Filipino, Vietnamese)	11	(1.4)
Middle Eastern (e.g., Egyptian, Iranian, Lebanese)	10	(1.3)
First Nations - Non-status	10	(1.3)
Latin American (e.g., Argentinean, Chilean, Salvadorian)	9	(1.1)
Metis	4	(.5)
First Nations - Status	4	(.5)
Prefer not to answer	3	(.4)
Indigenous/Aboriginal not included elsewhere	1	(.1)
Other (please specify)	1	(.1)
Do not know		
Inuit		
Total	790	(100.0)

Table 1.3: Distribution of respondents by Age, gender and sexual identity

Age, gender and sexual identity		Percent	Percent
What is your age?	16 years to 24 years	138	(17.5)
	25 years to 30 years	387	(49.0)
	31 years to 40 years	197	(24.9)
	41 years to 50 years	53	(6.7)
	51 years to 64 years	11	(1.4)
	65+ years	3	(.4)
	Prefer not to answer	1	(.1)
How would you describe your Gender Identity?	Please specify	1	(.1)
	Man	462	(58.5)
	Woman	291	(36.8)
	Transman	13	(1.6)
	Transwoman	10	(1.3)
	Non binary	6	(.8)
	Questioning	4	(.5)
	Two Spirit	1	(.1)
	Prefer not to answer	2	(.3)
How would you describe your Sexual Identity?	Heterosexual	498	(63.0)
	Bisexual	109	(13.8)
	Gay	91	(11.5)
	Asexual	37	(4.7)
	Lesbian	29	(3.7)
	Pansexual	11	(1.4)
	Prefer not to answer	5	(.6)
	Queer	5	(.6)
	Questioning	3	(.4)
	Please specify	2	(.3)
	Total	790	(100.0)

Table 1.4: Distribution of respondents by Income and number of dependents

Income and Number of Dependents		Number	(%)
What is your best estimate of your total personal income before taxes last year (2019)?	$0 to $10,000	40	(5.1)
	$10,001 to $20,000	69	(8.7)
	$20,001 to $29,999	90	(11.4)
	$30,000 to $59,999	234	(29.6)
	$60,000 to $ 89,999	164	(20.8)
	$90,000 to $ 119,999	101	(12.8)
	$120,000 to $ 149,999	63	(8.0)
	$150,000 or more	21	(2.7)
	Prefer not to answer	4	(.5)
	Do not know	4	(.5)
	Total	790	(100.0)
How many people does this income support?	Only me	188	(23.8)
	2 people	258	(32.7)
	3 people	175	(22.2)
	4 people	75	(9.5)
	5 people	47	(5.9)
	6 people	24	(3.0)
	7 people	7	(.9)
	8 people	2	(.3)
	9 people	4	(.5)
	10 people	6	(.8)
	Prefer not to answer	2	(.3)
	Do not know	2	(.3)
	Total	790	(100.0)

Table 1.5 Number and Percent by sources of Income		
Sources of Income	Number Agree	Responses%
Full time job	508	64.3
Part time job	169	21.4
Self-employed	71	9.0
Temporary work	68	8.6
Parent, friend, relative, partner	54	6.8
OW (Ontario Works)	48	6.1
EI (Employment Insurance)	37	4.7
Recycling (binning, buy/sell)	30	3.8
Ontario Trillium Benefit	30	3.8
GST/HST rebate	26	3.3
Ontario Disability Support Program (ODSP)	24	3.0
Sex for money	23	2.9
Selling drugs	19	2.4
Theft, robbing or stealing	18	2.3
Stipend or honoraria	17	2.2
Other illegal activity/activities	14	1.8
Panhandling	12	1.5
Selling cigarettes/tobacco	12	1.5
CPP (Canadian Pension Plan)	9	1.1
Other (please specify)	5	0.6
Selling needles	4	0.5
Prefer not to answer	4	0.5
Do not know	1	0.1
Total	790	100.0

Table 2.1: Distribution of respondents by self-identification of current position on the spectrum of substance use		
Position on Spectrum of substance use	Number	(%)
Social/occasional - you use the substance in an amount or frequency that is not harmful (e.g., drink on social occasion;	326	(41.7)
Dependence - you are psychologically and/or physically dependent on a substance and continue using, despite experiencing	113	(14.5)
Problematic - you experience negative consequences from using a substance (e.g., health, family, school, work, financial	111	(14.2)
Experimental - you try a substance and may or may not use it again	90	(11.5)
Regular - you use substances on a regular basis without any negative impacts	71	(9.1)
Prescribed - you use a medication as directed, under medical supervision	56	(7.2)
No use - you do not use any substances	11	(1.4)
Prefer not to answer	4	(.5)
Do not know		
Total	782	(100.0)

Table 2.2: Distribution of respondents by preferred substances		
Preferred Substances	Number	(%)
Alcohol	335	(42.8)
Prescription marijuana/cannabis	193	(24.7)
Methamphetamine (crystal, ice, glass, tina, meth, speed) or other forms of amphetamines	183	(23.4)
Nonprescription Marijuana/cannabis	162	(20.7)
Sleeping pills, barbiturates or other sedatives	127	(16.2)
Prescription painkillers from other sources (codeine, morphine, hydromorphone)	123	(15.7)
MDMA (molly/ecstacy)	114	(14.6)
Heroin (alone or mixed)	101	(12.9)
Prescription fentanyl prescribed by health care providers	100	(12.8)
Hashish	91	(11.6)
Crack	89	(11.4)
Prescription fentanyl from other sources	85	(10.9)
Other forms of cocaine	80	(10.2)
Inhalants or huffed	75	(9.6)
Benzodiazepines (benzos, xanax)	63	(8.1)
Other OTC (Over the counter) drugs	63	(8.1)
Prescription methadone/suboxone	60	(7.7)
PCP/angel dust (phencyclidine)	56	(7.2)
Edibles or concentrates	54	(6.9)
Prescription painkillers prescribed by health care providers (codeine, morphine, hydromorphone)	47	(6.0)
GHB gamma hydroxybutyrate (G)	43	(5.5)
Nonprescription or street methadone	36	(4.6)
I am currently not using any substances	34	(4.3)
Mushrooms or other hallucinogens	29	(3.7)
Shatter	28	(3.6)
LSD (acid, blotter)	23	(2.9)
Ketamine (special K)	16	(2.0)
Used any other drug/substance (please specify)	6	(.8)
Prefer not to answer	3	(.4)

Table 2.3: Distribution of respondents by all methods used to administer substances		
Methods used to administer substances	Number	(%)
Smoking	491	(62.8)
Oral	405	(51.8)
Injection	283	(36.2)
Snorting	225	(28.8)
Vaping	143	(18.3)
Transdermal (patches)	58	(7.4)
Rectally (booty bump)	55	(7.0)
Huffing	41	(5.2)
Vaginally	29	(3.7)
Prefer not to answer	11	(1.4)
Other (please specify)	4	(.5)
I do not know		
Total	782	(100.0)

Table 2.4: Distribution of respondents by to top three substances used in last 90 days

Top three substances used in last 90 days	Number	(%)
Alcohol	322	(41.2)
Methamphetamine (crystal, ice, glass, tina, meth, speed) or other forms of amphetamines	176	(22.5)
Prescription marijuana/cannabis	168	(21.5)
Nonprescription Marijuana/cannabis	137	(17.5)
Prescription painkillers (codeine, morphine, hydromorphone) from other sources	130	(16.6)
MDMA (molly/ecstacy)	114	(14.6)
Crack	105	(13.4)
Other forms of cocaine	105	(13.4)
Sleeping pills, barbiturates or other sedatives	98	(12.5)
Prescription fentanyl prescribed by health care providers	88	(11.3)
Heroin (alone or mixed)	85	(10.9)
Hashish	72	(9.2)
Benzodiazepines (benzos, xanax)	63	(8.1)
Prescription methadone/suboxone	60	(7.7)
Prescription fentanyl from other sources	58	(7.4)
I am currently not using any substances	51	(6.5)
Other OTC (Over the counter) drugs	48	(6.1)
Inhalants or huffed	45	(5.8)
PCP/angel dust (phencyclidine)	43	(5.5)
Prescription painkillers (codeine, morphine, hydromorphone) prescribed by health care providers	39	(5.0)
Edibles or concentrates	38	(4.9)
GHB gamma hydroxybutyrate (G)	37	(4.7)
Nonprescription or street methadone	37	(4.7)
Shatter	24	(3.1)
Mushrooms or other hallucinogens	22	(2.8)
LSD (acid, blotter)	20	(2.6)
Ketamine (special K)	14	(1.8)
Used any other drug/substance (please specify)	6	(.8)

Table 2.5: Distribution of respondents by to main reasons began using substances		
Main reasons began using substances	Number	(%)
Cope with unpleasant feelings (e.g., situational nervousness, sadness, fear etc.)	266	(34.0)
Pleasure/enjoyment/having fun	222	(28.4)
Life stressors (e.g., work/school stress)	178	(22.8)
Mental health/illness	172	(22.0)
Peer pressure	171	(21.9)
Enhanced sexual pleasure	170	(21.7)
Easy access to drugs	167	(21.4)
Family exposure	137	(17.5)
Boredom	133	(17.0)
Experimenting	120	(15.3)
Medical prescription/pain management	111	(14.2)
Homelessness	88	(11.3)
traumatic experiences, abuse or neglect	78	(10.0)
Poverty	75	(9.6)
Forced (by other individual/s)	69	(8.8)
Religion/cultural practice	57	(7.3)
Systemic oppression (e.g., racism, homophobia etc.)	50	(6.4)
Living with a disability	21	(2.7)
Other (please specify)	5	(.6)
Prefer not to answer	3	(.4)
Do not know		

Table 2.6: Distribution of respondents by all types of support to prevent problematic substance use		
Support to prevent problematic substance use	Number	(%)
Housing supports (e.g., access and availability of affordable and suitable housing options)	415	(53.1)
Social supports (e.g., Ensure communities have supportive places, spaces and social opportunities and support a sense of	389	(49.7)
Income supports (e.g., financial help to pay for living expenses)	369	(47.2)
Mental health supports (e.g., programs to help with mental illness and promote mental health)	310	(39.6)
Education and Awareness (related to effects of drug use and drug use safety)	283	(36.2)
Parenting supports (e.g., programs that enhance positive parenting skills and parent-child relationships)	264	(33.8)
Youth supports (e.g., Ensure children/youth have low cost or free access to recreational activities)	179	(22.9)
Other (please specify)	14	(1.8)

Table 2.7: Distribution of respondents by main reasons why currently use substance use		
Reasons why currently use substance	Number	(%)
Cope with unpleasant feelings (e.g., situational nervousness, sadness, fear etc.)	270	(34.5)
Pleasure/enjoyment/having fun	176	(22.5)
Dependency (i.e., withdrawal)	166	(21.2)
Mental health/illness	149	(19.1)
Enhanced sexual pleasure	147	(18.8)
Life stressors (e.g., work/school stress)	146	(18.7)
Peer pressure	141	(18.0)
Easy access to drugs	137	(17.5)
Medical prescription/pain management	129	(16.5)
Experimenting	103	(13.2)
Habit	95	(12.1)
Family exposure	91	(11.6)
Boredom	83	(10.6)
Poverty	66	(8.4)
traumatic experiences, abuse or neglect	63	(8.1)
Forced (by other individual/s)	51	(6.5)
Religion/cultural practice	49	(6.3)
Systemic oppression (e.g., racism, homophobia etc.)	48	(6.1)
Homelessness	40	(5.1)
Living with a disability	31	(4.0)
Other (please specify)	11	(1.4)
Prefer not to answer	3	(.4)
Do not know	2	(.3)
Total	782	(100.0)

Table 3.1: Distribution of respondents by types of services and support for substance use accessed in Peel last two years		
Services Accessed/Attempted to Access	Number	(%)
Addictions (withdrawal management, support groups, replacement therapy)	351	(45.0)
General practitioner/family doctor	287	(36.8)
Caregiver supports	270	(34.6)
Harm reduction (Needle Exchange Program/outreach)	230	(29.5)
Mental health	218	(27.9)
Hospitals	210	(26.9)
Housing and homelessness	112	(14.4)
Pharmacy	99	(12.7)
Other (please specify)	16	(2.1)
Total	780	(100.0)

Table 3.2: Distribution of respondents by Main Barriers faced when accessing substance use services in Peel		
Main Barriers faced	Number	(%)
Confidentiality concerns	219	(28.1)
Lack of services relevant for me as a youth/senior/woman/person of colour/2SLGBTQ+	219	(28.1)
Fear of other people finding out (community/family/cultural shame)	212	(27.2)
Inhibiting rules/policies (eg., have to be abstinent)	179	(22.9)
Lack of availability of services	163	(20.9)
Service provider lacked knowledge/I was never referred to services I needed	152	(19.5)
Long wait lists	149	(19.1)
Fear of arrest/criminalization/incarceration	143	(18.3)
High cost of service	135	(17.3)
Personal shame/embarrassment	135	(17.3)
Fear of child welfare services involvement	133	(17.1)
Work/school responsibilities (e.g., not being able to take time off work)	132	(16.9)
Insufficient opening hours	127	(16.3)
Stigma/discrimination by service provider	113	(14.5)
Family responsibilities (e.g., not being able to find alternative childcare options)	106	(13.6)
Agency was not physically accessible (e.g., not wheelchair accessible)	84	(10.8)
Transportation issues (e.g. service not on bus route, no money for transportation)	81	(10.4)
Cultural barriers (e.g. service not delivered in my language)	76	(9.7)
No access to communication device(s) (e.g., mobile phone, email, postal address)	65	(8.3)
Bad past experiences with service(s)	50	(6.4)
Did not know of service(s)	33	(4.2)
Family/partner influences	11	(1.4)
Other (please specify)	9	(1.2)
Total	780	(100.0)

Table 3.3: Distribution of respondents by Main Barriers faced when accessing substance use services in Peel		
Priorities for drug strategy	Number	(%)
Access to treatment services	423	(54.7)
Education and awareness regarding substance use, including reducing stigma	389	(50.3)
Access to harm reduction services	367	(47.5)
Addressing production, importation, and distribution of drugs	306	(39.6)
Advocacy to all levels of government to address housing challenges	276	(35.7)
Advocacy to all levels of government to improve access to education and employment opportunities	194	(25.1)
Other (please specify)	18	(2.3)
Total	773	(100.0)

Table 3.4: Distribution of respondents by priority group for receiving substance use related services and supports		
Priorities for drug strategy	Number	(%)
Homeless youth (16-24 years)	320	(41.4)
Youth (12-24 years)	317	(41.0)
2SLGBTQ+ (youth and adults)	263	(34.0)
Individuals living in poverty	252	(32.6)
Women	207	(26.8)
African, Caribbean and Black	168	(21.7)
Individuals experiencing with the justice system	142	(18.4)
Hidden users (those who are housed/and or not accessing services)	141	(18.2)
Individuals experiencing a mental health problem/illness	138	(17.9)
Indigenous	89	(11.5)
East/South East Asians	87	(11.3)
South Asians	74	(9.6)
Other (please specify)	13	(1.7)
Total	773	(100.0)

APPENDIX C

Priority group matrix

Target Group	Level of Risk	Level of Knowledge about Group	Our Capacity and Ease	Notes
Homeless Youth	High	Low	High	
Caledon Youth	Unknown	Low	Low	This is the only rural population that we are proposing to target
Youth	High	High	High	Potential focus on Grade 10-12
2SLGBTQ+ (youth & adults)	High	Low	Moderate	This includes questions specifically around PnP
Women	Unknown	Low	High	Potential focus on single mothers
White Men	High	High	High	This includes homeless White men, but not hidden users
Hidden Users (those who are housed and/or not accessing services	High	Moderate	Low	This includes the profile of White men who are overrepresented in overdose related deaths
South Asian (adults)	High	High	High	Potential focus on Punjabi community
East/ South East Asian (adults)	Moderate	Moderate	Low	This includes Chinese population that we do not have knowledge about
ACB (adults)	High	Moderate	Low	
Seniors	Low	Moderate	Moderate	There is a significant group of homeless folks who use substances that are seniors Potential focus on seniors in Mississauga

Moyo Health and Community Services. Community engagement: An engagement strategy for the Peel Integrated Drug Strategy. Internal Moyo report. Unpublished.

REFERENCES

1.Health Officers of B.C. A Public Health Approach To Drug Control in Canada [Internet]. 2005 [cited 2020 Dec 7]. Available from: https://www.markhaden.com/publications/Health%20Officer%20Council%20-%20a%20public%20health%20to%20approach%20to%20Drug%20Control-2005.pdf

2. Region of Peel - Public Health. The Changing Landscape of Health in Peel - A Comprehensive Health Status Report [Internet]. 2019 [2020 Nov 13]. Available from: https://www.Peelregion.ca/health/resources/pdf/CHSR-changing-landscape-health-Peel-full-report.pdf

3. Daley DC. Family and social aspects of substance use disorders and treatment. J Food Drug Anal. 2014;21(4):S73–6.

4. Public Health Ontario. Interactive Opioid Tool. Public Health Ontario [Internet]. 2018 [cited 2020 Dec 7]. Available from https://www.publichealthontario.ca/en/data-and-analysis/substance-use/interactive-opioid-tool#/ageSex

5. Public Health Ontario. Alcohol Harms Snapshot. Public Health Ontario [Internet]. 2018 [cited 2020 Nov 20]. Available from: https://www.publichealthontario.ca/en/data-and-analysis/substance-use/alcohol-harms

6. Government of Canada. Health effects of cannabis [Internet]. 2020 [cited 5 Feb 2021]. Available from: https://www.canada.ca/en/health-canada/services/drugs-medication/cannabis/health-effects/effects.html#shr-pg0

7. Public Health Ontario. Cannabis Harms. Public Health Ontario [Internet]. 2018 [cited 2020 Nov 20]. Available from: https://www.publichealthontario.ca/en/data-and-analysis/substance-use/cannabis-harms

8. Region of Peel. Opioid Overdoses [Internet]. 2020 [cited 2020 Dec 7]. Available from: https://www.peelregion.ca/opioids/overdoses.asp

9. Canadian Centre on Substance Use and Addiction. Impacts of the COVID-19 Pandemic on People Who Use Substances: What We Heard [Internet]. 2020 [cited 2021 Feb 2]. Available from: https://www.ccsa.ca/sites/default/files/2020-07/CCSA-COVID-19-Impacts-on-People-Who-Use-Substances-Report-2020-en.pdf

10. Public Health Ontario, Ontario Drug Policy Research Network, Office of the Chief Coroner, Ontario Forensic Pathology Service. Opioid Mortality Surveillance Report: Analysis of Opioid-Related Deaths in Ontario July 2017-June 2018 [Internet]. 2019 [cited 2021 Feb 2]. Available from: https://www.deslibris.ca/ID/10101054

11. Moyo Health and Community Services. Community engagement: An engagement strategy for the Peel Integrated Drug Strategy. Internal Moyo report. Unpublished.

12. Toronto Public Health, St Michaels, CAMH, Mount Sinai Hospital. We ask because we care: The Tri Hospital + TPH health equity data collection research project report [Internet]. September 2013 [cited 2021 Mar 20]. Available from https://www.stmichaelshospital.com/quality/equity-data-collection-report.pdf

13. Peel Public Health Income [Internet]. 2016 [cited 2021 Feb 2]. Available from: https://www.peelregion.ca/health/statusdata/SocioDemographics/income.asp

14. Region of Peel. Region of Peel's Housing Master Plan [Internet]. 2020 [cited 2021 Feb 2]. Available from: https://www.peelregion.ca/housing/_media/housing-master-plan.pdf

15. Region of Peel - Public Health. Supervised Consumption Site Needs Assessment and Feasibility Study for the Region of Peel [Internet]. 2019 [cited 2021 Feb 2]. Available from: https://www.peelregion.ca/opioids/pdf/consumption-site-needs-assessment.pdf

16. Cheng T, Wood E, Nguyen P, Kerr T, DeBeck K. Increases and decreases in drug use attributed to housing status among street-involved youth in a Canadian setting. Harm Reduct. J. 2014 [cited 2021 Feb 2];11(1):12

17. 1.Feng C, DeBeck K, Kerr T, Mathias S, Montaner J, Wood E. Homelessness Independently Predicts Injection Drug Use Initiation Among Street-Involved Youth in a Canadian Setting. J. Adolesc. Health. 2013 Apr [cited 2021 Feb 2];52(4):499–501

18. Region of Peel. 2016 Census Bulletin Immigration and Ethnic Diversity [Internet]. 2017[cited 2021 Feb 2]. Available from: https://www.peelregion.ca/planning-maps/CensusBulletins/2016-immigration-ethnic-diversity.pdf

19. Health Canada. Supervised consumption sites and services: Explained [Internet]. Government of Canada. 2018 [cited 2021 Feb 2]. Available from: https://www.canada.ca/en/health-canada/services/substance-use/supervised-consumption-sites/explained.html

20. Public Health Agency of Canada. Addressing Stigma: Towards a More Inclusive Health System [Internet]. 2019 [cited 2020 Dec 3]. Available from: https://www.canada.ca/content/dam/phac-aspc/documents/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/addressing-stigma-what-we-heard/stigma-eng.pdf

21. Transform Drug Policy Foundation. The War on Drugs: Promoting stigma and discrimination [Internet]. Date unknown [cited 5 Feb 2021]. Available from: https://transformdrugs.org/wp-content/uploads/2020/07/CTC-Stigma-briefing.pdf

22. Aubry T, Bloch G, Brcic V, Saad A, Magwood O, Abdalla T, et al. Effectiveness of permanent supportive housing and income assistance interventions for homeless individuals in high-income countries: a systematic review. The Lancet Public Health. 2020 [cited 2021 Jan 22];5(6):e342–60. Available from: https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(20)30055-4/fulltext

23. Baxter AJ, Tweed EJ, Katikireddi SV, Thomson H. Effects of Housing First approaches on health and well-being of adults who are homeless or at risk of homelessness: systematic review and meta-analysis of randomized controlled trials. J Epidemiol Community Health. 2019 [cited 2021 Jan 22];73(5):379–87. Available from: https://pubmed.ncbi.nlm.nih.gov/30777888/

24. Public Health Agency of Canada. Preventing Problematic Substance use in Youth [Internet]. 2018 [cited 2021 Jan 20]. Available from: https://www.canada.ca/content/dam/phac-aspc/documents/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/2018-preventing-problematic-substance-use-youth/2018-preventing-problematic-substance-use-youth.pdf

25. Cherner RA, Aubry T, Sylvestre J, Boyd R, Pettey D. Housing first for adults with problematic substance use. J Dual Diagn. 2017 [cited 2021 Mar 17];13(3):219-229. doi:10.1080/15504263.2017.1319586. Available from: https://pubmed.ncbi.nlm.nih.gov/28414579/

26. Oxford County Drug and Alcohol Strategy Steering Committee. Oxford County Community Drug and Alcohol Strategy [Internet]. 2018 [cited 2020 Dec 14]. Available from: https://oxchc.ca/oxford-county-community-drug-alcohol-strategy/

27. Middlesex-London Health Unit. Middlesex-London Community Drug and Alcohol Strategy [Internet]. 2018 [cited 2020 Dec 14}. Available from: https://static1.squarespace.com/static/599320d3b8a79baf4289fc66/t/5bc600c24785d31f3d3c4e4e/1539702994248/FINAL+CDAS+REPORT+October+2018.pdf

28. Canadian Public Health Association. Decriminalization of Personal Use of Psychoactive Substances [Internet]. 2017 [cited 2020 Nov 20]. Available from: https://www.cpha.ca/sites/default/files/uploads/policy/positionstatements/decriminalization-positionstatement-e.pdf

29.Toronto Public Health. Discussion Paper: A Public Health Approach to Drugs [Internet]. 2018 [cited 2021 Jan 21]. Available from: https://www.toronto.ca/wp-content/uploads/2018/05/9105-A-Public-Health-Approach-to-Drugs-Discussion-Paper.pdf

30. Oviedo-Joekes E, Guh D, Brissette S, et al. Hydromorphone Compared With Diacetylmorphine for Long-term Opioid Dependence: A Randomized Clinical Trial. JAMA Psychiat. 2016 [cited 2021 Jan 22];73(5):447-455. doi:10.1001/jamapsychiatry.2016.0109. Available from: https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2512237

31. Toronto Star. Preliminary Findings – Toronto Star analysis of TPS marijuana date (2003-2013) [Internet]. 2017 [cited 2021 Feb 10]. Available from https://www.thestar.com/news/insight/2017/07/06/toronto-marijuana-arrests-reveal-startling-racial-divide.html

32. Global Commission on Drug Policy. Advancing Drug Policy Reform: A New Approach to Decriminalization [Internet]. 2016 [cited 2021 Jan 21]. Available from: https://www.globalcommissionondrugs.org/wp-content/uploads/2016/11/GCDP-Report-2016-ENGLISH.pdf

33. Hughes C, Stevens A. What can we learn from the Portuguese decriminalization of illicit drugs? Br. J. Criminol. 2010 [cited 2021 Jan21]; 50:999–1022. Available from: https://pdfs.semanticscholar.org/4ab0/a481a65114f33667720d814b1c3f58ec6435.pdf?_ga=2.225629528.359100997.1612283816-1724314426.1603299585

34. EMCDDA & SICAD. 2014 National Report (2013 data) to the EMCDDA by the Reitox National Focal Point: Portugal New Developments [Internet]. 2014 [cited 2021 Jan 22]. Available from: https://www.emcdda.europa.eu/publications/national-reports/portugal-2014_en

35. Hughes C, Stevens A. A resounding success or a disastrous failure: re-examining the interpretation of evidence on the Portuguese decriminalization of illicit drugs. Drug and Alcohol Rev. 2012 [cited 2021 Jan 21]; 31(1): 101-113. Available from: https://pubmed.ncbi.nlm.nih.gov/22212070/

36. Mental Health Commission of Canada. Peer Support - Mental Health Commission of Canada [Internet]. 2021 [cited 2021 Jan 20]. Available from: https://www.mentalhealthcommission.ca/English/what-we-do/recovery/peer-support

37. Phillips K, Harrison J, Jabalee C. Supervising Peer Workers: A Toolkit for Implementing and Supporting Successful Peer Staff Roles in Mainstream Mental Health and Addiction Organizations. Centre for Excellence in Peer Support. Canadian Mental Health Association [Internet]. 2019 [cited 2021 Jan 20]. Available from: https://cmhawwselfhelp.ca/wp-content/uploads/2016/11/Supervising-Peer-Workers-Toolkit-CMHA-WW-2019.pdf

38. Boisvert RA, Martin LM, Grosek M, Clarie AJ. Effectiveness of a peer-support community in addiction recovery: participation as intervention: Peer-support community. Occup Ther Int. 2008 [cited 2021 Jan 21];15(4):205–20. Available from: https://pubmed.ncbi.nlm.nih.gov/18844242/

39. Tracy K, Wallace S. Benefits of peer support groups in the treatment of addiction. Subst Abuse Rehabil. 2016 [cited 2021 Jan 21]; 7:143–54. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5047716/

40. Davidson L, Amy CB, Guy K, er R a M. Peer support among persons with severe mental illnesses: A review of evidence and experience. World Psychiatry. 2012 [cited 2021 Jan 22];11(2):123–8. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3363389/

41. Bonn M, Touesnard N, Pugliese M, Cheng B, Comeau E, Bodkin C, et al. Securing Safe Supply During COVID-19 and Beyond: Scoping Review and Knowledge Mobilization. Canadian Institutes of Health Research [Internet]. 2020 [cited 2021 Jan 20]. Available from: https://cihr-irsc.gc.ca/e/52043.html

42. Ivsins A, Boyd J, Beletsky L, McNeil R. Tackling the overdose crisis: The role of safe supply. Int J Drug Policy. 2020 [cited 2021 Jan 22]; 80:102769. doi:10.1016/j.drugpo.2020.102769. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7252037/

43. Oviedo-Joekes E, Brissette S, Marsh DC, et al. Diacetylmorphine versus Methadone for the Treatment of Opioid Addiction. N Engl J Med. 2009 [cited 2021 Jan 22];361(8):777-786. doi:10.1056/NEJMoa0810635. Available from: https://www.nejm.org/doi/full/10.1056/nejmoa0810635

44.Oviedo-Joekes E, Palis H, Guh D, et al. Adverse Events During Treatment Induction With Injectable Diacetylmorphine and Hydromorphone for Opioid Use Disorder. J Addict Med. 2019 [cited 2021 Jan 22];13(5):354–361. doi:10.1097/ADM.0000000000000505. Available from: https://journals.lww.com/journaladdictionmedicine/fulltext/2019/10000/adverse_events_during_treatment_induction_with.4.aspx

45. Rai N, Sereda A, Hales J, Kolla G. Urgent call on clinicians: Prescribe alternatives to poisoned drug supply. Healthy Debate [Internet]. 2019 [cited 2021 Jan 22]. Available from: https://healthydebate.ca/opinions/safer-supply-opioids