BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
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AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

Thursday, May 16, 2019, 7:00 p.m.
399 Ridout Street North, London, Ontario
Side Entrance, (recessed door)
MLHU Boardroom

MISSION - MIDDLESEX-LONDON HEALTH UNIT

The mission of the Middlesex-London Health Unit is to promote and protect the health of our community.

MEMBERS OF THE BOARD OF HEALTH

Ms. Trish Fulton (Chair)
Ms. Maureen Cassidy (Vice-Chair)
Mr. John Brennan
Mr. Michael Clarke
Ms. Aina DeViet
Ms. Kelly Elliott
Ms. Tino Kasi
Mr. Ian Peer
Ms. Elizabeth Peloza
Mr. Matt Reid

SECRETARY-TREASURER

Dr. Christopher Mackie

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

MINUTES

Approve: April 18, 2019 - Board of Health meeting
Receive: May 2, 2019 - Finance & Facilities Committee draft meeting minutes

Item #	Delegation	Recommendation	Information	Report Name and Number	Link to Additional Information	Overview and Lead
Reports and Agenda Items						
1	**x**	**x**	**x**	May 2 Finance & Facilities Committee Meeting Update (Report No. 036-19)	May 2, 2019 – Agenda Minutes	To provide an update on reports reviewed at the May 2, 2019 Finance & Facilities Committee meeting. Lead: Matt Reid, Chair, Finance & Facilities Committee
2	**x**		**x**	Program update: Population Health Assessment and Surveillance Team (PHAS)	PHAS Program Template	Lead: Dr. Alex Summers, Associate Medical Officer of Health
3			**x**	Community Health Status Resource Strategic Project Update (Report No. 037-19)		To provide an update on the Community Health Status Resource Project. Lead: Ruth Sanderson, Epidemiologist
4	**x**		**x**	Program update: Program Planning and Evaluation Team	Program Planning and Evaluation Program Template	Lead: Jordan Banninga, Manager, Program Planning and Evaluation
5			**x**	Saving Lives. Changing Lives. Findings from the Temporary Overdose Prevention Site (TOPS) Evaluation (Report No. 038-19)	Appendix A Appendix B	To present the findings from the Temporary Overdose Prevention Site evaluation. Lead: Jordan Banninga, Manager, Program Planning and Evaluation
6	**x**		**x**	Program update: Nurse Family Partnership (NFP)	NFP Program Template	Lead: Heather Lokko, Director, Healthy Start and Jennifer Proulx, Manager, Nurse Family Partnership
7	**x**		**x**	Completion of the Canadian Nurse-Family Partnership Education Project (Report No. 039-19)	Appendix A	To provide an update on the completion of the Canadian Nurse-Family Partnership Education Project Lead: Jennifer Proulx, Manager, Nurse Family Partnership
8	**x**		**x**	Program Update:Young Adult Team	Young Adult Program Template	Lead: Anita Cramp, Manager, Young Adult
9	**x**		**x**	Program Update: Child Health Team	Child Health Program Template	Lead: Darrell Jutzi, Manager, Child Health
10		**x**		Health Canada Seeking Feedback on Measures to Limit Youth Access and Appeal of Vaping Products (Report No. 040-19)	Appendix A Appendix B	To request correspondence be sent to express support and recommendations for strengthened measures to limit you acess and

						appeal of vaping products. Lead: Ms. Donna Kosmack, Manager, South West Tobacco Control Area Network and Ms. Linda Stobo, Manager, Chronic Disaese Prevention and Tobacco Control
11			**x**	Harm Reduction Campaign (Report No. 041-19)	Appendix A	To provide an update on the Harm Reduction Campaign. Lead: Shaya Dhinsa, Manager, Sexual Health
12			**x**	Summary Information Report for May (Report No. 042-19)		To provide an update on Health Unit programs and services for May. Lead: Maureen Rowlands, Director, Healthy Living
13			**x**	Medical Officer of Health/ CEO Activity Report for May (Report No. 043-19)		To provide an update on the activities of the MOH/CEO for May. Lead: Dr. Christopher Mackie
Correspondence						
14			**x**	May 2019 Correspondence		To receive correspondence items a) though w), and refer item x) to staff.

OTHER BUSINESS

- Summary of the April 30th alPHa Board of Health Chair's teleconference regarding the 2019 Ontario Budget.
- Next Finance & Facilities Committee Meeting: Thursday, June 6, 2019 @ 9:00 a.m.
- Next Board of Health Meeting: Thursday, June 20 @ 7:00 p.m. and Wednesday June 26th @ 7:00 p.m.
- Next Governance Committee Meeting: Thursday, June 20, 2019 @ 6:00 p.m.
- Next Relocation Advisory Committee meeting: Wednesday June 26th @ 5:00 p.m.

CONFIDENTIAL

The Board of Health will move in-camera to consider matters regarding identifiable individuals, information (e.g., a trade secret or scientific, technical, commercial, or financial) that belongs to the Middlesex-London Health Unit and has monetary value and to consider confidential minutes from the May 2, 2019 Finance & Facilities Committee meeting and the April 18, 2019 Board of Health meeting.

ADJOURNMENT

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH

Thursday, April 18, 2019, 7:00 p.m.
399 Ridout Street North, London, Ontario
Side Entrance (recessed door)
MLHU Boardroom

MEMBERS PRESENT:
Ms. Trish Fulton (Chair)
Ms. Maureen Cassidy (Vice-Chair)
Ms. Aina DeViet
Mr. Ian Peer
Ms. Elizabeth Peloza
Mr. Matt Reid
Mr. John Brennan
Ms. Tino Kasi
Ms. Kelly Elliott
Mr. Michael Clarke

MEDIA:
Sean Irvine, CTV News

OTHERS PRESENT:
Dr. Christopher Mackie, Secretary-Treasurer
Ms. Elizabeth Milne, Executive Assistant to the Board of Health and Communications Coordinator (Recorder)
Dr. Alexander Summers, Associate Medical Officer of Health
Ms. Marilyn Atkin, Harm Reduction and Outreach Team Lead
Mr. Jordan Banninga, Manager, Program Planning and Evaluation
Mr. Joe Belancic, Manager, Procurement and Operations
Ms. Shaya Dhinsa, Manager, Sexual Health
Mr. Dan Flaherty, Manager, Communications
Mr. Brian Glasspoole, Manager, Finance
Ms. Donna Kosmack, Manager, Southwest Tobacco Control Area Network
Ms. Heather Lokko, Director, Healthy Start
Ms. Sarah Maaten, Epidemiologist
Mr. David Pavletic, Manager, Food Safety and Healthy Environments
Ms. Kendra Ramer, Manager, Strategic Projects
Ms. Maureen Rowlands, Director, Healthy Living
Mr. Alex Tyml, Online Communications Coordinator
Mr. Stephen Turner, Director, Environmental Health and Infectious Diseases
Mr. Endri Poletti, Architect
Mr. Tom Bes, BES Project Management

Chair Fulton called the meeting to order at 7:03 p.m.

DISCLOSURE OF CONFLICT OF INTEREST

Chair Fulton inquired if there were any disclosures of conflicts of interest. None were declared.

Chair Fulton made note of an addition to the agenda: walk-on Report No. 035-19 re: "Update on Opioid Overdose Deaths in Middlesex-London," which will be moved to the top of the agenda for the first presentation of the evening.

APPROVAL OF AGENDA

It was moved by Mr. Peer, seconded by Ms. Elliott, *that the **AGENDA** for the April 18, 2019 Board of Health meeting be approved as amended.*

Carried

MINUTES

It was moved by Mr. Reid, seconded by Ms. Cassidy, *that the **MINUTES** of the March 21, 2019 Board of Health meeting be approved.*

Carried

Update on Opioid Overdose Deaths in Middlesex-London (Report No. 035-19)

Mr. Turner introduced Ms. Sarah Maaten, Ms. Shaya Dhinsa, and Ms. Marilyn Atkin, who contributed to this report. Mr. Turner provided context for the report. Ms. Maaten reported to the Board regarding the recent increase in deaths related to opioid poisoning in Middlesex-London. Her report included a timeline of events for data collection, analysis of the surveillance data, and the strategies MLHU has implemented to reduce harms associated with opioid overdoses.

Discussion ensued on the following items:

- Additional strategies in place at street level to reach the appropriate populations.
- How information about programs and services is shared among community partners and those who use injection drugs.
- Trends in overdose data in the past five years, progress made since the opioid crisis was declared, and changes in the illicit drug supply since then.
- Fentanyl: the timeline of its arrival in the illicit drug supply in the community, its impact on overdose trends in London, and how it is becoming more difficult to test for it due to analog forms of the drug being produced and distributed.
- The distribution of illicit drugs across the country and the consideration of a national investigation into the trafficking of drugs in order to better prepare communities for pending infiltration of new drugs into the illicit drug supply.
- Coordination of data and information across the country to better understand the issues and impact that illicit drugs are having on communities.

Public Health Inspector Enforcement Actions – Q1 2019 (Report No. 027-19)

Mr. Turner and Mr. Pavletic introduced the report and answered questions.

It was moved by Ms. Elliott, seconded by Ms. DeViet, *that the Board of Health receive Report No. 027-19 re: "Public Health Inspector Enforcement Actions" for information.*

Carried

Chair Fulton introduced five program updates for the evening.

Program Update: Food Safety and Healthy Environments

Mr. Pavletic introduced the Food Safety Team and the Healthy Environment Team within the Environmental Health and Infectious Diseases Division. Mr. Pavletic provided a summary of key initiatives and outlined the teams' work focuses for 2019, which include a vulnerability assessment to deliver interventions aimed at addressing the impacts of climate change, updating the disclosure website to include other program area inspections, and developing culturally relevant program materials.

Discussion ensued on the following items:

- The number of regular food safety inspections compared to the number of enforcement actions required.
- The frequency of risk-based inspections on an annual basis.
- The process in place for enforcement actions and the difference in enforcement actions for food premises versus for recreational water premises.
- The number of Public Health Inspectors that inspect premises.
- Coordination with City of London staff regarding work and inspections related to vulnerable occupancies.
- Awareness, education, and training for newcomers and how staff employ education and cultural sensitivity during an intervention at an inspection.

Program Update: Southwest Tobacco Control Area Network (SW TCAN)

Ms. Kosmack provided an overview of the SW TCAN program within the Healthy Living Division, which coordinates high-priority areas of tobacco control across eight health units within the Southwest Region. Ms. Kosmack provided an overview of the budget structure for the SW TCAN, how the funding is distributed through MLHU, and a summary of the impact the program has had on smoking rates in Ontario.

Discussion ensued on historical trends for smoking rates in the province, the increase in vaping rates among youth, and the current status of the plain packaging legislation at the federal level.

It was moved by Ms. Cassidy, seconded by Ms. Elliott, *that the Board of Health receive Report No. 035-19 re: "Update on Opioid Overdose Deaths in Middlesex-London" for information.*

Carried

Program Update: Finance

Mr. Glasspoole provided an overview of the work of the Finance Team within the Healthy Organization Division and reviewed some of the team's main functions, including program budgeting and marginal analysis, financial planning, supporting two major audits per year, coordination of statutory reports to the Ministry, treasury services, and payroll and benefit administration. Mr. Glasspoole also outlined key initiatives planned for 2019, including (among others) updating financial systems, enterprise resource planning, and outsourcing of payroll administration.

Program Update: Communications

Mr. Flaherty provided an overview of the Communications program within the Office of the Medical Officer of Health and reviewed its key activities, including the Healthcare Provider Outreach program, media relations, advertising and promotions, online and social media activities, producing the Health Unit's annual report, graphic design, in-house graphic services, and graphic services procurement.

2018 Annual Report (Report No. 028-19)

It was moved by Mr. Peer, seconded by Ms. Cassidy, *that the Board of Health receive Report No. 028-19 re: "2018 Annual Report" for information.*

Carried

Program Update: Procurement and Operations

Mr. Belancic provided an overview of the Procurement and Operations program within the Healthy Organization Division. He reviewed how the team functions within the organization and some of the key

initiatives planned for 2019, which include contract management solutions, project planning, and the release of a tender to cover the budget to retrofit Citi Plaza.

Discussion ensued about procedures for RFPs versus sole-source contracts, and the cutoffs and criteria for each.

Location Project – Project Plan and General Contractor Pre-Qualification April 2019 (Report No. 030-19)

Mr. Belancic introduced and provided context for this report. He also noted some of the next steps in the process from a project management perspective, which include approving the selection of the pre-qualified contractors for fit-up, and the plan to have the general contractor select the sub-trades required for fit-up of the new space.

Mr. Clarke noted that he is not the same Michael Clark mentioned in the report.

Discussion ensued on the following items:

- The cost of the elevator extension and how much of the approved expenditure MLHU has spent on the work thus far.
- Additional details around the elevator, including updates and requirements associated with the fit-up and extension to the basement.
- MLHU's liability if the contractor selects the sub-trades.
- That any sub-trades selected will still need to meet MLHU's criteria, but that legal liability would flow through the main contractor.

It was moved by Ms. Kasi, seconded by Mr. Brennan, *that the Board of Health:*

1) *Receive Report No. 030-19BOH re: "Location Project – Project Plan Update and General Contractor Pre-Qualification April 2019" for information; and*
2) *Approve the selection of the Pre-Qualified General Contractors for Fit-Up at Citi Plaza.*

Carried

Impact of 2019 Provincial Budget (Report No. 031-19)

Dr. Mackie introduced and provided context for this report regarding the public health restructuring that emerged as part of the provincial budget announcement on April 11.

Dr. Mackie reviewed the information and projections regarding this announcement that he has received to date, noting that there are some steps MLHU can take to mitigate a potential deficit.

Ms. DeViet provided an update in regard to the alPHa teleconference she attended on behalf of the Board earlier this afternoon. The teleconference pertained to the provincial budget and changes to the structure of public health. Ms. DeViet provided a summary of the call and some key points from the discussion.

Ms. Fulton clarified that there had been two conference calls in regard to public health restructuring and the provincial budget: one for Boards of Health and one for Medical Officers of Health.

Discussion ensued on the following items:

- The two major components of the restructuring, which would be budget impacts and the reduction to ten health units from thirty-five across the province.
- The government's commitment to implementing the restructuring to ten health units by this time next year.
- That the Board is established by legislation and how new legislation with regard to the new structure might look.

- The economies of scale within the boundaries proposed for the ten new public health entities, and the potential of communicating this to the Ministry to help visualize the potentially increased costs associated with amalgamation.
- What a governance and service delivery model for ten health units might look like and how populations might be affected.
- How populations and municipalities within the new catchment areas might be involved in the consultations, and discussions regarding next steps in the restructuring.
- Advocacy by board members in their respective areas with respect to the restructuring.

Ms. Fulton reviewed the three mitigation strategies outlined in the report and invited further discussion.

It was moved by Ms. Cassidy, seconded by Mr. Reid, *that the Board of Health:*

1) *Receive Report No. 031-19 re: "Impact of 2019 Provincial Budget" for information; and*
2) *Approve the recommended steps under the section on "Mitigation."*

Carried

Medical Officer of Health/CEO Activity Report for April (Report No. 029-19)

It was moved by Mr. Brennan, seconded by Ms. Kasi, *that the Board of Health receive Report No. 029-19 re: "Medical Officer of Health Activity Report for April" for information.*

Carried

CORRESPONDENCE

It was moved by Ms. Cassidy, seconded by Mr. Peer, *that the Board of Health receive correspondence items a) through i) and k).*

Carried

Dr. Mackie introduced and provided context for correspondence item j).

It was moved by Mr. Clarke, seconded by Ms. Kasi, *that the Board of Health endorse correspondence item j): Private Members' Bill re: Inspection of Clinics.*

Carried

OTHER BUSINESS

Chair Fulton reviewed the next meeting dates and the alPHa fitness challenge scheduled for Board members before the May 16 meeting.

- Next Finance & Facilities Committee meeting: Thursday, May 2, 2019 @ 9:00 a.m.
- Next Board of Health meeting: Thursday, May 16, 2019 @ 7:00 p.m.
- Next Governance Committee meeting: Thursday, June 20, 2019 @ 6:00 p.m.

CONFIDENTIAL

At 9:04 p.m., it was moved by Ms. Peloza, seconded by Ms. Elliott, *that the Board of Health move in-camera to consider matters regarding identifiable individuals, information (e.g., a trade secret or scientific, technical, commercial, or financial) that belongs to the Middlesex-London Health Unit and has monetary value, and confidential minutes from the March 21, 2019 Board of Health meeting.*

Carried

At 9:05 p.m., everyone left the meeting except the Board of Health, Dr. Mackie, Ms. Milne, Dr. Summers, Ms. Rowlands, Ms. Lokko, Mr. Belancic, Mr. Bes, Mr. Poletti, Mr. Banninga, Mr. Glasspoole, and Mr. Turner.

At 9:41 p.m., it was moved by Ms. Peloza, seconded by Ms. Elliott, *that the Board of Health rise and return to public session.*

Carried

At 9:42 p.m., the Board of Health returned to public session.

It was moved by Ms. Elliott, seconded by Mr. Reid, *that Dr. Chris Mackie and the Board Chair consider meeting with Warden Kurtis Smith and Mayor Ed Holder to support advocacy efforts regarding the restructuring of public health and to discuss the importance of ensuring the delivery of public health at the local level.*

Carried

ADJOURNMENT

At 9:43 p.m., it was moved by Mr. Reid, seconded by Ms. Elliott, *that the meeting be adjourned.*

Carried

TRISH FULTON
Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

PUBLIC MINUTES
FINANCE & FACILITIES COMMITTEE
50 King Street, London
Middlesex-London Health Unit
Thursday, May 2, 2019 9:00 a.m.

MEMBERS PRESENT:	Ms. Maureen Cassidy Ms**.** Tino Kasi Mr. Matt Reid (Chair)
REGRETS:	Ms. Kelly Elliott Ms. Trish Fulton
OTHERS PRESENT:	Dr. Christopher Mackie, Secretary-Treasurer Ms. Lynn Guy, Executive Assistant to the Medical Officer of Health (Recorder) Ms. Laura Di Cesare, Director, Healthy Organization Mr. Brian Glasspoole, Manager, Finance
MEDIA:	Mr. Gerry Dewan, Reporter, CTV News London

At 9:09 a.m., Chair Reid called the meeting to order.

DISCLOSURE OF CONFLICT OF INTEREST

Chair Reid inquired if there were any disclosures of conflicts of interest. None were declared.

APPROVAL OF AGENDA

It was moved by Ms. Cassidy, seconded by Ms. Kasi, *that the **AGENDA** for the May 2, 2019 Finance & Facilities Committee meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by Ms. Kasi, seconded by Ms. Cassidy, *that the **MINUTES** of the March 7, 2019 Finance & Facilities Committee meeting be approved.*

Carried

NEW BUSINESS

4.1 Q1 Financial and Factual Certificate Update (Report No. 015-19FFC)

Mr. Glasspoole provided the details for this report. He noted that at this time, significant progress has been made toward the gapping target required to avoid a deficit, and further progress is expected over the year.

Dr. Mackie advised that even though the provincial government announced its budget last month, he could not say for certain what the financial impact would be for MLHU. The latest estimate is a $2.5M reduction, but this could range from $1M to $3.5M.

The Ministry announced that there will be a change in funding ratios, moving to a 70/30 split. The Health Unit currently works with an approximate ratio of 75/25, obtaining 75 percent of its funding from the Ministry and 25 percent from municipalities. Dr. Mackie noted that the Province has advised that there may be opportunities for some one-time funding to offset some of the loss of funds. It was noted that MLHU's

municipalities have not been asked for additional funds since 2005. It is not known at this time how much additional funding the municipalities will be asked to provide.

Dr. Mackie noted that there will be a phone call tomorrow morning with Ministry staff and he is hopeful that more questions will be answered at that time.

Dr. Mackie added that the boundaries for the ten new health unit entities are currently being developed and it is anticipated that they will be announced in the fall of this year.

It was moved by Ms. Cassidy, seconded by Ms. Kasi, *that the Finance & Facilities Committee review and recommend to the Board of Health to approve Report No. 015-19FFC re: "Q1 Financial Update and Factual Certificate."*

Carried

4.2 Financial Controls Checklist (Report No. 016-19FFC)

Mr. Glasspoole explained that this checklist provides financial accountability for the Health Unit and is a critical part of the organization's internal controls system. He advised that the Ministry of Health and Long-Term Care is currently revising the checklist and it is anticipated it will be completed for review within the month. The Health Unit is in compliance with all financial controls requirements of the Ministry.

It was moved by Ms. Cassidy, seconded by Ms. Kasi, *that the Finance & Facilities Committee receive Report No 016-19FFC re: "Financial Controls Checklist" for information.*

Carried

4.3 Q2 Physical Assets and Facilities Update (Report No. 017-19FFC)

Ms. Di Cesare noted that termination-of-lease letters have been given to the landlords for both of MLHU's London-based offices. There was discussion regarding the lease for 50 Front Street in Strathroy. Noted was the importance of continuing to have an office in the County to provide services to the residents who live there. However, in these uncertain times, staff will strive to negotiate a fair rate on a relatively short-term lease.

There was discussion about the many uncertainties that MLHU is currently facing.

It was moved by Ms. Kasi, seconded by Ms. Cassidy, *that the Finance & Facilities Committee review and recommend that the Board of Health:*

1) *Receive Report No. 017-19FFC re: "Q2 Physical Assets and Facilities Update" for information; and*
2) *Direct staff to begin negotiations with Canba Investments Limited regarding the Strathroy Office at 51 Front Street.*

Carried

OTHER BUSINESS

Next meeting: June 6, 2019.

CONFIDENTIAL

At 9:25 a.m., it was moved by Ms. Kasi, seconded by Ms. Cassidy, *that the Finance & Facilities Committee move in-camera to consider matters regarding identifiable individuals and information (e.g., a trade secret or scientific, technical, commercial, or financial) that belongs to the Middlesex-London Health Unit and has monetary value.*

Carried

At 9:38 a.m., it was moved by Ms. Kasi, seconded by Ms. Cassidy, *that the Finance & Facilities Committee return to public session.*

Carried

At 9:38 a.m., the Finance & Facilities Committee returned to public session.

ADJOURNMENT

At 9:39 a.m., it was moved by Ms. Cassidy, seconded by Ms. Kasi, *that the meeting be adjourned.*

Carried

At 9:39 a.m., Chair Reid *adjourned the meeting*.

MATT REID
Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 036-19

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2019 May 16

FINANCE & FACILITIES COMMITTEE MEETING – May 2, 2019

The Finance & Facilities Committee (FFC) met at 9:00 a.m. on Thursday, May 2, 2019. A summary of the discussion can be found in the draft minutes.

Reports	Recommendations for Information and the Board of Health's Consideration
Q1 Financial and Factual Certificate Update **(Report No. 015-19FFC)**	*That the Finance & Facilities Committee review and recommend to the Board of Health to approve Report No. 015-19FFC re: "Q1 Financial Update and Factual Certificate."* Carried
Financial Controls Checklist **(Report No. 016-19FFC)**	*That the Finance & Facilities Committee receive Report No. 016-19FFC re: "Financial Controls Checklist" for information.* Carried
Q2 Physical Assets and Facilities Update **(Report No. 017-19FFC)**	*That the Finance & Facilities Committee review and recommend to the Board of Health to:* *1) Receive Report No. 017-19FFC re: "Q2 Physical Assets and Facilities Update" for information; and* *2) Direct staff to begin negotiations with Canba Investments Limited regarding the Strathroy Office at 51 Front Street.* Carried

The FFC's next meeting will be on Thursday, June 6, at 9:00 a.m., at the Middlesex-London Health Unit, 50 King St., Room 3A.

This report was prepared by the Office of the Medical Officer of Health.

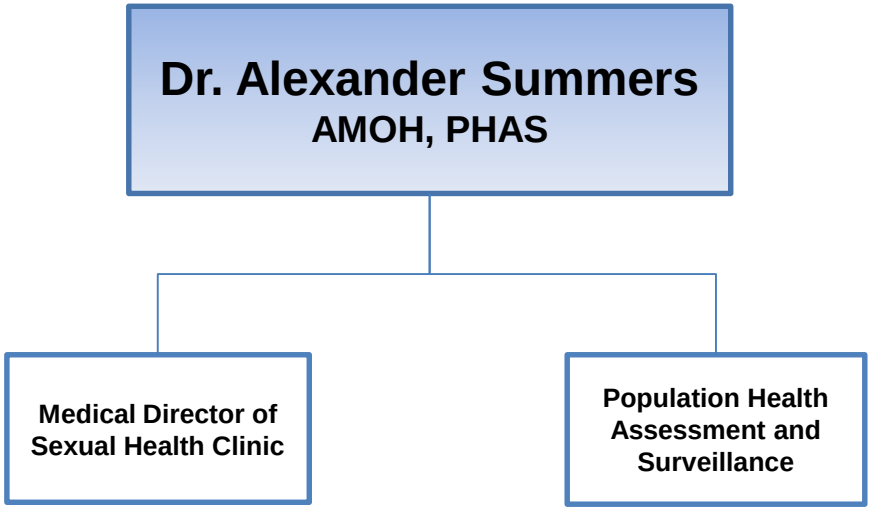
Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health / CEO

Office of the Medical Officer of Health
Associate Medical Officer of Health

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

Total FTEs – 6.50 FTEs

Total Budget – $889,666



Highlights:

- Provides medical leadership to the Environmental Health and Infectious Disease division, serves as the Medical Director of the Sexual Health Clinic and a Clinic Physician, manages the Population Health Assessment and Surveillance Team (PHAST), and provides oversight of medical student and resident physician placement and teaching
- In addition to supporting a number of team- and division-level projects, PHAST is currently revising MLHU's public facing online health status portal that will provide updated information on the health status of the residents of London and Middlesex across a broad range of indicators

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 037-19

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2019 May 16

COMMUNITY HEALTH STATUS RESOURCE STATEGIC PROJECT UPDATE

Recommendation

It is recommended that Report No. 037-19 re: "Community Health Status Resource Strategic Project Update" be received for information.

Key Points

- As part of the Ontario Public Health Population Health Assessment Standard, boards of health are required to assess and share information externally on the current health status of the local population and subpopulations in order to inform planning of interventions that are responsive to residents' needs.
- The Middlesex-London Health Unit meets these requirements, in part, through its on-line Community Health Status Resource.
- Approximately half of the Resource's content has been recently updated and internal processes are being strengthened to ensure ongoing sustainability.
- The Health Unit is uniquely positioned to support our community health partners via our expertise in population health assessment.

Background

Population health assessment is a core function of the public health system and a first step in planning community health programs and services that are responsive to residents' needs. It considers the health of populations and subgroups, and looks at the circumstances that affect residents' health, such as where they live, their level of education, and their income.

As part of the Ontario Public Health Population Health Assessment Standard, boards of health are required to assess current health status, health behaviours, preventive health practices, risk and protective factors, health care utilization relevant to public health, and demographic indicators, including the assessment of trends and changes. Boards of health must also provide this population health information to the public, community partners, and other health care providers so that they are aware of relevant and current population health information.

The Health Unit meets these population health assessment requirements, in part, through its online Community Health Status Resource. The Resource was launched in 2012 and is being enhanced through a 2018–19 strategic project. The project involves both updating the content of the Resource and embedding practices that will support routine, ongoing updating to ensure the health indicators remain relevant and the information is up-to-date.

Current Project Status

Updates have been published for half of the more-than-seventy health indicators in the Resource. Completed topics include: geography & demographics, social determinants of health (e.g., education, income, housing), injury, substance use, immunization, healthy pregnancy, birth and early development, and urban Indigenous health.

Enhancements include:

- Augmenting our assessment of health inequities, where the data permits, by rural/urban status, education, income, and employment status.
- Partnering with the Southwest Ontario Aboriginal Health Access Centre to include data from Our Health Counts London in the Resource (and thereby carrying out a recommendation for inclusion within our organizational plan for reconciliation).
- Increasing interpretation of findings to focus the reader on the meaning of the results.
- Including aggregated data tables to support the community's use of population health data.

Next Steps

Additional topics will be completed by mid-summer, including: general health, behavioural risk factors (e.g., healthy eating, physical activity, sleep), and infectious disease. Future areas of development in the fall will include: child and youth health, chronic disease, healthy environments, and oral health. Approaches to enhance ongoing updating are being documented and considered. Promotion of the Resource to key community partners is also being considered to ensure that partners are aware of this information and integrate it into their planning.

Conclusion

Through population health assessment initiatives such as the Community Health Status Resource, the Middlesex-London Health Unit is uniquely positioned within the local health system to identify groups whose health is at risk and to help identify health system priorities to support the overall health and wellbeing of the whole population.

This report was prepared by the Population Health Assessment and Surveillance Team, Office of the Medical Officer of Health.

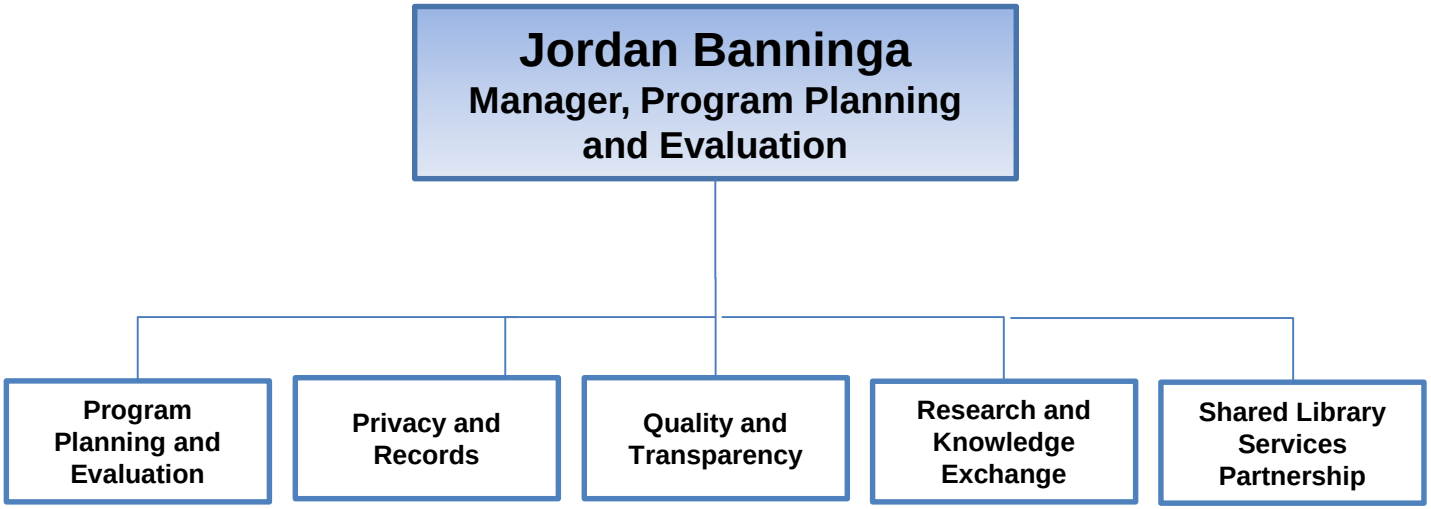
Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health / CEO

Healthy Organization
Program Planning and Evaluation

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

Total FTEs – 9.00 FTEs

Total Budget – $873,039



Program Highlights:

- The Program Planning and Evaluation (PPE) Team provides support for multiple programs relating to the foundational standards and organizational requirements.
- Priorities for 2019 include:
  - Continued implementation of the Planning and Evaluation and alignment with the Annual Service Plan
  - Updating and implementing records management practices in preparation for the move
  - Supporting strategic projects and program projects requiring Program Planning and Evaluation Team expertise
  - Implementing a client experience survey with selected MLHU teams
  - Reviewing MLHU access copyright needs and practices

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 038-19

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2019 May 16

SAVING LIVES. CHANGING LIVES. FINDINGS FROM THE TEMPORARY OVERDOSE PREVENTION SITE (TOPS) EVALUATION

Recommendation

It is recommended that Report No. 038-19 re: "Saving Lives. Changing Lives. Findings from the Temporary Overdose Prevention Site (TOPS) Evaluation" be received for information.

Key Points

- In 2018, the Program Planning and Evaluation Team evaluated the Temporary Overdose Prevention Site (TOPS) located at the Regional HIV/AIDS Connection (RHAC) to report on lessons gleaned from the first six months of operation and assess how well the site is meeting its intended outcomes.
- Findings reveal that the Temporary Overdose Prevention Site (now called a Consumption and treatment Services site), provides an essential service to reduce harms associated with drug use, including opioid-related overdoses. Through caring, compassionate, and stigma-free service delivery, TOPS has created a welcoming and non-judgmental environment that has allowed clients to feel accepted and cared for.
- There is also data indicating that activities at the site are promoting safer drug use practices and increasing linkages to health and social services for clients.

Evaluation Overview

In 2018, the Program Planning and Evaluation Team conducted a comprehensive process and outcome evaluation of London's Temporary Overdose Prevention Site (TOPS) to report on lessons gleaned from the first six months of operation and to document progress in meeting the intended outcomes.

The purposes of the evaluation were:

1. To conduct process and outcome evaluations of the impact and effectiveness of TOPS in Middlesex-London, Ontario.
2. To help inform the development and implementation of a Supervised Consumption Facility (SCF) in Middlesex-London, Ontario.

The evaluation used a concurrent mixed-methods design, collecting qualitative and quantitative data, to answer the evaluation questions. Primary data was collected using the following surveys and interviews:

- Customer satisfaction survey for clients (n=105)
- Survey of community residents and business owners within 120 metres of TOPS (n=15)
- Key informant interviews with clients (n=26), TOPS staff/leads (n=17), and key stakeholders providing services in the Aftercare Room at TOPS (n=9)

The Ministry of Health and Long-Term Care (MOHLTC) Overdose Prevention Site Monthly Reporting Form was used as a secondary data source to understand usage statistics at TOPS.

Findings

The Temporary Overdose Prevention Site in London, Ontario, provides an essential service to reduce harms associated with drug use, including opioid-related overdoses. Findings from the first six months of operation of the site provide evidence that the site is making a positive impact on many clients' lives. The site is not only saving lives, but also changing them.

The evaluation findings reveal that the site creates a safe, clean, and secure space for members of our community who use drugs. Services are delivered as intended and have exceeded Ministry service delivery expectations by offering on-site medical supports, wrap-around services, and Indigenous supports.

Given the exceptional value placed by clients, staff, and stakeholders on providing this set of services, many respondents offered suggestions to enhance service delivery. Suggestions for improvement included enhancements to hours of operation, space design, staff resources, operational policies, data collection processes, location, and the provision of additional services.

Through caring, compassionate, and stigma-free service delivery, TOPS has created a welcoming, safe, and non-judgmental environment that has allowed people to feel accepted. Building trusting relationships and creating a culture of trust at the site were identified as critical factors in providing opportunities to promote safer drug use and increase connections to health and social services for clients.

The findings also demonstrate the progress being made to reduce opioid-related deaths by directly responding to overdoses at the site (to date, no deaths have occurred on the site). Furthermore, there is evidence to suggest that some public order outcomes have been positively affected, as clients reported less public drug use and less disposal of gear in public spaces. However, greater effort will be needed to monitor and address other public order outcomes, such as loitering, garbage, drug selling/purchasing, and criminal activity within the vicinity of the site to ensure the safety of clients, residents, and businesses.

The site has transitioned from the Overdose Prevention Site model to become the city's interim Consumption and Treatment Service. It is recognized that the site is just one harm reduction strategy and cannot be expected to solve all of the interconnected and complex issues associated with the drug crisis. Ongoing efforts by many key stakeholders in the community will be required to address the crisis.

A Summary Report of the key findings can be found in Appendix A. The Comprehensive Report can be found in Appendix B. A virtual tour of the site was also developed by the Evaluation Team to help visualize the site's main spaces and illustrate how people access the services provided there (https://www.healthunit.com/temporary-overdose-prevention-site).

Next Steps

The evaluation findings will be used to improve service delivery at the interim site and future sites, as well as facilitate dialogue with persons who use drugs, key stakeholders, government, policymakers, and the broader community. The suggestions from the evaluation have been reviewed by the Regional HIV/AIDS Connection and MLHU Leadership. Some of the suggested improvements have already been made and action planning is underway for remaining suggestions that are feasible at the site.

This report was prepared by the Program Planning and Evaluation Team, Healthy Organization Division.

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Saving Lives. Changing Lives.

Summary Report
Findings from an Evaluation of London's Temporary Overdose Prevention Site

March 2019

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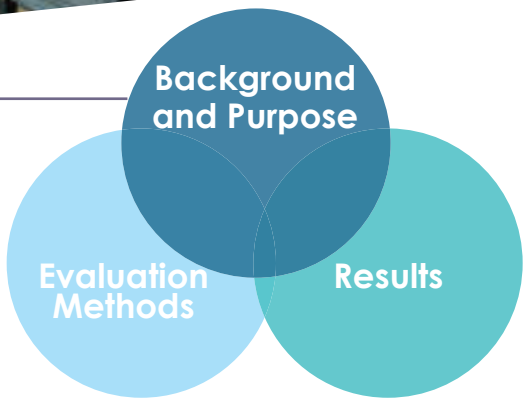


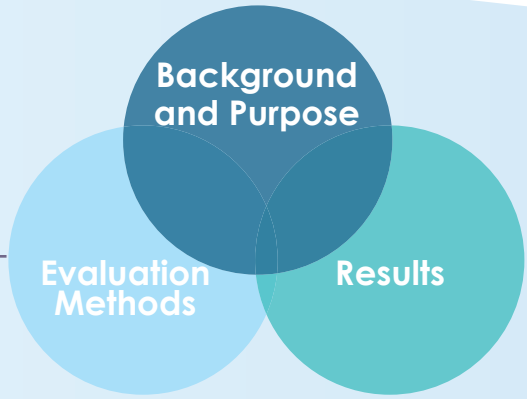
Summary Report

BACKGROUND AND PURPOSE:

Middlesex-London, Ontario, along with many other Canadian communities is experiencing an opioid crisis that has taken the lives of many people in our community. At the same time, there are increased rates of HIV infection and infectious endocarditis in people who use injection drugs (PWUD). Together, this overlapping drug and infectious disease crisis has drawn attention to a complex public health issue requiring the attention of local public health authorities and community partners.

In December 2017, to assist communities with this public health need, the Ministry of Health and Long-Term Care (MOHLTC) introduced a strategy: the establishment of Overdose Prevention Sites (OPS). Communities in need could apply to the MOHLTC to obtain approval and funding to establish an OPS. These sites are a low barrier, time-limited service for people to consume drugs in a supervised environment and facilitate connections to other health and social services. With the support of community partners, the Middlesex-London Health Unit and Regional HIV/AIDS Connection (RHAC) opened Ontario's first legally sanctioned Temporary Overdose Prevention Site (TOPS) at 186 King Street on February 12, 2018.

In the summer of 2018, a process and outcome evaluation was conducted to capture lessons learned in the first six months of operation, and to document the site's progress in meeting its intended outcomes.



EVALUATION METHODS:

The purpose of the TOPS Evaluation was:
1. To conduct process and outcome evaluations of the impact and effectiveness of TOPS in Middlesex-London, Ontario.
2. To help inform the development and implementation of a Supervised Consumption Facility in Middlesex-London, Ontario.

The evaluation aimed to answer the following five evaluation questions:

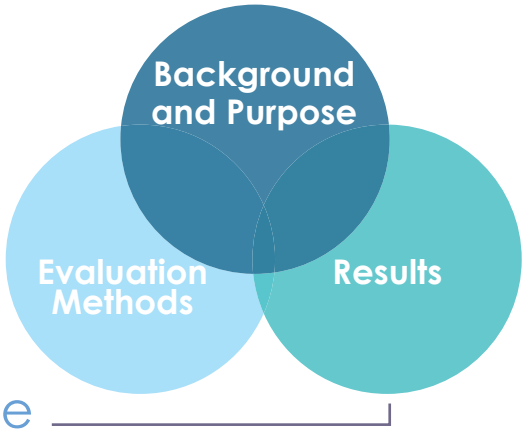
1. Who is using TOPS services and what substances are they using? (Process)
2. Are the services being provided as intended at TOPS? (Process)
3. Are the services adapting to client and community needs? (Process)
4. Are the intended benefits of TOPS being recognized? (Outcome)
5. How is TOPS impacting the lives of people who use drugs in Middlesex-London? (Outcome)

The evaluation used a concurrent mixed-methods design collecting qualitative and quantitative data to answer the evaluation questions. Primary data was collected using the following surveys and interviews:

- Customer Satisfaction Survey for Clients (n=105)
- Key Informant Interviews with clients (n=26), TOPS Staff/Leads (n=17) and stakeholders providing services in the aftercare room at TOPS (n=9)
- Survey of Community Residents and Business Owners within 120 metres of TOPS (n=15)

(NOTE: Due to the low response rate [2.6% response rate (15/570)], the quantitative findings could not be analyzed. Only qualitative comments from the respondents (n=12) have been included)

Secondary data from the Ministry of Health and Long-Term Care (MOHLTC) Overdose Prevention Site (OPS) Monthly Reporting Form was also used to understand usage statistics.



RESULTS:

PART 1: Usage Statistics for the Temporary Overdose Prevention Site

Visits

7152 Total number of visits between February 12 and August 31 2018
(Data Source: MOHLTC OPS Monthly Reporting Form)

70% of total visits (n=5018) occurred during the afternoon hours
(Data source: MOHLTC OPS Monthly Reporting Form)

30% of total visits (n=2134) occurred during the morning hours
(Data source: MOHLTC OPS Monthly Reporting Form)

74% (n=75) of Client Survey respondents reported using the site on the weekends
(Data source: Client Survey)

During the first six months of operation, February 12 to August 31, 2018, there were over 7,000 visits to the Temporary Overdose Prevention Site. The majority of visits occurred during afternoon hours between 12:00 pm and 4:00 pm (70%, n=5018), while 30% (n=2134) visited during the morning hours between 10:00 am and noon (Data source: MOHLTC OPS Monthly Reporting Form). Among client respondents, 74% (n=75) reported using the site on the weekends. (Data source: Client Survey)

Types of Drugs Consumed

The two most common drugs consumed by clients at TOPS were Hydromorphone (38.3%, n=2818) and Crystal Meth (26.4%, n=1945). Among the types of drugs reported, approximately 60% of the drugs consumed were opioids (i.e., hydromorphone, fentanyl, heroin, oxycodone, unspecified opioid). (Data source: MOHLTC OPS Monthly Reporting Form)

Hydromorphone (38.3%, n=2818) and **Crystal Meth** (26.4%, n=1945) were the two most commonly injected drugs reported by respondents. (Data source: MOHLTC OPS Monthly Reporting Form)

Peer-to-Peer assisted Injections

7.3% of visits (n=523) involved peer-to-peer assisted injections
(Data source: MOHLTC OPS Monthly Reporting Form)

A total of 523 peer-to-peer assisted injections occurred at the site during the first six months of operation which represents 7.3% of total visits. (Data source: MOHLTC OPS Monthly Reporting Form)

Fentanyl Test Strips

0.3% (n=25) of visits using fentanyl test strips
(Data source: MOHLTC OPS Monthly Reporting Form)

76% (n=78) of client respondents were willing to test their drugs for fentanyl
(Data source: Client Survey)

A low number of clients used fentanyl test strips during the first six months of operation (0.3%, n=25) to test their drugs for fentanyl. Some clients used test strips to confirm fentanyl, rather than rule out fentanyl (MOHLTC OPS Monthly Reporting Form). The majority (76%, n=78) of client respondents were willing to test their drugs for fentanyl; however, it appeared there was a lack of awareness about the availability of the fentanyl test strips and their intended use. (Data sources: Client Survey, Staff interviews)

Demographics

Self-Identification as Indigenous

Approximately **19%** (1145/5971) of visits self-identify as Indigenous
(Timeframe: April 1st and August 19th; Data Source: MOHLTC OPS Monthly Reporting Form)

Length of Injection Drug Use

62% (n=63) of client respondents indicated that they have been injecting drugs for more than 5 years. (Data source: Client Survey)

30% (n=31) reported using for one to five years. (Data source: Client Survey)

Length of Time Lived in London

79% (n=81) of client respondents had lived in London for 7 or more years. (Data source: Client Survey)

Frequency of Counterpoint Needle Syringe Program Use

95% (n=97) of client respondents were regular users of Counterpoint Needle Syringe Program prior to using TOPS. (Data source: Client Survey)

PART 2: Successes and Challenges Experienced during Service Delivery

Services

Client Satisfaction

Based on the quantitative and qualitative data, the majority of clients were satisfied with the TOPS services.

96% (n=98) of client respondents rated the quality of service and care received from TOPS staff as good or excellent (Data source: Client Survey)

89% (n=92) of client respondents reported they would be likely or extremely likely to recommend the site to other people who use drugs (Data source: Client Survey)

91% (n=93) of client respondents indicated that the rules and regulations rarely or never get in their way of using the site (Data source: Client Survey)

Many clients valued the services they have received at TOPS and would rather come to the site instead of using public spaces or elsewhere. (Data source: Client Survey and Client Interviews)

Services Exceeding MOHLTC Expectations

TOPS delivers the following services according to MOHLTC guidelines: (1) supervised drug injections, oral and intranasal drug consumption, (2) access to harm reduction supplies, (3) responding to overdoses with oxygen and naloxone, (4) peer-to-peer assisted injections, and (5) fentanyl test strips as a drug checking service. However, findings indicated minimal use of supervised oral and intranasal consumption and fentanyl test strips. (Data source: Staff and Stakeholder Interviews, MOHLTC OPS Monthly Reporting Form)

The site also exceeds service delivery requirements. These additional services include an onsite nurse or paramedic who assist to find veins, provide first aid and wound care assessment, as well as community partners who provide referrals to healthcare services. Clients, staff, and stakeholders recognized the value of these services. (Data source: Client Survey, Client Interviews, Staff Interviews, Stakeholder Interviews)

Wrap around service providers in the aftercare room:

Addiction Services Thames Valley (ADSTV),
London Intercommunity Health Center (LIHC),
Regional HIV/AIDS Connection (RHAC),
Southwest Ontario Aboriginal Health Access Center (SOAHAC),
Canadian Mental Health Association (CMHA), and
London CARes Homeless Response Services.

Wraparound services offered in the aftercare room were also noted as essential given the linkages made to mental health, addiction and treatment, housing and primary care. (Data source: Client Survey, Client Interviews, Staff Interviews, Stakeholder Interviews). Indigenous supports were also described as a valuable service with its focus on providing culturally appropriate care. (Data source: Staff Interviews, Stakeholder Interviews).

Future Enhancements to Services

While clients, staff and stakeholders value the services delivered at TOPS, several suggestions to enhance service delivery were provided. Suggestions included wound care services, primary health care, access to rehabilitation and treatment services, counselling services and food and refreshments. Suggestions for new services included supervised inhalation services, assistance by medical staff to help set up injections, recreational activities, and additional services to meet clients' basic needs such as personal hygiene and nutrition. (Data source: Client Survey, Client Interviews, Staff Interviews, Stakeholder Interviews)

Hours of Operation

The hours of operation (10:00 am – 4:00 pm Monday to Friday and 11:00 am – 3:00 pm Saturday and Sunday) were frequently reported as a service delivery challenge by clients, staff and stakeholders (Data source: Client Survey, Client Interviews, Staff Interviews, Stakeholder Interviews).

29% (n=30) of client respondents indicated that the hours of the site often or always get in their way of using the site; 27% (n=28) indicated that the operating hours sometimes got in their way of using the site (Data source: Client Survey)

Drug use occurs at all hours of the day, and when the site is not open, some clients reported that they use drugs alone and some reported injecting in public spaces (Data sources: Client Survey, Client Interviews). Staff indicated that although they would like to be able to increase the hours of operation, financial constraints continue to be the limiting factor (Data source: Staff Interviews).

Wait Time

60% (n=62) of client respondents indicated that wait time was rarely or never a barrier that gets in their way of using the site (Data source: Client Survey)

Feedback on the Client Survey revealed that for 60% (n=62) of clients wait time was rarely or never a barrier that gets in their way of using the site. However, many clients, staff and stakeholders expressed concerns through the qualitative findings that wait times can be problematic when client volume is high resulting in some clients choosing to leave the site and use elsewhere. (Data sources: Client Survey, Client Interviews, Staff Interviews, Stakeholder Interviews)

Staffing

Staff Characteristics and Skills

The most commonly reported staff characteristics and skills noted to facilitate service delivery included: (1) being nice, warm and friendly, (2) caring and compassionate, (3) understanding of client needs, (4) non-judgemental, (5) knowledgeable, and (6) skilled at de-escalation (Data sources: Client Survey, Client Interviews, Stakeholder Interviews, Staff Interviews). These characteristics and skills were described as essential for creating a safe, welcoming and comfortable environment at the site (Data Sources: Client Survey, Client Interview, Staff Interviews, Stakeholder Interviews).

Strategies to Build Relationships with Clients

Staff and stakeholders described effective strategies to engage clients: (1) ensuring consistency of staff and stakeholders at the site, (2) socializing with clients and using a conversational approach, (3) acknowledging clients as the experts, and (4) highlighting the site as the clients' space where they play a role in creating a safe environment and are encouraged to take ownership of the space. (Data sources: Staff Interviews, Stakeholder Interviews)

Staffing Changes

During the first six months of operation, changes related to staffing were implemented to support service delivery. These changes included: (1) the redistribution of existing staff at RHAC, (2) the addition of the runner to bring clients to and from the reception, (3) reinstating the role of the security guard, and (4) MLHU hiring additional staff for the site (Data sources: Staff Interviews).

Staff Resources, Role Clarity, Training, and Communication

Staff described limited resources as a frequent challenge because of the difficulties maintaining adequate staff coverage during illness, lunches, and breaktimes (Data source: Staff Interviews). Finding time to perform all of the necessary tasks at the site such as scheduling, creating databases, reporting to funders, managing tours, and media requests were also described as ongoing challenges. Roles of nurses and paramedics were described as an area that requires further clarity primarily in the area of wound care assessment. Areas for enhancement include communication between nursing staff and consistency of staff training (Data source: Staff Interviews).

Location

Location Strengths

For the majority of clients, the current site location was ideal.

78% (n=80) of client respondents indicated that the location was rarely or never a barrier for them to use the site
(Data source: Client Survey)

79% (n=80) of client respondents noted that the travel time to get to the site was rarely or never a barrier to using the site
(Data source: Client Survey)

Feedback from interviews with clients, staff and stakeholders identified several benefits regarding the location. These include: (1) central location, (2) convenient, (3) close to a bus route, (4) close to where clients stay and buy drugs, and (5) discrete with minimal signage. Locating the site within RHAC and alongside the Counterpoint Needle Syringe Program was also highly valued as a result of the familiarity and existing relationships that clients have with staff and the proximity to access clean gear (Data sources: Client Interviews, Staff Interviews, Stakeholder Interviews).

Location Limitations

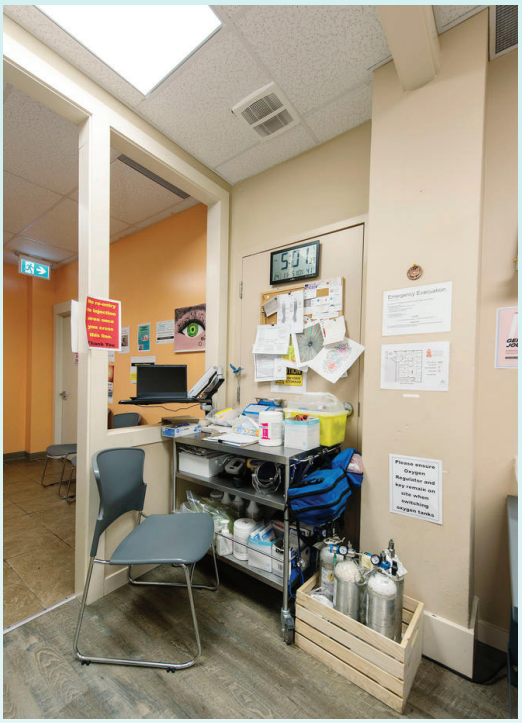
While the majority of clients satisfied with the site location, there were challenges reported by some respondents. These include: (1) travel time to get to the site, (2) concerns regarding fights, theft, loitering, drug use and drug transactions in the back alley and north entrance, and (3) concerns regarding an increased police presence at the north entrance of the building (Data Sources: Client Survey, Client Interview, Staff Interviews, Stakeholder Interviews). Some clients expressed fear that issues in the alley and north entrance of the site may place the site in jeopardy of closing. (Data Source: Client Survey, Client Interviews)

Considerations for Future Sites

Several respondents offered location considerations for future supervised consumption facilities including the need for multiple sites across the city, offering a mobile unit, and providing transportation services to the SCF sites (Data Sources: Client Survey, Client Interview, Staff Interviews, Stakeholder Interviews). A few clients also suggested providing a safe space for drug transactions at future sites in order to reduce the risk of thefts and ensure they are receiving the type and quality of drug requested. (Data Source: Client Survey)

Space Design

Open Room Layout and Open Table Design



The open layout of the Injection and Aftercare Rooms as well as the open tables in the injection space were noted as positive design features by some respondents because it enables conversations, encourages a sense of community and makes drug use feel less hidden and shameful. (Data Sources: Client Survey, Client Interview, Staff Interviews, Stakeholder Interviews). However, some respondents described the challenges experienced as it can be distracting for clients when the site is busy, makes it difficult to have private conversations, and does not provide privacy for clients injecting in private areas or for medical staff providing medical services. (Data Sources: Client Survey, Client Interview, Staff Interviews, Stakeholder Interviews) Private booths were recommended as a solution by some clients. (Data sources: Client Survey, Client Interviews)

While the welcoming and comfortable environment was noted as an important feature by many respondents, TOPS was viewed by some clients as being too inviting as it encourages clients to socialize and engage in packing/unpacking belongings leading to longer wait times (Data sources: Client Survey, Client Interview). Staff and stakeholders described challenges at times with moving clients along when there are high volumes of clients but also recognized that many do not want to leave the site because they want to hang out and socialize in the safe space at the site. (Data Source: Staff Interviews, Stakeholder Interviews)

Limited Space

Limited space was a frequently reported challenge by respondents as there are only four injection spaces, limited space to accommodate peer-to-peer assisted injections (e.g., jugular injections requiring floor space) and challenges in providing counselling and medical services in the small space. (Data Sources: Client Survey, Client Interview, Staff Interviews, Stakeholder Interviews)

Operation

Policies and Procedures

Staff and stakeholders identified strategies that contributed to the effective and efficient operation of the site, including the implementation of the Client Code of Conduct and deciding to allow peer-to-peer assisted injections. Key areas identified for improvement included operational policies related to responding to overdoses, needle and bodily splash incidents, and medical directives. (Data sources: Staff Interviews, Stakeholder Interviews)

Data Collection

Several improvements were made to the data collection process over the first six months of operation, such as providing explanations to clients regarding why specific data is collected, implementing an electronic data collection process, and refining the types of data collected. Additional areas for improvement in the data collection process were identified such as collecting intake questions and keeping track of referrals. (Data sources: Staff Interviews, Stakeholder Interviews).

Daily Huddles and Debriefs

Staff and stakeholders described the benefits of holding daily huddles before the site opens and debriefing sessions at the end of each day as it helps to ensure the smooth operation of the site. Huddles provide the opportunity to ensure that all staff and stakeholders are aware of important operational items. Debriefing sessions provide the opportunity to discuss critical incidents and strategies to address client behaviours. (Data sources: Staff Interviews, Stakeholder Interviews)

Measures to Ensure Client and Staff Safety

Measures in place to ensure client and staff safety included: (1) placement of signage reflecting rules of the site, (2) use of walkie-talkies, (3) re-introduction of the security guard, (4) controlled access to other rooms at RHAC, and (5) restricted client access to the site for some clients that have physically challenging behaviours or have challenges following site rules (Data sources: Staff Interviews, Stakeholder Interviews). Crisis Prevention Training was noted as valuable for staff; however, some staff noted that they had not yet received this training. (Data source: Staff Interviews)

PART 3: Impacts of the Temporary Overdose Prevention Site

Impacts on Clients

Positive Impacts on Clients

Many clients described positive changes that the site is having on their lives and this was echoed by what the staff and stakeholders have observed.

Two overarching and interconnected themes emerged related to positive impacts on clients: (1) reduction in harms associated with drug use, and (2) building trusting relationships and connections.

Reductions in Harms Associated with Drug Use

Findings from various data sources show reductions in the harms associated with drug use (Data sources: Client Survey, Client Interviews, Staff Interviews, Stakeholder Interview). These findings highlight progress being made to achieve the intended outcomes of the site and to address the immediate needs in responding to opioid-related overdoses.

• Preventing overdose deaths

No overdose deaths occurred
(Data Source: MOHLTC OPS Monthly Reporting Form)

19 overdoses treated with oxygen
(Data Source: MOHLTC OPS Monthly Reporting Form)

7 overdoses treated with naloxone
(Data Source: MOHLTC OPS Monthly Reporting Form)

5 Total number of calls to EMS related to an overdose (Data Source: MOHLTC OPS Monthly Reporting Form)

2 Total number of transfers to an emergency department related to an overdose
(Data Source: MOHLTC OPS Monthly Reporting Form)

91% (n=93) of client respondents agree/strongly agree they can access Naloxone easily at the site (Data source: Client Survey)

> ***I have overdosed here today. Those guys [TOPS staff] have saved my life. I would be dead at this exact moment if it wasn't for the site.***
> ***[Data Source – Client Survey]***

• Increasing safer drug use practices

74% (n=74) of client respondents agreed that they learned tips at the site to use drugs more safely
(Data source: Client Survey)

Several safer drug use practices were self-reported by client respondents including reusing gear less often (72%, n=60), less sharing of their used gear with others (36%, n=14), using sterile water more (34%, n=34), using alcohol swabs to clean injection sites more (43%, n=41), and heating their drugs before using more (43%, n=38). (Data source: Client Survey)

> ***It's very hygiene in here [TOPS]. If you don't have an alcohol swab, then they remind you and it's helpful.***
> ***[Data Source: Client Interview]***

• Creating a safe space

Many clients noted that the site provides a safe, clean and secure space to use drugs where they feel valued and accepted. This sense of safety and acceptance is in contrast to some of their experiences with police, security, shelter workers, and the public.
(Data sources: Client Survey, Client Interview)

> ***It's [TOPS] a safe place and you don't have to worry about doing illegal substances in public areas (e.g. outside and bathrooms).***
> ***[Data Source: Client Interview]***

Several clients described feeling less worried now because they have a safe place to use. For some clients, this reduces their ongoing fears of getting caught using or having drugs or drug paraphernalia on them while on the street, in public places, and in shelters. (Data Source: Client Survey, Client Interviews)

• Improving access to health and social services

89% (n=88) of client respondents agreed that staff have talked to them and helped them access other health and social services (Data Source: Client Survey)

Examples of referrals included wound care at clinics or hospitals, primary care, addiction counselling, recovery and addiction treatment services (e.g., detox clinic), mental health services, pain management clinics, housing supports, and testing and treatment for Hep C and HIV. (Data sources: Client Survey, Client Interviews, Staff Interviews, Stakeholder Interviews)

Many respondents in the qualitative feedback highlighted the value of incorporating the wrap-around at the site. The benefits of having medical staff onsite to provide basic first aid and wound care assessment were also noted. (Data sources: Client Survey, Client Interviews, Staff Interviews, Stakeholder Interviews)

From the perspective of staff, stakeholders and clients, the building of trusting relationships within TOPS helps to facilitate linkage and referrals to multiple health and social services. (Data sources: Client Survey, Client Interviews, Staff Interviews, Stakeholder Interviews)

Building Trusting Relationships and Connections

One of the key facilitators to support safer drug use behaviours was the building of trusting relationships and connections between staff/stakeholders and clients. Many staff and stakeholders described how clients lack trust in healthcare and social services because of previous negative experiences involving discrimination and stigmatization. The establishment of trusting relationships and the building of rapport at the site allows clients to feel safe which in turn encourages them to use the site regularly. With regular visits, staff and stakeholders indicated that clients are more willing to explore safer drug use practices and are having deeper conversations about their drug use and the impacts on their health and well-being. (Data sources: Staff Interviews, Stakeholder Interviews)

> ***With the relationships staff have with clients, clients share personal experiences and information like what led them to start using. Clients are opening up about their personal lives. None of the staff expected that. Clients have let the staff into their lives.***
> ***[Data Source: Staff Interview]***

From the qualitative data, clients, staff, and stakeholders identified that the site had influenced clients' lives in the following ways (Data sources: Client Survey, Client Interviews, Staff Interviews, Stakeholder Interviews):

95% (n=97) of client respondents indicated that they feel accepted at the site
(Data source: Client Survey)

> ***I feel more comfortable in my own skin being around people not judging me, no negativity, and more comfortable when I am using. THIS IS HUGE. They [staff] are here for us if we need to talk. It is HUGE to feel accepted - they do care - you do not feel shameful. That is amazing.***
> ***[Data Source: Client Survey]***

Increased feelings of acceptance and not being stigmatized or judged

Increased rapport, deeper connections and having someone trusted to talk to and who listens

Increased feelings of self-worth, sense of hope, feeling valued, cared for and loved

Increased sense of community and feelings of belonging

> ***I feel that I belong somewhere. I feel like everybody has the same problem, so if I say something people will understand. I do not feel like an outcast. I walk in here and it's a family. For once in my life, I feel like I belong.***
> ***[Data Source: Client Survey]***

Tracking data showed that for the first six months of operation, the site saw an increased number of clients self-identifying as Indigenous (Data source: MOHLTC OPS Monthly Reporting Form). The qualitative data indicated that the presence of Indigenous supports has allowed clients to reconnect with their Indigenous roots through the culturally appropriate care that is offered. (Data sources: Staff Interviews, Stakeholder Interviews)

From the qualitative data, the site also had enhanced peer-to-peer interactions in the following ways: (1) providing peer-to-peer assisted injections, (2) encouraging safer drug use practices, (3) monitoring for signs of overdose, (4) reinforcing rules at the site, (5) promoting use of the site, and (6) building friendships. (Data sources: Client Interviews, Staff Interviews, Stakeholder Interviews)

Negative Impacts on Clients

There were some unintended negative impacts on clients identified by a few clients, staff and stakeholders. These included (1) feeling intimidating using the site, (2) feeling ashamed that stakeholders see clients using the site, (3) feeling concerned about information about them being shared with external service providers, and (4) feeling concerned about the potential closure of the site. (Data sources: Client Survey, Client Interviews, Staff Interviews, Stakeholder Interviews)

Impacts on Staff

Positive Impacts on Staff

Many staff experienced positive impacts that their involvement at the site has had on both their professional and personal lives. Several staff expressed sincere gratitude and appreciation for their involvement. Many felt it was rewarding to see clients in an environment where they feel comfortable and were inspired by clients' commitment to survival. Staff also identified professional benefits including: (1) increased job satisfaction, (2) opportunities to put beliefs and values of harm reduction into practice, (3) increased knowledge of drug use practices, (4) increased understanding and compassion for client experiences, and (5) increased understanding of institutional barriers experienced by clients. (Data source: Staff Interviews)

> ***I truly learn something new every day. I am privileged to be in that space, I appreciate all the information that clients have to share with me. [Data Source: Staff Interview]***

Negative Impacts on Staff

Some staff identified unintended negative impacts the site had on their role and personal lives. These include: (1) feeling physically exhausted and stressed due to under-resourcing of staff, (2) concern about client well-being and availability of supports to meet their needs, (3) limited availability to perform other tasks to support clients, (4) overwhelmed with extensive media coverage and requests for information and tours of the site, and (5) feeling stressed about the uncertainty regarding the continuity of the site. (Data sources: Staff Interviews)

Impacts on Stakeholders and their Organizations

Positive Impacts on Stakeholders and their Organizations

Interviews with stakeholders also identified that stakeholders experienced high levels of satisfaction with their involvement at the site. Several were pleased that their organization supports and partners with other community organizations to deliver TOPS. Stakeholders also identified professional benefits including enhanced knowledge and skills in the following areas: (1) increased knowledge of client experiences, (2) increased knowledge of harm reduction philosophy and approaches, (3) increased understanding of the Indigenous community, culture and history, (4) increased knowledge of services and supports at other organizations, (5) enhanced skills in active listening, and (6) increased ability to connect with clients. (Data sources: Stakeholder Interviews)

Several stakeholders also described how their role has had an impact in different ways on their organizations. These include: (1) increased knowledge of drug use practices and harm reduction practices, (2) expanded the organizations' ability to reach clients from the population of PWUD, (3) created new approaches or services at their organizations to meet clients' needs, and (4) strengthened existing relationships between RHAC and stakeholder organizations. (Data sources: Stakeholder Interviews)

Negative Impacts on Stakeholders and their Organizations

While most stakeholders did not identify any unintended negative impacts regarding their involvement in TOPS, a few had concerns regarding (1) their organization's level of involvement and understanding of their role at TOPS, (2) their time to manage caseloads and priorities from their organization, and (3) the challenges of hearing client stories of violence and trauma. (Data sources: Stakeholder Interviews)

Impacts on Community

Perceived Benefits for the Community

Many clients described how TOPS provides a safe, secure and clean environment for them to use drugs which minimizes public drug use in public washrooms, alleys, and parks. (Data sources: Client Survey, Client Interview)

76% (n=70) of client respondents reported injecting less in public spaces
(Data source: Client Survey)

53% (n=32) of client respondents reported disposing of their gear less in public spaces since using TOPS
(Data source: Client Survey)

Several clients reported less public drug use now that the site exists, including some that indicated that they are not injecting at all in public spaces now. (Data source: Client Survey, Client Interview)

Some clients also shared that they are seeing positive impacts on the behaviour of other people who use drugs as they are witnessing less public drug use among their peers and less discarded needles in public spaces. Some clients also shared that they are grateful to have the site as they often feared members of the public including children seeing them using in public spaces. (Data source: Client Interviews)

Perceived benefits on the broader community were noted by clients, stakeholders, staff, business owners and residents. These include: (1) a recognition that TOPS is savings lives and delivering services in a compassionate way, (2) highlighting the site as a cost-effective strategy, (3) increased awareness about community residents regarding substance use, addictions and the impacts of overdoses, and (4) increased support and acceptance for TOPS and SCFs among community residents. (Data sources: Client Survey, Client Interviews, Staff Interviews, Stakeholder Interviews, Community Resident and Business Survey)

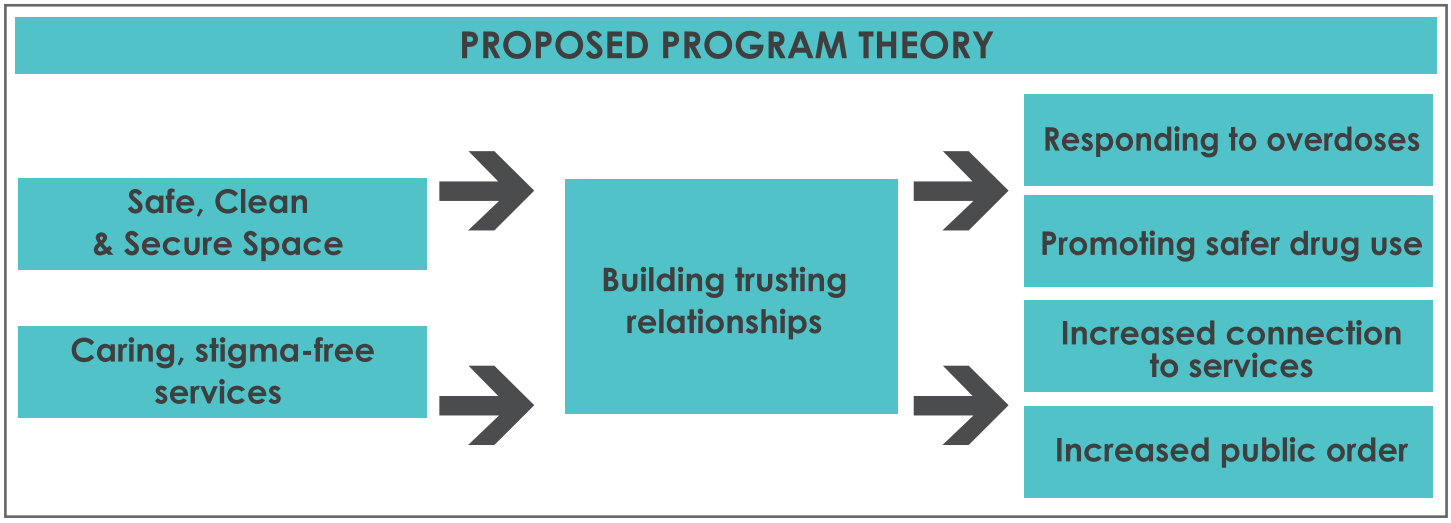
Perceived Concerns for the Community

While findings provide evidence that the site is having a positive impact on clients' lives and in the community, there were some perceived concerns raised about negative unintended impacts on the community noted by respondents on the Community Resident and Business Survey and through some key informant interviews with clients, staff, and stakeholders. The main concerns identified included: (1) concerns of public disorder including increased loitering, garbage and drug selling/purchasing around the site, (2) concerns of negative impacts on local businesses and residents due to criminal activity, and (3) concerns that the site promotes drug use. (Data sources: Client Survey, Client Interviews, Staff Interviews, Stakeholder Interviews, Community Resident and Business Survey)

Discussion

Overall, the Temporary Overdose Prevention Site in London, Ontario provides an essential service to reduce the harms associated with drug use including opioid-related overdoses. The evaluation findings reveal that the site creates a safe, clean and secure space for members of our community who use drugs. Based on the consolidated findings from the evaluation, a program theory has been proposed to identify key factors needed to reach the intended outcomes of TOPS (see Figure 1).

Figure 1: Proposed Program Theory for the Temporary Overdose Prevention Site



Through the caring, compassionate and stigma-free service delivery, TOPS has created a welcoming and non-judgmental space that has allowed people to feel accepted. Building trusting relationships between clients, staff and stakeholders was identified as a critical factor that enables clients to feel safe, secure and valued. Building trusting relationships provides the space for staff and clients to engage in deeper conversations about safer drug use practices and opportunities to connect them with health and social services.

The findings demonstrated direct progress being made to reduce opioid-related deaths by responding to overdoses. Furthermore, activities at the site also promote safer drug use practices and increase linkages to health and social services for clients. These outcomes are reducing potential harms for clients and promoting changes in their behaviours. The site is not only saving lives, but also changing them.

There was also evidence of changes to some public order outcomes. The existence of the site is leading to less public drug use and less disposal of gear in public spaces. However, findings also indicated that other public order outcomes such as loitering, garbage, and drug selling/purchasing may have increased in the vicinity of the site.

The evaluation findings provide a snap shot in time at the 6-month point of operation. Now that the site has been operating for over one year, there are many more lessons learned through its implementation. Many of the challenges that were raised during the evaluation are being addressed or in the process of further review to enhance service delivery. The site has transitioned from the Temporary Overdose Prevention Site under a new provincial model as of April 2019 to become the city's interim Consumption and Treatment Service. The findings from the evaluation are being utilized to inform planning for the permanent site.

It is recognized that TOPS is just one harm reduction strategy and cannot be expected to address all of the interconnected and complex issues associated with the drug crisis. Ongoing efforts by many key stakeholders in the community are required to address the crisis.

FUNDING

This evaluation was funded by the Middlesex-London Health Unit. The evaluation was conducted by Program Evaluators on the Program Planning and Evaluation Team at the Middlesex-London Health Unit in collaboration with Regional HIV/AIDS Connection.

ETHICS APPROVAL

The evaluation received ethics approval through the Public Health Ontario (PHO) Ethic Review Board.

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Saving Lives. Changing Lives.

Comprehensive Report
Findings from an Evaluation of London's Temporary Overdose Prevention Site

March 2019

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

Saving Lives. Changing Lives.

Findings from a Process and Outcome Evaluation of London's Temporary Overdose Prevention Site (TOPS)

Comprehensive Evaluation Report

March 2019

For information, please contact:

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To the clients, thank you for entrusting us with your stories, sharing how the site has impacted your day-to-day lives, and sharing your knowledge with us.

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    - London Cares Homeless Response Services
    - London InterCommunity Health Centre (LIHC)

    - Regional HIV/AIDS Connection (RHAC)
    - Southwest Ontario Aboriginal Health Access Centre (SOAHAC)
- Public Health Ontario Ethics Review Board
- Fraser Health Authority
- Ottawa Public Health
- Middlesex-London Health Unit's Health Equity Advisory Taskforce

Table of Contents

List of Acronyms

TOPS – Temporary Overdose Prevention Site
OPS – Overdose Prevention Site
SCF – Supervised Consumption Facilities
MLHU – Middlesex-London Health Unit
RHAC – Regional HIV/AIDS Connection
NSP – Needle Syringe Program
PWID – People who inject drugs
PWUD – People who use drugs
MOHLTC – Ministry of Health and Long-Term Care
HEP C – Hepatitis C
HIV - Human Immunodeficiency Viruses
iGas – Invasive Group A Streptococcal Disease

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Key Findings

The Temporary Overdose Prevention Site in London, Ontario provides a safe and secure environment to support supervised drug consumption, harm reduction and linkages to mental health, addiction treatment, health, and social services. The site is more than a place to use drugs safely under supervision; it has been referred to as a "safe haven" and "a demonstration of love" for some of the most vulnerable people in our community where they receive caring, compassionate and non-judgmental services.

- **Responding to overdoses:** In the first six months of operation, there were over 7,000 visits to TOPS, and no deaths occurred at the site. A total of 19 overdoses were reversed with oxygen/rescue breathing, and seven overdoses required treatment with naloxone.
- **Influencing safer drug use behaviour:** The majority of Client Survey respondents reported that they had learned strategies to use drugs more safely. Many are making changes to their drug use behaviour including reusing their own gear less, sharing their used gear less with others, using sterile water more, using alcohol swabs more and heating their drugs more before using.
- **Reduced public drug use and discarded gear:** Self-reported client data revealed that the majority of clients reported injecting and disposing of their gear less in public spaces since using TOPS. However, feedback from some clients, staff, stakeholders, community residents, and business owners noted concerns regarding increased loitering, garbage, and drug selling/purchasing in the area immediately around the site.
- **Creating a safe space for a vulnerable population:** Many clients noted that the site provides a safe, clean and secure space to use drugs. Several clients described how the site reduces their fears of getting caught using or having drugs or drug paraphernalia on them while on the street, in public places and in shelters.
- **Building trusting relationships and connections:** Overall, the findings from this evaluation reveal the significant value of human connection, building relationships and creating a culture of trust at the site. From the perspective of staff, stakeholders and client respondents the building of trusting relationships within TOPS helps to encourage safer drug use practices and facilitate linkage and referrals to multiple health and social services.
- **High level of client satisfaction:** The majority of client survey respondents rated the quality of service and care received as good or excellent and reported feeling accepted at the site. Many described not feeling stigmatized or judged at the site, which is a significant shift from the negative interactions they described within the healthcare, social service, and law enforcement systems. The caring, compassion, and kindness demonstrated through the service delivery at TOPS has made clients feel loved and valued as human beings. This has increased their sense of self-worth and hope.
- **Improving connection to health and social services:** The majority of client survey respondents agreed that staff have talked to them and helped them access other health and social services. Furthermore, qualitative findings identified that the building of trusting relationships at the site is increasing client acceptance of referrals to other health and social services.
- **Service delivery:** Services are delivered as intended and exceeding Ministry service delivery expectations by offering onsite medical supports, wrap-around services, and Indigenous supports.
- **Service delivery challenges:** Given the exceptional value that was placed on providing this service by clients, staff, and stakeholders, many respondents offered suggestions to enhance service delivery. Key suggestions focused on the hours of operation, space design, staff resources, operational policies and data collection process.
- **Considerations for the permanent SCFs:** Several respondents also offered service delivery, location, space design and operational considerations for future supervised consumption services.

Background

Local Context

Similar to many other communities across Canada, London, Ontario is experiencing a serious opioid crisis. The opioid crisis has become a significant public health issue that is having devastating impacts on individuals, families and communities (Public Health Agency of Canada, 2018) across the county. Nationally, in 2017, there were 3,996 apparent opioid-related deaths across Canada, which was up from the 3,005 in 2016 (Public Health Agency of Canada, 2018). In Ontario, the death rate had been slowly increasing until 2017 where it jumped significantly. 1,265 opioid-related deaths were reported in 2017, compared to only 867 in 2016. Additionally, preliminary numbers from the first six months of 2018 showed more than 638 deaths, indicating rates consistent with 2017 (Public Health Ontario, 2018).

Opioid-related death rates have been fluctuating in Middlesex-London since 2005 and, while Middlesex-London did not see the same increase as other areas reporting death rates in 2017, preliminary estimates for 2018 indicate higher rates than in the past (Public Health Ontario, 2018). In the first six months of 2018, there were 33 opioid-related deaths compared to 31 in all of 2017. Data from January to March 2018 show higher than usual monthly rates of death, but the rates from April to June were had returned to somewhat normal levels (Public Health Ontario, 2018).

Like many communities across Canada, Middlesex-London has felt the burden of this crisis through significant health, social and financial costs. Since 2004, the rate of emergency department visits related to opioid toxicity have been generally higher in Middlesex-London than the province, with the highest annual number being 316 reported in 2017 (Public Health Ontario, 2018). Similarly, the rate of opioid-related hospitalizations has been increasing in Middlesex-London and is increasing at a higher pace than the province (Public Health Ontario, 2018).

London is experiencing several overlapping issues related to the drug crisis including increased rates of Invasive Group A Streptococcal (iGAS) infections, infective endocarditis, Human Immunodeficiency Virus (HIV), and Hepatitis C (HEP C). In May 2016, Middlesex-London Health Unit declared a community outbreak as a result of increased rates of iGAS infections. Rates of infective endocarditis associated with injection drug use have also been on the rise over the last several years (MLHU, 2019a). Between 2014 and 2016, HIV rates increased in Middlesex-London (Public Health Ontario, 2019) where in 2016 approximately 70% of people diagnosed with HIV reported experience with injection drug use (MLHU, 2016). Since 2007, rates of Hepatitis C have also been significantly higher in Middlesex-London than the rest of the province (Public Health Ontario, 2019). Among those diagnosed with Hepatitis C in 2016, more than half of the people reported experience with injection drug use (MLHU, 2016). As a result of the increases in HIV and Hepatitis C infection rates, the Middlesex-London Health Unit declared a public health crisis in June 2016.

Relative to its population size, it has been estimated that London has one of the largest populations of injection drug users in Canada (MLHU, 2017a). There are an estimated 6,000 people who inject drugs (PWID) in London, which represent approximately 2% of London's total population of 385,000 (MLHU, 2017a).

Each year across London, there are more than 3 million needles distributed to people who inject drugs (MLHU, 2019b). Counterpoint Needle Syringe Programs offers free and confidential needle exchange services available at Regional HIV/AIDS Connection (RHAC), Middlesex-London Health Unit and My Sister's Place. Needle disposal bins are located at various strategic locations across London to support the collection of used needles, syringes and injection drug equipment. Although these services exist, there remain concerns regarding discarded needles, syringes, and other injection-related litter in London. Public drug use, public disorder associated with drug use, and potential risk of injury from used gear have

been expressed as concerns in the local community, which can lead to an increased risk of spreading diseases, such as Hepatitis C and HIV (MLHU, 2019b).

Literature Review Summary

The evidence base around SCFs continues to develop. Given the nature of the work, most of the research available on the effectiveness of SCFs is from observational and mathematical modelling studies. A recent systematic review of SCFs summarized the available literature up to May 2017 (Kennedy, Karamouzian, & Kerr, 2017). The majority of studies included in the review were conducted in Vancouver, Canada or Sydney, Australia. The review suggests SCFs are effective at meeting their public health objectives of mitigating overdose-related harms and drug-related risk behaviours such as syringe sharing, syringe reuse, injecting outdoors and rushed injections. SCFs also facilitate uptake of addiction treatment and other health care services (Kennedy et al., 2017). Furthermore, the review suggests improvement in public order outcomes such as public injecting, publicly discarded syringes and injection-related litter without increasing drug-related crime (Kennedy et al., 2017). Mathematical modelling studies have also shown that SCFs can be cost saving interventions through reduced disease transmission (Kennedy et al., 2017; Enns, Zaric, Strike, Jairam, Kolla & Bayoumi, 2016). Qualitative research has described these sites as providing safe, supportive environments for PWUD. It is within this safe context that bridges are being built for PWUD to access other health and social services, including addictions treatment (McNeil & Small, 2014; Kappel, Toth, Tegner & Lauridsen, 2016).

The implementation of SCFs continues to be controversial and is significantly impacted by political climate and community perceptions (Strike et al, 2014; Kolla, Strike, Watson, Jairam, Fischer & Bayoumi, 2017). To be successful in implementing SCFs it is imperative to include strong local champions, engagement of police and public discussion about the local context (Bayoumi & Strike, 2016; Young & Fairbairn, 2018). A more detailed summary of the Literature Review is included in Appendix A **-** Literature Review.

Site Description

In December 2017, the Ministry of Health and Long-Term Care (MOHLTC) approved a harm reduction strategy to meet the urgent public health needs of the opioid crisis: the establishment of Overdose Prevention Sites (OPS). Communities in need could apply to the MOHLTC to obtain approval and funding support to establish an OPS. These sites were established as a low barrier, time-limited service for people who use drugs to obtain targeted services to address the crisis related to opioid-related overdoses. With the support of community organizations, the Middlesex-London Health Unit and Regional HIV/AIDS Connection (RHAC) opened Ontario's first legally sanctioned Temporary Overdose Prevention Site (TOPS) at 186 King Street on February 12, 2018.

A detailed overview of the local context and a description of TOPS operations can be found in Appendix B - Local Context and Site Description. A virtual tour is also available which details each of the main rooms and how people access the services at the site. This tour can be found online at: https://www.healthunit.com/temporary-overdose-prevention-site

Evaluation Methods

The purpose of TOPS Evaluation was:

1. To conduct process and outcome evaluations of the impact and effectiveness of TOPS in Middlesex-London, Ontario; and
2. To help inform the development and implementation of a Supervised Consumption Facility in Middlesex-London, Ontario.

Given that it is Ontario's first legally sanctioned Overdose Prevention Site, conducting a process and outcome evaluation of TOPS was imperative to:

- Gather feedback on whether TOPS is being implemented as planned;
- Determine to what extent it is achieving the intended benefits;
- Provide feedback on whether or not TOPS is meeting client and community needs; and
- Help to understand what the client and community needs are regarding the establishment and operation of a Supervised Consumption Facility.

The findings may add to the existing evidence base regarding overdose prevention sites and/or permanent supervised consumption facilities.

Two types of evaluation were conducted concurrently: a process evaluation, and an outcome evaluation. The evaluation involved conducting a process evaluation by assessing how the intervention is being implemented. The outcome evaluation assessed the effectiveness of the intervention at reaching the intended outcomes. The evaluation aimed to answer the following five evaluation questions:

1. Who is using TOPS services and what substances are they using? (Process)
2. Are the services being provided as intended at TOPS? (Process)
3. Are the services adapting to client and community needs? (Process)
4. Are the intended benefits of TOPS being recognized? (Outcome)
5. How is TOPS impacting the lives of people who use drugs in Middlesex-London? (Outcome)

Design

The evaluation used a mixed-methods design collecting qualitative and quantitative data concurrently to answer the evaluation questions. A mixed-methods design was used to support the explanation of the quantitative and qualitative data, and to help enhance the credibility and integrity of the findings. A mixed-methods design was also utilized because different evaluation questions required different methods to gain a more comprehensive understanding. The quantitative and qualitative data were collected concurrently, and later compared to determine if there was any convergence or differences. Using this approach allowed the evaluation team to offset the weaknesses inherent within one method with the strengths of the other.

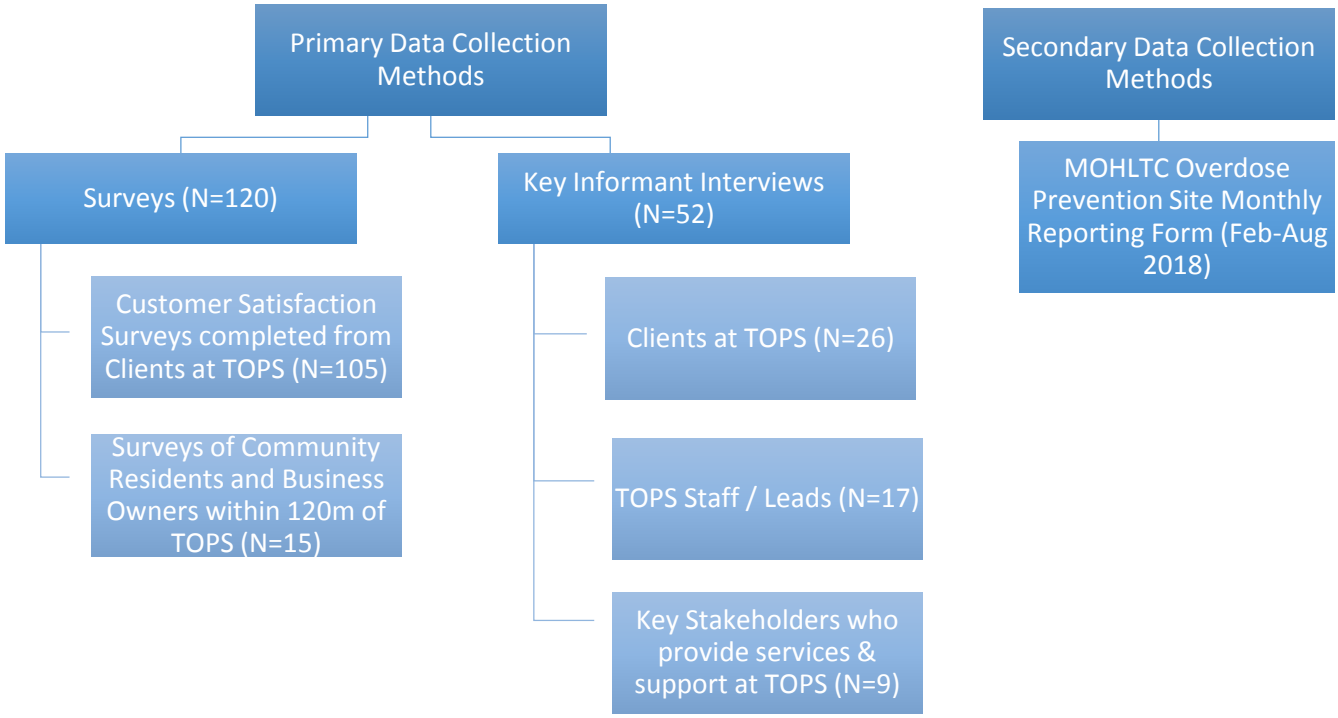
Two types of triangulation were used in this evaluation: (1) method triangulation by using different methods to answer the evaluation questions; and (2) data source triangulation by collecting data from different sources (Carter et al., 2014). The evaluation used primary and secondary data sources to collect information related to TOPS. Primary data was collected using both surveys and interviews as outlined in Figure 1.

Primary data was collected using the following surveys and interviews:

- Customer Satisfaction Survey for Clients (n=105)
- Survey of Community Residents and Business Owners within 120 metres of TOPS (n=15)
- Key informant Interviews with Clients (n=26), TOPS Staff/Leads (n=17) and stakeholders providing services at TOPS (n=9)

A secondary data source was also used to review usage statistics from the Ministry of Health and Long-Term Care (MOHLTC) Overdose Prevention Site Monthly Reporting Form.

Figure 1: Data Collection Methods and Sample Sizes



Using feedback from internal and external stakeholders, the evaluation team developed data collection tools adapted from tools used by Fraser Health Authority and Ottawa Public Health. The Evaluation Plan, Evaluation Matrix, and data collection tools were adapted with permission from the Fraser Health Authority based on their Supervised Consumption Site Evaluation Plan (Ewert, 2013) and from Ottawa Public Health based on their evaluation of their Interim Supervised Injection Service (Ottawa Public Health, 2018). The Evaluation Plan is included in Appendix C which provides an overview of the key evaluation questions, the type of data collected, the data sources and data collection tools and timelines. An Evaluation Matrix is also included in Appendix D which provides further details on the key indicators collected in the evaluation, data sources, and data collection methods.

Each data collection method is described and data collection tools are included in the following appendices:

- Appendix E - Customer Satisfaction Survey for Clients and Key Informant Interviews with Clients
- Appendix F - Survey of Community Residents and Business Owners within 120 meters of TOPS
- Appendix G - Key Informant Interviews with TOPS Staff/Leads
- Appendix H - Key Informant Interviews with Stakeholders Providing Service at TOPS

- Appendix I – Secondary Data: Ministry of Health and Long Term Care Overdose Prevention Site Monthly Reporting Form

Background of the Program Evaluators

All three Program Evaluators including two females and one male were involved in the data collection were members of the Program Planning and Evaluation Team at the Middlesex-London Health Unit. One of the Program Evaluator holds a Master's degree in Public Health (MPH) and over 5 years of survey data collection. Additionally, another Program Evaluator holds a Master's degree in Public Health (MPH) with 3 years in conducting process and outcome evaluations in public health, including experience administering surveys and conducting interviews to support evaluations. The third Program Evaluator holds a Master of Social Work (MSW) with over 12 years of experience in conducting process and outcome evaluations for public health interventions, including experience in conducting surveys, interviews and focus groups.

The evaluation was funded by the MLHU and conducted by MLHU staff. This may be viewed as less objective than an evaluation conducted by an independent consultant. However, the Program Evaluators conducting the evaluation are part of a separate team from the MLHU Team involved in supporting the implementation and delivery of TOPS. Prior to the beginning of the evaluation, none of the Program Evaluators had a relationship with any of the client participants. However, there were a few TOPS Staff that Program Evaluators had known previously through other work at MLHU and during the consultation phase of the evaluation.

Ethics Approval

The evaluation received ethics approval through the Public Health Ontario (PHO) Ethic Review Board. The evaluation also received approval through from the Middlesex-London Health Unit's Research Advisory Consultation (RAC) lead.

Results

Organization of the Results Section

The evaluation results have been organized into three parts:

Part 1: Usage Statistics and Demographics
- Who is using TOPS services and what substances are they using?

Part 2: Service Delivery
- Are the services being provided as intended at TOPS?
- Are the services adapting to client and community needs?

Part 3: Impacts
- Are the intended benefits of TOPS being recognized?
- How is TOPS impacting the lives of people who use drugs in Middlesex-London?

References to Data Sources

Throughout the Results section, data sources are referenced accordingly:
- Quantitative findings from the Customer Satisfaction Survey are specifically reference for each finding.
- Qualitative findings from both the Customer Satisfaction Survey and Client Interviews are referred to as feedback from "clients".
- Qualitative findings from the interviews with staff are referred to as feedback from "staff"
- Qualitative findings from the interviews with stakeholders are referred to as feedback from "stakeholders".
- Qualitative findings from the Survey of Community Residents and Business Owners are referred to as feedback from "residents and business owners".
- Quantitative findings from the MOHLTC OPS Monthly Reporting Form are specifically referenced for each finding.

PART 1: USAGE STATISTICS and DEMOGRAPHICS

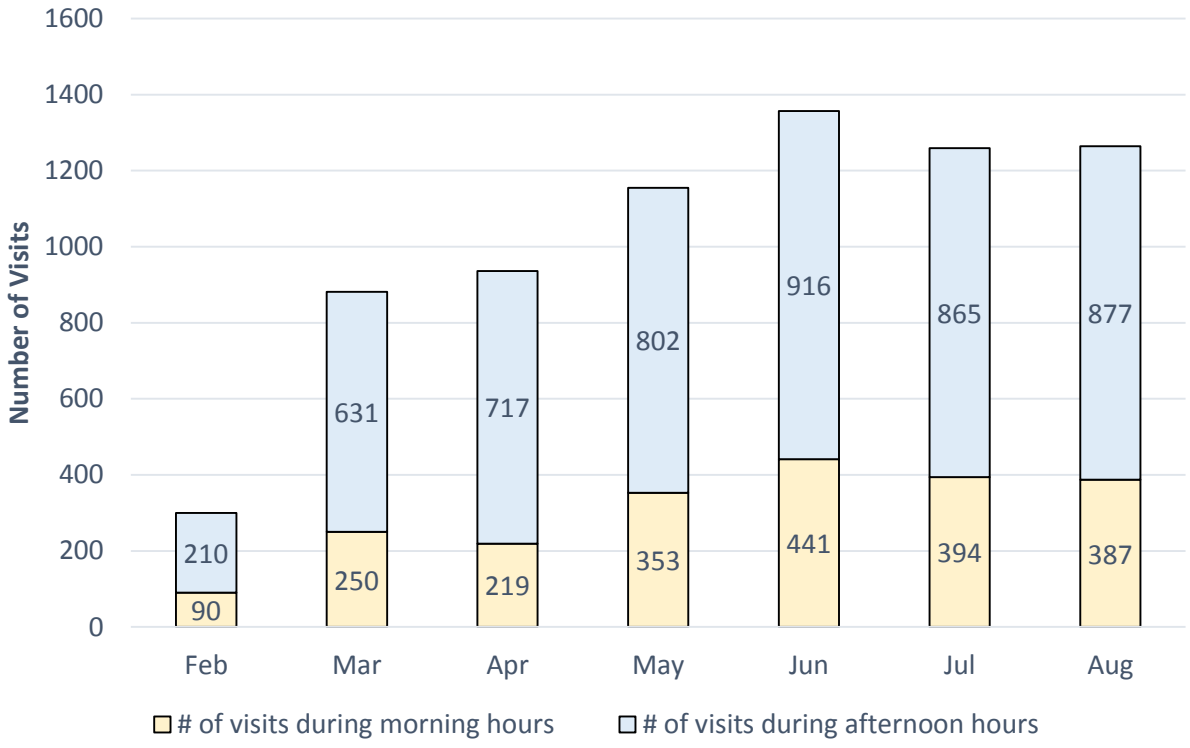
TOPS Usage Statistics

This section summarizes data collected during the February 12th to August, 31st, 2018 timeframe from the Ontario Ministry of Health and Long-Term Care (MOHLTC) Overdose Prevention Site Monthly Reporting Form. Client Survey and Client Interview data has also been incorporated into this section on usage statistics to help understand client usage patterns.

Visits

Between February 12th and August 31st of 2018, there were a total of 7152 visits at TOPS. **Figure 2** shows the number of visits to TOPS during each month. The majority of visits occurred during afternoon hours between 12-4 pm (70%, n=5018), while 30% (n=2134) were visits during the morning hours between 10 am and noon (see **Figure 2** in Appendix J).

Figure 2: Number of Visits to the Temporary Overdose Prevention Site, February 12, 2018 to August 31, 2018
[MOHLTC OPS Monthly Reporting Form, n=7152]



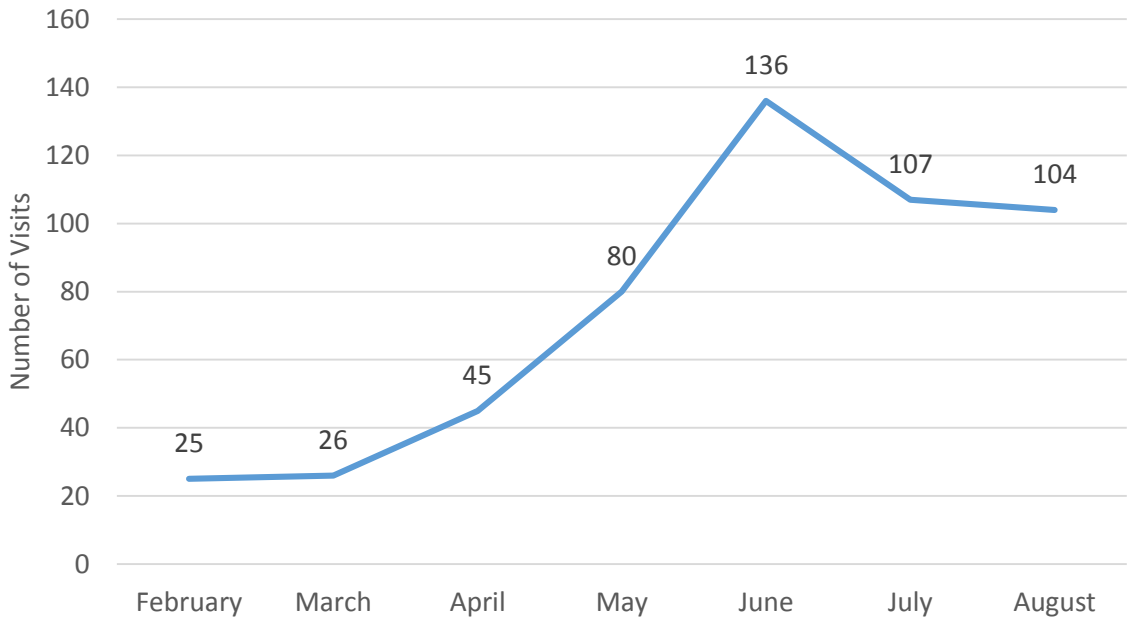
Usage of Site on the Weekends

Among the respondents on the Client Survey, 74% (n=75) reported using the site on the weekends (see **Figure 1** in Appendix K). Common reasons cited for not accessing the site on the weekends fell into three themes: (1) unware that the site was open on weekends, (2) not in the area on the weekends, or (3) site not accommodating to needs (e.g. limited hours of operation, inconvenient).

Peer-to-Peer Assisted Injections

A total of 523 peer-to-peer assisted injections occurred at the site between the February and August timeframe (see **Figure 3**). This represents 7.3% (523/7152) of total visits at the site involving peer-to-peer assisted injection over the entire timeframe.

Figure 3: Number of peer-to-peer assisted injections at the site between February and August 2018
[MOHLTC-OPS Monthly Reporting Form, n=523]

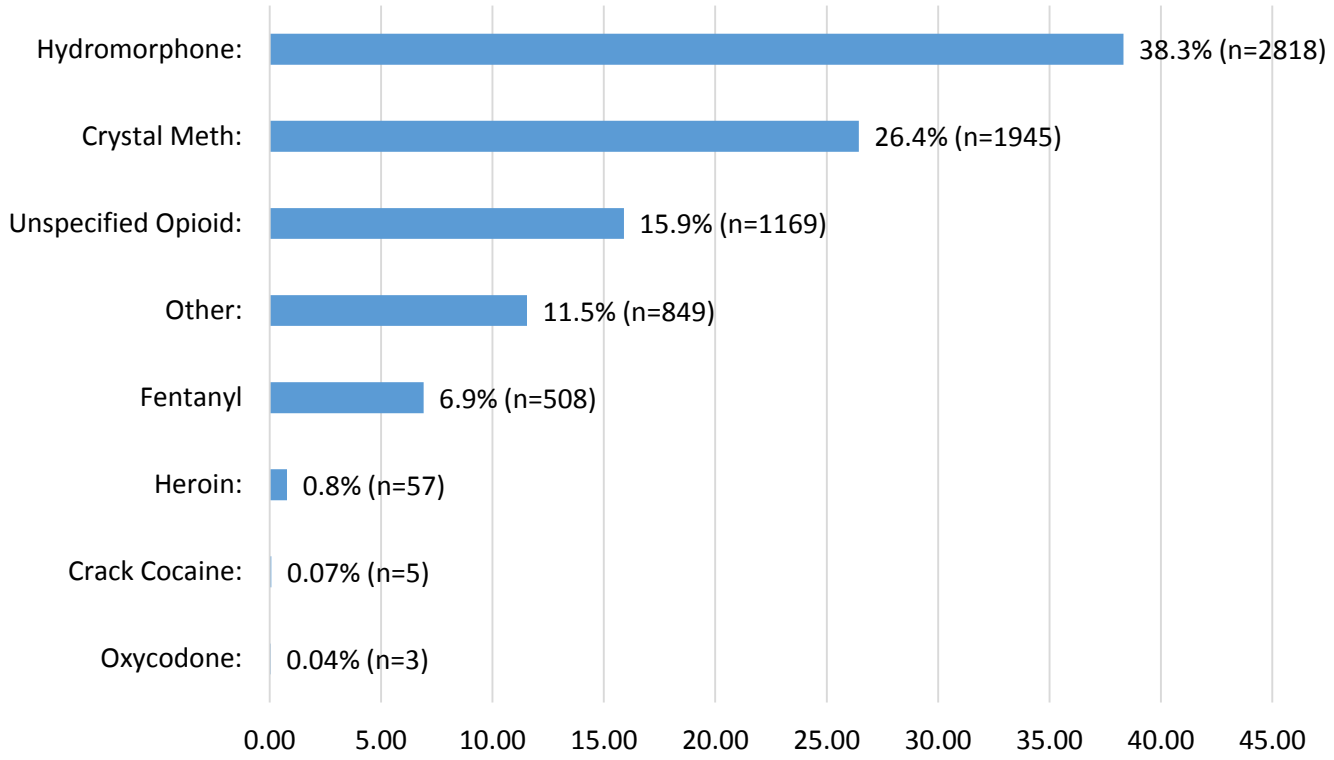


The proportion of visits per month where peer-to-peer assisted injections took place was high during the month of February (8.3%, 25/300) considering the site was only open for about half the month, and then decreased during the month of March (3.0%, 26/881) (see **Figure 4** in Appendix J). There was a steady increase in the proportion of peer-to-peer assisted injections during the months of April (4.8%, 45/936) and May (6.9%, 80/1155), and then the proportion peeked in the month of June (10.0%, 136/1357). The average monthly proportion of peer-to-peer assisted injections may be leveling off around 8%, as seen in July and August data.

Types of Drugs Consumed

The two most commonly drugs consumed by clients at TOPS clients were Hydromorphone (38.3%, n=2818) and Crystal Meth (26.4%, n=1945). Among the types of drugs reported, it is estimated that approximately 60% of the drugs consumed are opioids (i.e. hydromorphone, fentanyl, heroin, oxycodone, unspecified opioid). **Figure 4** shows the percentages of different types of drugs consumed by clients at TOPS between February and August 2018.

Figure 4: Percentage of Types of Drugs consumed by Clients at TOPS
[MOHLTC-OPS Monthly Reporting Form, n=7352*]



*Note: Some clients reported more than one type of drug per visit

Willingness to Test Drugs for Fentanyl

Roughly three-quarters of Client Survey respondents (76%, n=78) agreed or strongly agreed that they are willing to test their drugs for fentanyl and 19% (n=19) disagreed or strongly disagreed that they would be willing to use the test strips to test their drugs for fentanyl (see **Figure 3** in Appendix K).

Anecdotally, when most clients were asked this question during the survey, there was a lack of awareness that fentanyl test strips were available and the purpose for using them. This coincides with test strip usage statistics where only a few were completed during the first six months of operation as noted below. However, a few clients described the benefits of having the test strips available and encouraged a broader distribution of them through services and supports outside of the site, such as street outreach workers.

"I check my drugs for fentanyl more. Before I didn't test positive for fentanyl when using crystal, so I started testing my drugs. They should hand out the strips on the streets. It is very easy to overdose. "

[Data Source: Client Survey]

Fentanyl Test Strip Drug Checking Use

According to data reported on the MOHLTC Overdose Prevention Site Monthly Reporting Form, a total of 25 clients used fentanyl test strip drug checking services and each completed it for a total of 25 drug checks. This represents only 0.3% of all visits participating in the drug checking service at the site between February and August 2018.

Fentanyl Drug Checking Results

Of the 25 drug checks completed, 8 tested positive for traces of fentanyl. Types of substances identified by individuals checked using the Fentanyl Test Strips (see **Table 1** in Appendix J) include: Fentanyl (6 positive, 11 negative), Crystal Meth (1 positive, 6 negative), and Heroin (1 positive, 0 negative). From these results, it appears that some clients used the test strips to determine whether or not the substance actually was fentanyl, and only 6 of the 17 tested positive for fentanyl. These results indicate that some clients are concerned about whether or not what they purchased was actually fentanyl.

Among the 8 positive drug test results using the Fentanyl Test Strip Drug Check, three individuals noted that they discarded the drug and five indicated that they made no change (no action was taken). There were no individuals noting that they reduced the quantity of the drug consumed. During a stakeholder interview a story was shared when a clients' drug tested positive for fentanyl and the client made a decision to not use the drug. The client planned to follow-up with the dealer because of their concern that the drugs contained fentanyl.

Demographics

Self-identification as Indigenous

At the request from the Indigenous community leaders, tracking individuals who self-identify as Indigenous began in April 1, 2018 on the MOHLTC Overdose Prevention Site (OPS) Monthly Reporting Form. Between April 1st and August 19th, 1145 visits were recorded from individuals who self-identify as Indigenous. This reflects roughly 19% (1145/5971) of the total number of visits in the timeframe.

Length of Injection Drug Use

The majority (62%, n=63) of Client Survey respondents had been injecting drugs for more than 5 years, while 30% (n=31) reported using for one to 5 years. Only a few clients had been injecting drugs for less than one year (5%, n=5) and less than one month (3%, n=3). See **Figure 4** in Appendix K.

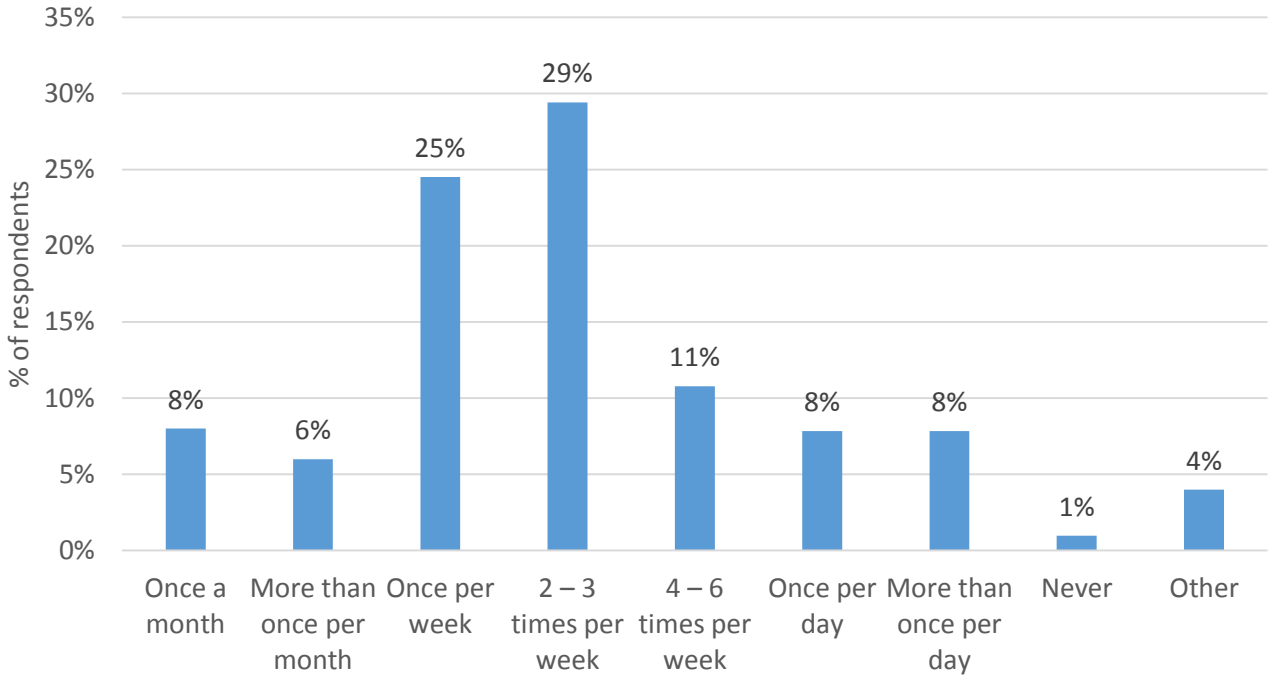
Length of Time Lived in London

The majority (79%, n=81) of Client Survey respondents had lived in London for 7 or more years (see **Figure 5** in Appendix K).

Frequency of Using Counterpoint Needle Syringe Program Prior to Using TOPS

Figure 5 shows Client Survey respondents' self-reported frequency of using Counterpoint Needle Syringe Program prior to using TOPS. Almost all (95%, n=97) of client respondents were regular users of Counterpoint Needle Syringe Program prior to using TOPS. The most frequently reported times, included 2-3 times per week (29%, n=30), once per week (25%, n=26), and 4-6 times per week (11%, n=11). The "other" category included descriptions such as "one time only" and "it depends".

Figure 5: Self-reported Frequency of using Counterpoint Needle Exchange Program at RHAC prior to using TOPS [Client Survey, n=102]



How Clients Found Out About TOPS

Most clients indicated through client interviews that they found out about the site through accessing services at RHAC or from their peers and friends. A few clients heard about the site from the media (e.g. radio, online). Given that almost all of the respondents had accessed the Counterpoint Needle Syringe Program at least once prior to accessing TOPS demonstrates that the placement of the site at RHAC helped to facilitate awareness and comfort level in coming to the site.

Reasons for Using the Site

When asked during the Client Interviews why they are using the site, many clients cited the benefits related to reducing the harms associated with drug use. Some also noted that it provides a safe and secure environment for them to use drugs that they would not otherwise have access to. Several described how the site prevents them from having to use public spaces which reduces the risks of getting caught by police.

Why are you using the site?

- Provides a safe, clean, comfortable and secure place to use drugs
- Provides a convenient, downtown location
- Prevents use of public spaces for drug use which may result in getting caught by police and subsequently fined or incarcerated
- Reduces harms associated with drug use (e.g. access to clean gear, do not have to carry gear,
- Reduces chances of being bothered by peers when using the site
- Offers support onsite if overdoses occur
- Reduces public needle waste
- Forming relationships with staff and peers

[Data Source: Client Interviews]

PART 2: SERVICE DELIVERY

Organization of Part 2

This section provides a summary of the findings gathered to answer two key evaluation questions:

- Are services delivered as intended?
- Are services adapting to client and community needs?

The findings gathered to answer these two questions have been integrated to highlight the successes and challenges encountered through service delivery at TOPS. The following five topic areas are covered in this section. Suggestions for improvement of TOPS and considerations for future supervised consumption facilities are also described at the end of each section.

1. Services
2. Staffing
3. Location
4. Space Design
5. Operation

1. Services

Client Satisfaction

Based on quantitative and qualitative data, the majority of clients were satisfied with the TOPS services (refer to **Table 1** in Appendix L for relevant key quotes).

- Almost all client survey respondents (96%, n=98) rated the quality of service and care received from TOPS staff as good or excellent (**Figure 8** in Appendix K). Only 5% (n=5) of clients rated the quality of service and care from staff as fair or poor.
- The majority of client survey respondents (85%, n=87) rated TOPS as a good or excellent place to take or use drugs (**Figure 9** in Appendix K). Only 16% (n=16) of clients rated the site as fair or poor place to take drugs.
- The majority of client survey respondents (89%, n=92) indicated they would be likely or extremely likely to recommend the site to other PWUD (**Figure 10** in Appendix K).
- The majority of client survey respondents (91%, n=93) said that the rules and regulations rarely or never get in their way of using the site (see **Figure 14** in Appendix K). Although a few clients did not agree with certain rules (e.g. no passing of drugs), for most clients the rules and regulations at the site were not a barrier to using the site.
- During client survey and interviews, many clients described the services as "great" and "amazing" and spoke of the value they placed on the TOPS services. Several clients noted that they would rather come to the site instead of using outside or elsewhere.

> *"The fact that staff and everybody, and how professional they are, it's encouraging for people to come back. I see that and it makes people come back. It doesn't make them want to use more but want to come back to a comfortable place to be and keep them away from the street and practice safe use habits."*
>
> *[Data Source: Client Interview]*

Services delivered according to MOHLTC expectations

According to many staff, TOPS is delivering services as intended and exceeding service delivery expectations from what was outlined in the MOHLTC's Overdose Prevention Sites: User Guide for Applicants (MOHLTC, 2018a). TOPS delivers the following services according to MOHLTC guidelines: (1) supervised drug injections, oral and intranasal drug consumption, (2) access to harm reduction supplies, (3) responding to overdoses with oxygen and naloxone, (4) peer-to-peer assisted injections, and (5) fentanyl test strips as a drug checking service. A brief description of the each of these services is discussed below and data tables illustrating key quotes are provided in **Table #1** in Appendix L.

Supervised drug injections, oral and intranasal drug consumption

- Staff confirmed that supervised injections, and supervised oral and intranasal drug consumption are available on site. Staff described that the majority of clients are using the site for injections and only recalled a few clients using the site for oral or intranasal drug consumption. Data from the MOHLTC OPS Monthly Reporting Form does not track the way in which drugs are consumed to confirm the type of drug consumption.

Access to harm reduction supplies

- Clients are provided with harm reduction supplies and have access to the Counterpoint Needle Syringe Program (NSP). The proximity of the Counterpoint NSP to TOPS was noted by many staff, stakeholders and clients as essential as it further increases access to harm reduction supplies by allowing clients to take supplies with them to use when the site is closed.

Responding to overdoses with oxygen or naloxone

- Many staff, stakeholders and clients described the benefits of having staff trained to administer oxygen and naloxone onsite in order to reverse overdoses and prevent overdose-related deaths. The site has two oxygen regulators, allowing staff to respond to two overdoses simultaneously. However, a stakeholder noted that the oxygen tanks are not on wheels, which makes it challenging to move the tank between clients, in the event of multiple overdoses. Several staff also noted that naloxone kit distribution and training is available to clients and many clients have accessed this service.

Peer-to-Peer Assisted Injections

- Allowing peer-to-peer assisted injections on site has helped many clients who cannot inject themselves or who inject in places that are hard for them to see. Staff have primarily observed peer-to-peer assisted injections when clients are injecting in the jugular. Some clients indicated that they are counted on for helping with peer-to-peer assisted injections and have helped their peers inject.

Fentanyl test strips as a drug checking service

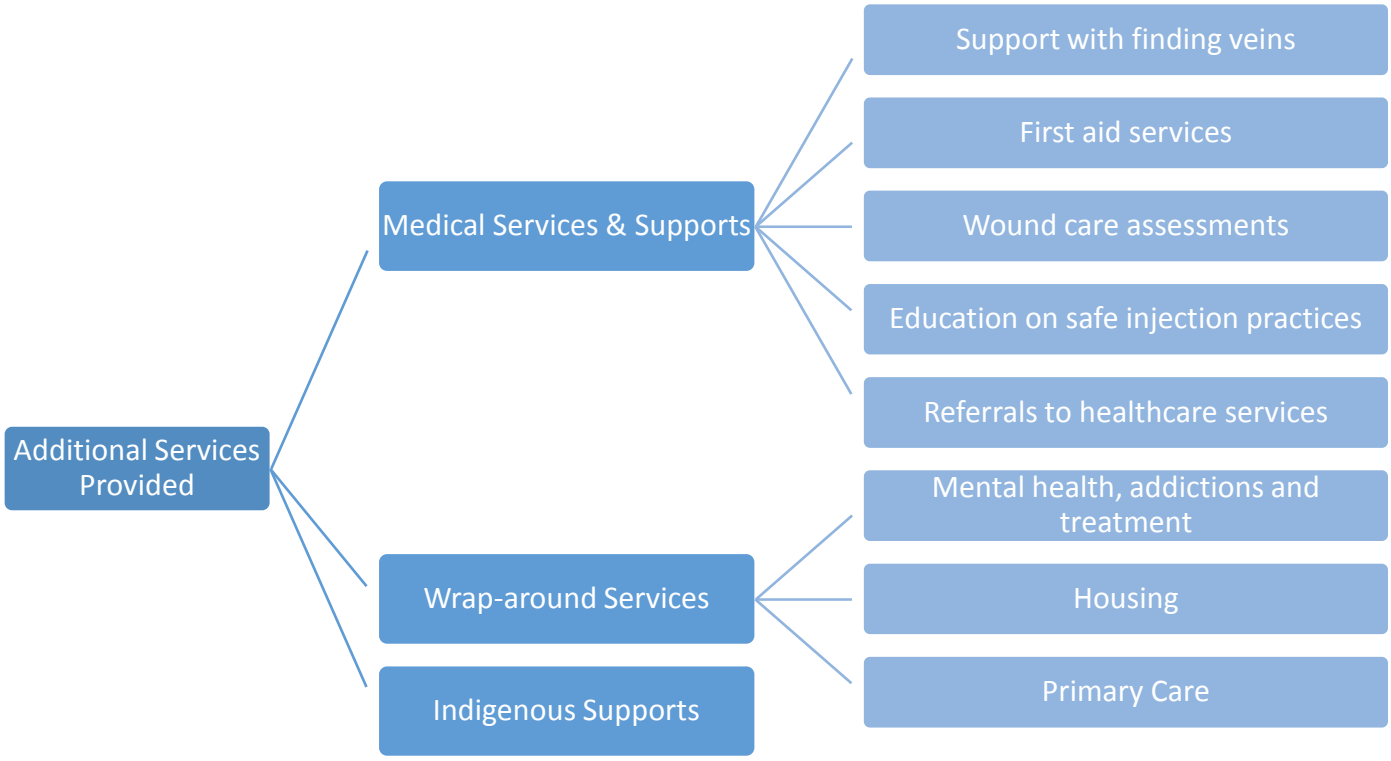
- Fentanyl test strips and education were reported to be available for clients who are interested in testing their substances. Although several staff indicated that Fentanyl test strips are available, it was noted that drug testing occurs less frequent. A few staff suggested some reasons why uptake may be low including inconsistencies in informing clients that it is available, inconclusive results, and a sense of urgency among clients to use drugs when they arrive. This was confirmed with the MOHLTC OPS Monthly Reporting Form were only a few clients had tested drugs between February and August 2018 (see Part 1: Usage Statistics).

Services Exceeding MOHLTC Expectations: Additional Onsite Services

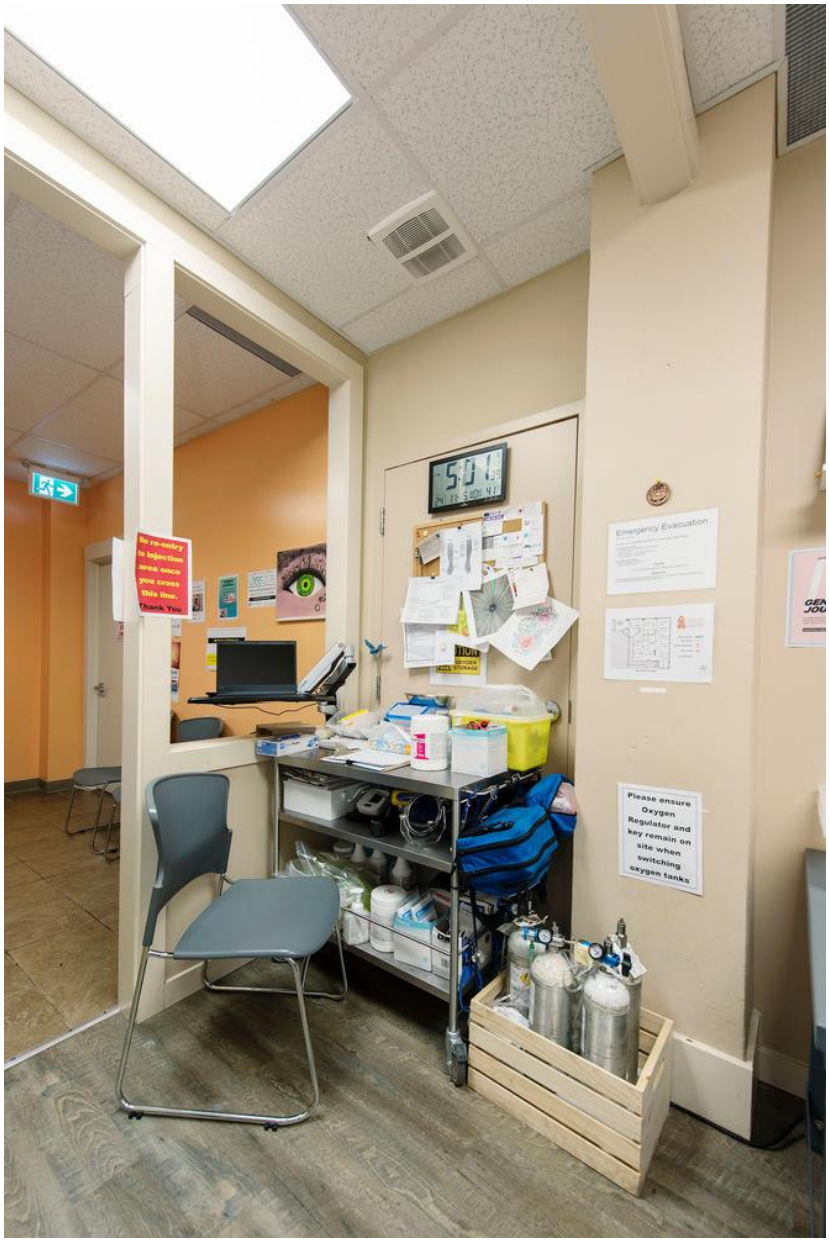
Several staff noted that TOPS is exceeding service delivery expectations initially outlined in the MOHLTC's Overdose Prevention Sites: User Guide for Applicants (MOHLTC, 2018a) and is providing additional services on site for clients that are more aligned with service provision of permanent supervised consumption facilities. These additional services including medical supports and wrap-around services were viewed by many respondents as extremely valuable at the site. **Figure 6** illustrated the three common themes and subthemes related to the additional services offered on site. A brief description of

the additional services is discussed below and data tables illustrating key quotes are provided in Table 1 in Appendix L.

Figure 6: Themes and sub themes relating to the additional services offered at the site



Medical Services and Supports



- Medical staff (i.e., nurses, paramedic) are available on site to provide assistance with finding veins, first aid services, wound care assessments, education on safe injection practices and referrals to healthcare services.
- First aid services were added to meet the needs of clients. When the site was initially set up, there was uncertainty regarding whether wound care or first aid services were going to be provided. Currently, medical staff at the site provide first aid services and wound care assessments to meet client needs. However, from the staff and stakeholder interviews there was overlapping terminology used as many used the terms "wound care" and "first aid services" interchangeably. A few staff mentioned that they are providing additional services beyond first aid services because they have the supplies to do so. However, there was a lack of clarity regarding how the services are defined and what they are permitted to deliver. This challenge is further described related to staffing later in Part 2.
- Many staff indicated that offering medical supports is a positive aspect of TOPS because it allows clients, who have previous negative experiences with healthcare services involving discrimination and stigmatization. Several clients described that these services are helpful onsite as many have fears of going to the hospitals. Clients described positive interactions with the medical staff who have helped assess their wounds.
- In addition to wound assessment services, additional days of testing for HIV and Hepatitis C has been added to meet the needs of clients. Prior to opening TOPS, this service was available at Regional HIV/AIDS Connections. However, since the opening of TOPS, additional days have been added to respond to client need as well as to increase access to testing services while clients are using the site.

Wrap-around Services

- Several clients, staff and stakeholders indicated the value of providing wrap-around services at TOPS through the collaboration of community organizations. Pooling resources together has allowed clients to connect and access services and supports in one spot.
- While facilitating community partnerships can be complicated and challenging, several staff and stakeholders noted that it has been successful and beneficial for the site. Stakeholders from community organizations are available on-site, in a set weekly schedule, to connect clients with services in mental health, addiction and treatment, housing, and primary care. Clients shared specific examples of being connected with blood testing for Hepatitis C, housing supports, pain management, hospitals, etc.
- Stakeholders and staff indicated that having a set schedule each week and consistent staffing helps provide consistency for clients to build relationships. A stakeholder shared that they have been working with a client who has been sleeping in stairwells for many years and is scared of staying in shelters. The stakeholder has been working to get the individual into stable housing.

Indigenous supports

- Indigenous supports were identified as a valuable service to offer at TOPS by staff and stakeholders. While these supports are part of the wrap-around Services delivered onsite, an Indigenous Outreach Worker from Southwestern Ontario Aboriginal Health Access Centre has been added full-time to the site as opposed other wrap-around services that are generally offered once per week.
- There were four common sub-themes that emerged related to the Indigenous supports such as (1) providing culturally appropriate care and building comfort with Indigenous clients to seek services, (2) helping honour the site as an Indigenous space, (3) having the ability to connect with clients because of the understanding of the historical context and systemic racism, and (4) having staff who are visibly Indigenous.
- By having Indigenous supports available on site, clients receive culturally appropriate care including having access to medicine bundles and opportunities to participate in sweats and smudging rituals. A few stakeholders also stated that clients are more comfortable sharing their story once they get to know the Indigenous staff. A stakeholder described a story regarding a client who cried when sharing his negative experiences with a social service agency for many years as there was a lack of understanding about the historical context and how it influenced the Indigenous community's perception of the social service agency.
- While it was noted that the Indigenous supports are beneficial to clients, through the evaluation there were no specific feedback from clients regarding the Indigenous supports.

Future Enhancements to Services

Given the value that many clients, staff and stakeholder placed on the services delivered at TOPS, several suggestions to enhance service delivery were provided. Overall, there is a recognized need to enhance existing services and offer additional services directly onsite as it is beneficial for clients to be able to make those immediate connections with services in the moment (refer to **Table 1** in Appendix L for relevant key quotes)

Wound care services

- The addition of basic first aid and wound care assessment has been beneficial for clients, as it allows them to receive an immediate assessment by medical staff on site. However, staff raised concerns about the lack of wound care services on site. Sending clients elsewhere for wound care services (e.g. packing of wounds) has been challenging, as some clients may not follow through and seek out the services because of additional barriers (e.g. distance is too far to travel, negative experiences accessing health care services). One client shared that nurses would like to provide more wound care services, but they are not allowed to do so. A stakeholder also mentioned that it is a missed opportunity to not provide healthcare services to clients who are at the site. However, a few staff explained that due to a lack of supplies and appropriate staffing (e.g. nurse practitioner to prescribe antibiotics), they are unable to offer wound care services on site for clients.

> *"I got stabbed a while ago and the nurses helped to take care of my wounds and abscess because I have a phobia of hospitals. But they were able to call the hospital when I needed it. The staff had been coming in everyday to change the gauze. The nurses want to do a lot for us, but they are not allowed to."*
>
> *[Data Source: Client Survey]*

Assistance by medical staff to help set up injections

- A few clients, staff and stakeholders suggested that there is a need to help some clients with their injections because some clients have difficulty finding veins and experience challenges with the mobility of their arms if they have an abscess. As a result, some clients further damage their veins as a result of multiple attempts. Clients have the option at the site to ask another peers for assistance, however, a few clients suggested that it would be ideal if medical staff (nurses, paramedic) were permitted to help set up or "flag" veins, which would be formally called "medical-assisted injection".

> *"The nurses can't help hit you, but they should be able to hit you if you are distraught. I had an abscess and couldn't move my arms, so I had to try hitting myself and kept missing so I waited for someone to come in and help me."*
>
> *[Data Source: Client Survey]*

Access to primary health care services

- Several clients described a need to have onsite access to primary health care services. This would help address their health concerns including pain management, abscesses, and HIV and Hepatitis treatment. It was also identified that services for foot care including a foot washing station would be beneficial at the site.
- A few clients specifically recommended walk-in type services or urgent care services onsite to address their health issues. It was also recommended by some staff that the role of current medical staff could be expanded to provide additional primary health care services including STI testing, immunizations, and outreach nursing.

Onsite access to rehabilitation and treatment services

- A few clients mentioned that it would be beneficial to have immediate access to rehabilitation (e.g. detox) and treatment services (e.g. withdrawal management). It was noted that there is a need to reduce wait times in order to increase access for clients into these types of services. This challenge was also described by staff who indicated that wait times are around 9 months to

obtain access to a residential treatment facility. Immediate access to rehabilitation services are needed when a client is ready to make a change. Otherwise, the window of opportunity may be lost.

Supervised inhalation services

- A few staff, stakeholders and clients identified that the site currently does not reach the population who use smoking as a way to consume their drugs. Access to smoking-related gear (e.g. glassware) at the site was also suggested by clients. However, the OPS exemption from the MOHTLC does not cover supervised inhalation services, and as a result would need to be explored as a possibility for future supervised consumption facilities.

Education on harm reduction

- Some clients identified the need for further onsite education on harm reduction, such as injection practices, naloxone training, risks of combining certain drugs (e.g. pain when injecting THC crystals) and the presence of harmful street drugs. Clients suggested various options for delivering this education including, workshops, group discussions, and TV monitors in the aftercare room.

Access to more counselling services on-site

- Some clients and staff mentioned that clients do not always have access to counselling on-site and as a result clients are missing opportunities to connect with counselling services. Intake for counselling services closes quickly when there is a high volume of clients. In addition, sometimes stakeholder organizations have had to cancel shifts in the aftercare room, limiting client access to services on-site. Community supports are not available to clients on the weekends when the site is open, further reducing clients' access to services.

Naloxone Distribution and Training

- During client surveys and interviews, some clients highlighted the need for equipping more people who use drugs with Naloxone kits at all times and training on how to use it. They spoke about the value of having their peer network trained to monitor for signs of overdose in the community.

Refreshments and food supports

- Several clients noted that they liked it when juice and cookies were offered when the site first opened, as it helped those who face food insecurities. However, during the time refreshments were provided, there was a notable increase in the amount of garbage (e.g. granola bar wrappers, juice boxes) around the building. To address this issue, staff explained that refreshments were discontinued and reserved for clients who need it the most (e.g. low sugar, have not eaten in days). Although this change was implemented to address the amount of garbage surrounding the site, staff noted that there is value in offering refreshments for clients, as most are dehydrated, experiencing homelessness and/or living under the poverty line.

Services to meet basic needs

- Several clients also recommended that they are in need of services to meet their basis needs, including personal hygiene and food insecurity. Clients suggested increased access to food, access to showers and bathrooms, clothing, hygiene products (e.g. toiletries, feminine hygiene products, etc.). Clients expressed that these services would be extremely beneficial to those who are homeless or unstably housed.

- A few clients also mentioned a need for having lockable storage for their personal belongings (e.g. lockers) and the need for a secure lockable area for their bikes (e.g. bike rack). In addition, it

was also recommended that clients are in need of a space to be able to charge their cell phones.
- A few clients mentioned the need for onsite support to help obtain identification, complete income taxes, applying for disability, employment supports, help with resumes, and other legal documents. Furthermore, assisting with transportation to appointments was identified as a needed service.

Recreational activities

- Some clients described a need for recreational activities on site. Clients suggested the need for a recreational space or lounge for them to hang out in, play games and socialize. Some also mentioned the need for such a space for them to cool down in the heat of summer and a space to warm up in the winter months.

Hours of Operation

The hours of operation were the most common reported service delivery challenge by clients, staff and stakeholders. Among Client Survey respondents, 29% (n=30) said the operating hours often/always get in their way and 27% (n=28) said the operating hours sometimes get in their way of using the site (**Figure 6** in Appendix K). The current hours of operation (i.e. 10 am – 4 pm Mon-Fri; 11am-3 pm Sat-Sun) were described by many respondents as a barrier for the following reasons:

- Drug use occurs at all hours of the day.
- The hours of operation do not coincide exactly with the hours of Counterpoint Needle Syringe Program or shelters.
- The hours of operation do not support those who work from 9 am-5 pm.
- The site is not open during statutory holidays.

A few clients also shared that they will still use drugs alone or in public spaces after the site closes. Staff indicated that although they would like increased hours, financial constraint continues to be the limiting factor.

Staff and several stakeholders have noted that overdoses have occurred outside the site afterhours. In one situation, two clients using fentanyl overdosed at the same time, 10 minutes after the site closed. Fortunately, staff were still on site and were able to successfully revive both clients.

The addition of weekend hours (11 am – 3 pm) was added in late February to reflect client need as weekend hours were not initially planned. Yet, client usage on the weekend was reported to be lower than weekdays. Among the clients who were surveyed, a quarter (26%, n=26) said they did not access the site on weekends. Lack of awareness of the weekend hours was the most commonly reported reason why the client did not use the site, followed by not being in the area on weekends, and the site not accommodating their needs. Staff also noted a challenge that wrap-around services are not provided in the aftercare room on weekends.

Preferred hours of operation

Among the clients who participated in the survey, 36% (n=37) wanted hours after 4pm and 35% (n=36) wanted both earlier and later hours. Fifteen percent (n=15) of clients had other suggestions including 24/7 access to the site. Only 10% (n=10) of clients indicated that the current hours were fine (see **Figure 7** in Appendix K).

Wait Time

Among clients who participated in the survey, 60% (n=62) indicated that the wait time rarely or never gets in their way of using the site. However, 33% (n=34) mentioned that the wait time to get into the

consumption room sometimes can be a barrier for them to use the site. Only 7% (n=7) of clients said the wait time often/always gets in the way of them using the site (**Figure 13** in Appendix K).

When there are higher wait times due to client volume, staff and clients mentioned that some clients will leave and use in public spaces or at home. Clients also mentioned that the wait time can be a challenge, particularly when feeling pill sick. When the site is full, several staff have observed up to 12 clients in the waiting room. As a result, a staff member mentioned that that they have had to rush clients while using the injection room.

Service Delivery Suggestions

The following list of suggestions were identified by clients, staff and stakeholders.

Site Communication and Promotion

- Provide messaging to PWUD in the community (e.g. potential site users) regarding any concerns they may have in accessing the site
- Increase awareness among clients and PWUD that the site is open on the weekends
- Increase understanding of the barriers for using the site among PWUD who currently do not access the site

Hours of Operation

- Increase hours of operation, including opening earlier in the morning and later in the evening (e.g. 12 hours, 24 hours).
- Remain open on holidays.
- Offer hours that coincide with the shelters closing in the morning hours.

Services and Supports

- Expand onsite wound care services to meet client needs (e.g. abscesses)
- Explore options to allow medical staff to provide medically-assisted injections (e.g. flagging veins)
- Enhance access to primary health care services onsite to address health concerns (e.g. pain management, HIV and Hepatitis treatment, foot care, immunizations, etc.)
- Offer onsite access to rehabilitation and treatment services
- Increased access to more onsite counselling services
- Increase awareness among clients and PWUD in the broader population that intranasal and oral consumption is permitted at the site
- Provide more education on the availability and use of fentanyl test strips among clients and PWUD in the broader population
- Provide more training to clients and PWUD on the use of Naloxone kits
- Consider permitting supervised drug inhalation (i.e. smoking of drugs) at the site and providing smoking gear (e.g. glassware).
- Offer wrap-around supports in the aftercare room on the weekends
- Enhance education on harm reduction to include client workshops, group discussions and/or use of TV monitors in the aftercare room
- Incorporate strategies to reduce the wait time such as setting a maximum time limit for individuals using the injection room and then ask individuals to move to the aftercare room.
- Offer refreshments and food supports, additional services to meet clients' basis needs (e.g. personal hygiene supplies, clothing, cell phone charging, obtaining identification, etc.)
- Provide lockable storage for clients' personal belongings and bike storage.
- Provide recreational activities in a lounge space onsite.

2. Staffing

Staff play an important role to ensure services are being delivered as intended. There were four key themes highlighted as successes regarding staffing: (1) staff characteristics and skills, (2) strategies to build relationships with clients, (3) strategies to enhance relationships with health and social services, and (4) supportive leadership. These themes and sub-themes are discussed in the sections below (refer to **Table 2** in Appendix L for relevant key quotes).

Staff Characteristics and Skills

Securing staff who are the right fit for supporting clients is a key component to ensuring the TOPS operates as intended. Some staff and stakeholders mentioned that a few staff and stakeholders started in their roles, but did not continue as they were uncomfortable in the site. The characteristics and skillsets of staff that are important to support service delivery included the following six sub-themes:

- **Nice, warm, and friendly:** Many clients described staff as nice, warm, and friendly which makes it easy for them to feel comfortable and talk to them. Several clients referred to staff as their peers, friends and family.
- **Caring and compassionate:** Clients noted that staff genuinely show care and compassion towards them. Some clients described situations where staff have provided supportive listening to help them through the grieving process when a close friend or family member had passed away.
- **Understanding of client needs:** Several clients indicated that staff are understanding of their needs and accommodating by helping them to determine solutions that can help them with their individual needs. Staff described how they have had conversations with youth, pregnant women and clients who disclose that they have never injected. As part of this discussion, staff will discuss how they have been using, what it means for their health and where they are in their addiction.
- **Non-judgmental:** Several clients described that staff do not judge them for using the site or any of their drug use practices. This non-judgmental approach was noted by staff as being critical to their approach so that clients feel comfortable and let their guard down.
- **Knowledgeable:** Several staff and stakeholders indicated that the RHAC staff are very knowledgeable in harm reduction and working with the PWUD population. Many mentioned that they have learned a tremendous amount from the mentoring provided by RHAC staff.
- **Skilled at de-escalation:** A few clients identified that staff are professional and skilled at dealing with arguments at the site. De-escalation skills were also noted as critical staff skills by both staff and the stakeholders. Stakeholders mentioned that staff were skilled at dealing with clients not following the code of conduct, including those who can present with challenging behaviours.

> *"The staff just have big hearts. Even when I see them outside, they help me. They are like my friend in my pocket."*
>
> *[Data Source: Client Interview]*

Strategies to build relationships with clients

During staff and stakeholder interviews, three common strategies were highlighted that have helped them to build relationships with clients as outlined below:

- **Consistency of staff and stakeholders:** Several staff and stakeholders noted the value of having consistent staff and stakeholders at the site. It is helpful for clients to see familiar faces in order to build a trusting and safe environment. Many RHAC staff were familiar to clients given their roles in Counterpoint Needle Syringe Program and other RHAC services. These pre-existing relationships were

instrumental in helping to onboard new staff and stakeholders to the site. For example, having new nursing staff present with RHAC staff helps clients to know that the new staff members are safe.

- **Conversational approach:** Several staff and stakeholders indicated socializing with clients and using a conversational approach to converse has helped build relationships. Telling jokes and singing with clients has helped to staff and stakeholders to get to know clients on a personal level. Some staff members also noted the use of crossword puzzles for clients to engage in initial conversations with staff can often lead them to open up to have conversations about their drug use and other life circumstances. While many noted that getting to know clients on a personal level helps build relationships, a few clients mentioned that it potentially breaks confidentiality by staffing referring to clients by name and singing songs such as "Happy Birthday".
- **Acknowledging clients as the experts and learning from clients:** Staff and stakeholders noted that there is mutual learning between them and clients regarding drug use practices. As a result, staff and stakeholders noted that it is helpful to acknowledge clients as the experts to help facilitate relationships. Clients are asked questions regarding injection practices to help staff and stakeholder understanding. This information can help staff and stakeholders tailor information and support more effectively.
- **Highlighting the site as the clients' space and encouraging them to take ownership:** Several staff also indicated that the space was highlighted as the client's space where they play a role in creating a safe environment and are encouraged to take ownership of the space. A bulletin board is posted inside the site where cards and artwork from clients are displayed. A few clients recommended that playing music, displaying more client artwork, artwork with positive and motivating messages could further enhance the environment at the site.

Strategies to enhance relationships with health and social services

Further to building relationships with clients, TOPS staff and stakeholders have also worked to enhance their relationships with health and social services in the community. During staff and stakeholder interviews, two common strategies were highlighted that have helped them to enhance relationships with health and social services as outlined below:

- **Contacting service providers directly to explain client needs:** If clients need immediate medical attention, staff will call the service providers directly to see if it is feasible for them to see the client on the same day. It was noted that services providers have been receptive to seeing TOPS clients on short notice.
- **Explaining client behaviours to service providers:** In addition to contacting service providers directly, staff and stakeholders indicated that they may explain potential client behaviours. For example, staff may explain that clients could verbally lash out if an authoritative approach is used given clients' previous experiences with accessing health and social services. Several clients indicated in interviews that they have had negative experiences with accessing care from health and social services which has resulted in a lack of trust and willingness to utilize these services.

Supportive TOPS leadership

The TOPS Leadership Team was noted as being supportive and approachable. If there are any concerns staff described that they feel comfortable speaking with the leadership team directly. Appreciation for the Leadership Team was expressed by staff and stakeholders as their roles have been critical to bring stakeholder organizations together to deliver wrap-around services at the site.

Staff Resources, Role Clarity, Training, and Communication

Staff Changes

During the first 6 months of operation, there were several changes related to staffing that were implemented to support service delivery, including:

- Redistribution of existing staff at RHAC,
- Addition of the runner role designated for bringing clients to and from the reception,
- Reinstating the role of the security guard, and
- MLHU hiring additional staff to accommodate staffing requirements for the site.

Staff Resources

While these changes were described by staff as necessary to support service delivery, many staff described ongoing challenges related to limited staffing resources that have resulted in difficulties maintaining adequate staff coverage during illness, lunches and breaktimes. It was noted that managing tasks such as scheduling, creating databases, reporting to funders, and managing tours and media requests also require a substantial amount of additional staff time. Furthermore, a lack of administrative support for managing tasks and communications was noted.

Clarity regarding roles of medical staff

It was noted that there was a lack of clarity regarding the roles of medical staff (i.e. nurses, paramedic) in regards to some areas, such as providing first aid versus providing wound care services onsite, filling out medical documentation for clients or answering medical questions relating to wound care. Furthermore, there were concerns expressed that nursing skills were not being fully utilized, since they are trained in tasks such as wound care, deep packing and changing the packing. It was also recommended that allowing medical staff to setup or "flag" injections for individuals could help to minimize the challenges that individuals have in finding their own veins or when abscesses make it difficult for them to move their arms. In addition, it was mentioned that the role of non-medical staff could be expanded to include additional tasks such as drawing blood for Point-of-Care (POC) testing. However, some staff expressed concerns about non-medical staff performing these types of tasks.

Communication between nursing staff

It was noted that only one nurse is scheduled to work at the site at a time and this results in nurses working in isolation from one another. It was identified that there was little to no formal opportunities for nursing staff to discuss critical incidents (e.g. overdoses) that occur with other nurses working at the site and nursing documentation issues that may arise.

Addressing ethical dilemmas regarding service provision

Stakeholders described some challenges that they have experienced when they know clients who use the site. They indicated that they address these scenarios on a case-by-case basis depending on the client feedback. Stakeholders also noted that ethical dilemmas have arose where they are aware that clients may be on suboxone or methadone but using the site or situations where clients are involved with Children's Aid Society.

Staff training

While it was noted that prior to starting at TOPS, staff were provided with a formal orientation and offered crisis prevention training, a few staff mentioned that they had not yet received the crisis prevention training. Furthermore, some staff mentioned that training that they had to complete on certain training modules (e.g. WHMIS) was not a good use of time and that training on medical directives would have been more relevant to their role at the site. The inconsistencies in staff training are reflective of differing organizational approaches to onboarding staff.

Staffing Suggestions

The following list of suggestions were identified by both staff and stakeholders.

Roles

- Improve role clarity for medical staff (i.e. nurses, paramedic).
- Consider expanding the role of medical staff to provide more medical services including wound care, STI testing, immunizations, and outreach nursing.
- Enhance administrative support for the site (e.g. Administrative Position).
- Consider creating specialized roles to manage the various tasks involved in running the site (e.g. managing press, creating electronic databases, reporting to Ministry, etc.).

Recruitment and Resourcing

- Increase number of staff to address issues of being under resourced and dealing with coverage issues.
- Ensure staff and stakeholders hired to work at the site are the right fit for the site and meet a set of core characteristics and skills (e.g. genuinely show care, compassion, kindness and show others that they are valued; provide services in a non-judgmental; friendly, approachable and welcoming; empathetic and understanding of individuals' needs; establish trusting relationships, etc.).
- Ensure an appropriate balance of shifts and length of shifts.
- Ensure staff are provided with sufficient breaks (i.e. 45-60 minutes for lunch).

Communication and Training

- Ensure continuity of staff communication and training by offering consistent updates through email or online learning modules to all staff at TOPS (e.g. how to keep the site safe, enhancing flow of the site, harm reduction model, trauma-informed care, appropriate terminology, providing consistency in messages to individuals regarding drug use practices, etc.).
- Offer crisis prevention intervention training for all TOPS staff and stakeholders.
- Enhance communication within designated roles (e.g. nursing) by offering weekly or monthly meetings to discuss documentation, and lessons learned from critical incidents.
- Provide ongoing education as new information emerges to staff and stakeholders in order to enhance knowledge of injection drug use, how to provide services to PWUD, common health conditions experienced by PWUD, etc.

3. Location

Staff, stakeholders and clients identified both strengths and limitations regarding the site location. Feedback on the proposed permanent supervised consumption facilities was also shared by some respondents as well as suggestions for consideration regarding future site. The themes and sub-themes regarding the location are discussed in the sections below and key quotes are provided in **Table 3** in Appendix L.

Location Strengths

For the majority of clients, the current site location was ideal. In fact, several clients indicated through client surveys and interviews that they would prefer the site to continue operating at the current location.

- The majority of client survey respondents (78%, n=80) indicated that the site being located at 186 King Street was rarely or never a barrier for them to use the site (see **Figure 11** in Appendix K).
- The majority of client survey respondents (79%, n=80) noted that the travel time to get to the site is rarely or never a barrier to using the site (see **Figure 12** in Appendix K).

During the interviews with clients, staff and stakeholders, there were several benefits described regarding the physical location of the site including that it is:

- centrally located,
- convenient,
- close to a bus route,
- close to where clients stay and/or buy drugs,
- discrete with minimal signage
- located at RHAC where many clients are familiar with staff and the supportive culture of existing harm reduction services
- located in close proximity to the Counterpoint Needle Syringe Program to access clean gear and where several clients have existing relationships with staff.

Location Limitations

While the majority of clients were satisfied with the site location, there were a few challenges expressed by some respondents regarding the site location as described below:

- **Travel Time:** Travel time to the site is far for some clients that live just outside of London.
- **Back alley and North Entrance:** Some clients noted that the back alley is sketchy with fights, thefts, loitering, drug use, and drug transactions occurring sometimes. Some clients expressed their fears that issues in the alley and north entrance of the site may place the site in jeopardy of closing. The cement blocks at the north entrance that were placed by a business owner were noted as a negative aspect of the location because it encourages loitering. Although noted as positive features by a number of clients, a few clients also noted that there is a lack of privacy and discreteness at the north entrance. Furthermore, limited signage at the north entrance was identified as a further challenge by a few respondents.
- **Police Presence:** A few clients also noted that the police presence at the north entrance of the building scares clients from using the site.

Reflections on the Proposed Supervised Consumption Facility Locations

Several clients, staff and stakeholders described positive and negative aspects regarding the proposed permanent supervised consumption facilities at the York Street and Simcoe Building locations as described below:

- **York Street Location:** Many clients thought that this location would be suitable as it is in close proximity to existing shelters and within close proximity to the downtown core. Staff also noted that they have heard mostly positive comments from clients about the proposed York Street location. However, stakeholders also heard that some of the clients mentioned that they would only use a SCF in the downtown area and will not go to the York Street location as it is too far east.
- **Simcoe Building Location:** There were mixed-reactions about the Simcoe building location from clients. A few clients thought that the Simcoe building would be an ideal location because of the high drug use in the area and the high volume of drug dealers that live in the building. Yet, a few clients stated that they would not use the Simcoe Building at all. Some clients expressed concerns about the proposed Simcoe building citing ongoing issues of criminal actiivties (e.g. theft), physical violence in the building (e.g. beaten with bats) and sexual assaults. Some clients also identified concerns for residents in the buildling who are clean or do not use drugs. Some staff also confirmed that they have heard that clients are concerned about the Simcoe location including many that state they will not use a SCF at that building. It was also noted that there are some individuals banned from the Simcoe building, so there was uncertainly as to how those types of issues would be addressed.

Willingness to Use Mobile sites

The willingness to use a mobile site was assessed among clients during the Client Survey. The majority of clients from the Client Survey (71%, n=71) indicated that they would be "extremely likely" or "likely" to use a mobile supervised consumption services van. However, a quarter of clients (25%, n=25) indicated that they would be unlikely or extremely unlikely to use a mobile supervised consumption services van (see **Figure 15** in Appendix K). Further investigation of the use of a mobile unit or van is needed to determine feasibility given feedback was only obtained from clients on the Client Survey.

Location Considerations for Future Sites

The following list of suggestions were identified by clients, staff and stakeholders.

North Entrance Improvements at TOPS

- Enhance strategies to mitigate loitering and improve the north entrance by reducing garbage, removing cement blocks, and increased lighting.

Proximity Considerations

- **Proximity to NSP:** Ensure that any future permanent sites are located in close proximity to a Needle Syringe Program in order to provide access to clear gear.
- **Near Shelters:** Ensure that any future sites are located near local shelters.

Location and Type of SCF Considerations

- **Multiple SCF locations:** Offer supervised consumption facilities in multiple locations across London, including one in the downtown core (e.g. located at RHAC for ease of accessibility)
- **Mobile sites:** Further investigate the use of a mobile unit or van to determine feasibility.
- **Temporary Overdose Prevention Site:** Offer a Temporary Overdose Prevention site along with permanent facilities due to the different rules and requirements for each type of site. For example, an outdoor site would provide an option for individuals where a larger space is more suitable given their behaviours that have led them to be restricted from TOPS.
- **Community Engagement:** Ensure that there is ongoing community engagement and monitoring if one of the permanent sites are located in a residential building (i.e. Simcoe Building) in order to ensure the safety of residents and enable ongoing support for those who are on the path to recovery or who do not use drugs.
- **Transportation Services:** Provide transportation to the supervised consumption facilities.
- **Safe space for drug transactions:** A few clients mentioned the need for a safe space at the site to make drug transactions, in order to reduce the risk of thefts and ensure they are receiving the type and quality of drug requested.

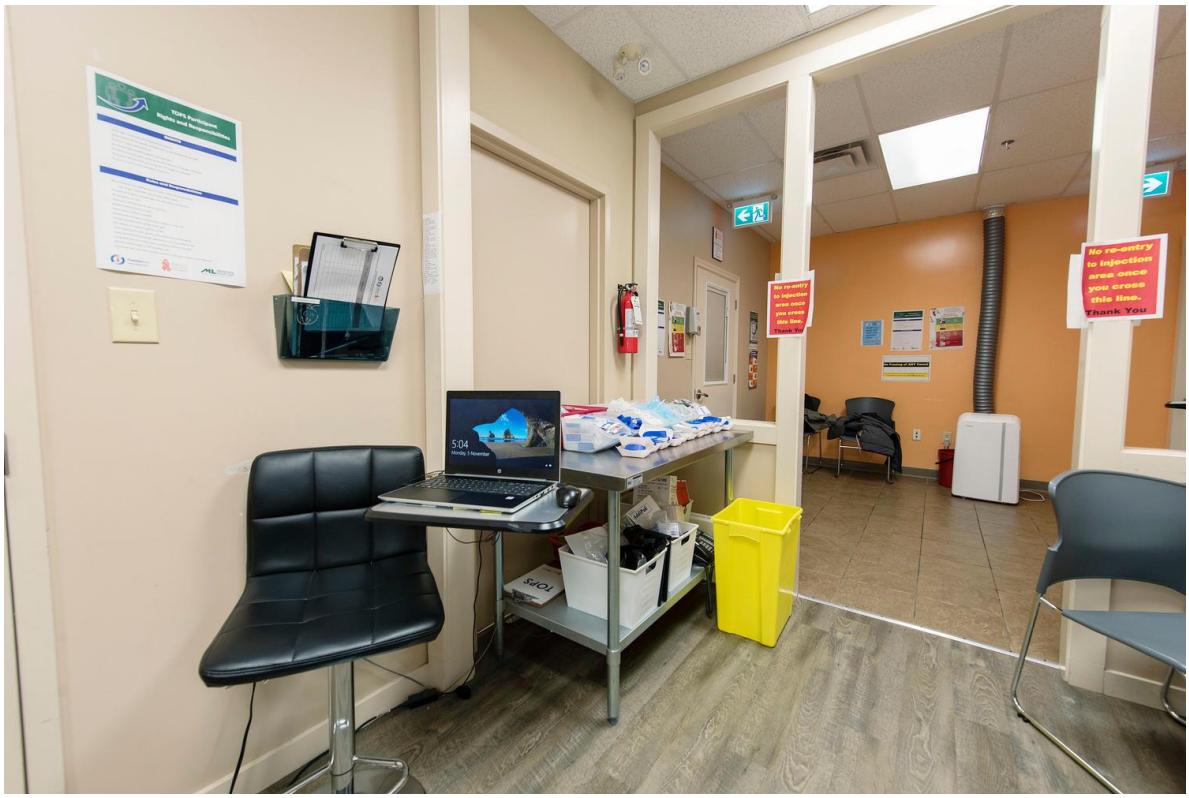
4. Space Design

Staff, stakeholders and clients identified both strengths, challenges, and areas for improvement regarding the design of the site. The key themes that emerged related to (1) open room layout and open table design, (2) inviting space, (3) limited space, and (4) temperature and ventilation (key quotes related to these themes are provided in **Table 4** in Appendix L).

Open Room Layout and Open Table Design

The open layout of the Injection and Aftercare Rooms as well as the open tables in the injection space were noted as positive design features by some respondents because it enables conversations, encourages a sense of community, provides a sense of comradery, and makes drug use feel less hidden and shameful.

While some respondents noted that the open room layout and open table design was ideal for the site, others commented that there are challenges with these designs. Some respondents described how it can distracting for clients when the site is busy and makes it difficult for clients to have private conversations with staff given that the aftercare room is adjacent to the injection room. Clients, staff and stakeholders also identified that the design does not provide privacy for clients who are injection in private areas or who do not want other peers to see what type of drug they are using. The open room layout also creates a lack of privacy for clients receiving medical services (e.g. first aid, wound care assessment). A few clients also indicated that they feel they are being watched by staff and other peers while in the injection room and would prefer to have booths for more privacy.



Inviting Space

Many clients, staff and stakeholders described the space as welcoming and inviting. In fact, some clients suggested further enhancements to the space with their desire to have a lounge or recreational space at the site; however, this would not be feasible given its current space constraints. Further enhancements to the environment included playing music, creating space to displaying client artwork and/or artwork that includes positive and motivational messages.

While many respondents felt the space was welcoming and inviting, some clients on the Client Survey mentioned that the space is too inviting and encourages clients to spend time socializing and packing/unpacking belongings leading to longer wait times. Staff and stakeholders identified challenges in moving clients from the injection room and aftercare space when client volumes are high, but also recognized that many do not want to leave the site because they want to hang out and socialize in the space of the site. While most clients refered to the space as inviting, one stakeholder described feedback received by one client that the space felt like jail with the numerous doors between the Waiting Room, Intake Space, Injection Room and Aftercare space. Futhermore, client access to washrooms was also noted by a few clients as a concern as they are required to be accompanied by a runner to and from the washroom that is located near the main reception of RHAC.

Limited Space

Limited space was a commonly reported as a challenge by staff, clients and stakeholders. There is only room for four injection spaces (i.e. 2 tables with a total of 4 chairs), which can lead to increased wait times. The limited space also makes it challenging to accommodate peer-to-peer assisted injections (e.g. jugular injections requiring floor space), to accommodate the behaviours of the most vulnerable and abandoned people, and to provide counselling and medical services in the small space (e.g. no space for foot washing station to address foot care needs).

Temperature and Ventilation

There were significant challenges temperature control and ventilation with the current building. The space is too hot in the summer months even with the use of portable air conditioners. The warm temperatures in the space were noted as being problematic for clients using Crystal Meth or those that are experiencing withdrawal symptoms. The ventilation of the site could also be improved to eliminate odors, including the odors from heating drugs.

Future Space Planning Suggestions

The following list of suggestions were identified by clients, staff and stakeholders.

Space Planning

- Increase amount of space for the site to allow for enhanced service delivery
- Provide a combination of open tables and private booths. The open table configuration will continue to encourage staff-client interaction and peer-to-peer interactions. The private booths will provide an option for individuals who prefer privacy.
- Increase the number of tables and chairs for injection in order to reduce wait time (average 8-12 spots)
- Provide sufficient space for jugular injections that require clients laying on the floor
- Provide a private, clean, sterile space for medical staff to offer first aid, testing, foot care/foot washing station, and other supports in a private environment
- Provide confidential, private space for counselling when conversations that start in the aftercare room require more privacy
- Provide greater separation for the aftercare space from the injection room in order to provide more privacy for clients.
- Provide a space for clients needing to reorganize their belongings that is not located in the aftercare area.
- Provide a community room or lounge area at the site to provide recreational and social activities at the site.
- Enhance the environment and atmosphere of the site by playing music, displaying client artwork and/or artwork that includes positive and motivational messages.

Temperature and Ventilation

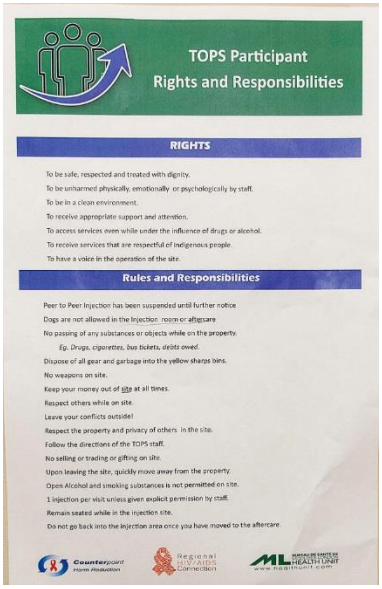
- Ensure proper ventilation at the site in order to reduce the odors associated with individuals who cook their drugs
- Ensure appropriate heating and cooling to improve temperature control of the site

5. Operations

Staff and stakeholders emphasized the smooth and efficient operation of TOPS. While there were many strategies helping to create operational success, there are also some challenges identified as well. Feedback on the operations of the site was primarily obtained from staff and stakeholders. However, there were a few clients that had comments regarding policies and the data collection process that have been noted. There were five key themes that emerged regarding successes and challenges experienced related to operations, including: (1) policies and procedures, (2) data collection, (3) daily huddles and debriefs, (4) measures to ensure client and staff safety, (5) strategies to address verbal abuse, and (6) financial resources to replace items (key quotes related to these themes are provided in **Table 5** in Appendix L).

Policies and Procedures

Staff and stakeholders identified strategies that contributed to the effective and efficient operation of the site including the implementation of the Client Code of Conduct and deciding to allow peer-to-peer assisted injections as outlined below:


TOPS Participant Rights and Responsibilities

RIGHTS

To be safe, respected and treated with dignity.
To be unharmed physically, emotionally or psychologically by staff.
To be in a clean environment.
To receive appropriate support and attention.
To access services even while under the influence of drugs or alcohol.
To receive services that are respectful of Indigenous people.
To have a voice in the operation of the site.

Rules and Responsibilities

Peer to Peer Injection has been suspended until further notice
Dogs are not allowed in the Injection room or aftercare
No passing of any substances or objects while on the property.
Eg. Drugs, cigarettes, bus tickets, debts owed.
Dispose of all gear and garbage into the yellow sharps bins.
No weapons on site.
Keep your money out of site at all times.
Respect others while on site.
Leave your conflicts outside!
Respect the property and privacy of others in the site.
Follow the directions of the TOPS staff.
No selling or trading or gifting on site.
Upon leaving the site, quickly move away from the property.
Open Alcohol and smoking substances is not permitted on site.
1 injection per visit unless given explicit permission by staff.
Remain seated while in the injection site.
Do not go back into the injection area once you have moved to the aftercare

- **Client Code of Conduct:** Overall, staff and stakeholders noted that the majority of clients are respectful of the code of conduct. The code of conduct outlines the rules of the site, and must be reviewed by all clients prior to using the site. The main rules of the site include, having to go back to the waiting room after using if the client wants to use the site again, no exchanges, sharing or trading of anything, no selling of drugs and no loitering around the building. Feedback from a few clients indicated that some clients do not agree with the rule "no exchanges of anything". Staff are vigilant about the rules being broken in the site, however mentioned that it is important to meet clients where they are at. This involves providing reminders, communicating expectations and reviewing and reinforcing the code of conduct.
- **Peer-to-Peer Assisted Injections:** Initially, peer-to-peer assisted injection was not permitted at TOPS, as this practice is not permitted in SCFs. This was reflected in earlier versions of the code of conduct, which indicated that only self-injections were permitted. This rule changed fairly quickly, after hearing feedback from clients that they cannot inject themselves and realizing that TOPS would be missing a sizable portion of the population. Permitted peer-to-peer assisted injections was one of the additional services that were permitted with the OPS exemption from the MOHLTC.

Areas for Improvement in Policies and Medical Directives

Staff and stakeholders describes some challenges regarding operational policies and medical directives and offered suggestions for improvement in these areas:

- **Challenges with the organization of the policy manual:** There were challenges noted with using the policy manual as there is no table of contents which makes it difficult to find the policy and procedures, when needed.
- **Inconsistencies in policies and medical directives for responding to overdoses:** Staff identified that there were inconsistencies between what is outlined in the policy manual and the medical directives for responding to overdoses. It was noted that the policy for responding to overdoses was revised to include an algorithm. However, it was noted the algorithm was

vague and did not include specifics such as how much time to wait between doses of naloxone. The revisions to the policy were also not reflected in the medical directive that medical staff at the site are required to follow. The medical directive lists a step wise response that does not align with the updated policy. There were concerns expressed from nursing and medical staff that they need to be following the medical directive consistently and that it aligns with their professional licencing bodies, or else it puts their license in jeopardy.

- **Challenges with documentation when responding to overdoses**: It was noted that there was a lack of clarity around the documentation required when responding to overdoses. For example, questions were raised as to whether there is a need to consistently document whether naloxone spray was switched between nostrils, and to document the amount administered.
- **Lack of required equipment for some medical directives:** It was noted that there are some unrealistic medical directives as there is a lack of required equipment to execute the medical directive. For example, there is a medical directive for testing for glucagon. However, there is no glucometer at the site to perform the test.
- **Lack of a policy for needle and bodily splash incidents:** It was noted there is a need to have a policy for needle stick and bodily splash incidents.
- **Contradictory policies between MLHU and RHAC:** It was also noted that there are some MLHU policies that contradict the RHAC policies. Since the medical staff are hired by the MLHU, there were concerns expressed about which policies the staff should be following.

Data Collection

Staff and stakeholders identified that several improvements were made to the data collection process over the first six months of operation as outlined below:

- **Providing explanations to clients regarding the rationale for collecting data and allowing clients to visibly see what is entered:** During the intake, client data such as their initials, birth date, the drug they are using is collected. Some clients expressed that there are too many questions being asked of them. To help address this concern, staff and stakeholders indicated that they have started to explain the reasons for collecting information. For example, information regarding the type of drug the client is helpful in the event that a client experiences an overdose. Information on needle tip size is gathered from clients to demonstrate which supplies require more funding from the Ministry. In addition, clients are also able to visually see what data is being entered about themselves to reduce their concerns.
- **Implementing an electronic data collection process rather than collecting data on paper:** Several improvements have also been made to the data collection process with the use of an electronic data collection process. Initially, some client data was being collecting data on paper and later entered into the computer. Stakeholders characterized this as being chaotic when there are four clients in the room from whom data needs to be collected. Now, staff have access to a computer, allowing them to directly capture the data electronically.
- **Reviewing and refining the type of data collected:** The types of data collected have been further refined to better meet client and community needs. Information on client referrals are now being collected by staff consistently. Furthermore, data on the number of people from the Indigenous community who use the site is now being collected.

Areas for Improvement regarding the Data Collection Process

While improvements were made to the data collection process during the first few months of operation, there were some further data collection challenges noted at the time of the evaluation, including:

- **Collecting intake questions and forms in the injection room:** There were difficulties raised by clients, staff and stakeholders with asking intake questions and completing forms (e.g. code of conduct) in the injection room because of client confidentiality concerns and interrupting clients using the site. It was recommended by both staff and stakeholders that client confidentiality and the flow of the site could be improved by asking intake-related questions and completing forms in the intake space prior to clients entering the injection room. The Evaluation Team was informed at the end of the evaluation that this change has been implemented to improve the data collection process and flow of the site.
- **Keeping track of referrals:** Keeping track of referrals made in the aftercare room was noted as an ongoing challenge. Providing a laptop in the aftercare room was recommended for stakeholders to keep track of referrals and be able to access information on community services.
- **Data entry into computer:** Technological challenges were noted with entering data into one computer for intake information, injection room information and referrals.
- **Nursing documentation:** There were challenges noted with inconsistencies of nursing documentation. It was suggested that tick boxes could be used for predetermined categories rather than using written descriptions for nursing documentation.

Daily Huddles and Debriefs

- **Huddles:** Huddles were raised as an important task to ensure the smooth operation of TOPS. Huddles occur every morning prior to opening TOPS with all TOPS staff and stakeholders present. Several staff indicated that huddles have been beneficial as it allows them to review such items as daily checklists, list of clients on restricted access, and walkie-talkie codes.
- **Debriefing Sessions:** Debriefing sessions occur at the end of every day and provide the opportunity for staff and stakeholders working that day to discuss critical incidents, how to address certain client behaviours, and discuss other incidents that they have encountered that they may continue to think about after the shift (e.g. will be on their minds at home).

Measures to Ensure Client and Staff Safety

There were several measures in place to ensure client and staff safety including the following:

- **Restricted client access to the site:** It was noted that at any given time, there are a few clients that are not permitted to use the site due to physically challenging behaviours (e.g. screaming at people, being loud and disruptive, physically tense, aggravated, displaying threatening behaviour), not following site rules (e.g. passing items, walking around with an uncapped needle) and/or experiencing mental health issues that may threaten others' safety (e.g. psychosis, hallucinations, delusions or paranoia) . Staff indicated that some clients are assessed on a day-to-day basis to determine whether or not they can use the site. Based on the staff assessment, there is a gradual progression to restricted access. If the staff find that the site may not be a good fit for the individual that day, the client is told to try again the following day and are asked to leave the property. If the issues persist the next time the client visits the site, the client is told to try again in 72 hours. Staff highlighted that the decision to turn a client away is made for that moment and each day is treated as a new day.
- **Use of walkie-talkies:** All staff and stakeholders at the site are required to carry a walkie-talkies to be able to communicate with staff outside the site when needed. Through the use of walkie-talkies staff communicate specific codes which notify the staff in other areas of RHAC of a situation inside the site.
- **Adequate staff coverage in the site:** The importance of having a minimum of three staff in the site at all times was noted. It is also necessary to have a staff member to be a runner who is available to get clients in and out of the site when needed (e.g. accompanying clients to the washroom at the main entrance of RHAC).
- **Re-introduction of the security guard:** It has been beneficial to have a full-time security guard on site, especially on weekend shifts when there are only three staff working at the site. Intially, a security guard was part of the staff complement when the site opened, but the staff observed that clients had an emotional reaction to the security guard's presence with the police-like uniform. As a result, the security guard was phased out of the site. However, as the weather changed, there was an increased activity (e.g. loitering, drug selling/purchasing) around the building. In response to these concerns, a securty guard was reintroduced to conduct sweeps around the building and move people along. However, a decision was made to ensure that the security guard wore casual clothing rather than the traditional security guard uniform.
- **Controlled access to other rooms at RHAC**: Access to each room of the site is key controlled by staff and stakeholders. There are also windows on many doors allowing staff outside to have a clear view of the site. A staff member mentioned that having many doors to the site has made them feel safer because they know that they could leave rooms of the site if they felt unsafe. The space is also designed in a way to only allow a certain number of people in the room.

- **Training on Crisis Prevention Training:** Training is also in place in ensure the safety of staff. A few staff mentioned that they have received training on crisis prevention intervention. This training teaches staff about being aware of their body language, getting out of a physical hold and the importance of their tone and not elevating their voice when someone's voice is elevated.
- **Placement of signage throughout the site:** Additional signage has been put up in the injection room to remind clients about the no sharing/exchanging rule, and not to break tips off syringes. When clients break off the tip, tiny pieces of a needle are left behind, posing a safety hazard to both clients and staff. Signage has also been posted to remind clients that once you go into the aftercare room from the injection room, you cannot go back in the injection room immediately. Clients are required to circle back around to the Wait Room and then the Intake Space prior to using the Injection Room a second time.
- **Placement of sharps bin on the floor near clients:** A sharps bin is placed on the floor beside the client who is injecting in the jugular, so that the used needle is disposed of, rather than having the client stand up and walk around with an used needle. Clients are also asked to remain seated when one of their peers is lying on the floor trying to inject.

Strategies to Address Verbal Abuse

Many staff and stakeholders noted that there is a level of verbal abuse that comes with the site and working with the population, however most staff and stakeholders mentioned that this is handled within reason as it is typically a projection of how the client is feeling (e.g. having a bad day). Staff and stakeholders indicated that swearing is the most common verbal abuse from clients which may be in response to telling clients that they are not following the site code of conduct. There were several effective strategies set up for staff and stakeholders to respond to incidents of verbal abuse from clients including the following:

- **Using de-escalation strategies:** Staff use strategies to try to de-escalate the situation, such as disengaging from the conversation or setting boundaries.
- **Understanding the context for the verbal abuse:** Staff also try to understand the needs of the clients and help them if they can. For example, if a client is frustrated because they can not find a vein, staff will ask the client if they would like support from a nursing staff.
- **Offering clients a modified service or restricting access**: Clients may be offered access to the harm reduction supplies through Counterpoint Needle Syringe Program, but not permitted to use TOPS. Clients may be asked to come back the next day if de-escalation strategies and other strategies are unsuccessful.

While these strategies were identified as effective for managing issues of verbal abuse at the site, a few staff and stakeholders described specific incidents of verbal abuse that made them feel unsettled and uncomfortable. It was suggested that common approaches and communication for all staff and stakeholders on how to address issues of verbal abuse would be beneficial including understanding which behaviours of clients cannot be tolerated at the site and which cannot be tolerated.

Supplies

There was an identified need for additional supplies at the site. It was noted that while the site has two oxygen regulators, which allows staff to respond to two overdoses simultaneously, the oxygen tanks are not on wheels. This makes it challenging to move the tank between clients, in the event of multiple overdoses at the same time. It is recommended that wheeled oxygen tanks be obtained.

There was also a lack of financial resources available to replace items (e.g. lighters, lamps) that go missing. It was noted that items such as the Pulse Oximetre, hand sanitizers, lighters and mirrors have been

stolen. It was suggested that it would be beneficial to secure those items to the tables in the Injection Room.

Suggestions for Operation

The following list of suggestions were identified by clients, staff and stakeholders.

Policies and Procedures

- Improve organization of the policies and procedures binder.
- Improve alignment and consistency with medical directives, and the site policies and procedures, and various professional bodies (e.g. Nurses, Paramedics).
- Create a policy for needle stick and body fluid splash incidents.
- Ensure all required medical supplies are available to respond to incidents that are outlined in the medical directives (e.g. glucometer is lacking).

Data Collection and Ongoing Monitoring and Evaluation

- Improve data collection procedures to improve efficiency and consistency for nursing documentation (e.g. use of tick boxes in charts).
- Gather information on how clients are consuming their drugs (i.e. injecting, orally, intranasally).
- Gather feedback from clients who self-identify as Indigenous to determine if the services meet their needs and gather feedback for suggested changes.
- Provide a laptop in the aftercare room for stakeholders to access agency information for referrals efficiently and a list of community services that are available.

Strategies to ensure client and staff safety

- Provide communication to all staff and stakeholders regarding common approaches and strategies to address verbal abuse.

Supplies

- Ensure appropriate equipment for responding to overdoses (e.g. provide a wheeled oxygen tank).
- Secure lighters, lamps and mirrors to the tables in the injection room.

PART 3: IMPACTS

Organization of Part 3

This section provides a summary of the findings gathered to answer two key evaluation questions:

- Are the intended benefits of TOPS being recognized?
- How is TOPS impacting the lives of people who use drugs in Middlesex-London?

The following four topic areas are covered in this section.

1. Impacts on Clients
2. Impacts on Staff
3. Impacts on Stakeholders and their Organizations
4. Impacts on the Community

Impacts on Clients

During the first 6 months of operation, there is evidence that the site is having a positive impact on many clients' lives. Many clients described positive changes that the site is having on their lives and feedback from staff and stakeholders also echoed the changes that they are witnessing. It is recognized that the term 'impacts' may have been interpreted by many respondents to be reflective of long-term, significant changes. However, the stories shared by clients, staff and stakeholders reveal that the site is having an influence on short-term changes in clients' day-to-day lives.

There were two overarching and interconnected themes that emerged related to positive impacts on clients (see **Figure 7**):

- Reduction in harms associated with drug use, and
- Building trusting relationships and connections

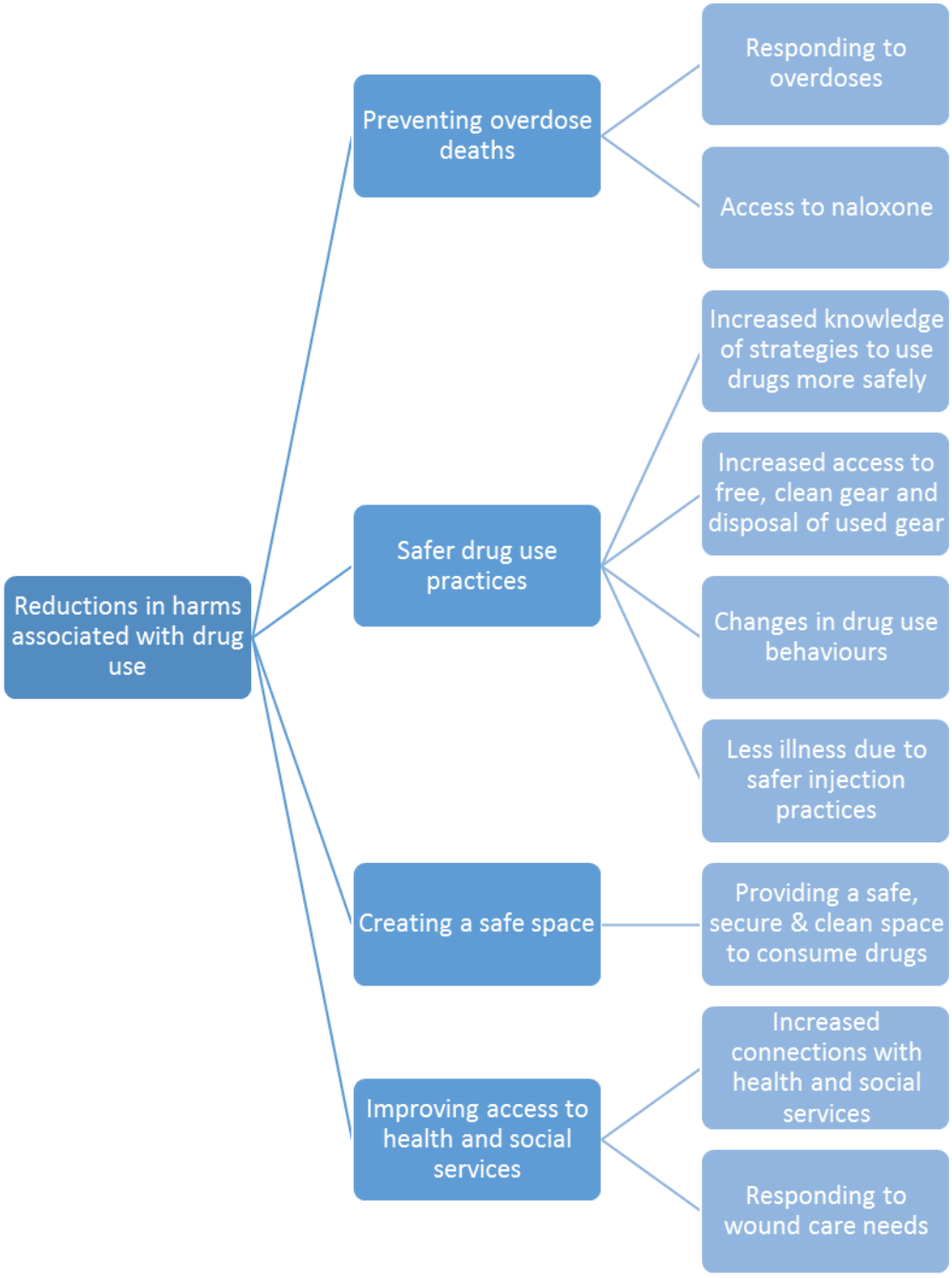
There were also a few unintended negative outcomes on clients' day-to-day lives that were identified that reflect fears that clients may experience.

Figure 7: Two Interconnected Themes Related to Impacts on Clients

Reductions in Harms Associated with Drug Use

Feedback from various data sources reported reductions in the harms associated with drug use. The findings highlight progress being made to achieve the intended outcomes of the site. The following chart demonstrates the five common themes and sub-themes that relate to the reported reductions in harms associated with drug use. Each of the themes and sub-themes are described briefly in the following section (refer to **Table 1** in Appendix M for key quotes related to each theme).

Figure 8: Themes and Sub-Themes related to Reductions in Harms Associated with Drug Use



Preventing Overdose Deaths

There were two common sub-themes related to preventing overdose deaths as described below:

Responding to overdoses

- Between February 12th and August 31, 2018, several overdoses were reversed by staff at TOPS. There were a total of 19 overdoses requiring treatment with oxygen/rescue breathing and a total of 7 requiring treatment with naloxone. There have been no deaths occurring at TOPS. Many clients, staff and stakeholders shared stories about the overdoses that have been reversed and the many lives that have been saved as a result of TOPS.
- While over half of client survey respondents (55%, n=56) noted that they had never experienced an overdose, several clients described feeling safer using the site because of the ability of staff to respond if an overdose occurs.
- While staff have the primary role in monitoring for potential overdoses, both stakeholders and clients were identified as playing a role in monitoring for signs of overdose (e.g. "on the nod") in the injection and aftercare rooms.
- Several staff and stakeholders also shared specific incidents where overdoses were experienced by individuals in the back entrance of TOPS after the site had closed, and by an individual in a car near the site. In these incidents, TOPS staff were able to respond and call EMS if required.

Access to Naloxone

- Clients also have access to naloxone kits through the site and can receive training for how to administer them. This service has also been available at the Counterpoint Needle Syringe Program; however, TOPS provides another opportunity for staff to increase awareness about the availability of the naloxone kits.
- Among the client survey respondents, 91% (n=93) agreed or strongly agreed with the statement "I can access Naloxone easily at the Overdose Prevention Site" (see **Figure 16** in Appendix K).

AT A GLANCE

0 Total number of deaths occurring in TOPS

19 Total number overdoses requiring treatment with oxygen/rescue breathing (0.3% of total visits)

7 Total number of overdoses requiring treatment with naloxone (0.09% of total visits)

Range of 1 to 3 doses of naloxone administered per overdose

5 Total number of calls to EMS related to an overdose

2 Total number of transfers to an emergency department related to an overdose

[Data Source: MOHLTC OPS Monthly

"I have overdosed here today. Those guys [TOPS staff] have saved my life. I would be dead at this exact moment if it wasn't for the site. I would be dead at this moment."

[Data Source: Client Survey]

Safer Drug Use Practices

Many clients reported increased safer drug use practices since they started using the site. There were four main outcomes related to increased safer drug use practices reported below from both the quantitative and qualitative data, including: (1) increased knowledge of strategies to use drugs more safely, (2) increased access to free, clean gear and to disposal of used gear, (3) changes in drug use behaviours, and (4) less illness due to safer injection practices.

Increased knowledge of strategies to use drugs more safely

- Among client survey respondents, 74% (n=74) either agreed or strongly agreed that they have learned tips to use drugs more safely (see **Figure 17** in Appendix K).
- Clients also described that they had learned tips to use drugs more safely, including the use of various supplies to reduce risks (e.g. alcohol swabs, cookers), increased knowledge of the effects of different types of drugs (e.g. fentanyl), and having help from nursing/medical staff in finding veins (e.g. use of a vein finder).
- Staff and stakeholders noted that many clients are increasingly more receptive to listen to the health information provided to them including safer injection practices.

Increased access to free, clean gear and disposal of used gear

- Many clients reported that it is beneficial for them to be able to access free, clean gear at the site and also be able to dispose of the used gear immediately following use. Many clients noted that this reduces the likelihood of used equipment being shared which in turn reduces illnesses associated with injection drug use.
- Staff and stakeholders also noted that many clients are also taking clean gear with them when they leave the site.

Changes in drug use behaviours

- There were several changes self-reported by clients that reflect safer drug use behaviours since they started using TOPS. See **Table 1** for further details on proportions of self-reported drug consumption behaviours.

Table 1: Client self-reported drug consumption behaviours since using TOPS [Data Source: Client Survey]

Drug Consumption Behaviours (number of respondents reporting behaviour in the past)	Less Proportion (%)	Stayed the Same Proportion (%)	More Proportion (%)
Reusing own gear (n=83)	**72%**	24%	4%
Sharing used gear with others (n=39)	**36%**	49%	15%
Using drugs alone (n=101)	**35%**	57%	8%
Amount of drug used (n=100)	**18%**	75%	7%
Feelings of being rushed while using drugs (n=98)	**44%**	43%	13%
Needing help to inject (n=66)	21%	64%	15%
Use of sterile water (n=99)	8%	58%	**34%**
Use of alcohol swabs to clean injection sites (n=95)	5%	52%	**43%**
Heating drugs before using (n=88)	9%	48%	**43%**

- **Reusing own gear:** Among the clients that reported reusing their gear in the past (n=83), 72% (n=60) of clients stated that they are reusing their own equipment less often now since they have started using the site (see **Table 1** above or **Figure 18** in Appendix K). Some clients commented that they are not re-using their gear not at all now. However, a few clients noted that when the site is closed they are sometimes re-using their own gear.

- **Sharing used gear with others:** Among the clients that reported sharing their used gear with others in the past (n=39), 49% (n=19) noted that their sharing of used gear has stayed the same, while 36% (n=14) noted that they are sharing used gear less (see **Table 1** above and **Figure 19** in Appendix K). It is worth mentioning that the majority of clients (n=63) who participated in the survey, had not engaged in sharing their used gear in the past.

- **Using drugs alone:** Among the clients that reported using drugs alone in the past (n=101), approximately one-third (35%, n=35) of survey participants noted that they are using drugs alone less often than before they started using the site. The majority of participants (57%, n=58) indicated that their drug use behavior in terms of using drugs alone has stayed the same (see **Figure 20** in Appendix K).

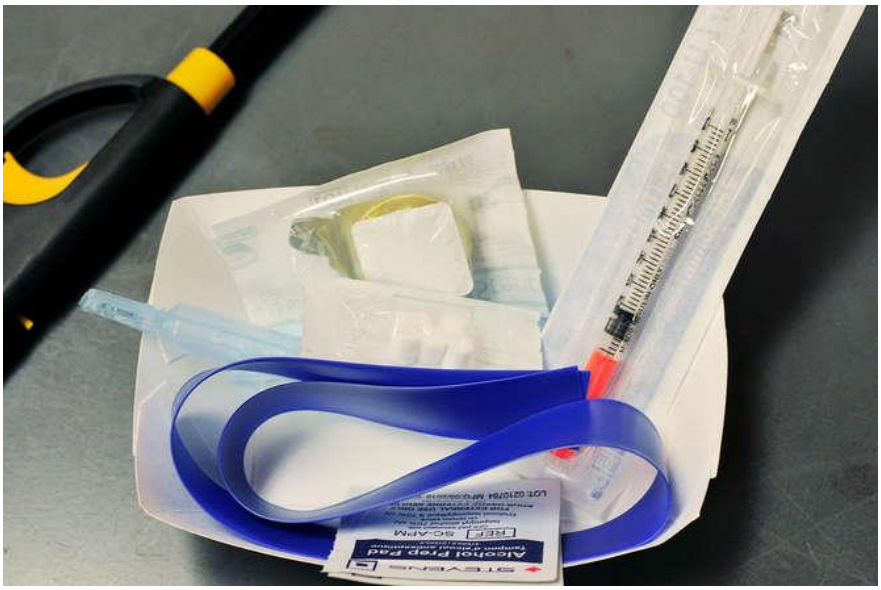
- **Amount of drug used:** Some clients (18%, n= 18) reported that they had reduced the amount of drug used since using TOPS (see **Figure 25** in Appendix K). In client interviews, some clients also shared that they are using less drugs now.

- **Feelings of being rushed while using drugs:** Many clients (44%, n=43) reported that they feel less rushed while using their drugs since using the site (see **Figure 26** in Appendix K). From survey and interview findings, clients also described feeling less stressed and rushed while using their drugs compared to the feelings that they have while using drugs in public spaces, such as public washrooms, or in public spaces where the public including children might be present.

- **Needing help to inject:** Among the clients that reported needing help injecting in the past (n=66), 21% (n=14) reported that they need less help injecting since starting to use the site. The majority of clients (64%, n=42) indicated that the need to have help injecting has stayed the same (see **Figure 21** in Appendix K).

- **Use of sterile water**: Among the clients that reported using sterile water in the past (n=99), 34% (n=34) reported that they are using sterile water more since using the site (see **Figure 22** in Appendix K). The majority of respondents (58%, n=57) noted that their use of sterile water has stayed the same since using the site.

- **Use of alcohol swabs to clean injection sites**: Among the clients who indicated that they had used alcohol swabs in the past (n=95), 43% (n=41) of respondents indicated that they are using alcohol swabs more since using the site (see **Figure 23** in Appendix K). The majority of clients (52%, n=49) indicated that their use of alcohol swabs has stayed the same.



- **Heating drugs before using:** Among clients who indicated that they had heated their drugs before using in the past (n=88), 43% (n=38) reported that they are now heating their drugs more often, while 48% (n=42) indicated that this had stayed the same (see **Figure 24** in Appendix K).

Client survey respondents were also asked to indicate whether or not the frequency of their drug use had changed since using TOPS.

- **Frequency of drug use:** When asked if there had been any changes to the frequency of their drug use among client survey respondents, 17% (n=17) reported a change, while the majority did not report a change (83%, n=82). Among those that reported a change, 12 clients indicated that their frequency of drug use had decreased since TOPS opened and 5 clients reported an increase in the frequency of drug use. From client surveys and interviews, some clients described how their frequency of their drug use has decreased. Staff also mentioned that some clients are accessing the site less and have come in to tell them that they have been using less drugs now since they started using the site or that they have a desire to change their drug use consumption. Some clients also indicated their desire to reduce their drug consumption or stop using drugs completely.

> *"Yes. I am barely using at all now, and if I do, I come here, to the site, it keeps my use regulated."*
>
> *[Data Source: Client Survey]*

Clients survey respondents were asked to identify any additional ways in which their drug use has changed since using the site that were not previously asked in the quantitative questions in **Table 1** above, they described feeling less stress with the availability of peer-to-peer assisted injections at the site, described changes in the types of drug that they are consuming, and less illness due to safer injection practices.

- **Peer-to-peer assisted injections:** The peer-to-peer assisted injections that are permitted at the site were also noted to reduce stress among clients. Staff, stakeholders and clients described how many clients struggle to find veins and that it is a relief when there is another peer that is able to help them to safely inject which can prevent further damage to their veins.

- **Types of drugs used:** Staff also mentioned that some clients are coming to use at the site when they are trying a new type of drug for the first time so that they are in a safe place with the necessary supports available. Staff also noted that some have changed the type of drug they have consumed that is known to have a lower risk of an overdose.

Less illness due to safer injection practices

Feedback on the client survey and interviews indicated that a few clients described how their safer injection practices have led to them experiencing less illness now (e.g. cellulitis). One client also described that the site reduces the likelihood of others taking used needles out of disposal bins to reuse. There were no specific questions asked of all respondents regarding self-reported illnesses on the Client Survey or Interview. However, a few clients discussed changes in the illnesses that they have experienced since using the site, and identified the benefit of having medical staff to recognize signs of infections (e.g. endocarditis) through the wound care assessment services.

"I haven't gotten cellulitis again. I was using at home when I had an apartment and I got cellulitis. I think it was because I was sharing cookers, but I haven't gotten since [using the site]."

[Data Source: Client Interview]

Creating a safe space

From the qualitative data, many clients, staff and stakeholders described how the site provides a safe and secure space as described below:

Providing a safe, secure space

- Many clients shared that the site provides a safe, secure space for them to use their drugs. They noted feeling less stressed due to the reduced risk of getting caught by police or security which may result in being charged or fined. Some clients described how they have had negative experiences and witnessed others being treated negatively by the police and security because they are injection drug users. This site offers a safe and secure place so that they are not struggling to find a place to use in the community.
- Some clients also described less stress because no one can take their drugs at the site and they do not have to share their drugs with others while using.
- Some clients also described that they feel safer and less worried using at the site compared to a shelter. They described the risks of getting caught at shelters with drugs, clean/used gear, or naloxone kits. A few clients described their experiences of getting kicked out of shelters for these actions as well as their fears of not being allowed to administer naloxone, if needed. They referred to the site as being a solution that provides them with a safe space to use drugs and dispose of gear at the site.

- Some clients also described how they feel safer using at the site because it is clean and secure compared to using in public washrooms and public alleys.
- Staff and stakeholders also noted that the site provides a place that they can now refer people to who may be using drugs in public spaces. They explained how they used to only be able to refer individuals to treatment services, such as the detox centres, if they encountered people injecting in public. However, these types of referrals would only be appropriate to those that are wanting to stop using drugs. The existence of the site provides a service and safe space for PWUD.

Improving access to health and social services

There were two common themes reported by clients, staff and stakeholders regarding increased access to health and social services as described below (refer to **Table 1** in Appendix M for relevant key quotes).

Connecting with health and social services

- The majority of client survey respondents (89%, n=88) either agreed or strongly agreed that staff have talked to them or helped them to access other health and social services (see **Figure 29** in Appendix K).
- From the qualitative data, many clients, staff and stakeholders described referrals to health and social service agencies to meet client needs. Furthermore, some clients also noted that through their interactions with staff and stakeholders they have gained the confidence to seek services beyond the site.
- Staff and stakeholders also recognized that more clients are becoming comfortable and willing to access other services beyond the site. They highlighted the value of incorporating the wrap-around service model at the site. Staff and stakeholders are continually finding ways to minimize the barriers to accessing services and help them to navigate the system through warm transfers (e.g. introducing clients to other service providers), arranging transportation to appointments and keeping track of client appointments.
- Clients, staff and stakeholders mentioned that many clients have a lack of trust and comfort level in accessing healthcare and social services because of previous experiences of discrimination and stigmatization that they have experienced accessing services in the past. This is a recognized challenge that exists for encouraging clients to get access to the services and supports that they need.
- Many clients are homeless or living in unstable housing which compounds the challenges for them to make it to

Examples of Health and Social Service referrals

- wound care from clinics or the hospital
- primary care & family physician
- addiction counselling,
- recovery and addiction treatment services (e.g. detox clinic)
- stabilization space (e.g. house at Victoria Hospital for people in crisis who feel they cannot use hospitals due to past trauma)
- mental health services
- pain management clinic (e.g. Rapid Access Addiction Medication (RAAM) Clinic, suboxone, methadone clinic)
- grieving counselling
- testing for Hepatitis C or HIV
- treatment for Hepatitis C or HIV
- arranging transportation to medical appointments or to the hospital, vaccinations, etc.
- housing supports (e.g. London Cares, shelters)
- foodbank
- dental services (e.g. SOAHAC)

appointments. Through dialogue with clients, staff and stakeholders are able to find out individuals' experiences with certain institutions or agencies in the past in order to determine appropriate referrals. For example, staff will try to connect clients with specific staff at community agencies that they know are caring and compassionate towards PWUD.

Responding to wound care assessment needs

- Some clients described the benefit of nursing/medical staff on site to provide wound care assessments and basic first aid when there are signs of an infection due to an abscess or signs of bacterial infections, such as Methicillin-resistant Straphylococcus Aureus (MSRA). One client described the experience of staff assessing an abscess and connecting them to health services. The abscess led to endocarditis, but the individual was able to receive treatment.
- Staff and stakeholders noted that some clients visit the site to get nursing/medical support with dressing changes even when they are not coming to use drugs at the site. Stakeholders also described the benefits of providing clients with wound care kits.

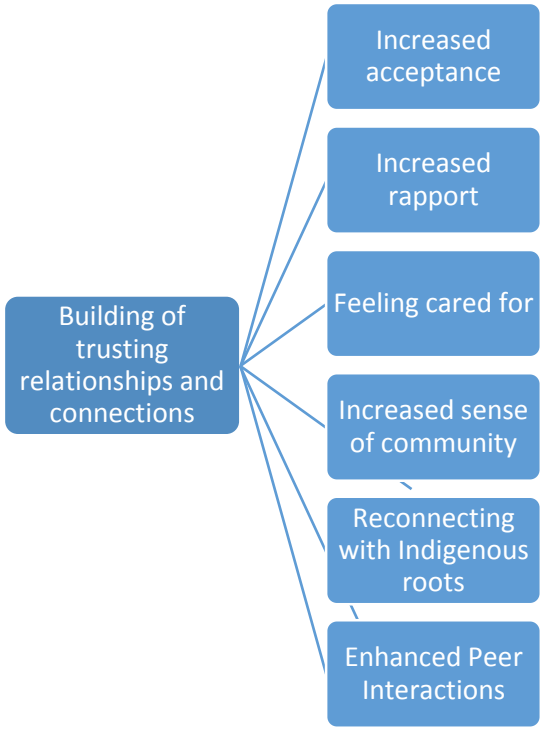
> *"I really think the wrap-around services and being responsive to the person in the moment is important. With this population you have to have the services there. If you want to look at your drug use you have to be responsive in the moment, if you are going to build trust [with the client]."*
>
> *[Data Source: Staff Interview]*

Building Trusting Relationships and Connections

From the feedback received by various respondents, one of the key facilitators to enabling positive impacts for clients are the building of trusting relationships and connections that have formed between staff/stakeholders and clients. The establishment of trusting relationships and the building of rapport has created an environment where many clients feel safe and secure. The findings from this evaluation reveal the significant value of human connection, building social relationships and creating a culture of trust.

Findings reveal that the site has changed clients' day-to-day lives in significant ways. Six sub-themes emerged within the broad theme of building trusting relationships and connections (see **Figure 9** below and refer to Table 2 in Appendix M for quotations).

Figure 9: Sub-Themes of the broader theme of "Building Trusting Relationships and Connections"



Increased feelings of acceptance and not being stigmatized or judged

- When asked to indicate their level of agreement with the statement "I feel accepted at the Overdose Prevention Site", 95% (n=97) of client survey respondents either agreed or strongly agreed that they feel accepted at the site (see **Figure 31** in Appendix K).
- Feelings of acceptance were a common theme throughout the conversations with clients. Some clients mentioned that this is the only place that they feel valued and accepted in our community. They described the staff as being non-judgmental, understanding of their needs, and treating them like human beings.

"It [the Temporary Overdose Prevention Site] gives me some dignity; they [Staff] treat me like a full-blown human being."

[Data Source: Client Interview]

- While most clients indicated that they feel accepted at the site, their perceptions of whether the broader community cares about them differed. While 42% (n=43) of client survey respondents agreed or strongly agreed with the statement "I feel the broader community cares about me", a similar proportion of 45% (n=46) disagreed or strongly disagreed (see **Figure 30** in Appendix K).

> *"I feel more comfortable in my own skin being around people not judging me, no negativity, and more comfortable when I am using. THIS IS HUGE. They [staff] are here for us if we need to talk. It is HUGE to feel accepted - they do care - you do not feel shameful. That is amazing."*
>
> *[Data Source: Client Survey]*

- Several clients described changes in the way that they feel about their experiences of using the site. Some clients described that when they first started using the site they were concerned and worried that they would be judged by staff and some were embarrassed using in front of staff. However, they described that now they feel accepted and supported at the site. Many clients described how they do not feel like they are being stigmatized or judged. These feelings are in juxtaposition to the feelings that they described experiencing when accessing services in the health and social service sector and law enforcement. Many clients expressed feelings of being stigmatized, discriminated against and treated poorly while accessing these types of services.
- Staff and stakeholders described how the site provides a space that is free from stigma and discrimination. When clients are new to the site, they have conversations with some clients as needed to ensure that they understand that by using the site they are actually taking care of their health and to not feel ashamed in accessing the services. At first, several clients were hesitant to use the site and expressed skepticism in accessing the services. However, they were surprised to find how comfortable and accepted they felt using the site.

> *"You feel down sometimes, having people judge. Having a place where I do not get judged, they [Staff] treat me like I am walking into my own home. That is huge for me."*
>
> *[Data Source: Client Interviews]*

Increased rapport, deeper connections and having someone trusted to talk to

- Several clients described the relationships that they have formed with staff and stakeholders that have resulted in them having someone trusted to talk to about their daily experiences and their past history. Clients described the staff as friendly, welcoming, approachable, and empathic. Clients noted that they are understanding of their needs, comforting, and go over and above to help them.

- Clients noted that staff provide opportunities to listen to them when they are upset or having a bad day. For example, some clients described experiences of having a family member or friend pass away and that the staff and stakeholders have helped them with their grieving process. A few clients described how they come to the site now just to talk to staff even when they do not plan to use drugs.
- Staff also described that coming to the site has become a daily routine for some clients even among those that do not plan to use drugs that day. Stakeholders also noted the supportive listening that staff provide to clients is making clients feel comfortable and helping to establish mutually trusting relationships. The site has become a place of trust.

> *"I really think it goes back to that rapport – I do not think we [TOPS staff] knew. We knew dynamic would change for us and clients. We didn't know it would create the rapport we now have with some of our clients – that rapport really able to tailor harm reduction and services."*
>
> *[Data Source: Staff Interview]*

- Staff described how they have known many of the clients for years because of they have been accessing clean gear through Counterpoint Needle Syringe Program. However, the environment of the site has deepened the level of conversations with clients. Clients are now opening up with them about their experiences that led to drug addiction, their experiences of trauma, sexual abuse, childhood sexual abuse, abuse from a partner, and the realities of what is happening on the streets. Staff and stakeholders mentioned that the experiences that clients share help them to identify their needs and then they can inform clients about supports that are available to them when they are ready.
- The intimacy that comes with the injection experience was described by staff as one of the contributing factors that seems to encourage clients to open up and share their personal feelings and experiences in a way that they had not done previously. Staff are seeing clients' talents, their personal interests, educational backgrounds and gaining an understanding of their family history.
- Staff also shared how they are starting to connect with clients who were initially guarded and those who did not stay at the site to hang out. Staff mentioned that many clients are now staying longer, are more relaxed now, and would like to discuss their future and changes that they would like to make to their drug use behaviours.

Increased feelings of self-worth, sense of hope, and feeling valued, cared for and loved

- Several clients shared that staff and stakeholders are caring, kind and compassionate and that they make them feel valued, cared for as individuals, and that their lives have meaning. Clients described feelings of being loved as a result of the trusting relationships that they have formed with staff at the site. Some clients described how they had never been treated with the kindness as they have been at TOPS. Some clients described changes that they are seeing among their peers, including learning how to interact better with others, smiling more, etc.
- Staff described that they are witnessing clients experience an increased sense of

> *"Someone being kind to you, that is the biggest thing you can have in a place like this [TOPS]. A lot of people already feel down, so having a person smile at you makes a hell of a difference."*
>
> *[Data Source: Client Interview]*

self-worth and increased sense of hope for their lives. One staff member called the site a "safe haven" for clients where they can start to recognize their self-worth and recognize that they are valued. Staff engage in conversations with clients to help them rethink their internal thought processes, so that they avoid labelling themselves as a 'junkie'.

> *"It's [TOPS] saving lives, validating worth, it's an opportunity to challenge stigma. People who come are hard on themselves. People say "I do not care about overdosing; I do not care about dying". That internal worthlessness, no hope, and this site is changing that, you are worth it and there is hope. You may not feel it but we do. But you got to think why are people coming, if they think they are worth nothing, because deep down somewhere they want help."*
>
> *[Data Source: Staff Interview]*

- Clients described how the staff are positive and use humour to create a supportive environment, which helps to inspire clients to smile and be happy. A few clients described how the site is one of the only services that they will go to because they feel valued and respected.
- Many clients expressed their sincere appreciation for the site and the ongoing support from staff and stakeholders for caring about them. Some have even showed their appreciation to staff in the form of gifts including artwork that they have created. These clients felt it was important to give back to the site and to thank the staff for the positive influences on their lives. A few clients also expressed their desire to contribute to the site through volunteering their time as way of giving back to show their appreciation for the services.
- Stakeholders described the culture of the site as being a key determining factor to its' success. Many described that the Harm Reduction Workers who are RHAC employees have been able to transfer the culture of RHAC into the site to create an environment that shows that clients are cared for in many ways, including through physical and verbal signs of affection (i.e. hugs, telling them they are loved and cared for).

Increased sense of community and feelings of belonging

- Some clients described how the site provides a sense of community for them and a place in which they feel that they belong. Some clients identified that they never thought that they would use a place like this, yet it has become a place where they look forward to coming to and some described that the staff are like family to them.

> *"I feel that I belong somewhere. I feel like everybody has the same problem, so if I say something people will understand. I do not feel like an outcast. I walk in here and it's a family. For once in my life, I feel like I belong."*
>
> *[Data Source: Client Survey]*

- Staff and stakeholders create a comfortable environment where they can tell jokes, laugh together, yet also be supportive during more challenging times when clients may be having a bad day.
- Several clients, staff and stakeholders described how there is already a strong sense of community that exists among the population of PWUD, which is evident by individuals sharing their belongings with others in need and watching out for each other in public. The strong sense of community that exists at RHAC prior to the establishment of the site was also noted as a contributing factor to create a strong sense of community within TOPS.

Reconnecting with Indigenous roots

- Both staff and stakeholders indicated that they are seeing an increasing number of clients identifying as Indigenous access the site.
- Many staff and stakeholders mentioned that the contributions of the stakeholder from SOHAC are helping to allow clients identifying as Indigenous reconnect with their Indigenous roots (e.g. sharing their family names and clan names, engaging in traditional practices, such as attending sweats, getting kits, and smudging).
- One stakeholder described that these experiences have been overwhelming for some because many have been disconnected from their Indigenous cultural practices as a result of their addiction. One Indigenous client was crying with overwhelming emotion when he was informed that he could smudge at the site with the stakeholder because he had been told by others in his life that he could not use the Indigenous medicines if he was using drugs. Some stakeholders also described how this experience was expressed by other clients who have avoided their organization for various services previously because they are not sober.

> *"The Indigenous clientele, within the community there is a great reluctance to come forward. But when you have a person from the Indigenous community in the Aftercare Room, they get the opportunity to get healing and reconnecting with their Indigenous roots, to help make those positive change. People start to attend sweats, and they were unwilling to do that before."*
>
> *[Data Source: Staff Interview]*

Enhanced Peer interactions

Several clients described peer interactions that they have had at the site that are having a positive influence on their lives and the lives of their peers in the following 6 ways: (1) providing peer-to-peer assisted injections, (2) encouraging safer drug use practices, (3) monitoring for signs of overdose, (4) reinforcing rules at the site, (5) promoting use of the site, and (6) building friendships.

- **Providing peer-to-peer assisted injections:** Clients, staff and stakeholders highlighted the benefits of allowing peer-to-peer assisted injections at the site. Some staff described how some clients can only inject in the jugular due to bad veins in other areas of their bodies. In these situations, clients rely on either a friend that has accompanied them to the site or another peer at the site who is willing to provide a jugular injection. Other clients provide support to their peers by helping them to find veins and will provide the injection for them if they are experiencing any difficulties. Staff and stakeholders noted that by allowing peer-to-peer assisted injections at the site, it can prevent further damage to individuals' veins and also can provide a teaching moment for staff to offer tips for safe injections.

> *"The peer-to-peer injection really helps a lot of people. . .. I know that originally that [peer to peer injections] wasn't allowed, but to have that has really helped because a lot of people can't hit themselves or angles that they can't see. The clients teach each other."*
>
> *[Data Source: Staff Interview]*

- **Encouraging safer drug use practices:** Clients, staff and stakeholders described several ways in which peers are encouraging safe drug use practices among each other. Many clients are taking clean gear to others outside of the site. Some clients promote others to use alcohol swabs before consuming their drugs and use cookers to heat their drugs. They are holding each other accountable to use drugs in safer ways. Some clients are also influencing other peers' decisions to consume orally rather than through injection.
- **Monitoring signs of overdose:** Staff and stakeholders described they are observing how peers monitoring each other for signs of overdose. For example, they check-in with each other for potential signs of overdose if someone looks like they are 'on the nod' while sitting in the aftercare room. During client surveys and interviews, some clients also shared the benefits of having their own Naloxone kits on them at all times and the training that they have received at the site to know how to use it. Many shared stories of losing friends and loved ones to overdoses or experiencing overdoses themselves.

> *"Peers will kind of check in with people who are in the Aftercare Room and make sure they are okay. If they are on the nod then they check in and say "hey, you doing okay" which is great. There are conversations about people looking out for one another on the streets. So that's nice to hear."*
>
> *[Data Source: Stakeholder Interview]*

- **Reinforcing rules at the site:** Clients, staff and stakeholders also described the peer-to-peer monitoring and reinforcement of the site rules that has naturally occurred. Clients speak up and raise concerns to other peers when there are peers that are not respectful of the site rules and the code of conduct. Many clients expressed concerns that they have that the site could be in jeopardy because of the behaviours of a few peers that are not following the rules at the site.
- **Promoting use of the site:** Several clients mentioned that they routinely telling others about the site if they are unaware that it exists, and remind other peers they see in the community to use the site. Furthermore, some clients described how they discourage others to use drugs in public spaces due to the risks involved.
- **Building friendships and mutual support:** Staff and stakeholders described how some clients are building friendships and providing mutual support to one another. They are witnessing acts of kindness and compassion between the interactions of the clients at the site. These situations illustrate a strong sense of community among people who use drugs.

> *"The caring between our clients, the mutual support. I've seen people dissuade people from using a drug, people say 'dude you do not want to do this let's go have a coffee'. We are seeing compassionate people and that's not what anybody expected."*
>
> *[Data Source: Staff Interview]*

Unintended Negative Impacts on Clients

There were a few unintended negative impacts on clients that were identified by clients, staff and stakeholders. Three themes emerged relating to (1) feeling intimidated and ashamed, (2) concerned about confidentiality, and (3) concerns about the future of the site (refer to **Table 3** in Appendix M for relevant key quotes).

Feeling intimidated and ashamed

- **Feeling intimidated using the site**
  While the majority of clients reported feeling safe and comfortable at the site, there were a few clients who mentioned that they feel a little intimidated using at the site because they feel like they are being watched by staff and peers. This was also echoed by a few stakeholders who were aware that a few clients feel intimidated.
- **Feeling ashamed and comfortable that stakeholders see clients using the site**
  A few stakeholders noted that some clients feel uncomfortable or ashamed using the site because they know the stakeholder from their interactions at other organizations or through personal connections (e.g. childhood friend, family member of their friend, etc.). In these situations, staff and stakeholders described how they let the client take the lead. For example, if the client identifies to staff that they know a stakeholder at the site and they do not feel comfortable using the site with them there, the staff member will speak to the stakeholder who will leave while the client is using the site.

Concerned about confidentiality and privacy

- **Feeling concerned about information being shared with external service providers**
  A few stakeholders also described how some clients have expressed concerns that staff or stakeholders may talk to other service providers (e.g. Children's Aid Society) regarding their use at the site. In these situations, stakeholders reassured clients they maintain confidentiality of their client relationship.
- **Feeling concerned about police presence at the site**
  Clients, staff and stakeholders described how clients feel concerned about police presence at the site and how this impacts their comfort level in accessing the site.

Concerns about the future of the site

- **Feeling concerned about the potential closure of the site**
  The uncertainty surrounding the potential closure of the site was also frequently noted by clients during the data collection timeframe. Staff and stakeholders also mentioned that they were aware that clients were concerned and stressed that they site might close. They described how some clients have started volunteering at the site to help clean up outside of the site of a desire to address some of the concerns regarding needle waste and garbage in the north entrance.

Impacts on Staff

Positive Impacts on Staff

Many staff mentioned positive impacts that their involvement at the site has had on them. Three key themes that emerged related to impacts on staff including: (1) increased job satisfaction, (2) increased knowledge and skills, and (3) application of harm reduction philosophy into practice. The following provides a brief description of these themes and sub-themes (refer to **Table 4** in Appendix M for relevant key quotes).

Increased Job Satisfaction

- **Building relationships**
  Several staff identified a high level of job satisfaction given their role at the site. Many described how it is very rewarding to build trusting relationships with clients and solid working relationships with colleagues as they are always looking out for each other and helping one another.
- **Feelings of gratitude**
  Many staff expressed a sense of gratitude and appreciation for their involvement in TOPS.
- **Feeling inspired from the clients' commitment to survival**
  Many staff also expressed feeling inspired from the clients' commitment to survival and seeing clients in an environment where they feel comfortable.

Increased Knowledge and Skills

- **Increased knowledge of drug use practices**
  Staff identified that their knowledge of drug use practices has increased as a result of the information shared by clients.
- **Increased understanding and compassion level for client experiences**
  Many staff described an increased understanding and deeper compassion for client experiences (e.g. effects of being pill sick, various forms of trauma).

> *"We have all been given a different hand, but we are all a few decisions away from being where they are. They didn't sign up for this, just being able to hear them and be kind and show them that we want you to be alive."*
>
> *[Data Source: Staff Interview]*

- **Increased comfort level in engaging in conversations with PWUD**
  Some staff indicated that they have an increased comfort level in engaging in conversations with people who use drugs at the site and in other contexts.
- **Increased understanding of institutional barriers**
  Some staff expressed an increased understanding of existing institutional barriers and practices that may not be meeting client's needs (e.g. hospitals, use of restraints on clients while EMS is transporting to hospital).

Application of Harm Reduction Philosophy into Practice

- **Provides opportunities to put beliefs and values of harm reduction into practice**
  Many staff reported that working at the site provides the opportunity to put beliefs and values of harm reduction and advocacy for PWUD into practice.

Negative Impacts on Staff

While all staff described positive impacts from their involvement, some staff noted unintended negative impacts that the site has had on their roles and on a personal level. There were two key themes related to negative impacts on staff, including: (1) increased stress levels and impacts on physical well-being, (2) concerns regarding meeting client needs. The following provides a brief description of these themes and sub-themes (refer to **Table 4** in Appendix M for key quotes).

Increased Stress Levels and Impacts on Physical Well-being

- **Feeling physically exhausted and stressed due to under-resourcing of staff**
  Some staff identified concerns related to being under-resourced with their staffing, and as a result felt physically exhausted, However, many also noted that even though it is exhausting, it is an extremely rewarding experience to work in the site each day. Some staff also experienced stress due to the effects of taking on clients' stories of trauma feeling concerned and worrying about clients throughout the week.
- **Overwhelmed with extensive media coverage and requests for info and tours of the site**
  Staff of the site did not anticipate the extensive media coverage and the interests from other jurisdictions in wanting to learn about the site. Responding to these inquiries and providing tours of the site was described as overwhelming, stressful and has added a considerable amount of demands on staff time.
- **Feeling stressed about the uncertainty regarding the continuity of the site**
  Some staff also noted stress and anxiety as a result of the uncertainty regarding the continuity of the site and the opinions expressed in the media, and by politicians and the government.

Concerns Regarding Meeting Client Needs

- **Concerned about client well-being and availability of supports to meet their needs**
  Several staff also expressed concerns regarding access to mental health, addictions and treatment services, such as wait times, that needs significant improvement in order to effectively serve the clients that are accessing TOPS.
- **Limited availability to perform other tasks to support clients**
  A few staff also expressed concerns that with the amount of hours that they have worked at the site that their time has been limited in being able to support clients in their regular role. They noted that they feel that they may not be supporting clients to the extent that they need for those who wish to make long-term changes.

Impacts on Stakeholders and their Organizations

Many stakeholders expressed high levels of satisfaction with their involvement at the site. Several mentioned that they are pleased that their organization was willing to support TOPS and form this partnership working towards the same goals. Several mentioned positive impacts that their involvement at the site has had on their role at TOPS and in their jobs at their organization. Many of these impacts on stakeholders were also similar to impacts identified by staff at the site as well. The findings are presented in the following two sections: positive impacts on stakeholder roles, and positive impacts on stakeholder organizations.

Positive Impacts on Stakeholder Roles

The impacts on stakeholder roles relate to three key themes: (1) increased knowledge, (2) enhanced skills, and (3) building relationships and connections (see **Table 5** in Appendix M for key quotes).

Increased Knowledge

- **Increased knowledge of client experiences**
  Many stakeholders described an increased knowledge of clients' day-to-day experiences, street knowledge and drug use practices through observational learning and conversations with clients (e.g. prevalence of jugular injections).
- **Increased knowledge of harm reduction philosophy and approaches**
  Many stakeholders also noted an increased knowledge of harm reduction philosophy and approaches through their conversations with TOPS staff and their experiences of providing support in the aftercare room at the site.
- **Increased knowledge of services and supports at other organizations**
  Some stakeholders described their increased knowledge of services and supports that are available at other organizations to support clients (e.g. housing supports, Indigenous supports).
- **Increased understanding of the Indigenous community, culture and history**
  A few stakeholders noted an increased understanding of the Indigenous community, culture and history (e.g. overrepresentation of homelessness, experiences of accessing health and social services). They referred to the value of having the Indigenous supports available at the site for clients and also has an added benefit of increasing staff and stakeholder awareness levels.

Enhanced Skills

- **Enhanced skills in active listening**
  A few stakeholders described enhancing skills in active listening in order to understand clients' needs and work with clients in the pre-contemplative state (e.g. learning how to support clients curious about making changes).

Building Relationships and Connections

- **Increased ability to build relationships with clients**
  Many stakeholders noted an increased ability to connect with new clients that did not previously access services through their organization and reconnect with existing clients in this new setting.

Positive Impacts on Stakeholder Organizations

Several stakeholders described how their role at the site has had an impact in different ways on their organization. The impacts on stakeholder organizations relate to the following four themes: (1) increased knowledge, (2) increased reach, (3) enhanced service delivery strategies, and (4) strengthened partnerships (see **Table 5** in Appendix M for key quotes):

Increased Knowledge

- **Increased knowledge of drug use practices and harm reduction practices**
  Many stakeholders described that there is an increased knowledge of drug practices and harm reduction practices among their colleagues in their organizations since their involvement in TOPS. Several described how they have been sharing their lessons learned from working at the site and transferring this knowledge to their fellow colleagues.

Increased Reach

- **Expanded the organizations' ability to reach clients from the population of PWUD**
  Some stakeholders mentioned that their involvement at TOPS has expanded their organizations' ability to reach clients from the population of PWUD given that they now have new clients through their referrals at TOPS.

Enhanced Service Delivery

- **Created new approaches or services at their organizations to meet clients' needs**
  A few stakeholders described new approaches or services that have been initiated at their organizations since TOPS has opened. For example, a Suboxone program is being developed and tailored for the Indigenous clients at SOAHAC.

Strengthened Partnerships

- **Strengthened existing relationships between RHAC and stakeholder organizations**
  A few stakeholders indicated that their organizations' involvement to date has strengthened the existing relationship that they had with RHAC in order to facilitate further collaboration in harm reduction services.

Negative Impacts on Stakeholders

There are a few unintended negative impacts identified by some stakeholders including: (1) level of organizational involvement, (2) managing workload, and (3) stakeholder well-being (see **Table 5** in Appendix M for key quotes):

Level of Organizational Involvement

- **Concerns regarding their organization's level of involvement and role in TOPS**
  A few stakeholders expressed concerns regarding their organization's level of involvement in the site to date. One stakeholder mentioned that their organization had to pull out support after a staff member left and they have not been able to have another staff member work at the site since due to limited staff resources. Another stakeholder stated that they had wished that their organization would increase the number of staff to support TOPS and address coverage issues at their organization when staff are working at TOPS. It was also mentioned that there were concerns regarding the organizations' understanding of the stakeholder's role at TOPS, and it was suggested that it would be beneficial to develop strategies to increase the organizations' understanding.

Managing Workload

- **Challenges managing caseload and other organizational priorities**
  Managing caseloads and other organizational priorities at the stakeholder organizations was noted as a challenge by two stakeholders.

Stakeholder Well-Being

- **Challenging to hear client stories of violence and trauma**
  A few stakeholders expressed concerns regarding hearing stories of violence shared by clients. It explained how some clients share stories of violence acts that they have engaged in with others, while other clients share traumatic stories of violence that they have experienced themselves.

Impacts on the Community

Perceived Benefits for the Community

Perceived benefits for the community were identified by clients, staff, stakeholders, and respondents on the Community Resident and Business Owners Survey (NOTE: Due to the low response rate [2.6% response rate (15/570)], the quantitative findings could not be analyzed. Only qualitative comments from the respondents (n=12) have been included). There were five key themes that emerged: (1) public order, (2) health outcomes, (3) cost-effectiveness, (4) community awareness of drug use, and (5) community acceptance and support (see **Table 6** in Appendix M for key quotes). It is recognized that these noted benefits were described as potential or perceived based on self-reported feedback.

Public Order

Many client respondents described how TOPS provides a safe, secure and clean environment for them to use drugs which minimizes public drug use in washrooms, alleys and parks.

- **Less public drug use**
  Among client survey respondents who reported injecting in public spaces in the past (n=92), 76% (n=70) reported that they are injecting less in public spaces since TOPS has opened (see **Figure 27** in Appendix K).

  From the Client Survey and interviews with clients, several also reported less public drug use now that the site exists, including some that indicated that they are not injecting at all in public spaces now. Several clients mentioned that they used to inject in public bathrooms or in public spaces, but now they will only use the site now rather than public spaces. Furthermore, some clients also shared that they are grateful to have the site as they often feared members of the public including children seeing them using in public spaces.

> *"I feel more safe coming here than injecting in bathrooms or alley ways because anyone can take your drugs. There is no safety and no protection in public places. This place has been life changing for me as I used to inject in alley ways and the bathroom at [a restaurant]."*
>
> *[Data Source: Client Survey]*

- **Reduced discarded gear in public spaces**
  Among the client survey respondents who reported disposing of their gear in public spaces in the past (n=60), 53% (n=32) reported that they are now disposing of their gear less in public spaces since they have been using TOPS (see **Figure 28** in Appendix K). Discarding gear in public spaces was explained to clients as littering in public and not to be confused with properly disposing used gear in needle recovery bins.

  In the interviews, clients shared that they are seeing positive impacts on the behaviour of other people who use drugs. Some noted that they are witnessing less public drug use among their peers and less discarded needles in public spaces.

> *"If people do not shun this [TOPS], it will be beneficial. There will be less needles. There will be more safety for the drug users. All of us working together is beneficial. It is beneficial for both the community and the users. "*
>
> *[Data Source – Client Survey]*

Health Outcomes

- **TOPS is savings lives and delivering services in a compassionate way**
  Feedback from a few respondents on the Community Resident and Business Owners Survey identified that the site is saving lives and delivering services in a compassionate manner.

Cost-effectiveness

- **Highlighting the site as a cost-effective strategy**
  Some staff and stakeholders mentioned that the site is cost effective given that the site is able to respond to overdoses which reduces the number of calls needed for EMS. The site also promotes safer injection practices which has the potential to reduce illnesses (e.g. HIV, Hepatitis C, endocarditis, etc.) requiring significant health care costs. However, there was also a differing perspective by a few respondents on the Community Resident and Business Owners Survey that the site is a waste of resources. It is important to recognize that the findings suggest that perceptions of staff and stakeholders who are involved directly in the day-to-day operations of the site vary from the perceptions among residents and business owners.

Community Awareness Around Drug Use

- **Increased awareness about substance use, addictions and the impacts of overdoses**
  Some staff and stakeholders described how the site has created more awareness about substance use and addictions and its impacts on the community. One stakeholder identified how one overdose death has a huge ripple effect on an entire community, because it affects clients, their families and the broader community. However, there are some concerns expressed by staff that there is a misrepresentation of the PWUD in the media because of the stigma that is associated with substance use. Substance use is often portrayed in the media as a moral choice reflecting a failure of the individual and it not considered a mental health issue.

Community Acceptance and Support

- **Increased support and acceptance for TOPS and SCFs**
  Staff also mentioned that the site has also helped to shift the attitudes of some members of the community to become more supportive of the site and more aware of the positive

impacts that the site can have. Yet, some staff also identified concerns that increasing work is needed to continue to shift the political and societal attitudes to reduce the stigma towards PWUD, and increase acceptance for supervised consumption facilities. Staff suggested a needs to raise awareness among the public regarding the experiences of PWUD, including what it is like to experience withdrawal/pill sick, a need to use drugs to feel normal versus getting high and the impacts of mental health on drug use.

Perceived Concerns for the Community

There were a few perceived concerns raised regarding potential negative impacts on the community with an emphasis on the immediate building and surrounding neighbourhood of TOPS as noted by clients, staff, stakeholders, and respondents on the Community Resident and Business Owners Survey (NOTE: Due to the low response rate [2.6% response rate (15/570)], the quantitative findings could not be analyzed. Only qualitative comments from the respondents (n=12) have been included). Two key themes emerged: (1) public order, and (2) community awareness around drug use (See **Table 6** in Appendix M for key quotes). It is recognized that these noted benefits were described as potential or perceived based on self-reported feedback.

Public Order

- **Increased public disorder including loitering, garbage and drug selling/purchasing around the site**

Feedback from the Community Resident and Business Owners Survey, revealed some perceived concerns expressed by respondents. These concerns included: increased public disorder, such as discarded drug equipment, increased loitering and increased drug transactions.

Staff also identified a few unintended negative impacts that the site has had on the building where the site is located. Staff mentioned that they were aware of research on Supervised Consumption Facilities and that other studies had reported that loitering, garbage and drug selling/purchasing did not increase in the vicinity of the sites. As a result, they were surprised to find that TOPS experienced an increase in loitering, garbage and drug selling/purchasing in the alley and north entrance of the site. It is perceived that a few individuals contributed to the increase based on staff feedback during interviews.

Many clients also expressed concerns about these behaviours and were concerned that the actions of a few people may put the site in jeopardy of closing.

Strategies have been put in place to address these concerns, including a full-time security guard (i.e. plain clothes) to conduct daily sweeps of the area to clean up needles and garbage and move people along to prevent loitering. The staff have also been able to establish a solid relationship with the police to increase

police foot patrol presence around the site and to address drug use/dealing around the site without arresting.

- **Negative consequences on local businesses and residents due to criminal activity**
  Respondents on the Community Resident and Business Owners Survey expressed some perceived concerns that the site has negatively impact the neighbourhood as a result of criminal activities such as vandalism.

  Staff also identified that the landlord of the building where the site is located has experienced difficulty renting units in the building since the site has opened. Furthermore, staff identified that there is a perception in the community that businesses in the local vicinity are suffering.

  A few staff also expressed concerned that some drug dealers have moved into the building. It is recognized that there are many contextual factors in the surrounding neighbourhood at the site make it difficult to attribute causality to the site with the perceived concerns. The site was described by staff as being the scapegoat for many long-term issues in the neighbourhood.

Community Awareness Around Drug Use

- **Promoting drug use**
  Feedback from the Community Resident and Business Owners Survey noted a perceived concern that the site promotes drug use as others see people injecting more in public spaces and witness more drug transactions in the neighbourhood.

Discussion

The Temporary Overdose Prevention Site in London Ontario provides an essential service to reduce the harms associated with drug use including opioid-related overdoses. The evaluation findings reveal that the site creates a safe, clean, and secure space for members of our community who use drugs. Based on the consolidated findings from the evaluation, a program theory has been proposed to identify key factors needed to reach intended outcomes of TOPS (see **Figure 10**).

Figure 10: Proposed Program Theory for TOPS

Through the caring, compassionate and stigma-free service delivery, TOPS has created a welcoming and non-judgmental space that has allowed people to feel accepted. Building trusting relationships between clients, staff and stakeholders was identified as a critical factor that enables clients to feel safe, secure and valued. The evaluation findings revealed the significant value of building relationships and creating a culture of trust at the site. Staff, stakeholders and clients have opportunities to engage in deeper conversations about safer drug use practices and clients' health needs in order to make connections with other health and social services.

The findings demonstrate direct progress being made to reduce opioid-related deaths by responding to overdoses. Furthermore, activities at the site also promote safer drug use practices and increase linkages to health and social services for clients. These outcomes are reducing potential harms for clients and promoting changes in their behaviours.

There was also evidence of changes to some public health order outcomes. The existence of the site is leading to less public drug use and less disposal of gear in public spaces. However, findings also indicated that other public order outcomes such as loitering, garbage, and drug selling/purchasing may have increased in the vicinity of the site.

These factors identified in the proposed program theory are discussed in more detail in the following sections in relation to findings gathered regarding service delivery and impacts. Future considerations for service delivery enhancements and monitoring outcomes are discussed.

Service Delivery

Client Satisfaction

A high level of client satisfaction was reported by client survey respondents who rated the quality of service and care they received as good or excellent. Many described not feeling stigmatized or judged at the site, which is a significant shift from the negative interactions they described within the healthcare, social services, and law enforcement systems. Staff meet people where they are at and treat them with dignity and respect, without creating any fear of judgement or shame. The caring, compassion, and kindness demonstrated through the service delivery at TOPS has made clients feel loved and valued as human beings. This has increased their sense of self-worth and hope.

Service Delivery Requirements

The findings demonstrate that the services at TOPS are meeting the MOHLTC OPS requirements. They are also offering additional services including medical supports and wrap-around support to provide linkages to services such as mental health, addictions, drug treatment, housing, HIV/Hepatitis C testing and treatment services. The site is directly connected to the Counterpoint Needle Syringe Program to further support clients in obtaining access to harm reduction supplies. The site also provides Indigenous supports as a key strategy in providing culturally appropriate care to reconnect individuals with their Indigenous roots.

While the site had over 7000 visits during the first 6 months, there may be more promotional efforts needed to reach people who use drugs who are not previously connected with services provided at RHAC and increase awareness of all services offered including intranasal and oral drug consumption and the availability and use of fentanyl test strips.

Given the evaluation findings, there is significant value in permitting peer-to-peer injections at the site. It was reported that many clients experience challenges with damaged veins and need help injecting from others. If peer-to-peer injections were not permitted, there is a risk that a proportion of the PWUD would not use the site. Furthermore, a few respondents suggested that it would be beneficial to have medical staff (i.e. nurses, paramedic) assist with setting up injections for clients that experience challenges with damaged veins. Regulations regarding assisted injections will be an important area to consider with the implementation of future SCFs as they have also been noted as areas of concern by PWUD in other sites were assisted injections were not permitted (Lange & Bach-Mortensen, 2019).

Hours of Operation and Wait Time

While many clients were grateful for the existence of the site, the hours of operation were reported as a key area for improvement. Both early and later hours were recommended as drug use occurs at all hours of the day. This was noted as a particular challenge for many clients who use local shelters and are asked to leave the shelter early in the morning. Similarly, when clients arrive at the site after 4 pm, they are faced with the dilemma of finding a safe place to use drugs. Furthermore, about 40% of clients reported that the wait time to use the site sometimes, often or always gets in their way of using the site. The hours of operation and wait time have been reported in the literature as key barriers among PWID to use a SCF (Petrar et al., 2007; Lange & Bach-Mortensen, 2019). It will be important to consider strategies to advocate for increased hours of operation and implement additional strategies to reduce wait times at the site.

Space Design

The open layout of the Injection and Aftercare Rooms were noted by many respondents as beneficial as it encourages conversations and provides a sense of comradery. Limited space was a frequently reported challenge as there are only four injection spaces, limited space to accommodate peer-to-peer assisted injections and challenges in providing counselling and medical services. Several considerations for space planning are provided for future supervised consumption facilities. Space planning is a critical component to the flow and function of the site. There are important considerations with the layout of the space that impact how clients use the various rooms of the site and also how the space functions to ensure client and staff safety.

Location

The current location of the site was reported to work well for many clients because it is centrally-located, convenient, close to a bus route and close to where clients stay or purchase their drugs. Distance to travel to an SCF has been as a key barrier noted in the literature among PWID (Petrar et al., 2007). However, the findings from this evaluation reveal that the distance to travel was not a barrier for the

majority of clients. This may be due to the fact that almost all clients had previously accessed the Counterpoint Needle Syringe Program located at RHAC. It is also recognized that the location could be a real or perceived barrier for PWUD that are not currently using the site.

Being directly located within RHAC and next to the Counterpoint Needle Syringe Program helped to transfer the supportive existing culture of their organizations to the site. With plans underway for two permanent Supervised Consumptions Facilities in Middlesex-London, it will be important for the leaders to review the recommendations provided from respondents related to proximity, location, operational and space planning. Given that some participants recommended multiple sites around the city and the majority of clients reported a willingness to use a mobile van, it is suggested that these considerations be reviewed when determining future service provision. Furthermore, the literature on cost-effectiveness studies suggests multiple, smaller SCF in communities where the population of people who use drugs is more dispersed than in locations such as Vancouver (Enns et al., 2016).

Operation

Operational polices were also noted as critical to support the smooth functioning of the site. The Code of Conduct was recognized as an important feature to ensure client and staff safety. The majority of clients reported that the rules and regulations rarely or never get in their way of using the site. However, there were some that expressed concerns regarding rules such as the "no passing rule" which restricts drug sharing. Similar concerns regarding restrictions and regulations were expressed by PWUD in other studies on SCFs (Lange & Bach-Mortensen, 2019). There were also several other measures in place including the use of walkie-talkies, areas with restricted client access, and the provision of Crisis Prevention Training for staff. However, staff identified challenges with specific policies such as medical directives, that need further clarity and consistent application. It is recognized that staff and stakeholders working in the site come with their own organizational policies, cultures, and practices. This is recognized as a success; however, it is also a challenge to bring diverse agencies together. Attention to these organizational elements will serve to enhance the overall culture at the site, as ongoing learning is gained through service delivery.

Data Collection

Several changes were implemented to the data collection process during the first few months of operation including where the data was collected and in providing clients with the rationale for collecting the data. However, some challenges remain including the tracking of referrals, technological challenges with data entry, and enhancements in nursing documentation.

Staffing

During the first 6 months of operation, some changes were implemented to improve service delivery in order to better meet client and community needs. There were staffing changes such as the addition of the runner role designated for bringing clients to and from reception/washrooms, and the refinement of the security guard role. The security guard was initially at the site when it first opened, but due to negative client perceptions of the presence of security at the site, the security guard was removed. However, during the summer of 2018, there was an identified need to reinstate the role of the security guard to provide support both inside and outside of the site in response to the increased garbage, loitering and drug selling/purchasing taking place in the north entrance of the site. The addition of the security guard role was described as very beneficial to help address client, staff and community concern.

Both staff and stakeholders are very passionate about their roles in the site and this is evident to clients. TOPS leadership and staff work tirelessly to advocate for this site and have a deep dedication to providing the services. The majority of staff and stakeholders described positive impacts that the site has had on themselves, including increased knowledge of clients' experiences, drug use practices, harm reduction practices, and awareness of community health and social services. The increased knowledge

and awareness in these areas were stated as being beneficial in improving their ability to support clients and engage in meaningful conversations.

Many staff and stakeholders also described having a deeper compassion level for clients with their increased understanding of the trauma that many clients have experienced over the course of their lives and the daily survival that they face in feeling pill sick. Both staff and stakeholders also noted an increased understanding of the institutional barriers that clients face through clients' sharing stories of stigma and discrimination that they have experienced through health, social and law enforcement systems. This increased level of awareness has profoundly impact their approaches to delivering a service that is low-barrier, stigma-free, inclusive and non-judgmental. There are many important lessons from the experiences of staff and stakeholders regarding the current model of service delivery that may be transferrable to other sectors providing support to PWUD.

While many staff and stakeholders expressed sincere gratitude and appreciation for their involvement at the site, staff resourcing was identified as a challenge. Many staff reported feeling physically exhausted due to under resourcing of staff, overwhelmed with the extensive media coverage, requests for tours of the site, and feeling stressed regarding the uncertainty of the site. Some stakeholders reported concerns regarding their organization's level of involvement in TOPS, face challenges managing caseloads for their roles back at their organization and recognized that there may be a limited understanding about their role at TOPS among their organizations. These negative unintended consequences identify some key areas for improvement that can be discussed among staff, stakeholders and their respective organizations.

Future Enhancements to Service Delivery

Several suggestions to enhance service delivery were provided, including wound care services, primary health care services, access to rehabilitation and treatment services and further education on harm reduction. Clients also requested the addition of recreational activities, smoking services, refreshments and services to meet their basis needs (i.e. food, clothing, hygiene). Given the wide range of enhancement services suggested, there is value in considering the site to be the access point to services for this vulnerable, marginalized population.

The feedback gathered on service delivery will help inform further changes to service delivery at TOPS and will be useful for planning of future supervised consumption facilities. Increasing hours of operation, increasing the amount of space, improving privacy for services, ensuring adequate staffing, enhancing operational policies, and data collection procedures will be important considerations for future site planning.

Impacts

Creating a safe space

The evaluation findings revealed that the site offers a safe, clean, and secure space for people who use drugs in our community. The existence of the space is recognized as a main outcome in itself. Yet, the evaluation findings highlight that this site is more than a place to use drugs safely under supervision, as it has been referred to as a "safe haven" where clients feel accepted and less stressed without the risk of the public seeing them and getting caught by police or security. A place free from the stigmatization and discrimination routinely experienced in society by many people who use drugs. A place where clients are recognizing their own self-worth, feeling valued and having a sense of hope for the first time in a long-time.

Other qualitative studies have reported on similar findings regarding users' perceptions of the SCFs. Users perceive SCFs to provide a safe environment that is free from violence and stigma (McNeil & Small, 2014).

While safer injection practices were also reported in these studies to influence health outcomes, the users reported that the primary benefit to the site is the creation of a safe environment (McNeil & Small, 2014). Furthermore, the findings of a recent systematic review of stakeholder perspectives of SCFs revealed that one of the most commonly reported benefits is the creation of a safe space for PWUD that reduces the risks of being caught in public spaces (Lange & Bach-Mortensen, 2019). These findings echo the experiences of TOPS clients given that the safe and secure space at the site enables them to feel less stressed, less stigmatized and more accepted.

Building Trusting Relationships

Building trusting relationships between clients, staff and stakeholders was identified as a critical factor that enables clients to feel safe, secure and valued. One of the key facilitators behind the identified impacts are the staff at the site. The compassion, genuine care, and love that staff have for clients has led to the formation of trusting relationships with some of the most vulnerable people in our community; people who are often overlooked, marginalized, and isolated from the health and social service system. Common strategies reported to facilitate relationship building with clients included surrounding them with familiar faces, using a conversational approach, acknowledging clients as experts, and socializing with clients.

The value of forming trusting relationships and the power of human connections cannot be underestimated. Findings indicated that many clients have formed friendships and are feeling valued and accepted as a result of their interactions with staff. The trusting relationships between clients, staff and stakeholders can lead to improved drug injection practices and a desire to seek further support from other health and social services. While the community of PWUD was described as close-knit and strong, the 'intimacy' of the site is providing a place for clients to feel a sense of belonging and community with others outside of the PWUD community. Staff and stakeholders are now part of their community at the site. Clients value having someone trusted to talk to at the site.

The findings also reveal the positive benefits that are occurring with peer-to-peer relationships at the site. Peers are providing peer-to-peer injections, encouraging safer drug use practices among one another and monitoring each other for signs of overdose. Furthermore, peers were noted as providing a supportive role in reinforcing the rules of the site. The site has become a space that many clients value and do not want others to be disrespectful of the site rules which could put the site in jeopardy.

Harm Reduction Outcomes

Early findings show progress towards meeting the intended outcomes established for the site. In the first 6 months of operation, the site has addressed the immediate need of responding to opioid-related overdoses. During the evaluation study period (Feb 12-Aug 31, 2018), all overdoses (19 treated with oxygen; 7 treated with naloxone) were reversed by staff and no deaths occurred. After one year of operation, TOPS has reversed 83 overdoses and still no deaths (MLHU, 2019c). Similar findings of mitigating overdose-related mortality have been reported elsewhere (Kennedy et al., 2017).

It appears that local efforts are making an impact on the opioid-related deaths in the Middlesex-London community (MLHU, 2019c). While data from the first quarter of 2018 reported an unprecedented 22 deaths due to opioid poisoning, data from the second and third quarters were substantially down with 12 reported deaths in the second quarter and 8 deaths in the third quarter (MLHU, 2019c). Findings indicated that almost none of the deaths in the second and third quarter revealed evidence of injection drug use, which suggests that other forms of drug use may have been used (MLHU, 2019c). Given that TOPS has been successful at reaching some PWUD, there may be a need to expand promotional efforts to increase awareness that the site can also be used for oral and intranasal drug consumption.

In addition to TOPS, there are a number of strategies by many stakeholders that have contributed to the reduction in opioid-related deaths, including naloxone distribution at pharmacies, outreach services,

harm reduction programs, and naloxone administration by first responders (MLHU, 2019c). London Police Services started equipping their officers with naloxone in June of 2018. Between June and the end of December of 2018, London Police Services reported that officers administered 96 doses of naloxone to 59 people experiencing an overdose and 57 of those individuals survived (MLHU, 2019c). Together the efforts by multiple community partners show evidence that opioid-related deaths are decreasing in our community. Given that there have been observed reductions in overdose-related ambulance services reported by a SCF in Australia (Salmon, vanBeek, Amin, Kaldor & Maher, 2010), ongoing monitoring of overdose-related service calls will help the Middlesex-London community further understand the impacts of the collective efforts during this opioid crisis.

Moreover, there has also been a reported reduction of more than 50% in new HIV diagnoses in the Middlesex-London community between 2016 and 2018 (MLHU, 2019). During this same time frame, the number of HIV cases reporting injection drug use as a risk factor has also decreased from 74% in 2016 to 52% of cases in 2018 (MLHU, 2019). Although these are promising trends, it important to note that no primary studies have directly assessed the impact of SCFs on HIV transmission (MacArthur et al., 2014). SCFs are viewed as an intervention that can complement other HIV/HCV prevention strategies as they are often accessed by individuals at increased risk for HIV/HCV infection.

In this evaluation, self-reported client data revealed that the majority of clients have learned strategies at the site to use drugs more safely. Findings from a recent systematic review of stakeholder perspectives of supervised injection facilities revealed that education on safer injection practices was a commonly reported benefit of the facilities (Lange & Bach-Mortensen, 2019). Furthermore, clients reported changes in their drug use behaviour including reusing their own gear less, sharing their own gear less with others, and feeling less rushed while using their drugs. Similar outcomes have also been consistently reported in the literature (Kennedy et al, 2017). Some clients also reported that the frequency of their drug use has decreased. It is important to continue monitoring these drug use behaviour outcomes.

Connection to Health and Social Services

While the evaluation findings do not report on the number of referrals, the majority of clients self-reported that staff have talked to or helped them connect with other health and social services. Respondents noted that the provision of wrap-around services was a critical factor in the success of the current service delivery model and also suggested more onsite services should be offered. Recent data reports that 186 clients at TOPS have been referred to addictions treatment, 144 clients to agencies providing housing support and 167 clients to additional healthcare services (MLHU, 2018). It appears that that at the root of increasing connections with health and social services is the building of trusting relationships between staff, stakeholders, and clients.

Public Order Outcomes

Evaluation findings also revealed that there was evidence of changes to some public health order outcomes. The existence of the site was described as a safe and secure place for PWUD which minimizes public drug use in public washrooms, alleys, and parks. Many clients reported less public drug use and less disposal of gear in public spaces. However, findings also indicated that other public order outcomes such as loitering, garbage, and drug selling/purchasing may have increased in the vicinity of the site. A few respondents on the Community Resident and Business Survey raised perceived concerns regarding negative impacts on local businesses and residents due to criminal activity in the area. It will be important in the future to establish routine monitoring of public order outcomes to have objective measures in place.

The staff have also strengthened their communication with police which has resulted in increased police foot patrol presence around the site. Facilitating ongoing dialogue between site leadership and surrounding businesses and neighbours living in close proximity of the site was reported as a key strategy

to continue in order to mitigate any negative impacts such as increased loitering and difficulty renting units in the residential building. Furthermore, there is a need for measuring and monitoring public order and crime-related outcomes in close proximity to the site. Given that other studies have reported improvements in public order outcomes such as public drug use and publicly discarded syringes and injection-related litter (Kennedy et al, 2017) and no changes (Kennedy et al., 2017) or a decrease in crime rates (Myer & Belisle, 2018), it will be important for these outcomes to be measured and monitored rather than relying solely on self-report data.

Future Evaluations

Ongoing monitoring of additional outcomes would be beneficial to describe the demographic characteristics of clients and demonstrate further impacts of the site. It recognized that there were limitations to the usage statistics that were reported on in the MOHLTC OPS Monthly Reporting Form (e.g. Ministry Reporting Form). It would be ideal to know how many clients are repeat clients, gather specific information regarding the total number of overdoses, number of referrals to health and social services organizations, client demographics (e.g. age, housing status, employment status, food security, etc.), in order to better understand who is using the site. Some of these indicators are currently being recorded and monitored regularly through the NEO database. However, only the Ministry Reporting form was used for the purposes of reporting on data for this evaluation. Self-reported information from evaluation participants described many clients as experiencing housing insecurity, unemployment and food insecurity, however, the evaluation did not collect demographic information from clients.

Future evaluations are needed to review the cost-effectiveness of the site as it was highlighted by staff and stakeholders as a cost-effective strategy, but described as a waste of tax payers' resources by some respondents on the Community Residents and Business Owners Survey. This evaluation did not explore measures of cost-effectiveness. However, this information may be valuable to inform the general public and useful to advocate for further funding.

While the surveys and interviews with clients in this evaluation helped to gather clients' stories of using the site and gain insight into changes that the site is having on their day-to-day lives, more in-depth experiences from clients will be helpful to explore the impacts after the site has been operating for a longer duration. Furthermore, some clients expressed interest in volunteering at the site and being involved in participating in future evaluations. A participatory evaluation approach would help to capitalize on their valuable experiences and empower them to share the impacts in a way that might help reduce stigma and discrimination towards PWUD.

Evaluation strengths, limitations and context

Strengths

Stakeholder Engagement

There were a number of strengths that supported the implementation of the evaluation. It was beneficial to have feedback in the evaluation's early planning stages from lead organizations and key stakeholders to help guide the development of the evaluation plan and questions. It was also an asset to seek formal support from senior management at stakeholder organizations for their staff to be engaged in the evaluation.

Client Recruitment

There were a number of factors that were strengths of the data collection process with clients at TOPS. The decision to conduct surveys and interviews directly at the site was beneficial because it was where they were already accessing services in an environment comfortable to them. Having TOPS staff inform clients at TOPS about the opportunity to participate in the evaluation was helpful because they had existing relationships with clients. Their existing relationships also helped to create a safe space for participants when staff introduced the Evaluation Team to participants.

MLHU Program Evaluator training

The agency orientation and training that TOPS Leads/Staff provided to the Program Evaluators was essential to ensure the ethical requirements and safety protocols were followed enabling the Program Evaluators to effectively engage with participants.

Methods

The semi-structured interviews with TOPS leads/staff, stakeholders and clients allowed for an in-depth and detailed account of participants' experiences. The semi-structured interviews permitted the Program Evaluators to ask more specific questions based on participants' responses in real-time in order to explore topics more fully and understand the complexities of their experiences.

Provision of Refreshments Due to High Temperatures

With the high temperatures of the office building at RHAC during the summer months, and in particular high room temperatures in the room where the majority of the surveys and interviews were conducted, it was very helpful to offer participants water and juice. Refreshments were provided in order to make participants comfortable and reduce the likelihood that participants rush through the survey or interview due to the high temperatures in the room.

Limitations

Evaluation plan development

Due to time constraints, the evaluation team was not able to ask clients to provide feedback on the evaluation plan and data collection tool. The perspectives of TOPS Leads and some key stakeholders was gathered; however, it may have been helpful to gather feedback on the use of terminology (e.g. public health terminology versus street language) in order to ensure accessibility and understanding of all survey and interview questions.

Sample Size

The low response rate [2.6% response rate (15/570)] for the Survey of Community Residents and Business Owners resulted in the inability to report on the quantitative findings. This could have been attributed to

participants only receiving one invitation to participant in the survey. Multiple reminders may have increased the response rate. However, due to costs in sending out multiple reminders via mail, only the initial invitation was mailed. The qualitative feedback received was summarized according to themes; however, the findings should be interpreted with caution given the extremely low response rate. Future research and evaluation studies should explore strategies to increase response rates.

Sampling Frame

The reach of the evaluation was limited to TOPS clients, staff and stakeholders who currently provide services at the site. Due to resource implications, the decision to narrow the sampling frame was made at the outset of the evaluation. It may have been helpful to hear the perspectives of PWUD who are not currently using TOPS to understand the barriers to use and gaps in service delivery. Engaging those not currently accessing TOPS should be considered for future research and evaluation studies.

The exclusion criteria for the client survey conducted excluded support people for clients. These individuals accompany clients to the site, but do not consume drugs themselves. Gathering their feedback as support people could have helped to further understand the impacts that the site may be having on clients and the broader community. This should be a consideration for future research and evaluation studies.

Recording Interviews

The decision not to audio-record the interviews limits the ability to have verbatim quotations. This decision was informed by key stakeholders during the development of the evaluation. They indicated that TOPS clients would not feel comfortable with this practice. As a result, an alternative solution was developed to record the feedback on the laptop and read it back fully to participants for validation. While this process extended the duration of the interview time, it was valuable to ensure that participants' feedback was captured accurately. Participants had the opportunity to add or alter any feedback that was recorded during the interviews.

Self-Reported Data

The primary data findings summarized in this report are based on self-reported participant information. It is recognized that self-reported data may vary at different time points based on the participants' comfort level in sharing their perspectives.

Social Desirability Bias

Some participants may have responded to questions in a manner perceived as more favourable by the Program Evaluators.

Recall Bias

There was a subset of questions on the client survey asking them to reflect on their consumption behaviours since the site had opened. It is recognized that their ability to recall whether their consumption behaviours may have increased, decreased or stayed the same may have been impacted by their ability to remember this information.

Duplication of responses

Due to the anonymity of the site, shift rotations of TOPS staff, and the rotations of Program Evaluators collecting data at the site, there may have been a couple of circumstances where the same clients at the site completed the survey more than once.

Conclusion

Overall, the Temporary Overdose Prevention Site in London Ontario provides a vital service to reduce the harms associated with drug use including opioid-related overdoses. The evaluation findings reveal that the site creates a safe and secure environment for members of our community who use drugs. Through the caring and compassionate service delivery, TOPS has created a welcoming, safe and non-judgmental environment that has allowed people to feel accepted.

Building trusting relationships and creating a culture of trust at the site were identified as critical factors in providing opportunities to promote safer drug use and increase connections to health and social services for clients. The findings also demonstrate the progress being made to reduce opioid-related deaths by directly responding to overdoses at the site where no deaths have occurred to date.

Furthermore, there is evidence to suggest that some public health order outcomes are positively affected with clients reporting less public drug use and less disposal of gear in public spaces. However, more efforts will be needed to monitor and address other public health order outcomes such as loitering, garbage, drug selling/purchasing, and criminal activity within the vicinity of the site in order to ensure safety for clients, residents and businesses. It is recognized that TOPS is just one harm reduction strategy and cannot be expected to address all of the interconnected and complex issues associated with the opioid drug crisis. Ongoing efforts by many key stakeholders in the community will be required to address the crisis.

Findings from the first six months of operation of the site provide evidence that the site is making a positive impact on many clients lives. The site is not only saving lives, but also changing them. Moving forward, it will be important to discuss how the findings can be used to help facilitate dialogue with PWUD, key stakeholders, government, policy makers, and the broader community regarding future implementation of permanent supervised consumption facilities.

The evaluation findings provide a snap shot in time at the 6-month point of operation. Now that the site has been operating for over one year, there are many more lessons learned through its implementation. Many of the challenges that were raised during the evaluation are being addressed or in the process of further review to enhance service delivery. The site has transitioned from the Temporary Overdose Prevention Site under a new provincial model as of April 2019 to become the city's interim Consumption and Treatment Service. The findings from the evaluation are being utilized to inform planning for the permanent site.

Appendix A: Literature Review

Literature Review

This section summarizes the current evidence base for safer consumption facilities, including the evidence for effectiveness on public health and public order outcomes, qualitative research into the perceptions of site users, and implementation challenges and facilitators. For the purposes of this discussion, the term safe consumption facility (SCF) will be used. Over the years the terminology has changed, often based on legal rules and regulations. However, the key features of these facilities have remained consistent; facilities where people can consume their own illicit drugs in a safe environment with medical supervision.

The evidence base around SCFs continues to develop. Given the nature of the work, most of the research available on the effectiveness of SCFs is from observational and mathematical modelling studies. A recent systematic review of SCFs summarized the available literature up to May 2017 (Kennedy, Karamouzian, & Kerr, 2017). The majority of studies included in the review were conducted in Vancouver, Canada or Sydney, Australia. This review suggests that SCFs are effective at meeting their public health objectives of mitigating overdose-related harms and drug-related risk behaviours such as syringe sharing, syringe reuse, injecting outdoors and rushed injections. SCFs also facilitate uptake of addiction treatment and other health care services (Kennedy et al., 2017). Furthermore, the review suggests improvement in public order outcomes such as public injecting, publicly discarded syringes and injection-related litter without increasing drug-related crime (Kennedy et al., 2017).

Overdose-related harms

The Kennedy et al. (2017) review suggests that SCFs offer a protective effect. The most compelling evidence where SCFs lead to a decrease in fatal overdoses is from a high-quality cohort study in Vancouver, BC that examined population-based overdose mortality rates before and after the SCF opened, using provincial coroner records. The rate of fatal overdoses decreased by 35% within a 500m radius of the SCF, compared to a 9.3% decrease outside the 500m radius during the same time period (Marshall, Milloy, Wood, Montaner, & Kerr, 2011). Another study estimated that 2-12 cases of fatal overdoses per year were averted in Vancouver as a result of the SCF (Milloy, Kerr, Tyndall, Montaner, & Wood, 2008).

In Australia, the demand for overdose related ambulance services was reduced in the immediate vicinity of the SCF (Salmon, van Beek, Amin, Kaldor, & Maher, 2010). The authors suggest SCFs may be most effective in reducing overdose related ambulance services and preventing overdose related deaths in areas of concentrated drug use.

Safer injection conditions

Another area of consistent findings includes the impact of SCFs on reducing drug-related risk behaviours such as syringe sharing, syringe reuse, injecting outdoors and rushed injections (Kennedy et al., 2017). Milloy & Wood (Milloy & Wood, 2009) identified a consistent pattern emerging within the results of peer-reviewed, published research where their pooled analysis estimated a 69% decrease in the likelihood of syringe sharing among SCF users.

Despite increases in safer injection practices, no primary studies have directly assessed the impact of SCFs on HIV and HEPATITIS C transmission (MacArthur et al., 2014). Modelling studies estimate that SCFs could reduce HIV and HEPATITIS C infections based on the observed reductions in syringe sharing (Enns et al., 2016; Pinkerton, 2011).

Addiction treatment

The Kennedy et al. (2017) review also identified an association between SCF use and uptake of various addiction treatment programs including detoxification services, methadone maintenance therapy, and other forms of addiction treatment for SCF users. Additional studies have continued to show a positive

association between attending an SCF and accessing withdrawal management services (Vipler et al., 2018) and co-located detoxification services (Gaddis et al., 2017), highlighting the potential role for SCF as a point of access for addiction treatment.

Access to other health and social services

In addition to increasing the uptake of addiction services, SCF use appears to increase the likelihood of accessing other health services including care for injection-related skin infections, treatment for medical conditions, utilization of education on safer drug use practices and counselling (Kennedy et al., 2017). Qualitative research in this area suggests the supportive environment within these types of facilities help people who use drugs (PWUD) feel comfortable engaging with staff about their needs. This fostered trust facilitates access to other supports like food, shelter and broader medical and social supports (McNeil & Small, 2014). The authors suggest that the supportive environment comes about "in large part because they disrupted stigmatization processes and improved trust in program staff (McNeil & Small, 2014, p. 156)." Another qualitative study characterized this fostered trust as "building bridges" between site users and service providers within the broader health and social sectors (Kappel, Toth, Tegner, & Lauridsen, 2016).

Public Order

Improvements in public order outcomes such as public injecting, publicly discarded syringes and injection-related litter were noted in the Kennedy et al. review (2017). Although much of this data is self-report from PWUD, residents, and business-owners, Wood and colleagues (Wood et al., 2004) conducted an environmental survey covering specific areas of the neighbourhood surrounding Vancouver's SCF and found that the opening of the SCF was associated with reduced public injections, reduced publicly discarded syringes, and reduced injection-related litter.

Crime-Related Outcomes

The Kennedy et al. (2017) review also reported studies evaluating the impact of SCFs on crime, violence or drug trafficking showed no change in crime rates in the areas adjacent to the SCF. More recently, Myer & Belisle (Myer & Belisle, 2018) used an interrupted time-series analysis with Vancouver police data and determined that there was a statistically significant decrease in total crime, including violent crime and property crime, in the police district where the SCF was located. It is important to note their analysis did not include data on drug selling or purchasing. Previous analysis of crude crime rates of drug trafficking in the downtown eastside of Vancouver showed no change (Wood, Tyndall, Lai, Montaner, & Kerr, 2006).

Cost-effectiveness

Multiple mathematical modelling studies from Vancouver have shown that their SCF is a cost-effective intervention (Kennedy et al., 2017). Findings of cost-effectiveness studies for other Canadian jurisdictions have also predicted that SCFs will be cost-effective compared to no SCFs, and have recommended multiple, smaller SCFs in settings where the drug population is more dispersed than in Vancouver (Enns et al., 2016). These cost-effectiveness studies have taken into account direct health care cost savings such as reduced disease transmission. However, as others have pointed out (Fairbairn & Wood, 2016), there are other benefits of SCFs such as improvements in public order and increased uptake of addiction services that are difficult to express in dollar values.

Perceptions of Site Users

Research has shown that the primary users of SCFs are those who are most marginalized; often those experiencing housing insecurity and unemployment (Potier et al., 2014). A meta-analysis of qualitative research found that various types of safer environment interventions (SEI), the majority being SCFs, were perceived by users as safe, regulated spaces they could occupy (McNeil & Small, 2014). These sites were perceived by users to be free from violence and real or perceived stigma, and to promote safer drug injecting practices by decreasing the barriers to safer injection and increasing their control over how they injected. These facilities created a safe micro-environment, and despite being primarily set up to influence health outcomes for PWUD, for the site users, they were first and foremost a safe environment (McNeil & Small, 2014).

Implementation

The implementation of SCFs is controversial and impacted by many components including the political climate and community perceptions. All levels of government have the ability to impact if sites can open [see the following for detailed accounts of the situation in Vancouver (Kerr, Mitra, Kennedy, & McNeil, 2017) and Toronto (Bayoumi & Strike, 2016). Furthermore, sites that have been granted approval to open, continue to experience challenges because of ongoing regulatory and operational restrictions. These challenges can put SCF staff in complex situations where they have two potentially conflicting roles as caregiver and enforcer (Small et al., 2011).

Community perceptions also impact the implementation of SCFs. Although support for the implementation of supervised injection facilities in Ontario increased between 2003 and 2009, the majority of people still had mixed opinions (Strike et al., 2014). Qualitative research into community members' perspectives in Toronto and Ottawa identified that community members were aware of potential health benefits for PWUD and supported ways to reduce the impact of drug use on their community health services. However, there were mixed opinions on the impact SCFs would have on the size of the PWUD population in their neighbourhoods, business profits, property values and drug-related crime (Kolla et al., 2017).

While there are community concerns about location as noted above, research has also shown that the largest barriers for PWID to use a SCF include the distance to travel, operating hours and wait times (Petrar et al., 2007). As more communities face HIV epidemics and rising death tolls related to opioid use, it will be important to find ways to adapt SCFs to be implemented in less densely populated regions compared to densely populated areas with high levels of injection drug use such as in Vancouver (Young & Fairbairn, 2018).

A key facilitator for successful implementation has been the presence of strong local champions (Bayoumi & Strike, 2016). In the Vancouver context, this included the drug user's community and a network of peer harm reduction champions (Young & Fairbairn, 2018). Engaging the local police department in discussions is also an essential component in moving towards SCF implementation (Young & Fairbairn, 2018). Furthermore, public discussion about the local context, including distribution of drug use, the prevalence of blood-borne infections, and issues of stigma and discrimination can also help shift community perceptions. In Toronto, public dialogue about opioid overdose deaths allowed community members to focus on an identifiable unmet health need and this helped support SCF implementation (Bayoumi & Strike, 2016).

Summary

Although the evidence base for SCFs is still developing, it has been shown that SCFs improve both public health and public order outcomes. Mathematical modelling studies have shown that SCFs can be cost

saving interventions through reduced disease transmission. Furthermore, these sites provide a safe environment that are used by PWUD. These safe, supportive environments help build bridges to accessing other health and social services including addictions treatment. Despite these positive outcomes, the implementation of SCFs continues to be controversial and is significantly impacted by political climate and community perceptions. To be successful in implementing SCFs it is imperative to include strong local champions, engagement of police and public discussion about the local context.

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Appendix B: Temporary Overdose Prevention Site Local Context and Site Description

Local Context

Since 2016, there have been a number of key stakeholders who have been working collaboratively to address the overlapping opioid and HIV crisis which allowed the Middlesex-London Health Unit (MLHU) and Regional HIV/AIDS Connection (RHAC) to mobilize resources to open Ontario's first legally sanctioned Temporary Overdose Prevention Site (TOPS).

On September 25, 2017, MLHU's Medical Officer of Health activated the Health Unit's Incident Management System (IMS) to escalate the response to the community's opioid crisis (MLHU, 2017b). Additionally, in 2017 the Opioid Crisis Working Group was formed and included representatives from The City of London, Middlesex-London Health Unit, Regional HIV/AIDS connection (RHAC), London Intercommunity Health (LIHC), Addiction Services of Thames Valley, London Police Service, London Health Sciences Centre (LHSC), London CAReS, Southwest LHIN, Middlesex-London EMS, an Indigenous leader, and a community member with lived experience. This group guided the community consultation process, necessary to complete the Supervised Consumption Facility (SCF) application.

A community consultation report was generated based on data collected between November and December 2017 (Centre for Organizational Effectiveness, 2018). While the findings were gathered to inform the development of SCFs in London, the community engagement process and findings were also applicable for the development of Temporary Overdose Prevention Site (TOPS). Findings from the public consultations indicated the importance of having integrated services linking to wrap-around support, treatment and addiction services, and rehabilitation services. It was also recommended that peers and Indigenous individuals be hired as staff to better provide culturally relevant services, and trauma and violence informed service delivery (Centre for Organizational Effectiveness, 2018).

The consultation gathered input from 334 participants at nine community consultations, 2145 responses to an online survey, and four focus groups with feedback from another 56 participants.

Respondents identified a number of benefits in establishing a SCF including:

- A reduction in the risk of injury and death from drug overdose;
- A reduction in risks of infectious diseases; and
- Linkages for people who use drugs to health, social and treatment services (Centre for Organizational Effectiveness, 2018).

Respondents also identified some concerns in establishing a SCF including:

- A negative impact on the reputation of the community;
- A perceived decrease in personal and child safety; and
- An increase in drug selling/trafficking in the site area (Centre for Organizational Effectiveness, 2018).

A number of suggestions regarding potential locations for SCF sites were identified from the community consultation meetings. Four key neighborhoods were identified: Old East Village, SoHo (South of Horton), East Hamilton, and the Downtown/Core. These 4 locations were also identified based on mapping of improperly discarded needles, and increased cases of HIV and Hepatitis C.

Key considerations when selecting a SCF site included potential impacts on the neighbourhood, businesses and populations, neighbourhood improvement efforts, the number of existing social services, community engagement commitment, site accountability, and community education (Centre for Organizational Effectiveness, 2018).

Site Application and Approval Process

In December 2017, Health Canada announced that it would grant temporary class exemptions to establish Urgent Public Health Need Sites (also referred to as overdose prevention sites) in provinces and territories experiencing an urgent public health need (MOHLT, 2018a).

On December 7, 2017, Ontario received an exemption under the new federal policy (Ministry of Health and Long Term Care, 2018). On January 11, 2018, the Ministry of Health and Long Term Care (MOHLTC) announced that applications for Overdose Prevention Sites were being accepted (MOHLTC, 2018). Overdose Prevention Sites (OPS) were to be established as a time-limited (3-6 months) service, with the possibility of being extended (MOHLTC, 2018). The OPS were intended to provide accessible, stigma free, essential health services to help reduce the growing number of overdose deaths in affecting some of the most vulnerable and marginalized populations in the province (Ministry of Health and Long Term Care, 2018).

With the support of community organizations, the MLHU and RHAC collaboratively submitted the first Ontario application for a Temporary Overdose Prevention Site (TOPS) on January 12, 2018 (MLHU, 2018b). On January 19, 2018, the Ontario government approved the application to become Ontario's first Temporary Overdose Prevention Site (TOPS) and provided a one-time funding of $130,700. TOPS (also referred to as "the site") officially opened in RHAC at 186 King Street, London, Ontario on February 12, 2018.

The site was granted permission to operate by the MOHLTC until August 15, 2018 (MLHU, 2018a). On August 14th, an extension for the site was granted to continue operating until September 30th, 2018, while the MOHLTC reviewed the effectiveness of Overdose Prevention Sites and Supervised Consumption Facilities. At the September 30th deadline, the exemption was extended again until October 31st as the MOHLTC finalized their review of recommendations.

On October 30, 2018, MOHLTC announced the decision to renew the federal exemption and allow TOPS to continue operating until as an interim facility until the permanent facilities are operational. It was also announced that both Temporary Overdose Prevention Sites and Supervised Consumption Facilities (SCF) would be required to operate under the requirements of the Consumption and Treatment Services model and there would be a limit of 21 sites allowed in Ontario (MOHLTC, 2018b).

During this time, applications for two permanent facilities received Federal approval and exemption under the Controlled Substances and Drugs Act. As of February 2019, municipal approval for City of London zoning applications for sites proposed for 466 York Street and 241 Simcoe Street were pending.

Community Drug and Alcohol Strategy

In October 2018, a comprehensive Community Drug and Alcohol Strategy was launched by a network of community partners coordinated by the MLHU and RHAC. The Middlesex-London Community Drug and Alcohol Strategy (CDAS) is a long-term comprehensive strategy to address substance use in London and the surrounding area based on a four pillar philosophy of prevention, treatment, harm reduction and enforcement. The CDAS partnership consists of more than 30 committed community partner organizations representing diverse sectors inducing health and social services, education, enforcement, municipalities, business, and people with lived expertise. One of the recommendations (N0. 13) within the harm reduction pillar involves working collaboratively to address the opioid crises within Middlesex-London (Middlesex-London Community Drug and Alcohol Strategy, 2018).

Description of the Temporary Overdose Prevention Site

Target Populations for the Temporary Overdose Prevention Site

The site is intended to provide support and harm reduction services to people who use drugs (PWUD). Individuals accessing the site include adults and youth greater than 16 years of age, who have a history of drug consumption.

Intended Outcomes

London, Ontario's Temporary Overdose Prevention Site was opened as a harm reduction program to respond to the growing opioid crisis in Middlesex-London. The site is intended to

- Prevent overdose deaths;
- Reduce the spread of infectious disease;
- Reduce unsafe consumption practices; and
- Increase access to health and social services.

Services

The site offers a low-barrier, hygienic, stigma-free environment for people to use pre-obtained drugs under the supervision of harm reduction workers and medical staff. TOPS operates on Monday to Friday from 10 am – 4pm on weekends from 11 am – 4pm. It is closed on Statutory holidays. The site is intended to provide support and harm reduction services to people who use drugs (PWUD).

The following services and supports are offered at the site:

- Supervised injection, oral, and intranasal drug consumption; (smoking is not permitted in the site);
- Overdose prevention and intervention (i.e. Use of oxygen and naloxone);
- Fentanyl test strips as a drug checking service;
- Peer-to-peer assisted injections;
- Education on safer consumption practices;
- Medical and counselling services; and
- Wrap-around supports such as referrals to drug treatment, mental health services, housing, primary care, indigenous support, income support, and other services.

Individuals are provided with a range of sterile harm reduction supplies, including:

- Syringes (e.g. 3 cc barrel syringes with separate tips, 27 & 28 gauge sterile syringes);
- Alcohol swabs (i.e. Alcohol prep pads);
- Sterile water;
- Sterile filters;
- Ties (i.e. Tourniquet); and
- Cookers.

Lighters are also available upon request to allow for people to cook their drugs prior to injecting them. Vitamin C is also available when heating their drugs to remove harmful bacteria. All supplies are provided in sterile packaging, with the exception of ties (i.e. tourniquets). All items are one-time use and are discarded afterwards into sharps disposal bins located at each table.

The site is staffed by medical professionals (e.g. nurse or paramedic), harm reduction workers, and staff from community agencies who offer support and encouragement to reduce high risk drug consumption practices, and provide education on safer injection practices and health risks associated with injection

drug use (e.g. soft tissue injuries, cellulitis, abscesses, iGAS, HEPATITIS C, HIV, etc.). Staff also assist with monitoring any complications resulting from substance use and responding to potential overdoses with the use of oxygen and/or naloxone. Referrals to health and social services in the community are also made to clients who express an interest in seeking out these services and supports.

The aftercare area provides another opportunity for PWUD to connect with community services. This space is staffed by employees from community agencies in addictions, mental health, housing support, and community outreach networks. The following organizations provide in-kind wrap-around support in the aftercare room: Addiction Services Thames Valley (ADSTV), London Intercommunity Health Center (LIHC), Regional HIV/AIDS Connection (RHAC), Southwest Ontario Aboriginal Health Access Center (SOAHAC), Canadian Mental Health Association (CMHA), and London CARes Homeless Response Services.

Location of the Temporary Overdose Prevention Site

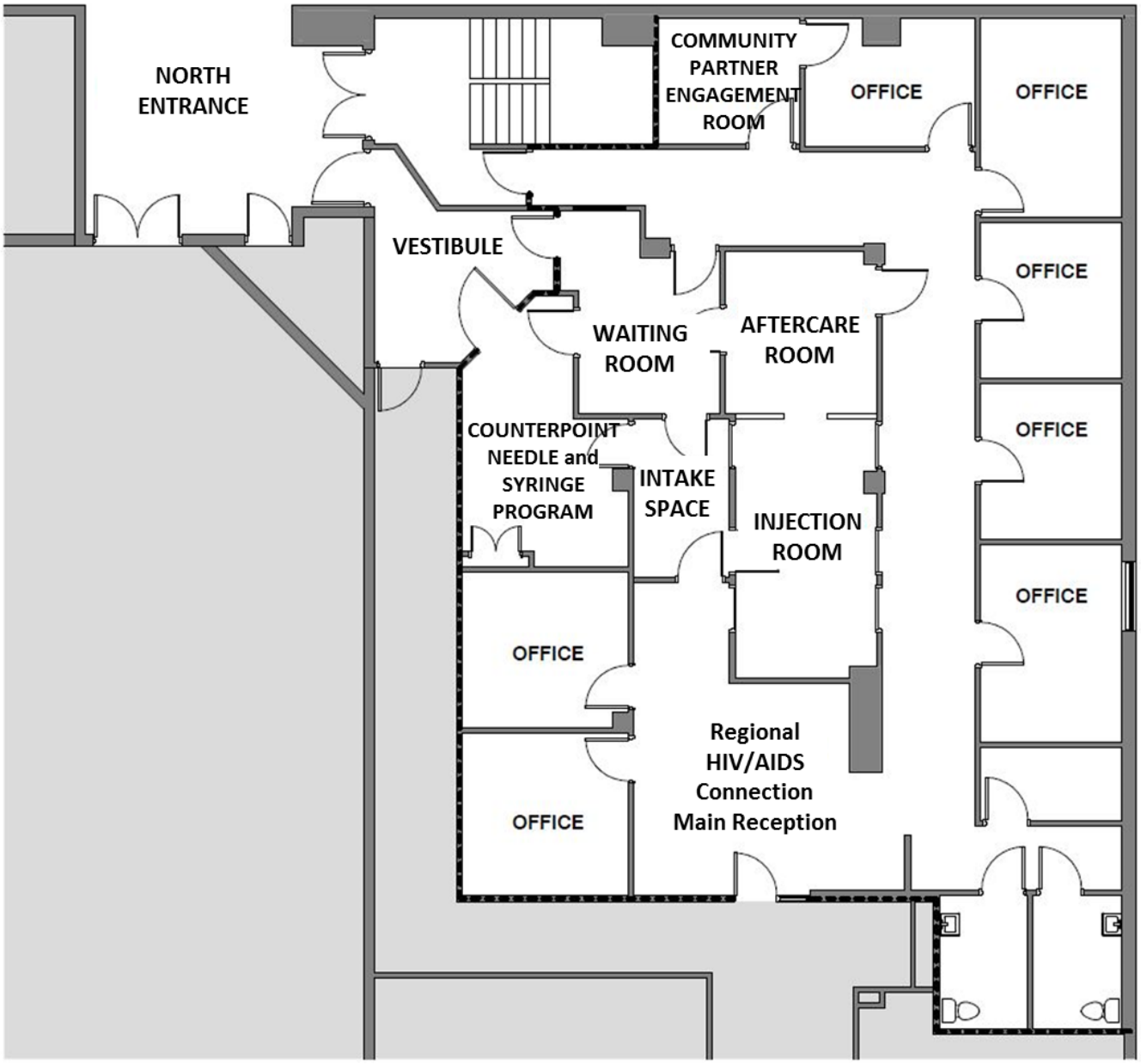
TOPS is located at 186 King St., London, Ontario in the same building and office space as RHAC in the downtown core. RHAC is an established leader in providing harm reduction services to individuals living with, or who are at risk for contracting, HIV, Hepatitis C, or other blood borne infections. RHAC operates the Counterpoint Needle Syringe Program where they work with people who use drugs to reduce the risk of HIV and other blood borne infections by providing free harm reduction supplies and information. The Counterpoint Harm Reduction Services offered at the same site also work as a referral source to other social services and health care agencies such as drug and alcohol treatment centers, doctors, hospitals, social workers, housing and welfare support agencies, legal aid, etc. Through its years of operation, RHAC has established relationships and connections with people who use drugs and is one of the main reasons why RHAC was selected as TOPS location. TOPS is embedded within RHAC and adjacent to the Counterpoint Needle Syringe Program.

Client Flow and Layout of the Temporary Overdose Prevention Site

The following section provides a brief description of the main rooms at the site and how PWUD at the site access the services and supports. The rooms of the site were constructed over a two- to three-week duration following the announcement. The site was integrated into the existing facility of RHAC from existing office spaces. A Floor Plan of the site is included below in Figure 1.

A virtual tour is also available which details each of the main rooms and how people access the services at the site. This tour can be found online at: https://www.healthunit.com/temporary-overdose-prevention-site/

Figure 1: Layout of the Temporary Overdose Prevention Site



Entry to the Site

Individuals can enter the waiting room directly through the north entrance of 186 King Street. While a person can access the site through the south entrance to Regional HIV/AIDS Connection (RHAC), they are strongly encouraged to use the north entrance as a direct customer service experience. However, if they do access through the south entrance, the receptionist lets the staff know there has been a request for customer service. A staff member greets the individual and goes with them to the waiting room.

Waiting Room

In the waiting room, staff greet individuals and find out the individual's service needs which may include the Temporary Overdose Prevention Site and/or Counterpoint Needle Syringe Program.

Intake Space

In the intake space, staff gather information from individuals before they can access the overdose prevention site. Upon their first visit, individuals will read or have a release of responsibility waiver read to them, and sign a user agreement and consent form. A code of conduct is reviewed with each individual and also posted in the waiting room, intake space, and in the injection room.

Injection Room

In the injection room, individuals are greeted by a harm reduction worker and asked to provide a code their unique code as a way to anonymously track their visits and log substances used at each visit. Individuals are also greeted by medical staff who are available to provide support in the injection room.

Within the injection room there is a nursing station, which is staffed by one medical professional (e.g. nurse or paramedic). The nursing station first aid, wound car supplies, Oxygen tanks, and Naloxone (Narcan). Both injectable and nasal Naloxone are available.

There are two tables with two chair each for people to sit (i.e. a total of 4 chairs) and use their pre-obtained drugs (either prescription or street drugs) with the supervision of both harm reduction workers and medical staff. Sterile harm reduction equipment and supplies are available in the injection room to help people use safely.

There is a zero tolerance policy for any dealing or sharing of drugs between clients at the site. To help with flow, individuals are asked to limit time in the injection room to 20 minutes although this is flexible based on individual's needs (e.g. if someone is having difficulty finding a vein).

Aftercare Room

In the aftercare room, individuals are greeted by staff from the community organizations providing services at TOPS and can be connected to various health and social services. This space provides an opportunity for people to be supervised in case of any complications including potential signs of overdose. The aftercare room is not a separate room from the injection room, but rather is separated by two columns and a three-foot half wall. When individuals are ready to leave the aftercare room, they exit back through the waiting room and out the north door.

Counterpoint Needle Syringe Program

The Counterpoint Needle and Syringe Program has been operating at Regional HIV/AIDS Connection for over 25 years. People can access various harm reduction supplies such as needles, syringes, cookers, ties, vitamin C, sharps containers of various sizes, alcohol swabs, sterile water, safe inhalation kits, filters, snorting kits, hot railing kits, and naloxone kits. People can choose to use the Counterpoint Needle Syringe Program before or after they have used the injection room.

Community Partner Engagement Room

One of the offices of RHAC is available as needed as private space for community partners to meet with individuals for intake, counselling, HIV/Hepatitis Point of Care testing, vaccines, etc.

Appendix C: Evaluation Plan

Evaluation Questions *What do you need to know?*	***Evaluation Question 1*** Are the services being provided as intended at TOPS?	***Evaluation Question 2*** Are the services adapting to client and community needs?	***Evaluation Question 3*** Are the intended benefits of TOPS being recognized?	***Evaluation Question 4*** Who is using TOPS services and what substances they using?	***Evaluation Question 5*** How is TOPS impacting the lives of people who use drugs in Middlesex-London?
Evaluation Purpose *How will results of the evaluation be used?* The purpose of this evaluation is to assess the implementation and impact of TOPS being implemented in Middlesex-London.	The evaluation findings will be used to highlight any gaps/weaknesses, as well as strengths in service delivery, to inform and improve service delivery as necessary. The findings will also help to ensure that TOPS remains accountable to stakeholders and the community about the impact of providing these services and maximizing the impact of the TOPS on the lives of clients.	The evaluation findings will inform necessary adaptations of services and delivery methods to meeting client and community needs.	The evaluation findings will be used to increase buy-in from stakeholders and community members. These finding can also help to provide evidence of the benefits of TOPS and the impact of TOPS on the Middlesex-London community.	The evaluation findings will help TOPS and other community organizations to tailor their services and supports to the populations accessing TOPS.	The evaluation findings will help provide the "lived experiences" of people accessing TOPS and the impact this service is having on their lives. The findings can also help minimize negative community perspectives and normalize the services needed by the community.
Rationale *Why is this question important?*	We need to understand if the services and support provided at TOPS were delivered as intended. If not, this will help us to understand what changes need to be made.	We need to understand if the services are meeting the needs of the clients and the community. If the services are not meeting the needs, what can we do to adapt the services at TOPS to meet the needs.	We need to understand if the intended benefits of TOPS are being recognized among clients, stakeholders, the broader community. This could ultimately increase public/community support for and acceptance of TOPS and future SCFs.	We need to understand the demographic characteristics of people using the TOPS services, the substances that are currently being used, the method used and the drugs (and # of) laced with Fentanyl in Middlesex-London community. This information can help to adapt services and support specifically targeted towards the populations accessing TOPS.	We need to understand the impact that TOPS is having on the people who are accessing the services, why they are accessing the services, what makes them keep coming back and where they would be without the services. We want to understand their experiences and perspectives.

Evaluation Questions *What do you need to know?*	***Evaluation Question 1*** Are the services being provided as intended at TOPS?	***Evaluation Question 2*** Are the services adapting to client and community needs?	***Evaluation Question 3*** Are the intended benefits of TOPS being recognized?	***Evaluation Question 4*** Who is using TOPS services and what substances they using?	***Evaluation Question 5*** How is TOPS impacting the lives of people who use drugs in Middlesex-London?
Type of Data *What measures/indicators are you looking for? Is this a qualitative or quantitative measure?* *NOTE: A sample of indicators have been included. See the Evaluation Matrix for the complete list of indicators.*	# of client visits (total) # of client visits during morning hours (10:00am-11:59am) # of client visits during afternoon hours (12:00pm-4:00pm) # of client visits where the injection was peer-assisted Description of the types of referrals to health and social services	# of services provided changed (have services been added or removed?) Hours of services changed (is TOPS opening earlier or later?) # of staff at TOPS changed (does TOPS require more, less or the same number of staff?) Type of staff at TOPS changed (has the type of staff required at TOPS changed?) Changes to the way services are offered at TOPS % of clients reporting they are satisfied with the services offered at TOPS Satisfaction of clients in community % of community residents / businesses (within 120m radius) supporting TOPS % of key stakeholders supporting TOPS	# of overdoses at TOPS # of overdoses among people who participated in drug checking (Fentanyl test strip) # of overdose deaths occurring in TOPS # of overdose events requiring treatment with oxygen/rescue breathing # of overdose events requiring treatment with naloxone at TOPS Range of doses of naloxone administered per overdose at TOPS # of calls to EMS at TOPS related to an overdose # of transfers to an emergency department related to an overdose at TOPS # of TOPS clients receiving safe injection education # of TOPS clients reporting needle sharing	Type of substance used # of clients that participated in drug checking (Fentanyl test strip) # of drug checks completed (Fentanyl test strip) Type of substance identified in test strip # of visits by clients under 25 years # of visits by clients between 25-64 years # of visits by clients over 65 years # of visits by clients where age group is unknown Length of time living in London	Impact of TOPS on their lives Reasons for accessing TOPS Reasons for continued use of TOPS Access to other services and supports through TOPS
Data Source *Where can you get the data?* *Identify if there are existing data or if new data needs to be collected*	Existing data source New data collection	New data collection	Existing data source New data collection	Existing data source New data collection	New data collection

Evaluation Questions *What do you need to know?*	***Evaluation Question 1*** Are the services being provided as intended at TOPS?	***Evaluation Question 2*** Are the services adapting to client and community needs?	***Evaluation Question 3*** Are the intended benefits of TOPS being recognized?	***Evaluation Question 4*** Who is using TOPS services and what substances they using?	***Evaluation Question 5*** How is TOPS impacting the lives of people who use drugs in Middlesex-London?
Data Tools *Are data collection tools required?* *Identify if data tools will be required to access existing data or collect new data. Document any known existing tools or indicate if tools will need to be developed.* *Note: If you are collecting **new** data, complete the **Data Collection Plan** for each data collection tool.*	Existing data sources: • Ministry of Health and Long-Term Care Overdose Prevention Sites (OPS) Monthly Reporting Form New data collection tools: • Key informant interviews (Client, Stakeholder, Staff) • Client surveys	New data collection tools: • Key informant interviews (Client, Stakeholder, Staff) • Client surveys • Surveys of Community Residents and Business Owners within 120m of the TOPS	Existing data sources: • Ministry of Health and Long-Term Care Overdose Prevention Sites (OPS) Monthly Reporting Form New data collection tools: • Client survey • Key informant interviews (Client, Stakeholder, Staff)	Existing data sources: • Ministry of Health and Long-Term Care Overdose Prevention Sites (OPS) Monthly Reporting Form New data collection tools: • Client survey • Key informant interviews (Client, Stakeholder, Staff)	New data collection tools: • Client survey • Key informant interviews (Client, Stakeholder, Staff)
Data Collectors *Who will collect/collate the data?*	TOPS staff Evaluation Team	Evaluation Team TOPS staff	Evaluation Team TOPS staff	TOPS staff Evaluation Team	Evaluation Team TOPS staff
Timeline *When will data be collected*	Ongoing to 6 months for existing data 6 months for new data collection	6 months	Ongoing to 6 months for existing data 6 months for new data collection	Ongoing to 6 months for existing data 6 months for new data collection	6 months
Data Analysis *Who will analyze the data?*	Evaluation Team	Evaluation Team	Evaluation Team	Evaluation Team	Evaluation Team
Communication *Who needs the results?* *Identify the audiences that need to hear about the evaluation results.*	Key stakeholders at TOPS TOPS staff/leads Community members Business owners	TOPS clients TOPS staff/leads People who use substances not accessing TOPS Key stakeholders at TOPS Community members Business owners	TOPS clients TOPS staff/leads People who use substances not accessing TOPS Key stakeholders at TOPS Community members Business owners	TOPS clients TOPS staff/leads People who use substances not accessing TOPS Key stakeholders at TOPS Community members Business owners	TOPS clients TOPS staff/leads People who use substances not accessing TOPS Key stakeholders at TOPS Community members Business owners

Appendix D: Evaluation Matrix for The Temporary Overdose Prevention Site (TOPS)

Evaluation Matrix for The Temporary Overdose Prevention Site (TOPS)

Evaluation Question 1: Are the services being provided as intended at the TOPS?					
Evaluation Sub-Questions	Indicators	Data Sources	Data Collection Methods	Timeline	Person Responsible
1.1 What is the pattern of client attendance at TOPS?	# of client visits (total)	Clients	OPS Monthly Reporting Form	Feb-Aug 2018	TOPS staff
	# of client visits during morning hours (7:00am-11:59am)	Clients	OPS Monthly Reporting Form	Feb-Aug 2018	TOPS staff
	# of client visits during afternoon hours (12:00pm-4:00pm)	Clients	OPS Monthly Reporting Form	Feb-Aug 2018	TOPS staff
	# of unique clients (frequency of use)	Clients	OPS Monthly Reporting Form	Feb-Aug 2018	TOPS staff
	# of clients requiring medical attention for overdose	TOPS staff	OPS Monthly Reporting Form	Feb-Aug 2018	TOPS staff
	# of client visits where the injection was peer-assisted	TOPS staff	OPS Monthly Reporting Form	Feb-Aug 2018	TOPS staff
	% of clients from the survey reporting use of the TOPS on the weekend (Q1a)	TOPS clients	Customer Satisfaction Survey	July-Aug 2018	Evaluation Team
	% of clients from the survey reporting use of the TOPS on Saturday only, Sunday only or Saturday and Sunday (Q1a)	TOPS clients	Customer Satisfaction Survey	July-Aug 2018	Evaluation Team
	Description of why the clients do not use the site on the weekends among those who indicated that they do not use the site on weekends (Q1b)	TOPS clients	Customer Satisfaction Survey	July-Aug 2018	Evaluation Team
	Description of how clients found out about TOPS	TOPS clients	Key Informant Interview with Clients	July-Aug 2018	Evaluation Team
1.2 Is the TOPS operating as it was intended to do?	Description of adherence to OPS guide and whether or not services are being delivered as planned	TOPS Staff	Key Informant Interviews	July-Aug 2018	Evaluation Team
	Description of whether or not staff and clients are following policies and procedures	TOPS Staff	Key Informant Interviews	July-Aug 2018	Evaluation Team
Evaluation Question 2: Are the TOPS services adapting to client and community needs?					
Evaluation Sub-Questions	Indicators	Data Sources	Data Collection Methods	Timeline	Person Responsible

2.1 Have there been any changes to the way TOPS services are offered at the site?	# of services provided changed (have services been added or removed?)	TOPS staff	Key informant interviews	July-Aug 2018	Evaluation Team
	Hours of services changed (is TOPS opening earlier or later?)	TOPS staff	Key informant interviews	July-Aug 2018	Evaluation Team
	# of staff at TOPS changed (does TOPS require more, less or the same number of staff?)	TOPS staff	Key informant interviews	July-Aug 2018	Evaluation Team
	Type of staff at TOPS changed (has the type of staff required at TOPS changed?)	TOPS staff	Key informant interviews	July-Aug 2018	Evaluation Team
	Description of changes to the way services are offered at TOPS	TOPS staff	Key informant interviews	July-Aug 2018	Evaluation Team
	Description of changes to the role of staff at TOPS since the TOPS opened	TOPS staff	Key informant interviews	July-Aug 2018	Evaluation Team
	Description of scenarios if clients were turned away from accessing the site	TOPS staff	Key informant interviews	July-Aug 2018	Evaluation Team
2.2 Have there been any changes to the way TOPS services are offered at stakeholder organizations as a result of their involvement in TOPS?	Description of changes to the way services are offered at the stakeholder organization	Stakeholders	Key Informant Interviews	July-Aug 2018	Evaluation Team
	Description of the types of services and supports that clients are accessing from the stakeholder organization	TOPS Staff Stakeholders	Key Informant Interviews	July-Aug 2018	Evaluation Team
2.3 Are the clients satisfied with the services offered at TOPS?	% of clients reporting their satisfaction level with the quality of services and care that they receive from staff (Q4)	TOPS clients	Customer Satisfaction Survey	July-Aug 2018	TOPS staff Evaluation Team
	% of clients reporting their satisfaction level with the TOPS as a place to take/use drugs (Q5)	TOPS clients	Customer Satisfaction Survey	July-Aug 2018	TOPS staff Evaluation Team
	% of clients reporting the likelihood of them recommending the TOPS to other people who use drugs (Q6)	TOPS clients	Customer Satisfaction Survey	July-Aug 2018	TOPS staff Evaluation Team
	Descriptions of experiences of using the TOPS (Q3)	TOPS Clients	Key Informant Interview	July-Aug 2018	Evaluation Team
	Descriptions of satisfaction levels among clients	TOPS Clients	Client survey and key informant interviews	July-Aug 2018	Evaluation Team
	% of clients reporting the site being located at 186 King Street as a factor that gets in the way of them using the TOPS (Q2a)	TOPS clients	Customer Satisfaction Survey	July-Aug 2018	TOPS staff Evaluation Team

	% of clients reporting that travel time to get to the site as a factor that gets in the way of them using the TOPS (Q2b)	TOPS clients	Customer Satisfaction Survey	July-Aug 2018	TOPS staff Evaluation Team
	% of clients reporting the waiting time to get into the consumption room as a factor that gets in the way of them using the TOPS (Q2c)	TOPS clients	Customer Satisfaction Survey	July-Aug 2018	TOPS staff Evaluation Team
	% of clients reporting the rules and regulations of the site as a factor that gets in the way of them using the TOPS (Q2d)	TOPS clients	Customer Satisfaction Survey	July-Aug 2018	TOPS staff Evaluation Team
	% of clients reporting the operating hours of the site as a factor that gets in the way of them using the TOPS (Q2e)	TOPS clients	Customer Satisfaction Survey	July-Aug 2018	TOPS staff Evaluation Team
	% of clients reporting their preference for different hours at the TOPS (Q3)	TOPS clients	Customer Satisfaction Survey	July-Aug 2018	TOPS staff Evaluation Team
	% of clients reporting their preference for earlier hours (before 10 am), later hours (after 4 pm) or both earlier and later at the TOPS (Q3)	TOPS clients	Customer Satisfaction Survey	July-Aug 2018	TOPS staff Evaluation Team
	Clients identification of other services that they would like offered at TOPS (Q7)	TOPS clients	Customer Satisfaction Survey	July-Aug 2018	TOPS staff Evaluation Team
	Description of changes to improve the site (Q5)	TOPS Clients	Key Informant Interviews	July-Aug 2018	Evaluation Team
	% of clients reporting prior use of the Counterpoint Needle Exchange Program at RHAC (Q14)	TOPS clients	Customer Satisfaction Survey	July-Aug 2018	TOPS staff Evaluation Team
	% of clients reporting prior use of Counterpoint Needle Exchange Program by frequency of use (Q14)	TOPS clients	Customer Satisfaction Survey	July-Aug 2018	TOPS staff Evaluation Team
	% of clients reporting likelihood of using mobile Supervised Consumption Services if available (Q15)	TOPS Clients	Customer Satisfaction Survey	July-Aug 2018	Evaluation Team
2.4 Are staff and stakeholders satisfied with how the TOPS is operating?	Description of the strengths and challenges of the site	TOPS Staff Stakeholders	Key Informant Interviews	July-Aug 2018	Evaluation Team
	Suggested areas for improvement in service delivery	TOPS Staff Stakeholders	Key Informant Interviews	July-Aug 2018	Evaluation Team
	Descriptions of encounters with issues of verbal or physical abuse at the TOPS	TOPS Staff	Key Informant Interviews	July-Aug 2018	Evaluation Team

	Description of the level of satisfaction or dissatisfaction with their personal and organization's involvement	TOPS Staff Stakeholders	Key Informant Interviews	July-Aug 2018	Evaluation Team
	Description of feedback provided by clients and suggested areas for improvement	TOPS Staff Stakeholders	Key Informant Interviews	July-Aug 2018	Evaluation Team
2.4 Are community residents/businesses within 120 meter radius supportive of TOPS?	% of community residents/businesses (within 120 m radius) who believe the TOPS will have a positive/negative impact	Community residents/business owners within 120 m of TOPS	Residents and Business Survey	July-Aug 2018	Evaluation Team
	% of residents/businesses within 120 m radius of the TOPS reporting the following types of changes (increases or decreases) since the TOPS opened: Injection-related waste public injection illegal drug transactions criminal activity number of overdoses	Community residents/business owners within 120 m of TOPS	Residents and Business Survey	July-Aug 2018	Evaluation Team
	% of residents/businesses (within 120 m radius) who believe that if there was NOT a TOPS that the following would increase or decrease in their neighbourhood: drug overdoses emergency and health care usage related to drug use and overdoses number of people who use drugs that use community services drug-related waste/litter in the neighbourhood public drug use number of people who use drugs number of illegal drug transactions in neighbourhood crime in neighbourhood	Community residents/business owners within 120 m of TOPS	Residents and Business Survey	July-Aug 2018	Evaluation Team
	Description of feedback provided by residents/businesses about the TOPS in their area	Community residents/business owners within 120 m of TOPS	Residents and Business Survey	July-Aug 2018	Evaluation Team

Evaluation Question 3: Are the intended benefits of the TOPS being recognized?					
Evaluation Sub-Questions	**Indicators**	**Data Sources**	**Data Collection Methods**	**Timeline**	**Person Responsible**
3.1 Has there been a decrease in overdose deaths among people who use drugs?	# of overdoses at TOPS	TOPS staff	OPS Monthly Reporting Form	Feb-Aug 2018	TOPS staff
	# of overdose deaths occurring in TOPS	TOPS staff	OPS Monthly Reporting Form	Feb-Aug 2018	TOPS staff
	# of overdose events successfully managed at TOPS	TOPS staff	OPS Monthly Reporting Form	Feb-Aug 2018	TOPS staff
	# of overdose events requiring treatment with oxygen/rescue breathing	TOPS staff	OPS Monthly Reporting Form	Feb-Aug 2018	TOPS staff
	# of overdose events requiring treatment with naloxone at TOPS	TOPS staff	OPS Monthly Reporting Form	Feb-Aug 2018	TOPS staff
	# of doses of naloxone administered at TOPS	TOPS staff	OPS Monthly Reporting Form	Feb-Aug 2018	TOPS staff
	# of calls to EMS related to an overdose	TOPS Staff	OPS Monthly Reporting Form	Feb-Aug 2018	TOPS staff
	# of transfers to an emergency department related to an overdose	TOPS Staff	OPS Monthly Reporting Form	Feb-Aug 2018	TOPS staff
	# of overdoses among people who participated in drug checking (Fentanyl test strip)	TOPS staff	OPS Monthly Reporting Form	Feb-Aug 2018	TOPS staff
3.1a Has there been a self-reported change in overdoses among clients that have used the TOPS?	% of client reporting a change in the number of times that they have overdosed as a result of using the TOPS (Q12)	TOPS Clients	Customer Satisfaction Survey	July-Aug 2018	Evaluation Team
	% of client indicating that they have never overdosed (Q12)	TOPS Clients	Customer Satisfaction Survey	July-Aug 2018	Evaluation Team
	% of clients indicating that they have not overdosed since using the TOPS (Q12)	TOPS Clients	Customer Satisfaction Survey	July-Aug 2018	Evaluation Team
Evaluation Question 4: Who is using the TOPS services and what substances they are using?					
Evaluation Sub-Questions	**Indicators**	**Data Sources**	**Data Collection Methods**	**Timeline**	**Person Responsible**
4.1 What substances are clients using at TOPS?	Type of substance used	TOPS clients	OPS Monthly Reporting Form	Feb-Aug 2018	TOPS staff
	# of clients that participated in drug checking (Fentanyl test strip)	TOPS staff	OPS Monthly Reporting Form	Feb-Aug 2018	TOPS staff

4.2 Are clients using the Fentanyl test strip drug checking service?	# of drug checks completed (Fentanyl test strip)	TOPS staff	OPS Monthly Reporting Form	Feb-Aug 2018	TOPS staff
	Type of substance identified by client that they checked using the Fentanyl test strips	TOPS staff	OPS Monthly Reporting Form	Feb-Aug 2018	TOPS staff
	# and % of positive results for Fentanyl test strip test	TOPS staff	OPS Monthly Reporting Form	Feb-Aug 2018	TOPS staff
	# and % of actions taken following a positive drug check result (i.e. reduced drug quantity, discarded drug, made no change, unknown)	TOPS staff	OPS Monthly Reporting Form	Feb-Aug 2018	TOPS staff
4.2 What are the demographic characteristics of the people accessing TOPS?	# of visits by clients under 25 years	TOPS clients	OPS Monthly Reporting Form	Feb-Aug 2018	TOPS staff
	% of clients reporting length of drug use/injecting prior to using the TOPS (Q8)	TOPS clients	Customer Satisfaction Survey	July-Aug 2018	Evaluation Team
	% of clients reporting the length of time living in London (Q16)	TOPS clients	Customer Satisfaction Survey	July-Aug 2018	Evaluation Team
	Description of how clients found out about the TOPS (Q1)	TOPS Clients	Key informant interviews	July-Aug 2018	Evaluation Team
Evaluation Question 5: How is the TOPS impacting the lives of people who use drugs in Middlesex-London?					
Evaluation Sub-Questions	Indicators	Data Sources	Data Collection Methods	Timeline	Person Responsible
How is TOPS having a positive/negative impact on your life?	Impact of TOPS on client lives (Q6: Client Survey; Q6 and Q9: Staff Interviews; Q8: Stakeholder Interviews)	TOPS clients TOPS Staff Stakeholders	Key informant interviews	July-Aug 2018	Evaluation Team
	% of clients reporting that the frequency of their drug use has changed since they have been using the TOPS (Q9)	TOPS Clients	Customer Satisfaction Survey	July-Aug 2018	Evaluation Team
	% of clients reporting that they feel more/less/same rushed when using/taking their drugs since the TOPS (Q10a)	TOPS Clients	Customer Satisfaction Survey	July-Aug 2018	Evaluation Team
	% of clients who have used drugs alone in the past reporting that they use alone more/less/same often since the TOPS (10b)	TOPS Clients	Customer Satisfaction Survey	July-Aug 2018	Evaluation Team

	% of clients reporting that they use/take more/less/same drugs since the TOPS (10c)	TOPS Clients	Customer Satisfaction Survey	July-Aug 2018	Evaluation Team
	% of clients who injected in public spaces in the past reporting that they now inject more/less/same frequent in public places since the TOPS (10d)	TOPS Clients	Customer Satisfaction Survey	July-Aug 2018	Evaluation Team
	% of clients who have disposed of gear in public spaces in the past reporting more/less/same frequent disposing of their gear in public spaces since the TOPS (10e)	TOPS Clients	Customer Satisfaction Survey	July-Aug 2018	Evaluation Team
	% of clients who have shared their gear in the past reporting more/less/same frequent level of sharing their gear now since the TOPS (10f)	TOPS Clients	Customer Satisfaction Survey	July-Aug 2018	Evaluation Team
	% of clients who re-used their gear in the past reporting more/less/same frequent re-using of their gear now since the TOPS (10g)	TOPS Clients	Customer Satisfaction Survey	July-Aug 2018	Evaluation Team
	% of clients who needed help injecting in the past reporting that they need more/less/same help with injecting now since the TOPS opened (10h)	TOPS Clients	Customer Satisfaction Survey	July-Aug 2018	Evaluation Team
	% of clients who had used sterile water in the past reporting that they use packaged water more/less/same frequency since the TOPS (10i)	TOPS Clients	Customer Satisfaction Survey	July-Aug 2018	Evaluation Team
	% of clients who had used alcohol swabs to clean injection sites in the past reporting more/less/same frequency since the TOPS(10j)	TOPS Clients	Customer Satisfaction Survey	July-Aug 2018	Evaluation Team
	% of clients who heated their drugs in the past reporting more/less/same frequency of heating their drugs since the TOPS (10k)	TOPS Clients	Customer Satisfaction Survey	July-Aug 2018	Evaluation Team
	Description of other ways in which clients drug use behaviours have changed since the TOPS (Q11)	TOPS Clients	Customer Satisfaction Survey	July-Aug 2018	Evaluation Team
	# of clients agreeing that they have learned tips to use/inject/take drugs more safely as a result of using the TOPS (Q13a)	TOPS Clients	Customer Satisfaction Survey	July-Aug 2018	Evaluation Team
	# of clients agreeing that they feel that the broader community cares about them as a result of using the TOPS (Q13b)	TOPS Clients	Customer Satisfaction Survey	July-Aug 2018	Evaluation Team

	# of clients agreeing that staff have talked to them or helped them to access other health and social services as a result of using TOPS (Q13c)	TOPS Clients	Customer Satisfaction Survey	July-Aug 2018	Evaluation Team
	# of clients agreeing that their feel accepted at the TOPS (Q13d)	TOPS Clients	Customer Satisfaction Survey	July-Aug 2018	Evaluation Team
	# of clients agreeing that it is easy for them to access Naloxone at the Overdose Prevention Site (Q13e)	TOPS Clients	Customer Satisfaction Survey	July-Aug 2018	Evaluation Team
	# of clients willing to test their drugs for Fentanyl at the TOPS (Q13f)	TOPS Clients	Customer Satisfaction Survey	July-Aug 2018	Evaluation Team
Why are clients accessing the services at TOPS?	Reasons for accessing TOPS (Q2)	TOPS clients	Key informant interviews with Clients	July-Aug 2018	Evaluation Team
What other services or support have clients been able to access because of the TOPS?	Description of Services/Support accessed	TOPS clients TOPS Staff Stakeholders	Key informant interviews	July-Aug 2018	Evaluation Team
Where would clients be without the services at TOPS?	Impact of TOPS on client lives (Q6a)	TOPS clients	Key informant interviews with Clients	July-Aug 2018	Evaluation Team
Have there been any positive/negative impacts that the TOPS has had on stakeholder organization?	Description of positive/negative unintended results/impacts on stakeholder organizations	Stakeholders	Key Informant Interviews	July-Aug 2018	Evaluation Team

Appendix E: Customer Satisfaction Survey and Key Informant Interviews with Clients

Introduction

The survey and key informant interviews with people who use drugs (PWUD) and who access the temporary overdose prevention site (TOPS) were conducted to:

- Determine satisfaction levels with the services provided at TOPS;
- Understand the impact that TOPS has had on their life; and
- Inform the development and implementation of future supervised consumption facilities (SCF).

Client Survey and Interview Implementation

Sampling and Recruitment

TOPS clients were recruited for the survey and interview using convenience sampling. Participants were identified by TOPS staff who had face-to-face interactions in the TOPS waiting room. TOPS Staff asked clients if they would like to find out more information about a study being conducted by the Middlesex-London Health Unit. They were informed of a survey and interview being conducted to gather their feedback on the site. A script for TOPS staff was provided to help with the initial recruitment stage (see Client Recruitment Script).

If clients were interested in finding out more about the evaluation, they were given the choice to participate before or after using the injection room. At this point, TOPS staff did not ask clients who were first time users of the site, non-English speaking, and those who were only accompanying people to the site. The number of clients who refused to participate was not recorded during the initial recruitment stage by TOPS Staff.

In some situations, clients were not told by staff about the evaluation being conducted. If clients were not following the site rules/code of conduct at the time or where exhibiting behaviors reflective of a delusional state, staff did not inform them about the evaluation that day. However, clients may have returned on subsequent days and were recruited by staff at that point as they were following site rules and/or in a better state with their mental well-being. This approach aligns with the site rules and code of conduct to ensure client and staff safety.

Time and Location of Data Collection

Data collection for clients at TOPS occurred over a 3.5-week duration between July 17th and August 12th including two weekends during this timeframe.

During the weekday shifts, surveys and interviews with participants were conducted in a private room called the Community Partner Engagement Room (also referred to among staff as the Counselling Room) located at Regional HIV/AIDS Connection on the same floor of TOPS Site. On the weekend shifts, surveys and interviews were conducted in the Intake Room for TOPS. On the weekends, RHAC and Counterpoint Needle Syringe Program are not opened and TOPS is only staffed by 3 individuals.

Inclusion and Exclusion Criteria

Prior to the start of the survey or interview process, three questions were asked to ensure that clients met the eligibility criteria. Clients who access TOPS were eligible to participate if all of the following criteria were met:

- They had used TOPS at least once since it had opened;

- They had used drugs in the past 6 months; and
- They were aged 18 years or older.

During the screening process, two clients did not meet all of the criteria above and were excluded from participating in the evaluation.

During the survey or interview process, if for any reason, the Program Evaluators recognized that a clients' ability to participate was compromised due to stress, physical or mental well-being, the data collection process was stopped. If applicable, clients were asked if they would like to speak to a TOPS staff to obtain further support. Alternatively, referrals were offered to the Mental Health and Addictions Crisis Centre.

Survey and Interview Administration

Surveys were administered face-to-face by two Program Evaluators. Using this approach, the Program Evaluators were available to address any issues that may arise due to literacy levels and provide further clarification on any questions. At the beginning of the survey and interview, clients were given information about the evaluation and a letter of consent (see Client Information Letter and Consent Form). Verbal consent to participate in the evaluation was obtained.

Quantitative and some qualitative data were collected using a client survey referred to as the Customer Satisfaction Survey (see Customer Satisfaction Survey). The surveys took approximately 15-30 minutes to complete.

The interviews with clients at TOPS were conducted in-person by two Program Evaluators using a semi-structured interview guide referred to as the "Client Interview Guide" (see Client Interview Guide). The interviews took approximately 20-30 minutes to complete. One Program Evaluator read the semi-structured interview guide and responses were recorded by the second Program Evaluators using field notes. To validate the field notes, at the end of the interview the note taker summarized the feedback provided and asked the participant to verify it for accuracy. At the request of the participant, the interviewer added or changed content in the interview field notes. This validation process contributed to the accuracy of data.

Survey and Interview Sample

A total of 105 Customer Satisfaction Surveys were completed with the aim for a sample of 100 participants. A total of 26 participants were interviewed for the key informant interviews with clients where the aim was to conduct 10-12 interviews. The qualitative feedback from the client interviews was monitored during the interview process to ensure that the sample size was large enough to reach data saturation.

Survey and Interview Analysis

The survey and interview included the collection of both quantitative and qualitative data. A description of the data analysis plans for each of these methods is described below:

Quantitative Data Analysis

Quantitative data from the surveys were entered into CheckMarket Survey Software and analyzed for descriptive statistics using Excel by the Program Evaluators. CheckMarket is an online survey platform which complies with MLHU privacy and confidentiality policies.

For all questions where the proportion of those reporting "I do not know" or "I prefer not to answer" was under 5%, those categories were excluded from the denominator. For questions where the proportion of those reporting "I do not know" and "I prefer not to answer" was 5% or over, the proportions are included in the analysis.

Qualitative Data Analysis

Qualitative data was analyzed in NVivo using inductive content analysis (Patton, 2002) to reveal themes and sub-themes that emerged directly from the data. This method permitted the Program Evaluators to gain an in-depth understanding of participants' experiences. Two Program Evaluators reviewed each interview transcript separately and developed a codebook of emerging codes for each of the qualitative data sources (i.e. Client Interviews, Client Survey (qualitative data), Staff Interviews and Stakeholder Interviews).

Qualitative data was uploaded in NVivo software (QSR NVivo 10). The Program Evaluators coded the transcripts using the preliminary codebooks. A second Program Evaluator reviewed the coded transcripts to identify any inconsistencies in the coding process. The Program Evaluators met to reconcile any discrepancies that arose during the coding process. Once the coding process was complete, the relationships between different themes were compared and contrasted across the sources of data to help understand the findings.

The Program Evaluators followed quality assurance steps during data collection and analysis (Guba & Lincoln, 1989) to ensure data trustworthiness, which included: (a) credibility – member-checking at the end of the interviews through validation of the interview transcript in order to ensure that feedback was accurately reflected; (b) confirmability – independent completion of the development of the coding frameworks for each data source; (c) dependability – Program Evaluators debriefed and reconciled the coding process to safeguard against bias and errors; and (d) transferability – providing documentation of study methods, procedures, and analyses in order for others to establish whether or not the findings may be transferable to other settings.

Thematic maps are presented for some of the qualitative findings to show a visual representation of the relationships between the key themes and sub-themes. Selected quotations from the interview transcripts have been included in the results section to illustrate key themes and full data tables with examples of key quotes are included Appendix L and Appendix M. Quotations not verbatim quotes that would be typically found in audio recorded transcripts; however, the participants validated the content of the transcripts by reviewing the full transcript.

Survey and Interview Limitations

Recording interviews

The decision not to audio-record the interviews limits the ability to have direct quotations. This decision was informed by key stakeholders during the development of the evaluation. They indicated that TOPS clients would not feel comfortable with this practice. As a result, an alternative solution was developed to record the feedback on the laptop and read it back to participants for validation.

Self-Reported Data

The primary data findings summarized in this report are based on self-reported participant information. It is recognized that self-reported data may vary at different time points based on the participants' comfort level in sharing their perspectives.

Social Desirability Bias

Some participants may have responded to questions in a manner perceived as more favourable by the Program Evaluators.

Recall bias

There was a subset of questions on the client survey decreased asking them to reflect on their consumption behaviours since the site had opened. It is recognized that their ability to recall whether their consumption behaviours may have increased, or stayed the same may have been impacted by their ability to remember this information.

Duplication of responses

Due to the anonymity of the site, shift rotations of TOPS staff, and the rotations of Program Evaluators collecting data at the site, there may have been a couple of circumstances where the same clients at the site completed the survey more than once.

Scripts, Consent and Data Collection Tools

Client Recruitment Script for use by TOPS Staff

When to Not Use this Script:

- First time users of TOPS
- Non-English Speaking clients

Hi **[insert client's first name]**,

The Middlesex-London Health Unit (MLHU) is doing a study to find out about clients' experiences at this Site. Would you like to find out more about the study? Your decision whether or not to hear more about the study will NOT affect any of the services and support you receive at the site and will not impact your relationship with the staff.

- If client indicates "Yes"

  State: "Would you like to do that before or after using the room?"

  - If they reply, "Now", walk client to the designated room to meet the Program Evaluator.

  - If they reply, "After using the room", state, "Ok, that's great. Just come back to see me when you are ready and I'll take you to meet with the health unit staff".

- If no: "Not a problem. If you change your mind later, feel free to let me know."

Client Survey and Interview Recruitment Script

Hi **[insert client's first name],**

I'm part of the Middlesex-London Health Unit (MLHU) evaluation team that is conducting an evaluation of this Temporary Overdose Prevention Site. We are hoping to hear about what you think of the site, and how the services can be improved here. We also want to know what will work best or will not work at future sites. Would you be interested in hearing more about the evaluation?

If yes, proceed to **eligibility criteria:**

- "OK, first I have a few questions to check if you're eligible to participate:
    - Are you 18 years or older?"
        - If yes, proceed
        - If no, "I'm sorry, we're looking for participants 18 years of age or older."
    - "Have you used or injected drugs within the past six months?"
        - If yes, proceed
        - If no, "I'm sorry, we're looking for participants who have used drugs within the past six months"
    - "Have you used the Overdose Prevention Site at any point since it opened in February 2018?"
        - If yes, proceed
        - If no, "I'm sorry, we're looking for participants who have used the Overdose Prevention Site since it opened."
    - Is this the first time you've participated in this study?
        - If yes: "Ok, now I would like to read you some information about the study"
        - If no, "I'm sorry, we're looking for people that haven't participated before."

If you decide to participate in this evaluation, there are a couple of options for you to consider. There is a short survey that takes approximately 10 minutes. You can choose to complete this survey yourself or we can ask you the questions. There is also the option to complete an interview that will take about 20 to 25 minutes to complete. This interview will ask a few more questions about your experience at the site and if it has made any difference in your life.

- If client indicates "Yes"

    - State: "Ok great. Are you interested in participating in just the survey, the interview, or both?"
    - If client agrees to complete survey, "Would you like us to ask the questions or would you like to fill it out yourself?"
        - Verbally administered
        - Self-administered

- [Proceed with consent process]

If no: "Not a problem. If you change your mind later, feel free to let me know."

Client Survey Information Letter and Consent Form

Temporary Overdose Prevention Site (TOPS) Evaluation

Thank you for your willingness to hear more about the "Temporary Overdose Prevention Site (TOPS) Evaluation" that is being conducted by the Middlesex-London Health Unit (MLHU).

What is this project about?

The purpose of this evaluation project is to understand the impact and effectiveness of the Temporary Overdose Prevention Site in Middlesex-London, Ontario. The findings from this evaluation will give us information we need to try to improve the services we offer. Additionally, the evaluation could inform the development and implementation of possible permanent Supervised Consumption Facilities (SFCs) in the future in Middlesex-London, Ontario.

Who can participate?

Anyone who is 18 years of age or older, has used or injected drugs in the past six months, and has used the Overdose Prevention Site at any point since it opened (in February 2018) is eligible to participate.

What do I have to do if I participate?

You will be asked a series of survey questions about your use of the site, your experiences with drug use, and any impacts that the site has had on your own life. This survey will take about 10 minutes to complete. Your participation is voluntary and your decision whether or not to participate will NOT affect any of the services and supports you receive from staff at the site.

Are there any benefits if I participate?

There are no direct benefits to you for participating, however, your answers may help us change our services to better meet the needs of all clients at the Overdose Prevention Site.

Are there any risks if I participate?

You may feel uncomfortable or upset answering some questions. You do not have to answer them if you do not want to. If you feel upset at any time, you can stop the interview and the evaluator will connect you with an RHAC staff member who can direct you to resources and supports that can help.

Are there any costs to me?

There are no costs to you to complete this survey apart from your time and effort.

How will my information be protected?

The information that you share with us will be confidential and anonymous, unless reporting is required by law. Interviews will be done in a private room, and we will not share your information or responses with TOPS staff or anyone else. We will not be collecting your name or other directly identifying information. We will keep all of your information safely secured in either a locked briefcase or filing cabinet, or on a password-protected computer server.

Payment for my time

You will receive $10.00 for taking part in this project. If you do not finish the survey, you will still receive $10.00.

Who will see the results of this project?

The results of the evaluation will be shared in reports and presentations within the Middlesex-London Health Unit and other local partner organizations. Results may also be published in academic publications or presented at conferences. Neither your name or any information that could identify you will be used.

What if I change my mind about doing the survey?

If while you are doing the survey you decide you do not want your answers to be included in the evaluation, you can tell the evaluator and your information will be destroyed. However, it you have completed the survey, then it will not be possible to remove your information, because we are not collecting your name and so will not be able to identify your responses.

What if I have questions about the project?

Please ask the evaluator now, or contact Jordan Banninga, Supervisor of the "Temporary Overdose Prevention Site (TOPS) Evaluation," at 519-663-5317 ext. 2408 or jordan.banninga@mlhu.on.ca.

What if I have questions about my rights as a participant?

This evaluation has received approval from Public Health Ontario's Ethics Review Board. If you have concerns about your rights as a participant in this project, you can contact the Research Ethics Coordinator at Public Health Ontario, by email at ethics@oahpp.ca, or by phone at 647-260-7206.

	YES	NO
Do you understand the information that has been shared with you?	☐	☐
Did you get the opportunity to ask any questions that you may have?	☐	☐
Are you aware that you can stop this survey at any time?	☐	☐
Do you want to participate in the study?	☐	☐

Signature

I described the project to the participant and answered their questions. I believe the person signing this document understands what is expected with regard to participation and is agreeing to participate. I have given a copy of this information form to the participant.

_____

Name of Person Who Obtained Consent (Please Print)

_____ _____

Signature of Person Who Obtained Consent Date Signed

Customer Satisfaction Survey (Client Survey)

Eligibility Questions:

* **Are you 18 years or older?**

☐ Yes
☐ No → if no, end survey.

* **Have you used or injected drugs in the past 6 months?**

☐ Yes
☐ No → if no, end survey.

* **Have you used the Overdose Prevention Site at any point since it opened in February 2018?**

☐ Yes
☐ No → if no, end survey.

We now have some questions for you about your use of the Overdose Prevention Site:

* Do you use the Overdose Prevention Site on the weekend?

☐ Yes, Saturday only → Skip the next question

☐ Yes, Sunday only → Skip the next question

☐ Yes, on Saturday and Sunday → Skip the next question

☐ I don't access the site on the weekends

☐ I don't know

☐ I prefer not to answer

* Please explain why you don't access the site on the weekends?

_____

* **How often do the following factors below get in the way of you using the Overdose Prevention Site?**

	1 Always	2 Often	3 Sometimes	4 Rarely	5 Never	6 I don't know	7 I prefer not to answer
The site being located at 186 King Street?	☐	☐	☐	☐	☐	☐	☐
Travel time to get to the site?	☐	☐	☐	☐	☐	☐	☐
Waiting time to get into the consumption room?	☐	☐	☐	☐	☐	☐	☐
The rules and regulations of the site?	☐	☐	☐	☐	☐	☐	☐
Operating hours of the site?	☐	☐	☐	☐	☐	☐	☐

What additional hours would you prefer?

☐ Earlier, before 10:00 AM
☐ Later, after 4:00 PM
☐ Both, earlier and later
☐ The current hours are fine
☐ I don't know
☐ I prefer not to answer

*** How would you rate the quality of services and care that you receive from staff?**

☐ Poor

☐ Fair

☐ Good

☐ Excellent

☐ I don't know

☐ I prefer not to answer

* **Overall, how would you rate the Overdose Prevention Site as a place to take/use drugs?**

☐ Poor

☐ Fair

☐ Good

☐ Excellent

☐ I don't know

☐ I prefer not to answer

* **How likely are you to recommend the Overdose Prevention Site to other people who use drugs?**

☐ Extremely likely

☐ Likely

☐ Neutral

☐ Unlikely

☐ Extremely unlikely

☐ I don't know

☐ I prefer not to answer

Are there other services you would like offered here at the Overdose Prevention Site? If so, please tell us which ones.

We now have some questions to ask you about your experiences with drug use in relation to the Overdose Prevention Site.

How long have you been injecting prior to using the Overdose Prevention Site?

☐ Less than one month

☐ Less than one year

☐ One to 5 years

☐ Greater than 5 years

☐ First injection at the Overdose Prevention Site

☐ I don't inject drugs

☐ I don't know

☐ I prefer not to answer

We now have some questions to ask you about your experiences with drug use in relation to the Overdose Prevention Site.

* **How long have you been injecting prior to using the Overdose Prevention Site?**

☐ Less than one month

☐ Less than one year

☐ One to 5 years

☐ Greater than 5 years

☐ First injection at the Overdose Prevention Site

☐ I don't inject drugs

☐ I don't know

☐ I prefer not to answer

We would like to know the effect that the Overdose Prevention Site has had on your day-to-day life.

* Do you think that the frequency of your drug use has changed since you've been using the Overdose Prevention Site?

☐ Yes

☐ No

☐ I don't know

☐ I prefer not to answer

How has the frequency of your drug use changed?

☐ Increased
☐ Decreased
☐ Stayed the same
☐ I prefer not to answer

Since the Overdose Prevention Site Opened, in what way(s) have your consumption behaviours changed?

	1 More	2 Less	3 Stayed the same	6 Not Applicable	4 I don't know	5 I prefer not to answer
Do you feel more or less rushed when using/taking your drugs, or has this stayed the same?	☐	☐	☐	☐	☐	☐
If you used alone in the past, would you say that now you use drugs alone more or less often, or has this stayed the same?	☐	☐	☐	☐	☐	☐
Do you use/take more or less drugs, or has this stayed the same?	☐	☐	☐	☐	☐	☐
If you injected in public spaces in the past, would you say that now you are injecting more in public spaces (parks, alleys, streets, etc.), less in public spaces (parks, alleys, streets, etc.), or has this stayed the same?	☐	☐	☐	☐	☐	☐
If you disposed of your gear in public spaces in the past, would you say that you are now disposing your gear more in public spaces (parks, alleys, streets, etc.), less in public spaces (parks, alleys, streets, etc.), or has this stayed the same?	☐	☐	☐	☐	☐	☐
If you shared your gear in the past, would you say that now you share your gear more often, less often with others, or	☒	☐	☒	☐	☐	☐

has this stayed the same?						
If you re-used your gear in the past, would you say that now you reuse your gear more often, less often, or has this stayed the same?	☐	☐	☐	☐	☐	☐
If you needed help injecting in the past, would you say that now you need help with injecting more often, less often, or has this stayed the same?	☐	☐	☐	☐	☐	☐
If you used sterile water in the past, would you say that now you use packaged (blue-pack) water more often, less often, or has this stayed the same (i.e., water from needle exchange program)?	☐	☐	☐	☐	☐	☐
If you used alcohol swabs to clean injection sites in the past, would you say that now you use alcohol swabs to clean injection sites more often, less often, or this has stayed the same?	☐	☐	☐	☐	☐	☐
If you heated your drugs in the past, would you say that now you heat your drugs more often, less often, or has this stayed the same?	☐	☐	☐	☐	☐	☐

* **Are there other ways in which your drug use behaviours have changes since the Overdose Prevention Site opened?**

☐ No

☐ Yes, please specify

.....

*	**As a result of using the Overdose Prevention Site, has the number of times that you have overdosed…**	
	☐ Increased	
	☐ Stayed the same	
	☐ Decreased	
	☐ I have never overdosed	
	☐ I have not overdosed since using the Overdose Prevention Site	
	☐ I don't know	
	☐ I prefer not to answer	

* As a result of using the Overdose Prevention Site, please tell us if you agree or disagree with the following statements:

	1 Strongly agree	2 Agree	3 Neither agree or disagree	4 Disagree	5 Strongly disagree	6 I don't know	7 I prefer not to answer
I have learned tips to use / inject / take drugs more safely.	☐	☐	☐	☐	☐	☐	☐
I feel that the broader community cares about me.	☐	☐	☐	☐	☐	☐	☐
Staff have talked to me or helped me to access other health and social services.	☐	☐	☒	☐	☐	☐	☐
I feel accepted at the Overdose Prevention Site.	☐	☐	☐	☐	☐	☐	☐
I can access Naloxone easily at the Overdose Prevention Site.	☐	☐	☐	☐	☐	☐	☐
I am willing to test my drugs for Fentanyl at the Overdose Prevention Site before using.	☐	☐	☐	☐	☐	☐	☐

* **Prior to using the Overdose Prevention Site, how often did you use the Counterpoint Needle Exchange Program here at Regional HIV/AIDS Connection (RHAC)?**

☐ Once per week

☐ 2 – 3 times per week

☐ 4 – 6 times per week

☐ Once per day

☐ More than once per day

☐ Never

☐ I don't know

☐ I prefer not to answer

☐ Other, please specify

.....

* **If there was a mobile Supervised Consumption Services van that could travel to you, how likely would you be to use it?**

☐ Extremely likely

☐ Likely

☐ Neutral

☐ Unlikely

☐ Extremely unlikely

☐ I don't know

☐ I prefer not to answer

* **How long have you lived in London, Ontario?**

☐ Under 1 year

☐ 1 – 3 years

☐ 4 – 6 years

☐ 7 or more years

☐ I don't live in London

☐ I don't know

☐ I prefer not to answer

Is there anything else you would like to tell us about the Overdose Prevention Site in our community that we haven't already talked about?

Client Interview Information Letter and Consent Form

Temporary Overdose Prevention Site (TOPS) Evaluation

Thank you for your willingness to hear more about the "Temporary Overdose Prevention Site (TOPS) Evaluation" being conducted by the Middlesex-London Health Unit (MLHU).

What is this project about?

The purpose of this evaluation project is to understand the impact and effectiveness of the Temporary Overdose Prevention Site in Middlesex-London, Ontario. The findings from this evaluation will give us information we need to try to improve the services we offer. Additionally, the evaluation could inform the development and implementation of possible permanent Supervised Consumption Facilities (SFCs) in the future in Middlesex-London, Ontario.

Who can participate?

Anyone who is 18 years of age or older, has used or injected drugs in the past six months, and has used the Overdose Prevention Site at any point since it opened (in February 2018) is eligible to participate.

What do I have to do if I participate?

As a participant in the evaluation project, you will be interviewed by someone from the project team. In the interview you will be asked questions about your use of the site, your experiences with drug use, and any impacts that the site has had on your own life. Completing the interview will take 20 to 25 minutes. Another member of the evaluation team will be present to take or type notes of the interview. He/she will read the notes back to you at the end to check that they are correct.

Your participation in the interview is voluntary and your decision whether or not to participate in this interview will NOT affect the services and support you receive from staff at the site.

Are there any benefits if I participate?

There are no direct benefits to you for participating, however, your answers may help us change our services to better meet the needs of all clients at the Overdose Prevention Site.

Are there any risks if I participate?

You may feel uncomfortable or upset answering some questions. You do not have to answer them if you do not want to. If you feel upset at any time, you can stop the interview and the interviewer will connect you with an RHAC staff member who can direct you to resources and supports that can help.

Are there any costs to me?

There are no costs to you to complete this interview apart from your time and effort.

How will my information be protected?

The information that you share with us will be confidential and anonymous, unless reporting is required by law. Interviews will be done in a private room, and we will not share your information or responses with TOPS staff or anyone else. We will not be collecting your name or other directly identifying information. We will keep all of your information safely secured in either a locked briefcase or filing cabinet, or on a password-protected computer server.

Will I receive payment for my time?

You will receive $15.00 for taking part in this interview. If you do not finish the interview, you will still receive $15.00.

Who will see the results of this project?

The results of the evaluation will be shared in reports and presentations within the Middlesex-London Health Unit and other local partner organizations. Results may also be published in academic or publications or presented at conferences. Neither your name or any information that could identify you will be used.

What if I change my mind about doing the interview?

If while you are doing the interview, you decide you do not want your answers to be included in the evaluation, you can tell the interviewer to remove your responses and your information will be destroyed. However, if you have completed the interview, then it will not be possible to remove your information, because we are not collecting your name and so will not be able to identify your responses.

What if I have questions about the project?

Please ask the evaluator now, or contact Jordan Banninga, Supervisor of the "Temporary Overdose Prevention Site (TOPS) Evaluation," at 519-663-5317 ext. 2408 or jordan.banninga@mlhu.on.ca.

What if I have questions about my rights as a participant?

This evaluation has received approval from Public Health Ontario's Ethics Review Board. If you have any concerns about your rights as a participant, you can contact the Research Ethics Coordinator at Public Health Ontario, by email at ethics@oahpp.ca, or by phone at 647-260-7206.

Client Interview Guide

1. How did you find out about the Overdose Prevention Site?
2. Why are you using the Overdose Prevention Site? (Note: Probe for "a" below if participants do not mention this)
    - What are your reasons for coming here?

3. Can you tell me about your experience using the Overdose Prevention Site? (Note: Probe for "a-f" below if participants do not mention these)
    a. Staff friendliness, responsiveness, reliability, helpfulness, approachability
    b. Staff understanding needs
    c. Connections made with staff
    d. Environment: welcoming, clinical/non clinical environment, space, size
    e. Connections made with other peers
    f. Staff at the Overdose Prevention Site e.g., nurses or harm reduction workers

4. What do you like most/least about the Overdose Prevention Site? **(Note: Probe for "a-c" below if participants do not mention these)**
    a. Needle Syringe Program at RHAC (i.e. Counterpoint)
    b. Relationship with staff
    c. Accessibility of the site

5. How would you change the Overdose Prevention Site to make it better? **(Note: Probe for "a-c" below if participants do not mention these)**
    a. Additional support staff or services
    b. Changes to the space, size, environment
    c. Changes to hours of operation

6. What impact has having the Overdose Prevention Site open had on your day-to-day life? **(Note: Probe for "a" below if participants do not mention it)**
    a. What if the site did not exist?

7. Before we end today, is there anything else you would like to share with us?

Note to interviewer: Provide a summary of the participants' responses to them for validation.

Do you agree or disagree with the summary?

☐ Agree

☐ Disagree

Is there anything you would like to add or change to the summary?

Appendix F: Survey of Community Residents and Business Owners within 120 meters of TOPS

Introduction

The survey of community residents and business owners within 120m of TOPS was conducted for the following purposes:
To understand satisfaction with and/or concerns about TOPS from residents and business owners within the surrounding neighbourhood of TOPS (120-metre radius of the site); and

- To inform development and implementation of future Supervised Consumption Facilities (SCF).

Business and Residents Survey Implementation

Sampling and Recruitment

The surveys were distributed through Canada Post using the Precision Targeter Direct Mail Service. A total of 570 residents and business owners were invited to participate. This service allowed for distribution to addresses within a 120m radius of the site. Residents and business owners received a recruitment and consent letter (see Recruitment and Consent Letter), a link to an online survey, a paper copy of the survey (see Business and Resident Survey), and a prepaid envelope.

Time and Location of Data Collection

The data collection phase occurred over a 3-week period in August 2018 for the survey to reach participants, to be completed (online or on paper), and for the paper surveys to be returned to the Middlesex-London Health Unit.

Inclusion and Exclusion Criteria

Community residents and business owners were eligible if they were:
Aged 18 years or older; and

- Live or work within a 120-metre radius of TOPS.

Survey Administration

The link to the online survey was accompanied by a randomly generated code that is required to complete the online survey. This code was included in the paper copy of the survey. The tracking code was unique and non-identifiable. This code allowed the evaluation team to ensure that participants did not submit the survey twice (online and in paper form), and thus avoiding duplication of data. This procedure minimized the likelihood of multiple responses being collected. In the event that the same tracking code was received more than once, only the first completed survey was included in the evaluation and additional surveys were destroyed. Additionally, the Canada Post Precision Targeter service only delivered one survey per address within the 120m radius.

Survey Sample

Of the 570 unique addressed that were mailed a survey, a total of 21 surveys were completed. Of those respondents, 12 respondents indicated that they were aged 18 years or older and live or work within a 120-metre radius of TOPS. This represents a response rate of 2%.

Survey Analysis

Due to the small sample size, only qualitative comments from the respondents on the survey were categorized by two Program Evaluators in Excel according to themes. Of those people that participated (n=12), there were diverse opinions that reflect both perceived benefits and

perceived concerns. The findings are reported on in Part 3 of the report on the section referring to "Impacts on the community".

Survey Limitations

Nonresponse Bias

The low response rate for the survey (2%) is a significant limitation to the findings of this survey due to a lack of representation of the population of interest.

Scripts, Consents and Data Collection Tools

Information Letter and Consent

Dear Community Member,

I am writing to invite you to participate in the Temporary Overdose Prevention Site (TOPS) Evaluation that the Middlesex-London Health Unit (MLHU) is conducting. You have been invited to participate because you live or work within a 120-metre radius of the TOPS.

Introduction:
The TOPS is Ontario's first government approved overdose prevention site that opened on February 12th, 2018 at Regional HIV/AIDS Connection (186 King Street, London). The site aims to reduce drug-use related harms, opioid overdoses and deaths, as well as promote health among people who use or inject drugs in Middlesex-London.

What is the purpose of this evaluation?
The purpose of this evaluation project is to understand the impact and effectiveness of the TOPS in Middlesex-London, Ontario. Additionally, the evaluation could inform the development and implementation of possible future permanent Supervised Consumption Facilities (SFCs) in Middlesex-London, Ontario.

What will your participation involve?
Your participation involves the completion of a survey. The survey asks questions about the Temporary Overdose Prevention Site (TOPS) and will take 5 to 10 minutes to complete. You will have the option to complete this survey online, using the link that has been provided below, or on paper, using the survey that has been included in this envelope. **Your participation is completely voluntary.** Your decision whether or not to participate in this survey will not affect the services that you receive from the Middlesex-London Health Unit. Your responses will be kept anonymous and confidential. **Please note, you may withdraw at any time without consequence.** If you decide to withdraw simply do not submit your survey. Once you submit your survey responses, we cannot remove your answers from the evaluation as the surveys are anonymous.

What are the benefits of completing this survey?
You will not benefit directly from taking part in this evaluation project. However, the results may help us to better understand the impact and effectiveness of the TOPS in the neighbourhood that it operates in and will help us as we plan for future permanent sites.

Are there any risks involved?
There are no known risks associated with completing this survey.

Are there any costs to you?
There is no cost to you to take part in the evaluation project apart from your time and efforts.

How will your information be protected?
The information that you provide by completing this survey will be kept confidential unless reporting is required by law. The evaluation team will take the following steps to protect your identity and keep all information confidential:

- All information you provide will be filed electronically on encrypted laptops and stored on a secure server. Paper surveys will be securely stored at MLHU offices in locked filing cabinets.
- Only members of the Evaluation Team will have access to individual data that has been provided in the survey. This data will be analyzed and aggregated by members of the Evaluation Team. No information that could identify you will be shared.
- Evaluation project data will be stored for 7 years at MLHU, and then destroyed.

How will evaluation results be shared?
The results of the evaluation will be shared in reports or presentations within the MLHU and other local partner organizations. Results may also be published in academic journals or presented at conferences.

What if you have questions about the evaluation?
If you have any questions about the study or concerns about taking part in this evaluation project, please contact Jordan Banninga, Supervisor of the "Temporary Overdose Prevention Site (TOPS) Evaluation," at 519-663-5317 ext. 2408 or jordan.banninga@mlhu.on.ca.

What if you have questions about your rights as a participant?
This project has received approval from Public Health Ontario's Ethics Review Board. If you have any concerns about your rights as a participant, you can contact the Research Ethics Coordinator at Public Health Ontario, by email at ethics@oahpp.ca, or by phone at 647-260-7206.

How do I complete the survey?
You have two options to complete the survey. You can either complete the survey online, using the link that has been provided below, or you can complete the paper copy of the survey that has been included in this form.

If completing the paper survey:
- Use the form attached to complete the survey.
- Please make sure to provide your consent by checking the box.
- The deadline to complete and mail this survey is **August 11th, 2018.**
- Please use the pre-addressed stamped envelope to send us the completed survey through the mail.

If completing the survey online:
- Use the following link: https://s-ca.chkmkt.com/TOPSsurvey
- Please enter this code: **"«Name»**" when you complete your survey.
- The deadline to complete this survey is **August 11th, 2018.**

By completing the survey, you have provided consent to the evaluation team to use your survey responses in the "Temporary Overdose Prevention Site (TOPS) Evaluation."

Thank you for your time,

Jordan Banninga
Manager of Program Planning and Evaluation
Middlesex-London Health Unit
50 King Street, London, ON
N6A 5L7
519-663-5317 ext. 2408
Jordan.banninga@mlhu.on.ca

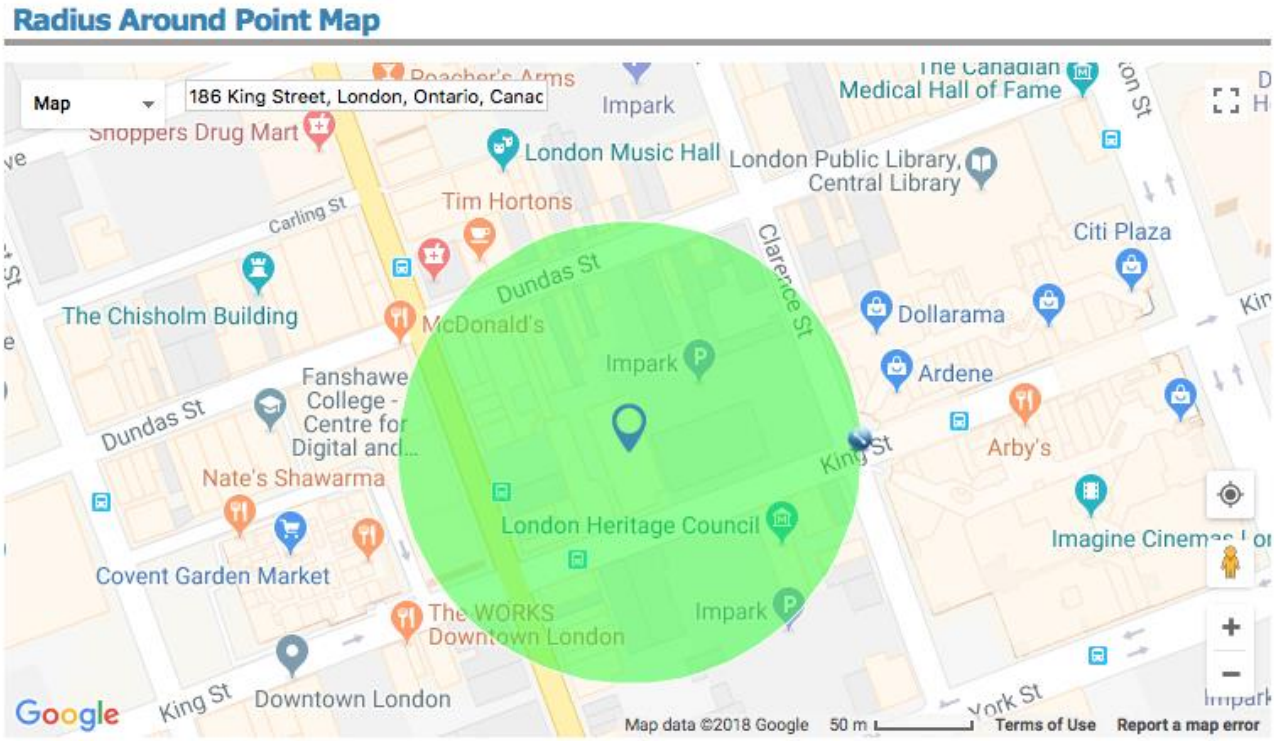
Business and Residents Survey

Eligibility Screening Question

I. **Do you live or work within 120 metres of 186 King Street?** (The green circle denotes the 120-metre radius)

(Check ONLY one)

☐ Yes
☐ No → **if no, please end the survey.**



II. **Are you 18 years of age or older?** (Check ONLY one)

☐ Yes
☐ No → **if no, please end the survey.**

---

1. **Are you a person living in the vicinity, a business owner, or both?** (Check ONLY one)
   ☐ Person living in the vicinity
   ☐ Business owner
   ☐ Both

2. **Do you know about the Temporary Overdose Prevention Site (TOPS) that opened on February 12th, 2018, in your neighbourhood?** (Check ONLY one)

☐ Yes
☐ No
☐ I don't know
☐ I prefer not to answer

We would like to get your perspectives on what you have observed since the Temporary Overdose Prevention Site (TOPS) opened in your neighbourhood on February 12th, 2018.

Since the opening of the Temporary Overdose Prevention Site (TOPS)…

3. **Injection-related waste, including discarded needles and syringes in your neighbourhood has…** (Check ONLY one)
   ☐ Decreased a lot
   ☐ Decreased a little
   ☐ Stayed the same
   ☐ Increased a little
   ☐ Increased a lot
   ☐ I don't know
   ☐ I prefer not to answer

4. **Public drug use / injection in your neighbourhood has…** (Check ONLY one)
   ☐ Decreased a lot
   ☐ Decreased a little
   ☐ Stayed the same
   ☐ Increased a little
   ☐ Increased a lot
   ☐ I don't know
   ☐ I prefer not to answer

5. **Illegal drug transactions in your neighbourhood have…** (Check ONLY one)
   ☐ Decreased a lot
   ☐ Decreased a little
   ☐ Stayed the same
   ☐ Increased a little
   ☐ Increased a lot
   ☐ I don't know
   ☐ I prefer not to answer

6. **Criminal activity in your neighbourhood has…** (Check ONLY one)
   - ☐ Decreased a lot
   - ☐ Decreased a little
   - ☐ Stayed the same
   - ☐ Increased a little
   - ☐ Increased a lot
   - ☐ I don't know
   - ☐ I prefer not to answer

7. **The number of people overdosing in your neighbourhood has…** (Check ONLY one)
   - ☐ Decreased a lot
   - ☐ Decreased a little
   - ☐ Stayed the same
   - ☐ Increased a little
   - ☐ Increased a lot
   - ☐ I don't know
   - ☐ I prefer not to answer

Research has shown that there are multiple benefits with the implementation of Overdose Prevention Sites and/or Supervised Consumption Facilities (formerly known as safe injection sites). The Temporary Overdose Prevention Site (TOPS) was introduced on February 12th, 2018, to help prevent opioid toxicity related deaths in our community.

In your opinion, if there was **NOT** a TOPS in your neighbourhood, **do you think that…**

8. **Drug overdoses would…** (Check ONLY one)
   - ☐ Increase a lot
   - ☐ Increase a little
   - ☐ Stay the same
   - ☐ Decrease a little
   - ☐ Decrease a lot
   - ☐ I don't know
   - ☐ I prefer not to answer

9. **Emergency and health care usage related to drug use and overdoses would…** (Check ONLY one)
   - ☐ Increase a lot
   - ☐ Increase a little
   - ☐ Stay the same
   - ☐ Decrease a little
   - ☐ Decrease a lot
   - ☐ I don't know
   - ☐ I prefer not to answer

10. **The number of people who use / inject drugs that are using community services (e.g., counselling, addiction treatment, housing, etc.) would…** (Check ONLY one)
    - ☐ Increase a lot
    - ☐ Increase a little
    - ☐ Stay the same
    - ☐ Decrease a little
    - ☐ Decrease a lot
    - ☐ I don't know
    - ☐ I prefer not to answer

11. **Drug-related waste/litter in the neighbourhood, such as improperly disposed needles and syringes, would…** (Check ONLY one)
    - ☐ Increase a lot
    - ☐ Increase a little
    - ☐ Stay the same
    - ☐ Decrease a little
    - ☐ Decrease a lot
    - ☐ I don't know
    - ☐ I prefer not to answer

12. **In general, public drug use / injection would…** (Check ONLY one)
    - ☐ Increase a lot
    - ☐ Increase a little
    - ☐ Stay the same
    - ☐ Decrease a little
    - ☐ Decrease a lot
    - ☐ I don't know
    - ☐ I prefer not to answer

13. **The number of people who use / inject drugs in my neighbourhood would…** (Check ONLY one)
    - ☐ Increase a lot
    - ☐ Increase a little
    - ☐ Stay the same
    - ☐ Decrease a little
    - ☐ Decrease a lot
    - ☐ I don't know
    - ☐ I prefer not to answer

14. **The number of illegal drug transactions in the neighbourhood would…** (Check ONLY one)
    - ☐ Increase a lot
    - ☐ Increase a little
    - ☐ Stay the same
    - ☐ Decrease a little
    - ☐ Decrease a lot
    - ☐ I don't know
    - ☐ I prefer not to answer

15. **Crime in the neighbourhood would…** (Check ONLY one)
    - ☐ Increase a lot
    - ☐ Increase a little
    - ☐ Stay the same
    - ☐ Decrease a little
    - ☐ Decrease a lot
    - ☐ I don't know
    - ☐ I prefer not to answer

16. **Overall, what kind of impact do you believe that the TOPS has had on your neighbourhood?** (Check ONLY one)
    - ☐ Very positive
    - ☐ Somewhat positive
    - ☐ Neutral
    - ☐ Somewhat negative
    - ☐ Very negative
    - ☐ I don't know
    - ☐ I prefer not to answer

17. **Do you have any additional feedback or thought that you would like to share with us about the TOPS in your neighbourhood? Please explain.**

    Response:

    _____

    _____

    _____

    _____

Thank You for Your Time!

Appendix G: Temporary Overdose Prevention Site Staff Interviews

Introduction

The key informant interviews with Staff/Leads at TOPS were conducted to:

- Understand the operations of TOPS, what is working well/not well and suggested changes or adaptations;
- Obtain their perspectives on client and staff impact; and
- Inform development and implementation of future Supervised Consumption Facilities (SCF).

Staff Interview Implementation

Sampling and Recruitment

A purposive sampling strategy was used whereby all TOPS Staff/Leads were invited to participate in a key informant interview. A contact list of all TOPS Staff/Leads was obtained by TOPS Program Lead at the Middlesex London Health Unit. TOPS staff/leads were contacted by email from the evaluation team using an email script (see Staff Recruitment Email). One reminder email was sent to Staff/Leads, then no further contact was made unless they initiated contact. Interviews were set up at a convenient location and date.

Time and Location of Data Collection

The data collection phase occurred over a 6-week period between July and August 2018. The interviews took approximately 1 to 1.5 hours in duration.

Interviews were conducted at a location convenient to the Staff/Leads. Meeting rooms at MLHU were utilized for the majority of the interviews. However, a few interviews also took place at RHAC in offices or in the Community Partner Engagement Room at the site.

Inclusion and Exclusion Criteria

All staff who work at TOPS were eligible to participate in the interview. Types of staff include:

- Public Health Nurse;
- Paramedic;
- Harm Reduction Worker; and
- Outreach Worker.

Interview Administration

At the beginning of the interview, information about the evaluation was provided to Staff/Leads in the Information and Consent Letter included in (see Staff Information and Consent Letter). Written consent to participate was obtained. A semi-structured interview guide was utilized for the interviews to guide the conversation with participants. This Staff/Leads Key Informant Interview Guide is located in (see Staff Interview Guide).

The interviews with Staff/Leads were conducted in-person with two MLHU Program Evaluators. One evaluator asked the interview questions and the other evaluator provided the note taking. A validation process was utilized at the end of each interview where the note taker summarized the feedback that was provided and asked the Staff/Leads to verify that it was accurate. If requested by the participant, the note taker added or changed content of the interview notes. This validation process was completed in order to add more trustworthiness of the data.

Interview Sample

A total of 22 TOPS Staff/Leads were invited to participate and 17 Staff/Leads agreed to participate.

Interview Analysis

Qualitative data was analyzed in NVivo using inductive content analysis (Patton, 2002) to reveal themes and sub-themes that emerged directly from the data. This method permitted the Program Evaluators to gain an in-depth understanding of participants' experiences. Two Program Evaluators reviewed each interview transcript separately and developed a codebook of emerging codes for each of the qualitative data sources (i.e. Client Interviews, Client Survey (qualitative data), Staff Interviews and Stakeholder Interviews).

Qualitative data was uploaded in NVivo software (QSR NVivo 10). The Program Evaluators coded the transcripts using the preliminary codebooks. A second Program Evaluator reviewed the coded transcripts to identify any inconsistencies in the coding process. The Program Evaluators met to reconcile any discrepancies that arose during the coding process. Once the coding process was complete, the relationships between different themes were compared and contrasted across the sources of data to help understand the findings.

The Program Evaluators followed quality assurance steps during data collection and analysis (Guba & Lincoln, 1989) to ensure data trustworthiness, which included: (a) credibility – member-checking at the end of the interviews through validation of the interview transcript in order to ensure that feedback was accurately reflected; (b) confirmability – independent completion of the development of the coding frameworks for each data source; (c) dependability – Program Evaluators debriefed and reconciled the coding process to safeguard against bias and errors; and (d) transferability – providing documentation of study methods, procedures, and analyses in order for others to establish whether or not the findings may be transferable to other settings.

Thematic maps are presented for some of the qualitative findings to show a visual representation of the relationships between the key themes and sub-themes. Selected quotations from the interview transcripts have been included in the results section to illustrate key themes. Quotations in the results section are not verbatim quotes that would be typically found in audio recorded transcripts; however, the participants validated the content of the transcripts by reviewing the full transcript.

Interview Limitations

Recording interviews

The decision not to audio-record the interviews limits the ability to have direct quotations. This decision was informed by key stakeholders during the development of the evaluation. They indicated that TOPS clients would not feel comfortable with this practice. As a result, an alternative solution was developed to record the feedback on the laptop and read it back to participants for validation.

Self-Reported Data

The primary data findings summarized in this report are based on self-reported participant information. It is recognized that self-reported data may vary at different time points based on the participants' comfort level in sharing their perspectives.

Social Desirability Bias
Some participants may have responded to questions in a manner perceived as more favourable by the Program Evaluators.

Recruitment Email, Consent and Data Collection Tool

Staff Recruitment Email

Hi [insert TOPS Staff/Lead first name],

As part of the Temporary Overdose Prevention Site (TOPS) Evaluation, we would like to invite you to participate in a key informant interview. We would like to obtain your perspectives on the operation of the TOPS since it has opened and your thoughts on the impact of TOPS on clients and staff. The interview will take approximately 45 minutes to 1 hour.

Overall, the purpose of the evaluation is to understand the impact and effectiveness of the TOPS in Middlesex-London, Ontario. Additionally, the project also aims to gather information to inform the development and implementation of future permanent Supervised Consumption Facilities (SFCs) in Middlesex-London, Ontario.

Your participation is completely voluntary and your responses will be kept anonymous and confidential. If you are willing to participate in an interview, please send some dates/times that would work for you to Daniel Murcia, Program Evaluator, and we will make those arrangements by [Insert date here]. Please note that your decision to participate in this evaluation will not impact your role or employment with the TOPS.

The results of the evaluation will be shared in reports or presentations within the MLHU and other local partner organizations. Results may also be published in academic conferences or publications.

Should you have any questions, please contact Jordan Banning, Supervisor of the "Temporary Overdose Prevention Site (TOPS) Evaluation," at 519-663-5317 ext. 2408 or jordan.banninga@mlhu.on.ca.

Thank you.

Kind Regards,

The TOPS Evaluation Team

Staff Information Letter and Consent

Introduction:

Thank you for your willingness to consider participating in an interview for the Temporary Overdose Prevention Site (TOPS) Evaluation. You have been invited to participate given your role as a staff member providing services at the TOPS or your role as a TOPS Lead. Before you decide whether to proceed with the interview, please read this document as it will provide you with more information about the evaluation project that is being conducted by the Middlesex-London Health Unit. It is important that you consider the information in this form. It includes details that will help you decide if you wish to take part.

What is the purpose of this evaluation?

The purpose of this evaluation project is to understand the impact and effectiveness of the TOPS in Middlesex-London, Ontario. Additionally, the evaluation could inform the development and implementation of possible future permanent Supervised Consumption Facilities (SFCs) in Middlesex-London, Ontario.

What will your participation involve?

Your participation involves completion of an interview, which will take 45 minutes to an hour. If you choose to participate in this interview, an interviewer will ask you a series of questions about the Temporary Overdose Prevention Site (TOPS), and another member of the Evaluation Team will be present to take or type notes on the conversation.

Your participation is completely voluntary and your responses will be kept anonymous and confidential. Your responses to this interview will not affect your role or involvement with the TOPS. Please note, you may withdraw at any time without consequence. There will be no consequences for choosing to not participate in this evaluation project.

Are there any benefits to taking part?

You will not benefit directly from taking part in this evaluation project. However, the results may help us to better understand the impact and effectiveness of the TOPS and plan for future sites.

Are there risks involved?

There are no known risks associated with this interview.

Are there any costs to you?

There is no cost to you to take part in the evaluation project apart from your time and efforts.

How will your information be protected?

The information that you provide by completing this survey will be kept confidential unless reporting is required by law. The project team will take the following steps to protect your identity and keep all information confidential:

- All information you provide during the interview will be filed electronically on an encrypted laptop and uploaded to a secure server. If handwritten notes are taken, these notes will be transported by two Evaluation Team Members to MLHU offices and securely stored at MLHU offices in locked filing cabinets.
- Only members of the Evaluation Team will have access to the data provided during the interview. This data will be analyzed by members of the Evaluation Team. No information that could identify you will be shared.
- Evaluation project data will be stored for 7 years at MLHU, and then destroyed.

How will evaluation results be shared?

The results of the evaluation will be shared in reports or presentations within the MLHU and other local partner organizations. Results may also be published in academic journals or presented at conferences. Once the evaluation has been completed, you will also receive a copy of the findings via e-mail.

What are your rights to take part or not take part?

You have the right to choose whether or not to participate, or stop the interview at any time. If you decide to no longer participate during the interview, information collected to that point will be deleted. However, if you decide you no longer want to participate after the interview has ended, it will no longer be possible to retrieve and delete your information as it was submitted anonymously.

What if you have questions about the evaluation?

If you have any questions about the study or concerns about taking part in this evaluation project, please contact Jordan Banninga, Supervisor of the "Temporary Overdose Prevention Site (TOPS) Evaluation," at 519-663-5317 ext. 2408 or jordan.banninga@mlhu.on.ca

What if you have questions about your rights as a participant?

This evaluation has received approval from Public Health Ontario's Ethics Review Board. If you have any concerns about your rights as a participant, you can contact the Research Ethics Coordinator at Public Health Ontario, by email at ethics@oahpp.ca, or by phone at 647-260-7206.

Signature:

I have read the information provided to me. I have had enough time to consider whether or not to participate. Any questions that I had have been answered in full. I understand that my responses will be anonymous, and that my identity will not be disclosed at any point. I also understand that my participation is completely voluntary, and I may withdraw from the study at any time. I also understand that if I withdraw participation after the interview has ended, it will not be possible to delete my information as it will have been submitted anonymously. I am 18 years old or over, and am legally able to provide consent.

Name of Participant (Please Print)

Signature of Participant

Date Signed

Staff Interview Guide

1. From your perspective, is the TOPS operating as it was intended to do? **(Note: Refer to MOHLTC OPS user guide information below to familiarize the leads with this question).** ***Note to interviewer: Provide each lead with a copy of this OPS user guide*** *- OPS are intended as low barrier, life-saving, time-limited services. OPS offer targeted services in order to address the crisis in opioid related overdoses. OPS will provide the following services: Supervised Injection, Naloxone, Provision of harm reduction supplies. OPS can provide or permit the following based on local need and capacity: Peer to peer assisted injection, supervised oral and intranasal drug consumption, Fentanyl test strips as drug checking service*

   (Note: Ask "a-d" only if these are not already provided as responses from the participant)

   a. Are we adhering the to the TOPS mission as outlined by the OPS guide?
   b. Are services being delivered as planned?
   c. Are staff following policies and procedures?
   d. Are clients following policies and procedures?

2. If you can think back to when you first started working at the TOPS, have any of the services/support provided changed? **(Note: Ask "a-d" only if these are not already provided as responses from the participant)**
   a. Have services been added or removed? Which services?
   b. Have staff been added or removed? Which staff?
   c. Have the hours of operation changed?
   d. How have these changes affected you/clients/TOPS?

3. Thinking about your current role at the TOPS, how has your role changed since the TOPS opened or since you began at the TOPS?

4. What do you think is working well at the TOPS? **(Note: Ask "a & b" only if these are not already provided as responses from the participant)**
   a. What are the main strengths of the TOPS operations?
   b. Are you satisfied with how the TOPS is operating?

5. What do you think is not working well at the TOPS? **(Note: Ask "a & b" only if these are not already provided as responses from the participant)**
   a. What are the main challenges of the TOPS operations?
   b. How could we improve/change services or service delivery to better serve the clients? **(**Note: Use challenges noted by participant in "a" above when asking about how to improve/change)**

6. From your perspective, have there been any positive or negative unintended results/impacts since the TOPS opened?

7. Have you received any feedback from clients about the TOPS that you can share with us? **(Note: Ask "a & b" only if these are not already provided as responses from the participant)**
   a. The services offered?

   b. The location?
   c. The hours of operation?
   d. The staff at the TOPS?

8. Given the nature of the services provided at the TOPS and the amount of time clients spend there, have you seen any changes in the relationships/connections between staff and clients? **(Note: Ask "a & b" only if these are not already provided as responses from the participant)**
   a. Have these relationships influenced the clients' willingness to seek other services/support?
   b. Do you think clients feel like they have more trusting relationships?

9. How do you think the TOPS is impacting the clients? **(Note: Ask "a" only if these are not already provided as responses from the participant)**
   a. Are you noticing any changes in clients? E.g., behavioral changes or any other changes such as attending more appointments or seeking/accessing more services?

10. Have any clients been turned away from accessing the TOPS? **(Note: Ask "a-c" only if these are not already provided as responses from the participant)**
    a. If so, why were they turned away?
    b. What was their reaction?
    c. How was it managed?

11. Have you encountered any issues of verbal or physical abuse at the TOPS? **(Note: Ask "a & b" only if these are not already provided as responses from the participant)**
    a. If so, how are instances of verbal or physical abuse managed?
    b. How can we ensure staff safety? **(**Note: Only ask this question if staff member offers this as an impact or concern).**

12. How has working at the TOPS impacted you? **(Note: Ask "a & b" only if these are not already provided as responses from the participant)**
    a. Do you have any concerns about working at the TOPS?
       i. Can you tell me about any positive or negative experiences you have had working at the TOPS?
    b. How can we improve staff satisfaction in their role at the TOPS?

13. Are there any stories you would like to share with us during your experience working at the TOPS? **(Note: Ask "a-c" only if these are not already provided as responses from the participant)**
    a. Connections with clients?
    b. Peer to peer experiences?
    c. Any emotionally charged experiences?

14. Do you have any other feedback that you would like to share with us?

Note to interviewer: Provide a summary of the participants' responses to them for validation.

Do you agree or disagree with the summary?

☐Agree

☐Disagree

Is there anything you would like to add or change to the summary?

Appendix H: Temporary Overdose Prevention Site Stakeholder Interviews

Introduction

The key informant interviews with stakeholders who provide services and supports at the temporary overdose prevention site (TOPS) were conducted to:

- Understand the impact of TOPS on their organization;
- Understand what is working well/not well and suggested changes;
- Obtain their perspectives on impact and satisfaction; and
- Inform development and implementation of future Supervised Consumption Facilities (SCF).

Stakeholder Interview Implementation

Sampling and Recruitment

All key stakeholders (community partners) who provided services and support at TOPS were invited to participate in a key informant interview. Given that there are multiple staff from key stakeholder organizations providing services at TOPS, there may be more than one staff member interviewed from a single organization.

There was no selection process for participants because each member may have different perspectives on TOPS. A contact list of all key stakeholders who provided services and support at TOPS was obtained by the TOPS Lead at the Middlesex-London Health Unit. Key stakeholders were contacted via email by the Program Evaluators using an email script (see Stakeholder Email Script). After the initial email, one reminder email was sent, then no further contact was made with the stakeholders unless they initiated contact at a later time.

Time and Location of Data Collection

The data collection phase occurred over a 7-week period between July and September 2018 and interviews were set up at a convenient location and date for the TOPS stakeholders. The majority of interviews took place at the stakeholders' office location for their organization. Meeting rooms at MLHU were utilized for a few of the interviews.

Inclusion and Exclusion Criteria

The stakeholders identified as the leads most involved with the services provided at TOPS were invited to participate in the semi-structured interview. There were eleven stakeholders who were invited from the following organizations:

- Addiction Services Thames Valley;
- Canadian Mental Health Association;
- Southwest Ontario Aboriginal Health Access Centre;
- London CAReS;
- London Intercommunity Health Centre;
- Middlesex-London Health Unit; and
- Regional HIV/AIDS Connection (RHAC).

Interview Administration

At the beginning of the interview, information about the evaluation was provided to key stakeholders in the Information and Consent Letter (see Stakeholder Information and Consent Form). Written consent to participate was obtained. A semi-structured interview guide (see Stakeholder Interview Guide) was used to guide the conversation with participants.

The interviews were conducted in-person by Program Evaluators and scheduled to ensure that two Program Evaluators were present during each interview. One evaluator asked the interview questions and the other evaluator took field notes. A validation process was used at the end of each interview where the note taker summarized the provided feedback and asked the key stakeholders to verify it for accuracy. If requested by the participant, the note taker added or changed content of the interview notes. This validation process was completed in order to add more accuracy to the data. The interviews took approximately 1 to 1.5 hours in duration.

Interview Sample

A total of eleven stakeholders were invited to participate and 9 stakeholders agreed to participate.

Interview Analysis

Qualitative data was analyzed in NVivo using inductive content analysis (Patton, 2002) to reveal themes and sub-themes that emerged directly from the data. This method permitted the Program Evaluators to gain an in-depth understanding of participants' experiences. Two Program Evaluators reviewed each interview transcript separately and developed a codebook of emerging codes for each of the qualitative data sources (i.e. Client Interviews, Client Survey (qualitative data), Staff Interviews and Stakeholder Interviews).

Qualitative data was uploaded in NVivo software (QSR NVivo 10). The Program Evaluators coded the transcripts using the preliminary codebooks. A second Program Evaluator reviewed the coded transcripts to identify any inconsistencies in the coding process. The Program Evaluators met to reconcile any discrepancies that arose during the coding process. Once the coding process was complete, the relationships between different themes were compared and contrasted across the sources of data to help understand the findings.

The Program Evaluators followed quality assurance steps during data collection and analysis (Guba & Lincoln, 1989) to ensure data trustworthiness, which included: (a) credibility – member-checking at the end of the interviews through validation of the interview transcript in order to ensure that feedback was accurately reflected; (b) confirmability – independent completion of the development of the coding frameworks for each data source; (c) dependability – Program Evaluators debriefed and reconciled the coding process to safeguard against bias and errors; and (d) transferability – providing documentation of study methods, procedures, and analyses in order for others to establish whether or not the findings may be transferable to other settings.

Thematic maps are presented for some of the qualitative findings to show a visual representation of the relationships between the key themes and sub-themes. Selected quotations from the interview transcripts have been included in the results section to illustrate key themes. Quotations in the results section are not verbatim quotes that would be typically found in audio recorded transcripts; however, the participants validated the content of the transcripts by reviewing the full transcript.

Interview Limitations

Recording interviews

The decision not to audio-record the interviews limits the ability to have direct quotations. This decision was informed by key stakeholders during the development of the evaluation. They indicated that TOPS clients would not feel comfortable with this practice. As a result, an alternative solution was developed to record the feedback on the laptop and read it back to participants for validation.

Self-Reported Data

The primary data findings summarized in this report are based on self-reported participant information. It is recognized that self-reported data may vary at different time points based on the participants' comfort level in sharing their perspectives.

Social Desirability Bias

Some participants may have responded to questions in a manner perceived as more favourable by the Program Evaluators.

Self-Reported Data

The primary data findings summarized in this report are based on self-reported participant information. It is recognized that self-reported data may vary at different time points based on the participants' comfort level in sharing their perspectives.

Social Desirability Bias

Some participants may have responded to questions in a manner perceived as more favourable by the Program Evaluators.

Recruitment Email, Consent and Data Collection Tool

Stakeholder Recruitment Email

Hi **[insert Stakeholders First Name]**,

As part of the Temporary Overdose Prevention Site (TOPS) Evaluation, we would like to invite you to participate in a key informant interview. We would like to obtain your perspectives on the TOPS and your role in providing support in the after-care room. We would like to gather your thoughts regarding what is working well/not working well and any suggested changes to the TOPS. The interview will take approximately 45 minutes to 1 hour.

Overall, the aim of the evaluation is to understand the impact and effectiveness of the Temporary Overdose Prevention Site (TOPS) in Middlesex-London, Ontario. Additionally, the project also aims to gather information to inform the development and implementation of future permanent Supervised Consumption Facilities (SFCs) in Middlesex-London, Ontario.

Your participation is completely voluntary and your responses will be kept anonymous and confidential. If you are willing to participate in an interview, please send some dates/times that would work for you to Daniel Murcia, Program Evaluator, and we will make those arrangements by **[Insert date here]**. Please note that your decision to participate in this evaluation will not impact your role or employment with the TOPS.

The results of the evaluation will be shared in reports or presentations within the MLHU and other local partner organizations. Results may also be published in academic conferences or publications.

Should you have any questions, please contact Jordan Banning, Supervisor of the "Temporary Overdose Prevention Site (TOPS) Evaluation," at 519-663-5317 ext. 2408 or jordan.banninga@mlhu.on.ca.

Thank you.

Kind Regards,

The TOPS Evaluation Team

Stakeholder Information Letter and Consent

Introduction:

Thank you for your willingness to consider participating in an interview for the Temporary Overdose Prevention Site (TOPS) Evaluation. You have been invited to participate given your role as someone who provides services at the after-care room at the TOPS. If you choose to participate in this interview, you will be asked questions about the Temporary Overdose Prevention Site (TOPS). Before you decide whether to proceed with the interview, please read this document as it will provide you with more information about the evaluation project that is being conducted by the Middlesex-London Health Unit. It is important that you consider the information in this form. It includes details that will help you decide if you wish to take part.

What is the purpose of this evaluation?

The purpose of this evaluation project is to understand the impact and effectiveness of the TOPS in Middlesex-London, Ontario. Additionally, the evaluation could inform the development and implementation of possible future permanent Supervised Consumption Facilities (SFCs) in Middlesex-London, Ontario.

What will your participation involve?

Participation involves completing an interview, which will take 45 minutes to an hour. An interviewer will ask you a series of questions related to the TOPS, and another member of the Evaluation Team will be present to take or type notes on the conversation.

Your participation is completely voluntary and there will be no consequences for choosing whether or not to participate in this evaluation project. Your participation in this interview will not affect your role or involvement with the TOPS. Your responses will be kept anonymous and confidential. Please note, you may withdraw your participation at any time without consequence.

What are the benefits of completing this interview?

You will not benefit directly from taking part in this evaluation project. However, the results may help us to better understand the impact and effectiveness of the TOPS, and plan for future sites.

Are there any risks involved?

There are no known risks associated with this interview.

Are there any costs to you?

There is no cost to you to take part in the evaluation project apart from your time and efforts.

How will your information be protected?

The information that you provide by completing this survey will be kept confidential unless reporting is required by law. The project team will take the following steps to protect your identity and keep all information confidential:
All information you provide during the interview will be filed electronically on an encrypted laptop and uploaded to a secure server. If handwritten notes are taken, these notes will be transported by two Evaluation Team Members to MLHU offices and securely stored at MLHU offices in locked filing cabinets.

- Only members of the Evaluation Team will have access to the data provided during the interview. This data will be analyzed by members of the Evaluation Team. No information that could identify you will be shared.
- Evaluation project data will be stored for 7 years at MLHU, and then destroyed.

How will evaluation results be shared?

The results of the evaluation will be shared in reports or presentations within the MLHU and other local partner organizations. Results may also be published in academic journals or presented at conferences. Once the evaluation has been completed, you will also receive a copy of the findings via e-mail.

What are your rights to take part or not take part?

You have the right to choose whether or not to participate, or to stop the interview at any time. If you decide to no longer participate during the interview, information collected to that point will be deleted; however, if you decide to no longer participate after the interview has ended, it will not be possible to delete your information as it will have been submitted anonymously.

What if you have questions about the evaluation?

If you have any questions about the study or concerns about taking part in this evaluation project, please contact Jordan Banninga, Supervisor of the "Temporary Overdose Prevention Site (TOPS) Evaluation," at 519-663-5317 ext. 2408 or jordan.banninga@mlhu.on.ca.

What if you have questions about your rights as a participant?

This evaluation has received approval from Public Health Ontario's Ethics Review Board. If you have any concerns about your rights as a participant in this project, you may contact the Research Ethics Coordinator at Public Health Ontario, by email at ethics@oahpp.ca, or by phone at 647-260-7206.

Signature:
I have read the information provided to me. I have had enough time to consider whether or not to participate. Any questions that I had have been answered in full. I understand that my responses will be anonymous, and that my identity will not be disclosed at any point. I also understand that my participation is completely voluntary, and I may withdraw from the study at any time. I also understand that if I withdraw participation after the interview has ended, it will not be possible to delete my information as it will have been submitted anonymously. I am 18 years old or over, and am legally able to provide consent.

Name of Participant
(Please Print)

Signature of Participant

Date Signed

Stakeholder Interview Guide

1. From your perspective, what impact, if any, has the TOPS had on your organization? **(Note: Ask "a & b" only if these are not already provided as responses from the participant)**
    a. What impact do you think your organization has had on the TOPS?
    b. Have there been any positive/negative unintended results/impacts on your organization since the TOPS opened?
        i. Have you noticed an impact on interactions with clients at the TOPS?
        ii. Have clients been more willing or less willing to access services/support from your organization?

2. If you can think back to when the TOPS first opened, have any of the services/support provided at your organization changed as a direct result of TOPS? **(Note: Ask "a-e" only if these are not already provided as responses from the participant)**
    a. Have services been added or removed? Which services?
    b. Have staff been added or removed? Which staff?
    c. Have the hours of operation changed?
    d. How have these changes affected you/clients/TOPS?
    e. Has your role or the amount of support provided by your organization at the TOPS changed since it opened?

3. What do you think is working well at the TOPS? **(Note: Ask "a & b" only if these are not already provided as responses from the participant)**
    a. What are the main strengths of the TOPS?
    b. Are you satisfied with how the TOPS is operating?
        i. What do you like most/least about the TOPS?
        ii. Is there anything you would change?

4. What do you think is not working well at the TOPS? **(Note: Ask "a & b" only if these are not already provided as responses from the participant)**
    a. **(Note: Use what stakeholder has said is not working well from Q4).** How could we improve or what needs to be changed to better serve the clients?
    b. How can we improve service delivery at the TOPS?
    c. What is your perspective on the feasibility of providing healthcare services, such as wound care and HIV/STI testing at the TOPS?

5. What type of feedback have you received from clients about the TOPS that you can share with us? **(Note: Ask "a-d" only if these are not already provided as responses from the participant)**
    a. The services offered?
    b. The location?
    c. The hours of operation?
    d. The staff at the TOPS?

6. Are clients from the TOPS accessing any of the services or support that you and your organization provide? **(Note: Ask "a & b" only if these are not already provided as responses from the participant)**

    a. If so, which services/support are they accessing?
    b. If not, is there anything that could facilitate access?

7. What is your level of satisfaction or dissatisfaction with your organization's involvement in the TOPS? Please describe.

8. Are there any stories you would like to share with us during your experience providing support at the TOPS? **(Note: Ask "a-c" only if these are not already provided as responses from the participant)**
    a. Connections with clients?
    b. Peer to peer experiences?
    c. Any emotionally charged experiences?

9. Do you have any other feedback that you would like to provide us?

Note to interviewer: Provide a summary of the participants' responses to them for validation.

Do you agree or disagree with the summary?

☐Agree

☐Disagree

Is there anything you would like to add or change to the summary?

Appendix I: Secondary Data: Ministry of Health and Long-Term Care Monthly Reporting Form

Introduction

The Ministry of Health and Long-Term Care (MOHLTC) Overdose Prevention Sites (OPS) Monthly Reporting Form was used primarily to answer the Evaluation Question, "Who is using TOPS services and what substances they are using?"

The data was analyzed to:

- Determine the number of client visits to TOPS
- Determine the number of overdoses and calls to Emergency Medical Services
- Understand client demographics
- Determine types of drugs consumed at visits

Sample

Data that is collected by TOPS Staff during service delivery is collated into an Excel spreadsheet template "MOHLTC Overdose Prevention Sites (OPS) Monthly Reporting Form". This form is required to be submitted to the MOHLTC each month by TOPS Leadership. This monthly data was provided to the Evaluation Team in aggregated form from TOPS Leads. The data did not include any client identifiers to respect the confidentiality, and anonymity to the information collected at TOPS.

Secondary Data Analysis
The Ministry of Health and Long-Term Care Overdose Prevention Sites (OPS) Monthly Reporting Form was compiled from the individual monthly reports by the Program Evaluator into one Excel file. The data was analyzed for descriptive statistics. Excel charts are provided in Appendix J.

Secondary Data Limitations

Missing Data

Data on client demographics was not recorded for age. There were some additional demographics recorded in the "Part E: Additional Comments" including Indigenous status for the months of April 1st and August 19th.

Due the way the data was reported for the type of treatment required when responding to overdoses, there is an inability to report on the total number of overdoses. Some overdoses may require treatment with both oxygen/recue breathing and naloxone.

Ministry of Health and Long-Term Care Monthly Reporting Form

Ministry of Health and Long-Term Care
Overdose Prevention Sites (OPS) Monthly Reporting Form

Please note: Data will be used for ministry reporting and evaluation purposes, and may also be shared internally and/or publicly reported. Data may be also shared with Health Canada upon request to support the exemption under s. 56(1) of the Controlled Drugs and Substances Act.

Please submit this form no later than one week after month's end (e.g. Feb. 7 for January data) by emailing this form to EOCLogistics.moh@ontario.ca, by verbally reporting the data to the Ministry Emergency Operations Centre at 1-866-212-2272, OR via fax at 416-212-4466.

Reporting site information:	OP Site ID:	_____
	Reporting Month and Year:	_____
	Number of days in operation for the reporting month:	_____
Part A: Client visits Please enter totals for the reporting month	Number of visits during **morning** hours:	_____ (between 7:00am and 11:59am)
	Number of visits during **afternoon** hours:	_____ (between 12:00 pm and 4:59pm)
	Number of visits during **evening** hours:	_____ (between 5:00pm and 9:59pm)
	Number of visits during **overnight** hours:	_____ (between 10:00pm and 6:59am)
	Number of visits where time period was not recorded:	_____
	Total number of visits:	**0**
	Number of visits where the injection was peer-assisted:	_____
Part B: Overdoses and calls to EMS Please enter totals for the reporting month	Number of overdoses requiring treatment with oxygen/rescue breathing:	_____
	Number of overdoses requiring treatment with naloxone:	_____
	Number of doses of naloxone administered:	_____
	Number of calls to EMS related to an overdose:	_____
	Number of transfers to an emergency department related to an overdose:	_____
	Number of deaths occurring in the OPS:	_____
Part C: Client demographics Please enter totals for the reporting month	Number of visits by clients **under 25 years**:	_____
	Number of visits by clients **between 25 and 64 years**:	_____
	Number of visits by clients **over 65 years**:	_____
	Number of visits by clients where age group is unknown:	_____
Part D: Types of drugs consumed	**Number of clients consuming the following substances (as identified by the client)**	
	Heroin:	_____
	Hydromorphone:	_____
	Oxycodone:	_____
	Crystal Meth:	_____
	Crack Cocaine:	_____
	Fentanyl	_____
	Unspecified Opioid:	_____
	Other:	_____
	Total:	0
Part E: Additional comments	Please provide any information you think is important to report regarding successes or challenges related to your OPS. For instance, this may include issues with staffing and resources, services offered, or service delivery. You may include additional information on non-identifiable client demographics (e.g., client gender, homelessness, etc.). Please **do not** include any personal or personal health information in your comments.	

Ministry of Health and Long-Term Care
Overdose Prevention Sites (OPS) Monthly Reporting Form

Please note: Data will be used for ministry reporting and evaluation purposes, and may also be shared internally and/or publicly reported. Data may be also shared with Health Canada upon request to support the exemption under s. 56(1) of the Controlled Drugs and Substances Act.

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	Number of visits during **evening** hours:	_____ (between 5:00pm and 9:59pm)
	Number of visits during **overnight** hours:	_____ (between 10:00pm and 6:59am)
	Number of visits where time period was not recorded:	_____
	Total number of visits:	**0**
	Number of visits where the injection was peer-assisted:	_____
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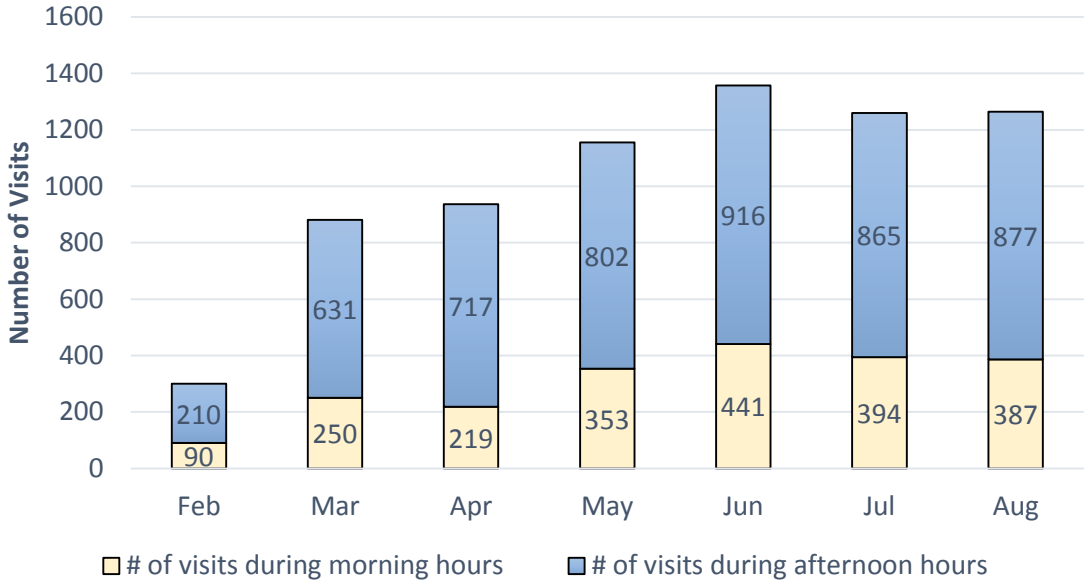
	Number of overdoses requiring treatment with naloxone:	_____
	Number of doses of naloxone administered:	_____
	Number of calls to EMS related to an overdose:	_____
	Number of transfers to an emergency department related to an overdose:	_____
	Number of deaths occurring in the OPS:	_____
Part C: Client demographics Please enter totals for the reporting month	Number of visits by clients **under 25 years**:	_____
	Number of visits by clients **between 25 and 64 years**:	_____
	Number of visits by clients **over 65 years**:	_____
	Number of visits by clients where age group is unknown:	_____
Part D: Types of drugs consumed	**Number of clients consuming the following substances (as identified by the client)**	
	Heroin:	_____
	Hydromorphone:	_____
	Oxycodone:	_____
	Crystal Meth:	_____
	Crack Cocaine:	_____
	Fentanyl	_____
	Unspecified Opioid:	_____
	Other:	_____
	Total:	0
Part E: Additional comments	Please provide any information you think is important to report regarding successes or challenges related to your OPS. For instance, this may include issues with staffing and resources, services offered, or service delivery. You may include additional information on non-identifiable client demographics (e.g., client gender, homelessness, etc.). Please **do not** include any personal or personal health information in your comments.	

Appendix J: Part 1 – Data Charts for MOHLTC Overdose Prevention Site Monthly Reporting Form

Visits

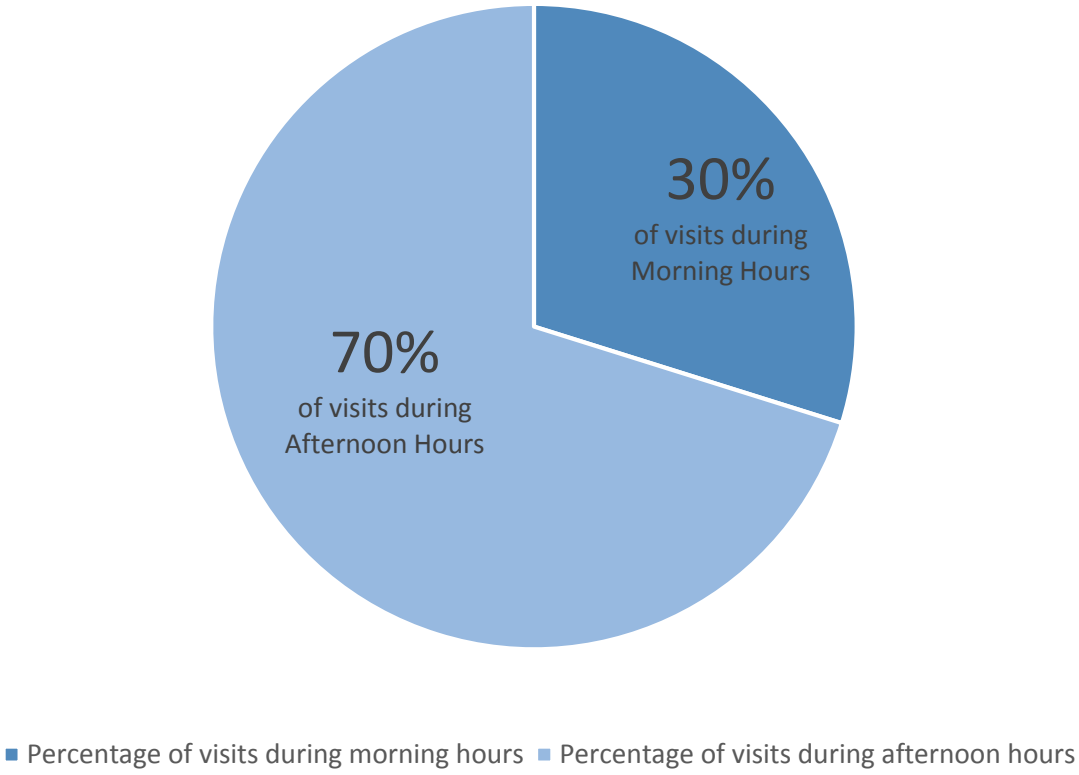
Between February 12th and August 31st of 2018, there were a total of 7152 visits at TOPS. **Figure 1** shows the number of visits to TOPS during each month for the first six months of operation.

Figure 1: Number of Visits to the Temporary Overdose Prevention Site, February 12, 2018 to August 31, 2018 [MOHLTC-OPS Monthly Reporting Form, n=7152]



The majority of visits occurred during afternoon hours between 12-4 pm (70%, n=5018), while 30% (n=2134) were visits during the morning hours between 10 am and noon. **Figure 2** illustrates the proportion of visits during the morning hours versus the afternoon hours.

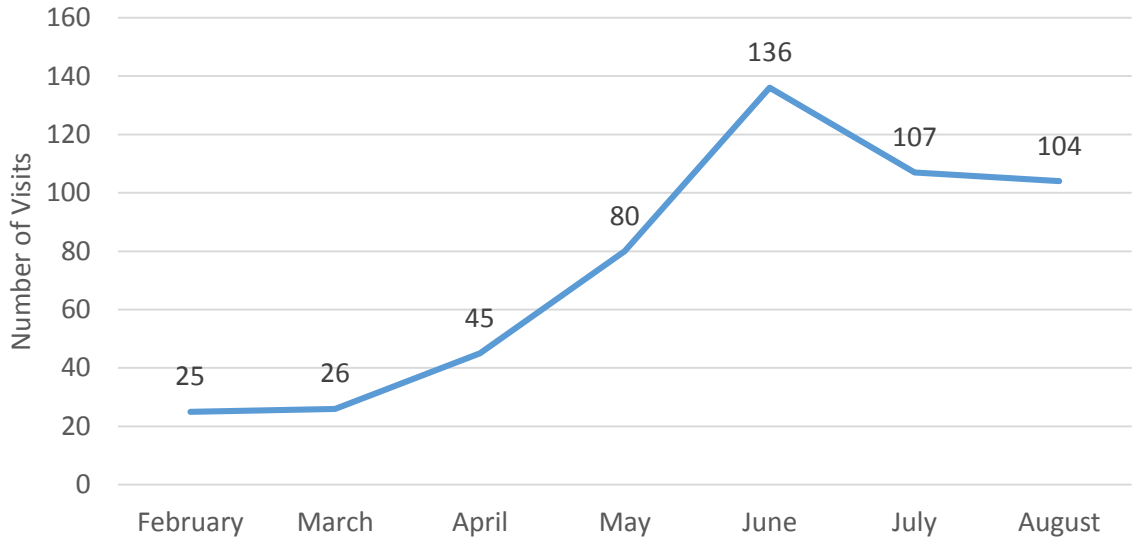
Figure 2: Percentage of Visits to TOPS during the morning and afternoon timeframes [MOHLTC-OPS Monthly Reporting Form, n=7152]


30%
of visits during
Morning Hours
70%
of visits during
Afternoon Hours
Percentage of visits during morning hours
Percentage of visits during afternoon hours

Peer-to-Peer Assisted Injections

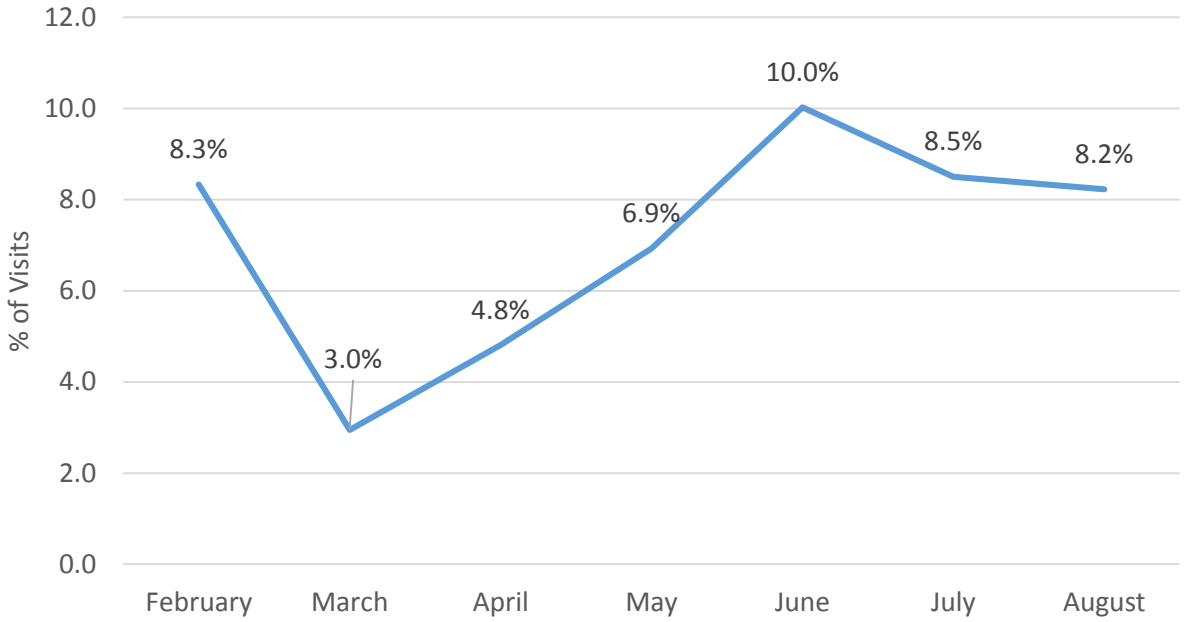
A total of 523 peer-to-peer assisted injections occurred at the site between the February and August timeframe **(see Figure 3).** This represents 7.3% (523/7152) of total visits at the site involving peer-to-peer assisted injection over the entire timeframe.

Figure 3: Number of peer-to-peer assisted injections at the site between February and August 2018 [MOHLTC-OPS Monthly Reporting Form, n=523]



The proportion of visits per month where peer-to-peer assisted injections took place was high during the month of February (8.3%) considering the site was only open for about half the month, and then decreased during the month of March (3.0%) **(see Figure 4).** There was a steady increase in the proportion of peer-to-peer assisted injections during the months of April (4.8%) and May (6.9%), and then the proportion peeked in the month of June (10.0%). The average monthly proportion of peer-to-peer assisted injections may be leveling off around 8%, as seen in July and August data.

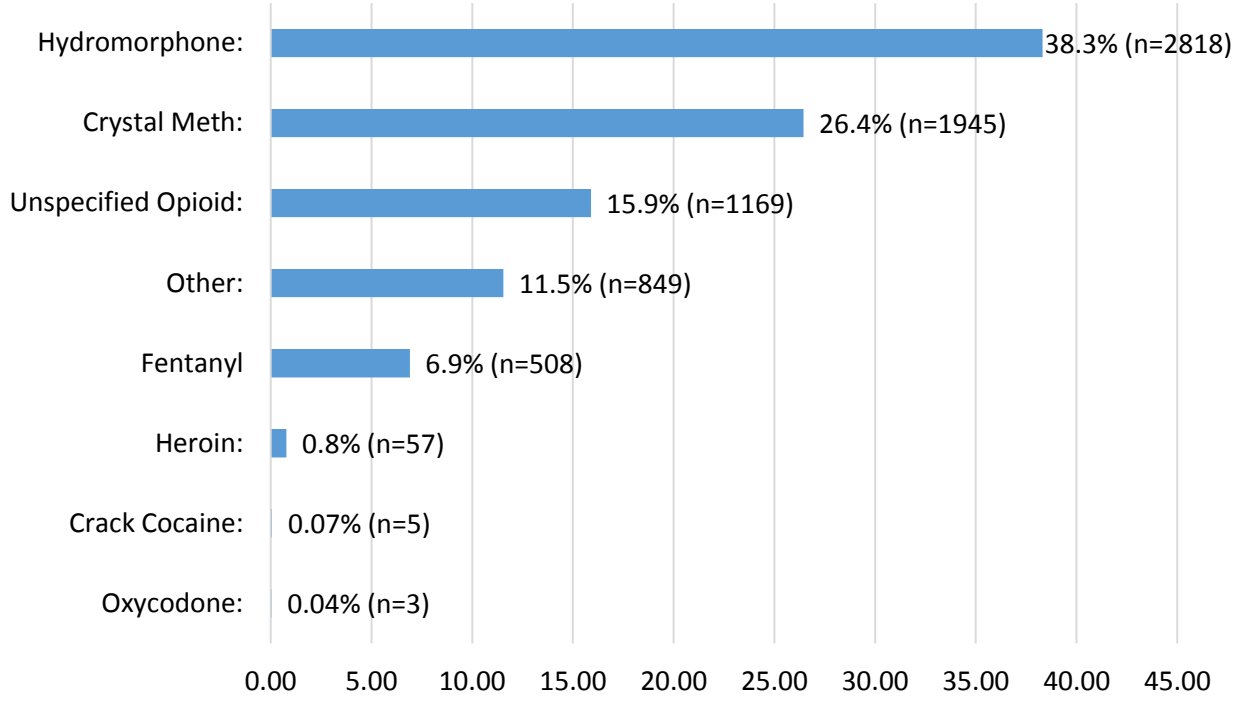
Figure 4: Percentage of Visits per month where Peer-to-peer assisted Injections took place
[MOHLTC-OPS Monthly Reporting Form, n=523]



Types of Drugs consumed

The two most commonly injected drugs reported by survey respondents were Hydromorphone and Crystal Meth. Among the types of drugs reported, it is estimated that approximately 60% of the drugs consumed are opioids (i.e. hydromorphone, fentanyl, heroin, oxycodone, unspecified opioid). **Figure 5** shows the percentages of different types of drugs consumed by clients at TOPS between February and August 2018.

Figure 5: Percentage of Types of Drugs consumed by Clients at TOPS [MOHLTC-OPS Monthly Reporting Form, n=7352*]



*Note: Some clients reported more than one type of drug per visit

Fentanyl test strip drug checking use

A total of 25 clients used fentanyl test strip drug checking services and each completed it for a total of 25 drug checks. This represents only 0.3% of all visits participating in the drug checking service at the site between February and August 2018.

Fentanyl drug checking results

Of the 25 drug checks completed, 8 tested positive for traces of fentanyl (see Table 1). Types of substances identified by individuals checked using the Fentanyl Test Strips, include: Fentanyl (6 positive, 11 negative), Crystal Meth (1 positive, 6 negative), and Heroin (1 positive, 0 negative). From these results, it appears that some clients used the test strips to determine the substance actually was fentanyl, and only 6 of the 17 tested positive for fentanyl. These results indicate that some clients are concerned about whether or not what they purchased was actually fentanyl.

Table 1: Types of substances checked for fentanyl using the fentanyl test strips [MOHLTC-OPS Monthly Reporting Form, n=25]

	Positive	Negative	Invalid
Fentanyl	6	11	0
Crystal Meth	1	6	0
Heroin	1	0	0
Total	8	17	0

Demographics

Self-identification as Indigenous

At the request from the Indigenous community leaders, tracking individuals who self-identify as Indigenous began in April 1, 2018 on the MOHLTC Overdose Prevention Site (OPS) Monthly Reporting Form. Between April 1st and August 19th, 1145 visits were recorded from individuals who self-identify as Indigenous. This reflects roughly 19% (1145/5971) of the total number of visits in the timeframe.

Appendix K: Client Survey Quantitative Findings

Part 1: Quantitative Findings from the Client Survey related to Usage of the Site and Participant Demographics

Usage of Site on the Weekends

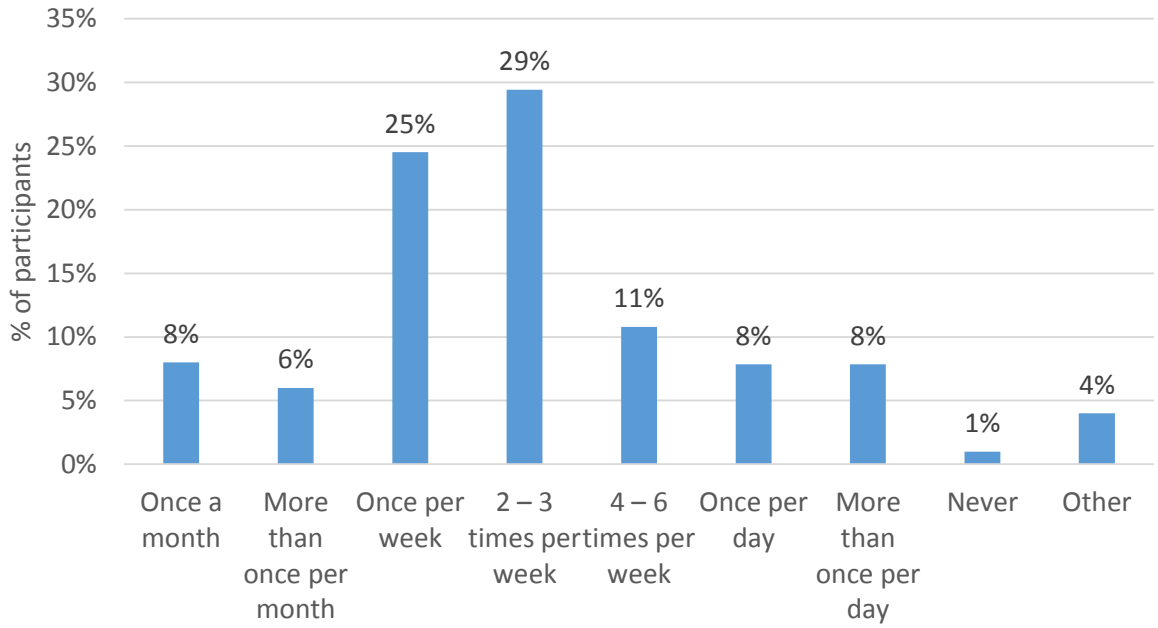
Among the respondents on the Client Survey, 74% (n=75) reported using the site on the weekends and 26% (n=26).

Figure 1: Use of site on weekends [Client Survey, n=101]

Frequency of Using Counterpoint Needle Syringe Program Prior to Using TOPS

Figure 2 shows the frequency of clients' self-reported use of Counterpoint Needle Syringe Program prior to using TOPS. The most frequently reported times, included 2-3 times per week (29%, n=30), once per week (25%, n=26), and 4-6 times per week (11%, n=11). The "other" category included descriptions such as "one time only" and "it depends".

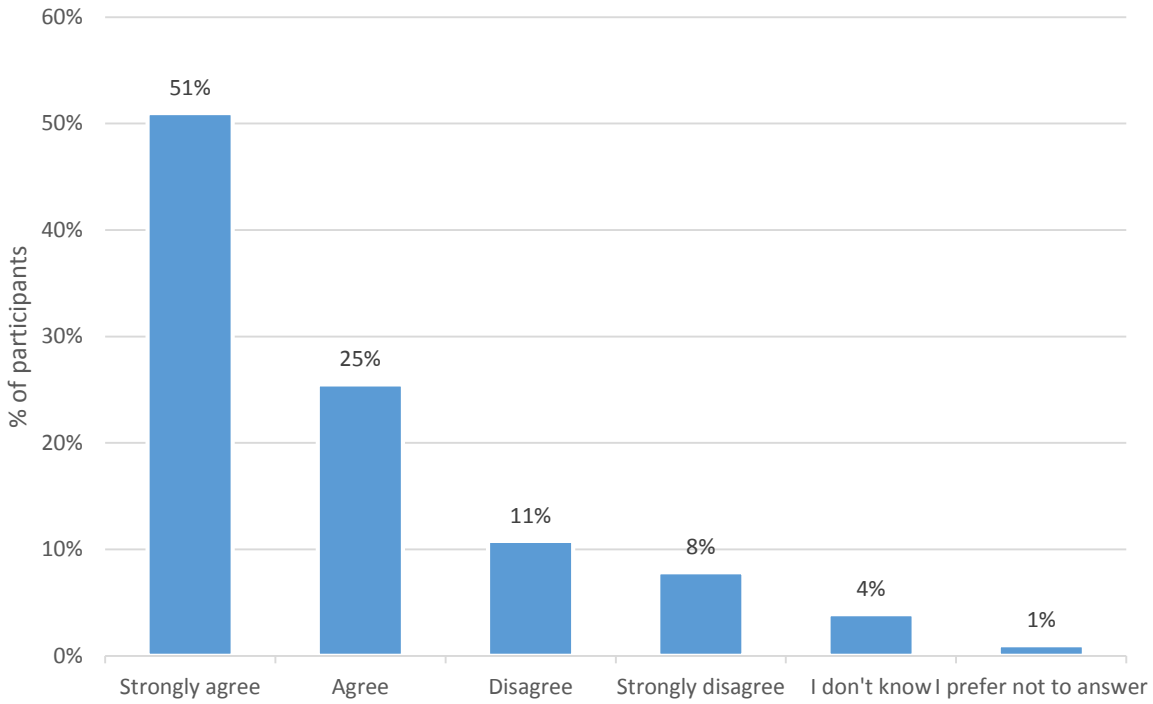
Figure 2: Frequency of using Counterpoint Needle Syringe Program at RHAC prior to using TOPS [Client Survey, n=102]



Willingness to Use Test Drugs for Fentanyl

A question on the Client Survey asked clients to report on their level of agreement or disagreement with the following statement "I am willing to test my drugs for fentanyl at the Overdose Prevention Site before using". Roughly three-quarters of survey respondents (76%, n=78) agreed or strongly agreed that they are willing to test their drugs for fentanyl and 19% (n=19) disagreed or strongly disagreed that they would be willing to use the test strips to test their drugs for fentanyl.

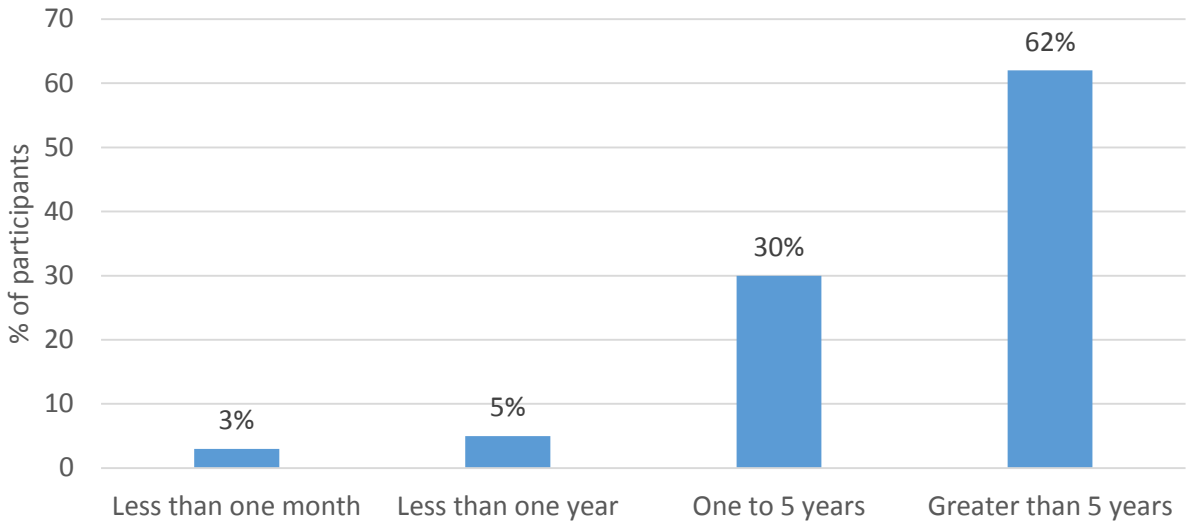
Figure 3: Level of agreement/disagreement with the statement "I am willing to test my drugs for fentanyl at the Overdose Prevention Site before using" [Client Survey, n=102]



Length of Injection Drug Use

Among clients who participated in the Client Survey, the majority of clients (62%, n=63) indicated that they have been injecting drugs for more than 5 years, while 30% (n=31) reported using one to 5 years. Only a few clients had been injecting drugs for less than one year (5%, n=5) and less than one month (3%, n=3).

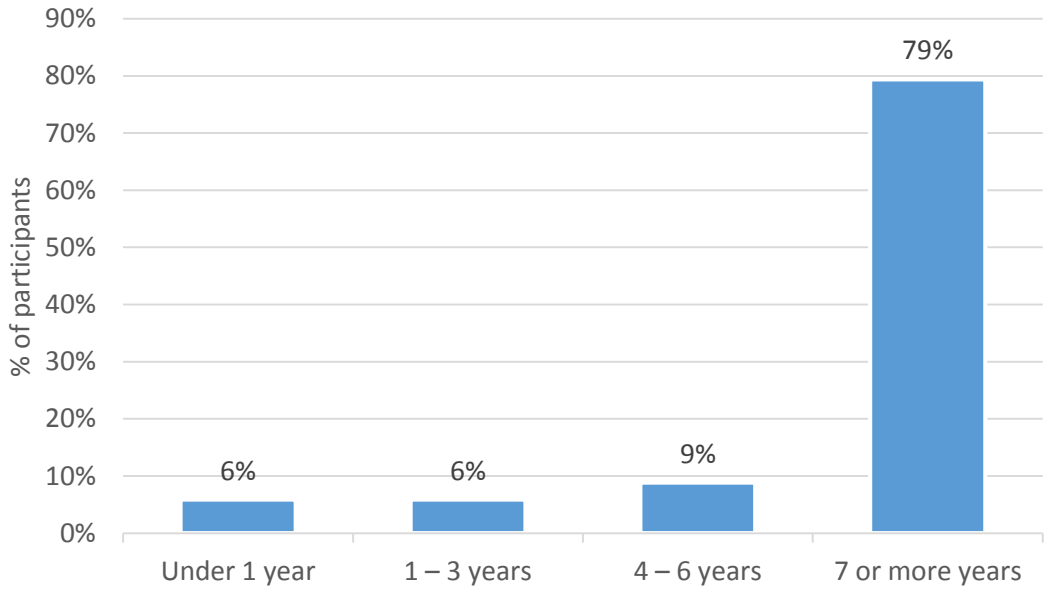
Figure 4: Length of time injecting drugs [Client Survey, n=102]



Length of time lived in London

Self-reported survey data from clients indicate that the majority (79%, n=81) of survey participants have lived in London for 7 or more years.

Figure 5: Length of time lived in London, Ontario [Client Survey, n=102]

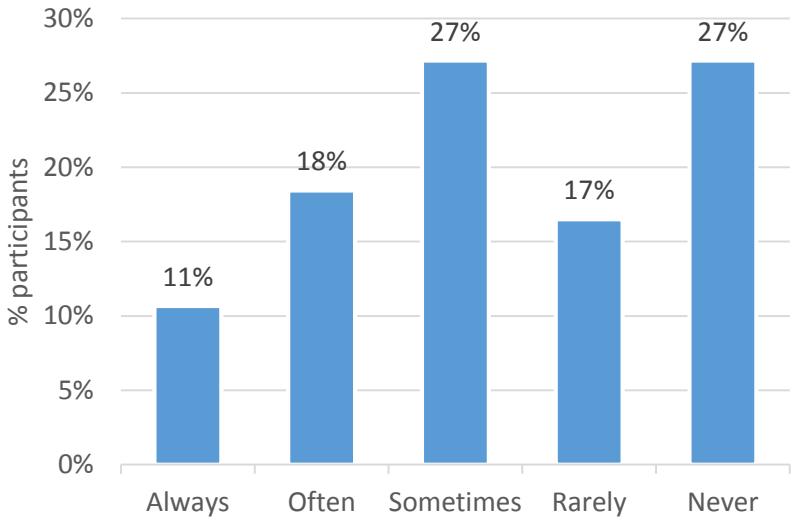


Part 2: Quantitative Findings from the Client Survey

TOPS Operating Hours

Among Client Survey respondents, 29% (n=30) mentioned that the hours of the site often or always get in their way of using the site. There were 27% (n=28) of clients who indicated that the operating hours sometimes got in their way of using the site (Figure 6).

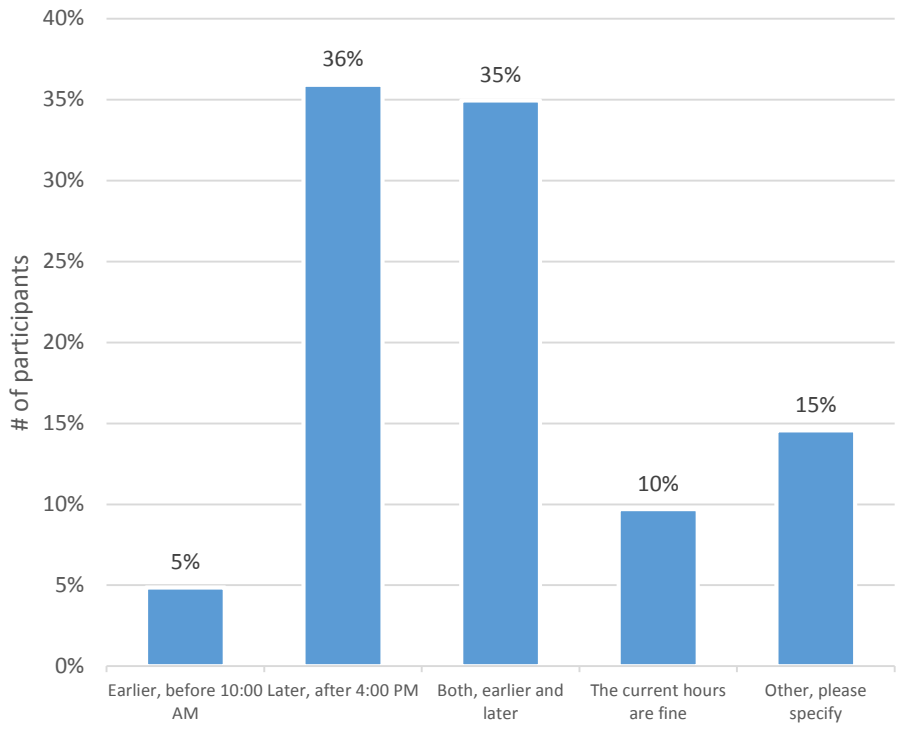
Figure 6: Client Survey responses to "How often does the operating hours of the site get in the way of you using the site?" [Client Survey, n=103]



Preferred Hours of Operation

Among the clients who participated in the survey, 36% (n=37) of clients indicated wanting later hours after 4pm. There were 35% (n=36) of clients wanted earlier and later hours. There were 15% (n=15) of clients who had other suggestions which included the suggestion for 24/7 access to the site (see **Figure 7).**

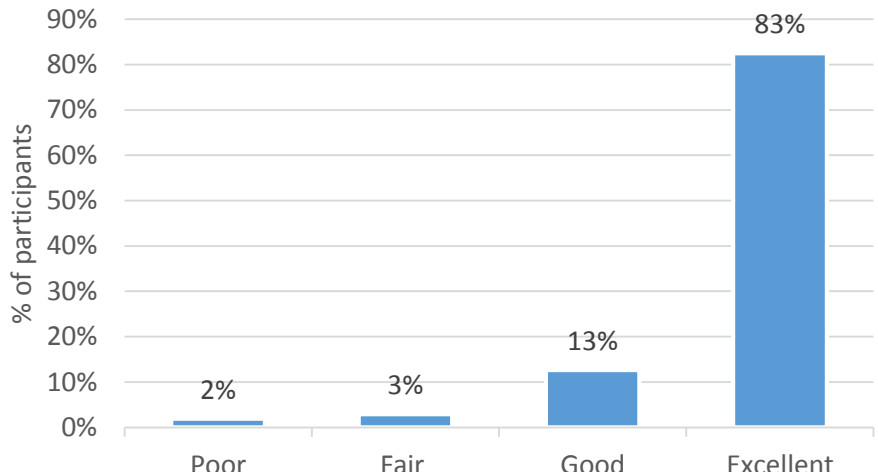
Figure 7: Client Survey responses to "What additional hours would you prefer?" [Client Survey, n=103]



TOPS Client's Satisfaction with Services

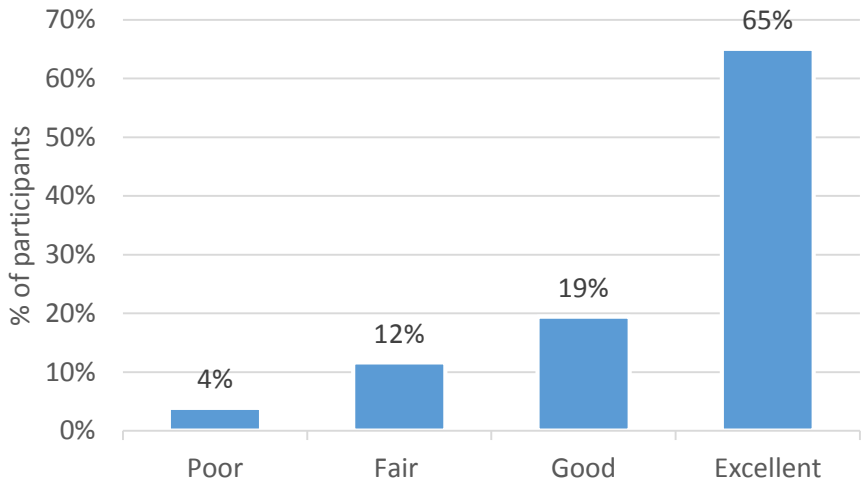
A high level of satisfaction was also reported among clients who participated in the surveys. Almost all clients (96%, n=98) rated the quality of service and care received from TOPS staff as good or excellent (**Figure 8).** Only 5% (n=5) of clients rated the quality of service and care from staff as fair or poor.

Figure 8: Client responses to "How would you rate the quality of services and care received from TOPS Staff?" [Client Survey, n=103]



A high level of satisfaction was also reported among clients in their rating of the site as a place to take or use drugs. The majority of clients (85%, n=87) rated TOPS as a good or excellent place to take or use drugs (see **Figure 9**). Only 16% (n=16) of clients rated the site as fair or poor place to take drugs.

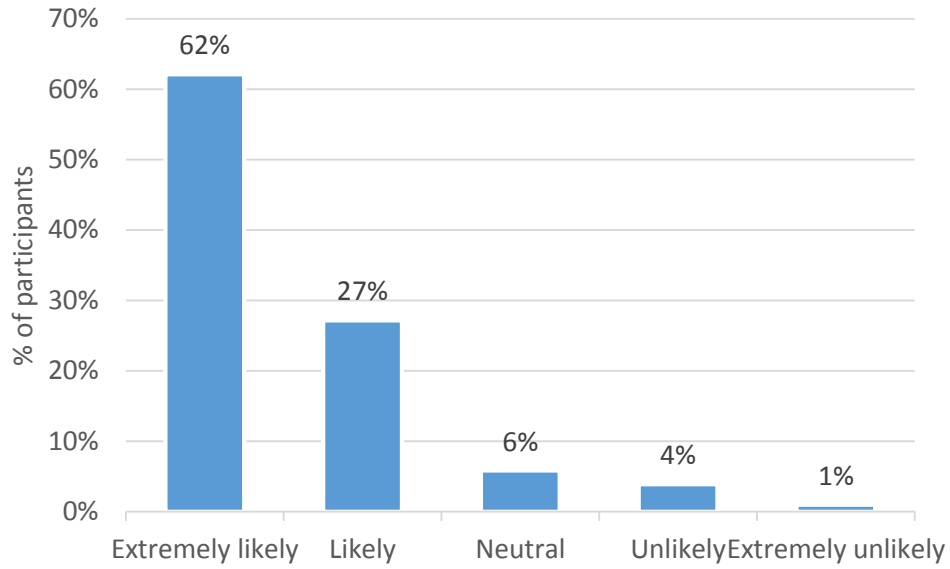
Figure 9: Client responses to "Overall, how would you rate the Overdose Prevention Site as a place to take/use drugs?" [Client Survey, n=103]



Likeliness to Recommend TOPS to Others

Eighty-nine percent (n=92) of clients who participated in the survey said they would be likely or extremely likely to recommend the site to other PWUD (**Figure 10**).

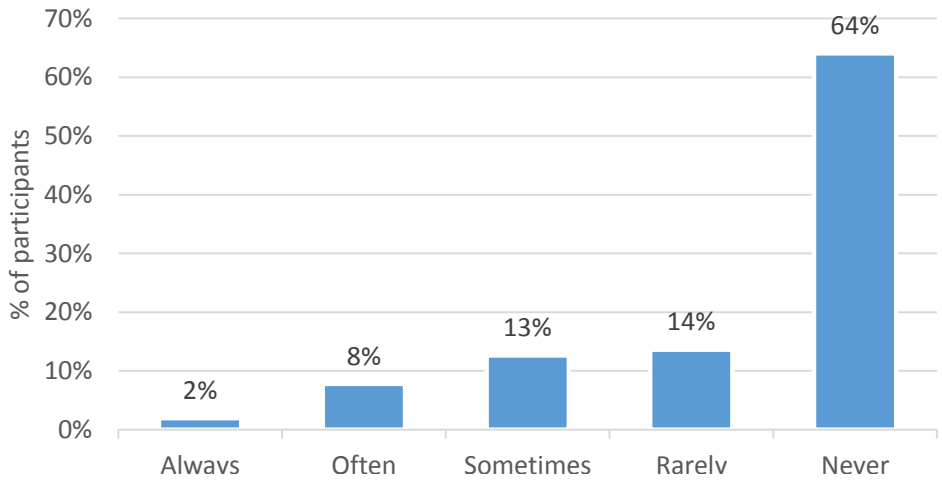
Figure 10: Client responses to "How likely are you to recommend the site to other users?" [Client Survey, n=103]



Factors Affecting Use of the Site: Location

Among the clients who participated in the survey, 13% (n=13) mentioned that the location sometimes gets in the way of them using the site and 10% (n=10) found that the location is often or always a barrier for them to use the site (**Figure 11**).

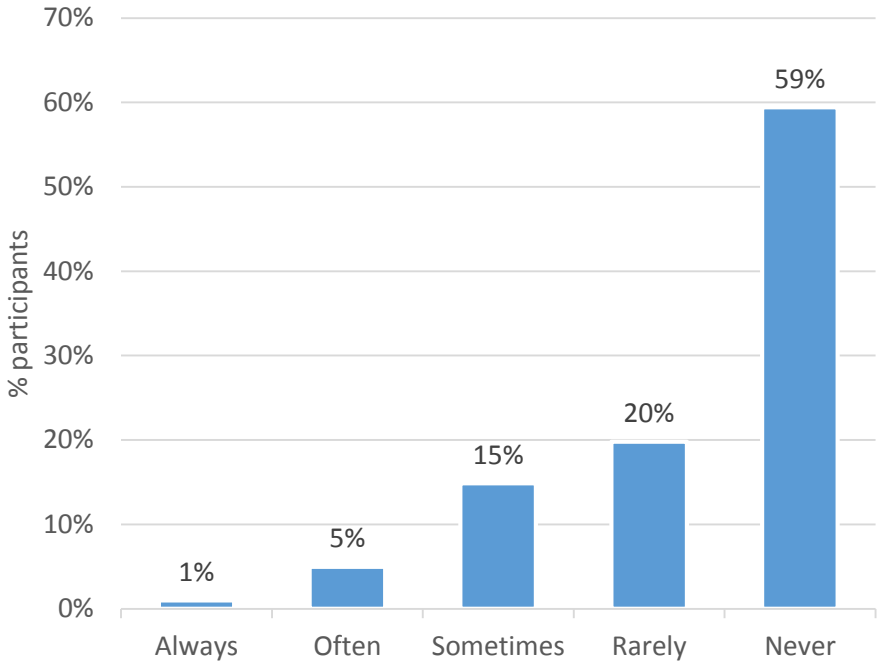
Figure 11: Client responses to "How often does the location of the site get in the way of you using the site?" [Client Survey, n=103]



Factors Affecting Use of the Site: Travel Time

However, among clients who responded to the survey, 79% (n=80) noted that the travel time to get to the site is rarely or never a barrier to using the site (**Figure 12**).

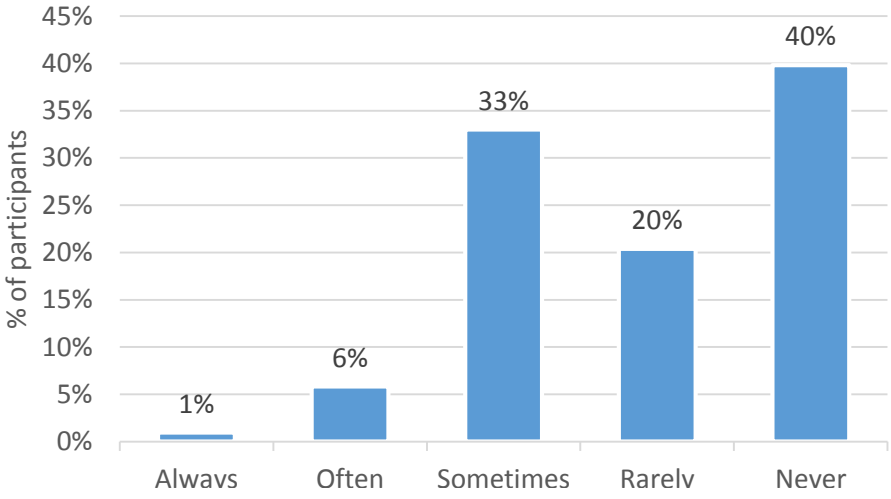
Figure 12: Client responses to "How often does the travel time get in the way of you using the site?" [Client Survey, n=101]



Factors Affecting Use of the Site: Wait Time

Among clients who participated in the survey, 60% (n=62) indicated that the wait time rarely or never gets in their way of using the site. However, 33% (n=34) mentioned that the wait time to get into the consumption room sometimes can be a barrier for them to use the site. For 7% (n=7) of clients the wait time often or always gets in the way of them using the site (**Figure 13**).

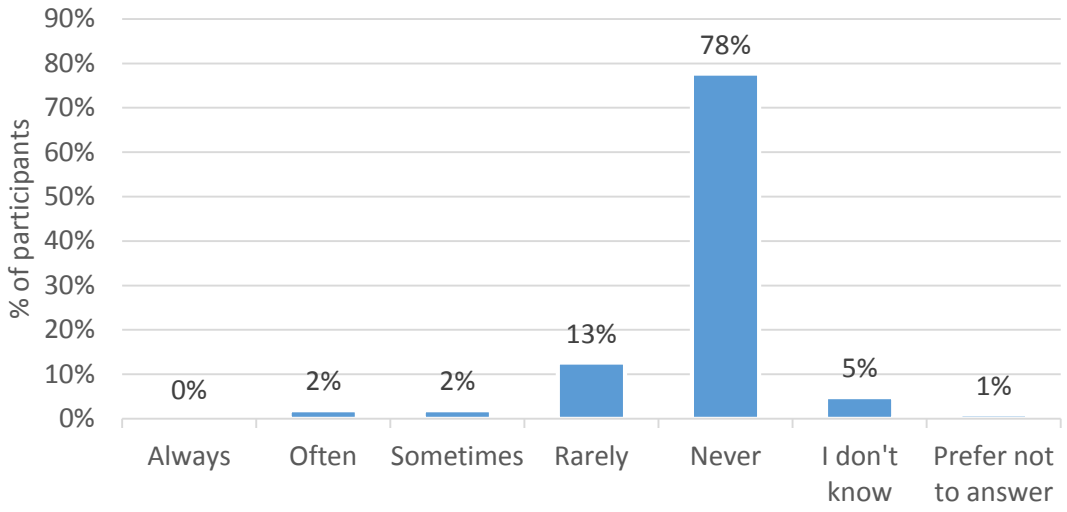
Figure 13: Client response to "How often does the wait time to use the site get in the way of using the site? [Client Survey, n=103]



Rules and Regulations

Among clients who participated in the survey, over 91% (n=93) said that the rules and regulations rarely or never get in their way of using the site (**Figure 14**).

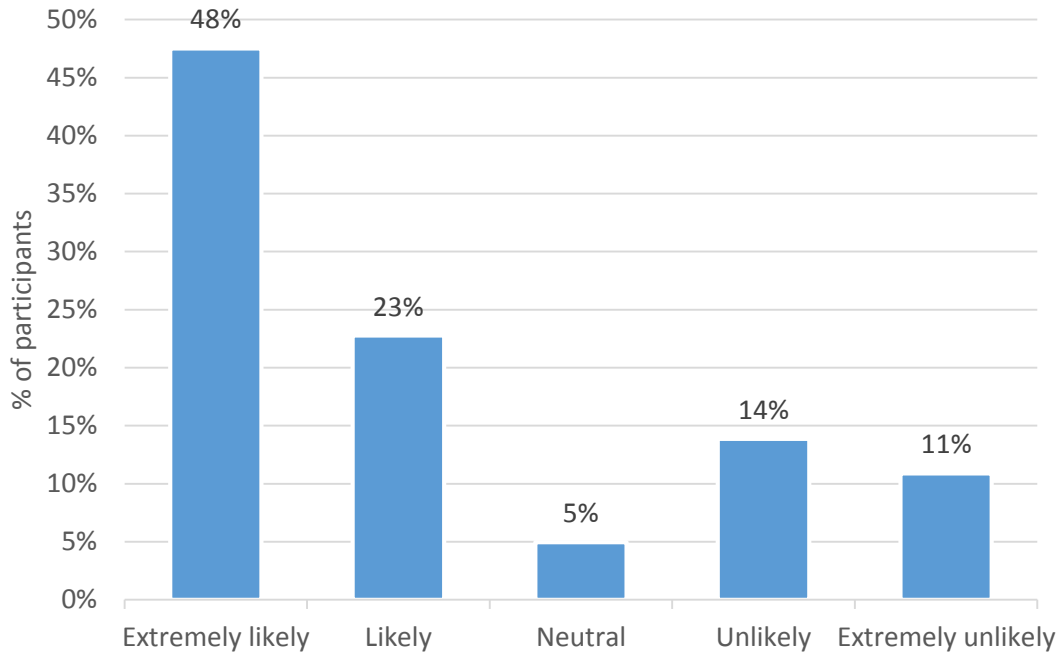
Figure 14: Client Survey self-reported data to "How often do the rules and regulations of the site get in the way of you using the site?" [Client Survey, n=103]



Willingness to Use a Mobile Site

The majority of clients (71%, n=71) indicated that they would be "extremely likely" or "likely" to use a mobile supervised consumption services van. However, a quarter of clients (25%, n=25) indicated that they would be unlikely or extremely unlikely to use a mobile supervised consumption services van (**Figure 15**).

Figure 15: Client Survey self-reported data to "If there was a Mobile Supervised Consumption Services van that could travel to you, how likely would you be to use it?" [Client Survey, n=101]

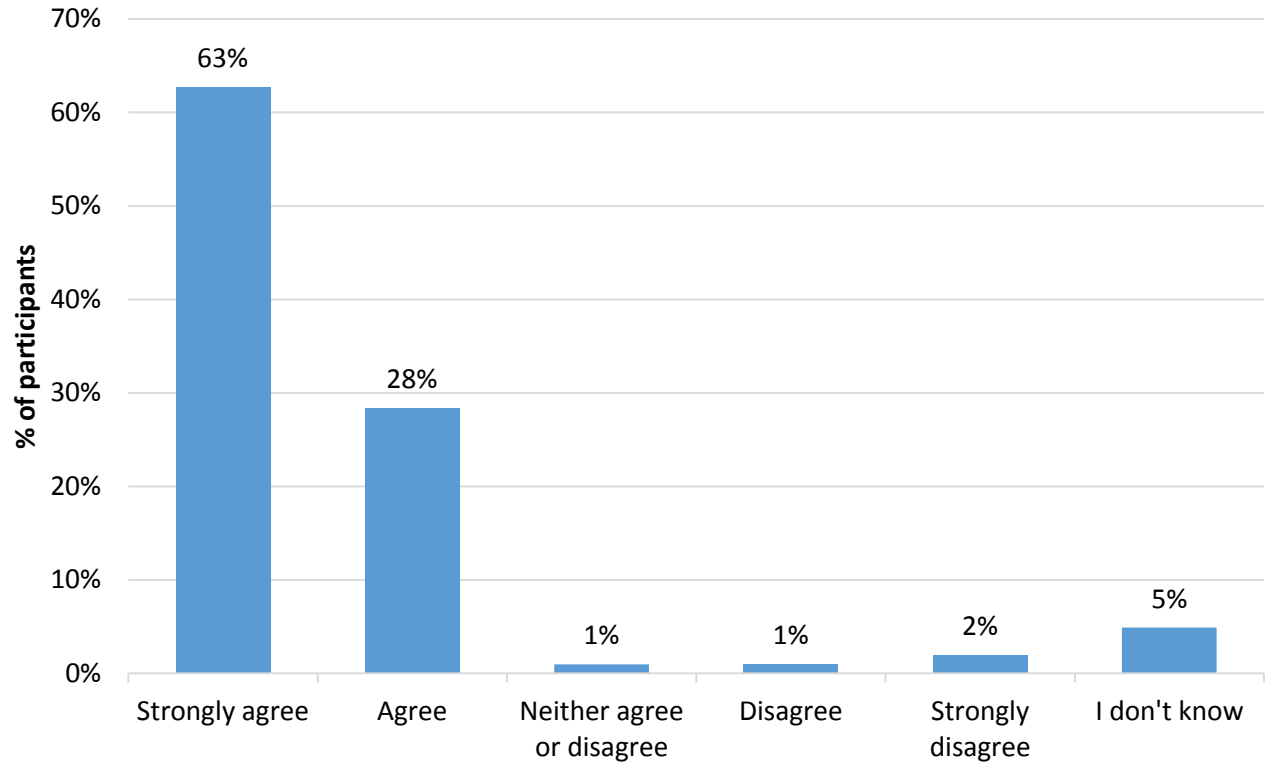


Part 3: Quantitative Findings from the Client Survey related to Impacts

Access to Naloxone

Among the Client Survey participants, 91% (n=93) of participants agreed or strongly agreed with the statement "I can access Naloxone easily at the Overdose Prevention Site" (see Figure 16).

Figure 16: Level of agreement/disagreement with the statement "I can access Naloxone easily at the Overdose Prevention Site" [Client Survey, n=102]

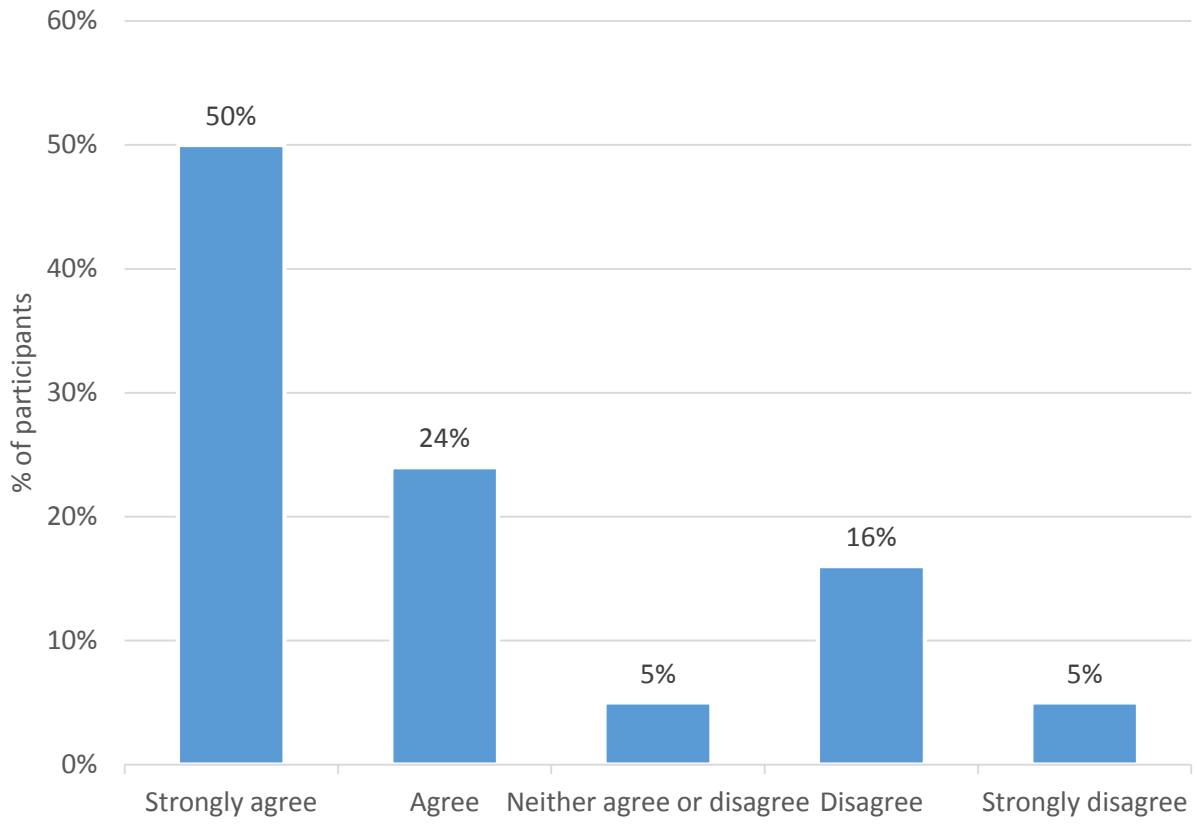


Increasing Safer Injection Behaviours

Increased knowledge of strategies to use drugs more safely

Among the clients surveyed, 74% (n=74) either agreed or strongly agreed that they have learned tips to use drugs more safely (see **Figure 17).**

Figure 17: Level of agreement/disagreement with the statement "I have learned tips to use/inject/take drugs more safely" [Client Survey, n=100]



Changes in Drug Use Behaviours

Reusing Their Own Gear

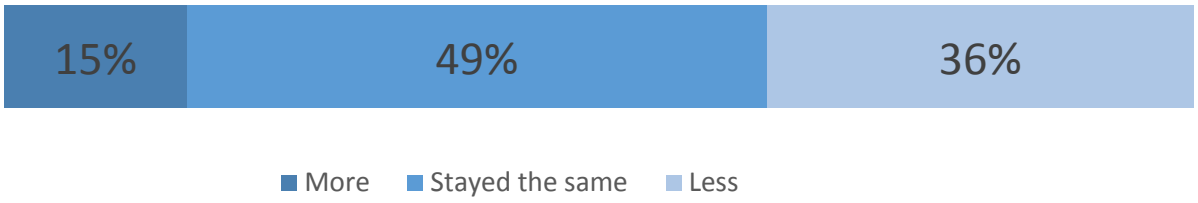
Among the clients that reported reusing their gear in the past (n=83), 72% (n=60) of clients stated that they are reusing their own equipment less often now since they have started using the site (see **Figure 18**).

Figure 18: Client Survey self-reported data "If you reused your gear in the past, would you say that now you reuse your gear more often, less often, or has this stayed the same?" [Client Survey, n=83]

Sharing of Used Gear

Among the clients that reported sharing their used gear with others in the past (n=39), 49% (n=19) noted that their sharing of used gear has stayed the same, while 36% (n=14) noted that they are sharing used gear less (see **Figure 19).**

Figure 19: Client Survey self-reported data "If you shared your gear in the past, would you say that now you share your used gear with others more often, less often, or has this stayed the same?" [Data Source: Client Survey, n=39]



Using Drugs Alone

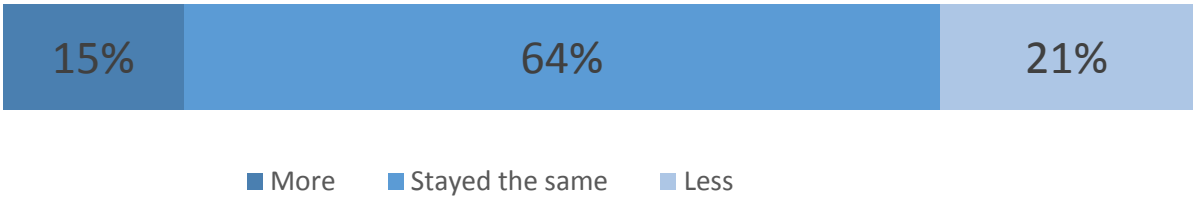
Among the clients that reported using drugs alone in the past (n=101), approximately one-third (35%, n=35) of survey participants noted that they are using drugs alone less often than before they started using the site. The majority of participants (57%, n=58) indicated that their drug use behavior in terms of using drugs alone has stayed the same (see **Figure 20**).

Figure 20: Client Survey self-reported data "If you used alone in the past, would you say that now you use drugs alone more or less often, or has this stayed the same" [Client Survey, n=101]

Needing Help to Inject

Among the clients that reported needing help injecting in the past (n=66), 21% (n=14) reported that they need less help injecting since starting to use the site. The majority of clients (64%, n=42) indicated that the need to have help injecting has stayed the same (see **Figure 21**).

Figure 21: Client Survey self-reported data "If you needed help injecting in the past, would you say that now you need help with injecting more often, less often or has this stayed the same" [Client Survey, n=66]



Using Sterile Water

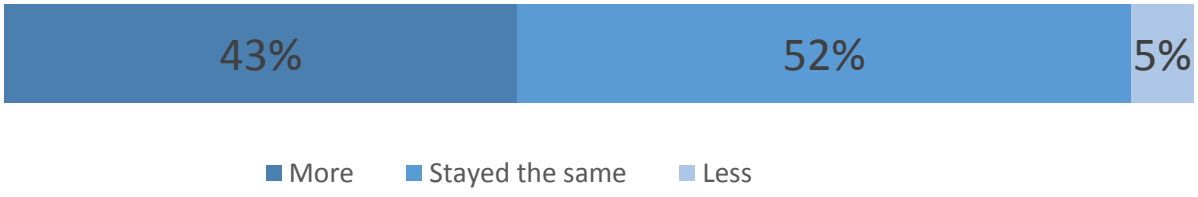
Among the clients that reported using sterile water in the past (n=99), 34% (n=34) reported that they are using sterile water more since using the site. The majority of respondents (58%, n=57) noted that their use of sterile water has stayed the same since using the site (see **Figure 22**).

Figure 22: Client Survey self-reported data "If you used sterile water in the past, would you say that now you use packaged (blue-pack) water more often, less often or has this stayed the same" [Data Source: Client Survey, n=99]

Use of Alcohol Swabs to Clean Injection Sites

Among the clients who indicated that they had used alcohol swabs in the past, 43% (n=41) of respondents indicated that they are using alcohol swabs more since using the site. The majority of clients (52%, n=49) indicated that their use of alcohol swabs has stayed the same (see **Figure 23**).

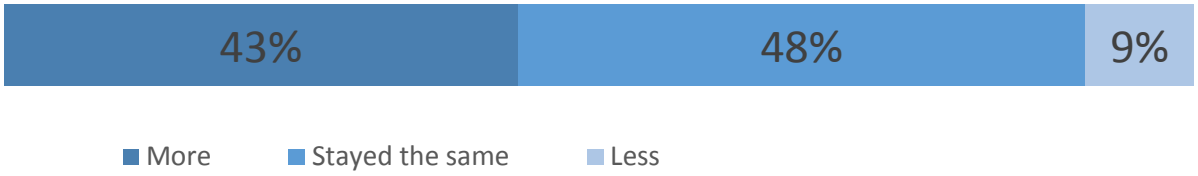
Figure 23: Client Survey self-reported data "If you used alcohol swabs to clean injection sites in the past, would you say that now you use those more often, less often or has this stayed the same" [Client Survey, n=95]



Heating Drugs Before Using

Among clients who indicated that they had heated their drugs before using in the past, 43% (n=38) reported that they are now heating their drugs more often, while 48% (n=42) indicated that this had stayed the same (see **Figure 24**).

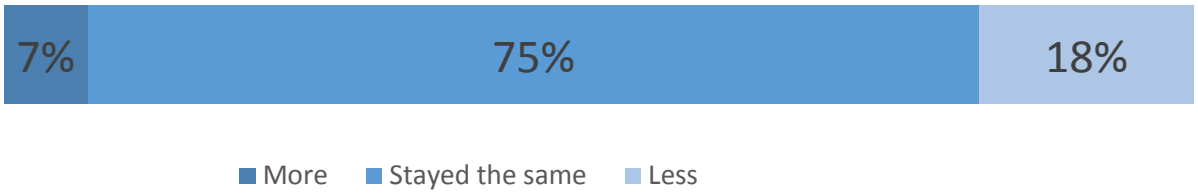
Figure 24: Client Survey self-reported data "If you heated your drugs in the past, would you say that now you heat your drugs more often, less often or has this stayed the same" [Data Source: Client Survey, n=88]



Changes in the Amount and Type of Drug Used

When asked if there had been any changes to the frequency of their drug use among Client Survey participants, 17% (n=17) reported that there had been a change, while the majority did not report a change (83%, n=82). Among those that reported a change, 12 clients indicated that their frequency of drug use had decreased since TOPS opened and 5 clients reported an increase in the frequency of drug use.

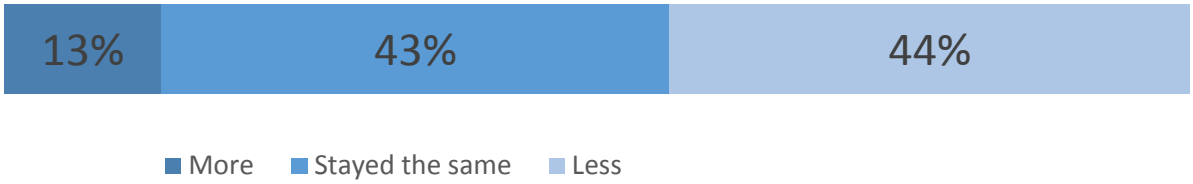
Figure 25: Client Survey self-reported data "Do you use/take more or less drugs, or has this stayed the same?" [Client Survey, n=100]



Feelings of Being Rushed While Using Drugs

When asked if they felt more or less rushed when using their drugs since using the site, 44% (n=43) reported feeling less rushed (see **Figure 26**).

Figure 26: Client Survey self-reported data "Do you feel more or less rushed when using/taking your drugs, or has this stayed the same?" [Client Survey, n=98]



Less Public Drug Use

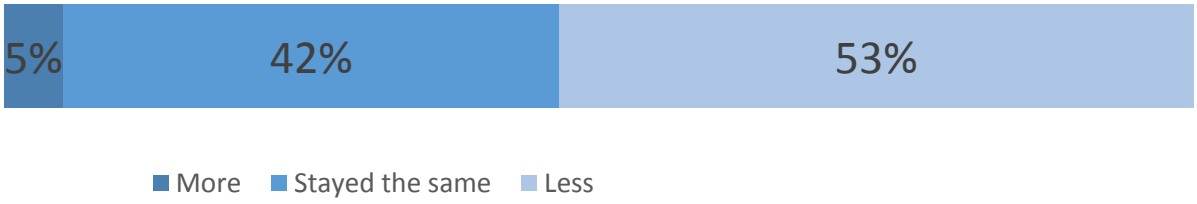
Among clients who reported injecting in public spaces in the past (n=92), 76% (n=70) reported that they are injecting less in public spaces since TOPS has opened (see **Figure 27**).

Figure 27: Client Survey self-reported data "If you injected in public spaces in the past, would you say that now you are injecting in public spaces more often, less often, or has this stayed the same?" [Client Survey, n=92]

Reduced Discarded Gear in Public Spaces

Among the clients that reported disposing of their gear in public spaces in the past (n=60), 53% (n=32) reported that they are now disposing of their gear less in public spaces since they have been using TOPS (see **Figure 28).**

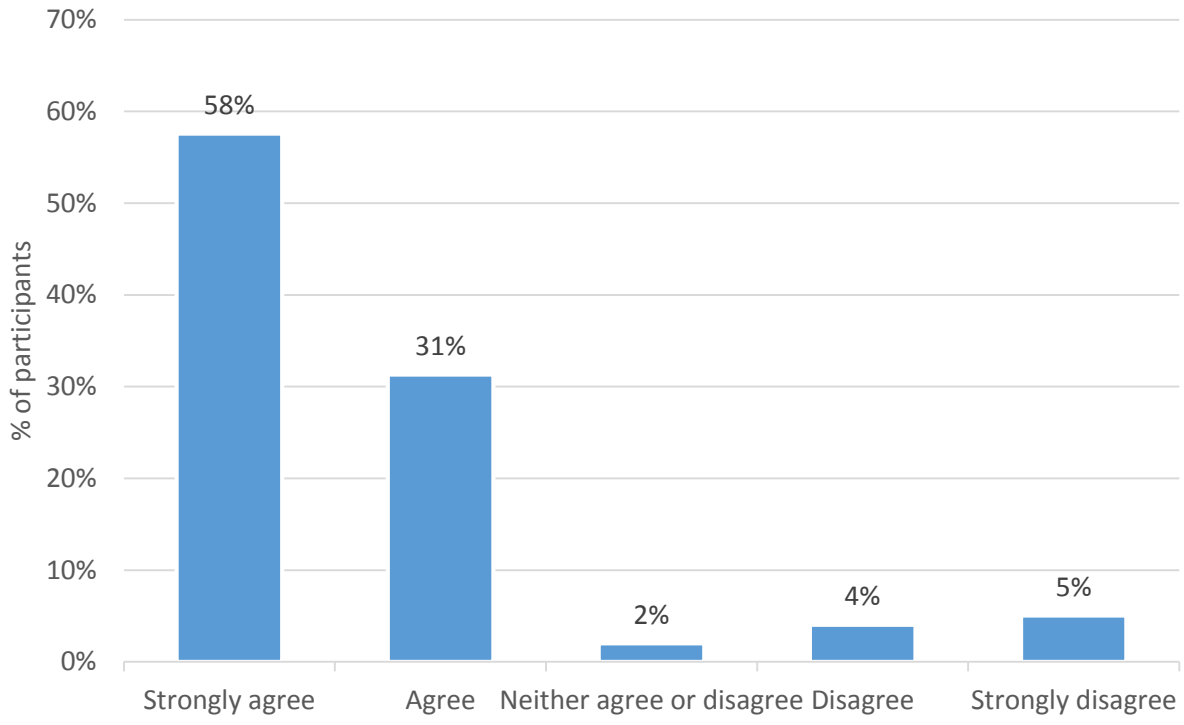
Figure 28: Client Survey self-reported data "If you disposed of gear in public spaces in the past, would you say that now you are disposing of gear in public spaces more often, less often, or has this stayed the same?" [Client Survey, n=60]



Connecting with Health and Social Services

The majority of clients (89%, n=88) either agreed or strongly agreed that staff have talked to them or helped them to access other health and social services (see **Figure 29**).

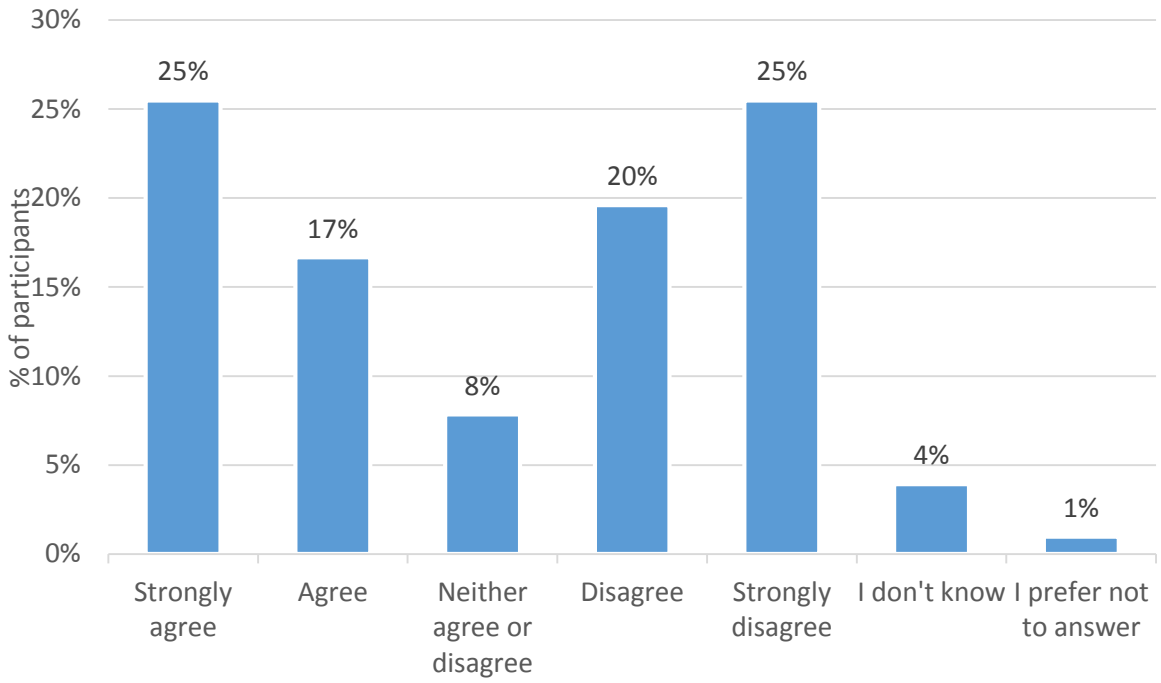
Figure 29: Client Survey self-reported data level of agreement with the statement: "Staff have talked to me or helped me to access other health and social services" [Client Survey, n=99]



Perceptions of the Community Caring About Them

While 42% (n=43) agreed or strongly agreed with the statement "I feel the broader community cares about me", a similar proportion of 45% (n=46) disagreed or strongly disagreed (see **Figure 30**).

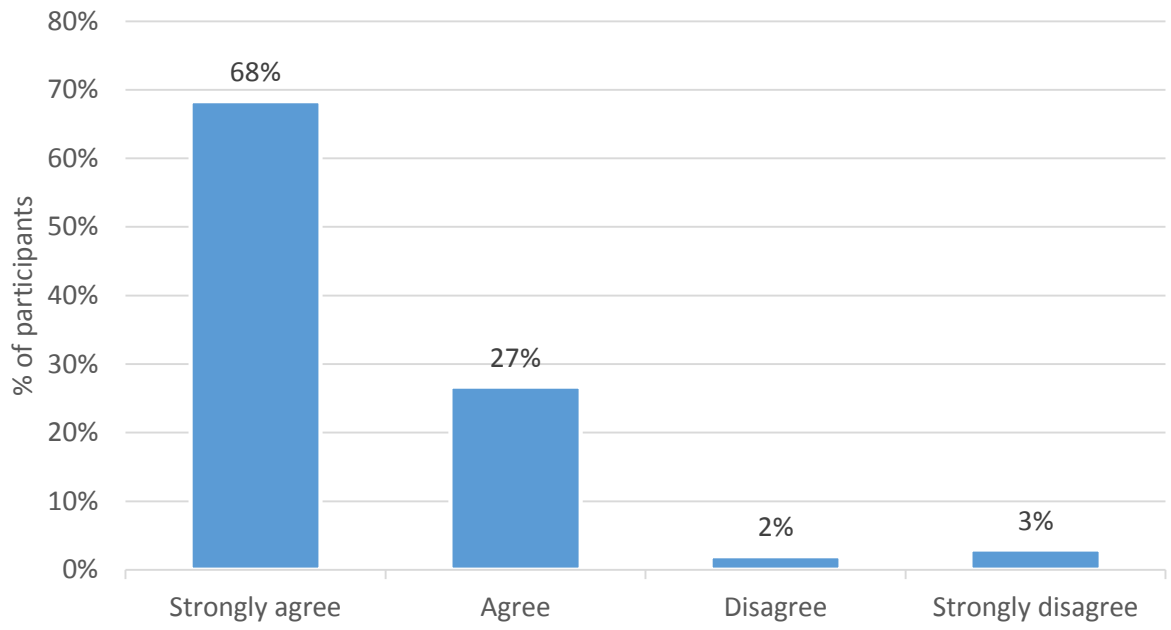
Figure 30: Level of agreement/disagreement with the statement: "I feel the broader community cares about me" [Client Survey, n=102]



Increased Feelings of Acceptance and Not Being Stigmatized or Judged

When asked to indicate their level of agreement with the statement "I feel accepted at the Overdose Prevention Site", 95% (n=97) either agreed or strongly agreed that they feel accepted at the site (see **Figure 31**).

Figure 31: Level of agreement/disagreement with the statement: "I feel accepted at the Overdose Prevention Site" [Client Survey, n=101]



Appendix L: Qualitative Data Tables to support themes related to Part 2 Service Delivery

Table 1: Quotations to support themes related to Services

Successes and Challenges: Services		
Theme	Sub-Theme	Relevant Quotes
TOPS client's satisfaction with services		*They are friendly, caring, accepting. They put a smile on your face. Always open doors, they welcome you in. - They don't judge anyone, which I really like. - Thankful for this place.* *[Data Source: Client Survey]* *I love this place. Staff are wonderful. They go above and beyond and make sure you are taken care of, set up with tests, etc.* *[Data Source: Client Survey]* *The staff here are good people. They inspire people to be happy. They have been really good and I am really impressed. They actually care about us. They don't just treat us like they are robots.* *[Data Source: Client Survey]*
Services delivered according to MOHLTC expectations	*Supervised drug injections, oral and intranasal drug consumption*	*I have never seen anyone use intranasal or orally….. Most of it [drug consumption] is IV.* *[Data Source: Staff Interview]* *I don't know if I have ever seen anyone do an intranasal consumption, maybe only once. I wonder if clients know that they can do that there, most people might think that it is all injection. This is my perception. I don't think I have ever seen anyone do intranasal. We are so focused on injection, that maybe we haven't let people know that they can do other things. Maybe when they first come in, we can ask them what drugs they are using, asking if they are injecting or snorting, asking them how they are going to use.* *[Data Source: Staff Interview]*
	Access to harm reduction supplies	*It is easy, convenient, to have all your gear, clean gear, ready so you can use. The convenience of it. No other reasons. The fact that you need gear, it [TOPS] is convenient, you come here to get gear so you might as well use it [TOPS]. You won't get arrested here [TOPS].* *[Data Source: Client Interview]*
	Responding to overdoses with oxygen or naloxone	*It [TOPS] is a safe haven, you can use here [TOPS] and not get in trouble. There is a doctor on site so if you go down there is someone here.* *[Data Source: Client Interview]* *It is convenient, they [Staff] have naloxone in case you go down.* *[Data Source: Client Interview]*

Successes and Challenges: Services		
Theme	Sub-Theme	Relevant Quotes
	Peer-to-Peer Assisted Injections	*We all know one another [peers]. There have been times I've been asked to help others inject safely and properly [peer-to-peer injection]* *[Data Source: Client Interview]* *Someone asked me if I could jug [hit on the neck] them, and I did, one of their veins was a rodeo, when you stick it [the vein] and it runs away.* *[Data Source: Client Interview]* *It's really great to see the peer support going on. So there are people knowing techniques for injecting people with small veins, or how to be able to inject that is safer. There is a lot of peer learnings that occurs. And for TOPS to have peer to peer injections is good. It's a relief when someone has been trying for so long and when a peers comes in it's a relief.* *[Data Source: Stakeholder Interview]*
	Fentanyl strips as a drug checking service	*I am happy that they [clients] are coming in, that they are hearing us, it is a better quality of life, they are using safely, in a safe place, they know their risks. They are getting their drugs tested for fentanyl, there was a client with crystal meth, then when it was positive (his test) [positive for fentanyl] he decided not to use, he went back to his dealer. Giving them the ability, they don't have to use it, going back to their dealer – look this drug was dirty, it was cut.* *[Data Source: Stakeholder Interview]* *Sometimes the test [fentanyl test] t is also inconclusive. When they come into the room, they are asked what are you using today, oh I think it's fentanyl, then they will say he we have these strips if you want to try. It isn't said to all the clients, there isn't much of a delay [to get the results], like 30 seconds. When they come in, they don't really care, they just want to use. There is that education from harm reduction, that it is there for them if they want to use.* *[Data Source: Staff Interview]*
Services exceeding MOHLTC Expectations: Additional onsite services	*Medical services and supports*	*I got stabbed a while ago and the nurses helped to take care of my wounds and abscess because I have a phobia of hospitals. But they were able to call the hospital when I needed it. The staff had been coming in everyday to change the gauze. The nurses want to do a lot for us, but they are not allowed to.* *[Data Source: Client Survey]*

Successes and Challenges: Services		
Theme	Sub-Theme	Relevant Quotes
		This is a one-stop shop; in case you have a wound you can talk to a nurse that will help, you know, with what you need to do with your wound. *[Data Source: Client Interview]* *Having a nurse and EMS, for an abscess or having them help with re-bandaging is helpful for clients. It's a safe space for people.* *[Data Source: Stakeholder Interview]*
	Wrap-around services	*I come here if I'm having a bad day. The nurses help me with my blood testing for Hepatitis. They are helping me connect with other resources in the community as well, like London Cares…. There is just somebody that cares.* *[Data Source: Client Interview]* *There's a lot of support staff here and services, like overdose kits, HIV testing, Hepatitis testing.* *[Data Source: Client Interview]* *RHAC is a wonderful partner that specializes in Hepatitis and HIV, LGBTQ rights,. . . [other stakeholders] can bring in social determinants of health, housing, assessments to link with primary care and mental health. . .. . that wrap-around support. We have a set schedule, ... clients get to know our schedules.* *[Data Source: Stakeholder Interview]* *The thing that I love the most about TOPS is that we have people from so many agencies working at the aftercare room. . .. Pooling resources together, having everyone together in one spot is beautiful.* *[Data Source: Stakeholder Interview]*
	Indigenous supports	*. . .. [It] builds an extra level of comfort for people [clients] accessing the TOPS that there is Indigenous people here. . .. The space [TOPS] is being honored as an indigenous space.* *[Data Source: Stakeholder Interview]* *When you have a person from the indigenous community in the Aftercare room they get the opportunity to get healing and reconnecting with their indigenous roots, to help make those positive change. People start to attend sweats, and before they were unwilling to do that before.* *[Data Source: Staff Interview]*

Future Enhancements to Services	*Wound care services*	*In the beginning when I first started, it was communicated to me that it should be first aid. We have equipment there that promotes more than first aid, we have different equipment for open sores. It is a little bit more than first aid, but clients really appreciate and it is really nice to do this for them. There isn't a line that I shouldn't cross in terms of wounds – I tell them keep it clean, change the bandages, that is all that I can do. What is considered first aid and what is more than that would be nicer so I could know what that is.* *[Data Source: Staff Interview]*
	Assistance by medical staff to set up injections	*The nurses can't help hit you, but they should be able to hit you if you are distraught. I had an abscess and couldn't move my arms, so I had to try hitting myself and kept missing so I waited for someone to come in and help me.* *[Data Source: Client Survey]* *Only thing – but could be very controversial is to have individuals be able to have their injections set up for them so having the needle already set into their arm. Because sometime people are trying to find their vein and it's hard for them and hard for us to watch. So having staff to get that ready and find the vein and trained in that.* *[Data Source: Stakeholder Interview]*
	Access to primary health care services	*Doctor for people who are using medication to help with bad pain. Would be helpful to book an appointment and get a small script.* *[Data Source: Client Survey]* *Medical services (steps beyond what a nurse can do) so having a doctor one day a week to prescribe for harm reduction.* *[Data Source: Client Survey]* *Urgent walk-in clinic because a lot of us don't have family doctors. One time I waited in a clinic from open to close and I didn't even get to see the doctor. Having an office to come and talk to a nurse would be helpful.* *[Data Source: Client Survey]* *I wish we had the means to have more because that would mean to have a doctor. How would it be to have that for people who use? A lot of participants their status is HIV positive whether it's for injection. Stating your status is a lot – making that discussion a little simpler and gentle.* *[Data Source: Stakeholder Interview]*

	Onsite access to rehabilitation and treatment services	*Immediate access to detox, you can't make people wait or else it won't happen (you can't cold turkey them).* *[Data Source: Client Survey]* *Treatment services - more capacity to get people into treatment.* *[Data Source: Client Survey]*
	Supervised Inhalation services	*Smoking inside, I don't like shooting up because my veins are almost shot, so I would rather just smoke up.* *[Data Source: Client Survey]* *We are missing out on a large number of people of substance users. If people are not able to smoke in the site, they are still at risk, so we are missing out on them.* *[Data Source: Stakeholder Interview]*
	Education on harm reduction	*Workshops to teach people to inject properly, lifesaving workshops (e.g. information on naloxone), what you're injecting? what street drug is out there right now to keep up-to-date.* *[Data Source: Client Survey]* *Courses on harm reduction and how to safely use and put your syringes away* *[Data Source: Client Interview]*
	Access to more counselling services on-site	*More one-on-one counselling.* *[Data Source: Client Survey]* *More social workers, someone you can talk to.* *[Data Source: Client Survey]*
	Naloxone distribution and training	*Many addicts don't know how to use naloxone kits. They need training on it. They need to be able to show and demonstrate how you use is. Everyone coming into the site should be asked, shown, and encourage to take kits. . . .it would save a lot of people's lives. It saved my life (naloxone). I just did a small toke off the tinfoil and feel down.* *[Data Source: Client Survey]*
	Refreshments and food supports	*Providing snacks and juice in the aftercare area. You don't always get enough to eat. It would be great to have a little bite to eat. It would help.* *[Data Source: Client Survey]*
	Services to meet basis needs	*Food bank items, including food for people with special needs, certain conditions (e.g. peanut allergy), dietary restrictions.* *[Data Source: Client Survey]*

		Several street people use the site, need to have hygiene products, toothpaste, socks, hygiene kits. *[Data Source: Client Survey]* *Life skill things, such as getting an ID, things that clients don't usually get around to doing (e.g., income taxes), more outlets to get legal things done.* *[Data Source: Client Survey]*
	Recreational activities	*Socializing with people in the waiting room, I see me doing that. We should almost have like a club or a coffee house, so I can sit there jamming, you know what I am saying.* *[Data Source: Client Interview]* *Maybe one thing would be to break down one of those walls [in the TOPS] and have a ping pong table here.* *[Data Source: Client Interview]*
Hours of operation challenges		*Not enough hours. It is mostly night time when you need them.* *[Data Source: Client Survey]* *I didn't know that it was open on the weekend. There needs to be a sign put up to advertise the weekend hours.* *[Data Source: Client Survey]* *I would like to change the hours; more hours are better. As many hours as possible. Vancouver is open 22 hours/day. Something similar to that.* *[Data Source: Client Interview]* *Clients are disappointed when they show up at 4:05pm. There was an overdose that happened right after it closed, they overdosed outside and they were able to come in and find staff. There was an intervention and the person did survive. They used naloxone and chest compressions and the person went to the hospital. It was a significant overdose.* *[Data Source: Stakeholder Interview]* *Lots of feedback about the hours. My shift starts at 10:30 [on the weekend at TOPS] and people don't come in till 11AM and people say "I was dope sick and I can't wait that long so I do it outside" and also closing at 4 typically people will check in at 2 at shelters and they will get rid of harm reduction equipment. So making it [the hours] longer so people can use and then go back to the shelter. So people can use more safely.* *[Data Source: Stakeholder Interview]*

Table 2: Quotations to support themes related to Staffing

Successes and Challenges: Staffing		
Theme	Sub-Theme	Relevant Quotes
Staff Characteristics and Skillset	*Nice, warm and friendly*	*One thing that I like the most is the staff make me feel welcomed, that will cause more people to want to use the site because they feel welcomed. The people here [TOPS Staff] make me feel welcomed.* *[Data Source: Client Interview]*
	Caring and compassionate	*The staff are really in tune with the people here, they really do care, you know with your heart that they do. . . That is very huge, so huge. Even when they are seeing someone in a worse shape than me, they have never told them to stay away.* *[Data Source: Client Interview]* *There's been a lot. There's been you know serious conversations, joking around conversations. It's nice to know that these people [Staff] they are individuals; they are genuinely caring people. Three of the staff in particular, I have had a sit down and have had a heart to heart and it wasn't about the drugs or the substance talk, but it was about what I was going through with my family. They [Staff] were there as a sounding board, they were there to give me advice.* *[Data Source: Client Interview]*
	Understanding of client needs	*They [staff] are more like peers than they are guards. . .. they can slide into your conversations-they are your friends not jail guards, part of your life without your drugs, there is an understanding.* *[Data Source: Client Interview]*
	Non-judgmental	*The staff are kind and courteous and don't judge you.* *[Data Source: Client Interview]* *They [Staff] don't judge you for what you are doing or how you are doing it. There's no discrimination coming here [TOPS].* *[Data Source: Client Interview]*
	Knowledgeable	*The staff, they are good and they are helpful, I have learned a lot from them [Staff]. They [Staff] have good information; I am not used to reading. The staff have and provide information about safe practices.* *[Data Source: Client Interview]* *The level of expertise and understanding throughout the people who work there on harm reduction . . . very strong background on evidence and they are able to convey this to clients who use their services. They are*

Successes and Challenges: Staffing		
Theme	Sub-Theme	Relevant Quotes
		able to communicate education in an informal way that is not academic. *[Data Source: Stakeholder Interview]*
	Skilled at de-escalation	*Two seconds ago there was an argument in there and you notice the tension rises and the staff step up and you can tell how experienced they are.* *[Data Source: Client Interview]*
Strategies to build relationships with clients	*Consistency of staff and stakeholders*	*If you can commit to 1 day consistently this help builds relationship with clients. . . helps when clients are coming in and they are able to connect with staff, overtime this has resulted with relationship with client and nurse, outreach, or community partners. It is part of establishing trust and allowing client to hopefully engage in conversation whether that leads to referrals or them coming back to use the services. I think that once clients get to know staff and develop a little rapport and trust, that's when you can start those conversations. . . this definitely helps with referrals and client comfort as they get familiar with staff. Now it isn't only the harm reduction workers, so now if one of the person is a familiar face, that helps, hey I work with that person, you can trust them as well.* *[Data Source: Staff Interview]*
	Conversational approach	*This is the most professional unprofessional place that I have worked in. Everything is so solid, but it gives that opportunity to have fun, visit people, we hang out there.* *[Data Source: Stakeholder Interview]*
	Acknowledging clients as the experts and learning from clients	*Some people say they don't want to be watched, so I say I'm not watching you, just checking to see if you are okay. I'll see something with somebody using a syringe for example and so I will ask "can you explain that to me". I'm always learning, it's important for them to know that they are experts.* *[Data Source: Staff Interview]*
	Highlighting the site as the clients' space and encouraging them to take ownership	*It is like really cleaning up after yourself. It is this ownership, being proud of the space that you have access to, that is working.* *[Data Source: Staff Interview]*
Strategies to enhance relationships with health and social services	*Contacting service providers directly to explain client needs*	*We have developed relationships with the hospitals. So there are doctors, and social workers who we work with. We call when we know that a person isn't going to stay in Emerg. We call and they will either come here or we will send them there, and that's happening because of the*

Successes and Challenges: Staffing		
Theme	Sub-Theme	Relevant Quotes
		trust that we have. When we call [community organization/hospital], we say "we know that your clinic is only open till 5 but this guy is refusing, is it at all possible for you to see this guy?", and they say absolutely. We use this when we need to, we don't abuse it. *[Data Source: Staff Interview]*
	Explaining client behaviours to service providers	*People say they've been kicked out of the hospital. But we explain that the client may verbally lash out, so you may have been approaching him in an authoritative way, he's in withdraw so he might lash out. and we really try to be respectful – there's the client's truth and there's our truth and the truth lies somewhere in the middle. My experience with social service staff, is if everyone is blaming the other, they don't see there is truth in all of it.* *[Data Source: Staff Interview].*
Supportive TOPS Leadership		*There is so much attention from the media and politicians. They are always requesting our time we are in here before 8am and leaving after 7pm. Our leadership works 14 hours a day to keep things going but never complaining. Without resources we are stuck where we are.* *[Data Source: Staff Interview]*
Areas for Improvement: Staff Resources, Role Clarity, Training, and Communication	*Staff resources*	*I worry about fatigue here [TOPS], because people can't pee without having coverage. I worry about staff resiliency. We were here until 6pm debriefing and we can't stop in the middle of the day. I worry about the staff and also the clients.* *[Data Source: Staff Interview]*
	Clarity regarding roles of medical staff	*I should be doing wound care, all I am able to do is clean up, because I don't have the supplies. But I could be doing wound care, doing deep packing, changing the packing. . . I feel like my skills are not being used there. I asked to do this and they said no because some people are not trained. I struggled with this, feeling that my skills are not being used.* *[Data Source: Staff Interview]*

	Communication between nursing staff	*I think that nursing staff are very isolated because we work 1 nurse at the time, so we don't have time to talk to each other. . .. Some days, you're there for the full day so you don't see the nurse at all. Other times you don't have the 30 minutes to talk to the other nurse because you are with a client or something. I would like to see more communication with other nurses, since we work in isolation, I may be doing something differently, I think it would also be a good learning opportunity.* *[Data Source: Staff Interview]*
	Addressing ethical dilemmas regarding service provision	*Also some of the struggles that we've talked about as an organization, just so that we can talk deeper about it on a regular basis. So if someone is coming in and using opiates but we know they are on suboxone [or] we know that they are on methadone, or someone involved in CAS and using substance with having a child there. So dealing with a bit of the ethical dilemma.* *[Data Source: Stakeholder Interview]*
	Staff training	*Having proper staff orientation and training, anytime a new person comes in. Because when you are in the room it's a lot more, so we've been doing it as we go, but proper training and orientation.* *[Data Source: Staff Interview]* *Training with everyone, RHAC had a day away, they had a day to talk about the trauma, you just silo people if you are having training for the site, you need a training from everyone, you need to be part of the team. You feel like a temp; you don't feel part of the team. There are different teams, RHAC, agencies, and MLHU.* *[Data Source: Staff Interview]* *They (the employer) assume that you have the experience coming in, it would be good to have the training for everyone, I know RHAC staff have that training, but other staff might not. Things to look for. I get I had to do orientation at the health unit, but it was a waste of time. Train me on what to do in an overdose, or go through the medical directives, I had to do the modules, what a waste of time. The most important thing was not something we went through - the medical directives. If I was in charge, I would train specifically for the site, how to keep safe, the flow, and the directives.* *[Data Source: Staff Interview]*

Table 3: Quotations to support themes related to Location

Strengths and Limitations: Location		
Theme	Sub-Theme	Relevant Quotes
Location Strengths		*Yeah, that [NSP] is a helpful aspect, it is a one-stop shop, on the weekend they have things [gear] ready for you, so when you are using, they just ask you if you need gear, so they give you those packages.* *[Data Source: Client Interview]* *It [TOPS] is convenient – I pick up my drugs here [surrounding location] so I can just use here [site] rather than going home to use. I like the staff. They [staff] keep gear, I can pick up gear, in case I need it.* *[Data Source: Client Interview]* *The convenience is what I like the most – I am downtown a lot. I have to come here to sell drugs or to buy drugs, so with having the site here, I don't have to go home to do it and I don't have to use a public washroom. I come here to get my cleans [new gear] anyways, so I can just do a hit here [at TOPS] while I am here getting more gear.* *[Data Source: Client Interview]*
Challenges with the location	*Travel time*	*The area makes it difficult, if I find something [drugs], I will find somewhere to use before I make it here.* *[Data Source: Client Survey]* *If you're sick I'm not going to walk to the site, I'm going to shoot up in the bathroom.* *[Data Source: Client Survey]* *There should be more than one site, because that's people's excuse. They don't want to walk or take the bus to the site, so they end up doing it at the park.* *[Data Source: Client Survey]*
	Back alley and north entrance	*Well look outside, the big cement blocks. It's cold. There is no sign saying anything, if you are not a user, you don't know where to go. Having a sign in the back would be good – would make the neighbours feel good.* *[Data Source: Client Interview]* *It can be sketchy using the alleyway, people get robbed and get into fights so people might not use.* *[Data Source: Client Interview]*

	Police presence	*There were 2 police cars, they scare people, that was yesterday. It was scaring people off – people were coming through the front door. I don't know what their [Police] thoughts are on this. If people start getting arrested coming here [TOPS], they are not going to go.* *[Data Source: Client Interview]* *They also worry about police being present. E.g. A guy had used a little bit of crystal meth, and when coming out, he saw the police so he ate all of his crystal meth because he didn't want to be caught with possession. Thankfully he came back and then he went to the hospital, although he was hesitant to go.* *[Data Source: Stakeholder Interview]*
Reflections on the Future Supervised Consumption Facility Locations	*York Street Location*	*There's some people who won't go East but will use a site downtown.* *[Data Source: Stakeholder Interview]*
	Simcoe Building Location	*If you put it at Simcoe, there will be a lot of traffic. . . I think that is a really wise decision. That would be perfect, if you want drugs there, you go there too, there is a lot of dealers and countless dealers in that building. . .. A friend of me died there [a few] months [ago], he injected with fenty (fentanyl) and he died right there [Simcoe building]. If there was a site there [Simcoe], he could've used it.* *[Data Source: Client Interview]* *Personally I think that they should keep it here [at RHAC] – but that is my problem. I will never go to Simcoe, or that building, there is a lot of robberies there and people getting jumped. Nothing good comes out good of that building.* *[Data Source: Client Interview]*
	Multiple sites across London	*I like to have both locations opened, the location here is ideal, have a location at the east end of Dundas too.* *[Data Source: Client Interview]* *I would like to see another site opened, there is a need. You [decision-makers] need to send it to the deep east, Clarke area, there is a lot of [drug] use there.* *[Data Source: Client Interview]* *I can see 3 sites. That could be enough to cover the city – one to the east end, 5 blocks to Argyle mall; right here [downtown], if it is 3 block radius it is good to walk; then White Oaks, and the downtown core – 4 to 5 radius of the downtown core.* *[Data Source: Client Interview]* *With the [shelter], when they are doing the random screens - If there was one right in the [shelter] then I don't need to*

		have drug paraphernalia on me. I would just go and use it there and have no need to have it [gear] on me or be giving it [gear] to others. It would save me a lot of hassle and not having to be kicked out. *[Data Source: Client Interview]*
	Mobile unit or van	*Having something mobile would be great for people.* *[Data Source: Stakeholder Interview]*

Table 4: Quotations to support themes related to Space Design

Successes and Challenges: Space Design		
Theme	Sub-Theme	Relevant Quotes
Open Room Layout and Open Table Design	*Open room layout and open table design benefits*	*The space is enough, the fact that everyone is open, the biggest thing is feeling hidden about it [drug use] or shameful, like a bathroom, when you feel hidden it works on the psyche that you are doing something bad. The open configuration is better than having stalls, that's how I see it. [Data Source: Client Interview]* *Having everyone, or the option to have peers not individually separated. It is a big advantage that I am afraid we might lose moving forward with SCF. This has allowed people, I don't want to say sense of community, but they can talk to us. It makes a big conversation, allows someone who may not be comfortable to engage with us, or other peers. This has been a great thing. [Data Source: Staff Interview]*
	Open room layout challenges	*It is so small in there [aftercare room], if you wanted to say something private you couldn't. You need an office for someone who wants to talk to someone, someone to talk to. [Data Source: Client Interview]* *The staff – sometimes it feels like they are jumping on you. They [staff] are always looking at you. If you are doing it in the river, no one is looking. But here, it isn't about getting you to leave, they [staff] are just always talking to you. It isn't a bad thing. It [TOPS] would be better if it was just a cubicle, here it is open, today I was seeing buddy here with his pants down using…The space itself, when you are using [drugs] you have someone else seeing what you're doing or they [other people in the injection room] are seeing you. [Data Source: Client Interview]* *More space to have more services, a room for nurses to do first aid, if someone has an abscess you can't predict when it is going to burst. Having a little medical space would be good for privacy, dignity, it would allow the nurse to do more. [Data Source: Stakeholder Interview]*

Inviting space		*Some do a social thing, but should just come in and out, but some people are socializing, they should socialize outside here (the site).* *[Data Source: Client Interview]* *The only thing that I don't like about it, doesn't have to do with the people at the site, but the other users who use the site. For example, some people will organize their bags, or they're talking, and they don't do what they are supposed to be doing in there. Sometimes I will go in and use and some people will still be finishing their paperwork.* *[Data Source: Client Interview]*
Limited space		*It [environment] could be bigger. There is always people in the waiting room waiting. More than four people at once. 8 spaces would be good.* *[Data Source: Client Interview]* *Hopefully we have a bigger permanent site, so we can have more people in at the time, like 8 to 12 people at a time.* *[Data Source: Client Survey]* *Need a bigger area, there has been the odd person get up and leave, reality is that they are going to shoot up outside. - double the space for clients.* *[Data Source: Client Survey]* *The intimacy of the room I love it, but it can be very squishy. When it is busy it can get claustrophobic, it is crammed, both love hate. Especially when you have someone on the floor in the injection space, for various reasons…it is tight space...I like that there is no booth, I think that is nice.* *[Data Source: Staff Interview]*
Temperature and ventilation		*I think I would make it [TOPS] bigger and fix the a/c – the standalone a/c is not as good. It doesn't do a good job. If you put a bigger one [A/C Unit] it would be better, especially with doors opening and closing so often.* *[Data Source: Client Interview]* *That [186 King] building doesn't have air conditioning. So you have someone on meth or going through withdraw and not having air conditioning isn't good.* *[Data Source: Stakeholder Interview]*

Table 5: Quotations to support themes related to Operations

Successes and Challenges: Operations		
Theme	Sub-Theme	Relevant Quotes
Successes: Policies and Procedures	*Client Code of Conduct*	*People sometimes follow the rules and some don't and get kicked out. - Sometimes people see others breaking the rules and speak up about it. We don't want the site to close. It will ruin it for everyone, if one person doesn't follow the rules.* *[Data Source: Client Survey]* *People using the site, they are very respectful of the site and each other. They respect the staff and they abide by the rules. I think that's going well.* *[Data Source: Stakeholder Interview]*
	Peer-to-peer Assisted injections	*The peer to peer injection really helps a lot of people. There is a lot of people who come in who can't hit themselves. I know that originally that [peer to peer injections] wasn't allowed, but to have that has really helped because a lot of people can't hit themselves… Originally we had people wait for someone [peers] to come through who they were familiar with. Now they [clients] come in together, we sit them together, helps the flow. They teach other people, it is a teaching moment and they [clients] are all gaining from it.* *[Data Source: Staff Interview]*
Areas for Improvement in Policies and Procedures	*Challenges with the organization of the policy manual*	*I know a book [policy and procedures binder], it is really long, no table of contents, I don't know how to find anything…If it was accessible – we have put post it notes on it so I can flip to it.* *[Data Source: Staff Interview]*
	Inconsistencies in policies and medical directives for responding to overdoses	*We have a Narcan protocol that says that if a client doesn't respond to the initial dose we need to call EMS. This is not what we have been doing – it has never been told to us that we have to follow this book. There is an algorithm that has been printed that is not aligned with the book [policy manual]* *[Data Source: Staff Interview]*
	Challenges with documentation when responding to overdoses	*I did my documentation for the overdose we had at the back, so no one knows the time between, did they switch noses, I only know from what we know. We had a lot of people there, plus clients looking to help. It was a good result and we did an hour debrief, but we couldn't say somethings like amount of time between doses because no one was paying attention.* *[Data Source: Staff Interview]*

Successes and Challenges: Operations		
Theme	Sub-Theme	Relevant Quotes
	Lack of required equipment for some medical directives	*All the medical directives. If you are expecting a glucometer for glucagon – then you need to provide me with a glucometer.* *[Data Source: Staff Interview]*
	Lack of a policy for needle and bodily splash incidents	*We had an incident with a client, we don't have a procedure for anything like body fluid splash, or having a needle stick.* *[Data Source: Staff Interview]*
	Contradictory policies between MLHU and RHAC	*There are health unit policies, then RHAC policies, some are similar and others contradict each other. So on my first week there I was asking which one should I be using, which one should I follow.* *[Data Source: Staff Interview]*
Successes: Data Collection	*Providing explanation to clients regarding the rationale for collecting data and allowing clients to visibly see what is entered*	*Any information we obtain, we share with them, they can observe any data entry and see visually what we are entering.* *[Data Source: Staff Interview]* *We show people things with the data that they give us. [example] So different size tips. So if people identify that they use a certain type of tip then we can provide this information to the Ministry to show what we need funding for and why we need funding for.* *[Data Source: Staff Interview]*
	Implementing an electronic data collection process rather than collecting data on paper	*We got a laptop, we went from paper to use the database to track stuff – collecting data and stuff like that. That's great.* *[Data Source: Staff Interview]*
	Reviewing and refining the type of data collected	*We are making a module as we go, we are literally piloting as we go… Data is hard to collect in that, you want to be low barrier. It's just staying true to what you need to know than what you want to know. Our indigenous community came to us and said we need to have stats on how many people from the indigenous community use drugs, now we collect that.* *[Data Source: Staff Interview]* *There have been referrals, now we are getting number of people getting referred to addiction services, mental health, housing so that is now captured.* *[Data Source: Staff Interview]*

Successes and Challenges: Operations		
Theme	Sub-Theme	Relevant Quotes
Areas for Improvement: Data Collection	*Collecting intake questions and forms in the injection room*	*I feel like we are interrupting, I think it would be better to ask the questions (e.g. what drug used) before the person comes into the space [consumption room]. You could walk in and ask all the questions we need to collect. It would be great if that was asked before in the waiting room and clients are given the gear and then go into the space to do what they need to do. It's less intrusive, so it would be more efficient.* *[Data Source: Stakeholder Interview]* *The flow can be changed to be a bit better. Questionnaire (rules and last drug used, etc.) can be done in the waiting room, so that they [clients] are set up and ready to go when they come into the site. So while clients are sitting down, it's a good time to get their information. Otherwise the flow is really good.* *[Data Source: Staff Interview]*
	Keeping track of referrals	*I know they want to get a laptop in the aftercare room. So we can track better when we are making referral, so it can be helpful. Right now at the end of the day we try to recall and remember where we referred people. . . The laptop would also make it easier to have the resources at hand, and being able to find the phone numbers of agencies.* *[Data Source: Stakeholder Interview]*
	Data entry into computer	*So, I am going to talk about a challenge in my role. Computer is great and we also have paper. When you are sitting in my role you are doing the work of 3 administratively. I am doing the intake, which ideally would take place in the waiting room, then info about the injection space, then from another room [aftercare room] then hearing about what referrals are being made so when I discharge someone I am trying to figure out the referrals. Having to do all those 3 things on 1 computer can be challenging. There is no way that the data that could be put from aftercare, it is not reflective of all the referrals. For me that is one of the biggest challenge, because I know it is important to have data and I don't think we are capturing it all.* *[Data Source: Staff Interview]* *As the primary, there is a written intake sheet you have to complete as clients come in. And then there is a list where you duplicate the information and then you have to enter it into the computer. So those are points where you are not making connections with the clients. I find that concerning because we are missing the opportunity to connect with them. It's too complicated to the point*

Successes and Challenges: Operations		
Theme	Sub-Theme	Relevant Quotes
		that I think it's wrong. Because you have to check people in and check them out, so it's hard to keep track when you are trying to remember people's codes when they leave, and when there is more than one client in the room. Generally, the thing about NEO is that there is no consistency. *[Data Source: Staff Interview]*
	Nursing documentation	*Charting for the nursing staff can be improved, I know this is already in the works. We are looking to see if we can make nursing documentation more streamlined. Currently we chart on the sheet, so anytime you have an interaction then you need to chart. So we are looking to have some tick boxes so that its quicker. If clients see that you are writing, then they may experience a bit of paranoia from seeing us write. So you have to write about the situation, what you provided and what the plan is in the notes. Having tick boxes (e.g. education provided) will help us chart quickly.* *[Data Source: Staff Interview]*
Daily Huddles and debriefs	*Huddles*	*Huddles in the morning about the previous shift. At the end of day, they ask what your drive home will be like.* *[Data Source: Staff Interview]* *They debrief every morning and talk about what the look out for in the morning. They also review oxygen in the morning. The nurse is responsible for the oxygen but the harm reduction worker works with them.* *[Data Source: Staff Interview]*
	Debriefing session	*We are good at debriefing in case anything going on. What is your drive home going to look like? Is there anything that sticks out? They [TOPS staff/leads] are very clear in making a point – everyone sits down and talks about things. . . It [TOPS] is a positive environment to work in.* *[Data Source: Stakeholder Interview]* *A friend of mine from childhood, someone who is street involved came to use the site. I saw her and thought if she acknowledges me, then I will leave but she just pretended to not know me. It was hard for me to know that someone you know was injecting. For me it was a bit uncomfortable. But we debrief at the end of each day and sit down and talk about 'what happened today?' and 'if you walk out the door, what will go out with you?". In this instance, the debriefing was helpful for me.* *[Data Source: Stakeholder Interview]*

Successes and Challenges: Operations		
Theme	Sub-Theme	Relevant Quotes
Measures to ensure client and staff safety	*Restricted client access to the site*	*We de-escalate as much as we can. It's like, today's not a good day so we are going to ask you to go, and we'll see you tomorrow. They tend to respond to that, we haven't had any physical reaction to that. We give chances but ultimately we have to follow through. If they come back and they still can't follow through then we say you can't come back to the site for 72 hours. Because of our controlled entrance, it's helps. We talk about the situation and say we can't have you walk around with an uncapped syringe and they leave. We have a gradual progression to restricted access.* *[Data Source: Staff Interview]* *We have a handful of people that are really physically challenging to manage in the site, so whether it be walking around with an uncapped syringe, or threatening behaviours are the only ones that we can't serve well because of the physical space, because it would limit the number of people who can access the site at the same time. Because of their use and body movement and difficulty with moving them along, we can't have other people use the site. We have approximately 5 people for whom the site is just not designed to deal with.* *[Data Source: Staff Interview]*
	Use of walkie-talkies	*The walkie system is key to safety.* *[Data Source: Staff Interview]* *If anything became a concern all staff have walkie-talkies and you are never alone and they would activate the walkie-talkie. Whenever there is an issue, we stop serving clients so they use the walkie to put the services on hold.* *[Data Source: Staff Interview]*
	Adequate staff coverage in the site	*I know that RHAC staff and even with MLHU staff, having lunch coverage is very difficult because there is no break.* *[Data Source: Stakeholder Interview]*
	Re-introduction of the security guard	*We started to see people dealing around the facility and were asking people to move along so we don't get things shut down, so we have brought in security. It's [security] from the harm reduction lens not from an enforcement lens. I think it was about addressing each concern as it came up. Be ready to have strategies in place to reduce loitering or reduce garbage. We also have the needle bins outside but people sometimes don't use it. When we started, security was on the inside. He was wearing a police like uniform, you could see*

Successes and Challenges: Operations		
Theme	Sub-Theme	Relevant Quotes
		people [clients] have a physical reaction to that. We don't need security inside, but outside it's out of our control. We trained them [security] on harm reduction and partnered with them and had them shadow to see how we interacted with people. *[Data Source: Staff Interview]* *It has been very positive for staff [to have the security guard], on the weekend there is only 3 staff no one else around. It is nice to have that extra person to go check outside, we are not staffed to go outside. For clients, personally speaking, he [security] engages really well with clients, they are really comfortable with him. Some clients will identify it good as well, some clients were worried about things going on outside – they were worried it [TOPS] might close. They are happy someone is checking up outside – they are happy we [TOPS] are here.* *[Data Source: Staff Interview]*
	Controlled access to other rooms at RHAC	*We do space design so only certain amount of people in the room. Also being aware of your body posture and being aware of the doors. We have a self-contained wait room. They cannot access anywhere in the building, but they can leave.* *[Data Source: Staff Interview]*
	Training on Crisis Prevention Training	*The de-escalation, if you can't deescalate then you might contribute to someone [client] escalating. I don't know if the nurses have that training but the staff [RHAC] here do. The training is called Crisis Prevention Intervention which teaches about being aware of your body language and getting out of a physical hold and the stance you take and how you have a conversation with someone and if someone's voice is elevated, if you elevate your voice, then the person is going to elevate their voice again. There's different levels and we have a policy where we don't get physical with anyone, so there are different levels of training you can take.* *[Data Source: Staff Interview]*

	Placement of signage throughout the site	*Clients for the most part [following policies and procedures], the biggest thing right now it has been about the passing. We originally had no passing of any drugs, but now they are trying to pay others who have helped them. This has become a blurred line, we just put signs of no exchange of anything. It gets complicated, drugs money and cigarettes we are trying to stick to. They share crushers, lighters, that goes under – it is not a big deal. The exchange of stuff has been a big thing for them.* *[Data Source: Staff Interview]* *I know that one is that we put a sign that once you go into the chill out room after the injection room that you cannot go back.* *[Data Source: Staff Interview]*
	Placement of sharps bins on the floor near clients	*We also ask people to remain seated, if someone is injecting in the floor – we put a sharps container in the floor so they don't get up with the needle.* *[Data Source: Staff Interview]*
Strategies to address verbal abuse	*Using de-escalation strategies*	*If somebody for example, somebody was struggling to find a vein and I was saying something to somebody else, and he told me to shut my mouth. In that instance, it was better to disengage from conversation, give him the space he needs to do what he needs to do. And when he came again, having the conversation with him that it was disruptive and said some things that were disrespectful to staff, and say that if it happens again he will be asked to leave immediately. So we set that boundary, so sometimes it's better to wait depending on who the individual.* *[Data Source: Staff Interview]* *There are times when escalation is happening and we tap out on each other. Someone comes in and we tap the person out because the strategy might not work and seeing a new face may help the individual. And it also allows the staff the tap out because they may start to take things personally.* *[Data Source: Staff Interview]*
	Understanding the context for the verbal abuse	*Not acting appropriately, like yelling, raising their voice if they get really angry. Sometimes it is something outside, but most often times when they [clients] get angry it is because they can't find their drugs – they think that someone has taken their drugs so they tend to get really upset. They [clients] sometimes start yelling, not at anyone specifically, but at the fact that they have lost their drugs. I mean, that would make some individuals [other clients] uncomfortable because if they are trying*

		to use, if clients are yelling. Pacing is also one of those behaviors. *[Data Source: Staff Interview]* *I think when you are service provider and the clients come in and are having a bad day and they have verbal escalation, I don't take that personally, because otherwise you may escalate things. I know people have bad days and I get it. So learning that has been huge.* *[Data Source: Staff Interview]* *Yes, verbal is, sometimes when you don't have any power, words are the only things you can speak. Swearing is a way of language on the street. Somebody may say "fuck this" or "fuck that" so they [clients] may not perceive it as abusive. But some people do cross that line and they are asked to leave.* *[Data Source: Staff Interview]*
	Offering clients a modified service or restricting access	*Typically, if someone is getting like that [upset, escalated] there is a need or want that is not getting met. If there are wanting to do something that is unsafe or they are asking for something that we can't, experience anything degree of perceptual disturbance – they are questioning us and what goes on the site. We are able to level them – them wanting to smoke inside, listen we don't have the ventilation, then everyone will have to leave. If they understand and still are upset, then we need to move them along for others safety. Clients know that we are serious when we are telling people that that is enough.* *[Data Source: Staff Interview]*
Supplies	*Replacing supplies*	*There are some resources [funding] that I wish I had more – that we would be more efficient, the sink, having a mirror in both tables, wish never ran out of lighters. We don't always have the resources to replace those things – that is tough – sometimes we can't replace them and it is tough because we [TOPS staff] want to support clients.* *[Data Source: Staff Interview]* *In other sites they [lighters] are attached on the tables. When they [materials such as lighters] walk away we don't have money to replace them. Resources would be beneficial for clients to have that we can't replace because of financial restraints.* *[Data Source: Staff Interview]*
	Wheeled oxygen tanks	*There are small things like having a wheely for the oxygen tank but they are small things, Just with oxygen tank you want to be careful because if numerous people are overdosing you want to be able to wheel to them.* *[Data Source: Stakeholder Interview]*

Appendix M: Qualitative Data Tables to Support Findings related to Part 3 Impacts of the Temporary Overdose Prevention Site

Table 1: Quotations to support themes related to harms associated with drug use

Impacts on Clients: Reductions in harms associated with drug use		
Theme	Sub-Theme	Relevant Quotes
Reductions in harms associated with drug use	*Preventing overdose deaths*	*I have overdosed here today. Those guys [TOPS staff] have saved my life. I would be dead at this exact moment if it wasn't for the site. I would be dead at this moment.* *[Data Source – Client Survey]* *I have gone down from using fentanyl before here [TOPS] and they [Staff] were right there, using oxygen and everything. The experience is pretty good. I have seen them [Staff] take care of other people when they have gone down as well - they [Staff] have been able to help with oxygen.* *[Data Source: Client Interview]* *It's [TOPS] nothing but positive. I'm definitely thankful for it [TOPS]. That's why we need these places [OPS] to prevent life or death situation. Its' so positive.* *[Data Source: Client Interview]*
	Safer drug use practices	*Less risky of getting disease. It's very hygiene in here [TOPS]. If you don't have an alcohol swab, then they remind you and it's helpful.* *[Data Source: Client Interview]* *Yes. I'm more responsible about it now. I can handle it better - having drugs and not have it. This place helped me realized that I need to be more responsible and helped me talk about different situations.* *[Data Source: Client Survey]* *Yes. I am barely using at all now, and if I do, I come here, to the site, it keeps my use regulated.* *[Data Source: Client Survey]* *I haven't gotten cellulitis again. I was using at home when I had an apartment and I got cellulitis. I think it was because I was sharing cookers, but I haven't gotten since [using the site].* *[Data Source: Client Interview]* *We would have more sick people if we didn't have the site, because we used to share [needles and gear] a lot, especially when you have 10 needles and when you are broke, we share.* *[Data Source: Client Interview]*
	Creating a safe space	*The fact that staff and everybody, and how professional they are, it's encouraging for people to come back - I see that and it makes people come back. It doesn't make them want to use more but want to come back to a comfortable place to be and keep them away from the street and practice safe use habits.* *[Data Source: Client Interview]*

		Positive is that people were injecting outside and in our washrooms and now we have solution and telling them to come inside and do it. It speaks to our mission, the courage to do what is right in the face the opposition and stigma. We live and breathe our values. *[Data Source: Staff Interview]* *It's [TOPS] a safe place and you don't have to worry about doing illegal substances in public areas (e.g. outside and bathroom). I don't personally do that but people do. They [Staff] make it very comfortable for you and that there is no judging here.* *[Data Source: Client Interview]* *Basically, I don't have another place to safely use or to feel comfortable when using. If you are in a bathroom and someone is knocking on the door, most people are using to feel better or happy. So it [TOPS] is a safe place. You don't have to worry about leaving things behind. It [TOPS] is clean place you don't have to worry about disease. The staff give me a secure feeling – they are happy to see you, they remember you, they care about you.* *[Data Source: Client Interview]* *It's [environment] good, friendly safe and clean. It doesn't feel like a hospital. Hospitals make people feel uncomfortable.* *[Data Source: Client Interview]* *A lot of people would be struggling to find out where to use, the police they would have a lot of arrests. I have seen a big difference; this [arrests] isn't happening as much. They [Police] are not very nice in dealing with the junkies, not sure if you have been outside to see how they [Police] treat the junkies. Junkies are not using outside when this is [TOPS] open, they are not using in the street, so the police aren't arresting them.* *[Data Source: Client Interview]* *I don't have to worry about security guards kicking in the bathroom door. You can use here and leave your stuff.* *[Data Source: Client Survey]* *A lot of the reason why you would be on restriction [From accessing shelters] is for using or having drug paraphernalia. At the [shelter], they do random screens and if they find anything, they kick you out. So having a site like this would save a lot of those issues.* *[Data Source: Client Interview]* *The fety (fentanyl) is killing people and there is a lot of that around. The nurses here [TOPS] are definitely a good thing. There is someone OD'ing at [the shelters] all the time. I know guys who have gone down multiple times. If I had naloxone, they [staff] wouldn't let me go and give it to them. It is sad, they don't want to get a lawsuit. I have seen it, at [a shelter], this happens all the time. I had 3 naloxone kits. If you are going to do it, you can't tell staff.* *[Data Source: Client Interview]*

	Improving connection to health and social services	*I love this place. Staff are wonderful. They go above and beyond and make sure you are taken care of, set up with tests, etc.* *[Data Source: Client Survey]* *A [while] after the site opened I went to the hospital because the staff here caught the endocarditis and sent me to the hospital.* *[Data Source: Client Survey]* *I have used the nurses here. My drug of choice is opioid. I bought something that I thought was fentanyl. It was actually crystal meth. I had never thought of that. It gave me a 7-day headache, so I first came here [TOPS] to see the nurse, to ask if I should go to the hospital, is it worthwhile? If I didn't have that, I could find that I could have something major in my spinal fluid, if I didn't get the information/advice from someone [staff] I wouldn't maybe have gone. The nurses have never not done anything people don't ask about. They give you the confidence to do these things [seek services].* *[Data Source: Client Interview]* *They [staff] have helped me contact my HIV contact. They have trained me to use Nar- can [Naloxone]. They [staff] have also helped me reach out to the foodbank. They [staff] have helped me get to some blood work and sent me in a taxi over to [the hospital].* *Data Source: Client Interview]* *I think that we've had clients that we have never had been able to have more than 2 sentence interaction with. Now they sit down and have conversations with us. We are connecting them with services we didn't even know they needed before when we talked to them in NSP. We never got the opportunity to offer assistance in NSP. Having the community partners, we are seeing the connections to those supports deepen and increase.* *[Data Source: Staff Interview]*

Table 2: Quotations to support themes related to building of trusting relationships and connections

Impacts on Clients: Building of trusting relationships and connections		
Theme	Sub-Theme	Relevant Quotes
Building of Trusting relationships and connections	*Increased sense of community and feelings of belonging*	*I feel that I belong somewhere. I feel like everybody has the same problem, so if I say something people will understand. I do not feel like an outcast. I walk in here and it's a family. For once in my life, I feel like I belong. [Data Source: Client Survey]* *When I first heard about the site, I thought I would never use it ... it is nice to have a place to go, to get to know the staff because they wonder and care why they didn't see me in a few days. There is a sense of community at the site. - You got people who care about you - makes you feel like you mean something to someone, it's nice. [Data Source: Client Interview]*
	Increased rapport and having someone trusted to talk to and who listens	*Staff here are very friendly, they let you hang out and talk if no one is here using. They helped me through depression. It stops us from using in parks and school yards where we need to hide. I come here if I'm dope sick or if I do not have any dope. I can sit and talk. [Data Source – Client Survey]* *I really think it goes back to that rapport – I do not think we [TOPS staff] knew. We knew dynamics would change for us and clients. We didn't know it would create the rapport we now have with some of our clients – that rapport really makes us able to tailor harm reduction and services. [Data Source: Staff Interview]* *We've had a ton of people say I want to talk about my drug use and what that looks like. We've had people have a full on emotional meltdown, or saying 'I'm sick and tired of this life'. [Data Source: Staff Interview]* *The relationships I have been able to build with people have been amazing. You can see the shift when clients come in before [earlier when the site opened] and they were guarded and suspicious and now they are relaxed and happy and engaged. That has been amazing to see actually… as the relationships have grown people have been willing to tell you more things…The relationship has allowed them to feel safe, and I can say, "Here, this is how I can help you". You need to have that relationship if you are going to refer people to other things [services]. [Data Source: Staff Interview]* *It's a trust of us that gets people coming back to us. If this was a room where people didn't know the staff in this room, then they won't connect with other services. I do not know if I can prove that, but I think so. I think it's all about coming in the room and knowing this person and that this person who knows this person so there is that trust in the room. …Substance use is not a straight line, it's an up and down thing and you catch people where we can and give people*

		the support and services when they need because of that trusting relationships. *[Data Source: Staff Interview]* *With the relationships staff have with clients, clients share personal experiences and information like what led them to start using. Clients are opening up about their personal lives. None of the staff expected that. Clients have let the staff into their lives. The other day I was in the room with another staff when a client was sharing her story about a stillborn. She just told us her story.* *[Data Source: Staff Interview]* *I actually think that even though it is a small space it creates an atmosphere of intimacy but people are able to be vulnerable in front of us, with us, and with their peers in a way I do not think would have happened outside of the injection room. This has allowed us to build strong rapport with clients – since they have been in the injection room, things have changed since the injection room. The rapport allows us to know more about them [clients] – this allows us how to provide harm reduction information.* *[Data Source: Staff Interview]*
	Increased feelings of self-worth, sense of hope and feeling valued, cared for and loved	*Someone being kind to you, that is the biggest thing you can have in a place like this [TOPS]. A lot of people already feel down, so having a person smile at you makes a hell of a difference. [Data Source: Client Interview]* *[The staff person] makes everyone feel like they are valued and welcomed. The other staff have been wonderful as well.* *[Data Source: Client Interview]* *When I first heard about the site, I thought I would never use it ... it is nice to have a place to go, to get to know the staff because they wonder and care why they didn't see me in a few days. There is a sense of community at the site. - You got people who care about you - makes you feel like you mean something to someone, it's nice.* *[Data Source: Client Interview]* *It sounds weird, I almost look forward to, I've developed friendship and relationship with staff, not anything more than on a professional basis. I'd like to say friendship because a lot of us are here every day. Friendships have been a combination of both harm reduction workers and nurses. I know that's part of [the staff person's] job, but at the side, [this staff person is] very supportive and caring and helped me out in a couple of situations. [This staff person has] given me some good advice, not having to do with drugs but in general life. [This staff person] makes you feel welcomed and loved. A lot of people don't get that.* *[Data Source: Client Interview]*

		There was someone who I haven't seen for a while and I was so happy to see him, we told him that we missed him, and he was like "I didn't know anyone cared". People feel missed and loved. *[Data Source: Stakeholder Interview]* *I think one of the ways – the TOPS has impacted clients is showing them that people care for them, genuinely care for them. For some people, they haven't seen that before and that gives them hope. And that is all that we could ever want as workers to give people [clients] hope to make sure they are safe in whatever they are doing. To really show them that they have value, we [TOPS] value them, that is huge.* *[Data Source: Staff Interview]* *It's [TOPS] saving lives, validating worth, it's an opportunity to challenge stigma. People who come are hard on themselves. People say "I do not care about overdosing; I do not care about dying". That internal worthlessness, no hope, and this site is changing that, you are worth it and there is hope. You may not feel it but we do. But you got to think why are people coming, if they think they are worth nothing, because deep down somewhere they want help. They are reaching out in their own way. 6000 times [client interactions] in 6 months.* *[Data Source: Staff Interview]*
	Increased feelings of acceptance and not being stigmatized or judged	*It [the Temporary Overdose Prevention Site] gives me some dignity; they [Staff] treat me like a full-blown human being.* *[Data Source: Client Interview]* *You feel down sometimes, having people judge. Having a place where I do not get judged, they [Staff] treat me like I am walking into my own home. That is huge for me.* *[Data Source: Client Interview]* *Someone being kind to you, that is the biggest thing you can have in a place like this [TOPS]. A lot of people already feel down, so having a person smile at you makes a hell of a difference.* *[Data Source: Client Interview]* *I feel more comfortable in my own skin being around people not judging me, no negativity, and more comfortable when I am using. THIS IS HUGE. They [staff] are here for us if we need to talk. It is HUGE to feel accepted - they do care - you do not feel shameful. That is amazing.* *[Data Source: Client Survey]* *I've seen changes in people who have experienced that love. It's changed some people for the better. There's some people that before the site came around, whatever their upbringing may have been, or their lifestyle. I do not know what it's like, but they come here on a regular basis and have learnt how to interact and feel and be able to smile and that's not what this [TOPS] is all about. The*

		more important thing is the clean use and awareness; it's created more safe habits for a lot of people. The fact that staff and everybody, and how professional they are, it's encouraging for people to come back - I see that and it makes people come back. It doesn't make them want to use more but want to come back to a comfortable place to be and keep them away from the street and practice safe use habits. *[Data Source: Client Interview]* *I think people who are street involved have found that this is a safe haven, that there is a place they can come in and go let me gather my thoughts, whether it's in the waiting room, aftercare room. This is a place of timeout for them to take a breath of fresh air. I also think that they start to recognize their own self-worth as well when we start to shut down their stinking thinking. When they start to identify that they are a stupid junkie, or I do not deserve the hospital care. We shut it down and say you aren't a junkie, you have a mental health issue. When you can reframe, they realize oh yeah I 'm not a piece of shit.* *[Data Source: Staff Interview]* *It's the foundation of dignity and respect and meeting people where they are at which opens the door for 'I want to change', or 'I do not want to do this.* *[Data Source: Staff Interview]* *I think that from a harm reduction approach, understanding that there is education about using clean needles every time, allowing client to come in to be accepted for their life choices, once you start to establish relationships and trust, you will see that this opens conversations of where they are and where they want to be.* *[Data Source: Staff Interview]* *It's [TOPS] saving lives, validating worth, it's an opportunity to challenge stigma. People who come are hard on themselves. People say "I do not care about overdosing; I do not care about dying". That internal worthlessness, no hope, and this site is changing that, you are worth it and there is hope. You may not feel it but we do. But you got to think why are people coming, if they think they are worth nothing, because deep down somewhere they want help. They are reaching out in their own way. 6000 times [client interactions] in 6 months.* *[Data Source: Staff Interview]* *Kindness is proving to be a strategy that is effective and cost efficient and is allowing people to have confidence to ask for help and that – because of the rules and because people are used to being treated fairly and equitably we are seeing more people open up and share their trauma and getting more and more request for assistance and help people make change with the issues they face.* *[Data Source: Staff Interview]*

	Reconnecting with indigenous roots	*The Indigenous clientele, within the community there is a great reluctance to come forward. But when you have a person from the indigenous community in the Aftercare Room, they get the opportunity to get healing and reconnecting with their indigenous roots, to help make those positive change. People start to attend sweats, and they were unwilling to do that before.* *[Data Source: Staff Interview]*
	Enhanced peer interactions	*People sometimes follow the rules and some don't and get kicked out. - Sometimes people see others breaking the rules and speak up about it. We don't want the site to close. It will ruin it for everyone, if one person doesn't follow the rules.* *[Data Source: Client Survey]* *Some personalities that we wouldn't talk to outside, but we are in a room together, you are in the environment and you all talk because everyone's talking. As weird as it may sound, I have made some friends, we are all good people but it's just our lives. There are all walks of life, there are people who you wouldn't think touch drugs, and others who society would call a street bum or junkie.* *[Data Source: Client Interview]* *I am very happy that the site is here. I feel very well taken care of. I recommend the site to all the people that I use drugs with.* *[Data Source: Client Survey]* *I remember an older woman (50s) all of her veins were shit, so she couldn't find a vein that worked, a guy sitting on the other side of the room, could tell that she was struggling…so he went there and helped her and he did it with such a gentleness and helped her use (it was in a very private place) and they didn't know each other before that. Crazy stuff, a powerful experience... you do not see that there is not that type of brother and sister approach in general folks. This allows you to learn about the value of being with each other, something that we are losing.* *[Data Source: Stakeholder Interview]* *We have people who will either not want to – cook your drugs – we get people doing the same thing, where peers are, they know at this point, so when someone does not do one of those things – the clients will rouse them a little bit and hand them what they need. It is already in the table in front of them – figure out. They [clients] have learned and now they are holding each other [peers] accountable – it is nice to see. This one guy in particular, he never wants to cook. His one friend, every single time is telling him – use the cooker. So he uses the cooker, which is what we are asking of him.* *[Data Source: Staff Interview]* *We had a client come in who had not used IV before. One of the other workers had a chat with him – he was determined that he was going to use. We wanted to provide a safe space, and then he was in the room. Another peer came in, they recognized each other. This*

		other peer was like "what are you doing? You do not want to do this! You do not want to go down this road". They hugged each other. I sat there in awe. The love they had for each other created that space where that peer was able to say, "you do not need to do this, you do not need this". We all gave them that space – no staff needed to intervene. At the end of this chat, the individual said, "I was feeling thirsty anyways" and he consumed orally. *[Data Source: Staff Interview]* *Peers will kind of check in with people who are in the Aftercare room and make sure they are okay. If they are on the nod then they check in and say "hey, you doing okay" which is great. There are conversations about people looking out for one another on the streets. So that's nice to hear.* *[Data Source: Stakeholder Interview]* *There is a lot of peer help, if people are trading, or littering, or being mouthy, they [peers] will step in and say you can't do that shit here. They want the site to be open. So they kind of manage it themselves.* *[Data Source: Stakeholder Interview]* *The caring between our clients, the mutual support. I've seen people dissuade people from using a drug, people say 'dude you do not want to do this let's go have a coffee'. We are seeing compassionate people and that's not what anybody expected.* *[Data Source: Staff Interview]* *General observation how peers treat each other – they look after each other way better than me and my neighbour- that speaks volume about the sense of community that population has and how RHAC is able to foster that sense of community within that space. In many ways, that group of people [PWID], all they have is each other.* *[Data Source: Stakeholder Interview]*

Table 3: Quotations to support themes related to Negative Impacts on Clients

Unintended Negative Impacts On Clients		
Theme	Sub-Theme	Relevant Quotes
Feeling intimidating and ashamed	*Feeling intimidated using the site*	*I have some concerns. I guess everyone has seen you here, I am one to keep to myself and quiet, I don't like to have other people seeing me use. It's been okay though, nothing bad at all.* *[Data Source: Client Interview]* *The space itself, when you are using [drugs] you have someone else seeing what you're doing or they [other people in the injection room] are seeing you.* *[Data Source: Client Interview]* *I think clients are a little intimidated. Some say they feel like they are being watched... I remember a guy saying, I just feel that the staff are always hovering and coming too close.* *[Data Source: Stakeholder Interview]*
	Feeling ashamed and uncomfortable that stakeholders see clients using the site	*There are times when friends or family members have come in, they saw me, and they left. I didn't know about their drug use. I have been working with [TOPS Leadership] about this – trying to be conscious and how to leave if people are going to use. There was a girl who I knew, and when she saw me her eyes got full of tears and she just left.* *[Data Source: Stakeholder Interview]* *A negative impact – I had one with a client of mine. He caught a glimpse of me as he was coming into using the site. I was holding the door open for another client. This client wasn't comfortable with me being there while he was injecting.* *[Data Source: Stakeholder Interview]*
Concerned about confidentiality and privacy	*Feeling concerned about information being shared with external service providers*	*People saying what if I come in and you call CAS?* *[Data Source: Stakeholder Interview]*
	Feeling concerned about police presence	*I wondered about client engagement. If there was a way to increase this, clients sometimes are scared to go to TOPS they worry about CAS or police. If there was a way to increase client comfort. It might be the location, it might also be about communicating through media or brochure, how it is safe and ways it is safe. Communicating that the police isn't here, patrol, but they patrol everywhere.* *[Data Source: Stakeholder Interview]*

Concerned about the future of the site	*Feeling concerned about the potential closure of the site*	*This to me is an important key to keep it going [TOPS] – it needs to be kept - the service, I am worried because London is really small town, the council, they don't want anything metropolis here. Drug use is in your backyard, wake up. We need to help it [drug use] or it is going to get worse. We need to conceal it. The council needs to understand this. This [TOPS] is a good thing, it is.* *[Data Source: Client Interview]*

Table 4: Quotations to support themes related to impacts on staff

Impacts on Staff		
Theme	Sub-Theme	Relevant Quotes
Increased job satisfaction	*Building relationships*	*It's exhausting, but I love it. You are in there [site] watching, talking, laughing, educating, sometimes you are in there doing 10 things at once, I can do it, but at the end of the day I'm done. There's so much satisfaction about being in the room, about being able to connect with people, singing, singing happy birthday, showing kindness, have a joke, or saying "I'm sorry you are going through this, can I help you?".* *[Data Source: Staff Interview]* *It has bonded me with my coworkers that I have never experienced. When you are part of an overdose, I have been present for 6 [overdoses] – my team has my back and I have their back. We are calm. We work so well together, we are in sync together, we communicate well, make decisions. Together everyone achieves more – take it to the grave. When you go through those kinds of life saving experiences together. You are bonded in a way that I haven't experienced in the past – that enhances our ability to work together.* *[Data Source: Staff Interview]*
	Feelings of gratitude	*I have grown, my clients and coworkers teach me things every day. I am able to share this knowledge with other people, staff, colleagues and the community. This is a privilege to be working with everyone I work with.* *[Data Source: Staff Interview]* *Everyday there is something, I walk home and my [spouse] will ask what happened at work. And every single day it's full of grace and humanity and it's great.* *[Data Source: Staff Interview]* *It's exhausting. It's a very real thing, I've been exhausted for 6 months, but on a service spiritual level, it's made me recognize how close even the most grounded people are to the lives of our clients that we serve. There is the separation between the life that I've had the good fortune to live since*

		30 onward and the life my kids can enjoy right now; it is just an unforeseen event from what these folks live. These conditions blindsided our clients as well, they didn't see this future. I'm very appreciative. Gratitude comes very easily now. I don't take things for granted. *[Data Source: Staff Interview]*
	Feeling inspired from the clients' commitment to survival	*I felt humbled to be in the space and to see how each client has come from to where they are, despite the challenges, they are coming to the service and they are willing to share the space, they are compelling and willing to share the space.* *[Data Source: Staff Interview]* *I get inspired by a lot of these stories because I look at people's commitment to survival and people just make bad choices, but when you see the back story and you see what got them here you see that that's a perfectly good choice. I want to be out there advocating on their behalf and talking to medical staff and showing the humane and kind way to talk to people with substance use.* *[Data Source: Staff Interview]*
Increased knowledge and skills	*Increased knowledge of drug use practices*	*I truly learn something new every day. I am privileged to be in that space, I appreciate all the information that clients have to share with me.* *[Data Source: Staff Interview]* *Personally, I really believe in harm reduction and supervised consumption facilities, but because I am not an injection user and I hadn't seen anyone inject before, it was hard for me because since I had never seen it, I wouldn't know to suggest to someone the steps to do an injection safely. Like, I have read about it, but it's different. It has been helpful to see people how they inject, and that experience, because now I can talk to someone to tell them what they need and tell them about things that they can do safely – this has been helpful for me.* *[Data Source: Staff Interview]*
	Increased understanding and compassion level for client experiences	*Well, I am emotional. I have worked in mental health and with vulnerable populations for 12 years. You kind of feel like you've seen it all and you've heard all the trauma, then you come here and you're like whoa, this is a whole new level of trauma. Some people is heartbreaking and you think of course you are going to numb all your emotions with an addiction because how else can you get through the day.* *[Data Source: Staff Interview]* *We have all been given a different hand, but we are all a few decisions away from being where they are. They didn't*

		sign up for this, just being able to hear them and be kind and show them that we want you to be alive. *[Data Source: Staff Interview]* *So, my understanding changed when they are injecting certain drugs they do it not to feel high but to feel normal and get through the day. When you have anxiety or feeling sick, using is a warm hug that allows you to feel better or relaxed. Understanding what pill sickness looks like changes, once someone uses they can get on with their day, because right now at that time, they feel like they are dying.* *[Data Source: Staff Interview]*
	Increased comfort level in engaging in conversations with PWUD	*This makes me better equipped as a nurse elsewhere – I feel comfortable if someone tells me they inject drugs, I feel more comfortable. It is not something I get uneasy about or get uncomfortable about. It is much easier to have that conversation with someone [who uses drugs] now.* *[Data Source: Staff Interview]*
	Increased understanding of institutional barriers	*There are barriers everywhere to meet clients in the hospital. Here, people have been in the trenches working with this population in a while and seeing how they validate people and their knowledge and willingness to share and teach you. Every client that came in, [Staff member] knew them all, [Staff member] was hugging them, it was the most beautiful thing. These are people who are not getting love or kindness. I've learned so much about inclusivity, acceptance, and not being judgmental and meeting clients where they are at.* *[Data Source: Staff Interview]*
Application of harm reduction philosophy into practice	*Provides opportunity to put beliefs and values of harm reduction into practice*	*We get comments about how caring we are coming from a place of genuine, you actually care, you do not get paid to care, you are here because you are invested in the work you do, because you care. It goes back to our values – we have the courage to do what is right and the clients see that.* *[Data Source: Staff Interview]*
Negative Unintended Impacts on Staff		
Increased stress levels and impacts on physical well-being	*Feeling physically exhausted and stressed due to under resourcing of staff*	*Our workload at RHAC has tripled. There's stress and change. It's like snow globe and it's been shaken up. It's been over 6000 visits in six months. It's intense. The wait room, it used to be in and out, but now it's more people which is fine but we have to manage it.* *[Data Source: Staff Interview]*
	Overwhelmed with extensive media coverage and requests for information and tours	*Because of the nature of the service being new to our community and being very high profile, we are managing a lot of tours. There are a lot of [other organizations] who are looking to open TOPS in other jurisdictions, so there are constant requests of how are you doing it. We are the first in*

		Ontario doing this through the government sanctioned service. It's very demanding, which we didn't anticipate this. [Data Source: Staff Interview]
	Feeling stressed about uncertainty regarding the continuity of the site	*The trauma and the issue that we are being affected by, is the uncertainty of our roles and how long the [government] will continue wasting time examining evidence and opinions. We shouldn't be considering the opinions, only the evidence. [Data Source: Staff Interview]*
Concerns regarding meeting client needs	*Concerned about client well-being and availability of supports to meet their needs*	*Our society, media and politician portray it as a choice. When you do not have no other tools and no mental health counselling services. You are going to wait 9 months (for free counselling, you get 3-4 sessions), it's bullshit. We consistently see people unable to deal with the trauma and that feeds into the addiction. We have dismantled our mental health services in this province. [Data Source: Staff Interview]*
	Limited availability to perform other tasks to support clients	*Because of the busyness of the site, my ability to assist people to make long term changes with substance use has diminished because my time is helping with the site rather than helping with the changes they [clients] desire. [Data Source: Staff Interview]*

Table 5: Quotations to support themes related to impacts on stakeholders and their organizations

Positive Impacts on Stakeholders Roles		
Theme	Sub-Theme	Relevant Quotes
Increased Knowledge	*Increased knowledge of the client experiences*	*For us, the positive impact is to increase the street knowledge of counsellors, most have Masters of Social Work, some of them don't have the lived experience, so talking to clients while they are managing allows you to provide better counselling. You have a better understanding of the physical symptoms, routines, barriers, it is a private moment and you get to know them better. For a counsellor that is the best thing, to be in a private moment with people.* *[Data Source: Stakeholder Interview]* *Simply how individuals go about using substances, literally from taking your substance to prepare the substance and cut the substance with and draw it up and how and where they are injecting. Some of the trends around that. I learnt that jugging, it's quite prevalent. I thought it was more rare and helped me understand the frequency in which it occurs and the risk with that. The step by step process helped me to better talk with people about harm reduction strategies like cooking their drugs and changing their filter or standing up with an uncapped needle. Also the trends in terms of the substance being used has been helpful for me.* *[Data Source: Stakeholder Interview]*
	Increased knowledge of harm reduction philosophy and creating a supportive culture	*It's a change with being there, that has been helpful for me, in that I'm able to learn more about outreach, about how to work with individuals who are in the pre-contemplative stage, practices of substance use and deeper understanding of the philosophy and practice of harm reduction.* *[Data Source: Stakeholder Interview]* *I think that RHAC staff are so skilled and have taken the lead in teaching us and their culture, taking some of their culture and bringing it back to [Stakeholder Organization], we have a great culture, but the staff there have been phenomenal and they are very caring about their clients. The culture, so I guess there it is more, there doesn't seem like there is authority, but for me there is always authority over a client, but with them, they give a hug to the clients, we do not do that here. They say I love you to a client and hug them, you know, I would get fired if I did that. It's like family and friends there.* *[Data Source: Stakeholder Interview]*

	Increased knowledge of services and supports at other organizations	*So, unintended impacts …I think one of the positives has been though all the interactions with service providers, I think that SOAHAC's profile has been raised with other organizations, so they know more about SOAHAC than they did.* *[Data Source: Stakeholder Interview]*
	Increased understanding of the Indigenous community, culture and history	*Sharing things with staff and helping them understand that things are the way the are – talking about homelessness, indigenous people are overrepresented in many things, in homelessness, housing that we get is not the best on the reserves.* *[Data Source: Stakeholder Interview]*
Enhanced skills	*Enhanced skills in active listening*	*If people [clients] are having a bad day, and they want to rant, we can talk to them. Today someone had a bad because security stole their pillow and sleeping bag and they threw them out. Now I can talk to them, reflect their feelings, I was never a good active listener, but now I can because I am thinking of ways to better find solutions.* *[Data Source: Stakeholder Interview]*
Building relationships and connections	*Increased ability to connect with new clients and reconnect with existing clients*	*The fact that there are clients who I would have never met, if it weren't for TOPs. It's been really rewarding to have individuals who use the site to trust me. Two clients who use the site, who have come to me now for housing supports and I'm working toward getting those guys stable housing. One guy has been sleeping in stairwell for over 12 years. Some are scared to stay in shelter. So working with these guys has been really rewarding.* *[Data Source: Stakeholder Interview]*
Positive impacts on Stakeholder Organizations		
Increased knowledge	*Increased knowledge of drug practices and harm reduction practices among their colleagues in their organizations*	*My background as an addiction counsellor, harm reduction has been my philosophy, but I didn't know what this was until I was at the TOPS. So many things that I didn't know that I was missing. One of my coworkers was showing someone how to use something with the ice, cooking with ice so it [wax] spreads to the end. That person was teaching that person how to use best. Harm reduction isn't about allowing people – who are we to allow? It is about teaching people the safer ways [to use].* *[Data Source: Stakeholder Interview]*
Increased reach	*Expanded the organizations' ability to reach clients from the population of PWUD*	*So the impact it [TOPS] has had on our organization has put us in touch with a new population of indigenous people that we haven't had access to. As you know PWID, don't tend to access doctors, it is not part of their day…So this has allowed us to get in touch with people who are at the highest need of care.* *[Data Source: Stakeholder Interview]*

Enhanced service delivery	*Created new approaches or services at their organizations to meet clients' needs*	*I guess, there is TOPS influence on new programs that we [stakeholder organization] are developing – not old ones changing, but new ones that are being developed. [Data Source: Stakeholder Interview]*
Strengthened partnerships	*Strengthened existing relationships between RHAC and stakeholder organizations*	*Positive thing about our relationship is that it gotten stronger even though we had high collaboration [between RHAC and the organization] before. But having our staff in the site and having the relationships with [RHAC staff] and we can build relationships with clients and we can carry that over to the work we [the organization] do. [Data Source: Stakeholder Interview]*
Negative Unintended Impacts on Stakeholders		
Level of organizational involvement	*Concerns regarding their organization's level of involvement and role in TOPS*	*There's excitement to be involved at TOPS, it would be more helpful to have more staff from our organization involved for coverage and chat through some of the things that we are experiencing there. Having a little bit more supervision around TOPS so if our supervisors knew more about how it feels to have a shift there, just so that we can chat with them about the challenges. If feels like the organizations are excited but it's a bit distance. [Data Source: Stakeholder Interview]* *There's excitement to be involved at TOPS, it would be more helpful to have more staff from our organization involved for coverage and chat through some of the things that we are experiencing there. Having a little bit more supervision around TOPS so if our supervisors knew more about how it feels to have a shift there, just so that we can chat with them about the challenges. [Data Source: Stakeholder Interview]*
Managing workload	*Challenges managing caseloads and other organizational priorities at stakeholder organization*	*I still struggle – because I am still at TOPS every other [week] – so we also have numbers that we have to see as part of the [stakeholder organization], so I have to do double the work to do my work at the TOPS. [Data Source: Stakeholder Interview]*
Stakeholder Well-Being	*Challenging to hear client stories of violence and trauma*	*Another [client] was speaking about a violent or threatening incident. So I had a client elsewhere and I knew the person as related to the other person and the incident was quite threatening and that was hard for me because I knew the other side of the story. Some of the violence I hear is hard for me. [Data Source: Stakeholder Interview]*

Table 6: Quotations to support themes related to impacts on the community

Impacts on the community: Perceived Benefits on the Community		
Theme	Sub-Theme	Relevant Quotes
Public Order	*Less public drug use*	*I feel more safe coming here than injecting in bathrooms or alley ways because anyone can take your drugs. There is no safety and no protection in public places. This place has been life changing for me as I used to inject in alley ways and the bathroom at [a restaurant].* *[Data Source: Client Survey]* *It stops us from using in parks and school yards where we need to hide.* *[Data Source – Client Survey]* *It's good for people because they can come in here and do it and avoid the risk shooting up outside and getting caught and going to jail, especially if it's someone I care about.* *[Data Source: Client Interview]* *A lot of people would be struggling to find out where to use, the police they would have a lot of arrests. I have seen a big difference; this [arrests] isn't happening as much. They [Police] are not very nice in dealing with the junkies, not sure if you have been outside to see how they [Police] treat the junkies. Junkies are not using outside when this is [TOPS] open, they are not using in the street, so the police aren't arresting them.* *[Data Source: Client Survey]*
	Reduced discarded gear in public spaces	*This is a place to use properly with clean needles. A lot of mentally [ill] drug users in the community, so this is good because they are disposing properly.* *[Data Source: Client Survey]* *I think without the site there would be more garbage and contaminated needles everywhere, I think the site is reducing that, it has to be.* *[Data Source: Client Interview]* *But for the overall well for downtown London its good. Mainly so that there's no needles everywhere and in bathrooms and there could be blood like Hepatitis and HIV, so it [TOPS] is keeping clean. This place [TOPS] is a clean place and clean environment and they give you alcohol swabs. Junkies use places where everyone is shooting up and they don't filter it properly. So this is just a clean place.* *[Data Source: Client Interview]*

		That it's [TOPS] good and they need it because people are shooting up in bathrooms. They [Clients] are shooting up everywhere and that's putting needles everywhere and getting pricked. With the fentanyl, it's good they are able to help when people are having an overdose. *[Data Source: Client Survey]* *But this place provides a safe place and it protects the community, and it creates jobs. I totally agree with it. The needle use and the way people dispose of gear, that's the problem with society.* *[Data Source: Client Survey]*
Health Outcomes	*TOPS is saving lives and delivering compassionate services*	*I support TOPS (and potential SIS) in my neighbourhood because I believe it will save lives. Having RHAC deliver their continued support to folks who inject drugs in a compassionate and informed way makes me proud of London.* *[Data Source: Community Resident and Business Survey]*
Cost-effectiveness	*Highlighting the site as a cost-effective strategy*	*Then, for folks that care more about money, it is saving millions of dollars by saving a lot of expenses, HIV, Hepatitis, ambulances, hospital visits, etc. Saves a lot of Money.* *[Data Source: Stakeholder Interview]*
Community Awareness around Drug Use	*Increased awareness about substance use, addictions and the impacts of overdoses*	*I would say that it [TOPS] has helped to create some awareness around substance use and some of the consequences of substance use in the community.* *[Data Source: Stakeholder Interview]*
Community Acceptance and Support	*Increased support and acceptance for TOPS and SCFs*	*The message about harm reduction is that people are more familiar and aware. People who were on the fence are more supportive of it now.* *[Data Source: Staff Interview]*
Impacts on the Community: Perceived Concerns for the Community		
Public Order	*Increased public disorder including increased loitering, increased garbage, discarded needle waste and drug selling/purchasing surrounding the site outside*	*The increased number of needles - street activity has increased in a negative way (hang outs) - waste of money to tax payers.* *[Data Source: Community Resident and Business Survey]* *Stop providing needles!!! STOP!!! They scream and shout, flair, weave, lie down, mentally unavailable. Cloud of negativity surrounds areas! Addicts and mentally ill should have recovery places. The cops do 0 - ZERO! It happens daily, needle paraphernalia, needles, wrapping and zoned out on the disgusting downtown. Addiction is self-induced. They break windows, doors, furniture and hearts.* *[Data Source: Community Resident and Business Survey]* *Unintended is the amount of garbage, that has been a problem, I don't know what it was like before but it has*

		become a busy walkway that has resulted in a lot of garbage. I understand for people and business around here. Security is helping with that piece. *[Data Source: Staff Interview]* *They {neighbours] are just frustrated with [clients] hanging out back, deals out back, people using outback when it [TOPS] is full. We were originally doing 4 sweeps, asking people [loitering outside] what is going on, what do you need? If not can you move along?* *[Data Source: Staff Interview]*
	Negative consequences on local businesses and residents due to criminal activity	*We were never asked or informed about 'TOPS' being placed in our residence building. The increase in vagrants and drug abusers has certainly and negatively affected our ability to enjoy our home.* *[Data Source: Community Resident and Business Survey]* *There has been an extremely obvious increase in negative situations since TOPS. My car is broken into and vandalized frequently. People shoot up on my lawn. I see needles everywhere and constantly approached by aggressive drug users. Thanks a lot for negatively impacting the contributing working people in this area.* *[Data Source: Community Resident and Business Survey]* *Drug dealers have moved into the building, but no one knows that. I know the staff have struggled with people selling around the facility. They [staff] are more cautious of it now. I'm pretty certain that high end drug dealers rent places at [the residential building where the site is located].* *[Data Source: Staff Interview]*
Community Awareness around Drug Use	*Promoting drug use*	*I thought I would be open minded about these programs but it's become common to see people injecting in the street and selling the drug more openly. These sites seem to be promoting that it's okay to do these drugs so people are less cautious to do them openly on the street. I'm now scared for my child to play in Victoria Park for fear of needles.* *[Data Source: Community Resident and Business Survey]*

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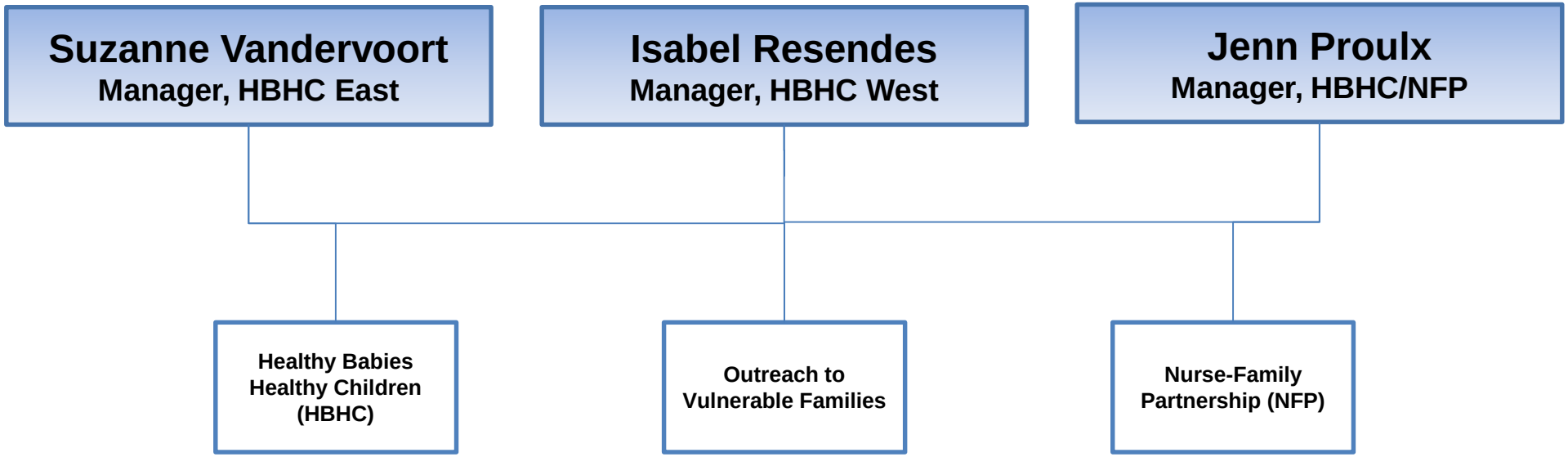
Healthy Start
Best Beginnings

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

Total FTEs – 30.80 FTEs

Total Budget – $3,105,295



Program Highlights:

- Populations served: pregnant women, and families with children from birth to school entry
- HBHC program screening, assessment, blended home visiting, and service coordination for those identified with risk
- Lead agency for NFP in Ontario (intensive PHN support program for young, first-time, socially disadvantaged mothers)
- Public Health Nurse outreach provided to family shelters in Middlesex-London
- Address preconception health, healthy pregnancies, breastfeeding / infant feeding, healthy growth and development, mental health promotion , and healthy sexuality

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 039-19

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2019 May 16

COMPLETION OF THE CANADIAN NURSE-FAMILY PARTNERSHIP EDUCATION (CaNE) PROJECT

Recommendation

It is recommended that Report No. 039-19 re: "Completion of the Canadian Nurse-Family Partnership Education Project" be received for information.

Key Points

- The Nurse-Family Partnership® (NFP) is an evidence-based home visiting program targeting young, low-income, first-time mothers.
- The Canadian Nurse-Family Partnership Education (CaNE) Project demonstrated that the new model of education: 1) prepared public health nurses and supervisors to implement the program with a high degree of fidelity to the program's core model elements; and 2) was perceived to be sustainable to provide education to a growing NFP workforce in Canada.
- NFP implementation will continue in five health units, with MLHU as the Ontario licence-holder.

Background

The Nurse-Family Partnership® (NFP) is an evidence-based intensive home visiting program for young, low-income, first-time mothers with demonstrated positive effects on pregnancy, children's subsequent health and development, and parents' economic self-sufficiency. Since 2008, steps have been taken in Ontario and British Columbia to adapt and evaluate NFP in Canada. In 2015, MLHU launched the Canadian Nurse-Family Partnership Education (CaNE) Project to collaboratively develop, pilot, and evaluate a Canadian model of education for public health nurses (PHNs) and managers responsible for delivering NFP (see Report No. 048-16 re: "Summary Information Report for July 2016" and Report No. 019-17 re: "The Canadian Nurse Family Partnership Education (CaNE) Project Update").

Findings from the Canadian Nurse-Family Partnership Education (CaNE) Project

The CaNE Project has concluded (see Appendix A) and key findings include the following:

- NFP is acceptable to PHNs and supervisors as a public health intervention to address maternal and child health outcomes among a priority population of vulnerable women and their children.
- Following completion of the education, PHNs and supervisors were able to implement the program with a high degree of fidelity to 13 of the program's 14 core model elements.
- To deliver NFP with fidelity, a three-phase approach to education with a range of teaching and learning strategies was needed. Face-to-face education was highly valued for some components.
- Completion of the CaNE education, practice support from the NFP Practice Lead, and fidelity to core model elements may have contributed to PHNs' ability to retain a majority of clients.
- Approximately one in five pregnant women referred to public health were eligible for NFP, and NFP PHNs were exceptionally successful in converting referrals into enrolments.
- Public health units were highly successful in reaching and enrolling eligible women, but enhancement of recruitment strategies are required to enroll women earlier in pregnancy.

- Public health nurses and supervisors provided key recommendations for ongoing improvements and the development of new elements for the Canadian NFP education model.
- The Canadian NFP education model was perceived to be sustainable for providing education to a growing NFP workforce in Canada.
- Learning outcomes were identified to inform development of tools for ongoing evaluation of e-learning and in-person learning.

Implementation of the Nurse-Family Partnership Program in Middlesex-London

Since the CaNE Project began, MLHU has received 155 referrals to the NFP program. Of these, 124 women met program eligibility criteria and consented to participate, of which number 82 remain actively engaged in the NFP program. Program intake data demonstrates the complex challenges experienced by women enrolled: 98% reported an annual income of less than $20,000; 69% of participants had less than a high-school education; 20% were precariously housed; 57% reported smoking; 24% reported using alcohol; 30% reported using cannabis; and 4% reported using street drugs.

MLHU has demonstrated a high degree of fidelity to the NFP program's core model elements throughout implementation, resulting in a high degree of confidence that program outcomes will be similar to those measured in research. While data must be interpreted cautiously with a small sample size, early outcome data reflects this assumption. For example, patterns indicate a trend toward decreased substance use when measured for a second time at 36 weeks' gestation, including a significant reduction in reports of smoking and cannabis use, as well as zero clients reporting use of alcohol or street drugs. Additionally, at 6 months postpartum, 66% of mothers reported some breastfeeding and 26% reported exclusive breastfeeding; these rates are comparable or favourable to breastfeeding rates reported across Middlesex-London (64% and 9% respectively). Additional outcome data will be available as clients continue to progress through the program.

NFP Implementation in Ontario Post-CaNE Project

MLHU holds the NFP licence in Ontario and is finalizing memorandums of understanding with other NFP-implementing public health units in Ontario, including: City of Toronto (Public Health Division), Regional Municipality of York (Public Health Branch), Regional Municipality of Niagara (Public Health Branch), and City of Hamilton (Public Health Services). Capacity to add additional health units in Ontario under MLHU's licence will be dependant upon the RCT results. Implementing agencies are sharing costs (e.g., licensing, consultancy fees, salary/benefits for an Ontario NFP Nursing Practice Lead, and education costs).

The Ontario NFP Provincial Advisory Committee will continue to facilitate collaboration, policy and practice consultation, and ongoing communication among various stakeholders. Additional members from the Indigenous health, child protection, and poverty reduction sectors are being recruited. The Canadian Collaborative for NFP (with Ontario and B.C. representation), which provides guidance and cohesion at a national level for NFP in Canada, is holding an in-person meeting in the fall of 2019 with a focus on visioning for the NFP Program in Canada into 2021 and beyond.

Conclusion

NFP is an evidence-based program that is critical to achieving positive maternal and child outcomes among priority populations in Middlesex-London. The CaNE Project's successful conclusion has provided key findings to guide NFP in Canada.

This report was submitted by the Nurse-Family Partnership Team, Healthy Start Division.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health/CEO

Canadian Nurse-Family Partnership Education (CaNE):

Project Overview & Report of Key Findings

The CaNE pilot project was led by Middlesex-London Health Unit with McMaster University as the 3rd Party Evaluator

April 2019

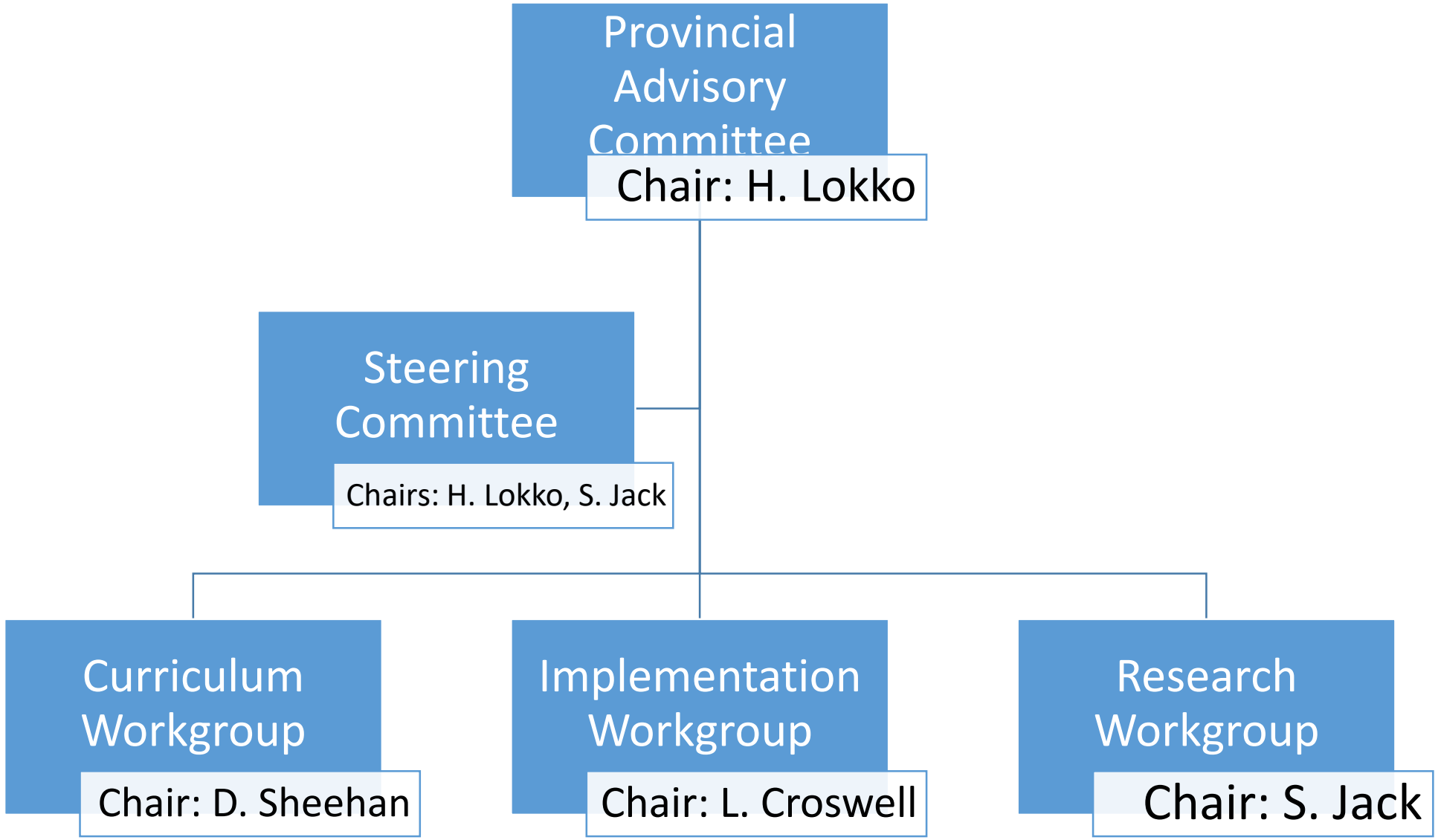
Canadian Nurse-Family Partnership Education (CaNE) Pilot Project Goals

1) ***Develop*** a Canadian model of Nurse-Family Partnership (NFP) education for public health nurses (PHNs) and supervisors;
2) ***Deliver*** this novel model of education to PHNs and supervisors hired to deliver the NFP program in participating Ontario public health units
3) ***Evaluate*** the acceptability of this model of education and to ***explore*** how this training prepared teams to implement NFP with fidelity to the program's core model elements.

NFP Adaptation & Evaluation in Canada

2008-2012	2012-present	2008-ongoing
• Pilot study to determine program acceptability & feasibility to deliver NFP through public health programming • Hamilton Public Health Services	• British Columbia Healthy Connections Project (BCHCP): Randomized controlled trial to determine NFP effectiveness • BCHCP Process evaluation to document NFP delivery & implementation in 5 BC Health Authorities • Healthy Foundations Study	• Adaptation and development of Canadian program materials • Visit-to-visit guidelines, assessment forms, facilitators, nurse instructions, implementation manuals, website • ***Nurse & supervisor core NFP education***

CaNE Project Governance



Curriculum Development

Curriculum Development

Existing NFP core education curricula

Family Nurse Partnership UK model

US Core Education

Consultations & Collaborations

US National Service Office – Education Manager/Instructional Designer

Prevention Research Centre- International NFP consultants, DANCE

British Columbia Provincial Coordinator

Canadian nurse theorists & nurse educators/researchers

E-learning/IT consults

Canadian NFP Public Health Nurses & Supervisors

Hamilton feasibility & acceptability study

BC Healthy Connections Process Evaluation

Canadian Core Nurse-Family Partnership Education

NFP Canada Program Model

Revised to reflect addition of recent NFP innovations & nursing theory

NFP Curriculum

NFP Foundations

- Online e-learning modules
- Independent or team-based study
- Supervisors –additional 3 modules

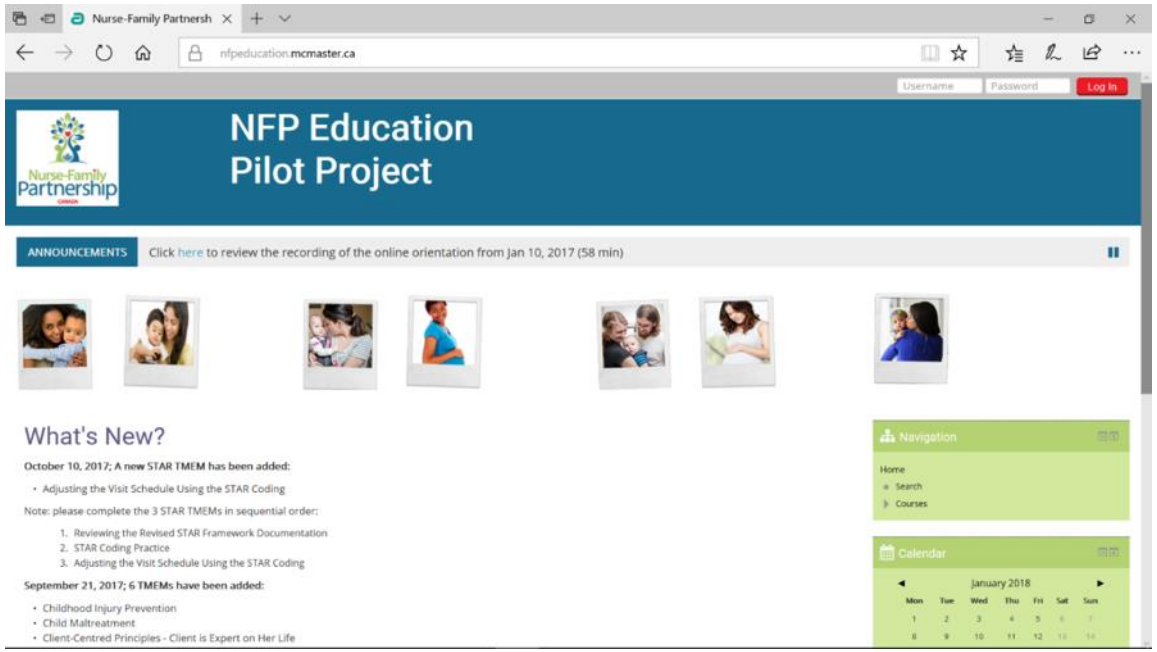
NFP Fundamentals

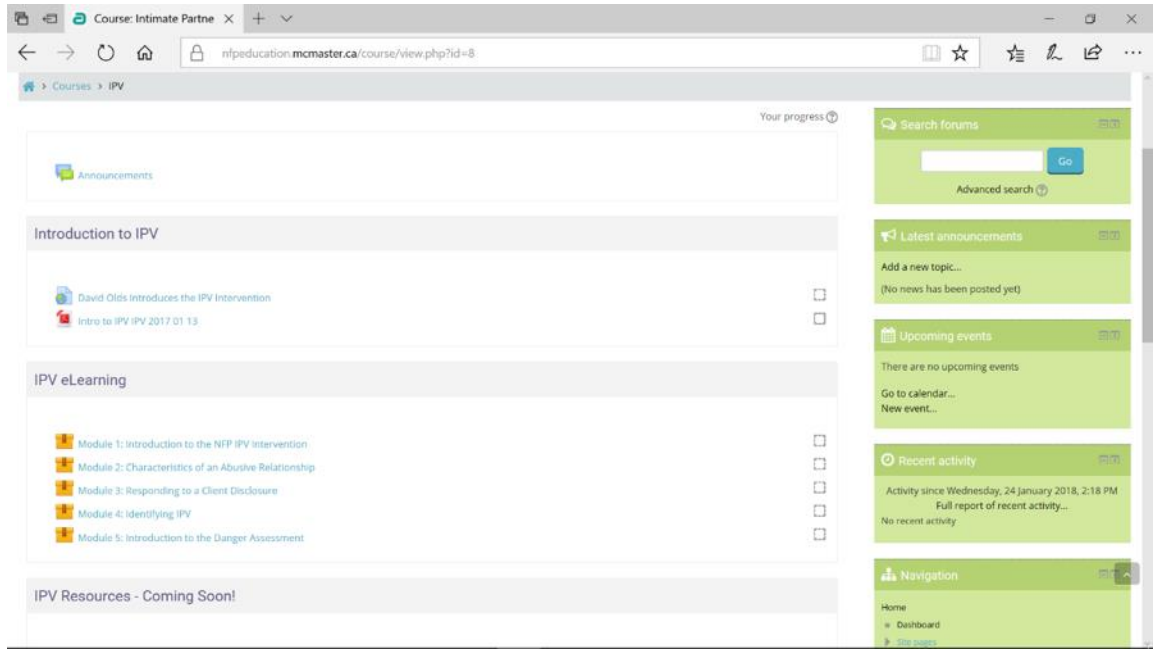
- 5 days in-person education (nurses & supervisors)
- 4 days in-person education (supervisors)

NFP Consolidation and Integration

- Team meeting education modules
- Job shadowing
- IPV system navigation & in-person workshop
- ASQ/Keys to Caregiving/NCAST

E-Learning Platform (Moodle)





Implementation

NFP Delivery through Public Health

Participating Health Units	Toronto Public Health
	Middlesex London Health Unit
	York Region Public Health
	Niagara Region
Client Eligibility	Young, first-time mother
	Experiencing social and economic disadvantage
	Referred early in pregnancy, before 28 weeks gestation

NFP Core Model Elements (CME)

Element 1: Client participants voluntarily in the Nurse-Family Partnership (NFP) program

Element 2: Client is a first-time mother

Element 3: Client meets socioeconomic disadvantage criteria at intake

Element 4: Client is enrolled in the program early in her pregnancy and receives her first home visit no later than the 28th week of pregnancy

Element 5: Each client is assigned an identified NFP nurse who establishes a therapeutic relationship through individual NFP home visits

Element 6: Client is visited face-to-face in the home, or occasionally in another setting (mutually determined by the NFP nurse and client), when this is not possible

Element 7: Client is visited throughout her pregnancy and the first two years of her child's life in accordance with the current standard NFP visit schedule or an alternative visit schedule agreed upon between the client and nurse

Element 8: NFP nurses and supervisors are registered nurses or registered nurse-midwives with a minimum of a baccalaureate /bachelor's degree.

Element 9: NFP nurses and supervisors develop the core NFP competencies by completing the required NFP educational curricula and participating in on-going learning activities.

Element 10: NFP nurses, using professional knowledge, judgment and skill, utilize the Visit-to-Visit Guidelines; individualizing them to the strengths & risks of each family, and apportioning time appropriately across the six program domains.

Element 11: NFP nurses and supervisors apply the theoretical framework that underpins the program (self-efficacy, human ecology, and attachment theories) to guide their clinical work and achievement of the three NFP goals.

Element 12: Each NFP team has an assigned NFP Supervisor who leads and manages the team and provides nurses with regular reflective supervision

Element 13: NFP teams, implementing agencies, and national units collect/and utilize data to: guide program implementation, inform continuous quality improvement, demonstrate program fidelity, assess indicative client outcomes, and guide clinical practice/reflective supervision.

Element 14: High quality NFP implementation is developed and sustained through national and local organized support

Evaluation


Nurse-Family
Partnership
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Nurse-Family
Partnership
CANADA

Primary Research Question

Following completion of the Canadian Nurse-Family Partnership education program, are Ontario public health nurses and supervisors able to implement and deliver the NFP program with fidelity to the core model elements, with a specific focus on the following fidelity indicators:

1) public health nurse and supervisor caseloads;
2) duration of the program;
3) service dosage to the program;
4) content of home visits; and
5) client eligibility?

Secondary Research Questions

What are NFP public health nurses', supervisors' and NFP educators' perceptions and experiences of the content and delivery methods of the NFP Canada model of education?

What is the overall level of acceptability of the NFP model of education to NFP public health nurses and supervisors?

How can public health nurse and supervisor knowledge and competencies be measured to demonstrate effectiveness of the education models in improving knowledge, skills and attitudes?

What tools can be used to effectively assess professional performance to determine if NFP public health nurses integrate new knowledge and skills into practice?

Methods

Design:

Mixed methods case study evaluation

Sites:

York, Middlesex-London, Toronto, Niagara (n=4)

Participants:

Total n=22

- Educators (n=2)
- Supervisors (n=4)
- Public Health Nurses (n=16)

Methods

Data Sources:

- Interviews
  - Focus Groups with PHNs (2 x 3 sites) n=6
  - 1:1 Interviews with PHNs (n=16), Supervisors (n=9), NFP Canada Educators (n=4)
- Evaluation forms from online & in-person training (n=21)
- Implementation data (being tracked by participating sites) n=311 NFP clients (3 sites Jan 1 2017-Sept 30, 2018; 1 site April 25 2018-Sept 30 2018)
- Supervisor narrative summaries
- Demographics questionnaire

Key Findings: Implementation and Delivery of NFP with Fidelity to Core Model Elements

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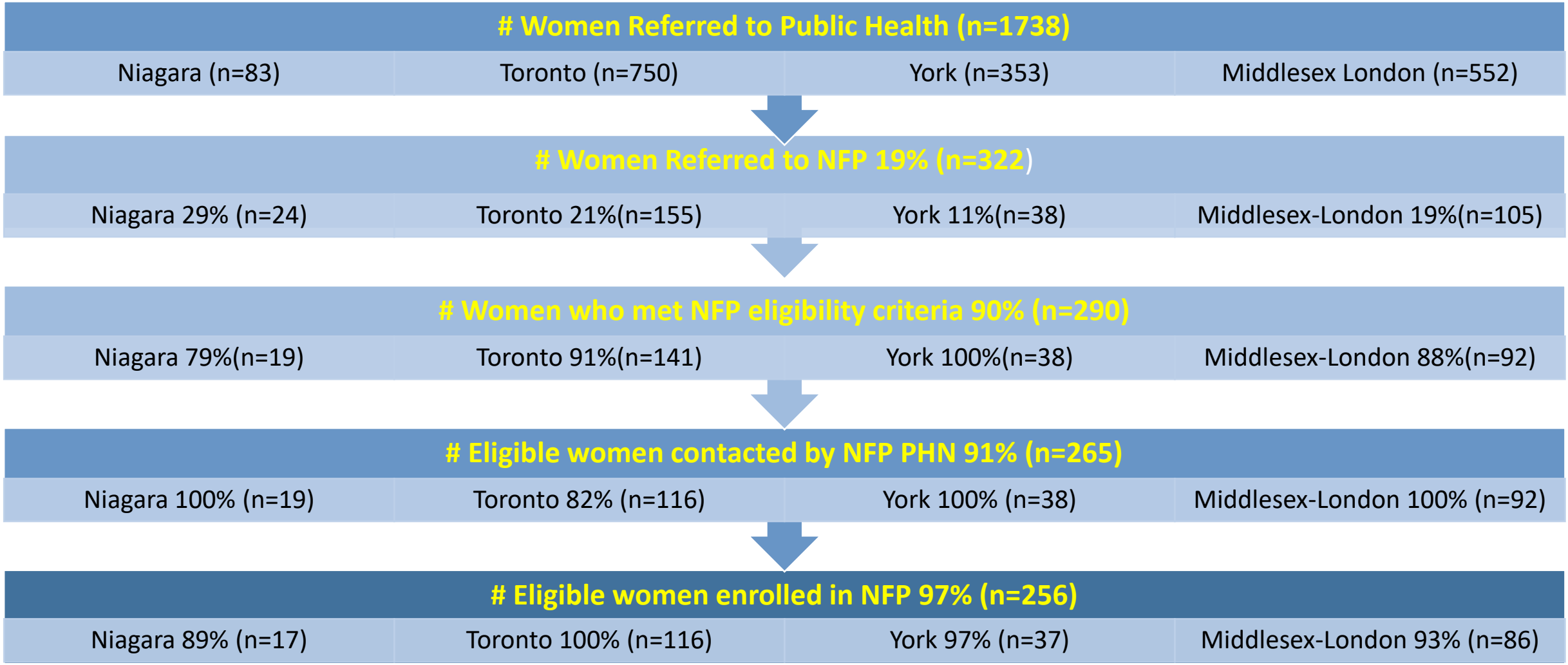
Sample Description

	NFP PHNs (n=16)	NFP Supervisors (n=4)	NFP Canada Educators (n=2)
Age (mean years; range)	43.4 (25-64)	47.25 (38-59)	49.0 (34-64)
Nursing experience (mean years employed; range)	19.1(1.5-33)	23.5(16-32)	26.0(10-42)
Public health experience (mean years in public health; range)	15.4(2.5-28)	17.8(14-30)	17.5(10-25)
Home visiting experience (mean years home visiting experience; range)	13.4(3-28)	13.5(3-20)	14.5(10-19)



NFP Referral and Enrollment Patterns

NFP Client Retention

Over a 21-month period (January 4, 2017-September 30, 2018)

- Of the 245 clients who had one or more home visits
  - 71% remained active in the program at time of data submission
  - 28% were discharged at a later date
  - 0.8% were “re-activated” into the program

CME 1: Client participates voluntarily in the NFP program

- During the first home visit encounter, all NFP PHNs are required to discuss the voluntary nature of the program and seek the woman's permission to enroll her in the program.

- Based on program summary reports from supervisors, the majority of women (97%) contacted by an NFP PHN agreed to be enrolled in the program.

CME 2: Client is a first-time mother

- Overall, 99.67% (305/306 records) of pregnant women enrolled were identified as first-time mothers (first live birth).

- Only one participant was listed as not a first-time time mother; data were missing on five participants.

CME 3: Client meets socioeconomic disadvantage criteria at intake

Client Age at Time of NFP Enrollment

Public Health Unit	Mean age in years (range)
Provincial	**18 years**
Toronto	18 (14-22)
York	20 (18-24)
Middlesex-London	16 (14-26)
Niagara	18 (14-25)

CME 4: Client is enrolled in the program early in her pregnancy and receives her first home visit no later than 28 weeks gestation

91.8% of eligible women were enrolled no later than the 28th week of pregnancy

Enrollment Period	% women enrolled (n)
Enrolled ≤ 16 weeks gestation	35.1% (n=94)
Enrolled between 17-25 weeks	36.2% (n=97)
Enrolled between 26-28 weeks	20.5% (n=55)
Enrolled ≥ 28 weeks	8.2% (n=22)

Sources of Client Referrals

Referral Source	% women referred from source (n)
Public health services (e.g. Intake phone line)	21.2% (n=66)
Community partners	18.3% (n=57)
Self-referrals	12.5% (n=39)
Doctor's offices	10.6% (n=33)
Children's Aid Society	7.1% (n=22)
No referral data available	30.2% (n=94)

CME 5: Each client is assigned an NFP nurse who establishes a therapeutic relationship through individual home visits

- Consensus that frequency of home visits and length of program provide PHNs with time & flexibility to establish and nurture a therapeutic relationship with the client, particularly with those who have histories of trauma.

If we weren't seeing them weekly or biweekly and we were just doing the monthly like HBHC did, or sometimes in 6 weeks, you don't have that chance to really support them and provide the best follow up and support that you need to give them. But you have that chance here in the NFP program. So I think definitely the frequency of seeing the client helps build the relationship to make this program more effective. **[NFP PHN]**

CME 6: Client is visited face-to-face in the home or occasionally in another setting

Encounter Type	% (no. visits)
Completed home visits	84.5% (n=2,280)
Completed alternate visits	8.9% (n=297)
Attempted home visits	1.9% (n=65)
Scheduled home visit, cancelled by client	4.1% (n=138)
Scheduled home visit, cancelled by PHN	0.5% (n=18)

CME 6: Client is visited face-to-face in the home or occasionally in another setting

Location of Home Visit	% (no. visits)
Client's home	70.7%% (n=1,996)
Family/friend's home	4.9% (n=137)
Public health unit	3.3% (n=95)
Doctor's office/clinic	1.6% (n=49)
Other	18.4% (n=523)

CME 6: Client is visited face-to-face in the home or occasionally in another setting

Alternate Visit Type	% (no. contacts)
Telephone visit with client	48.5% (n=144)
Texting with client	19.7% (n=59)
Case conference	11% (n=33)
Attending appointment with client	7.4%% (n=22)
Other	9.7% (n=29)
Unknown	3.4% (n=10)

CME 7: Client is visited throughout her pregnancy and the first two years of her child's life in accordance with current NFP visit schedule

Using data available, we were able to estimate that 60% of clients continued with the program into the infancy phase

Program Phase	Mean # Home Visits (range)
Pregnancy	7.40 (1-35)
Infancy	11.6 (1-41)
Toddlerhood	N/A

CME 7: Client is visited throughout her pregnancy and the first two years of her child's life in accordance with current NFP visit schedule

Reasons for Discharge	% (no. clients)
Client-initiated discharge	37.7% (n=26)
Lost to follow-up	17.4% (n=12)
Client moved	29.0% (n=20)
Pregnancy loss/infant death	5.8% (n=4)
PHN unable to provide NFP	1.4% (n=1)
Client lost custody of the child	2.9% (n=2)
No reason provided or data missing	5.8% (n=4)

CME 8: NFP nurses/supervisors are registered nurses with a minimum of a bachelor's degree

100% of NFP PHNs and supervisor held, as a minimum, a bachelor's degree in nursing

CME 9: NFP nurses/supervisors develop core NFP competencies through completion of core NFP education

Cohort/Timeline	NFP Foundations	NFP Fundamentals
Cohort 1	January-February 2017 (n=3 supervisors; n=11 PHNs) December 2017-February 2018 (n=1 PHN)	February 2017 (n=3 supervisors; n=12 PHNs)
Cohort 2	March-April 2018 (n=1 supervisor; n=5 PHNs)	April 2018 (n=1 supervisor; n=5 PHNs)

CME 10: NFP nurses…apportion time appropriately across the six program domains

	Distinct visits (n)	Personal Health (%)	Environmental Health (%)	Life Course Development (%)	Maternal Role (%)	Family & Friends (%)
PREGNANCY						
Benchmark		35-40%	5-7%	10-15%	23-25%	10-15%
Total/Mean	1,433	41%	13%	12%	21%	13%
INFANCY						
Benchmark		14-20%	7-10%	10-15%	45-50%	10-15%
Total/Mean	1,375	23%	9%	13%	43%	12%
TODDLERHOOD						
Benchmark		10-15%	7-10%	18-20%	45-50%	10-15%
Total/Mean	10	16%	12%	19%	42%	11%

- ***Deeper understanding*** of theoretical principles.
- PHNs ***better positioned to apply theoretical principles*** in home visits, to describe practice decisions, and explain to clients rationale for practice activities
- ***Self-efficacy theory***- transformed how PHNs approached, supported and worked with women
- ***Uptake of critical caring theory***- complemented SDOH work & provided language to describe PHNs' form of caring & approach to social justice

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CME 11: NFP nurses & supervisors apply the theoretical framework that underpins the program to guide their clinical work….

Core Model Elements 12, 13, 14

Each Team has assigned NFP supervisor	NFP Teams collect & utilize data to guide implementation, CQI etc	High quality NFP implementation is developed and sustained nationally & locally
• All 4 NFP teams had a designated NFP supervisor • No data about supervision collected	• Each team collected program data • Some data irregularities (different interpretations of codes) • Database development required to collect data so it can be used to meet all program functions.	• High quality local implementation support provided through newly created Ontario NFP Practice Lead position • Nationally – Canadian NFP Collaboration examining governance issues

Acceptability of Canadian model of NFP Education: Key Findings

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Nurse-Family Partnership CANADA

Online platform

- User-friendly
- Easy to navigate
- Provided flexibility
- Meaningful organization
- Supportive & engaging learning features
- *“I liked the fact that a lot of it built on each ...* ***every chapter built on another piece”***

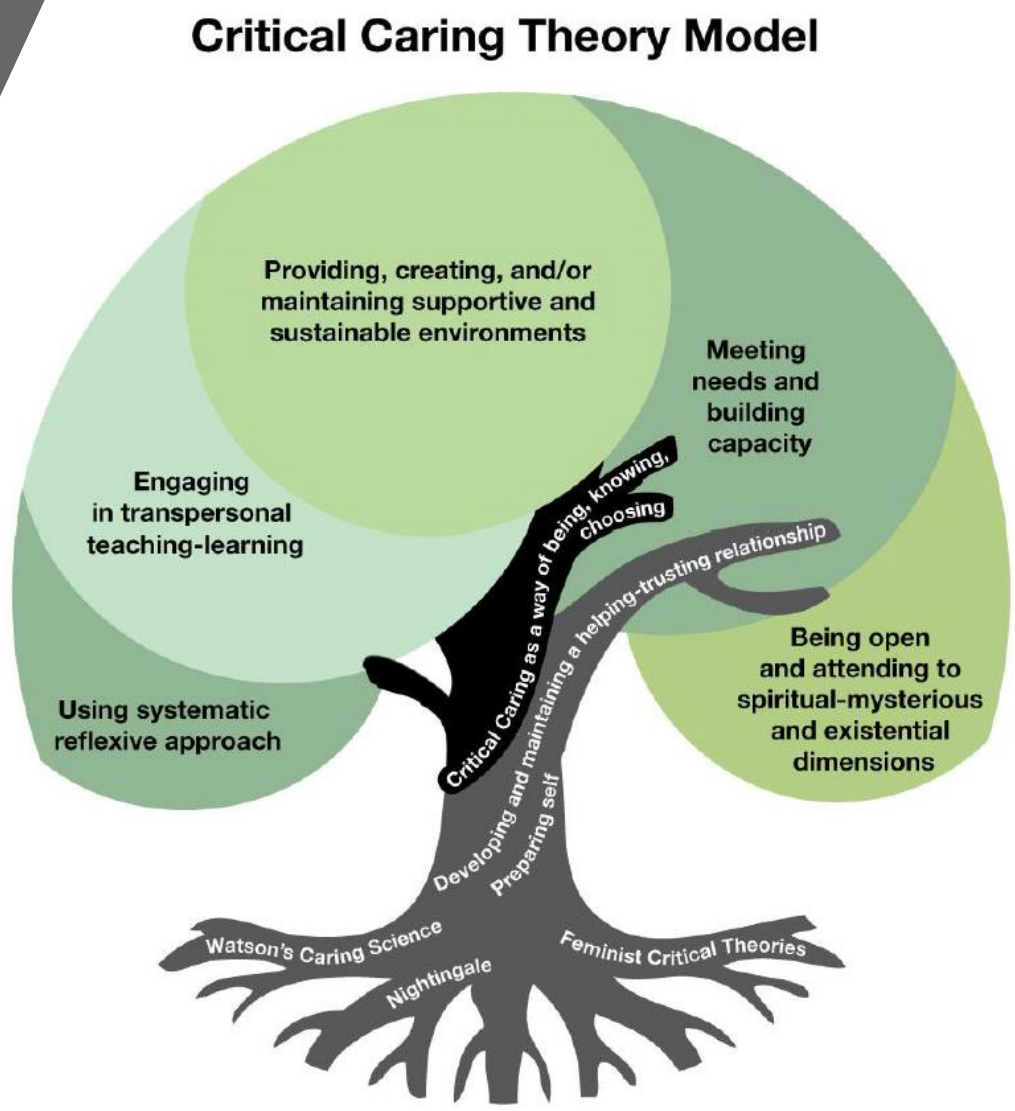
Area for improvement

- not fully *“truly online”*

NFP Foundations – Delivery method & Content Organization

NFP Foundations - Content

- *"Set the stage"*
- Provided learners with language to:
  - describe the professional practice of nurse home visitors
  - articulate the components of home visiting they intrinsically valued
- Theory explicitly linked to elements of the NFP program model
- Challenge for learners: Awareness of a form/tool, yet lack of understanding on "how to" use…



Falk Raphael & Betker (2015)

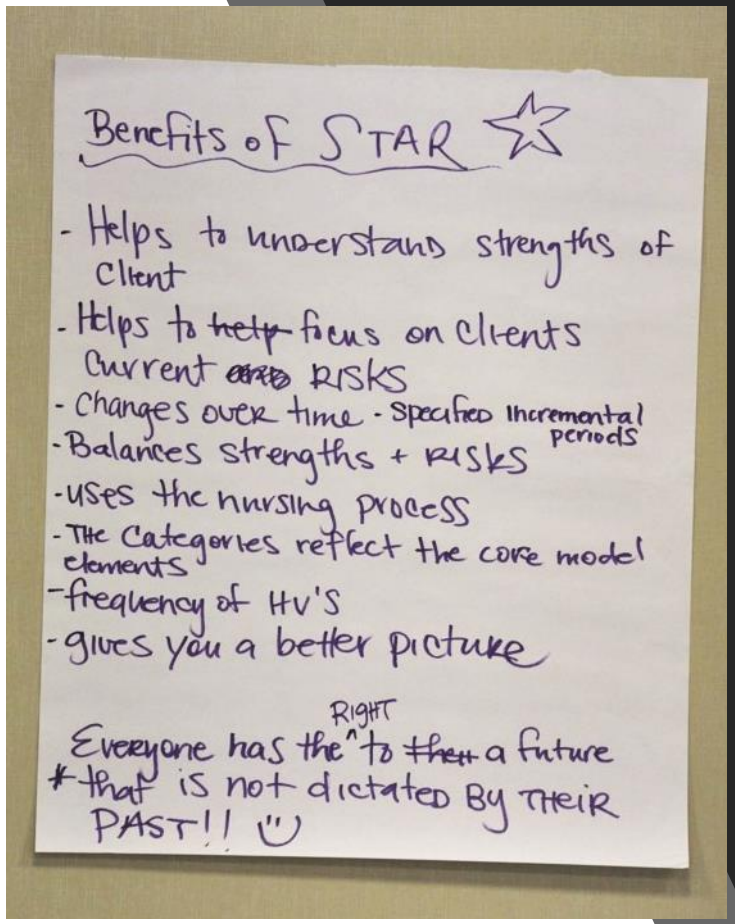
NFP Fundamentals: Delivery

“I know good teaching and it was really well done. Like very adult centered, beautifully facilitated. Like a nice combination of technology use and, and discussion and things like that, so. It was really good. It was really good education.”

NFP Fundamentals: Delivery

It was such a benefit to be able to meet with the other public health units going through this training to be able to draw on everyone's experience in home visiting. Because these nurses bring with them a wealth of experience, right? And knowledge that fits very nicely with implementation of NFP. So the training enhances our knowledge and skills but we can really leverage them too, to learn from each other even before we're implementing NFP.

NFP Fundamentals - Content

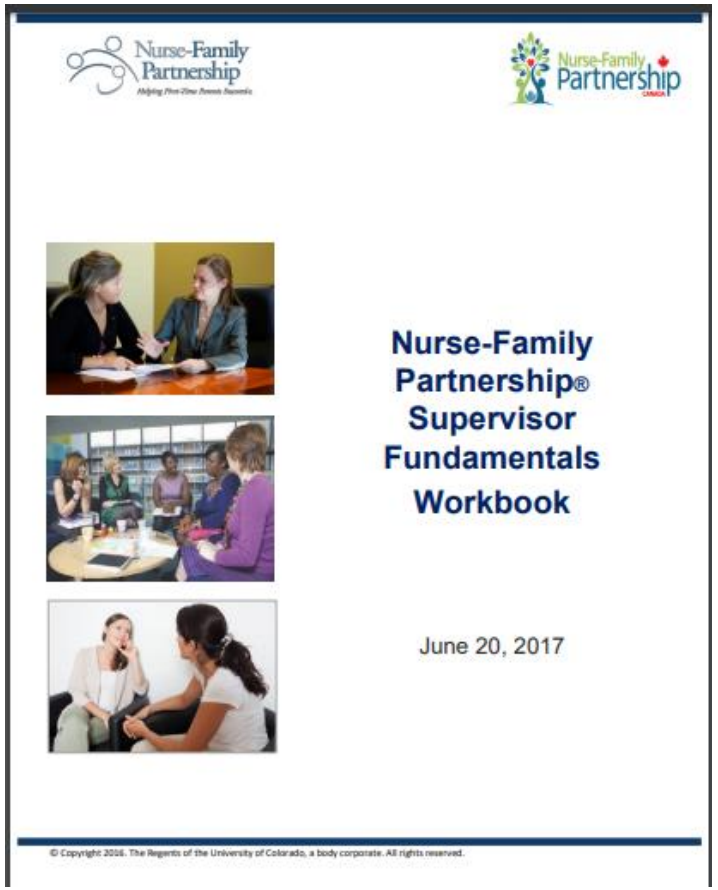


- Highly value new knowledge/skills: TVIC, IPV
- Most engaged with interactive learning strategies
- Process evaluation format allowed for using emerging findings from Cohort 1 to enhance Cohort 2 sessions

IPV Education – Delivery and content

“It's an incredible piece of work for them because they really do see the true value in talking about the relationships in such an intense way...there's something about the content of the wheels that actually is very logical and I think it's the calmness that the nurse presents it in that allows the client the time to think and reflect on what's going on.”

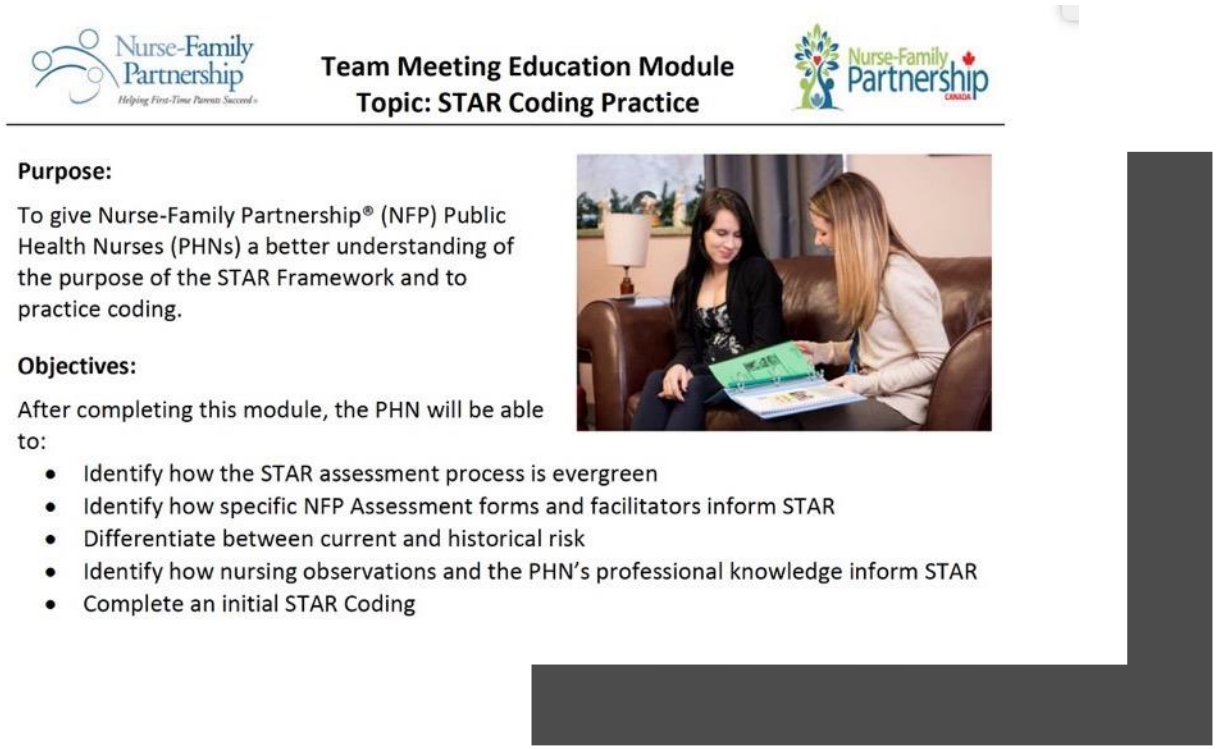
NFP Fundamentals – Supervisor education



NFP Consolidation & Integration – Job shadowing

- Clear expectations about nature and purpose (for both PHN and nurse mentor)
- Interest in observing how PHNs:
  - Use and complete assessment tools and facilitators
  - Introduce to the client NFP specific assessments or interventions
  - Complete required activities following a home visit
- Local job shadowing as more sustainable approach moving forward

NFP Consolidation & Integration – Team Meeting Education Modules (TMEMs)



Nurse-Family Partnership
Helping First-Time Parents Succeed

Team Meeting Education Module
Topic: STAR Coding Practice

Nurse-Family Partnership CANADA

Purpose:

To give Nurse-Family Partnership® (NFP) Public Health Nurses (PHNs) a better understanding of the purpose of the STAR Framework and to practice coding.

Objectives:

After completing this module, the PHN will be able to:

- Identify how the STAR assessment process is evergreen
- Identify how specific NFP Assessment forms and facilitators inform STAR
- Differentiate between current and historical risk
- Identify how nursing observations and the PHN's professional knowledge inform STAR
- Complete an initial STAR Coding

- Good *"grab-and-go kits"*
- Barriers to completing the recommended 10 TMEMs/year
  - Time
  - Competing required training at local public health units
- Provided a list of suggestions for future TMEM topics

Overall Acceptability to PHNs and Supervisors

"Everything has a purpose. And you know when you look back in hindsight you can just see how, how nicely it flowed to do some self-study and then to get together and have that face-to-face and then have a little bit of time to implement and then have your shadowing opportunity and then the integration phase…I see the growth in myself and in the nurses."

Summary of Key Lessons Learned

Overall, NFP is acceptable to PHNs and supervisors as a public health intervention to address maternal and child health outcomes among a priority population of vulnerable women and their children.

Following completion of the Canadian NFP model of education, PHNs and supervisors demonstrated the capacity to implement the program with a high degree of fidelity to 13 of the 14 core model elements.

To have the knowledge & skills to deliver NFP with fidelity, a 3-phase approach to education that included a range of teaching & learning strategies was necessary. Face-to-face education highly valued for skill development & of NFP specific forms, processes, and activities.

Summary of Key Lessons Learned

Completion of the CaNE education, practice support from the NFP Practice Lead, and fidelity to core model elements may have contributed to PHNs' abilities to retain a majority of clients in the program.

Approximately 1/5 pregnant women referred to public health were eligible for NFP; NFP PHNs were exceptionally successful in converting referrals to enrolments.

Public health units highly successful in reaching and enrolling women eligible for program. Community engagement is required to identify strategies to increase the number of women enrolled < 16 weeks gestation

Summary of Key Lessons Learned

Public health nurses and supervisors provided key recommendations for ongoing improvement, and development of new elements, to the Canadian NFP model of education (e.g. increase number of interactive elements in NFP Foundations online modules).

The Canadian model of NFP education was perceived to be sustainable to provide education to a growing NFP workforce in Canada, and with the use of online learning, would also meet needs of future NFP sites outside of Ontario.

Learning outcomes identified to inform development of tools for ongoing evaluation of e-learning and in-person learning.

NFP in Ontario: Current Status

- Continue to offer NFP program in 5 health units
- Communication & Dissemination Planning:
  - Three reports of key findings
  - PowerPoint Presentation
  - Infographics
  - Peer-reviewed publication
  - Ongoing development & enhancement of curriculum components

Project Contacts

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www.healthunit.com

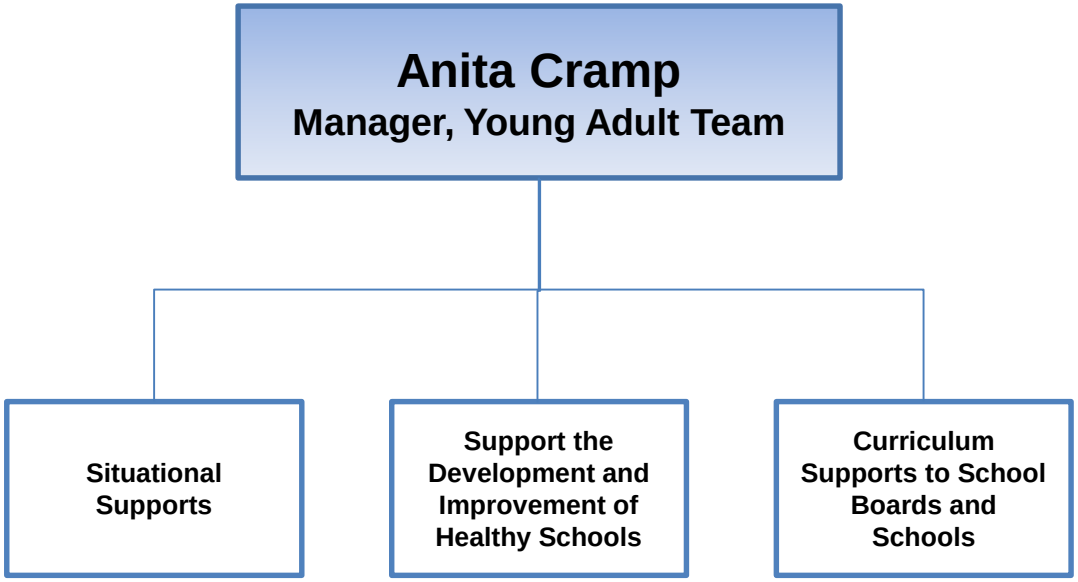
McMaster University

Healthy Living
Young Adult Team

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

Total FTEs – 10.5 FTEs

Total Budget – $1,137,457



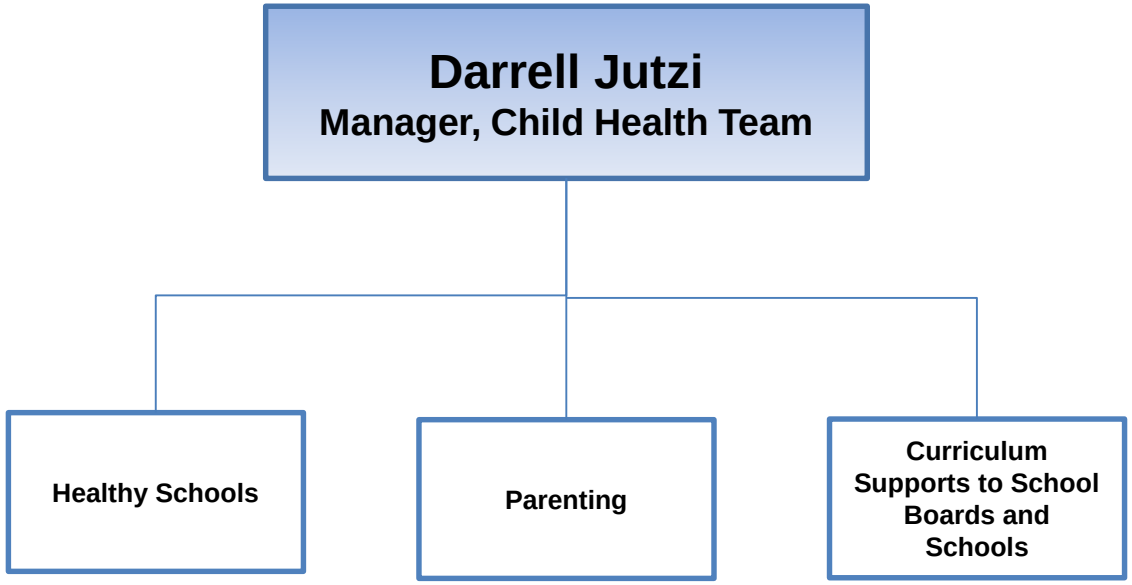
Program Highlights:

- Enhance sexual health services including expanding 3-month contraception starts in schools for young women who have transportation and confidentiality barriers and implementation of STI testing onsite
- Leverage social media for the dissemination of health promotion messages targeted at youth
- Enhance school board partnerships through the implementation of a Partnership Declaration and Data Sharing agreement

Healthy Living
Child Health

Total FTEs – 15.5 FTEs

Total Budget – $1,685,760



Program Highlights:

- Development and implementation of evidence informed toolkits to support healthy school environments
- Enhance the partnership and planning with school boards and schools through the implementation of a Partnership Declaration and Data Sharing Agreement
- Promote and facilitate the School Travel Planning program in identified school communities
- Increased collaboration and planning with Settlement Service Agencies to support newcomer families in schools
- Continue to develop and coordinate an engagement and communication plan for MLHU programs and services in the school setting

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 040-19

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie Medical Officer of Health / CEO

DATE: 2019 May 16

HEALTH CANADA SEEKING FEEDBACK ON MEASURES TO LIMIT YOUTH ACCESS AND APPEAL OF VAPING PRODUCTS

Recommendations

It is recommended that the Board of Health:

1) ***Receive Report No. 040-19 re: "Health Canada Seeking Feedback on Measures to Limit Youth Access and Appeal of Vaping Products";***
2) ***Submit a letter to the Tobacco Control Directorate of Health Canada, attached as Appendix A, expressing its support and recommendations for strengthened measures to limit youth access and appeal of vaping products; and***
3) ***Endorse and submit a letter prepared by the Southwest Tobacco Control Area Network, attached as Appendix B, to the Tobacco Control Directorate of Health Canada on behalf of the eight public health units in southwestern Ontario.***

Key Points

- On April 11, 2019, Health Canada issued an opportunity for stakeholders and members of the public to provide comments on proposed measures, under the authority of the *Tobacco and Vaping Products Act*, to limit youth access and appeal of vaping products. The deadline for submissions is May 25, 2019.
- Health Unit staff prepared a letter for Board of Health approval (attached as Appendix A) to express its support and propose recommendations for considerations on how to limit youth access and appeal of vaping products.
- Staff from the Southwest Tobacco Control Area Network, prepared a letter (attached as Appendix B) for endorsement and submission by the Middlesex-London Board of Health on behalf of the eight public health units in southwestern Ontario.

Background

Vaping rates are increasing dramatically across Ontario. Vaping is safer than tobacco cigarettes; however, this does not mean that they are harmless. Vaping products that contain nicotine are addictive, and nicotine alters brain development in youth, including the areas of the brain that relate to focus and learning. Nicotine also impacts areas of the brain that control addiction pathways, making it harder to quit.

Even without nicotine, e-cigarettes don't produce harmless water vapour. There is conclusive evidence that e-cigarette use increases airborne concentrations of particulate matter, heavy metals, and other toxic chemicals. In addition to direct health risks, the National Academies of Sciences, Engineering and Medicine have determined that there is substantial evidence that e-cigarette use increases the risk of ever using combustible tobacco cigarettes among youth and young adults.

It is important to prevent the use of vaping products by youth and non-tobacco users, and regulatory measures that would restrict flavours, regulate product and packaging design, and reduce youth access are important policy levers to help contribute to this public health goal.

Health Canada Seeking Feedback on Measures to Limit Youth Access and Appeal of Vaping Products

On February 5, 2019, Health Canada announced measures to address vaping by Canadian youth. A Notice of Intent (NOI) was issued in conjunction with an announcement about a public education campaign that is currently in market across the country. Health Canada opened a forty-five-day consultation period to obtain feedback on the proposed measures set out in the NOI to limit vaping product advertising. The Middlesex-London Board of Health submitted two letters proposing recommendations for consideration by Health Canada on how to strengthen measures to limit vaping product advertising via regulation (Report 026-19).

On April 11, 2019, Health Canada opened a community consultation to gather comments on additional regulatory measures to reduce youth use of vaping products. As outlined in Health Canada's consultation document, the scope of the regulatory measures includes:

- Prohibiting the manufacture and sale of vaping products with certain flavours or flavour ingredients and/or prohibiting the promotion of certain flavours;
- Restricting the concentration and/or delivery of nicotine in vaping products;
- Regulating design features;
- Restricting online retail access;
- Restricting product packaging; and
- Increasing regulatory transparency and openness.

Opportunity for Strong Measures through Federal Regulation

The *Tobacco and Vaping Products Act* provides restrictions on the promotion of flavoured vaping products and prohibits lifestyle advertising, sponsorships, testimonials or endorsements, and other advertising that could be appealing to youth. However, further regulatory measures are needed to reduce youth access and appeal of vaping products.

MLHU's Chronic Disease Prevention and Tobacco Control Team and Southwest Tobacco Control Area Network Team have both prepared submissions to Health Canada for Board of Health approval and submission, attached as Appendices A and B, respectively. The letters express support for the *Tobacco and Vaping Products Act* and propose recommendations for consideration by Health Canada.

This report was prepared by the Healthy Living Division.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health / CEO

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Appendix A to Report No. 040-19

Tobacco Products Regulatory Office
Tobacco Control Directorate, Controlled Substances and Cannabis Branch
Health Canada
Address Locator 0301A, 150 Tunney's Pasture Driveway
Ottawa, Ontario
K1A 0K9
Email: hc.pregs.sc@canada.ca

RE: RESPONSE TO POTENTIAL REGULATORY MEASURES TO REDUCE THE YOUTH ACCESS AND APPEAL OF VAPING PRODUCTS

The Middlesex-London Health Unit (MLHU) shares Health Canada's concerns regarding the increase in vapour product use by young people in Canada. MLHU applauds Health Canada's commitment to work with provincial and territorial partners to enhance national collaborative and cooperative efforts to reduce youth vaping. In Ontario, local Public Health Units play an important role in working with parents, schools, community and social service agencies, and municipalities to prevent youth, young adults and non-tobacco users from using vaping products, and to promote compliance and enforce the provisions outlined in the *Smoke-Free Ontario Act, 2017.* Regulatory measures that would reduce youth access and appeal would be an important step forward, and we are pleased to be able to provide input on the proposed measures.

Research suggests that adolescents are using vaping products at an alarming rate. According to the 2017 Canadian Student Tobacco, Alcohol and Drugs Survey, student usage of vaping products in Canada increased by 30% per year between 2015 and 2017.[i] When the *Tobacco and Vaping Products Act* was passed in 2018, innovative products that are appealing to youth began to show up in the Canadian market place. These vaping products deliver higher concentrations of nicotine per puff than older models of e-cigarettes and traditional tobacco cigarettes.[ii] Nicotine is a highly addictive substance that can have adverse effects on the developing brain.[iii] The US Food and Drug Administration has declared e-cigarette use an epidemic among young people after research showed a 78% increase in vaping among high school students between 2017 and 2018 in the United States.[iv,v] Not only do vaping products put youth and young adults at risk of nicotine dependence, there is substantial evidence that e-cigarette use increases the risk of ever using combustible tobacco cigarettes among youth and young adults. Increased usage of vaping products by youth, young adults, and non-tobacco users threatens to undermine the success of previous tobacco control measures in reducing tobacco use in Canada.[vi]

Under the *Smoke-Free Ontario Act, 2017 (SFOA, 2017),* smoking and the use of vaping products is prohibited on school grounds and within 20 metres of school property. The use of vaping products inside and outdoors on school property has become a substantial problem for elementary and secondary school staff. Between October 2018 and April 2019, the Health Unit's Tobacco Control Team received 64 complaints from school staff and parents in the Middlesex-London region about young people vaping on school property. Vapour products are not only being used outside on school property, but they are being used inside school washrooms, classrooms and on school buses. More complaints regarding vaping on school property have been received between January 1st and April 30th, 2019 than in the entire calendar year of 2018. Health Unit Inspectors, designated by the Ontario Ministry of Health and Long-Term to enforce the *Smoke-free Ontario Act, 2017*, have reported that students caught vaping on school property are indicating that because of their addiction to nicotine, they are unable to wait for class breaks to leave school property to use their vaping products. Public Health Nurses that work within the secondary schools in the Middlesex-London area have reported that students have disclosed situations where they have experienced adverse reactions to high doses of nicotine, including headaches, nausea, elevated heart rate, general malaise and in extreme situations, seizures. According to the manufacturer, a single pod that is used in the JUUL e-cigarette device contains as much nicotine as a pack of cigarettes.[vii] The current regulations in place regarding the manufacturing and design of e-cigarettes are inadequate to protect youth.

It is commendable that the *Tobacco and Vaping Products Act* has restrictions on the promotion of flavoured vapour products and prohibits lifestyle advertising, sponsorships, testimonials or endorsements, and other advertising that could be appealing to youth; however, further regulatory measures are needed to reduce youth access and appeal.

Prohibiting the Manufacture and Sale of Vaping Products with Certain Flavours/Flavour Ingredients and/or Prohibiting the Promotion of Certain Flavours

"Flavor is a multisensory perception" that involves taste, aroma, and feelings of cooling and burning within the mouth and throat.[viii] The documented evidence within the food consumer science literature demonstrates that flavour impacts the appeal of consumable goods, and that flavour preferences direct food selection. [ix,x] Youth and young adults are particularly influenced by flavours, with heightened preferences for sweet flavours and a greater dislike to bitter food tastes, with preferences generally diminishing with age.[xi,xii] Due to pervasive marketing and promotion tactics, and the addition of attractive candy and fruit flavours to vapour products, sales of e-cigarettes are growing rapidly across Canada and around the world.[xiii,xiv,xv] Youth and young adults are using e-cigarettes because they are perceived to be "fun" or "cool".[xvi] Worldwide sales for e-cigarettes reached $6 billion in 2014, with over one thousand e-liquid flavours available in the marketplace under the banner of 460 different brands.[xvii]

Under the *Tobacco and Vaping Products Act*, it is illegal to promote that an e-substance contains confectionary, dessert, soft drink, energy drink or cannabis flavours, and the package, by way of illustrations or design, cannot indicate that the e-substance is flavoured with these classes of flavours. However, according to the Ontario Tobacco Research Unit, a quick search of Canadian online vaping product retailers showed that there is substantial promotion of e-substances that contain confectionary, dessert, soft drink and other flavours that are appealing to youth.[xviii] The Health Unit's Tobacco Control Team has observed e-substances available for sale from retail stores in Middlesex-London that promote the inclusion of flavours that are appealing to youth. **Therefore, to reduce youth appeal of flavoured e-cigarettes, the Health Unit recommends that the Federal Government takes action to prevent the promotion of youth-appealing flavours by Canadian online vaping retailers. In addition, the Health Unit recommends that Health Canada strengthens the current approach to regulating flavoured e-substances to include tighter prohibitions on the manufacturing and sale of e-substance flavours that are attractive to youth and adolescents, with an overall reduction/market cap on the number of flavours available for sale in Canada**. **Nicotine replacement therapy is only available in a limited number of flavours; therefore, vapour product flavours should be limited to those available with traditional nicotine replacement therapy.**

Restricting the Concentration and/or Delivery of Nicotine

Nicotine is a highly addictive substance that poses significant risk, especially to young people. The brain continues to develop until an individual reaches the approximate age of 25. Exposure to nicotine during brain development can result in nicotine addiction, mood disorders, permanent lowering of impulse control, and changes in attention and learning. [xix] While data has suggested that young people may be unaware that vaping products contain nicotine, there are growing concerns about youth seeking out vaping products for the nicotine hit. Anecdotally, MLHU staff have conversed with young people who have admitted to using vapour products for the nicotine "hit". Trends such as "nicking out" have becoming increasingly more popular with young people within the Middlesex-London jurisdiction. Students that have been caught vaping inside school washrooms and classrooms have disclosed to Health Unit Inspectors and Public Health Nurses that they are unable to wait for class breaks to leave school property to vape due to nicotine cravings. In addition, youth have disclosed that they compete with each other to see who will vomit or pass out first from using their e-cigarettes. These trends would suggest that for some young people, the allowable nicotine content in vapour products is at dangerously high levels. **To reduce youth appeal and to protect the developing youth brain, the Health Unit recommends that acceptable nicotine concentration levels for vapour products should be more closely aligned with the approved nicotine concentrations for nicotine replacement therapeutic products (e.g. patches, gum, mist, inhalers, lozenges) that are already approved and regulated as cessation aids in Canada**. **The nicotine concentration level for e-substances should not exceed 21 mg/ml. This level is in alignment with the European**

Union Tobacco Products Directive (20 mg/ml), which states that this concentration allows for delivery of nicotine that is comparable to a standard cigarette.[xx]

Appearance, Shape, and Sensory Attributes, and Packaging Design

In November 2019, Canada will join the 13 other countries that have already implemented plain and standardized tobacco product packaging regulations. With strict promotion and advertising rules in effect for tobacco products across Canada, the package became an important marketing tool for tobacco manufacturers. Acting as mini billboards, the tobacco industry used colours, images, logos, slogans and distinctive fonts, finishes, and sizing configurations of packages to make their product appealing and attractive to existing and new tobacco users. [xxiv] The design of the package can make its contents appear safe to use, undermining the visibility, credibility and effectiveness of health warnings. Studies have determined that the colour, shape and size of a package can influence consumer behaviour and contributes to consumer perceptions of the product.[xxi] There is substantial documented evidence that confirms that plain packaging reduces the attractiveness of tobacco products, particularly among young people and women, making plain and standardized tobacco product packaging one of the most effective tobacco control policy measures to reduce consumption.[xxii,xxiii,xxiv]

The same principles and body of evidence can be applied to the regulation of vapour products and their packaging. Devices are being manufactured to look like small, discrete everyday objects, including USB memory sticks, so that youth can attempt to hide vaping behaviour from teachers and parents.[xxv] In Middlesex-London, the ability to "stealth vape" in school washrooms and classrooms is undermining efforts that school staff and MLHU are taking to promote and enforce the *SFOA, 2017* on school property. E-cigarette use on school property is normalizing e-cigarette use among youth; the ability to skirt the law increases the appeal of these products. The devices come in many shapes, colours and sizes, which allow the consumer to customize and personalize their e-cigarette, which complements the lifestyle messaging that youth are receiving from the internet and on social media, in convenience stores, and at gas stations. The lifestyle messaging often depicts cheerful and stylish smokers taking back "their right to smoke" in public by using e-cigarettes instead [xv]. The messaging promotes e-cigarettes as a safe alternative to tobacco products, without communicating the potential health concerns related to inhalation of toxic chemicals, heavy metals, and nicotine found in the vapour. [xix] **To reduce youth appeal, the Health Unit recommends that Health Canada uses the same approach that has been applied to tobacco and cannabis products, by enacting plain and standardized vapour product design and packaging requirements.**

Restricting Online Retail Access

Besides the availability of e-cigarette devices at retail outlets such as convenience stores, gas stations, grocery stores, tobacconist shops, and specialty vape stores, e-cigarette devices and e-substances are widely available for sale through websites and social media.[xxvi] While many online e-cigarette vendors use age-verification measures during online purchase, people under the age of 18 years are still able to purchase e-cigarettes and e-substances online. Research conducted by Williams, Derrick, and Ribisl (2015) in North Carolina showed that the overall success rate for youth purchases of e-cigarettes online was 93.7%. False birth dates were entered into the website and no delivery company attempted to verify recipients' ages at point of delivery, with 95% of e-cigarette deliveries being left at the door. [xxvii] Youth under the age of 19 years in the Middlesex-London area have disclosed that they have successfully purchased e-cigarette devices and e-substances online. The measures Health Canada has suggested to enhance the verification of age and identity of online purchasers of vapour products are warranted. It is noted in the consultation document that some of these measures are not currently used federally for other age-restricted products, including alcohol or cannabis. **The Health Unit recommends that strict age-verification measures be required for online sales, including age-verification at time of purchase and proof of legal age at delivery. The Health Unit recommends that these measures be considered for online sales of all age-restricted products in Canada.**

Increasing Regulatory Transparency and Openness

Local public health units, non-governmental organizations, health care practitioners and all levels of government across Canada need to be responsive to the social and health impacts that the use of tobacco and vapour products have on individual and population health. Ensuring that Canadians remain informed of tobacco and vapour product industry practices is important to supporting the efforts of health, non-governmental and governmental agencies to be able to respond to and reduce the burden of nicotine addiction. British American Tobacco plc, Altria Group Inc., Japan Tobacco Inc., Imperial Brands plc, Philip Morris International Inc., VMR Products LLC, NJOY Inc., International Vapor Group, Vapor Hub International Inc., and FIN Branding Group LLC are the predominant companies that are operating in the e-cigarette market. [xxviii] The tobacco industry has a long history of deceptive marketing and advertising practices, and authoring reports with biased data that lied about the addictive nature of tobacco and downplayed the health burden from tobacco use. [xxiv] Ensuring that Canadians have an accurate picture of tobacco and vapour product industry non-compliance with federal regulations, through annual reports and a public disclosure system, would encourage and promote voluntary compliance while keeping Canadians informed of industry activities. **The Health Unit recommends that vapour product manufacturers be held to the same level of accountability and scrutiny as tobacco product manufacturers, through the enactment of vapour product information and reporting regulations. The Health Unit also recommends that Health Canada dedicate research funding to better understand the potential benefits and risks associated with the use of vapour products. Research findings can be used to inform the development of future regulations.**

Inspectors, designated by the Ontario Ministry of Health and Long-Term Care to enforce the *Smoke-Free Ontario Act, 2017* and employed by the eight public health units in southwestern Ontario, meet on a bi-monthly basis to ensure consistent enforcement and application of the rules pertaining to the sale, supply, promotion and use of tobacco and vapour products in Ontario. The ad hoc participation of Health Canada staff involved in the promotion and enforcement of the *Tobacco and Vaping Products Act* would be welcomed at these meetings. Collaboration between local public health units and Health Canada inspectors would be of mutual benefit because it would provide an opportunity to share retailer business intelligence and to share information that supports mutual goals of risk-based enforcement activities. Coordination of enforcement activities could ensure that enforcement visits from Health Canada and local health unit inspectors are spaced out over the course of the year, contributing to an enhanced enforcement presence and improved referral processes between agencies.

The proposed regulatory measures outlined in the consultation document could be an important first step to reduce youth access and appeal of vaping products in Canada. Youth vaping is a significant public health concern, and we thank you for opportunity to share our suggestions with you for your consideration.

Sincerely,

Trish Fulton, Chair
Middlesex-London Board of Health

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Appendix B to Report No. 040-19

Tobacco Products Regulatory Office
Tobacco Control Directorate, Controlled Substances and Cannabis Branch
Health Canada
Address Locator 0301A, 150 Tunney's Pasture Driveway
Ottawa, Ontario
K1A 0K9

RE: RESPONSE TO POTENTIAL MEASURES TO REDUCE YOUTH ACCESS AND APPEAL OF VAPING PRODUCTS

The Southwest Tobacco Control Area Network (SW TCAN) strongly supports Health Canada's exploration of potential measures to reduce youth access and the appeal of vaping products in Canada. These measures are an important step forward, and we are pleased to be able to have the opportunity to provide input.

Research suggests that adolescents are using vaping products at an alarming rate. According to the 2017 Canadian Student Tobacco, Alcohol and Drugs Survey, student usage of vaping products in Canada increased by 30% per year between 2015 and 2017.[1] Concerns about youth vaping increased after the introduction of new vaping products in 2018. Vaping products recently introduced into the market place are reported to deliver higher concentrations of nicotine per puff than older types of e-cigarettes and tobacco cigarettes.[2] Nicotine is a highly addictive substance that can have adverse effects on the developing brain[3]. The US Food and Drug Administration has declared e-cigarette use an epidemic among young people after research showed a 78% increase in vaping among high school students between 2017 and 2018 in the United States.[4,5] Not only do vaping products put youth and non-tobacco users at risk of nicotine dependence and subsequent combustible cigarette use, their usage threatens to undermine previous successes tobacco control measures have had at reducing tobacco use in Canada.[6]

It is commendable that the *Tobacco and Vaping Products Act* has restrictions on the promotion of flavoured vapour products, and prohibits lifestyle advertising, sponsorships, testimonials or endorsements, and other advertising that could be appealing to youth. However, further regulatory measures are needed to reduce youth access and the appeal of vaping products to young people.

Prohibiting the Manufacture and Sale of Vaping Products with Certain Flavours or Flavour Ingredients and/or Prohibiting the Promotion of Certain Flavours

"Flavour is a multisensory perception" that involves taste, aroma, and feelings of cooling and burning within the mouth and throat.[7] The documented evidence within the food consumer science literature demonstrates that flavour impacts the appeal of consumable goods, and that flavour preferences direct food selection.[8,9] Youth and young adults are particularly influenced by flavours, with heightened preferences for sweet flavours and a greater dislike of bitter food tastes, with preferences generally diminishing with age.[10,11] Due to pervasive marketing and promotion tactics, and the addition of attractive candy and fruit flavours to e-cigarettes and vapour products, sales of e-cigarettes are growing rapidly across Canada and around the world.[12,13,14] Youth and young adults are using e-cigarettes because they are perceived to be "fun" or "cool".[15] Worldwide sales for e-cigarettes reached $6 billion in 2014, with over one

thousand e-liquid flavours available in the marketplace under the banner of 460 different brands.[16]

Under the *Tobacco and Vaping Products Act*, it is illegal to promote that an e-substance contains confectionary, dessert, soft drink, energy drink or cannabis flavours, and the package, by way of illustrations or design, cannot indicate that the e-substance is flavoured with these classes of flavours. However, according to the Ontario Tobacco Research Unit, a quick search of Canadian online vaping product retailers showed that there is substantial promotion of e-substances that contain confectionary, dessert, soft drink and other flavours that are appealing to youth.[17] Therefore, to reduce youth appeal of flavoured e-cigarettes, the SW TCAN recommends that the Federal Government takes action to prevent the promotion of youth-appealing flavours by Canadian online vaping retailers. In addition, the SW TCAN recommends that Health Canada strengthens the current approach to regulating flavoured e-substances to include tighter prohibitions on the manufacturing and sale of e-substance flavours that are attractive to youth and adolescents, with an overall reduction/market cap to the number of flavours available for sale in Canada. Nicotine replacement therapy is only available in a limited number of flavours, and we see no reason vaping devices need to provide more flavour selections than traditional nicotine replacement therapy.

Restricting the Concentration and/or Delivery of Nicotine

Nicotine is a highly addictive substance that poses significant risk, especially to young people.[18] The teenage brain continues to develop until an individual reaches the approximate age of 25. Exposure to nicotine during brain development can result in nicotine addiction, mood disorders, permanent lowering of impulse control, and changes in attention and learning.[19] While data has suggested that young people may be unaware that vaping products contain nicotine, we agree with Health Canada's statement that this may not reflect current trends, as the landscape is rapidly changing.[20] Anecdotally, public health staff in the SW TCAN have heard from young people that they use vapour products for the "nicotine hit". Trends such as "nicking out" have seemingly becoming more popular with young people in our TCAN. We have been told of games where young people compete to see who will vomit or pass out first. These trends would suggest that for some young people, nicotine content in vapour products adds to the products' appeal.

The SW TCAN would like to see nicotine concentration levels for vapour products aligned with the approved nicotine concentrations for nicotine replacement products (e.g. patches, gum, mist, inhalers, lozenges) that are already approved and regulated as cessation aids in Canada. Therefore, we believe nicotine concentration levels for e-substances should not exceed 21 mg/ml. This level is in alignment with the European Union Tobacco Products Directive (20 mg/ml), which states that this concentration allows for delivery of nicotine that is comparable to a standard cigarette.[21]

Restricting Online Retail Access

The SW TCAN would like to see measures taken to further restrict online sales of vapour product to young people. When speaking with young people caught vaping on school property, Tobacco Enforcement Officers often ask where they obtained their vapour product, and it is not uncommon to hear that they were obtained online. Recently, an enforcement officer in the SW TCAN had a young man in elementary school admit to ordering his device online. The student indicated that he had "simply clicked a button" to say he was of legal age, and he arrived home from school before his parents so that he could obtain the package from the mail box before

being caught. The evidence would suggest that this story from our region of Ontario is not an isolated event, but rather one example of the way many young people are getting their hands on vapour products. A study conducted in North Carolina showed that the overall success rate for youth purchases of e-cigarettes online was 93.7%.[22] False birth dates were entered into the website and no delivery company attempted to verify recipients' ages at point of delivery, with 95% of e-cigarette deliveries being left at the door.[23]

The measures Health Canada has suggested to enhance the verification of age and identity of online purchasers of vapour products are warranted. It is noted in the consultation document that some of these measures are not currently used for other age restricted products, such as alcohol or cannabis. It is the opinion of the SW TCAN that strict age-verification measures be required for online sales, including age-verification at time of purchase and proof of legal age at delivery. The SW TCAN also recommends that these measures be considered for online sales of all age-restricted products in Canada.

Appearance, Shape, and Sensory Attributes, and Packaging Design

In November 2019, Canada will join the 13 other countries that have already implemented plain and standardized tobacco product packaging regulations. With strict promotion and advertising rules in effect for tobacco products across Canada, the package became an important marketing tool for tobacco manufacturers. Acting as mini billboards, the tobacco industry used colours, images, logos, slogans and distinctive fonts, finishes, and sizing configurations to make their product appealing and attractive to existing and new tobacco users.[24] The design of the package can make its contents appear safe to use, undermining the visibility, credibility and effectiveness of health warnings.[25] Studies have determined that the colour, shape and size of a package can influence consumer behaviour and contributes to consumer perceptions of the product.[26] There is substantial documented evidence that confirms that plain packaging reduces the attractiveness of tobacco products, particularly among young people and women, making plain and standardized tobacco product packaging one of the most effective tobacco control policy measures to reduce consumption.[27,28,29]

The same principles and body of evidence can be applied to the regulation of vapour products and their packaging. Devices are being manufactured to look like small, discrete everyday objects, including USB memory sticks, so that youth can attempt to hide vaping behaviour from teachers and parents.[30] To reduce youth appeal, the SW TCAN recommends that Health Canada uses the same approach that has been applied to tobacco and cannabis products, by enacting plain and standardized vapour product design and packaging requirements.

Increasing Regulatory Transparency and Openness

Ensuring Canadians are aware of tobacco industry practices is a valid and important initiative. The tobacco industry has a long history of deceptive marketing and advertising practices, and authoring reports with biased data that lied about the addictive nature of tobacco and downplayed the health burden from tobacco use.[31] Ensuring that Canadians have an accurate picture of tobacco and vapour product industry non-compliance with federal regulations, through annual reports and a public disclosure system, would encourage and promote voluntary compliance while keeping Canadians informed of industry activities. The SW TCAN recommends that vapour product manufacturers be held to the same level of accountability and scrutiny as tobacco product manufacturers, through the enactment of vapour product information and reporting regulations. The SW TCAN also recommends that Health Canada dedicate research funding to better understand the potential benefits and risks associated with

the use of vapour products. Research findings can be used to inform the development of future regulations.

Inspectors, designated by the Ministry of Health and Long-Term Care to enforce the *Smoke-Free Ontario Act, 2017* and employed by the eight public health units in southwestern Ontario, meet on a bi-monthly basis to ensure consistent enforcement and application of the rules pertaining to the sale, supply, promotion and use of tobacco and vapour products in Ontario. The ad hoc participation of Health Canada staff involved in the promotion and enforcement of the *Tobacco and Vaping Products Act* would be welcomed at these meetings. Collaboration between local public health units and Health Canada inspectors would be of mutual benefit because it would provide an opportunity to share retailer business intelligence and to share information that supports mutual goals of risk-based enforcement activities. Coordination of enforcement activities could ensure that enforcement visits from Health Canada and local health unit inspectors are spaced out over the course of the year, contributing to an enhanced enforcement presence and improved referral processes between agencies.

The proposed regulatory measures outlined in the consultation document could be an important first step to reduce youth access and appeal of vaping products in Canada. Youth vaping is a significant public health concern, and we thank you for opportunity to share our suggestions with you for your consideration.

Sincerely,

Trish Fulton, Chair
Middlesex-London Board of Health

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MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 041-19

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2019 May 16

HARM REDUCTION CAMPAIGN

Recommendation

It is recommended that the Board of Health receive Report No. 041-19 re: "Harm Reduction Campaign" for information.

Key Points

- Between April 1, 2007, and March 30, 2017, people who inject drugs (PWID) (aged ≥18 years) made up 54.6% of first-episode infective endocarditis cases admitted to hospitals in London, Ontario.
- Local research studies published in the *Journal of Acquired Immune Deficiency Syndromes* (April 1, 2019) indicate that sharing the residue left in cookers after preparing Hydromorph Contin for injection can be linked to the transmission of HIV.
- The findings of the Harm Reduction Project Report indicate that PWID are aware of the harms associated with sharing or reusing injection drug preparation equipment and will try to minimize harm when presented with options on how to do so.

Background

In June 2016, MLHU issued a public health alert related to rapidly increasing rates of HIV, Hepatitis C (HCV), invasive Group A Streptococcal (iGAS) disease, and infective endocarditis among people who inject drugs (PWID) (Board of Health Report Nos. 005-19 and 021-17, Appendix A). Original research by MLHU and partners has led to innovative responses to these issues, and substantially impacted these epidemics.

Between April 1, 2007, and March 30, 2017, PWID (aged ≥18 years) made up 54.6% of first-episode infectious endocarditis cases admitted to hospitals in London, Ontario. There are multiple factors thought to impact the rate of infectious endocarditis in PWID, including: specific drugs being more likely to support the breeding of bacteria that commonly cause infectious endocarditis such as Staphylococcus aureus (S. aureus); the reuse of injection drug preparation equipment; and the drug preparation methods used by PWID. Multiple factors impacting the rates of both infectious endocarditis and HIV among PWID were found to include:

- the availability of prescription Hydromorph Contin for illicit drug use;
- the residue of solubilized Hydromorph Contin, known as "wash," in used cookers, and the perceived street value of that residue;
- the controlled-release substance present in Hydromorph Contin that has been shown to prolong the lifespan of bacteria and HIV;
- the reuse or sharing of cookers to resolubilize a "hydro" wash for subsequent injections; and
- the preparation method used when solubilizing a hydro wash in a previously used cooker. A key conclusion of the study was that bacterial and viral counts could be reduced by simply heating the hydro wash to a boil, thereby reducing the risk of infection from infectious endocarditis and HIV.

In June 2017, local research was released advising PWID and agencies that serve them about the harm reduction benefits of heating hydromorphone before injection. Local research studies published in the *Journal of Acquired Immune Deficiency Syndromes* indicate that sharing the residue left in cookers after preparing hydros for injection can be linked to the increased risk of transmission of HIV.

As a result of these studies, the researchers recommend that PWID should "cook" their wash. Although this message has been actively communicated to some portions of the population who inject Hydromorph Contin, there are others who may not be receiving this information. Recognizing that there may be knowledge deficits and unknown barriers to adopting the practice of "cooking" that have not been met by the communication to date, the Health Unit was asked to assess and implement a harm reduction campaign to address these gaps.

Cook Your Wash – Harm Reduction Campaign Project

In September 2018, a project team was formed that included two Western student researchers engaged by Dr. Michael Silverman at St. Joseph's Health Care, along with two program evaluators and the sexual health promoter from the Middlesex-London Health Unit. The purpose of the project was to identify potential barriers among PWID to heating the wash, and to establish the most effective methods for disseminating harm reduction information to the PWID population. Project study methods included focus group sessions comprised of PWID and key informant interviews with frontline staff from eleven community agencies that support PWID.

Key Project Findings

The key findings of the project included (Appendix A):

- The three most consistent steps used to prepare hydros include crushing, dissolving, and cooking.
- Currently, the provincial program to provide injection drug preparation equipment does not include a pill crusher or a heat source.
- PWID are using in innovative ways to crush their drugs and/or to sustain a heat source.
- Other items such as a lighter are often repurposed as a crusher, which can introduce bacteria into the solute.
- PWID will typically use a lighter as a heat source when they cook.
- Significant barriers to cooking identified by PWID included the time it takes to cook when dope sick, negative peer influences, and environment (weather conditions/safety/public scrutiny).
- The Temporary Overdose Prevention Site (TOPS) and Consumption Treatment Services (CTS) eliminate environmental barriers such as the risk of being caught injecting in a public place.
- TOPS/CTS is only useful for those who know about it and are able to access services during hours of operation.
- PWID peer-to-peer word of mouth and one-to-one interactions with an outreach worker are considered the most trusted sources for information/education about harm reduction.

Next Steps

The findings of the Harm Reduction Project Report indicate that PWID are aware of the harms associated with sharing or reusing injection drug preparation equipment and will try to employ techniques to minimize harm when doing so. The next steps to ensure the findings of the study and report are communicated to PWID will include: communicating project outcomes to senior leaders at community agencies supporting this project; using feedback from project study participants to inform a harm reduction campaign; developing key messaging to include with resources such as lighters, posters, fact sheets, and labels; offering education sessions to PWID peers and frontline staff to ensure information is consistent and shared among the PWID population as well as within and between agencies; and advocating for the inclusion of heat sources and/or pill crushers to the list of harm reduction items funded by the Ontario Harm Reduction Program.

This report was prepared by the Sexual Health Team, Environmental Health and Infectious Disease Division, and the Population Health Assessment and Surveillance Team.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health/CEO

Harm Reduction Campaign Project Report

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Introduction

In recent years, North America has seen a significant increase in the incidence of Infective Endocarditis (IE) in people who inject drugs (PWID) (Slipczuk et al., 2013). This trend is consistent with data from the Middlesex-London Health Unit catchment area. From April 1, 2007, to March 30, 2017, PWID (≥ aged 18 years) made up 54.6% of first-episode IE cases admitted to hospitals in London, Ontario, Canada (Rodger et al., 2018). This study also indicated that PWID are at an increased risk for reinfection (Rodger et al., 2018). There are multiple factors thought to impact the rate of IE in PWID including, specific drugs being more likely to breed the bacteria like Staphylococcus aureus (S. aureus) that commonly cause IE; the reuse of injection drug preparation equipment (IDPE); and the preparation methods.

The hypothesis that particular drugs may increase the risk of IE in PWID is further supported by Weir and colleagues, who demonstrate the correlation between an increase in hydromorphone[1] (hydros) prescriptions and admissions of PWID for IE in Ontario, Canada (Weir et al., 2019). Local research was conducted with PWID by Mitra and et al. (2017) on the acceptability of a supervised injection site to support the increased use of Hydromorphone Controlled Release (HCR) capsules. Researchers hypothesize that the binding agents in HCR act as a nutrient source for bacteria (S. aureus) and viruses (Human Immunodeficiency (HIV) and Hepatitis C (HCV) (Lake & Kennedy, 2016; Shah et al., 1996).

The preparation methods of HCR for injection may also amplify the risk of infection. As a result of the low solubility HCR[2], the opioid must be crushed and dissolved before injection. It is common when using hydros that some of the leftover opiates are retained in the filter and cooker after the initial use. The remaining opioid in the used injection drug preparation equipment (IDPE) can be reused by solubilizing the residual drug with water (Kasper et al., 2018). This residual is referred to as a "wash" that can be stored, reused, or resold (Roy, Arruda, & Bourgois, 2011)[3]. Retaining the wash, and any other IDPE for the subsequent injection can increase the risk for blood-borne infections (Weir et al., 2019).

Laboratory studies demonstrate heating (or "cooking") the hydros (wash) to a boil before injection can significantly reduce the presence of HIV (Ball et al., 2018) and methicillin-resistant and methicillin-susceptible S. aureus[4] (Kasper et al., 2018). In June 2017, local researchers informed program staff and partners at Regional HIV/AIDS Connection (RHAC), London Intercommunity Health Center (LIHC), and the Middlesex-London Health Unit (MLHU) about the benefits of heating hydromorphone before injection. Since then, these agencies have been communicating this information to their clients who inject hydros. Also, these findings were shared more widely in the *London Free Press* (Richmond, 2017a, 2017b; Sher, 2018).

[1] In this case, Hydromorphone refers to dihydromorphinone and Hydromorphone Controlled Release (HCR). Dihydromorphinone and Hydromorphone Controlled Release sold under the brand names Dilaudid and Hydromorph Contin (HMC) respectively. PWID refer to Dilaudid and HMC as "Dee's" and hydros respectively. For the purposes of this report both HMC and Dilaudid will be referred to as "hydros".
[2] HCR capsule contains small beads that must be crushed prior to injection.
[3] HMC is more likely to produce a wash or multiple washes; however, Dilaudid can also produce a wash.
[4] Which can cause IE.

As a result of these studies, it was recommended by researchers that PWID should "cook your wash." This message was actively communicated to some portions of the population who inject hydros; however, there may be communication deficits and other unknown barriers to adopting the practice of "cooking", that are unmet by the communication to date. The purpose of this project was to identify barriers and the most effective dissemination methods to increase the uptake of this harm reduction practice.

Methods

Population

Focus group participants were required to meet the following inclusion criteria:

- Have injected hydros in the past six months,
- aged 18 years or older,
- speak and have a good command of the English Language, and
- have the capacity to provide consent.

Focus group participants were excluded under the following conditions:

- Do not inject hydros or
- are unable to give consent.

Front-line staff (FLS) at both RHAC and LIHC identified participants at each site who met the criteria.

FLS participants for key informant interviews were required to meet the following inclusion criteria:

- Have permission from their CEO/ED to participate,
- aged 18 years or older,
- speak and have a good command of the English Language, and
- work closely with PWID.

FLS were excluded under the following conditions:

- Do not provide services to PWID.

Design and Data Collection Tools

Between November 29, 2018, and January 30, 2019, 12 structured interviews were conducted with FLS from 11 agencies who support clients who inject hydros. Approval from each agency's Executive Director was sought before recruiting any FLS to participate. Each interview had between one and four FLS present, an interviewer, and a recorder who was taking notes. The notes were read back to interviewees for approval. Each interview was approximately one hour in length.

On December 12th and 13th, 2019, two focus groups with people who inject hydros were conducted at RHAC and LIHC. There was a total of 16 participants across both focus groups. Each focus group had one

outreach expert, one moderator, and two recorders to take notes. FLS from various agencies who work with PWID recruited clients for the focus groups. Before attending the focus groups, all participants were screened and consented to participate. Each participant received a meal plus a $40.00 cash incentive. During the focus group, the benefits associated with cooking a hydros wash were presented to participants by the outreach expert. While this is not typically part of a focus group methodology, the presentation was essential to ensure the harm reduction message was accurately conveyed to the group.

Qualitative Analysis

This project intended to determine the most effective ways to disseminate the "cook your wash" message across the PWID community. A summative inductive content analysis (Hsieh & Shannon, 2005) was conducted where a coding framework was established based on the focus group and interview guide; however, during the analysis process additional themes were added to the framework. This form of content analysis involved quantifying and comparing codes. The analysis was conducted using NVivo 10 for Windows with two independent analysts. One analyst attended all focus groups and interviews, and the other analyst was not involved in the project before the data analysis phase. The detailed coding reports were populated in NVivo 10 for Windows and further analyzed in Microsoft© Excel.

Approval

The Middlesex-London Health Unit's internal Research Advisory Consultation Lead approved the methodology and risk of the project in November 2018.

Results

The two independent analysts had a moderate-strong agreement for the majority of FLS Interviews and Focus Groups, with an average Kappa of 0.79. After coding the results independently, analysts reviewed any discrepancies in coding until full agreement was reached across all sources.

Source	Interrater reliability (Cohen's Kappa coefficient)	Level of agreement
Interview 1	0.58	Weak
Interview 2	0.78	Moderate
Interview 3	0.72	Moderate
Interview 4	0.81	Strong
Interview 5	0.77	Moderate
Interview 6	0.90	Strong
Interview 7	0.80	Strong
Interview 8	0.85	Strong
Interview 9	0.94	Almost perfect
Interview 10	0.73	Moderate
Interview 11	0.68	Moderate
Interview 12	0.83	Strong
Focus Group 1	0.79	Moderate
Focus Group 2	0.87	Strong

Figure 1. Initial interrater reliability by source with the level of agreement. Level of agreement based on research by McHugh (2012).

Understanding Hydros Preparation

The focus group participants described how to prepare hydros in the following three steps;

- crushing,
- dissolving in water (or other solution), and
- cooking or heating.

The order and the details of each step varied across focus group participants. The use of a pill crusher was only mentioned once by focus group participants. The majority of participants described repurposing other items such as a BIC© lighter, metal marker, ink pen with a metal tip, the top of nail polish or mascara, etc. to crush hydros. Focus group participants also described using injection drug preparation equipment

(IDPE) in innovative ways to crush hydros. For example, some clients will place the green cooker handle, included in the safe injection kits, on the plunger end of a 1cc syringe or the needle side of a 3cc syringe and use this to crush their hydros inside the cooker.

The perspectives of the focus group participants were mixed regarding whether to dissolve the hydro beads before crushing or to crush then dissolve. Some participants indicated that allowing the 'hydros beads' to sit in water made the crushing process easier. Regardless of the order, crushing and dissolving hydros in a solution were identified as necessary steps by all participants.

Many of the focus group participants included heating or cooking as part of their drug preparation. A few clients indicated heating hydros for at least 10 seconds or until the mixture bubbles.[5] FLS also indicated clients typically use lighters to heat hydros,

"…most of them are smokers, so they will have a lighter on them."

Some participants specifically mentioned the use of a lighter for cooking, but highlighted that a spark from a lighter and an alcohol swab could also be used to cook,

"Even if you have a lighter that doesn't work, all you need is an alcohol swab to spark it."

There were participants in the focus group who indicated they did not cook or did not include cooking when describing their drug preparation methods. For others, cooking occurs at certain times, but not others,

"I heat the first hit, and then I don't cook the wash."

"I'll heat for my last hit."

Focus group participants who did not cook their hydros often reported using the "Shake and Bake" method. When using this method, participants will crush the drug, remove the plunger and place the crushed drug in the syringe with some water, the mixture is shaken and then injected. Typically, the drug is not filtered or heated before injection when using this process. Participants described using this method with "Dees" or Dilaudid,

"I've been doing a 'cold shake' with Dilaudids, with no filter, the 'shake and bake'."

Sharing and Reusing Injection Drug Preparation Equipment

Injection Drug Preparation Equipment

Majority of focus group participants indicated they have shared IDPE with someone or would reuse their equipment. In particular, the group discussed sharing or reuse of needles and syringes with the highest frequency; however, participants were aware of the harms associated with sharing and reusing IDPE. Participants discussed that sharing or reusing equipment is likely occurring in specific circumstances,

[5] Heating the drug for 10 seconds or until it comes to a rolling boil is considered best practice.

"I usually don't reuse, but sometimes [I will reuse] the 3 [cc] barrel, or if it's my last one. I try not to reuse any of my gear though…"

"If it's my last rig [needle and syringe] and it's barbed, I'll sharpen it…"

Whenever possible, focus group participants described how they reduce harm when sharing or reusing IDPE,

"The 3s [3cc syringe] you can change the tip, I'll draw it up, and then I'll switch the tip."

However, some participants had experienced illness as a result of sharing or reusing IDPE and were strongly against this practice,

"There isn't a reason to reuse gear, London cares will come out to wherever you are [….] As much as you're sick, there is no point in grabbing a dirty rig…"

"I don't share gear, only clean stuff."

Sharing or Reusing Hydro Washes

With regards to sharing hydro washes, focus group participants spoke about how to store hydros washes with the greatest frequency. Preferences for how to store a wash for later use varied widely across focus group participants. Many participants indicated they would fold the cooker in half and then place it in a garment of clothing (e.g. pants, bra, underwear etc.) to preserve a wash.

"Fold the cooker in half, wrap it up in tissue paper put [it] in a pocket."

Other participants reported storing washes in a small bag without folding the cooker.

"I don't fold it [the cooker] I just put it in the bag."

FLS from organizations whose primary role is healthcare and outreach have also observed clients using these storage methods. Members of the focus group described using an additional cooker and green cooker handle to hold both cookers together. In some cases, focus group participants described holding two cookers together, one inside the other (Figure 2A) or the inside of both cookers facing each other (Figure 2B). In both, the two cookers are held together with the green cooker handle.


Figure 2A


Figure 2B

Figure 2. References to sharing or reusing washes across all participant groups by percent.

"I use two cookers, cup them, on inside the other and then put the green holder on."

When describing their storage methods, some focus group members indicated they would try to remove any remaining drug out of the cotton filter by squeezing it out and then throw the filter away. The primary reason given for removing the cotton filter from the wash during storage was to avoid cotton fever.

While the method for storing hydro washes varied across participants, the perspective that a wash has value was consistent across participants. Sharing a wash because of its value was the second most

frequently referenced topic among focus group participants and the most referenced topic with FLS when discussing the sharing or reuse of washes. A FLS reflects on the sharing or reuse of washes,

"They share their washes; they will give someone one [wash] for a place to stay for the night."

"The cookers are quite flimsy, especially if they have already been folded, unfolded and reheated again. Clients have concerns about losing their wash…"

"People exchange washes for anything, [….] people are trying to get as much of the drugs."

Members of the focus groups discussed the value of washes, but their comments also reflected instances in which they would be unwilling to give a wash to someone else or use a wash themselves.

"I won't give someone dirty gear, but I will give them my wash. I won't give it to someone if I double dip [put my needle into the cooker more than once]."

"I'll take you down the street to get you drugs; I'll tell them I haven't been feeling well for the past three days, and you shouldn't use my wash."

"People think it's because you're greedy, but you just don't want to put them at risk."

These comments indicate those focus group participants have an awareness of the harms associated with taking a wash from someone else and giving a wash to someone else. While participants discussed cooking as part of their preparation method, there were only two instances where they specifically mentioned cooking their hydros wash (as opposed to their initial hydros preparation or hit). Conversely, others indicated they cook the initial hydros preparation, but not the wash. Regardless of when participants said they would cook, it is an inconsistent practice,

"I don't cook the first pull, but I'll cook the wash. I don't sometimes because I don't have a lighter, or I don't have time."

Throughout the discussion, focus group participants seemed to delineate between the sharing of IDPE and the sharing of a wash (in a cooker). While it was clear that some participants were aware of the harms associated with sharing or reusing a wash, focus groups members referenced the harms associated with sharing other IDPE twice as many times as the harms associated with sharing a cooker with a hydros wash. It was unclear if all participants perceived sharing a hydros wash as being equivalent to sharing other IDPE; however, in at least one case, sharing a wash was referred to as IDPE (or "gear").

"I don't feel good about giving my used gear [used cooker]. I don't feel comfortable giving to someone knowing there is a risk there."

"I cook my wash and the second pull; I know there are a lot of people who will say they will cook your wash, but they don't."

Barriers to Cooking Hydros

FLS and focus group participants identified fourteen barriers to cooking hydros. There were four leading barriers to cooking hydros that were consistent across PWID and the three groups of FLS agencies (in

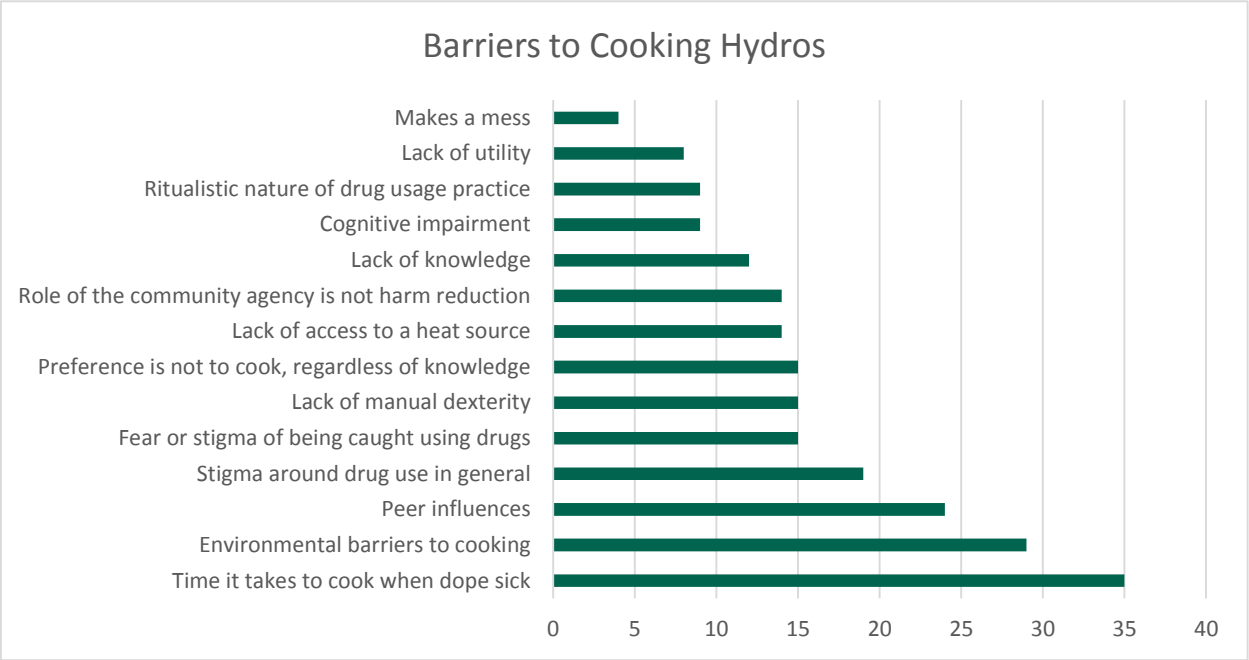

Figure 3. Number of references to the barriers to cooking hydros across all participant groups.

order of frequency); the time required to cook hydros when feeling dope sick, environmental barriers to cooking, peer influences, and the stigma around drug use in general. The fifth most commonly identified barriers to cooking were, the preference not to cook regardless of knowledge, a lack of manual dexterity, and the lack of a heat source.

From the perspective of PWID, the time it takes to cook when dope sick was the principal barrier to cooking. Many focus group participants indicated that ten additional seconds needed to cook when preparing a hit is a significant obstacle,

> *"If you are sick, you're gonna hit that shit. I'm not going to bother cooking it."*

In many cases, PWID described the moments feeling dope sick before a hit as a time to weigh various factors. Cooking is not the only step skipped in the hydros preparation process when time is a concern; focus group participants referred to the "shake and bake" method (described above).

> *"I cook it more for the quality of the hit. If it were the other way around [the hit was better without cooking], I probably wouldn't cook."*

The second most identified barrier to cooking hydros by PWID was peer influences. Specifically, focus group participants indicated they listen to their peers, and this is particularly true for people who are new to injecting hydros,

"New users will do what they see others doing."

Participants indicated the only time they would be less inclined to trust other PWID is if the person appears to be sick or is constantly unwell. The third most common hindrance to cooking by PWID was the preference not to cook, even when there is an awareness of the harms of not cooking hydros. In a few instances, during the focus groups, participants specifically mentioned knowing it was safer to cook hydros, but they enjoy not cooking. One participant indicated they were willing to risk infection to maintain this preference,

"I just enjoy it [not cooking] psychologically, I'm willing to take the risk."

FLS from all agency types identified environmental barriers to cooking with the highest frequency, followed by the time it takes to cook when dope sick and the stigma associated with drug use. In some instances, environmental barriers were specific to having to prepare hydros outside or in a public place. FLS indicated that concealing drug use is a serious concern if a PWID needs to inject in a public place. Cooking can make drug practice more difficult to conceal due to the black residue left on the bottom of the cooker after cooking with a lighter. During the focus groups, some participants noted the black residue could be avoided by ensuring the lighter and cooker to do not make contact; however, this process requires a longer cooking time.

Also, if a client is using outdoors, it may be difficult for a low-quality lighter to hold a flame long enough to cook. Unstable housing is another environmental factor that can make it difficult to cook regularly. While not coded as a separate theme, FLS referenced safety concerns in 17% of environmental concern references. Safety concerns were not associated with any other barrier. The FLS also identified the time it takes to cook when feeling dope sick as a significant barrier to cooking hydros. One FLS compared the seconds taken to cook hydros before a hit as "a lifetime".

"Those 6-8 seconds is a lifetime, especially when you are dope sick."

Mental health agencies highlighted cognitive impairment as the third most referenced barrier to cooking.

Beliefs about Cooking Hydros

The main belief about cooking hydros identified by FLS and PWID was the concern that cooking would weaken the impact of the drug. This belief appeared to have an impact on cooking behaviours and could be considered a barrier to cooking hydros.

"There is a perception that cooking hydros will wreck the drug here in London, … You don't hear it as much today, but back in 2017."

Some focus group participants believed cooking increases the viscosity of the drug making it more difficult to draw up into the syringe; however, this belief did not appear to discourage cooking behaviours. In the focus groups, a few participants held an alternative view about cooking. Some indicated they believe cooking hydros improved the quality of the high.

While not specifically related to cooking, individuals in the focus groups indicated adding Vitamin C to the hydro mixture increases the quality of the high of the first hit or the hit of subsequent washes.

Facilitators to Cooking Hydros

Overall, the greatest facilitator to cooking hydros was the trust clients have in staff at community agencies (31%), followed by the need for additional injection drug preparation equipment (IDPE) (25%), and using the Temporary Overdose Prevention Site (TOPS) (20%). (Please see the Appendix for an additional description of these references.)

While PWID indicated that additional IDPE and being at TOPS assist them in cooking their hydros, the risk for infection or reinfection was the primary facilitator for cooking. Many focus group participants indicated they were ill or knew someone who was ill as a direct result of not cooking hydros.

"I do it [cook] out of experience, I've been in the hospital four times with blood infections."

"It wasn't until I got a blood infection and [started going to] TOPS, that I started cooking."

A number of the focus group participants affirmed that when community agencies and other peers began talking about cooking hydros more frequently, which has made it easier to remember to cook.

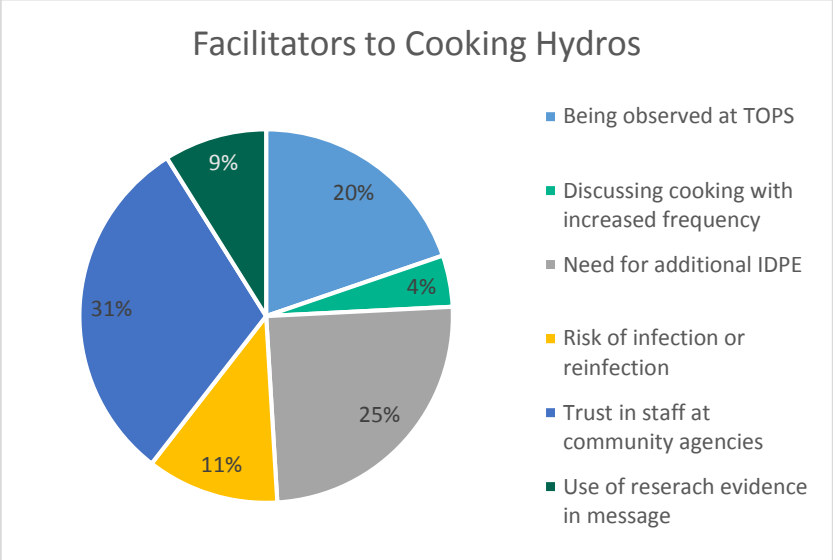

Figure 4. References to facilitators to cooking hydros across all participant groups by percent.

FLS also commonly reported that additional IDPE and being at TOPS as facilitators; however, the trust between staff and client was seen as the leading facilitator to cooking by FLS. Even though trust in staff at community agencies was not a leading facilitator to cooking by focus group participants, it does ring true for some,

"… [It's fine] when you hear it from another [PWID], but it's more believable if you hear it from a nurse or outreach worker."

Only FLS at mental health agencies placed the need for additional injection drug equipment over the trust in staff. Both mental health and agencies that work with street-involved people believe incorporating research evidence into the message would facilitate cooking; whereas, the included agencies that provide healthcare or outreach services perceived using at TOPS as being the greatest facilitator to cooking.

FLS indicated if PWID have an unstable housing situation, but can make it to TOPS, this can significantly mitigate many environmental barriers.

Adjusting Hydros Preparation Methods

FLS from all organization types indicated they would provide suggestions of how to reduce harm with their clients that use hydros; however, organizations that provide healthcare and outreach services referred to guiding their clients with the highest frequency. The majority of these references described opportunities to support clients with their hydros preparation method at the Temporary Overdose Prevention Site (TOPS). When it comes to cooking, these organizations consistently provide this as a suggestion to their clients. Staff indicated clients are receptive to the suggestion of cooking their hydros in most cases; however, this is dependant on the specific client and how they are feeling,

> *"It depends on the person, the day and what's going on for them, how responsive they'll be [to the suggestion of cooking]. [….] When you do have the conversation, it's a learning opportunity. It might not be right before the hit, but it might be a conversation that we have after the hit."*

Only FLS from a couple of organizations referred to guiding their clients about cooking their hydros a few times.

Effective Methods for Knowledge Translation

Who Should Give and Receive the Message?

When asked who should provide the message to "cook your wash" to PWID, participants referenced one-to-one with an Outreach Worker, with the highest frequency. While organizations that provide healthcare and outreach services supported this message, this was also reinforced by the other organization types and most importantly focus group participants,

> *"There is a bunch of front-line staff, as long as you guys know, that's your best bet. They come in contact with people who use every day."*

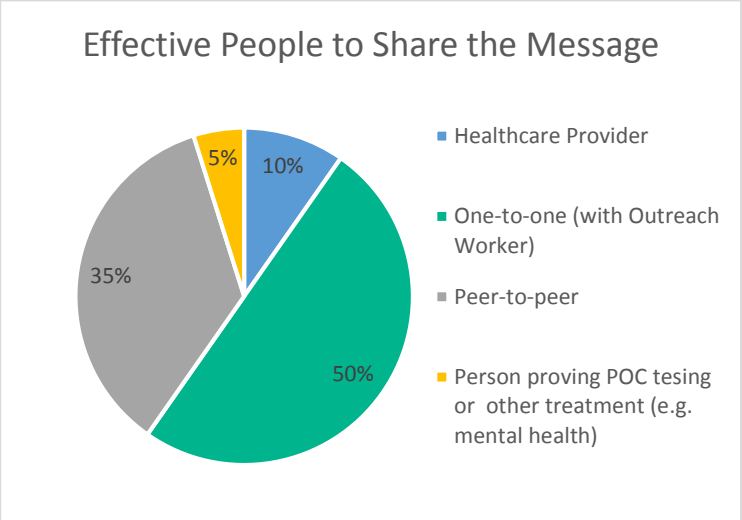

Figure 5. References to effective people to share the message to across all participant groups by percent.

In this case, the participant is referring to FLS who have one-to-one interactions with PWID. Additionally, a couple of members of the focus group indicated the staff at London Cares who operate the Homeless Response Services Mobile Unit would be a good source to provide the message.

Providing the message through peers was the second most referenced group who were believed to be effective in providing this message. When referenced, peers simply denoted other PWID. From the perspective of FLS, word of mouth among PWID is one of the fastest ways to share a message.

"… in the injection community information moves so fast."

Focus group participants indicated that peers share messages by word of mouth, but also by performing this harm reduction behaviour in front of other people who inject hydros,

"[We,] the people who care enough to come to the focus group need to tell five people, and then they will tell their friends."

"If someone is surrounded by people who cook their dope, then they will start [cooking]."

There were a couple of comments from FLS that discuss sharing the message with clients through a more formal peer support program. A formal peer program would include specific peers who would provide the message to other members in their peer group.

"They are going to listen to someone who's been there, rather than someone who has an 'education'"

"Peer support programs are amazing, and we should have more for sure. There is a guy at […] who is a user, and he is an advocate for harm reduction."

However, other FLS were more cautious with regards to peer-to-peer knowledge, indicating it is important to select the most appropriate peer for the position. It is important the peer is trusted among their peers but is also skilled at delivering the message. Participants also indicated healthcare providers and the individuals who provide Point of Care (POC) testing and other services such as mental health or wound care treatment might also be useful in disseminating this message.

In addition to peers and outreach workers, all participant groups recommended that all staff at community agencies who work with PWID should be made aware of the importance of cooking hydros, to ensure the message is consistent within and between agencies.

What Words Should the Message Include?

In terms of specific words to include in the message, PWID used the word "cook" twice as often as "heat" when describing cooking a hydros wash. The focus group participants almost exclusively used the word "cook" when discussing this practice. The word "boil" was only used a few times across all the FLS interviews. The word "gear" was the most common word to describe IDPE in general; however, focus group participants often used the word "rig" when discussing preparing a needle and syringe for injection. FLS staff highlighted the importance of collaborating with PWID to ensure the most appropriate language is used to deliver the message.

Where to Share the Message?

The Temporary Overdose Prevention Site (TOPS), other community agencies and a place where a group of PWID could meet were identified as the most effective places to disseminate the message. FLS and participants indicated TOPS as being the best place to receive the message. From the perspective of the focus group participants, TOPS is a good place to provide the message because PWID are already receiving the message there, and it is a place where they go for additional support. TOPS is also a useful place to relay this message because it eliminates many of the identified barriers to cooking such as the fear of being caught doing drugs.

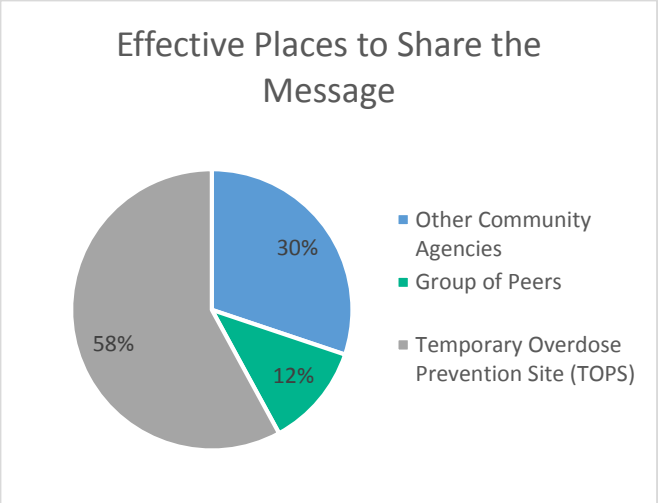

Figure 6. References to effective places to share the message across all participant group by percent.

"TOPS will help people cook because you don't have to worry about getting caught [using] in a washroom."

It may also minimize the environmental barriers that make it difficult to cook,

"You do feel safer [when using the site]."

the need for a heat source,

"They provide the lighters at TOPS when you ask for one."

and may even allow PWID to overcome preferences and re-evaluate if cooking is worth the time during dope sickness.

"TOPS helps me cook it every time. It makes me feel worthy of injecting safely. I have more self-esteem because the people there give a shit about me."

"People need to feel better about themselves; we need a reason to be safe. TOPS makes us feel safe."

All focus groups members recommended any community agency that supports PWID is a good place to share this message. Participants suggested bathrooms within each agency as a good place to provide the message. Additionally, pharmacies and clinics that provide treatment for PWID (e.g. methadone clinics) may also be useful locations.

How to Share this Message?

Both FLS and focus group participants provided a variety of recommendations about how best to share the message with PWID. Almost half (47%) of the recommended items were a type of heat source, with a lighter as the most popular choice. Further, a lighter was the only heat source specifically mentioned by focus group participants when describing their preparation methods. FLS also indicated that many of their clients already have lighters.

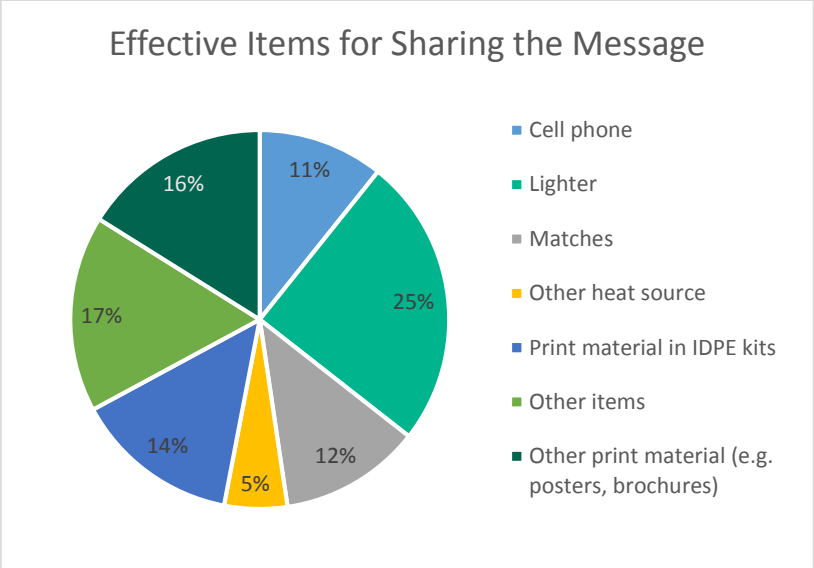

Figure 7. References for effective items for sharing the message across all participant groups by percent.

> *"Clients typically use lighters to cook, most of them are smokers, so they will have a lighter on them."*

While most focus group participants typically have lighters, they are easily lost or stolen. Also, this did not convince some participants that a lighter was enough to get people to cook.

> *"Lighters are probably not going to help people cook."*

> *"Adding a heat source, but not necessarily [a lighter] because a lot of people have lighters."*

A focus group participant highlighted that providing lighters as IDPE may become cost prohibitive,

> *"Funding-wise, people will steal. It [providing lighters] could get very expensive."*

The cost associated with providing lighters was further supported by FLS who emphasized the importance of being able to offer any item needed for injection drug preparation continually. Providing IDPE and then discontinuing an item without a suitable replacement will make it difficult for clients to adopt an adjustment like cooking into their injection drug preparation practices.

> *"Whatever it is, it has to be continuous. We are not going to set-up a client on a new way of doing things and then say we don't have it anymore."*

Alternatively, matches were also suggested as an option for a heat source. FLS indicated matches as more sustainable financially and would be less likely to be traded or stolen. FLS also provided examples of matches being offered previously within the Middlesex-London community and in other jurisdictions. However, it was highlighted by focus group participants that matches would be less convenient than a lighter for cooking.

FLS and focus group participants both emphasized the importance of accompanying the message with a visual or image. All participant groups also echoed the need for the message to be predominately visual. Whether or not the image should be on a poster or some other print material was mixed. Some respondents indicated it might be difficult for a poster with this message to stand out if it is surrounded by a host of other messages. Ensuring the message stands out could be particularly problematic at TOPS given the amount of signage on site.

What May Not Work

FLS did not indicate any specific words that would be problematic to include in the message,

"In terms of language, nothing is really taboo."

But they emphasized the need for the message to be short, in plain language and to avoid using any superfluous words. Additionally, FLS highlighted that the wording of the message should be suggestive rather than directive and not include words like "don't" or "must." Further, FLS indicated the message should not be judgemental in any way, indicating the individual was doing something wrong by not cooking their hydros.

"The message needs to be … something that doesn't mean that you [the client] messed-up in some way. A message that is non-judgemental truly."

Discussion

There are three key steps to preparing hydros that appear to be consistent among users; crushing, dissolving in water (or another solution), and cooking. Other items such as a lighter are often repurposed as a crusher; however, many PWID are using new IDPE in innovative ways to crush their hydros. The order of the first two steps is often interchangeable. When dissolved, PWID will typically use a lighter to cook. Many PWID report cooking but do so inconsistently outside of TOPS where there are additional barriers to cooking. Lastly, if the 'shake and bake' method is used to prepare hydros, the preparation is not usually cooked.

PWID identified the time it takes to cook when dope sick and peer influences as the most substantial barriers to cooking. Unlike other barriers, merely providing a heat source or the risk of infection is less likely to diminish these hindrances to cooking. Similarly, if peers tell PWID that cooking will negatively impact the high, facilitators like research evidence describing the benefits of cooking may have little impact. However, the ability to use at TOPS along with the environment at TOPS may be enough to reduce these barriers. Additionally, being at TOPS can also eliminate environmental barriers and the risk of being caught using drugs in a public place. While ensuring clients can use TOPS appears to be an effective way for PWID to cook consistently, it is only useful for those who can get to TOPS during its hours of operation. Also, some PWID are not comfortable using TOPS and based on the findings of this study, this is more problematic for women than for men.

The findings of this report support that PWID are aware of the harms associated with sharing or reusing IDPE and will try to minimize harm when doing so. Despite knowledge of these harms, some PWID do share or reuse IDPE; however, for some, the risk of becoming ill is greater. Sharing or reusing hydro

washes were discussed with much higher frequency than sharing or reusing IDPE. PWID spoke at length about how they store hydro washes; this is likely because of the value of the wash. It appears that PWID do not perceive sharing or reusing a cooker with a wash to be as harmful as sharing other IDPE; as long as new equipment is used for the initial preparation. This belief could be reinforcing the lack of perceived utility to cooking.

Aside from the perceived lack of utility to cooking, the only belief identified that could inhibit cooking was based on the fact that some PWID believe that cooking hydros may ruin the quality of the high. Since peers communicate this belief, the influence that peers who have negative beliefs about cooking is a barrier to cooking. This belief did not appear to be consistently believed by many participants, but could be problematic if heard by newer, more impressionable users.

PWID identified the risk of infection or reinfection as the greatest facilitator to cooking. While the use of research evidence in the message was only mentioned a few times by PWID, it may be beneficial if a message about the risk of becoming ill was well supported by research evidence. The message should be accompanied by an impactful visual or image to improve the uptake of the message. In addition to keeping the message as short as possible, certain words were identified to increase the acceptability of the message further. PWID may need to be further consulted regarding the specific terms to include in the message. Ideally, outreach workers and other front-line staff should provide this message consistently. It may be valuable to have peers support the delivery of this message, but more information and processes may be needed to ensure the successful dissemination of this message. Regardless of whether peers will play a formal role in delivering this message, it is important that people who inject hydros are further consulted on the final message.

All participant groups identified the need for additional IDPE, specifically a heat source and a sterile crusher. PWID have been addressing the need for a sterile crusher by using existing IDPE in innovative ways. The repurposing of existing IDPE increases the likelihood that these items will be consistently used. Other items (not included in the IDPE) that are used as crushers, can potentially transfer bacteria into the hydro solution. From the perspective of PWID, a lighter was the most frequently identified heat source; however, both participant groups indicated the presence of lighters as relatively common in the injection drug community. Due to the presence of other barriers, some people who inject hydros were not convinced that providing their peers with a lighter would lead to more cooking. Lastly, FLS staff stressed the importance of the continued and consistent supply of any offered heat source.

Limitations

The decision not to audio-record the FLS interviews and focus groups with PWID limited the use of the direct quotations. Key stakeholders informed this decision during the development of the study. They indicated that PWID would not feel comfortable with this practice. To address this issue, interview and focus group notes were taken on a laptop and read back to participants for validation.

Many of the PWID in the focus groups were selected by FLS at the organizations hosting the focus group. It is possible the views of these participants reflect the opinions of a subset of the PWID community that

use these services. The views of PWID who do not use these community services may be underrepresented in this analysis.

Summative inductive content analysis was the most appropriate methodology for this project because it enables the counting and comparison of coded material to identify the most effective way to communicate with PWID; however, this method has the potential to miss under-referenced themes within the focus group or interview. This limitation is particularly problematic when topics discussed are of sensitive nature. However, since FLS were discussing their day to day work and PWID were referencing a frequent practice (injection drug use), this is not likely a limitation in this case.

Appendix

Project Team

Name	Team Role	Position	Organization
Marilyn Atkin	Data collection support	Program Lead, Community Outreach and Harm Reduction	Middlesex-London Health Unit (MLHU)
Christine Brignall	Data collection support, Evaluation consultation, Analyst, Report author	Program Evaluator	
Sheila Densham	Project lead	Health Promoter	
Shaya Dhinsa	Project sponsor	Manager, Sexual Health	
Elyse Labute	Analyst, Report editor	Program Evaluator	
Meera Shah	Data collection support	Research Assistant	St. Joseph's Health Care London
Dr. Michael Silverman	Subject matter expert	Infectious Diseases Clinic Physician	
Ryan Wong	Data collection support	Research Assistant	
Sameena Vadivelu	Data collection support, Evaluation consultation	Program Evaluator	MLHU

Code Descriptions

This section includes a brief description of the codes used to analyze the data.

Code	Description
Need for additional IDPE	The need for additional equipment to safely inject that is not currently included in the safe injection kits, the needle exchange program or any other organization that provide free IDPE.
Being at TOPS	Includes items that describe the comfort and safety clients feel when injecting at TOPS; positive changes in cooking beliefs or behaviours as a result of being at TOPS.
Using research evidence in the message	Includes items that describe the positive changes in cooking beliefs or behaviours when the benefits of cooking are supported by research evidence. This also includes the presentation of figures or images depicting the results of a research study.
The risk of infection or reinfection	Includes items that describe the positive changes in cooking beliefs or behaviours due to the increased risk of contracting an infection or becoming ill as a result of not cooking.
Discussing cooking with increased frequency	Includes items that describe a positive change in cooking beliefs or behaviours as a result of the topic of cooking being discussed more often (typically by FLS). Also, the importance PWID place on messages that are heard with increased frequency.

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MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 042-19

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2019 May 16

SUMMARY INFORMATION REPORT – MAY 2019

Recommendation

It is recommended that Report No. 042-19 re: "Summary Information Report - May 2019" be received for information.

Key Points

- Overview of the TVDSB, Southwestern Public Health, MLHU School Partnership Declaration, which sets out why and how we work collaboratively to reach one common goal: the well-being of children and youth.

TVDSB Partnership Declaration

In 2017, the Council of Ontario Directors of Education (CODE) and the Council of Ontario Medical Officers of Health (COMOH) recommended that district school boards (DSBs) and public health units (PHUs) create a Partnership Declaration outlining a shared commitment to creating and sustaining healthy school environments and communities that contribute to the well-being of children and youth. Included in this recommendation are guidelines to advance the creation of the Partnership Declaration. MLHU and the Southwestern Health Unit both serve the same school board partners and thus decided to work collaboratively to create one Partnership Declaration with the Thames Valley District School Board (TVDSB).

The Partnership Declaration sets out why and how we work collaboratively to reach one common goal: the well-being of children and youth. Declaration committee membership includes representation from PHU managers, dietitians, and health inspectors, and DSB superintendents, principals, learning supervisors, and learning coordinators. Example terms and expectations outlined in the Declaration include strategies for enhanced collaborative planning, opportunities for sharing data, and joint assessment of the need for public health services and resources in schools.

The Partnership Declaration for TVDSB, Southwestern Public Health, and MLHU is complete, and will be signed by the Director of Education and the Medical Officers of Health. The Partnership Declaration is an important step in helping community institutions meet their required public health outcomes. We look forward to working closely with TVDSB and Southwestern Public Health, and building collaborative partnerships.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health / CEO

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 043-19

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2019 May 16

MEDICAL OFFICER OF HEALTH ACTIVITY REPORT FOR MAY

Recommendation

It is recommended that the Board of Health receive Report No. 043-19 re: "Medical Officer of Health Activity Report for May" for information.

The following report presents activities of the Medical Officer of Health (MOH) for the period of April 8, 2019, to May 3, 2019.

April 8	Met with Dr. Lisa Simon, Associate Medical Officer of Health, Simcoe Muskoka District Health Unit, to tour the London Temporary Overdose Prevention Site (TOPS) Chaired teleconference meeting of advisory group in regard to the Council of Medical Officers of Health (COMOH) position on climate change
April 9	Phone meeting with Board of Health (BOH) Chair to discuss the agenda for the Board's upcoming meeting
April 10	Chaired meeting of the COMOH Executive Committee Met with Ed Holder, Mayor, City of London, to discuss the opioid crisis
April 11	Phone meeting with planning group for the April 28 Public Health Physicians of Canada Continuing Professional Development (PHPC CPD) Day: Problematic Substance Use Session Attended the City of London Budget Analysis Session at City Hall
April 12	alPHa Executive Committee teleconference in regard to the provincial budget announcment Participated in several media interviews in regard to the provincial budget announcement
April 15	Attended session three of the "Leading From the Inside Out: Tranforming Leadership" session delivered by Pillar Nonprofit Network Phone meeting with Kevin Davis, Mayor, Brantford, to discuss the opioid crisis
April 16	Teleconference with alPHa Board members in regard to the 2019 budget
April 17	One-on-one phone call with Ms. Peggy Doe, Coach Meeting with Ms. Kelly Gillis, Carswell Partners
April 18	Met with staff from Sagecomm for an interview in regard to housing and the social determinants of health Attended the Board of Health meeting
April 23	Attended Vic Fedeli's Address on Budget 2019 event, sponsored by the London Chamber of Commerce

April 24	Participated in COMOH teleconference Met with Kate Young, MP for London West, to discuss the local opioid crisis
April 25	Attended the Middlesex Municipal Day event held in Strathroy-Caradoc
April 26	Participated via teleconference in the alPHa Board of Directors meeting
April 28	Presented at the Public Health Physicians of Canada Conference in Ottawa
April 30	Phone call with Dr. David Williams to discuss matters of public health interest
May 1	Attended a meeting of local public sector CEO/CAOs at the Chef's Table One-on-one phone call with Ms. Peggy Doe, Executive Coach
May 2	Attended the Finance & Facilities Committee meeting Attended the Keeping Women and Children Safer by Sheltering Men advisory meeting
May 3	Guest speaker on the Ask Me Anything morning program at CJBK Radio Participated in alPHa Executive Committee teleconference Participated in teleconference with Ministry staff in regard to Public Health Modernization

This report was submitted by the Office of the Medical Officer of Health.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health / CEO

CORRESPONDENCE – MAY 2019

a) Date: 2019 March 29
Topic: North Bay Parry Sound District 2018 Annual Report
From: North Bay Parry Sound District Health Unit
To: Ontario Boards of Health

Background:

On March 29, 2019, North Bay Parry Sound District Health Unit released its 2018 Annual Report showcasing accomplishments over the past year.

Recommendation: Receive.

b) Date: 2019 April 3
Topic: *Bill 60, An Act to amend the Ministry of Community and Social Services Act to establish the Social Assistance Research Commission*
From: Peterborough Public Health
To: The Honourable Lisa MacLeod, The Honourable Christine Elliott

Background:

On April 3, 2019, the Board of Health for Peterborough Public Health wrote to Ministers Lisa MacLeod and Christine Elliott in support of the North Bay Parry Sound District Health Unit's call for the establishment of the Social Assistance Research Commission. Refer to correspondence item l) in the March 21, 2019 Board of Health agenda.

Recommendation: Receive.

c) Date: 2019 April 3
Topic: Child Visual Health and Vision Screening
From: Southwestern Public Health
To: The Honourable Christine Elliott

Background:

On April 3, 2019, Southwestern Public Health's Board of Health wrote to Minister Christine Elliott expressing concerns regarding funding for the Child Visual Health and Vision Screening protocol. To ensure that the program is operational and sustainable, it is requested that additional funding be provided to implement this program within schools for all senior kindergarten children.

Recommendation: Receive.

d) Date: 2019 April 3
Topic: Funding for Healthy Babies, Healthy Children program
From: Peterborough Public Health
To: The Honourable Lisa MacLeod

Background:

On April 3, 2019, the Board of Health for Peterborough Public Health wrote to Minister Lisa MacLeod in support of the Thunder Bay District Health Unit's call to action regarding funding for the Healthy Babies, Health Children program funding. Refer to correspondence item b) in the January 24, 2019 Board of Health agenda.

Recommendation: Receive.

e) Date: 2019 April 2
Topic: Strengthening the *Smoke-Free Ontario Act, 2017*
From: Perth District Health Unit
To: The Honourable Doug Ford

Background:

On April 2, 2019, the Board of Health for Perth District Health Unit wrote to Premier Doug Ford in support of strengthening the *Smoke-Free Ontario Act, 2017* to address the promotion of vaping. The Perth District Health Unit supports banning all advertisements at any point-of-sale location where youth have access thereby to restrict promotion of vaping products at vapour product retailers. Refer to correspondence item n) in the March 21, 2019 Board of Health agenda.

Recommendation: Receive.

f) Date: 2019 April 4
Topic: Post-2018 municipal election
From: Association of Local Public Health Agencies (alPHa)
To: Ontario Boards of Health, Board of Health members

Background:

The Association of Local Public Health Agencies (alPHa) congratulates all Board of Health members on becoming elected officials and representing their communities, and becoming advocates on behalf of their constituents. Municipally elected officials can play an essential role in supporting public health unit activity by becoming members of their local Board of Health.

Recommendation: Receive.

g) Date: 2019 April 12
Topic: Association of Municipalities Ontario (AMO) 2019 budget highlights
From: Association of Local Public Health Agencies (alPHa)
To: Board of Health Chairs

Background:

On April 12, 2019, the Association of Local Public Health Agencies (alPHa) issued a bulletin regarding the 2019 provincial budget. With respect to public health in 2019–20, the government will: a) improve program and back-office efficiencies by adjusting provincial-municipal cost sharing of

public health funding; b) by 2020–21, establish 10 regional public health entities and 10 new regional Boards of Health with one common governance model; and c) by 2021–22, expect changes to lead to annual savings of $200 million.

Recommendation: Receive.

h) Date: 2019 April 12
Topic: Ontario Budget 2019
From: Association of Local Public Health Agencies (alPHa)
To: Boards of Health

Background:

On April 12, 2019, the Association of Local Public Health Agencies (alPHa) issued a news release expressing concern regarding the provincial government's plans to restructure Ontario's public health system and reduce its funding by $200 million per year. This outcome will greatly reduce the ability to deliver the frontline local public health services that keep people out of hospitals and doctors' offices.

Recommendation: Receive.

i) Date: 2019 April 10 (received April 16)
Topic: Support for *Bill S-228, Child Health Protection Act*
From: Public Health Sudbury & Districts
To: Ontario Boards of Health

Background:

On April 10, 2019, the Public Health Sudbury & Districts Board of Health wrote to the Senate of Canada reaffirming full support for *Bill S-228, Child Health Protection Act*, which would ban food and beverage marketing to children under 13. Regulation of food and beverage marketing to children is considered an effective and cost-saving population-based intervention to improve health and prevent disease.

Recommendation: Receive.

j) Date: 2019 April 17
Topic: Restructuring Ontario's public health system
From: KFL&A Public Health
To: The Honourable Christine Elliott, The Honourable Steve Clark

Background:

On April 17, 2019, the Board of Health of KFL&A Public Health wrote to Ministers Christine Elliott and Steve Clark expressing disappointment about the proposed $200-million-per-year reduction in funding for local public health services. These reductions will impact the ability to deliver frontline public health services. KFL&A Public Health requests that the Province of Ontario maintain its current funding formula and stop the planned reduction of Ontario public health units from 35 to 10

and instead initiate consultations with municipalities and public health agencies on the public health system in Ontario.

Recommendation: Receive

k) Date: 2019 April 17
Topic: Modernization of alcohol retail sales in Ontario
From: Simcoe Muskoka District Health Unit
To: The Honourable Christine Elliott

Background:

On April 17, 2019, the Simcoe Muskoka District Health Unit Board of Health wrote to Minister Christine Elliott urging the Government of Ontario to develop a comprehensive provincial alcohol strategy. Refer to correspondence item e) in the February 21, 2019 Board of Health agenda. Recent changes in the way alcohol is sold and the 2019 Ontario Budget released on April 11, 2019, suggest that economic interests are superseding the health and well-being of Ontarians. The Simcoe Muskoka District Health Unit encourages the government to develop a provincial alcohol strategy and include a monitoring and evaluation plan to measure intended and unintended impacts of policy change.

Recommendation: Receive.

l) Date: 2019 April 18
Topic: Public health restructuring
From: Thunder Bay District Health Unit
To: Ontario Boards of Health

Background:

On April 17, 2019, the Board of Health for Thunder Bay District Health Unit (TBDHU) issued a resolution to affirm its support for TBDHU. In addition, TBDHU requests that the Province of Ontario maintain its current funding for TBDHU and initiate consultation with municipalities and public health agencies on the public health system in Ontario.

Recommendation: Receive.

m) Date: 2019 April 18
Topic: 2019 Budget and public health impact
From: Perth District Health Unit
To: The Honourable Doug Ford, The Honourable Christine Elliott

Background:

On April 18, 2019, the Board of Health for the Perth District Health Unit wrote to Premier Doug Ford and Minister Christine Elliott regarding the proposed changes to local public health. The Board moved to request that the Province of Ontario maintain the current funding formula and initiate consultations with municipalities and public health agencies on the public health system in Ontario.

Recommendation: Receive.

n) Date: 2019 April 18
Topic: U=U community sign-on submission
From: Bob Leahy, Managing Director (Canada) and Global Outreach Director, Prevention Access Campaign
To: Dr. Christopher Mackie, Medical Officer of Health/CEO

Background:

On April 18, 2019, the Middlesex-London Health Unit received confirmation for signing up in support for U=U and joining the U=U network. Refer to correspondence item p) in the March 21, 2019 Board of Health agenda in which the Board of Health endorsed the Council of Ontario Medical Officers of Health (COMOH) resolution on HIV case management.

Recommendation: Receive.

o) Date: 2019 Apri1 19
Topic: alPHa communication on the Ontario Budget 2019 and teleconference summary
From: Association of Local Public Health Agencies (alPHa)
To: Board of Health Chairs

Background:

On April 19, 2019, the Association of Local Public Health Agencies (alPHa) issued the draft minutes of their teleconference held on April 18, 2019, along with their communication on the Ontario Budget, alPHa's news release, and communication materials to be shared with Board of Health chairs.

Recommendation: Receive.

p) Date: 2019 April 24
Topic: alPHa Position Statement – Impact of Reducing Investments in Public Health
From: Association of Local Public Health Agencies (alPHa)
To: Ontario Boards of Health

Background:

On April 24, 2019, the Association of Local Public Health Agencies issued a position statement regarding the 2019 Ontario Budget and its concerns regarding the restructuring of Ontario's public health system.

Recommendation: Receive.

q) Date: 2019 April 24
Topic: 2019 Ontario Budget
From: Halliburton, Kawartha, Pine Ridge District Health Unit
To: The Honourable Doug Ford, The Honourable Christine Elliott

Background:

On April 24, 2019, the Board of Health for the Halliburton, Kawartha, Pine Ridge District Health Unit wrote to Premier Doug Ford and Minister Christine Elliott regarding its concern over the Government of Ontario's plans to restructure Ontario's public health system. Halliburton, Kawartha, Pine Ridge urges the government to leave the current public health structure as it is.

Recommendation: Receive.

r) Date: 2019 April 24
Topic: Ontario's public health system
From: Leeds, Grenville and Lanark District Health Unit
To: The Honourable Christine Elliott, The Honourable Steve Clark

Background:

On April 23, 2019, the Board of Health for Leeds, Grenville and Lanark District Health Unit (LGLDHU) wrote to Ministers Christine Elliott and Steve Clark expressing support for the LGLDHU's staff in all the work they perform. The LGLDHU Board of Health is disappointed by the Government of Ontario's budget announcement to restructure Ontario's public health system and recommends several principles to be adopted in the development of the Regional Public Health Entity. These principles include: a) no loss of service to our community, b) meaningful involvement in planning, c) integrity of health units, d) similar health unit populations be grouped together, e) equitable access to new positions for current employees, f) effective back-office support, and g) an appropriate municipal role in governance.

Recommendation: Receive.

s) Date: 2019 April 24
Topic: Support for *Bill 60, Establishing Social Assistance Research Commission*
From: Halliburton, Kawartha, Pine Ridge District Health Unit
To: The Honourable Doug Ford

Background:

On April 18, 2019, the Board of Health for the Halliburton, Kawartha, Pine Ridge District Health Unit wrote to Premier Doug Ford in support for the establishment of a Social Assistance Research Commission under the *Bill 60, Ministry of Community and Social Services Act, 1990*. Refer to correspondence item b), above, and correspondence item l) in the March 21, 2019 Board of Health agenda.

Recommendation: Receive.

t) Date: 2019 April 25
Topic: Endorsement of Ontario Dietitians in Public Health letter on *Bill 60*
From: KFL&A Public Health
To: The Honourable Lisa MacLeoad

Background:

On April 25, 2019, the KFL&A Board of Health wrote to Minister Lisa MacLeod in support for *Bill 60*, which is to establish a Social Assistance Research Commission. Refer to correspondence items b) and s), above, and correspondence item l) in the March 21, 2019 Board of Health agenda.

Recommendation: Receive.

u) Date: 2019 April 25
Topic: Expansion of sales of beverage alcohol in Ontario
From: KFL&A Public Health
To: The Honourable Doug Ford

Background:

On April 25, 2019, the KFL&A Public Health Board of Health wrote to Premier Doug Ford urging the provincial government to ensure that any plan to address the safe and responsible sale and consumption of beverage alcohol includes a wide range of evidence-based policies. In addition, KFL&A asks the Government of Ontario to indicate how much alcohol consumption will increase with the proposed expansion over the next five years, and how much this increased consumption will cost the justice, social, and health care systems.

Recommendation: Receive.

v) Date: 2019 April 25
Topic: Endorsement of the Children Count Task Force recommendations
From: KFL&A Public Health
To: The Honourable Doug Ford

Background:

On April 25, 2019, the KFL&A Public Health Board of Health wrote to Premier Doug Ford endorsing the Children Count Task Force recommendations, which aim to effectively measure the health and well-being of children and youth to inform local, regional, and provincial programming.

Recommendation: Receive.

w) Date: 2019 April 29
Topic: Public health modernization
From: Dr. David C. Williams, Chief Medical Officer of Health
To: Chairpersons, Board of Health
Medical Officers of Health, Public Health Units
Chief Executive Officers, Public Health Units

Background:

On April 29, 2019, Dr. David Williams wrote to all public health units outlining how modernizing and streamlining the role of public health across the province will better coordinate access to health promotion and disease prevention programs at the local level. The Ministry of Health and Long-Term Care has been working to define how the public health sector can contribute to the patient experience and better align itself to the new Ontario Health Agency, local Ontario Health teams, and the health system at large. The Ministry is proposing to change the cost-sharing arrangement with municipalities beginning in 2019–20 to reflect a 70% (provincial)–30% (municipal) split for Regional Public Health Entities. The Ministry will be arranging calls with each health unit to discuss annual business plans and budget submissions, as well as the planned changes for this year and related mitigation opportunities.

Recommendation: Receive.

x) Date: 2019 May 3
Topic: RHAC Position Statement – Sex Work
From: Mr. Brian Lester, Executive Director, Regional HIV/AIDS Connection (RHAC)
To: Dr. Christopher Mackie, Medical Officers of Health /CEO

Background:

On May 3, 2019, Regional HIV/AIDS Connection (RHAC) announced the release of the organization's position on sex work. The statement is posted to their website and aligns with the organization's harm reduction philosophy. RHAC supports the decriminalization of sex work by the Government of Canada.

Recommendation: Refer to staff for report.

Annual Report

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North Bay Parry Sound District
Health Unit

Bureau de santé
du district de North Bay-Parry Sound

Letter from the Medical Officer of Health

Throughout 2018, change has been the only constant. At the beginning of the year, the new Ontario Public Health Standards came into effect with multiple changes to regulations, protocols, and guidelines throughout many public health programs, as well as the advent of a new Annual Service Plan and Accountability Agreement.

The current government is committed to healthcare reform in an effort to improve primary care access and ending hallway medicine.

The Health Unit's North Bay office moved into its new building reuniting staff under one roof for the first time in years.

There were many unknowns and challenges to overcome in 2018. More than ever, adaptation and innovation were fundamental to successfully navigating change and responding to local needs. The following are examples of such efforts that turned obstacles into opportunities:

- In February 2018, the new oral health clinic for eligible adults with limited or no access to dental care opened at the Health Unit. This clinic provides preventive, routine, and emergency dental treatment for those who otherwise could not afford oral health care.

- For the first time the Health Unit opened its teaching kitchen in the new facility providing many community groups and residents with food literacy, skills and food safety training opportunities. Equally important, creating a sense of community and social well-being with a shared food experience.

- The Northern Fruit and Vegetable Program was launched with the primary goal of improving the likeability of vegetables and fruits among kids, since we know the majority of Canadian children and youth aren't getting enough.

- In an effort to continue to build on established relationships and engage in new ones, an Indigenous Engagement Coordinator position was created. The goal is to build capacity of our staff to engage with Indigenous communities in meaningful ways.

- Youth engagement continued to be a priority with an inventive For Youth-by-Youth anti-vaping campaign as well as a very successful youth-led mental health conference "Be Well".

Dr. Jim Chirico

- Adapting to a reduction in the number of needles being returned to the Health Unit's needle exchange program an innovative needle exchange buy-back campaign was piloted in November and December of 2018. This trial yielded a significant increase in the number of needles

returned and helped to establish important trust among clientele and staff.

- The Healthy Living team facilitated the implementation of the Parry Sound drug strategy group who was tasked with addressing the complex issues surrounding substance use through a public health harm reduction lens.

- The Health Unit has been mandated with the responsibility of Infection Prevention and Control lapse investigations when complaints are received from the public. A collaborative model was instituted by Environmental Health and Communicable Disease Control teams to ensure an effective and efficient response to protect the health and safety of the public.

- Smoke-Free Ontario changes came into effect necessitating revisions and updates to policies, procedures and enforcement.

- The historic legalization of cannabis took place on October 17, 2018 with significant public health implications with respect to education, awareness, health risks, harm reduction initiatives, and enforcement. The following highlight some of the Health Unit's endeavors:
  - Community cannabis survey.
  - Comprehensive social media campaign.
  - Provided information & resources to youth, parents, schools in order to prevent use and reduce harms.
  - Participated in cannabis forums in the community as well as schools.

- An important breastfeeding campaign called "Normalize It" was launched within the district to support moms who wish to breastfeed in public and feel more supported.

- The Nipissing Parry Sound Public Health Atlas was developed and posted on the Health Unit's website. The Atlas provides information about the populations in the Nipissing and Parry Sound districts, including population counts, language, housing, income, family living arrangements, and more. This important and relevant data helps communities and partners make decisions based on the best available evidence.

- As a result of a coordinated collaboration among multiple Health Unit programs and community partners, the spread of a potentially fatal disease in infants was averted when a pertussis outbreak emerged.

These are but a few highlights of the work public health has undertaken over the past year. It exemplifies the passion among staff to realize our vision of a healthy life for everyone in our communities. I invite you to read the entire report to give you a better understanding of why the Health Unit truly is your lifetime partner in healthy living.

Dr. Jim Chirico
Medical Officer of Health / Executive Director
North Bay Parry Sound District Health Unit

Board of Health

In 2018, the Board of Health elected Nancy Jacko as Chairperson and Mike Poeta as Vice-Chairperson. The Board's Finance and Property Committee elected Don Brisbane as Chairperson and Heather Busch as Vice-Chairperson. The Board's Personnel Policy, Labour/Employee Relations Committee elected Stuart Kidd as Chairperson and John D'Agostino as Vice-Chairperson. Municipal elections occurred on October 22, 2018. This will see a turnover in a number of Board of Health members for the 2019-2022 term.

2018 Board of Health Members			Date Appointed/Term Ended
NIPISSING DISTRICT			
Central Appointees	Mac Bain	Municipal Appointee	2015 to November 14, 2018
	Dave Butti	Citizen Appointee	2014 to November 14, 2018
	Nancy Jacko	Citizen Appointee	2014 to November 14, 2018
	Stuart Kidd	Citizen Appointee	2014 to November 14, 2018
	Tanya Vrebosch	Municipal Appointee	2014 to November 14, 2018
Eastern Appointee	Chris Jull	Municipal Appointee	2014 to November 14, 2018
Western Appointee	Guy Fortier	Municipal Appointee	2014 to November 14, 2018
PARRY SOUND DISTRICT			
North East Appointee	Heather Busch	Municipal Appointee	2014 to November 14, 2018
Western Appointee	Don Brisbane	Citizen Appointee	2014 to November 14, 2018
South East Appointee	Les Blackwell	Municipal Appointee	2015 to November 14, 2018
PROVINCIAL APPOINTEES			
	John D'Agostino	Public Appointee	2016 to present
	Gary Guenther	Public Appointee	2017 to present
	Mike Poeta	Public Appointee	2017 to present

Public Health Snapshot

4,570 individual dental screenings at area schools and Health Unit locations in our district.

1,177 children received dental care through the Health Unit's Healthy Smiles Ontario program.

7,390 vaccinations administered at the Health Unit offices.

3,520 vaccinations administered during the annual grade seven school clinics.

7,927 private water samples submitted by homeowners.

407 animal bite reports investigated.

51 human acquired ticks submitted for testing.

819 retail food premises inspected.

6,730 client visits to our sexual health clinics.

79 confirmed outbreaks.
- 34 enteric outbreaks in long-term care home/hospital.
- 43 respiratory outbreaks in long-term care home/hospital.
- 2 community outbreaks.

550 confirmed cases of diseases of public health significance.

227 individuals received breastfeeding education.

76 people attended Triple P Parenting Program seminars.

1,490 infant/child feeding consults.

535 Quit Clinic appointments were held in 2018.

21 youth volunteer placements held at the Health Unit.

Welcome to YOUR new Health Unit

(Strategic Priority 4, Aim 1)

2018 was a monumental year for the North Bay office of the North Bay Parry Sound District Health Unit. On May 14, 2018 the new facility opened to the public.

Every detail was designed with clients and the community in mind. The downtown location was chosen to allow ease of access to services and programs by clients. The Health Unit is now within walking distance for many clients, it is accessible by the Kate Pace Way (North Bay's bike path), by city transportation, and has plenty of visitor parking.

The Health Unit has created a safer and positive environment for everyone, with all gender washrooms open to the public and water stations for anyone to fill up their water bottles. The new family-friendly room is a community space for anyone in the area who needs a place to change or feed their child. The addition of a teaching kitchen has reduced barriers to education related to nutrition, food skills, and safety for both clients and community partners.

The amalgamation of our three North Bay offices to one location has reduced barriers to service and created a collaborative environment for staff and clients alike. Clients accessing services from one of our clinics may now be referred to another service all in the same visit and within the same building.

The North Bay office of the Health Unit will continue to capitalize on the new opportunities that amalgamation has created, which will result in better service and public health for our community as a whole.

Mitchell Jensen Architects designed the building, which won the 2018 WoodWorks! Northern Ontario Excellence Award.

Completion of the 2014-2018 Strategic Plan

The end of 2018 saw the successful completion of the 2014-2018 Strategic Plan. Eighty-five percent of outcomes across the four priority areas were completed with the remaining 15% projected to be completed this year. In addition to the strategic priority stories featured throughout this report, additional highlights include:

Successful implementation of 'Families in the Kitchen' weekly food skills program for at-risk families, using the new Health Unit teaching kitchen as a community hub for programming.

Increased understanding of food purchasing behaviours of grade 9-12 students through implementation of 'Healthy Food Zones' student survey.

Organizational positive spaces practices put in place such as all gender washrooms.

Framework created to guide how the Health Unit assesses, engages, participates and evaluates partnerships to ensure alignment with organizational mandate and strategic priorities.

A final report on the 2014-2018 Strategic Plan will be available on the Health Unit website on April 30, 2019.

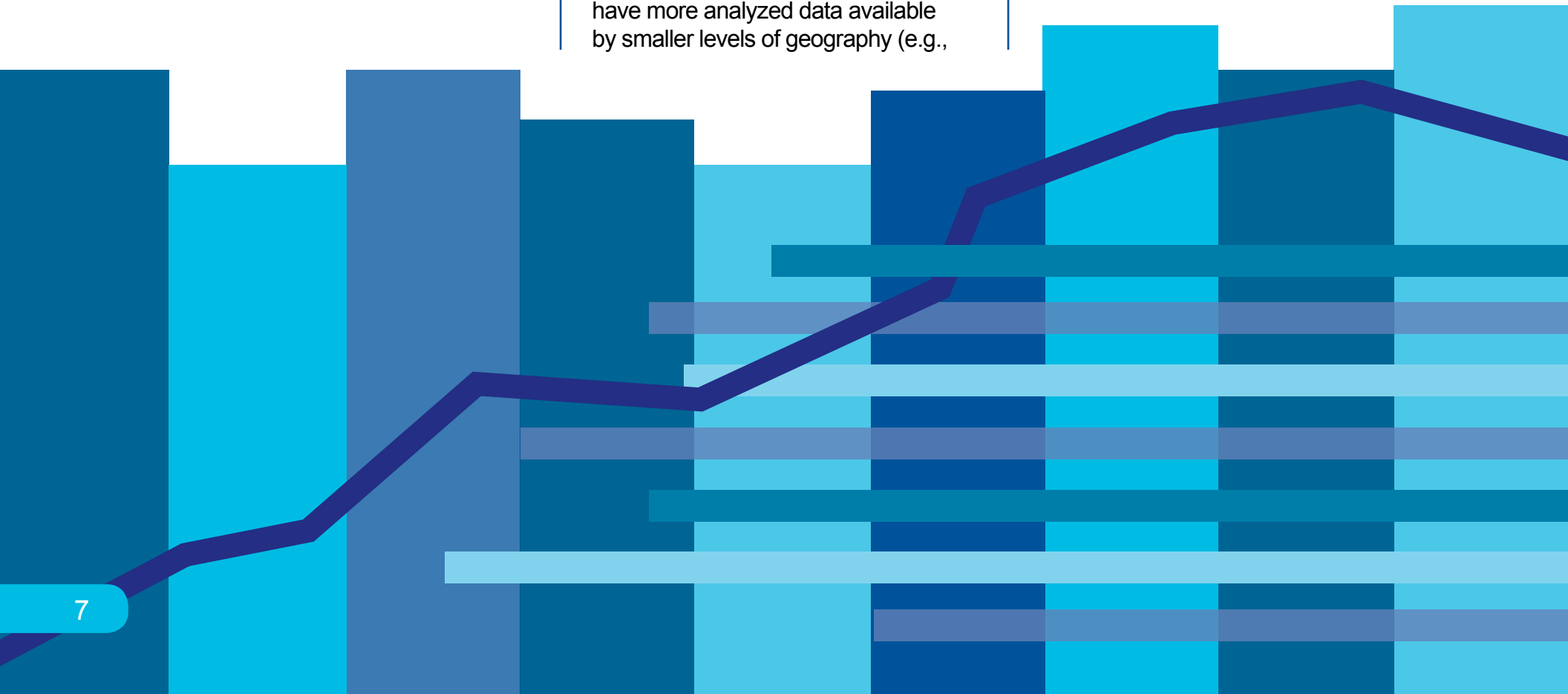
Atlas

(Strategic Priority 4, Aim 3)

In August, the Health Unit launched the Nipissing Parry Sound Public Health Atlas, an interactive dashboard displaying select regions (e.g., municipalities, unorganized areas, First Nation reserves) within the Health Unit's district. The dashboard utilizes line graphs to show trends over time, and bar graphs to compare cities or other areas of interest.

The Atlas includes the option to sort by relevant indicators collected from the census, including the percentage of the population living in low-income households, language spoken at home, and population counts by age and sex. Counts and percentages can be compared to geographies nearby, or the province or districts as a whole. The Health Unit continues to work to have more analyzed data available by smaller levels of geography (e.g., neighbourhoods), and add measures for more data as available.

The availability of local-level data to support evidence-based decision-making was not only a 2014-2018 strategic priority, but was required by staff and community partners, to have relevant data for evidence-based decisions.



Sharing Information to Promote Healthy Living for All

(Strategic Priority 4, Aim 4)

The Health Unit, in collaboration with four other health units across the province and McMaster University, has been working on a two-year project to address issues surrounding the dissemination of community health material to organizations who would benefit from the information to better serve their clients.

This project, which aligns with the Health Unit's 2014-2018 strategic priorities, recognizes that public health has the ability to access and analyze a lot of data, however, there are at times a gap in knowledge transfer. The project resulted in the development of a guide describing how public health agencies, across the province, can share useful information with other service agencies in their community.

While public health must follow strict ethical regulations about personal information, there is data about communities and neighborhoods, which could help community organizations provide better services, especially to those in greater need.

Currently the guide's dissemination process is in review and is expected to be implemented in the spring of 2019.

Health Equity

(Strategic Priority 4, Aim 2)

The Health Unit is striving for a region where everyone can achieve their best possible health, making it essential to reduce barriers faced by people in the community.

The Health Unit recognizes that to improve the overall health of everyone in our district, there are some services that need to adapt to better reach those who may have barriers to service. The Health Unit has been working to improve staff's ability to better understand, identify, and take action on those unfair and avoidable factors that can result in poorer health for members of the community.

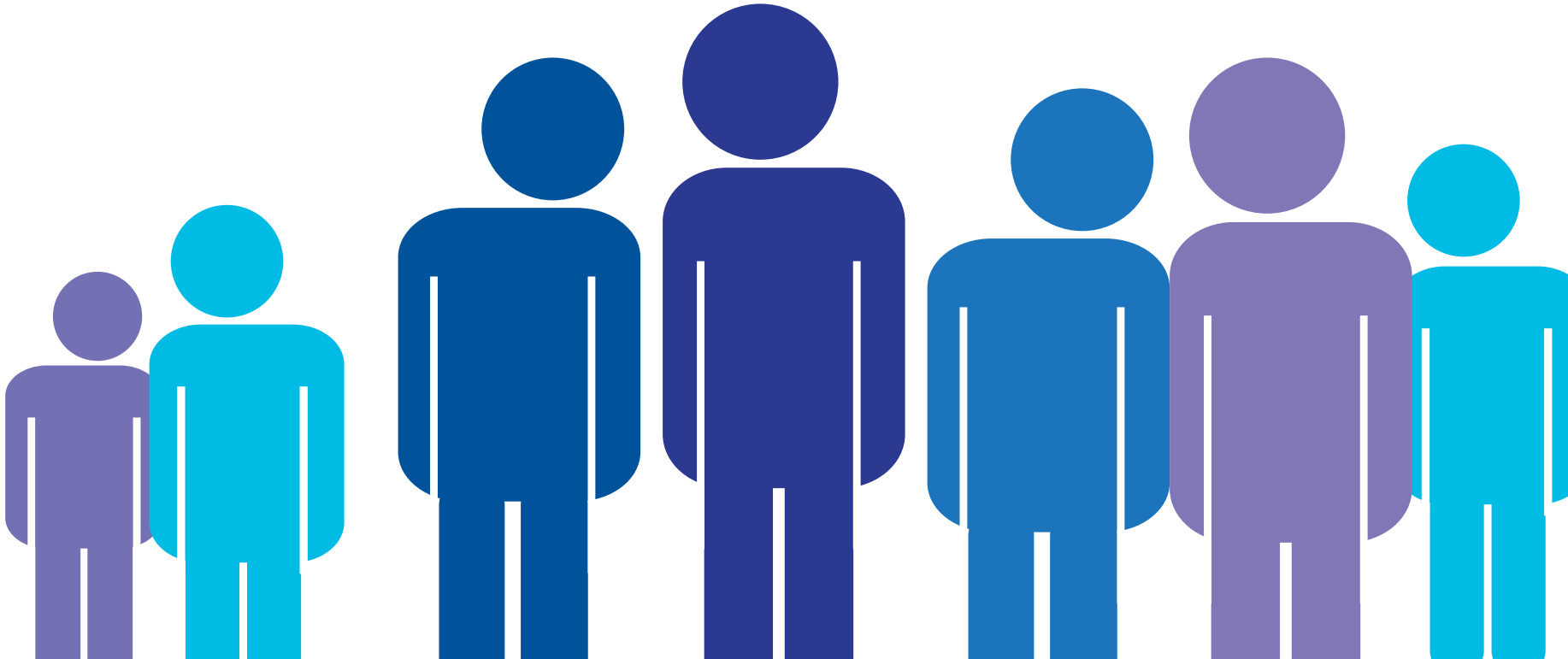
Part of the Health Unit's work involves reviewing information available on the obstacles faced by people living across the district and using the information towards creating better ways to meet the needs of people facing these barriers. The committee is also working to develop policies to ensure that all of our work considers these challenges.

Talking Together to Improve Health

Since 2017, the Health Unit has been part of a research project, through Public Health Ontario's Locally Driven Collaborative Project, called Talking Together to Improve Health. The goal of the project is to develop mutually beneficial and respectful principles and practices of engagement between First Nation communities and local public health agencies in northeastern Ontario. The research includes five other public health units, academic researchers, and First Nation community representatives. Guidance is provided throughout the process by the Indigenous Circle advisors.

The project has been broken into five phases, including a literature review, a survey of public health units, developing the key information, meeting with First Nation communities and sharing the outcomes and recommendations. Reports and findings from the research will be shared in 2019.

Applying the findings will lay the foundation for long term, mutually beneficial and respectful relationships with First Nation communities and are an important step in working towards improving opportunities for health for all.



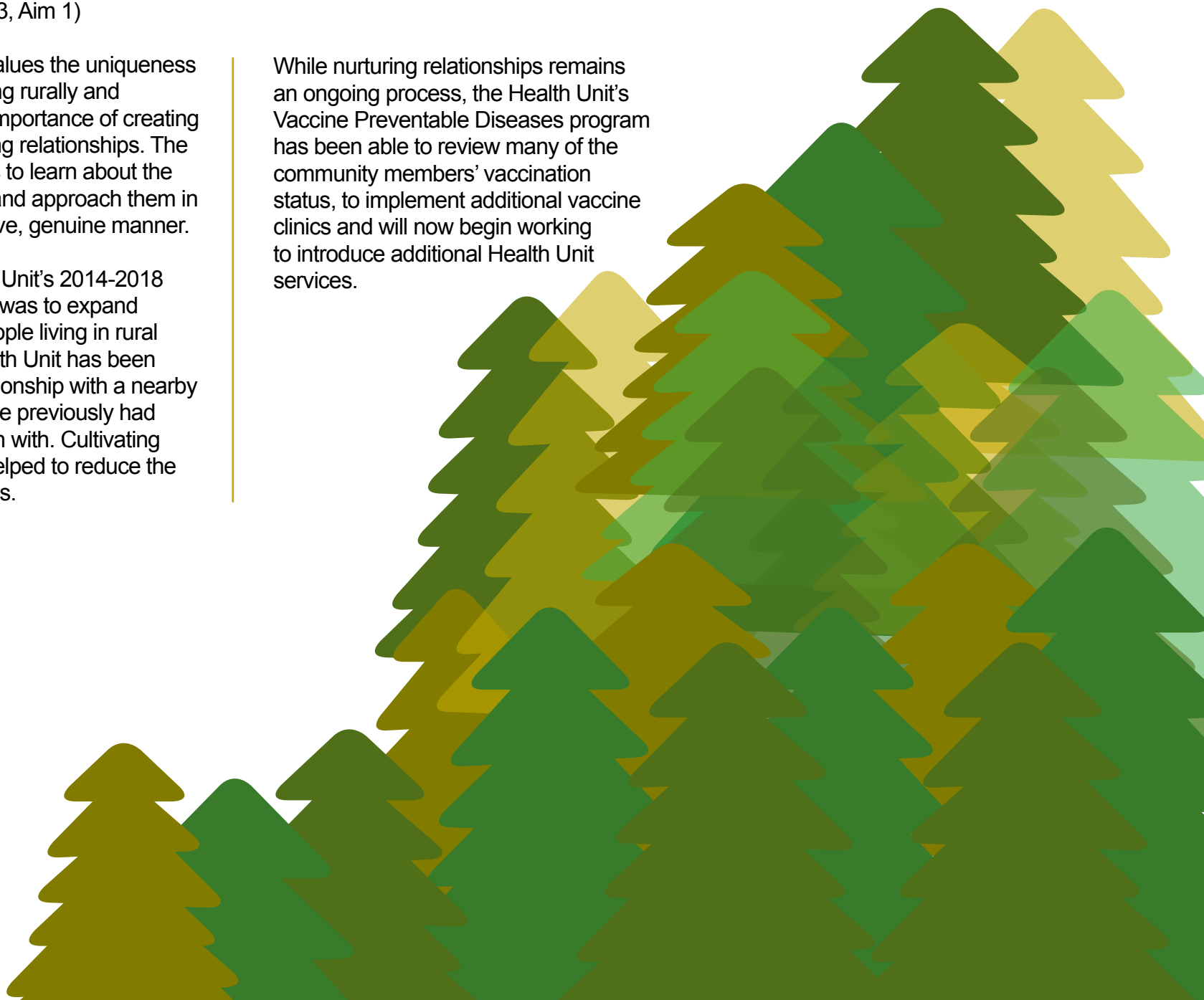
Providing Services to Rural Communities

(Strategic Priority 3, Aim 1)

The Health Unit values the uniqueness of populations living rurally and understands the importance of creating meaningful, trusting relationships. The Health Unit strives to learn about the people we serve and approach them in a culturally sensitive, genuine manner.

One of the Health Unit's 2014-2018 strategic priorities was to expand reach to those people living in rural settings. The Health Unit has been developing a relationship with a nearby community who we previously had minimal interaction with. Cultivating this relationship helped to reduce the spread of Pertussis.

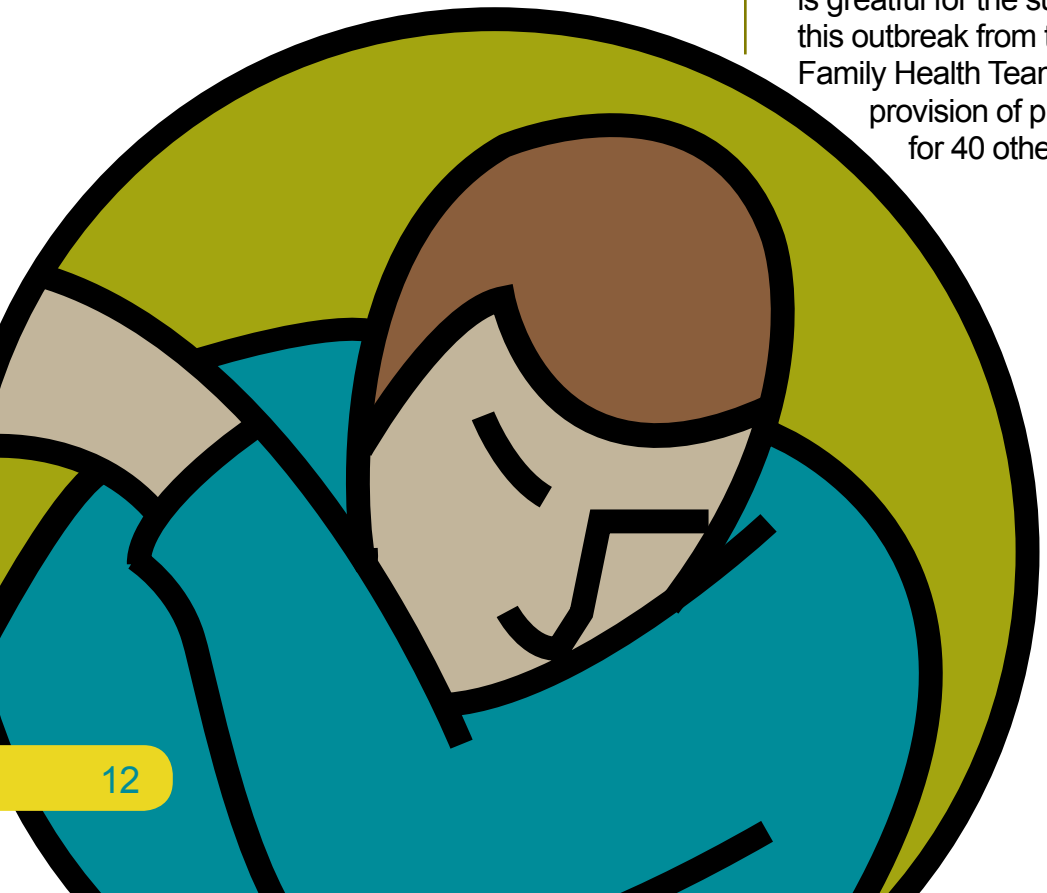
While nurturing relationships remains an ongoing process, the Health Unit's Vaccine Preventable Diseases program has been able to review many of the community members' vaccination status, to implement additional vaccine clinics and will now begin working to introduce additional Health Unit services.



Pertussis (Whooping Cough) Outbreak

Pertussis is a highly contagious respiratory disease caused by bacteria and is known for uncontrollable, violent coughing, which often makes it hard to breathe. After coughing fits, someone with pertussis often needs to take deep breaths, which result in a “whooping” sound. Pertussis can affect people of all ages, but can be very serious for babies, susceptible pregnant women, and elderly people.

Cases of pertussis and vulnerable contacts were identified by the Health Unit over the year and public health strategies were implemented to limit the spread of this disease. Public health interventions included community outreach, immunization, health teaching, and consultation regarding treatment. The Health Unit identified 36 cases; 51 people who were in close contact with the cases, 30 of those were high risk. Fourteen people were immunized to prevent future infections. The Health Unit is greatful for the support received during this outbreak from the Powassan & Area Family Health Team who facilitated the provision of preventative medication for 40 others.



Communicable Disease Investigations

The Health Unit received 1,135 reports of communicable disease.

These included, but were not limited to:

- **Tuberculosis**
- **Hepatitis C**
- **Meningitis**
- **Influenza**
- **Pertussis**
- **Salmonellosis**

Vaccination Statistics

1,678

influenza vaccines administered by the Health Unit Oct. – Dec. 31.

16,274

student immunization records assessed for compliance with Immunization of School Pupils Act.

3,520

vaccinations administered during the annual grade 7 school clinics.

6

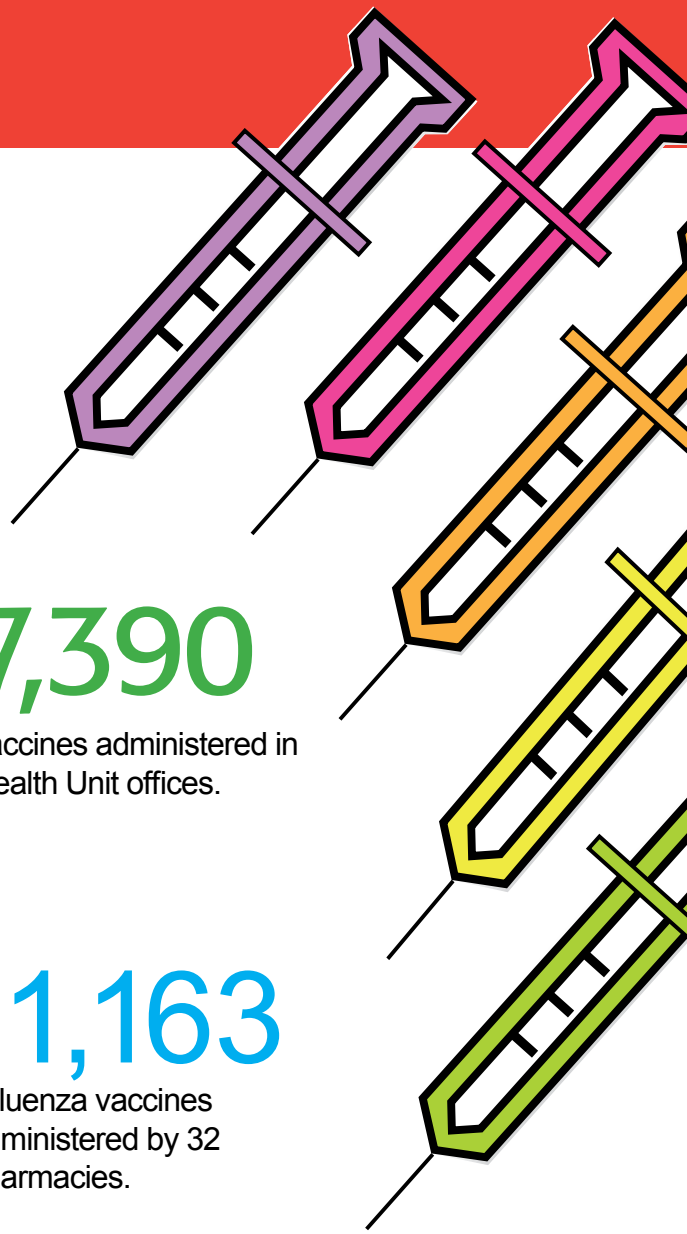
community influenza clinics offered in the fall.

7,390

vaccines administered in Health Unit offices.

11,163

influenza vaccines administered by 32 pharmacies.



Adult Oral Health

Oral health is an important part of our overall health and can affect our self-esteem, social relationships, and how we eat and speak. Pain and infection, which may arise from oral diseases, can affect employability, work attendance, performance, and learning potential. Medical conditions such as diabetes, respiratory diseases, and cardiovascular issues can also be affected by poor oral health.

In February 2018, the new Adult Dental Clinic, for eligible adults with limited or no access to dental care, opened at the Health Unit's North Bay office. The clinic provided preventive, routine, and emergency dental treatment to 561 clients. Attendance at the clinic was high, with 89% attendance rate. The need for this clinic was evident as 68% of clients presented with one or more areas of untreated tooth decay, 62% with dental pain and 18% with a dental abscess. By the end of the year, there was a five-month waiting list for an appointment.

When asked in a survey, "What has coming to this clinic meant to you?" clients' responses included:

"Everything! The pain I have endured has been unbearable and now I see a pain free future."

"It meant a great deal! I thought there was no one to help me when I couldn't afford dental care. Amazing. Thank you!"

"To live again/so happy I am almost crying. Thank you."

A special thanks to Low Income People Involvement of Nipissing (LIPI), District of Nipissing Social Services Administration Board (DNSSAB) and North Bay Oral Surgery for supporting this program. Together we are working to provide equitable access to dental care and to improve the health of adults in our communities who have challenges accessing dental services.

Adult Stats

- **561 clients were treated at the Adult Dental Clinic.**
- **147 adults in receipt of Ontario Works for a total of 316 appointments.**
- **144 adults with the Ontario Disability Support Program for a total of 334 appointments.**
- **262 low wage income earners who met the Health Unit eligibility for a total of 660 appointments.**
- **6 adults accessed Non-Insured Health Benefits for First Nations for a total of 11 appointments.**
- **2 adults accessed Interim Federal Health Plan benefits for resettled refugees for a total of 2 appointments.**

Healthy Smiles Ontario

Good oral health is important for a child's self-esteem, sense of well-being and overall health. Together with parents, the Health Unit is working to improve the health of children in our communities. Healthy Smiles Ontario (HSO) is a free dental program that provides preventive, routine, and emergency dental services for eligible children and youth 17 years and under from low-income households.

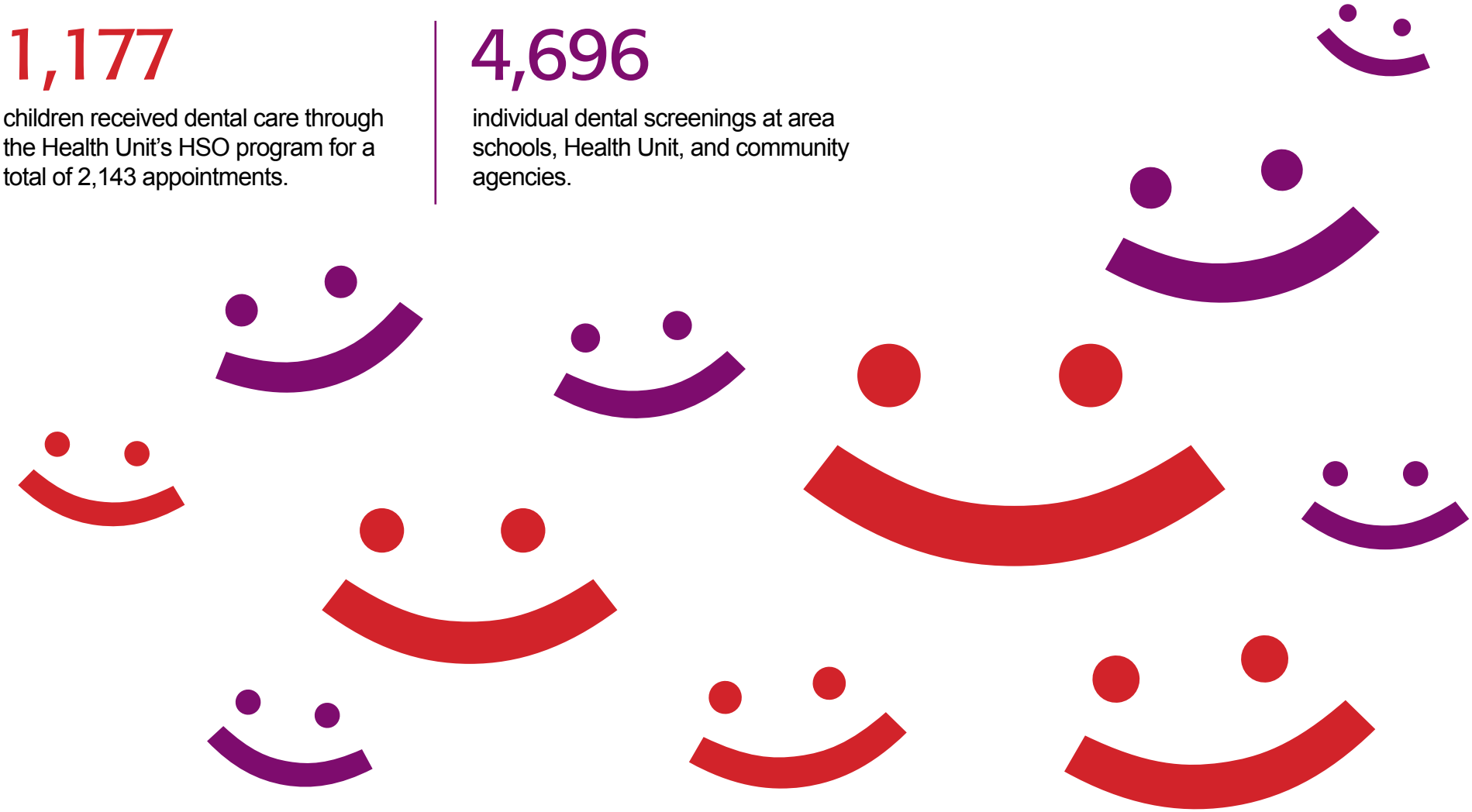
In 2018:

1,177

children received dental care through the Health Unit's HSO program for a total of 2,143 appointments.

4,696

individual dental screenings at area schools, Health Unit, and community agencies.



Sexual Health

Sexual health is about healthy behaviours and attitudes towards sex, respecting others, understanding consent, and much more. The Health Unit's Sexual Health program provides testing and treatment to help prevent sexually transmitted infections, provides contraceptives, including emergency contraception at cost, and provides pregnancy testing and education about the available options if they or their partner becomes pregnant.

6,730 client visits

to our sexual health clinics.

- **77%** presented as female.
- **23%** presented as male.
- Approximately **78%** of clients were seen in our North Bay office.
- **9%** in designated secondary schools across our district.
- **11%** in our Parry Sound office.
- less than **1%** in our Burk's Falls office and satellite clinics.

The total number of cases of reportable sexually transmitted infections (STIs) increased in 2018, which is consistent with trends across Ontario.

- **442** cases of chlamydia (an increase of 17%).
- **42** cases of gonorrhea (an increase of 35%).
- **6** cases of syphilis and HIV.

The Sexual Health program is working closely with the Ministry of Health and Long-Term Care to assess why chlamydia and gonorrhea rates continue to increase, and to determine how best to address this issue.

Harm Reduction

In collaboration with community partners, the Health Unit provides harm reduction services, such as our needle exchange program, to clients throughout the community. Evidence* shows that these services are effective at reducing serious infections (such as hepatitis C and HIV) in people who use drugs, help to build relationships with clients, connect clients to other Health Unit and community programs, and decrease the number of used needles found in the community.

- **1,439** needle exchange visits, where clients had access to new needles and other injection drug supplies, safer inhalation kits, safer smoking kits, and naloxone kits.
- **68%** of clients identified as male.

** Best Practice Recommendations for Canadian Harm Reduction Programs that Provide Service to People Who Use Drugs and are at Rick for HIV, HCV, and other Harms: Part 1(Rep.). (n.d.). retrevied from https://www.catie.ca/ga-pdf.php?file=sites/default/files/BestPracticeRecommendations_HarmReductionProgramsCanada_Part1_August_15_2013.pdf*

** Best Practice Recommendations 2 for Canadian Harm Reduction Programs that Provide Services to People Who Use Drugs and are at Risk for HIV, HCV, and Other Harms: Part 2 (Rep.). (n.d.). Retrieved from https://www.catie.ca/sites/default/files/bestpractice-harmreduction-part2.pdf*

Sharps Buy Back

The Sharps Buy Back campaign launched in November, as part of the Health Unit's harm reduction strategy, and was extended into December, due to the campaign's success. The purpose of the campaign was to encourage individuals to come to our new North Bay office, while also spreading awareness about how to properly pick up sharps. The campaign targeted the Health Unit's current needle exchange clients and individuals in the community who might benefit from needle exchange services. During the campaign, the Health Unit provided a $5 grocery gift card for every 100 used sharps (e.g. needles or syringes) brought to the North Bay office.

During the Sharps Buy Back Campaign, the Health Unit received **39,281** used sharps, averaging **19,640** sharps each month, a large increase from previous months. In the six months leading up to the campaign, the Health Unit received an average of 3,985 returned used sharps per month. This represents a nearly five-fold increase in the number of needles returned, during the campaign.

The campaign created the opportunity to build and strengthen therapeutic relationships between Health Unit staff and clients. The campaign encouraged new individuals to visit our Health Unit and learn about our services. It also enabled staff to refer many clients to other services within the organization such as the Oral Health program, Vaccine Preventable Diseases, the Quit Clinic, and Sexual Health program. Many clients expressed gratitude for the gift cards and told staff that they would be used to purchase their basic needs like food and hygiene products.

Naloxone Program

In an effort to combat the increasing number of overdose deaths in Ontario, the Ministry of Health and Long-Term Care implemented the Ontario Naloxone Program in 2017. Through this program, the Health Unit is able to distribute naloxone kits to people who use drugs, their friends, and their families, as well as to community partners to help prevent overdose deaths in our community.
Naloxone kits were provided across our district as follows:

- **291** to community agencies.
- **138** to fire departments.
- **59** to police services.
- **51** to clients who use opioids.
- **70** to people reporting to be a friend or family member of someone who uses opioids.

Cannabis

Prior to the legalization of cannabis in October, the Health Unit created a comprehensive social media campaign focused on dispelling myths related to cannabis and aimed to inform the public about ways to reduce harm associated with cannabis use. Canada's Lower-Risk Cannabis Use Guidelines were used throughout the campaign.

Staff from the Health Unit coordinated and attended several cannabis information sessions, including parent's nights and panel sessions, to provide information and resources to members of the public.

The largest session was the Cannabis Forum, a partnership between the Health Unit, Ontario Provincial Police, North Bay Police, and a pharmacist, held in North Bay. The session was designed to allow members of the public to ask questions about cannabis and receive information to help navigate laws and health outcomes, concerning cannabis use.

Beyond sessions, the Health Unit provided resources to parents, schools, and other youth-serving agencies with the aim of preventing use and reducing cannabis-related harms among youth. This included promoting the Cannabis Talk Kit on social media and providing free resources at reception and on the Health Unit website.

To better understand our community's knowledge, behaviours, and attitudes related to cannabis, the Health Unit conducted a Community Cannabis Survey. The survey asked the public questions about their previous use, their understanding of harm reduction strategies related to cannabis, and driving while impaired. This survey will serve as a benchmark for understanding cannabis in our community following legalization. Survey results are expected to be released in early 2019.

Hand Hygiene

Hand washing, when done correctly, is the single most effective way to prevent the spread of illness. Hand hygiene education provided to children has the potential to considerably decrease the amount of times that they are absent because of illness.

The Health Unit partnered with third year Nipissing University and Canadore College collaborative Bachelor of Science in Nursing students to offer hand hygiene education sessions to students in elementary schools across the Health Unit district. A total of 20 schools participated with over 1,700 students learning about germs, how they are spread, and how to protect themselves and others by properly washing their hands. The Health Unit also offered hand hygiene education sessions to child care centres, long-term care homes and retirement homes.

A total of 254 children from seven child care centres and a total of 132 residents and staff from four long-term care homes and retirement homes participated in hand hygiene education sessions.

For Youth by Youth Anti-Vaping

The Health Unit runs a Youth Volunteer Program where students aged 13 to 17 years learn about public health and create public health campaigns. One campaign specifically focused on addressing the rise in e-cigarette use among youth. The goal of the project was to inform other youth, in the Health Unit's district, about the potential health risks of vaping.

Youth volunteers discussed vaping trends and looked at research regarding the health effects of vaping. The volunteers learned how to plan and run a health communication campaign, discussed effective ways to reach youth, and created key messages for their campaign. The campaign consisted of five social media posts, a video, two posters, a fact sheet, and a set of trivia questions.

Volunteers also planned and set-up a booth at a local youth conference, Be Well, where they shared information with youth through a trivia game, as well as the posters and fact sheets.

The posters are still being used by high schools in our district, and have been requested by other health units. The campaign helped lay a foundation for youth engagement work on this emerging public health issue.

For Youth by Youth Be Well

Expectations of youth are high; balancing school, extra-curricular activities, home life and maintaining a job can be difficult, and can impact overall mental well-being. According to the Ontario Student Drug Use and Health Survey (OSDUHS), one in every five students in our region report their mental or emotional health as either fair or poor*.

In the spring, ten Health Unit youth volunteers planned and hosted the Be Well Conference, a youth-led mental health event. Approximately 75 students and 15 community partners from the North Bay area attended.

Collaboration was a key focus of conference planning. Youth volunteers worked closely with community partners to develop and deliver workshops that promoted healthy choices by providing trusted information in a youth-friendly format. Stigma, healthy relationships, social media and leadership are all examples of topics covered throughout the conference. Youth Volunteers worked closely with a Health Unit Community Health Promoter to make decisions related to logistics, branding, and conference activities.

The conference was a success - students left better informed on ways to deal with stress in their life and that they are not alone.

** North Bay Parry Sound District Health Unit Planning & Evaluation Services. (2017). Mental health among students in grades 7 to 12 in the NBPSDHU region. Retrieved from https://www.myhealthunit.ca/en/community-data-reports/resources/Reports-Statistics--Geographic-Profiles/well-being-and-mental-health/MH-care-gr7to12-NBPSDHU-region-2014-15-Nov-23-2017.pdf on January 17, 2019.*

The Northern Fruit and Vegetable Program Kicked off in 2018!

The Health Unit administered the Northern Fruit and Vegetable Program (NFVP), in partnership with the Ministry of Health and Long-Term Care and the Ontario Fruit and Vegetable Growers' Association, to **11,464** students in **61** elementary and intermediate schools throughout the Health Unit's district. The NFVP provided two servings of fruit and vegetables each week, from February to June, to students at participating schools.

Research has shown that Canadian children are not getting enough servings of fruits and vegetables. NFVP helps to fill that gap while working to improve the likeability of fruits and vegetables. Educators have found the program to have positive results.

The program not only provided the fruits and vegetables to students, but educators were provided additional resources for classroom activities based on the fruit and vegetables provided.

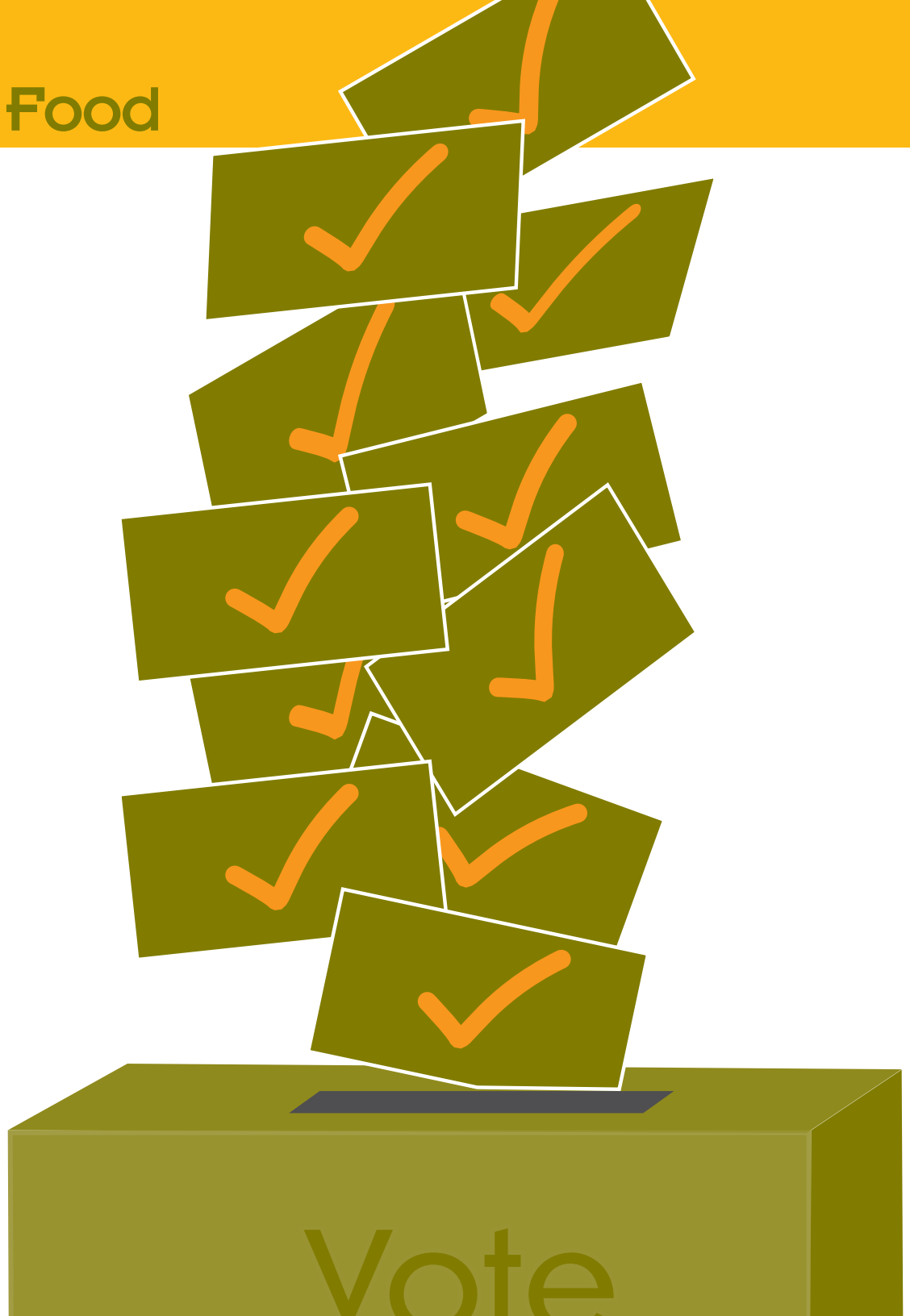
"The children at my school have decided to really embrace this program. I have never seen so many kids eating broccoli at nine in the morning," said one educator.

We're Voting for Food

In April 2018, the Health Unit partnered with the Nipissing Area Food Roundtable to host We're Voting for Food. The event, which had roughly 50 individuals in attendance, was focused on emphasizing the importance of income solutions to address food insecurity and informed decision making when voting. Food insecurity affects one in seven households in the Nipissing and Parry Sound districts.

The event encouraged MPP candidates to share their party's position and strategies to reduce food insecurity. Two MPP candidates attended and one sent a statement. Social service leaders from the Health Unit, the Low Income People Involvement of Nipissing, and the District of Nipissing Social Services Administration Board also spoke about the impact of food insecurity locally and the need for change.

The Health Unit continues to advocate for income measures, like increased social assistance and minimum wage rates, to reduce food insecurity in Ontario.



Student Placements

Effective post secondary student placements contribute to the development of a strong public health workforce, which helps the Health Unit to achieve a vision of a healthy life for everyone in the community.

The Health Unit supported **23** student placements throughout 2018. The students were enrolled in nursing, social work, dietetic internships, master of kinesiology, and physical health education programs. The Health Unit also worked with Nipissing University and Canadore College's collaborative Bachelor of Science in Nursing program to support the education of third year nursing students with specific health promotion projects. Projects focused on falls prevention for the Indigenous population and hand hygiene education in schools across our district.

The Health Unit values the contribution that students make to public health and wish them the very best in their future careers.

Normalize it!

In 2015, a Health Unit survey found that 51% of local mothers did not feel comfortable breastfeeding in public. This can negatively impact the duration of breastfeeding for mothers who are trying to reach their breastfeeding goals, while still getting out to do daily living activities.

In an effort to reduce barriers to continued breastfeeding, the Health Unit launched the Normalize It campaign during National Breastfeeding Week. The goal of the campaign was to normalize breastfeeding by changing perception of breastfeeding in public and encouraging a supportive environment in our community for nursing mothers. Four life size cutouts of mothers breastfeeding their children were rotated throughout 24 locations, including colleges, community centres and private businesses, across the Health Unit's district over a two week period. A corresponding Facebook contest invited mothers to take photos of the cutouts spotted in the community or of themselves breastfeeding and send them to the Health Unit. These images were shared on Facebook and the three images with the most 'likes' won.

The campaign had great visibility within the Health Unit's district, with nine media stories over the campaign period. The imagery and tag Normalize It will continue to be used throughout 2019 in other breastfeeding friendly material to extend the message throughout all breastfeeding promotion and activities.

Photoshoot

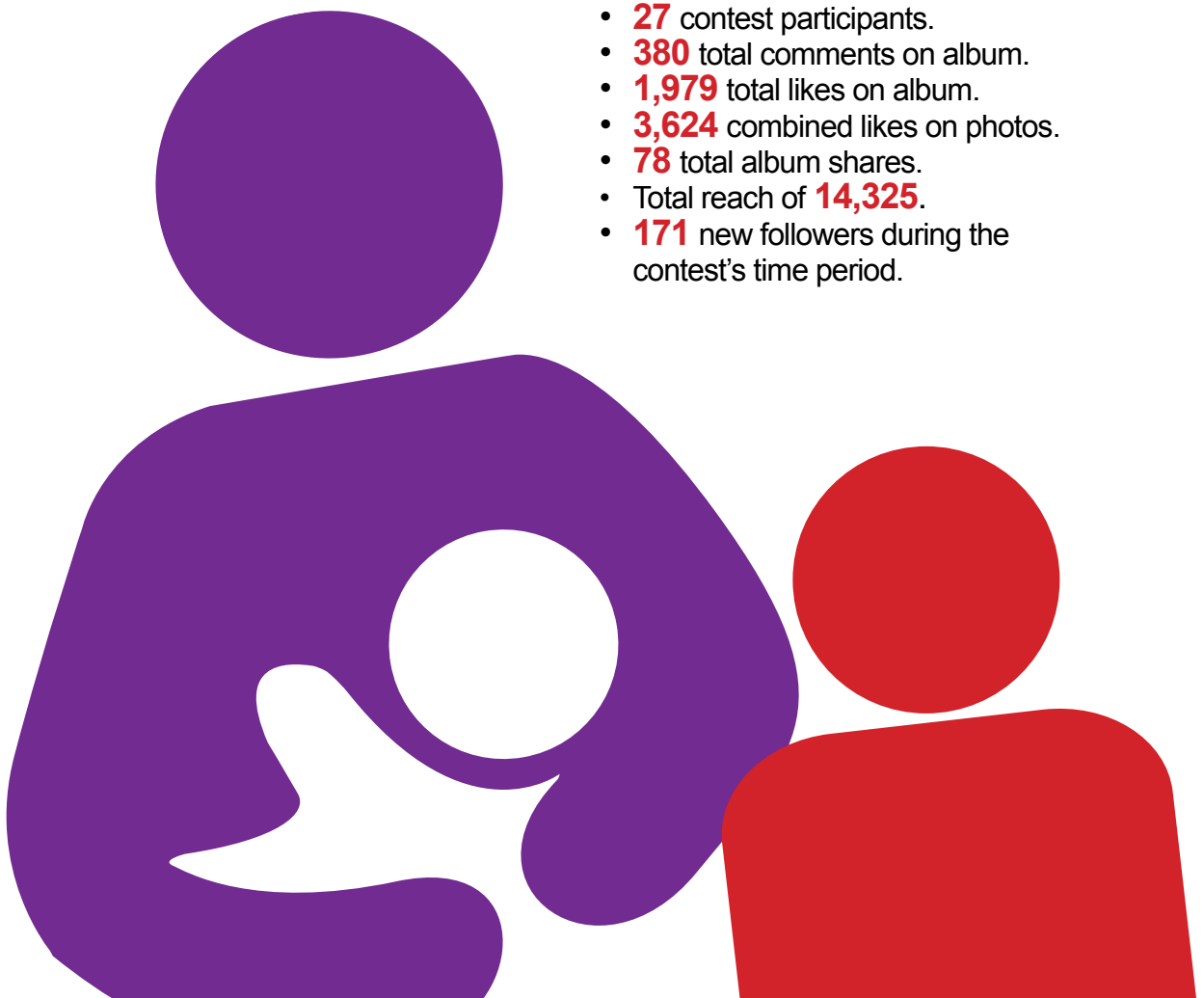
- **11** mothers and babies participated in the photoshoot cutouts.

Cutouts locations

- **10** in North Bay.
- **1** in Sturgeon Falls.
- **10** in East Parry Sound.
- **3** in West Parry Sound.

Social media contest

- **27** contest participants.
- **380** total comments on album.
- **1,979** total likes on album.
- **3,624** combined likes on photos.
- **78** total album shares.
- Total reach of **14,325**.
- **171** new followers during the contest's time period.



Changes to Regulations, Protocols, and Guidelines

In 2018, the Health Unit witnessed multiple changes to regulations, protocols, and guidelines. The new regulations came in effect on July 1, 2018 and included; the Food Premises Regulation 493/17, Public Pools 494/17, Recreational Camps 503/17, Camps in Unorganized Territory 502/17, Personal Service Settings 136/18, Rabies Immunization 497/17, and Smoke-Free Ontario Act, 2017 (and its related Regulation). The changes impact/affect individuals and/or owners/operators in the way they conduct their businesses.

Some of the guidelines introduced include:

- Healthy Environments and Climate Change Guideline, released on March 20, 2018.
- Management of Avian Chlamydiosis in Birds Guideline, Management of Avian Influenza or Novel Influenza in Birds or Animals Guideline and Management of Echinococcus Multilocularis Infections in Animals Guideline.
- Management of Potential Rabies Exposures Guideline.
- Operational Approaches for Food Safety Guideline.
- Operational Approaches for Recreational Water Guideline, released on February 5, 2018.
- Personal Service Settings Guideline.
- Small Drinking Water Systems Risk Assessment Guideline.

Protocols and guidelines outline ways of implementing the Ministry of Health and Long-Term Care (MOHLTC) Ontario Public Health Standards (OPHS). The Health Unit's Public Health Inspectors (PHIs) and Tobacco Enforcement Officers (TEOs) utilized a progressive enforcement approach to ensure compliance, in our district.

The PHIs and TEOs took the opportunity to educate organizations about the updates to the regulations, protocols and guidelines during their routine inspections. It is only after education, should an organization refuse to be compliant, that they would receive a warning followed by charges.

Smoke-Free Ontario Act, 2017

The Smoke-Free Ontario Act, 2017 came into effect on October 17, 2018. The Smoke-Free Ontario Act, 2006 was specific to tobacco products only, where the new Smoke-Free Ontario Act, 2017 now includes cannabis and electronic cigarettes. These changes required organizations to update their no-smoking signs in their work places, such as entrances, exits, work vehicles, and washrooms.

The Health Unit created a campaign to promote the updates, specifically to inform employers in the Nipissing and Parry Sound districts about the new Smoke-Free Ontario Act, 2017 adhesive signs that are available free at the Health Unit, and to increase awareness of the changes made to the Smoke-Free Ontario Act, 2017, in regards to the legalization of cannabis.

The campaign resulted in over **1,500** adhesive signs picked up and roughly, **15** packages compiled for the Chamber of Commerce, municipalities, and businesses within our district.

Safe Water

Drinking Water

7,927 drinking water samples submissions from private homes were submitted to Public Health Laboratories for detection of bacteria presence. Approximately 20% of the private water samples tested showed presence of Total Coliform and around 3% indicated the presence of E. coli.

The Health Unit worked with individuals who wished to consult with Public Health Inspectors after receiving their water results. The consulted individuals were provided information including potential causes and ways to resolve the identified issue.

Public Beaches

Throughout the summer of 2018, Public Health Inspectors conducted surveillance of 61 public beaches. 1,405 water samples were collected, both weekly and monthly depending on the water quality at each beach. Harmful Algal Blooms (HAB) were detected at lakes across the district including:

- Callander Bay
- Deer Lake
- Lake Bernard
- Lake Nosbonsing
- Lake Talon
- Lynx Lake
- Ottawa River
- Pickerel Lake
- Rankin Lake
- Roberts Lake
- Three Mile Lake
- Tilden Lake

The Health Unit made the public aware through a number of communications channels including news releases and social media posts. Data from public beach collection contribute to the Great Lakes water management.

2018 Inspections

Inspection of Retail Food Premises

- 819 retail food premises inspected and 216 re-inspections.

Responding to Complaints at Retail Food Premises

- 86 food program complaints investigated.

Education of Employees and Owners/ Operators of Retail Food Premises

- 20 food handler certification courses offered.
- 127 exams proctored.
- 98% food handlers certified.

Inspection and Consultation with Organizers of Community Food Events

- 626 special event applications reviewed.
- 40 inspections of community special events.

Implement corrective Measures at Regulated Water Systems to Ensure Safe Drinking Water

- 58 boil water advisories.
- 21 drinking water advisories.

Inspection of Public Pools and Spas

- 118 inspections were completed on 43 Class A & B public pools and 30 re-inspections.
- 37 inspections completed on 12 public spas and 12 re-inspections.
- 8 inspections completed on 2 public wading pools.
- 9 inspections were completed on 5 splash pads.

Investigation of Animal Exposure Incidents

- 407 animal bites reports investigated.

Promote the Rabies Vaccination to Animals

- 51 mandatory vaccination letters issued to animal owner.

Inspection of Facilities to Prevent Infectious Diseases and Hazards

- 29 children's recreational camps inspected and 2 re-inspections.
- 30 group homes inspected.
- 1 active treatment centre inspected.
- 1 correctional institution inspected.
- 1 home for special care inspected.
- 70 Licensed child care centres inspected and 5 re-inspections.
- 193 personal service establishments inspected and 4 re-inspections.

Vector Borne Disease Surveillance

- 51 human acquired ticks submitted for testing.

Education to Tobacco Vendors

- 385 educational visits.

Inspect Tobacco Vendors

- 128 tobacco vendors inspected and 8 re-inspections.

Inspect Workplace/Public Places under the Smoke-Free Ontario Act

- 1,031 inspections of workplaces/public places and 58 re-inspections.
- 98 warnings issued.
- 3 tickets issued to non-compliant workplaces/ public places.

2018 Health Unit Published Reports

2016/17 Influenza summary (February 2018)

Enhanced 18-month well-baby visits (July 2018)

Tobacco use during pregnancy (October 2018)

Reasons for provision of liquids other than breastmilk (November 2018)

Confidence and breast milk provision (October 2018)

Intended duration of breast milk provision (October 2018)

Solid food provision to infants in the NBPSDHU region (January 2018)

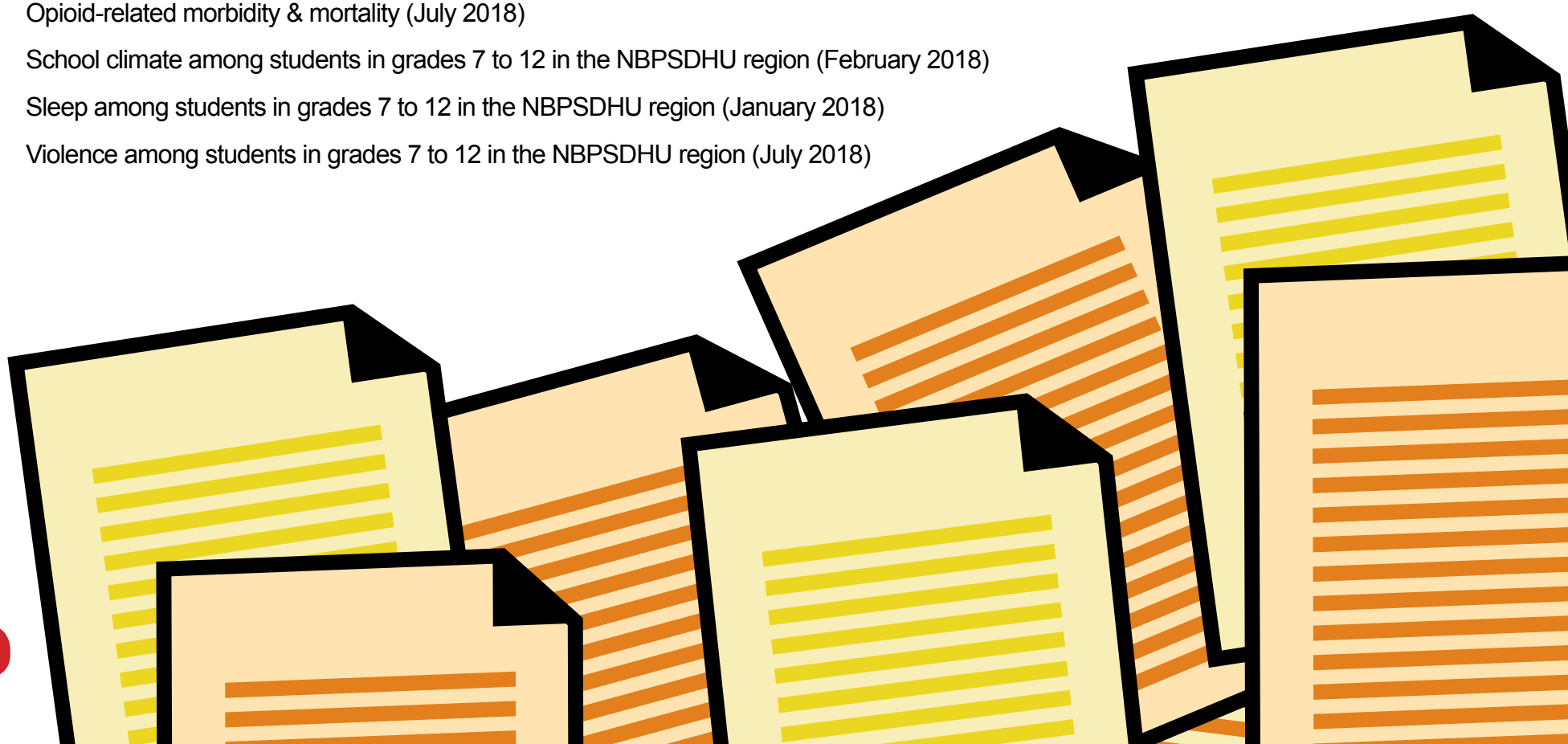
Infant oral health (February 2018)

Opioid-related morbidity & mortality (July 2018)

School climate among students in grades 7 to 12 in the NBPSDHU region (February 2018)

Sleep among students in grades 7 to 12 in the NBPSDHU region (January 2018)

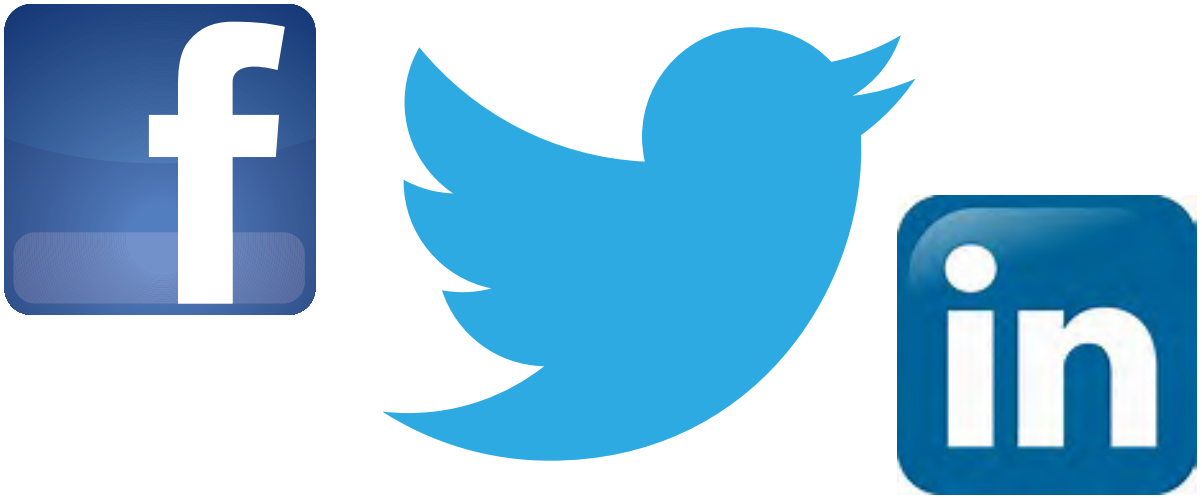
Violence among students in grades 7 to 12 in the NBPSDHU region (July 2018)



Communications

Over the past year, the Communications department:

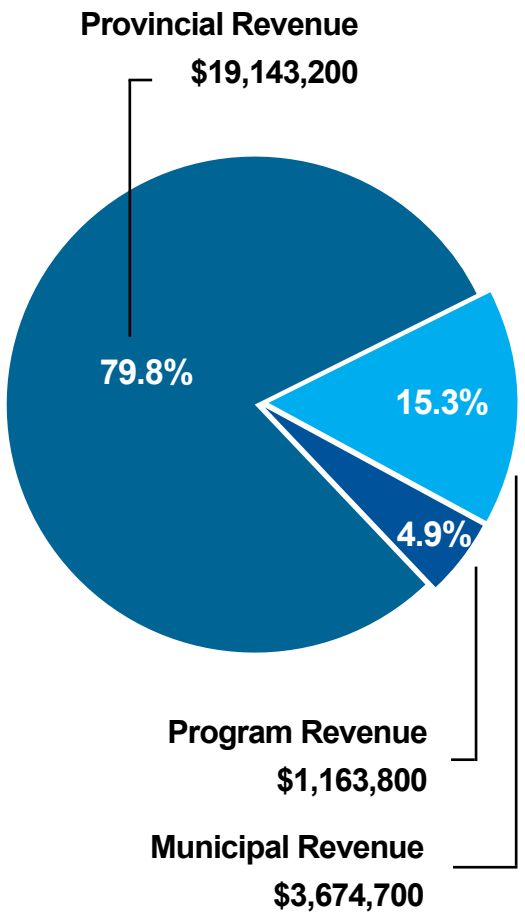
- Refreshed the layout of the Health Unit's website and made it mobile friendly. Since inception the site has had **30,975** visits from **20,749** unique visitors resulting in **84,623** page views.
- Issued **25** news releases, and were featured in over **150** stories.
- Grew our Facebook presence with **1,169,335** overall impressions with the average post reaching **1,793** people.
- Grew our Twitter presence with **90,454** overall impressions.
- Ran a campaign to promote the Health Unit resulting **15,357** impressions on Facebook **13,135** impressions on Twitter.



2018 Unaudited Expenditures by Program & Service

Program & Service	Dollars ($)
Occupancy & Information Technology	2,815,800.00
Food/Water/Rabies/Other Environmental Hazards	2,175,900.00
Reproductive & Child Health, Healthy Babies	2,108,500.00
Organizational Supports	2,104,600.00
Chronic Disease/Injury Prevention/Substance Use	2,016,900.00
Sexual Health	1,682,100.00
Dental Services	1,678,800.00
Vaccine Preventable Disease	1,421,400.00
Communicable & Infectious Disease Control	1,235,700.00
Research & Quality Assurance	904,300.00
Building & Land	852,100.00
Office of the Medical Officer of Health	464,300.00
Smoking and Tobacco	449,800.00
Genetics	280,200.00
Communications & Community Information Office	261,400.00
Vector Borne Disease	169,500.00
Emergency Preparedness	127,800.00
Total Expenditures	**20,749,100.00**

Total Revenue 2018:



Peterborough Public Health
1889-2019 LOCAL & STRONG

Jackson Square, **185 King Street**, Peterborough, ON K9J 2R8
P: **705-743-1000** or 1-877-743-0101
F: 705-743-2897
peterboroughpublichealth.ca

April 3, 2019

The Honourable Lisa MacLeod
Minister of Children, Community and Social Services
Hepburn Block, 6th Floor
80 Grosvenor Street
Toronto, ON M7A 1E9
lisa.macleod@pc.ola.org

The Honourable Christine Elliott
Deputy Premier and Minister of Health and Long-Term Care
College Part, 5th Floor
777 Bay Street
Toronto, ON M7A 213
christine.elliott@pc.ola.org

Dear Ministers:

RE: Bill 60 (An Act to amend the Ministry of Community and Social Services Act to establish the Social Assistance Research Commission)

I am writing to you on behalf of the Board of Health for Peterborough Public Health in support of the North Bay Parry Sound District Health Unit's call for the establishment of the Social Assistance Research Commission (SARC). We urge the passing of Bill 60 as an important step towards fiscal responsibility for health care costs and to address health inequities associated with food insecurity.

Food insecurity is inadequate or insecure access to food due to financial constraints. It is an extremely significant cost to the Ontario health care system. Between 2005 and 2010, health care costs were 23-121% higher for Ontarians in food insecure households. Having enough money for healthy food is critical for health and well-being, and when people are food insecure, they are more likely to suffer chronic health conditions such as heart disease, diabetes, and cancer.

Our region has some of the highest food insecurity rates in Ontario, with 1 in 6 households worrying about not having enough money for food. In 2013-14 in Ontario, 64% of households on social assistance experienced food insecurity. The root cause of food insecurity is insufficient income to pay for food. In 2018, a single man in our region on Ontario Works had only $105 left after paying market rent for a bachelor apartment, but the cost of food was just over $300 (See the attached 2018 Limited Incomes Report). If social assistance rates are insufficient to meet rent and food costs, our residents on social assistance cannot meet these and other basic needs, such as utilities, clothing, and transportation? Basic needs of residents on social assistance must be met to ensure that all Ontarians can achieve physical, mental and social well-being.

Establishment of a SARC would determine the cost of living for Ontario residents on social assistance. This is an important step towards residents having adequate income for food which in the long term will lower costs to the Ontario Health System.

Furthermore, our Board of Health is committed to addressing upstream approaches to support health, and striving for equity in our community. We view adequacy of income as crucial to the health and well-being of all residents. On behalf of the Board of Health, I respectfully urge the Standing Committee on Social Policy to promptly move ahead with hearings on Bill 60.

Sincerely,

Original signed by

Councillor Kathryn Wilson
Chair, Board of Health

/ag
Encl.

cc: The Honourable Doug Ford, Premier of Ontario
The Honourable Vic Fedeli, Minister of Finance
Local MPPs
Association of Local Public Health Agencies
Ontario Boards of Health

North Bay Parry Sound District Health Unit
Bureau de santé du district de North Bay-Parry Sound
Your lifetime partner in healthy living.
345 Oak Street West, North Bay, ON P1B 2T2 TEL 705-474-1400 FAX 705-474-8252
70 Joseph Street, Unit 302, Parry Sound, ON P2A 2G5 TEL 705-746-5801 FAX 705-746-2711
myhealthunit.ca 1-800-563-2808

February 27, 2019

The Honourable Doug Ford
Premier of Ontario
Legislative Building, Room 281
Queen's Park
Toronto, ON M7A 1A1

The Honourable Christine Elliott
Deputy Premier and Minister of Health and Long-Term Care
College Park, 5th Floor
777 Bay Street
Toronto, ON M7A 2J3

The Honourable Lisa MacLeod
Minister of Children, Community and Social Services
Hepburn Block, 6th Floor
80 Grosvenor Street
Toronto, ON M7A 1E9

The Board of Health for the North Bay Parry Sound District Health Unit (Board) would like to share with you the resolutions passed at our recent meeting on February 27, 2019. The resolutions highlight our continued support of staff and community stakeholders to reduce health inequities, and our support for Bill 60, an act to amend the Ministry of Community and Social Services Act to establish the Social Assistance Research Commission. A copy of the motion passed is included as Appendix A.

One in seven households in our Health Unit region experience food insecurity. Included is a copy of our 2018 Food Insecurity poster, highlighting this important statistic, as Appendix B. Our goal with this key messaging is to emphasize the magnitude of this issue in our area. The full report is available on our website.

While our community has a broad gamete of important social service and food charity programs in place to assist those experiencing food insecurity, this complex issue cannot be adequately or sustainably addressed at the local level. Food insecurity is defined as inadequate or insecure access to food due to financial constraints, which highlights low income as the root of the problem. Our Health Unit continues to raise awareness about the importance of income security for low income Ontarians, in an effort to reduce food insecurity rates. Food insecurity is a significant public health problem because of its great impact on health and well-being. In light of the release of the new Canada's Food Guide, it is important to note that these dietary recommendations are out of reach for many low-income Canadians.

While there are a number of risk factors for being food insecure, social assistance recipients are at particularly high risk. Research has shown that 64% of households in Ontario receiving social assistance

experience food insecurity, demonstrating that social assistance rates are too low to protect recipients from being food insecure. For this reason, our Board supports Bill 60, an act to amend the Ministry of Community and Social Services Act to establish the Social Assistance Research Commission. This group will make recommendations on social assistance policy, including social assistance rates based on the real costs of living in regions across Ontario, taking into account the cost of healthy eating. Our Health Unit, community partners and households receiving social assistance are eagerly awaiting the release of more details about the changes that will be made to Ontario's social assistance system following Minister MacLeod's announcement on November 22, 2018. Please consider the establishment of the Social Assistance Research Commission as part of the changes that will ensue by prioritizing Bill 60.

Last year, we expressed our support and feedback to the previous government on the *Income Security: A Roadmap for Change* report. This report was prepared in collaboration with many experts, including Indigenous representatives, and has already undergone a public consultation process. Please take into account the elements outlined in this report when implementing changes to the current social assistance system. We emphasized this last August, when we expressed our concern about the cancellation of the basic income pilot project and the reduction to the scheduled increase to social assistance rates in 2018.

Thank you for taking the time to review this information and we will look forward to hearing next steps in strengthening income security in Ontario.

Sincerely,

Original Signed by Dr. Jim Chirico

James Chirico, H.BSc., M.D., F.R.C.P. (C), MPH
Medical Officer of Health/Executive Officer

Original Signed by Don Brisbane

Don Brisbane
Vice-Chairperson, Board of Health

Enclosures (2)

Copied to:
Victor Fedeli, MPP, Nipissing
Norm Miller, MPP, Parry Sound-Muskoka
John Vanthof, MPP, Timiskaming-Cochrane
Robert Bailey, MPP, Sarnia-Lambton
Paul Miller, MPP, Hamilton East-Stoney Creek
North Bay Parry Sound District Health Unit Member Municipalities
Joseph Bradbury, Chief Administrative Officer, DNSSAB
Janet Patterson, Chief Administrative Officer, PSDSSAB
Loretta Ryan, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health

North Bay Parry Sound District Health Unit
Bureau de santé du district de North Bay-Parry Sound
Your lifetime partner in healthy living.
345 Oak Street West, North Bay, ON P1B 2T2 TEL 705-474-1400 FAX 705-474-8252 | myhealthunit.ca
70 Joseph Street, Unit 302, Parry Sound, ON P2A 2G5 TEL 705-746-5801 FAX 705-746-2711 | 1-800-563-2808

Appendix A

NORTH BAY PARRY SOUND DISTRICT HEALTH UNIT
BOARD OF HEALTH

RESOLUTION

DATE: February 27, 2019 **MOVED BY:** Mike Poeta

RESOLUTION: #BOH/2019/02/04 **SECONDED BY:** Dan Roveda

***Whereas**, The Nutritious Food Basket Survey results show that many low income individuals and families do not have enough money for nutritious food after paying for housing and other basic living expenses; and*

***Whereas**, The Board of Health for the North Bay Parry Sound District Health Unit recognizes the impact of adequate income on food security and other social determinants of health; and*

***Whereas,** Food insecurity rates are very high among social assistance recipients; and*

***Whereas**, Bill 60 (An Act to amend the Ministry of Community and Social Services Act to establish the Social Assistance Research Commission) would help ensure social assistance rates are indexed to inflation, reviewed on an annual basis, and reflect regional costs of living including the cost of a Nutritious Food Basket; and*

***Whereas**, the Ontario Public Health Standards require public health units to assess and report on the health of local populations, describing the existence and impact of health inequities;*

***Therefore Be It Resolved,** That the Board of Health for the North Bay Parry Sound District Health Unit continue to support the efforts of employees and community stakeholders to reduce health inequities, including food insecurity; and*

***Furthermore Be It Resolved,** That the Board of Health support Bill 60 (An Act to amend the Ministry of Community and Social Services Act to establish the Social Assistance Research Commission); and*

***Furthermore Be It Resolved,** That the Board of Health provide correspondence of these resolutions to district municipalities, Ontario Boards of Health, Victor Fedeli, MPP (Nipissing), Norm Miller, MPP (Parry Sound-Muskoka), John Vanthof, MPP (Timiskaming-Cochrane), the Honourable Doug Ford (Premier), the Honourable Lisa MacLeod (Minister of Community and Social Services), the Honourable Christine Elliott (Minister of Health and Long-Term Care) and the Association of Local Public Health Agencies (alPHa).*

CARRIED: ✓ **VICE-CHAIRPERSON:** *Original Signed by Don Brisbane*

1 in 7

Nipissing and Parry Sound homes are food insecure because they don't have enough money.

This can mean:

- Worrying about running out of food
- Eating less healthy food
- Skipping meals
- Having poor health

Be informed myhealthunit.ca/foodinsecurity

North Bay Parry Sound District Health Unit

SOUTHWESTERN Public Health
Oxford • Elgin • St.Thomas

St. Thomas Site
Administrative Office
1230 Talbot Street
St. Thomas, ON
N5P 1G9

Woodstock Site
410 Buller Street
Woodstock, ON
N4S 4N2

April 3, 2019

Honourable Minister Christine Elliott
Minister of Health and Long-Term Care
80 Grosvenor Street, 10th Floor, Hepburn Block
Ministry of Health and Long-Term Care
Toronto, Ontario, M7A 1E9

Delivered via email
Christine.elliott@ontario.ca

Dear Minister Elliott,

On behalf of the Board of Health for Southwestern Public Health (SWPH), we applaud the Ministry of Health and Long-Term Care (MOHLTC) for striving to achieve optimal health and wellness for school-aged children and youth. It is, however, with concern that I am writing to you regarding funding for the Child Visual Health and Vision Screening protocol. The Child Visual Health and Vision Screening protocol was introduced in 2018 (by the MOHLTC) and provides direction to boards of health on child visual health and vision screening services to be offered in the school setting.

Childhood vision screening programs have the potential to detect refractive errors, strabismus and other similar conditions which impact visual acuity and in turn benefit an affected child's visual and general development. We endorse the implementation of the Child Visual Health and Vision Screening protocol to provide vision screening services in the school setting. The protocol requires 100% of all senior kindergarten children to be screened utilizing three different screening tools requiring a minimum of 10-15 minutes per child per screening. In our jurisdiction, there are approximately 2200 children that will need to be screened to maintain the standard in each school year.

To ensure this program is operational and sustainable, it is requested that additional funding be provided to implement this new vision screening program within schools.

Thank you for your consideration of our comments and request. We look forward to hearing from you. For further information, please contact David Smith, Program Director of School Health at dsmith@swpublichealth.ca or 519-631-9900 ext. 1245.

Sincerely,

Larry Martin
Chair, Board of Health

Copy: Members, SWPH Board of Health
C. St. John, CEO, SWPH
M. Nusink, Director of Finance, SWPH
Association of Local Public Health Agencies
Ontario Boards of Health

Peterborough Public Health
1889-2019 LOCAL & STRONG

Jackson Square, **185 King Street**, Peterborough, ON K9J 2R8
P: **705-743-1000** or 1-877-743-0101
F: 705-743-2897
peterboroughpublichealth.ca

April 3, 2019

The Honourable Lisa MacLeod
Ministry of Children, Community and Social Services
56 Wellesley Street West, 14th Floor
Toronto, ON M74 1E9
lisa.macleod@pc.ola.org

Dear Minister MacLeod:

Re: Funding for the Healthy Babies, Healthy Children Program

At its meeting on March 13, 2019, the Board of Health for Peterborough Public Health considered correspondence from Thunder Bay District Health Unit (TBDHU) regarding the above noted matter. We are in full support of TBDHU's call to action and share their concern and the concern of other local public health agencies regarding the Healthy Babies, Healthy Children (HBHC) program funding.

Similarly, to other communities the demand for HBHC services in our community continues to climb, the need is great. As well, Peterborough Public Health has seen an increase in the complexity of clients in the HBHC program.

As you are aware, in 2016 the firm MNP performed a review of the HBHC program provincially and found a funding gap of approximately $7.08M (Ministry of Children and Youth Services-Healthy Babies, Healthy Children Program Review Executive Summary p.7). This gap continues to grow every year with increases in salaries, benefits and operational costs. This gap creates barriers by reducing our reach to at-risk clients and families, as well as creating a wait-list for our services.

We appreciate your attention to this important public health issue.

Sincerely,

Original signed by

Councillor Kathryn Wilson
Chair, Board of Health

/ag
Encl.

cc: Local MPPs
Association of Municipalities of Ontario
Association of Local Public Health Agencies
Ontario Boards of Health

Thunder Bay District
Health Unit

MAIN OFFICE
999 Balmoral Street
Thunder Bay, ON P7B 6E7
Tel: (807) 625-5900
Toll Free in 807 area code
1-888-294-6630
Fax: (807) 623-2369

GREENSTONE
P.O. Box 1360
510 Hogarth Avenue, W.
Geraldton, ON P0T 1M0
Tel: (807) 854-0454
Fax: (807) 854-1871

MANITOUWADGE
1-888-294-6630

MARATHON
P.O. Box 384
Marathon Library Building
Lower Level,
24 Peninsula Road
Marathon, ON P0T 2E0
Tel: (807) 229-1820
Fax: (807) 229-3356

NIPIGON
P.O. Box 15
Nipigon District
Memorial Hospital
125 Hogan Road
Nipigon, ON P0T 2J0
Tel: (807) 887-3031
Fax: (807) 887-3489

TERRACE BAY
P.O. Box 1030
McCausland Hospital
20B Cartier Road
Terrace Bay, ON P0T 2W0
Tel. (807) 825-7770
Fax: (807) 825-7774

TBDHU.COM

November 21, 2018

SENT VIA EMAIL

The Honourable Lisa MacLeod
Minister of Children, Community and Social Services
14th Flr, 56 Wellesley St W,
Toronto, ON
M7A 1E9

Dear Minister MacLeod,
On behalf the Thunder Bay District Health Unit (TBDHU) Board of Health, it is with significant concern that I am writing to you regarding funding for the Healthy Babies, Healthy Children (HBHC) Program.

The Healthy Babies Healthy Children (HBHC) program is a prevention/early intervention initiative designed to ensure that all Ontario families with children (prenatal to age six) who are at risk of physical, cognitive, communicative, and/or psychosocial problems have access to effective, consistent, early intervention services and is a mandatory program for Boards of Health.

In 1997 the province committed to funding the Healthy Babies Healthy Children program at 100%. Province wide funding allocations have been essentially "flat-lined" from an original allocation that was completed in 2008, with the exception of the one-time funding increases for implementation of the 2012 Protocol. In the interim, collective agreement settlements, travel costs, pay increments and accommodation costs have increased the costs of implementing the HBHC program. Management and administration costs related to the program are already offset by the cost-shared budget for provincially mandated programs.

Simultaneously the complexity of clients accessing the program has increased requiring that more of the services be delivered by professional versus non-professional staff. The TBDHU has made every effort to mitigate the outcome of this ongoing funding shortfall however it has become increasingly more challenging to meet the targets set out in HBHC service agreements. At the current funding level services for these high-risk families will be reduced.

In 2016 the firm MNP performed a review of the HBHC program provincially and found that "based on the activities of the current service delivery model, and using the targets outlined in the service agreements … there is a gap in the current funding of the program of approximately $7.808M." (Ministry of Children and Youth Services - Healthy Babies Healthy Children Program Review Executive Summary p.7)

The Thunder Bay District Board of Health continues to advocate that the Ministry of Children, Community and Social Services fully funds the Healthy Babies Healthy Children program, including all staffing, operating and administrative costs.

…/2

Thank you for your attention to this important public health issue.

Sincerely,

Original Signed by

Joe Virdiramo, Chair
Board of Health
Thunder Bay District Health Unit

cc. Michael Gravelle, MPP (Thunder Bay-Superior North)
Judith Monteith-Farrell, MPP (Thunder Bay-Atitkokan)
All Ontario Boards of Health

Perth District Health Unit
653 West Gore Street
Stratford, Ontario N5A 1L4
(519) 271-7600 • www.pdhu.on.ca

April 2, 2019

The Honourable Doug Ford
Premier of Ontario
Legislative Building, Queen's Park
Toronto, ON M7A 1A1

Dear Premier Ford:

Re: Strengthening SFOA, 2017

On March 20, 2019 the Board of Health of the Perth District Health reviewed correspondence from the Renfrew County and District Health Unit and passed a motion to send a letter regarding strengthening the *Smoke-Free Ontario Act, 2017* to address the promotion of vaping.

Vaping among youth has increased in the last two years[1], and e-cigarette use has been found to increase the risk of cigarette use in youth[2]. The Perth District Health unit is concerned that increased exposure to vapour products through display and promotion will lead to further increased vaping and tobacco use in youth, negating the progress made over the last twenty years to de-normalize tobacco use.

While the *Smoke-Free Ontario Act, 2017* and accompanying regulation included many favourable changes regarding smoking of tobacco, cannabis and vaping of any substances, further strengthening of the Act is needed. The current legislation only bans vaping product displays at retail outlets and does not restrict other types of retail promotion for vaping products at vapour product retailers. This has led to widespread advertising both in and outside of these premises, exposing kids and youth to vapour product marketing. We have seen creative advertisements such as, displays, posters and signs that are affixed to windows, on power walls, hung from ceilings, and attached to the pumps and concrete bollards at gas stations.

We are concerned about the appeal of these vapour products advertisements on children and youth as the sheer magnitude of this advertising can make these products seem socially desirable. The evidence clearly states that non-tobacco users should not start using vapour products; especially youth and young adults[3]. In addition to the risk of e-cigarette use increasing future combustible tobacco use and the known health effects from tobacco, public health is concerned about the detrimental impacts that nicotine exposure can have on the developing brain[4].

The Perth District Health Unit supports the strengthening of the *Smoke-Free Ontario Act, 2017* to include banning all advertisements at any point of sale location where youth have access. This prohibition should be inclusive of any type of physical or electronic promotion including window and countertop displays, 3D models of vapour products, posters, signs, free-standing advertising (both in-store and outside store premises) and images on convenience store screens.

Sincerely,

Kathy Vassilakos, Chair
Board of Health

.../over

References:

1. Propel Centre for Population Healthy Impact, University of Waterloo. Canadian Student Tobacco, Alcohol and Drugs Survey Overview of Results, 1994-2016/17; 2018
2. National Academies of Sciences, Engineering, and Medicine. Public Health Consequences of E-Cigarettes. Washington National Academies Press. Published 2018. Accessed March 29, 2019
3. Berry, K. M., Fetterman, J. L., Benjamin, E. J., Bhatnagar, A., Barrington-Trimis, J. L., Leventhal, A. M., & Stokes, A. (2019). Association of Electronic Cigarette Use With Subsequent Initiation of Tobacco Cigarettes in US Youths. *JAMA network open*, *2*(2), e187794-e187794.
4. England, L.J., Bunnell, R.E., Pechacek, T.F., Tong, V.T. and McAfee, T.A., 2015. Nicotine and the developing human: a neglected element in the electronic cigarette debate. American Journal of Preventive Medicine, 49(2), pp.286-293.

MK/mr

c. Randy Pettapiece, MPP Perth Wellington
Ontario Boards of Health

alPHa
Association of Local PUBLIC HEALTH Agencies

CONGRATULATIONS on Your Successful 2018 Municipal Election

The job you've taken on is extremely important. As an elected official, you are a leader in your community and an advocate on behalf of your constituents. You are part of a local government that plays an essential role in building a vibrant and sustainable community. You will make meaningful decisions that impact everyone who lives, works, learns and plays in your community. It's a big responsibility and we want you to know that your local public health unit shares your enthusiasm for ensuring everyone living in your community is as healthy as possible.

Today's health threats are more likely to be chronic diseases such as obesity, diabetes and heart disease rather than infectious diseases.

It is now understood that good health comes from a variety of factors and influences, 75% of which are not related to the health care delivery system.

These determinants of health are interconnected and contribute to the health of the population (see graphic next page).

Where we've been & **where we are now**

At the turn of the twentieth century, local governments targeted efforts on the provision of clean drinking water, sewers and garbage disposal—all major contributors to preventing disease. During this time, public health delivered vaccines in the community to prevent infectious diseases like smallpox, diphtheria, typhus, cholera and tuberculosis, polio, and mumps. The success of these past interventions by government and public health can be seen a century later: Today, these diseases are non-existent or minimal in Ontario.

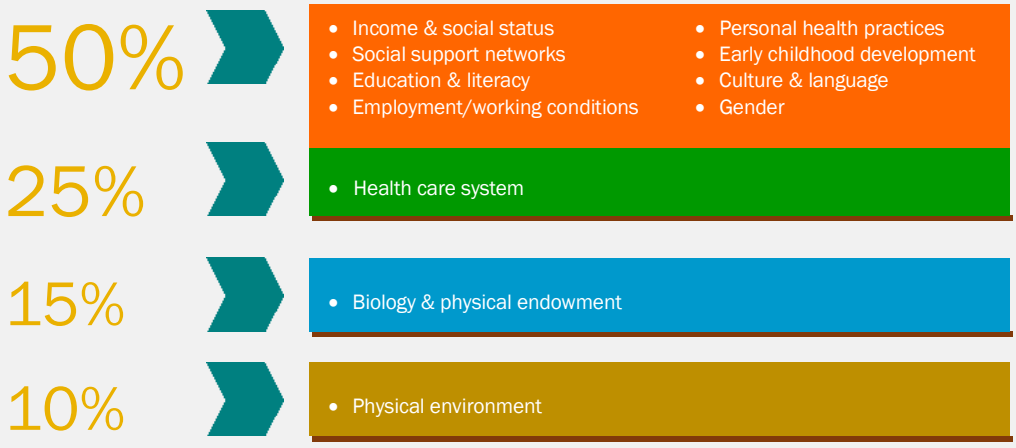
Why focus on health & **what you can do**

- Two-thirds of Ontarians over 45 have one or more chronic disease(s)
- Over 50% of Ontario's adults and about 20% of youth are overweight
- Obesity has a direct effect on the rate of Type 2 diabetes and heart disease
- Nearly half of all cancer deaths are related to tobacco use, diet and lack of physical activity
- As much as half of the functional decline between the ages of 30 and 70 is due not to aging itself but to an inactive lifestyle

Local governments can play a unique role in shaping the local conditions that have an impact on the health of individuals and communities. For example, elected officials make important decisions that impact citizens' health in:

- Community planning and the built environment
- Parks and recreation facilities and their programming
- Health-related policies

What influences our health?



alPHa
Association of Local PUBLIC HEALTH Agencies

The Association of Local Public Health Agencies (alPHa) is a non-profit organization that provides leadership to Ontario's boards of health and public health units. The Association works with governments and other organizations to advocate for a strong and effective public health system in the province, as well as public health policies, programs and services that benefit all Ontarians.

As a member of a board of health, you are automatically a member of alPHa.

For more information:

info@alphaweb.org

www.alphaweb.org

@PHAgencies

Watch our video What is Public Health?
https://youtu.be/qhl595Q0ohg

What is **population and public health**?

Your public health unit and the board of health which governs it use a population health approach. Population health focuses on the interrelated conditions and factors that influence the health of populations over the life course. It does this by:

- identifying the root causes of a problem, and developing evidence-based strategies to address it
- improving aggregate health status of the whole community, while considering the special needs and vulnerabilities of sub-populations
- working through partnerships and intersectoral cooperation
- finding flexible and multi-dimensional solutions for complex problems
- encouraging public involvement and community participation

What is the **role of boards of health**?

Municipal elected officials can play an essential role in supporting public health unit activity by becoming a member of a local board of health. The role of a board of health is to provide public health programs and services in the areas specified in the provincially mandated *Ontario Public Health Standards*. The responsibilities of a board of health are to:

- uphold legislation governing the board of health's mandate under the *Health Protection and Promotion Act* and others, and meet government expectations on accountability, governance and administrative practices as outlined in the *Public Health Accountability Framework and Organizational Requirements*
- be aware of changing community trends and needs in order to develop policies to protect and promote community health
- represent the health unit in the community
- ensure the health unit's finances are adequate and responsibly spent
- hire a medical officer of health who is responsible for the management of the health unit

AMO Association of Municipalities Ontario

April 11, 2019

2019 Budget Highlights

Here are the immediate highlights of the 2019 Provincial Budget. Many of these items are provided at a high level. A detailed Budget Bill will follow in the coming days.

The Fiscal Environment

- The Provincial government has committed to **balancing the budget** by 2023-24 in a responsible way. To 2023-24, total revenue is projected to grow at an average annual rate of 3%. Program expense over the same period is expected to grow at an average rate of 1%.
- The government is now projecting a deficit of $11.7 billion in 2018-19, $10.3 billion in 2019-20, $6.8 billion in 2020-21, and $5.6 billion in 2021-22.

Changes related to the role of municipal governments

- The **Social Assistance** system reform is expected to result in an estimated annual saving of over $1 billion at maturity by simplifying the rate structure, reducing administration, cutting unnecessary rules, and providing greater opportunities to achieve better employment outcomes.
- The Province will not be increasing the value of the municipal share of the **provincial gas tax** program as had been anticipated. Currently it is $364 million to 107 municipal governments. The government will consult with municipalities to review the program parameters and identify opportunities for improvement.
- The Province will introduce legislation to permit municipal governments to designate public areas, such as parks for the **consumption of alcohol**. There are other alcohol reforms contained in the budget such as the creation of a tailgating permit for eligible sporting events and extending hours of service in licensed establishments to a 9 am start, seven days a week.
- Investing $3.8 billion for **mental health**, addictions and housing supports over 10 years, beginning with the creation of a mental health and addictions system.
  - In 2019–20, a $174 million investment will support community mental health and addictions services, mental health and justice services, **supportive housing** and acute mental health inpatient beds.
- On **property assessment**, the province will be conducting a review to explore opportunities to:
  - "Enhance the accuracy and stability of property assessments;
  - Support a competitive business environment;
  - Provide relief to residents"; and
  - Changes to the composition of the Board of the Municipal Property Assessment Corporation (MPAC) to increase the representation of property taxpayers. (This would dilute current municipal government representatives.)

- On **public health** in 2019-20, the government will:
  - Improve program and back office efficiencies by adjusting provincial-municipal cost sharing of public health funding;
  - By 2020-21, establish 10 regional public health entities and 10 new regional boards of health with one common governance model; and
  - It is expected by 2021-22, that these changes will lead to annual savings of $200 million.

- **Land ambulance** dispatch services will be streamlined by integrating Ontario's 59 emergency health services operators (e.g. 52 EMS, Ornge) and 22 provincial dispatch communication centres.

- Making home ownership and renting more affordable by helping to increase the supply of housing that people need through the forthcoming **Housing Supply Action Plan**. Details to come.

- Municipalities will be required to provide real-time reporting of **sewage outflows** and the government will update policies related to municipal wastewater and stormwater.

- Create 15,000 new **long-term care beds** over the next five years and upgrade 15,000 older long-term care beds to provide more appropriate care to patients with complex health conditions. In addition to the over 6,000 new beds previously allocated, 1,157 new long-term care beds will immediately be allocated to 16 projects across the province.

- The Province will explore **revenue sharing**, including Northern communities in the mining, forestry, and aggregates sectors.

- Regarding the **Ontario Provincial Police**, the government will explore opportunities to "encourage workforce optimization, including vacancy management, overtime and scheduling" to save $30 million annually starting in 2019-20 without impacting front-line policing and community safety.
- The government will invest $16.4 million over two years to create a province-wide strategy to help combat **gun and gang related crime**.

Changes affecting your Community

- The government will invest $315 million over five years as part of its **Broadband and Cellular Strategy** which will be released later this year.

- The new CARE (Ontario Childcare Access and Relief from Expenses) tax credit would provide about 300,000 families with up to 75 per cent of their eligible **child care** expenses and allow families to access a broad range of child care options, including care in centres, homes and camps.

- Individual seniors with annual incomes of $19,300 or less, or senior couples with combined annual incomes of less than $32,300, will be able to receive **dental services** in public health units, community health centres and Aboriginal Health Access Centres across the province.

- The government is reviewing the forestry sector to develop a strategy that includes: challenges the industry currently faces; initiatives to encourage innovation and reduce red tape; and methods to promote made-in-Ontario wood products.

- The government will hold consultations to repeal the *Far North Act* and remove red tape on economic development projects like the **Ring of Fire**. Environmental assessment studies have been initiated for all-season access roads to the Ring of Fire.

- The province is proposing to develop an **immigration pilot initiative** to disperse the benefits of immigration across Ontario. The budget also proposes changes to the Ontario Immigrant Nominee Program aimed at modernizing the program to better address labour market shortages.

- **Energy conservation** and efficiency programs will be phased out saving up to $442 million.

- A return to the default benefit limit of $2 million for those who are catastrophically injured in an accident, after it was previously reduced to $1 million in 2016.

AMO will continue to review the budget document and related bills and provide further updates and details as needed in the days ahead.

AMO Contact: Matthew Wilson, Senior Advisor, mwilson@amo.on.ca, 416-971-9856 extension 323.

Association of Local PUBLIC HEALTH Agencies

2 Carlton Street, Suite 1306
Toronto ON M5B 1J3
Tel: (416) 595-0006
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E-mail: mail@alphaweb.org

Providing leadership in public health management

NEWS RELEASE

April 12th, 2019 **For Immediate Release**

Ontario Budget 2019 – Reducing Investments in Public Health

The Association of Local Public Health Agencies (alPHa), which represents Ontario's Medical Officers of Health, Boards of Health members and front-line public health professionals throughout the province, is surprised and deeply concerned to learn of the Government's plans to restructure Ontario's public health system and reduce its funding by $200M per year.

"Investments in keeping people healthy are a cornerstone of a sustainable health care system. We have spent considerable time since the election of the new Government communicating the importance of Ontario's locally-based public health system to ending hallway medicine," said alPHa President Dr. Robert Kyle. "The reality is that this $200M savings is a 26% reduction in the already-lean annual provincial investment in local public health. This will greatly reduce our ability to deliver the front-line local public health services that keep people out of hospitals and doctors' offices."

In order to achieve this reduction, the Government is proposing to replace 35 public health units and 35 local boards of health with 10 larger regional entities with boards of health of unknown composition and size. As alPHa pointed out in its response to the previous Government's Expert Panel on Public Health Report (which proposed a similar reduction), the magnitude of such a change is significant and will cause major disruptions in every facet of the system. "The proposed one-year time frame for this change is extremely ambitious, and we hope that the government will acknowledge the need to carefully examine the complexities of what it is proposing and move forward with care and consideration," added Dr. Kyle.

Public Health initiatives show a return on investment. Much of the success of our locally-based public health system can be attributed to partnerships with municipal governments, schools and other community stakeholders to develop healthy public policies, build community capacity to address health issues and promote environments that are oriented towards healthy behaviours. The health protection and promotion needs of Ontarians vary significantly depending on their communities, and preserving these partnerships is essential to meeting them regardless of the number of public health units.

We look forward to receiving more details of this plan from the Ministry so that we can work with them to ensure that Ontario's public health system continues to draw strength from dedicated local voices and effective partnerships and maintains the capacity to deliver essential front-line health protection and promotion services while working to meet the Government's stated goals of broader municipal engagement, more efficient service delivery, better alignment with the health care system and more effective staff recruitment and retention.

- 30 -

For more information regarding this news release, please contact

Loretta Ryan
Executive Director
(647) 325-9594
(416) 595-0006 ext. 22

About alPHa

The Association of Local Public Health Agencies (alPHa) is a non-profit organization that provides leadership to Ontario's boards of health and public health units. The Association works with governments and other health organizations, to advocate for a strong and effective local public health system in the province, as well as public health policies, programs and services that benefit all Ontarians. Further details on the functions and value of Ontario's public health system are available in alPHa's 2019 Public Health Resource Paper (https://bit.ly/2G8F3Ov)

Public Health
Santé publique
SUDBURY & DISTRICTS

April 10, 2019

All Ontario Senators
The Senate of Canada
Ottawa, ON K1A 0A4

Dear Honourable Ontario Senators:

Re: Support for Bill S-228, Child Health Protection Act

On behalf of the Board of Health for Public Health Sudbury & Districts, please accept this correspondence reaffirming our full support for Bill S-228, Child Health Protection Act, which, when passed, would ban food and beverage marketing to children under 13 years of age.

Food and beverage advertisements directed at children can negatively influence lifelong eating attitudes and behaviours (including food preferences, purchase requests, and consumption patterns). Regulation of food and beverage marketing to children is considered an effective and cost saving population-based intervention to improve health and prevent disease.

In 2016, the Board of Health supported a motion in support of Bill S-228 and urged the federal government to implement a legislative framework to protect child health by ensuring protection from aggressive marketing of unhealthy food and beverages. Additionally, the Association of Local Public Health Agencies and the Ontario Dietitians in Public Health have submitted letters expressing their full support for Bill S-228.

The Board of Health for Public Health Sudbury & Districts commends you for your leadership in the development of this landmark piece of legislation. Bill S-228 has passed its third reading in the House of Commons and is awaiting royal assent. As a critical step to improving the health of Canadians, we respectfully request that you pass Bill S-228 without further delay.

Sincerely,

René Lapierre, Chair
Board of Health, Public Health Sudbury & Districts

cc: Association of Local Public Health Agencies
Ontario Boards of Health

Sudbury
1300 rue Paris Street
Sudbury ON P3E 3A3
t: 705.522.9200
f: 705.522.5182

Rainbow Centre
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Unit / Unité 130
Sudbury ON P3C 5N3
t: 705.522.9200
f: 705.677.9611

Sudbury East / Sudbury-Est
1 rue King Street
Box / Boîte 58
St.-Charles ON P0M 2W0
t: 705.222.9201
f: 705.867.0474

Espanola
800 rue Centre Street
Unit / Unité 100 C
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t: 705.222.9202
f: 705.869.5583

Île Manitoulin Island
6163 Highway / Route 542
Box / Boîte 87
Mindemoya ON P0P 1S0
t: 705.370.9200
f: 705.377.5580

Chapleau
101 rue Pine Street E
Box / Boîte 485
Chapleau ON P0M 1K0
t: 705.860.9200
f: 705.864.0820

Toll-free / Sans frais
1.866.522.9200

phsd.ca

KFL&A Public Health

April 17, 2019

The Honourable Christine Elliott, Deputy Premier
Minister of Health and Long-Term Care
Hepburn Block 10th Floor
80 Grosvenor Street
Toronto, ON M7A 1E9

The Honourable Steve Clark
Minister of Municipal Affairs and Housing
17th Floor
777 Bay Street
Toronto, ON M5G 2E5

Dear Ministers:

Ontario's local public health system is an essential part of keeping communities safe and healthy. Public health delivers excellent return on investment and works on the front line to protect our communities from illness and promote health and wellbeing. The services provided by public health, centred on Ontario's Public Health Standards, ensure that our population stays out of the health care system and remain well for as long as possible.

As the Chair of the Board of KFL&A Public Health, I unequivocally support KFL&A Public Health and its staff in the work that they do. The needs of Ontarians are variable and preserving partnerships locally is essential. Local knowledge and expertise to ensure the health of our communities is not something that our region can afford to lose.

Our Board of Health was surprised and disappointed to learn of the Government of Ontario's plans to restructure Ontario's public health system. The proposed $200 million per year reduction in funding for local public health services represents a significant strain on the ability of local public health agencies like KFL&A Public Health to continue to deliver on their mandate. A reduction in funding that represents 26% of the budget cannot happen without cutting services. These cuts will impact our ability to deliver the front-line public health services that keep people out of hospitals and doctors' offices and will ultimately mean a greater downstream cost to the health care system.
KFL&A Public Health's Board is requesting the Province of Ontario maintain and augment the health protection, promotion, and prevention mandate of KFL&A Public health. Furthermore, we request the Province of Ontario maintain the current 75 percent provincial, 25 percent municipal funding formula for KFL&A Public Health and public health programs in Ontario. We request that the Province of Ontario stop the planned reduction of Ontario public health units from 35 to 10 and the planned reduction by $200 million from public health and instead initiate consultations with municipalities and

public health agencies on the public health system in Ontario. Finally, we have directed the Medical Officer of Health and the staff of KFL&A Public health to work with the Association of Local Public Health Agencies to coordinate and support their efforts to respond to cuts to public health in Ontario. We called upon the municipalities that fund KFL&A Public Health to do the same.

Money invested into public health is money well spent; prevention is the fiscally responsible investment for our communities. There is strong evidence to support the excellent return on investment that public health offers, with an average of $14 of upstream savings for every $1 investment in public health services.

It has been fifteen years since the last major public health crisis in this province, and we have learned well from those lessons. We do not wish to repeat the mistakes of the past; the cuts proposed by this government have the potential to jeopardize our ability to protect the health of the people of Ontario.

Ontario has an integrated, cost-effective, and accountable public health system. Boards of health provide programs and services tailored to address local needs across the province. The public health system works upstream to reduce demands and costs to the acute care sector while providing essential front-line services to local communities. Modest investments in public health generate significant returns. In short, public health plays an important role in our work, our families, and our communities. Divestment from it would be a loss for all.

Sincerely,

Denis Doyle, Chair
KFL&A Board of Health

Copy to: *Hon. D. Ford, Premier of Ontario*
Hon. H. Angus, Deputy Minister of Health and Long-Term Care
Ian Arthur, MPP Kingston and the Islands
Daryl Kramp, MPP Hastings-Lennox and Addington
Dr. David William, Chief Medical Officer of Health
Loretta Ryan, Association of Local Health Agencies
Ontario Boards of Health
Board of Health members
Kelly Pender, CAO, County of Frontenac
Brenda Orchard, CAO, County of Lennox and Addington
Mayor B. Paterson and City Councillors
Monica Turner, Director of Policy, Association of Municipalities of Ontario

April 17, 2019

The Honourable Christine Elliott
Deputy Premier and Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Minister Elliott:

Re: Urgent provincial action needed to address the potential health and social harms from the ongoing modernization of alcohol retail sales in Ontario

On behalf of the Simcoe Muskoka District Health Unit (SMDHU) Board of Health, I am writing to urge the Government of Ontario to develop a comprehensive provincial alcohol strategy to mitigate harms and monitor the health impacts of increasing access and availability of alcohol in Ontario.

Alcohol costs to the individual and society are significant. In 2014, Ontario spent $5.34 billion on alcohol-related harms, including $1.5 billion for healthcare and $1.3 billion for criminal justice.[1] Since 2015, alcohol use has contributed to more than 43,000 emergency room visits and 66 hospitalizations per day, a significant and avoidable burden on Ontario's healthcare system.[2]

It is well established that increased alcohol availability leads to increased consumption and alcohol-related harms. A comprehensive, provincially led alcohol strategy can help mitigate the potential harms of alcohol use as the government liberalizes access. Such a strategy should include:

- Strong policies to minimize the potential health and social harms of alcohol consumption;
- An improved monitoring system to track alcohol-related harms;
- Rigorous enforcement of alcohol marketing regulations, and;
- Public education and awareness campaigns aimed at changing attitudes and social norms around consumption.

The Ontario Government has committed to ensure the health and safety of our communities as it increases the availability of alcohol; however, recent changes in the way alcohol is sold and the 2019 Ontario Budget 'Protecting What Matters Most' [3] released on April 11, 2019 suggest that economic interests are superseding the health and well-being of Ontarians and further diminishes the likelihood of meeting the goal of ending hallway medicine. Recent changes that raise the potential for increased alcohol-related harms include reducing the minimum retail price of beer to $1.00, halting the annual inflation-indexed increase in the beer tax, and extending the hours of sale for alcohol retail outlets. This is in conjunction with the anticipated changes of legislation permitting municipalities to designate public areas for consumption of alcohol, advertising happy hour and creating a tailgating permit for eligible sporting events including post-secondary events.

The SMDHU Board of Health has on numerous occasions sent advocacy letters to the provincial government to support healthy alcohol policy, most recently in 2017, calling on the government to

prioritize the health and well-being of Ontarians by enacting a comprehensive, evidence-based alcohol strategy.

We believe it is possible to create a healthy alcohol culture in Ontario that balances interests in public health, government revenue, economic development, and consumer preferences without sacrificing the health of Ontarians. We support both the Council of Ontario Medical Officers of Health and Association of Local Public Health Agencies' request to ensure such a balance, and we thereby encourage the government to develop a provincial alcohol strategy that incorporates health goals.[4, 5] This would include a monitoring and evaluation plan to measure intended and unintended impacts of policy change. Now is the time for Ontario to take leadership and address the harms of alcohol use in our province.

Thank you for your consideration.

Sincerely,

ORIGINAL Signed By:

Anita Dubeau
Chair, Board of Health

cc. Hon. Vic Fedeli, Minister of Finance
Ken Hughes, Special Advisor for the Beverage Alcohol Review
Doug Downey, MPP Barrie-Springwater-Oro-Medonte
Jill Dunlop, MPP Simcoe North
Andrea Khanjin, MPP Barrie-Innisfil
Norman Miller, MPP Parry Sound-Muskoka
Hon. Caroline Mulroney, MPP York-Simcoe
Jim Wilson, MPP Simcoe-Grey
Dr. David Williams, Chief Medical Officer of Health for Ontario
Loretta Ryan, alPHa Executive Director
Ontario Boards of Health

References

1. The Canadian Centre on Substance Use and Addiction. (2018) Canadian Substance Use Costs and Harms in the Provinces and Territories (2007–2014)
2. Ontario Public Health Association. (2018) The Facts: Alcohol Harms and Costs in Ontario.
3. Ministry of Finance of the Ontario Government, 2019 Ontario Budget Protecting What Matters Most, April 11, 2019 , Honourable Victor Fedeli
4. Council of Ontario Medical Officers of Health, Re: Alcohol Choice & Convenience Roundtable Discussions [Letter written March 14, 2019 to Honorable Vic Fedeli].
5. Association of Local Public Health Agencies, Re: Alcohol Choice & Convenience Roundtable Discussions [Letter written March 8, 2019 to Honorable Vic Fedeli].

Board of Health Resolution

Thunder Bay District Health Unit

MOVED BY: K. O'Gorman SECONDED BY: D. Smith

SOURCE: TBDHU Board of Health DATE: April 17, 2019 **Page 1 of 1**

RESOLUTION NO.: 54b-2019

ITEM NO.: 8.10

X	CARRIED		AMENDED		LOST		DEFERRED/ REFERRED

J. McPherson
CHAIR

RE: Public Health Restructuring

THAT with respect to Public Health Restructuring, the Board of Health:

1. Affirms its support for the Thunder Bay District Health Unit;
2. Requests the Province of Ontario to maintain the health protection and health promotion mandate of the Thunder Bay District Health Unit;
3. Requests the Province of Ontario to maintain the current 75 percent provincial, 25 percent municipal funding for the Thunder Bay District Health Unit;
4. Requests the Province of Ontario to stop the planned reduction of Ontario public health units from 35 to 10 and planned reduction of $200 million from public health, and instead initiate consultation with municipalities and public health agencies on the public health system in Ontario;
5. Directs the Medical of Health of the Thunder Bay District Health Unit to work with the Association of Local Public Health Agencies to support their efforts on responding to the provincial cuts to public health in Ontario;
6. Requests the Province of Ontario to recognize the vast distance and lack of homogeneity in Ontario, north of the French River.

Accordingly, the Province should ensure that distances are manageable and that public health units are not overwhelmed because they are providing service to areas that are too large and vast.

FOR OFFICE USE ONLY --- RESOLUTION DISTRIBUTION

	TO:	*INSTRUCTIONS:*	*TO:*	*INSTRUCTIONS:*
1	Dr. DeMille		S. Stevens	
2.	L. Dyll		S. Oleksuk	
3	L. Roberts		T. Royer	
4	T. Rabachuk			
5				
6				File Copy

April 18, 2019

The Honourable Doug Ford
Premier of Ontario
Legislative Building, Queens Park
Toronto, ON M7A 1A1
Sent via e-mail: doug.ford@pc.ola.org

The Honourable Christine Elliott
Deputy Premier and Minister of Health and Long-Term Care
Hepburn Block 10th Floor
80 Grosvenor Street
Toronto, ON M7A 1E9
Sent via email: christine.elliott@pc.ola.org

Dear Premier Ford and Minister Elliott

During its regular board meeting on April 17, 2019, the Board of Health for the Perth District Health Unit reviewed the budget tabled by the government of Ontario on April 11, 2019 with regard to proposed changes to local public health, specifically:

- Changes to municipal-provincial cost-sharing (2019-2020)
- 35 local agencies to become 10 regional (2020-21)
- $200M reduction (2021-2022) (Current provincial funding is ~$750M)

Background considerations included:

- the alPHa letter to Dr. Devlin (regarding the First Report of the Premier's Council on Improving Healthcare and Enduing Hallway Medicine: *Hallway Health Care: A System Under Strain*) outlining the important role of Public Health in keeping communities strong and healthy and preventing people from becoming patients, and the excellent return on investment delivered by public health programs and services
- previous reports on the organization of public health in Ontario including the 2006 Report of the Capacity Review Committee, *Revitalizing Ontario's Public Health Capacity* and the 2017 Report of the Ministers Expert Panel *Public Health within an Integrated Health System*
- current work being taken to amalgamate Perth District Health Unit with Huron County Health Unit.

…/2

Given the significant changes being proposed, the board moved to:

- Request the Province of Ontario to maintain the health protection and health promotion and prevention mandate of the Perth District Health Unit;
- Request the continued support of the Province of Ontario for the merger of the Perth District Health Unit and Huron County Health Unit;
- Request the Province of Ontario to maintain the current 75% provincial, 25% municipal funding formula for the Perth District Health and public health programs in Ontario;
- Request the Province of Ontario to stop the planned reduction of Ontario public health units from 35 to 10 and planned reduction of $200 million (2021-2022) from public health and instead initiate consultations with municipalities and public health agencies on the public health system in Ontario;
- Direct the Medical Officer of Health and the Perth District Health Unit to work with the Association of Local Health Agencies to coordinate and support their efforts on responding to the Provincial cuts to public health in Ontario.

Sincerely,

Kathy Vassilakos,
Chair, Perth District Health Unit

cc: Mr. Randy Pettapiece, MPP Perth Wellington
Mayor Dan Mathieson, City of Stratford
Mayor Todd Kasenburg, North Perth
Mayor Robert Wilhelm, Perth South
Mayor Rhonda Ehgoetz, Perth East
Mayor Al Strathdee, Town of St. Marys
Mayor Walter McKenzie, West Perth
Dr. David Williams, Chief Medical Officer of Health, MOHLTC
All Boards of Health
All Health Units
Association of Local Public Health Units

From: "**Bob Leahy**" <baxter@accel.net>
Date: Thu, Apr 18, 2019 at 3:19 PM -0400
Subject: RE: U=U Community Sign-On Submission
To: "Christopher Mackie" <Christopher.Mackie@mlhu.on.ca>
Cc: "Bruce Richman" <bruce@preventionaccess.org>, "Cameron Kinker" <cameron@preventionaccess.org>

Hello Christopher

Thank you so much for signing up to show your support for U=U. We're honoured Middlesex-London Health Unit has joined with 850 other leading organizations from nearly 100 countries. We're proudly adding Middlesex-London Health Unit to the Community Partner's page. Thank you so much for your partnership. Middlesex-London Health Unit is now in the U=U network and will be kept up to date with the latest resources including social marketing campaigns, research, media coverage, position statements, and training opportunities to support you as you share the life changing U=U message with your communities.

Next steps

As a next step, we hope you'll join us in continuing to build a critical mass of accurate online messaging and use every platform to communicate the message. Feel free to check out our Resources page for materials as well as +series, a new customizable, downloadable campaign with posters, videos & GIFs based on authentic stories to inform about #UequalsU & encourage engagement in care. Below are communications strategies that our Community Partners have taken to raise awareness about U=U.

Social media

Announcing the Community Partnership with the hashtag #UequalsU which is connecting folks from all over the world. Sample tweets/Facebook post:

- @ Middlesex-London Health Unit is proud to join @PreventionAC #UequalsU movement to declare people on effective HIV treatment can't pass it on through sex
- @ Middlesex-London Health Unit joins leading researchers and organizations in the field to declare #HIV #undetectable is untransmittable #UequalsU #cantpassiton
- It's time to communicate loud and clear to all people living w/HIV, providers, policymakers, and the public that people living w/HIV on effective treatment can't pass it on! We support #UequalsU #cantpassiton
- #UequalsU is a public health argument for universal access to treatment & care to improve lives and prevent new transmissions. Spreading awareness about the U=U science is essential for ending the epidemic. It's a fact: #HIV #Undetectable = Untransmittable #LeaveNoOneBehind
- We must treat #HIV stigma like a public health emergency & #UequalsU as an effective response. It's time for everyone to take action and share the great news! #ScienceNotStigma

Suggested accounts to follow and retweet/share to stay in the social media loop:

- PAC Twitter account: @PreventionAC
- PAC Instagram: @PreventionAC
- BR Twitter account: @BR999
- Matthew Hodson from @aidsmap: @Matthew_Hodson
- Terrence Higgins Trust: @THTorguk
- CATIE: @CATIEinfo
- U=U Facebook: https://www.facebook.com/groups/UequalsU/

Other Partner hashtags:

#CantPassItOn
#DCTakesonHIV

Statements / Press releases
Issuing statements and/or press releases endorsing the U=U message:
NIH Office of AIDS Research: http://bit.ly/UUnihoar
SHM, Australia: http://bit.ly/UUashm
NAM aidsmap, UK - http://bit.ly/UUaidsmap
AIDS United, USA - http://bit.ly/UUAUnited
CATIE, Canada - http://bit.ly/UUCATIE
END AIDS NY 2020 Community Coalition, USA http://bit.ly/UUNYVLS
NASTAD, USA - http://bit.ly/UUNastad2
British HIV Association, UK http://bit.ly/UUBHIVA
ICASO / INA, Canada/New Zealand - http://bit.ly/UUICASO
The Well Project, USA - http://bit.ly/UUWellProj
Ryan White HIV/AIDS Program: http://bit.ly/rwcolleagueletter2018
NIAID Blogpost: http://bit.ly/niaidsciencevalidatesuu

Updated websites
We encourage all Community Partners to update their online communications. We recognize that for some organizations, updating websites may be a complicated process. We're here to help review sites and suggest ideas.

Live events
Partners have organized forums, conferences and U=U dance-parties, marched in Pride events, and staged rallies to celebrate and inspire action!

Thank you so much for joining the message and the movement. Please feel free to reach out to me with any questions or more information. We look forward to staying in touch as the U=U community continues to share this life-changing, stigma-busting, transmission-stopping news!

All the best,

Bob

Bob Leahy
Managing Director (Canada) and Global Outreach Director, Prevention Access Campaign www.preventionaccess.org

From: U=U Community Partners [mailto:noreply@123formbuilder.io]
Sent: Tuesday, April 16, 2019 3:51 PM
To: baxter@accel.net
Subject: U=U Community Sign-On Submission

Name	Christopher Mackie
Organization	Middlesex-London Health Unit
Email	Christopher.Mackie@mlhu.on.ca
City	London
State	Ontario
Country	Canada
Website	www.healthunit.com
Facebook	www.facebook.com/middlesex.london.health.unit/
Twitter	@MLHealthUnit
Phone	519-663-5317x2444
Message	At its March 21, 2019 meeting, under Correspondence item p), the Middlesex-London Board of Health voted to endorse the Council of Ontario Medical Officers of Health (COMOH) resolution on HIV case management which affirms the understanding that an undetectable HIV viral load poses effectively no risk of HIV transmission within a comprehensive public health approach to sexual health. COMOH further acknowledges the importance of communicating the Undetectable = Untransmittable (U = U) message as part of a comprehensive public health approach to sexual health.

	The Middlesex-London Board of Health understands the importance of ensuring that science drives policy rather than an enforcement approach. The U=U message provides an opportunity to improve access to treatment and care, increase testing rates and decrease transmission rates.
	I am authorized to endorse on behalf of this organization.

The message has been sent from 72.142.104.34 (Canada) at 2019-04-16 15:51:05 on Chrome 73.0.3683.103
Entry ID: 800

alPHa
Association of Local PUBLIC HEALTH Agencies

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Providing leadership in public health management

DRAFT MINUTES

Board of Health Chairs Teleconference Regarding 2019 Ontario Budget

Thursday, April 18, 2019 – 12:30 to 1:30 PM

Chair: Trudy Sachowski, alPHa Chair BOH Section

PRESENT:

Trudy Sachowski alPHA BOH Section Chair	Northwestern		Paul Ryan, Chair	Northwestern
			Keith Egli, Chair	Ottawa
Lee Mason, Chair	Algoma		Nando Iannicca, Chair	Peel
Joe Faas, Chair	Brant		Kathy Vassilakos	Perth
Carmen McGregor alPHa Past-President	Chatham-Kent		Kathryn Wilson, Chair	Peterborough
			Kerri Davies, Vice Chair	Peterborough
John Henry, Member			Sue Perras, Chair	Porcupine
Kirsten Gardner, Member	Durham		Janice Visneckie Moore, Chair	Renfrew
Mitch Twolan, Chair	Eastern Ontario			
Cammie Jaquays, Chair	Grey Bruce		Anita Dubeau, Chair	Simcoe
John Logel, Vice Chair	HKPR		Larry Martin, Chair	Southwestern
Fred Eisenberger, Chair	HKPR		Rene Lapierre, Chair	Sudbury
Jo-Anne Albert	Hamilton		James McPherson, Chair	Thunder Bay
Denis Doyle, Chair	Hastings P. E.		Carman Kidd, Chair	Timiskaming
Wess Garrod alPHa Vice President	KFL&A		Joe Cressy, Chair	Toronto
	KFL&A		Elizabeth Clarke, Chair	Waterloo
Bill Weber, Chair			Chris White, Chair	Wellington-Dufferin
Doug Malanka, Chair	Lambton		Kenneth Blanchette	Windsor-Essex
Anita Deviet, Mbr	Leeds Grenville			
Barb Greenwood, Mbr	Middlesex-London		Loretta Ryan, Executive Director	alPHa
Nancy Jacko, Mbr	Niagara			
	North Bay		Susan Lee	alPHa

1.0 CALL TO ORDER / APPROVAL OF AGENDA

The Chair called the meeting to order at 12:30 PM EDT. The purpose the meeting was to discuss the 2019 provincial budget announcement of April 11th and its impacts on public health. Attendees included Board of Health Chairs and/or their designates, BOH Section members on the alPHa Executive Committee, Loretta Ryan, Executive Director, and Susan Lee, Manager, Administrative and Association Services. It was noted that other constituent bodies of the association such as the Executive Committee of the alPHa Board and the Medical Officers of Health (COMOH) had recently met via teleconference on this topic. A roll call of attendees took place.

2.0 PROVINCIAL BUDGET 2019 / ONTARIO HEALTH SYSTEM RESTRUCTURING

alPHa Executive Director L. Ryan summarized the recent 2019 Ontario Budget announcements regarding public health restructuring, governance and funding. The number of health units will be reduced from the current 35 to 10 which will be governed by regional boards and there will be a $200 million reduction in public health funding by 2021-22. A new dental program for low-income seniors was also announced.

In response, alPHa has issued a summary of budget highlights with regards to public health and a news release outlining its concerns. The association has also been active in a media outreach. Updates on these activities can be found on the alPHa website (www.alphaweb.org) and twitter (@PHAgencies).

Comments from the floor centred on the actions that boards of health have taken to date since the announcement. Many have written to the province with their concerns. A number of boards asked others on the call to share their correspondences and news releases. Toronto City Council for example, has endorsed a motion by its board of health to oppose the changes. Ottawa's board is focusing on ensuring public health has an opportunity to influence and provide input into the implementation phase. Boards of health were encouraged to reach out to their local MPPs and local councils to share concerns with them. alPHa's Executive Director offered to collate board of health correspondence and news releases for distribution/sharing on the alPHa website and asked health units to email their correspondences and resources to loretta@alphaweb.org

In addition to concerns over the budget, several participants expressed frustration with the lack of information and detail. Concern was also expressed regarding the province's lack of transparency and consultation with health units and boards of health. The issue of the potential for further downloading onto municipalities was raised. At least one health unit is discussing business continuity plans to address health unit staff loss.

Next steps were suggested as follows:

- develop messaging to preserve the local element in the new structure
- engage First Nations communities, Indigenous organizations and community partners
- be ready to provide input on implementation process (line up our expertise)
- several courses of action were discussed including a summit, additional teleconferences, meetings with MPPs and mayors, sharing information, and alPHa mobilizing public health units to undertake a pubic relations campaign aimed at the general public to help support public health's concerns over potential negative impacts and losses that would result. The idea of using unique and local stories reflecting the diversity of communities and highlighting public health's value as part of the messaging was raised.

There was consensus for alPHa to:

- continue to work with the Association of Municipalities of Ontario
- share board of health correspondence and news releases with the broader membership (list to be posted on alPHa website)
- act as the voice of all boards of health on this matter and facilitate public health unit messaging that reflects the local diversity of Ontario's communities and the value of public health
- hold a second teleconference with BOH Chairs next week for further discussion (tentatively scheduled for Thursday)

- these issues be brought to the attention of alPHa's Executive Committee/Board for discussion (Executive Committee of alPHa's board is holding a teleconference on Tuesday, April 23rd and there is an alPHa Board meeting on Friday, April 26th.)

4.0 OTHER BUSINESS

None.

5.0 NEXT TELECONFERENCE / ADJOURNMENT

- Next teleconference TBA. The meeting adjourned at 1:25 PM.

alPHa
Association of Local
PUBLIC HEALTH
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Dear alPHa Members,

Re: 2019 Ontario Budget, Protecting what Matters Most

Unlike previous recent budgets, the 2019 Ontario Budget contains a section devoted specifically to Modernizing Ontario's Public Health Units, so the traditional chapter-by-chapter summary of other items of interest to alPHa's members will be delayed as our immediate focus will be need to be on the significant changes that are being proposed for Ontario's public health system.

It appears that the Government intends to create efficiencies through streamlining back-office functions, adjusting provincial-municipal cost-sharing, and reducing he total number of health units and Boards of Health from 35 to 10 in a new regional model. As details about how they will do this are scarce, verbatim excerpts from the two areas that are directly relevant are reproduced here (*comments added in italics*):

VERBATIM EXCERPT FROM CHAPTER 1, A PLAN FOR THE PEOPLE: MODERNIZING ONTARIO'S PUBLIC HEALTH UNITS (P. 119)

"Ontario currently has 35 public health units across the province delivering programs and services, including monitoring and population health assessments, emergency management and the prevention of injuries. Funding for public health units is shared between the Province and the municipalities.

However, the current structure of Ontario's public health units does not allow for consistent service delivery, could be better coordinated with the broader system and better aligned with current government priorities. This is why Ontario's Government for the People is modernizing the way public health units are organized, allowing for a focus on Ontario's residents, broader municipal engagement, more efficient service delivery, better alignment with the health care system and more effective staff recruitment and retention to improve public health promotion and prevention.

As part of its vision for organizing Ontario public health, the government will, as first steps in 2019-20:

- Improve public health program and back-office efficiency and sustainability while providing consistent, high-quality services, be responsive to local circumstances and needs by adjusting provincial-municipal cost-sharing of public health funding (*ed. Note: what this means is not spelled out, i.e. it is not clear how such an adjustment would contribute to efficiency and if they are considering a change to the relative share, they have not revealed what it will be*).

- Streamline the Ontario Agency for Health Protection and Promotion to enable greater flexibility with respect to non-critical standards based on community priorities (*ed. Note: again, not spelled out*).

The government will also:

- Establish 10 regional public health entities and 10 new regional boards of health with one common governance model by 2020-20 (*based on the excerpt from chapter 3 below, it is likely that this means consolidation and not the establishment of another regional layer*);

- Modernize Ontario's public health laboratory system by developing a regional strategy to create greater efficiencies across the system and reduce the number of laboratories; and

- Protect what matters most by ensuring public health agencies focus their efforts on providing better, more efficient front-line care by removing back-office inefficiencies through digitizing and streamlining processes.

VERBATIM EXCERPT FROM CHAPTER 3, ONTARIO'S FISCAL PLAN AND OUTLOOK (HEALTH SECTOR INITIATIVES, P. 276-7):

Health Sector expense is projected to increase from $62.2B in 2018-19 to $63.5B in 2021-22, representing an annual average growth rate of 1.6% over the period…Major sector-wide initiatives will allow health care spending to be refocused from the back office to front-line care. These initiatives include:

- Modernizing public health units through regionalization and governance changes to achieve economies of scale, streamlined back-office functions and better-coordinated action by public health units, leading to annual savings of $200M by 2021-22.

Gordon Fleming and Pegeen Walsh (ED, OPHA) were able to ask a couple of questions of clarification of Charles Lammam (Director, Policy, Office of the Deputy Premier and Minister of Health and Long-Term Care), and he mentioned that strong local representation and a commitment to strong public health standards will be part of the initiative, and the focus of the changes is more on streamlining the governance structure. He also indicated that many of the details (including the cost-sharing model) will need to be ironed out in consultation with municipal partners and hinted that there is a rationale behind the proposed number of health units though he couldn't share that level of detail at this time.

Please click here for the portal to the full 2019 Ontario Budget, which includes the budget papers, Minister's speech and press kits.

alPHa's Executive Committee will be holding a teleconference at 9 AM on Friday April 12 to begin the formulation of a strategic approach to obtaining further details about the foregoing and responding to the proposals. As always, the full membership will be consulted and informed at every opportunity.

We hope that you find this information useful.

Loretta Ryan,
Executive Director

Association of Local PUBLIC HEALTH Agencies

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Providing leadership in public health management

NEWS RELEASE

April 12th, 2019 **For Immediate Release**

Ontario Budget 2019 – Reducing Investments in Public Health

The Association of Local Public Health Agencies (alPHa), which represents Ontario's Medical Officers of Health, Boards of Health members and front-line public health professionals throughout the province, is surprised and deeply concerned to learn of the Government's plans to restructure Ontario's public health system and reduce its funding by $200M per year.

"Investments in keeping people healthy are a cornerstone of a sustainable health care system. We have spent considerable time since the election of the new Government communicating the importance of Ontario's locally-based public health system to ending hallway medicine," said alPHa President Dr. Robert Kyle. "The reality is that this $200M savings is a 26% reduction in the already-lean annual provincial investment in local public health. This will greatly reduce our ability to deliver the front-line local public health services that keep people out of hospitals and doctors' offices."

In order to achieve this reduction, the Government is proposing to replace 35 public health units and 35 local boards of health with 10 larger regional entities with boards of health of unknown composition and size. As alPHa pointed out in its response to the previous Government's Expert Panel on Public Health Report (which proposed a similar reduction), the magnitude of such a change is significant and will cause major disruptions in every facet of the system. "The proposed one-year time frame for this change is extremely ambitious, and we hope that the government will acknowledge the need to carefully examine the complexities of what it is proposing and move forward with care and consideration," added Dr. Kyle.

Public Health initiatives show a return on investment. Much of the success of our locally-based public health system can be attributed to partnerships with municipal governments, schools and other community stakeholders to develop healthy public policies, build community capacity to address health issues and promote environments that are oriented towards healthy behaviours. The health protection and promotion needs of Ontarians vary significantly depending on their communities, and preserving these partnerships is essential to meeting them regardless of the number of public health units.

We look forward to receiving more details of this plan from the Ministry so that we can work with them to ensure that Ontario's public health system continues to draw strength from dedicated local voices and effective partnerships and maintains the capacity to deliver essential front-line health protection and promotion services while working to meet the Government's stated goals of broader municipal engagement, more efficient service delivery, better alignment with the health care system and more effective staff recruitment and retention.

- 30 -

For more information regarding this news release, please contact

Loretta Ryan
Executive Director
(647) 325-9594
(416) 595-0006 ext. 22

About alPHa

The Association of Local Public Health Agencies (alPHa) is a non-profit organization that provides leadership to Ontario's boards of health and public health units. The Association works with governments and other health organizations, to advocate for a strong and effective local public health system in the province, as well as public health policies, programs and services that benefit all Ontarians. Further details on the functions and value of Ontario's public health system are available in alPHa's 2019 Public Health Resource Paper (https://bit.ly/2G8F3Ov)

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Providing leadership in public health management

Impact of Reducing Investments in Public Health
alPHa Position Statement
April 24, 2019

The Association of Local Public Health Agencies (alPHa), which represents Ontario's Medical Officers of Health, Boards of Health and frontline public health professionals throughout the province, remains deeply concerned about the Government's plans to restructure Ontario's public health system. Following a briefing hosted by the Chief Medical Officer of Health last Thursday afternoon, we are further concerned about the recently announced changes to the provincial/municipal cost-sharing formula that funds local public health.

On April 11, in the 2019 Ontario Budget, the Government announced that it will replace 35 public health units and 35 local boards of health with 10 larger regional entities with boards of health of unknown composition and size, with the exception of City of Toronto, which will be one of the Regions. The Government's significant reduction in the provincial contribution to the funding formula is of concern, especially as the first phase takes effect in this current fiscal year. Complicating matters is that further details are not known at this time and the proposed one-year timeframe for the reduction from 35 to 10 public health units is extremely ambitious given the complexities of delivering public health services. The magnitude of these changes is significant and will cause major disruptions in every facet of the system. This will result in substantial reductions in frontline public health services such as vaccination programs and outbreak investigations. We are particularly concerned about the reduction in funding to Toronto Public Health that will see the provincial contribution reduced within three years to 50% because infectious diseases do not stop at municipal borders and all areas of the province needs sufficient funding to adequately protect the public. Given all of this, alPHa is calling upon the Ontario Government to re-consider the cuts and the timelines.

Key public health responsibilities are mandated by the Ontario Public Health Standards and local delivery of these contributes to ensuring that Ontarians have safe and healthy communities:

- Chronic Disease Prevention and Well-Being
- Emergency Management
- Food Safety
- Health Equity
- Healthy Environments
- Healthy Growth and Development
- Immunization
- Infectious and Communicable Diseases Prevention and Control
- Population Health Assessment
- Safe Water
- School Health, including Oral Health
- Substance Use and Injury Prevention

Much of the success of our locally based public health system can be attributed to partnerships with municipal governments, schools and other community stakeholders to develop healthy public policies, build community capacity to address health issues and promote environments that are oriented towards healthy behaviours. The health protection and promotion needs of Ontarians vary significantly depending on their communities, and preserving these partnerships is essential to meeting them regardless of the number of public health units.

Public health works as a system that is greater than the sum of its parts. By leveraging the skills and experience of boards of health, nutritionists, nurses, health promoters, inspectors, epidemiologists, doctors, dentists and dental hygienists, board members and administrators, and more, the health of Ontarians is supported and protected. Public health delivers promotion, protection and prevention services on behalf of, and in partnership with, the Ontario Government which has the responsibility for the health of the people of Ontario.

One of the ways to end hallway medicine is to prevent illness. Local public health agencies reduce the demand for hospital and primary care services by keeping people healthy. Building healthy communities through an efficient, proactive and locally managed public health system--one that is mandated to lead on preventative measures to protect and promote the health of Ontarians--can go a long way to reducing that demand. When combined with stable, designated funding, the public health system has the capacity to relieve pressure on doctors and hospitals. Furthermore, accountability is firmly established by provincial legislation and policy ensuring that the money spent on public health is spent effectively and with purpose.

Ontario's public health system delivers value for money, ensuring Ontarians remain healthy, and are able to contribute fully to a prosperous Ontario. Studies have shown tremendous return on investment. For example, every $1 spent on:

- **mental health and addictions** saves $7 in health costs and $30 dollars in lost productivity and social costs;
- **immunizing children** with the measles-mumps-rubella vaccine saves $16 in health care costs; and
- **early childhood development and health care** saves up to $9 in future spending on health, social and justice services.

In short, public health actions now can result in fewer emergency room and doctor's office visits today and in the future. Local public health's impact is beyond simply reducing health care dollars. Local public health ensures that healthy people can support a strong economy, providing a direct economic impact. The old adage 'an ounce of prevention is worth a pound of cure' is certainly relevant to public health.

We look forward to receiving more details of this plan from the Ministry of Health and Long-Term Care so that we can work with the government. To this end, alPHa will continue to communicate with the Minister, the Hon. Christine Elliott, and Dr. David Williams, Chief Medical Officer of Health, towards ensuring that alPHa members, and its partners including the Association of Municipalities of Ontario and the City of Toronto, are extensively consulted before final decisions are made with respect to the governance, management and administration of a regionalized public health system and the delivery of frontline public health programs and services.

We can help ensure that Ontario's public health system continues to draw strength from dedicated local voices and effective partnerships. It will be crucial to maintain the capacity to deliver essential frontline health protection and promotion services while working to meet the Government's stated goals of broader municipal engagement, more efficient service delivery, better alignment with the health care system and more effective staff recruitment and retention.

alPHa acknowledges, appreciates and supports the voices of all its members. We encourage you to meet with your local mayors, municipal council(s), MPs and MPPs. We also encourage you to make use of alPHa's resources:

- Speaking Notes – Toronto Board of Health Meeting April 15th
- alPHa News Release - Budget 2019 & PH Restructure
- alPHa Memo to Members - Budget 2019
- alPHa Post-Election Flyer
- alPHa Pre-Budget Submission 2019
- Resource Paper
- Local Public Health Responses
- alPHa Submission - Expert Panel on Public Health
- alPHa Promotional material including the brochure and video
- Follow alPHa on Twitter: @PHAgencies

alPHa will continue to keep our members updated and advocate on their behalf so that Ontarians continue to have a local public health system that remains on the frontlines to protect and promote the health of all Ontarians.

For more information, please contact:

Loretta Ryan
Executive Director
(647) 325-9594

About alPHa

The Association of Local Public Health Agencies (alPHa) is a non-profit organization that provides leadership to Ontario's boards of health and public health units. The Association works with governments and other health organizations, to advocate for a strong and effective local public health system in the province, as well as public health policies, programs and services that benefit all Ontarians.

HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT

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The Honourable Doug Ford
Premier of Ontario
Legislative Building, Queen's Park
Toronto, ON M7A 1A1
(Sent via email to: premier@ontario.ca)

The Honourable Christine Elliott
Deputy Premier and Minister of Health and Long-Term Care
Hepburn Block 10th Floor
80 Grosvenor Street
Toronto, ON M7A 1E9
(Sent via email to: christine.elliottco@ola.org)

April 24, 2019

Dear Premier Ford and Minister Elliott

Re: 2019 Ontario Budget, Protecting What Matters Most - Chapter 1, A Plan for the People: Modernizing Ontario's Public Health Units

Ontario's local public health system is an efficiently run and essential part of keeping communities safe and healthy. Public health delivers excellent return on investment and works on the front line to protect our communities from illness and promote health and wellbeing. The services provided by public health, centred on Ontario's Public Health Standards, ensure that our population stays out of the health care system and remain well for as long as possible.

As the Chair of the Board for the Haliburton, Kawartha, Pine Ridge (HKPR) District Health Unit, the Board and I unequivocally support HKPR District Health Unit and its staff in the work that they do. The needs of Ontarians are variable and preserving partnerships locally is essential. Local knowledge and expertise to ensure the health of our communities is not something that our region can afford to lose.

Our Board of Health was surprised and are concerned to learn of the Government of Ontario's plans to restructure Ontario's public health system. The proposed $200 million per year reduction in funding for local public health services represents a significant strain on the ability of local public health agencies like HKPR District Health Unit to continue to deliver on their mandate. A reduction in funding that represents 26% of the budget cannot happen without cutting services. These cuts will impact our ability to deliver the front-line public health services that keep people out of hospitals and doctors' offices and will ultimately mean a greater downstream cost to the health care system.

HKPR District Health Unit's Board is requesting the Province of Ontario maintain and augment the health protection, promotion, and prevention mandate in the service of public health. We request that the Province of Ontario stop the planned reduction of Ontario public health units from 35 to 10 and the planned reduction by $200 million from public health.

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Money invested into public health is money well spent; prevention is the fiscally responsible investment for our communities. There is strong evidence to support the excellent return on investment that public health offers, with an average of $14 of upstream savings for every $1 investment in public health services. It has been fifteen years since the last major public health crisis in this province, and we have learned well from those lessons. We do not wish to repeat the mistakes of the past; the cuts proposed by this government have the potential to jeopardize our ability to protect the health of the people of Ontario.

Ontario has an integrated, cost-effective, accountable and transparent public health system. Boards of health oversee the provision of preventative programs and services tailored to address local needs across the province. The public health system works upstream to reduce demands and costs to the acute care sector while providing essential front-line services to local communities. Modest investments in public health generate significant returns in the long term. In short, public health plays an important role in our work, our families, and our communities. Divestment would be a loss for all.

The Board of Health for the HKPR District Health Unit implores your government to leave the current structure as it is, delivering excellent and local preventative care to our community. The information we have to date is concerning and we request a detailed timeline to allow for the planning and stability in the delivery of such well-needed public health services. How will this proposed system re-structuring 'modernize' healthcare and improve on an already well-functioning system? Please provide details of how the HKPR District Health Unit and other units across Ontario will continue to deliver services under the new model with a much leaner budget. Public Health Units currently deliver quality preventative care throughout Ontario, saving the province billions of dollars in health care delivery costs.

Sincerely

BOARD OF HEALTH FOR THE HALIBURTON,
KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT

Cammie Jaquays
Chair, Board of Health

CJ:ed

Attached: 2019 Ontario Budget Summary, Dr Lynn Noseworthy, Medical Officer of Health at Haliburton, Kawartha, Pine Ridge District Health Unit

cc (via email): Hon. H. Angus, Deputy Minister of Health and Long-Term Care
Dave Piccini, MPP Northumberland-Peterborough South
Laurie Scott, MPP Haliburton-Kawartha Lakes-Brock
Dr. David William, Chief Medical Officer of Health
Municipalities within the Haliburton, Kawartha, Pine Ridge District Health Unit area
Ontario Boards of Health
Loretta Ryan, Association of Local Public Health Agencies
Board of Health Members

Leeds, Grenville & Lanark District
HEALTH UNIT
Your Partner in Public Health

April 23, 2019

VIA ELECTRONIC MAIL

The Honourable Christine Elliott, Deputy Premier
Minister of Health and Long-Term Care
Hepburn Block 10th Floor
80 Grosvenor Street
Toronto, ON M7A 1E9

The Honourable Steve Clark
Minister of Municipal Affairs and Housing
17th Floor
777 Bay Street
Toronto, ON M5G 2E5

Dear Ministers:

Ontario local public health units play a crucial role in ensuring the safety, health and well-being of Ontario communities and their people. This crucial role is played out daily as Public Health Units work diligently and professionally to protect our communities from illnesses and promote health and well-being. These services centred on Ontario's Public Health Standards and related Public Health Programs like Smoke Free Ontario and Healthy Smiles ensure that our population remains healthy and does not end up requiring costly care and treatment in hospital emergency rooms and wards.

As Chair of the Board of the Leeds, Grenville and Lanark District Health Unit (LGLDHU), I can confirm the Board's unconditional support of the LGLDHU and its staff in all the work that they do. The health needs of Ontarians are variable and preserving local partnerships with municipalities and others is essential to ensuring the effectiveness, efficiency and success of health programs and services. It is this Board's view that the LGLDHU is right sized and right staffed to professionally deliver health unit services for and in partnership with the municipalities served.

With this backdrop, our Board of Health was surprised, disappointed and confused by the Government of Ontario's budget announcement to restructure Ontario's Public Health system that changes the Provincial-Municipal funding formula by downloading costs to municipalities after budgets have been set. The latter will place a significant strain on the ability of local public health units like LGLDHU to continue to deliver on their mandate. Moreover, it has been reported that the Public Health budget represents approximately 2% of the Province's total health expenditures and that every dollar spent has an average of $14 of upstream savings. With this in mind, it is difficult to comprehend how a $200 million dollar provincial reduction in prevention services will contribute to lowering future overall health care costs.

Leeds, Grenville & Lanark District HEALTH UNIT
Your Partner in Public Health

Before the Budget's new directions for public health units are fully implemented, the LGLDHU Health Board recommends for your consideration that any change in the funding ratio should be done in consultation with AMO and the municipalities rather than unilaterally by the province. The 2019 public health municipal levy has already been established, and municipalities are already more than a quarter into their fiscal year.

As the Regional Public Health Entity to replace the LGLDHU has not yet been announced, the LGLDHU Health Board further recommends that the Ministry consult with Public Health Ontario, the Association of Local Public Health Agencies, the Council of Medical Officers of Health, and other experts in the field before the Regional Public Health Entity is implemented to ensure it will improve the effectiveness and efficiency of public health services in the community.

Additionally, the LGLDHU Board of Health recommends that the following principles in the development of the Regional Public Health Entity be adopted to ensure this change in public health governance and organization is as effective and efficient as possible while maintaining the strong public health presence and impact in our community:

a. *No loss of service to our community* - All current employees providing programs and services under the Foundational and Program Standards as listed in the 2019 Annual Service Plan continue to be funded within the Regional Public Health Entity to provide service in Lanark, Leeds, and Grenville.

b. *Meaningful involvement in planning* – The needs and assets of the Lanark, Leeds and Grenville communities are considered in the planning of any public health programs and services for the community.

c. *Integrity of Health Unit* - The Health Unit functions as a unit and service and programs will be difficult to maintain if the health unit is split into two.

d. *Like Health Unit Populations Be Grouped Together* – Collaboration will be more effective and efficient if the populations are similar among the health units in the Regional Public Health Entity.

e. *Equitable access to positions* - All Management and Administrative positions in the new Regional Public Health Entity must be open to all our current employees through a competition process.

f. *Effective "back office" support* – All services included in the "back office" support provided by the Regional Public Health Entity be at the same quality or better than currently exist in the Health Unit.

g. *Appropriate municipal role in governance* – The public expects that their municipal tax dollars are overseen by the municipal politicians they elect. For the municipal public health investment, this currently occurs through representatives from obligated municipalities on the Board of Health.

Leeds, Grenville & Lanark District
HEALTH UNIT
Your Partner in Public Health

The Leeds, Grenville and Lanark District Health Unit provides high quality public health programs and services in collaboration with local partners, including municipalities, to promote and protect health of the population. The LGLDHU Board of Health includes all obligated municipalities who provide funding to the Health Unit, and this relationship extends to working with municipalities on important public health concerns. The current grant from the provincial government is insufficient to respond to all the requirements in the Ontario Public Health Standards and Accountability Framework, therefore, any reduction in provincial funding will cause a reduction in programs and services that will impact the population's health.

I look forward to working collaboratively with you to continue to provide exemplary public health programs and services to the people of Leeds, Grenville and Lanark.

Sincerely

Doug Malanka
Board Chair

cc: Leeds, Grenville and Lanark District Board of Health
Hon. Doug Ford, Premier of Ontario
Hon. Helen Angus, Deputy Minister of Health and Long-Term Care
Dr. David Williams, Chief Medical Officer of Health
Randy Hillier, MPP – Lanark, Frontenac, Kingston
Monica Turner, Director of Policy, Association of Municipalities of Ontario
Leeds, Grenville and Lanark Municipalities
Loretta Ryan, Association of Local Public Health Units
Ontario Boards of Health

HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT

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1-866-888-4577

April 18, 2019

The Honourable Doug Ford
Premier of Ontario
Legislative Building, Queen's Park
Toronto, ON M7A 1A1
Sent via e-mail: premier@ontario.ca

Dear Premier Ford:

Re: Support for Bill 60, Establishing a Social Assistance Research Commission

At its meeting held on April 18, 2019, the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit discussed correspondence from the North Bay Parry Sound District Health Unit regarding the establishment of a Social Assistance Research Commission under the *Ministry of Community and Social Services Act, R.S.O. 1990, c.M.20* (Bill 60).

Inadequate income and food insecurity result in poor health outcomes and higher health care costs. Current social assistance rates do not meet the minimum basic needs of shelter and food, putting recipients of social assistance programs at greater risk for poor health outcomes and mortality. The Board of Health agrees with the recommendations provided in North Bay Parry Sound's resolution (attached) and supports Bill 60, an Act to amend the *Ministry of Community and Social Services Act* to establish the Social Assistance Research Commission.

We appreciate your consideration of this important public health issue.

BOARD OF HEALTH FOR HALIBURTON,
KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT

Cammie Jaquays, Chair, Board of Health

Cc (via email) : The Hon. Christine Elliott, Minister of Health and Long-Term Care
The Hon. Lisa MacLeod, Minister Responsible for Women's Issues, Minister of Children, Community & Social Services
The Hon. Laurie Scott, MPP Haliburton-Kawartha Lakes-Brock
David Piccini, MPP Northumberland-Peterborough South
Dr. David Williams, Ontario Chief Medical Officer of Health
Ontario Boards of Health
Loretta Ryan, Association of Local Public Health Agencies

Attachment

North Bay Parry Sound District Health Unit
Your lifetime partner in healthy living.
Bureau de santé
345 Oak Street West, North Bay, ON P1B 2T2 TEL 705-474-1400 FAX 705-474-8252 | myhealthunit.ca
70 Joseph Street, Unit 302, Parry Sound, ON P2A 2G5 TEL 705-746-5801 FAX 705-746-2711 | 1-800-563-2808

February 27, 2019

The Honourable Doug Ford
Premier of Ontario
Legislative Building, Room 281
Queen's Park
Toronto, ON M7A 1A1

The Honourable Christine Elliott
Deputy Premier and Minister of Health and Long-Term Care
College Park, 5th Floor
777 Bay Street
Toronto, ON M7A 2J3

The Honourable Lisa MacLeod
Minister of Children, Community and Social Services
Hepburn Block, 6th Floor
80 Grosvenor Street
Toronto, ON M7A 1E9

The Board of Health for the North Bay Parry Sound District Health Unit (Board) would like to share with you the resolutions passed at our recent meeting on February 27, 2019. The resolutions highlight our continued support of staff and community stakeholders to reduce health inequities, and our support for Bill 60, an act to amend the Ministry of Community and Social Services Act to establish the Social Assistance Research Commission. A copy of the motion passed is included as Appendix A.

One in seven households in our Health Unit region experience food insecurity. Included is a copy of our 2018 Food Insecurity poster, highlighting this important statistic, as Appendix B. Our goal with this key messaging is to emphasize the magnitude of this issue in our area. The full report is available on our website.

While our community has a broad gamete of important social service and food charity programs in place to assist those experiencing food insecurity, this complex issue cannot be adequately or sustainably addressed at the local level. Food insecurity is defined as inadequate or insecure access to food due to financial constraints, which highlights low income as the root of the problem. Our Health Unit continues to raise awareness about the importance of income security for low income Ontarians, in an effort to reduce food insecurity rates. Food insecurity is a significant public health problem because of its great impact on health and well-being. In light of the release of the new Canada's Food Guide, it is important to note that these dietary recommendations are out of reach for many low-income Canadians.

While there are a number of risk factors for being food insecure, social assistance recipients are at particularly high risk. Research has shown that 64% of households in Ontario receiving social assistance

.../2

experience food insecurity, demonstrating that social assistance rates are too low to protect recipients from being food insecure. For this reason, our Board supports Bill 60, an act to amend the Ministry of Community and Social Services Act to establish the Social Assistance Research Commission. This group will make recommendations on social assistance policy, including social assistance rates based on the real costs of living in regions across Ontario, taking into account the cost of healthy eating. Our Health Unit, community partners and households receiving social assistance are eagerly awaiting the release of more details about the changes that will be made to Ontario's social assistance system following Minister MacLeod's announcement on November 22, 2018. Please consider the establishment of the Social Assistance Research Commission as part of the changes that will ensue by prioritizing Bill 60.

Last year, we expressed our support and feedback to the previous government on the *Income Security: A Roadmap for Change* report. This report was prepared in collaboration with many experts, including Indigenous representatives, and has already undergone a public consultation process. Please take into account the elements outlined in this report when implementing changes to the current social assistance system. We emphasized this last August, when we expressed our concern about the cancellation of the basic income pilot project and the reduction to the scheduled increase to social assistance rates in 2018.

Thank you for taking the time to review this information and we will look forward to hearing next steps in strengthening income security in Ontario.

Sincerely,

James Chirico, H.BSc., M.D., F.R.C.P. (C), MPH
Medical Officer of Health/Executive Officer

Don Brisbane
Vice-Chairperson, Board of Health

Enclosures (2)

Copied to:
Victor Fedeli, MPP, Nipissing
Norm Miller, MPP, Parry Sound-Muskoka
John Vanthof, MPP, Timiskaming-Cochrane
Robert Bailey, MPP, Sarnia-Lambton
Paul Miller, MPP, Hamilton East-Stoney Creek
North Bay Parry Sound District Health Unit Member Municipalities
Joseph Bradbury, Chief Administrative Officer, DNSSAB
Janet Patterson, Chief Administrative Officer, PSDSSAB
Loretta Ryan, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health

North Bay Parry Sound District Health Unit
Your lifetime partner in healthy living.
Bureau de santé du district de North Bay-Parry Sound
345 Oak Street West, North Bay, ON P1B 2T2 Tel 705-474-1400 Fax 705-474-8252 | myhealthunit.ca
70 Joseph Street, Unit 302, Parry Sound, ON P2A 2G5 Tel 705-746-5801 Fax 705-746-2711 | 1-800-563-2808

Appendix A

NORTH BAY PARRY SOUND DISTRICT HEALTH UNIT
BOARD OF HEALTH

RESOLUTION

DATE: February 27, 2019 **MOVED BY:** Mike Poeta

RESOLUTION: #BOH/2019/02/04 **SECONDED BY:** Dan Roveda

***Whereas**, The Nutritious Food Basket Survey results show that many low income individuals and families do not have enough money for nutritious food after paying for housing and other basic living expenses; and*

***Whereas**, The Board of Health for the North Bay Parry Sound District Health Unit recognizes the impact of adequate income on food security and other social determinants of health; and*

***Whereas,** Food insecurity rates are very high among social assistance recipients; and*

***Whereas**, Bill 60 (An Act to amend the Ministry of Community and Social Services Act to establish the Social Assistance Research Commission) would help ensure social assistance rates are indexed to inflation, reviewed on an annual basis, and reflect regional costs of living including the cost of a Nutritious Food Basket; and*

***Whereas**, the Ontario Public Health Standards require public health units to assess and report on the health of local populations, describing the existence and impact of health inequities;*

***Therefore Be It Resolved,** That the Board of Health for the North Bay Parry Sound District Health Unit continue to support the efforts of employees and community stakeholders to reduce health inequities, including food insecurity; and*

***Furthermore Be It Resolved,** That the Board of Health support Bill 60 (An Act to amend the Ministry of Community and Social Services Act to establish the Social Assistance Research Commission); and*

***Furthermore Be It Resolved,** That the Board of Health provide correspondence of these resolutions to district municipalities, Ontario Boards of Health, Victor Fedeli, MPP (Nipissing), Norm Miller, MPP (Parry Sound-Muskoka), John Vanthof, MPP (Timiskaming-Cochrane), the Honourable Doug Ford (Premier), the Honourable Lisa MacLeod (Minister of Community and Social Services), the Honourable Christine Elliott (Minister of Health and Long-Term Care) and the Association of Local Public Health Agencies (alPHa).*

CARRIED: ✓ **VICE-CHAIRPERSON:** *Original Signed by Don Brisbane*

Appendix B

1 in 7

Nipissing and Parry Sound homes are food insecure because they don't have enough money.

This can mean:

- Worrying about running out of food
- Eating less healthy food
- Skipping meals
- Having poor health

Be informed myhealthunit.ca/foodinsecurity

Health Unit

KFL&A Public Health

April 25, 2019

VIA: Electronic Mail (lisa.macleodco@pc.ola.org)

Honourable Lisa MacLeod
Minister of Children, Community and Social Services
80 Grosvenor Street
Hepburn Block 6th Floor
Toronto, ON M7A 2C4

Dear Minister MacLeod:

RE: Endorsement of The Ontario Dietitians in Public Health letter on Bill 60

The Kingston, Frontenac and Lennox & Addington (KFL&A) Board of Health passed the following motion at its April 24, 2019 meeting:

> **THAT the KFL&A Board of Health endorse the letter by The Ontario Dietitians in Public Health, regarding support for Bill 60, establishing a Social Assistance Research Commission, and send correspondence to the Honourable Lisa MacLeod, Minister of Children, Community and Social Services.**
>
> **FURTHER THAT a copy of this letter be forwarded to:**
> 1) **Honourable Doug Ford, Premier of Ontario**
> 2) **Honourable Christine Elliot, Deputy Premier and Minister of Health and Long-Term Care**
> 3) **Paul Miller, MPP Hamilton East-Stoney Creek (co-Sponsor of Bill 60)**
> 4) **Robert Bailey, MPP Sarnia-Lambton (co-Sponsor of Bill 60)**
> 5) **Ian Arthur, MPP Kingston and the Islands**
> 6) **Randy Hillier, MPP Lanark-Frontenac-Kingston**
> 7) **Daryl Kramp, MPP Hastings-Lennox and Addington**
> 8) **Monica Turner, Director of Policy, Association of Municipalities of Ontario**
> 9) **Loretta Ryan, Association of Local Public Health Agencies**
> 10) **Ontario Boards of Health**
> 11) **The Ontario Dietitians in Public Health, Carolyn Doris and Mary Ellen Prange**

One in 10 households in KFL&A area experience food insecurity. Income is the root cause of food insecurity and is a key determinant of health. As such, responses are needed to address food insecurity. Bill 60 has the potential to improve income security for social assistance recipients, and hence, food security. The Ontario Dietitians in Public Health's support of Bill 60 aligns with KFL&A Public Health's commitment to addressing health disparities, such as food insecurity.

KFL&A Public Health

The KFL&A Board of Health urges the Government of Ontario to support Bill 60 and create a Social Assistance Research Commission to recommend rates of provincial social assistance that is grounded in an analysis of the cost for basic and other necessities.

Yours truly,

Denis Doyle, Chair
KFL&A Board of Health

Copy to: Hon. D. Ford, Premier of Ontario
Hon. C. Elliot, Deputy Premier and Minister of Health and Long-Term Care
P. Miller, MPP Hamilton East-Stoney Creek (co-Sponsor of Bill 60)
R. Bailey, MPP Sarnia-Lambton (co-Sponsor of Bill 60)
I. Arthur, MPP Kingston and the Islands
R. Hillier, MPP Lanark-Frontenac-Kingston
D. Kramp, MPP Hastings-Lennox and Addington
M. Turner, Director of Policy, Association of Municipalities of Ontario
L. Ryan, Association of Local Public Health Agencies
Ontario Boards of Health
The Ontario Dietitians in Public Health, C. Doris and M.E. Prange

April 25, 2019

VIA: Electronic Mail (doug.ford@pc.ola.org)

Honourable Doug Ford
Premier of Ontario
Premier's Office
Room 281
Legislative Building, Queen's Park
Toronto, ON M7A 1A1

Dear Premier Ford:

RE: Minimizing harms associated with the announced expansion of the sale of beverage alcohol in Ontario

The Kingston, Frontenac and Lennox & Addington (KFL&A) Board of Health passed the following motion at its April 24, 2019 meeting:

THAT the KFL&A Board of Health ask the Government of Ontario to outline the actions that they will take to implement their commitment to the safe and responsible sale and consumption of alcohol in Ontario as noted in the 2019 provincial budget; and

THAT the KFL&A Board of Health strongly urge the provincial government to ensure that any plan to address the safe and responsible sale and consumption of beverage alcohol include a wide range of evidence-based policies including: implementing alcohol pricing policies, controlling physical and legal availability, curtailing alcohol marketing, regulating and monitoring alcohol control systems, countering drinking and driving, educating and promoting behaviour change, increasing access to screening and brief interventions, and surveillance, research and knowledge exchange, and that this plan be funded, and monitored for effectiveness; and

THAT the KFL&A Board of Health ask the Government of Ontario to indicate how much alcohol consumption will increase with the proposed expansion over the next five years, how much this increased consumption will cost the justice, social and health care systems over the next five years, and the fiscal plan to pay for these anticipated costs;

AND FURTHER THAT correspondence be sent to:

1) **Honourable Doug Ford, Premier of Ontario**
2) **Honourable Vic Fedeli, Minister of Finance, Chair of Cabinet**
3) **Honourable Christine Elliot, Provincial Minister of Health and Long-term Care, Deputy Premier**
4) **Ian Arthur, MPP Kingston and the Islands**
5) **Randy Hillier, MPP Lanark-Frontenac-Kingston**
6) **Daryl Kramp, MPP Hastings-Lennox and Addington**

KFL&A Public Health

7) **Loretta Ryan, Association of Local Public Health Agencies**
8) **Dr. David Williams, Chief Medical Officer of Health, Ministry of Health and Long-term Care**
9) **Ontario Boards of Health**

The recent release of the 2019 Ontario budget includes a number of changes to increase the choice and convenience of beverage alcohol for consumers. However, this same document, while assuring Ontarians that safe and responsible sale and consumption of alcohol in Ontario is, and will continue to be, a top priority, the document does not include any specific action by the Government of Ontario to realize this goal. The KFL&A Board of Health would be pleased to hear the government's plans for safe and responsible sale and consumption of alcohol. Furthermore, there are many evidence-based strategies that protect and promote health that KFL&A Public Health would encourage the government to include in this plan.

In addition, evidence from other provinces have demonstrated that increases to the availability of alcohol had negative social and health outcomes, including increased alcohol-related traffic incidents and suicides. These are the short-term impacts of the over-consumption of alcohol. Longer term effects will result in increased chronic diseases such as cancers and heart disease both of which are costly to manage and treat. There is no reason to believe that the expansion of beverage alcohol sales in Ontario will not have the same result – an increase in alcohol consumption with the concomitant increase in health, social and justice services use, and hence, costs. The KFL&A Board of Health would also be pleased to hear from the provincial government regarding how much the increase in alcohol availability is anticipated to impact consumption and the use of health, social and justice services. Furthermore, the KFL&A Board of Health would ask that the government provide a plan for how these anticipated expenses will be funded.

Yours truly,

Denis Doyle, Chair
KFL&A Board of Health

Copy to: The Honourable Christine Elliott, Minister of Health and Long-Term Care, Deputy Premier
The Honourable Lisa Thompson, Minister of Education
The Honourable Lisa MacLeod, Minister of Children, Community and Social Services and Minister Responsible for Women's Issues
Ian Arthur, MPP Kingston and the Islands
Randy Hillier, MPP Lanark-Frontenac-Kingston
Daryl Kramp, MPP Hastings-Lennox and Addington
Loretta Ryan, Association of Local Public Health Agencies
Ontario Boards of Health

KFL&A Public Health

April 25, 2019

VIA: Electronic Mail (doug.ford@pc.ola.org)

Honourable Doug Ford
Premier of Ontario
Premier's Office
Room 281
Legislative Building, Queen's Park
Toronto, ON M7A 1A1

Dear Premier Ford:

RE: Endorsement of the Children Count Task Force Recommendations

The Kingston, Frontenac and Lennox & Addington (KFL&A) Board of Health passed the following motion at its April 24, 2019 meeting:

That the KFL&A Board of Health endorse the Children Count Task Force Recommendations and send correspondence to:

1) **The Honourable Doug Ford, Premier of Ontario**
2) **The Honourable Christine Elliott, Minister of Health and Long-Term Care, Deputy Premier**
3) **The Honourable Lisa Thompson, Minister of Education**
4) **The Honourable Lisa MacLeod, Minister of Children, Community and Social Services and Minister Responsible for Women's Issues**
5) **Ian Arthur, MPP Kingston and the Islands**
6) **Randy Hillier, MPP Lanark-Frontenac-Kingston**
7) **Daryl Kramp, MPP Hastings-Lennox and Addington**
8) **Loretta Ryan, Association of Local Public Health Agencies**
9) **Ontario Boards of Health**

At present, there are approximately 50 federal programs collecting health data on the Canadian population, many of which include school age children and youth. Notwithstanding the number of sources, data collected from these surveys are not always collected in a way that provides representative results at the regional and local levels. As such, Ontario needs a coordinated and cost-effective system for measuring the health and well-being of children and youth to inform local, regional and provincial programming. Such a system will enable stakeholders at all levels (local, regional and provincial) to effectively measure the health and well-being of our kids, and in turn, the return on investment in relevant programs.

To address this gap, the Children Count Task Force has made one overarching recommendation, which is to create a secretariat responsible for overseeing the implementation of the systems, tools, and resources required to improve the surveillance of child and youth health and well-being in Ontario. To further support this secretariat, the task force made an additional five recommendations:

- **Recommendation 1**: Create an interactive web-based registry of database profiles resulting from child and youth health and well-being data collection in Ontario schools.
- **Recommendation 2**: Mandate the use of a standardized School Climate Survey template in Ontario schools and a coordinated survey implementation process across Ontario.
- **Recommendation 3**: Develop and formalize knowledge exchange practice through the use of centrally coordinated data sharing agreements.
- **Recommendation 4**: Develop and implement a centralized research ethics review process to support research activities in Ontario school boards.
- **Recommendation 5**: Work with the Information and Privacy Commissioner (IPC) of Ontario to develop a guideline for the interpretation of privacy legislation related to student health and well-being data collection in schools.

The KFL&A Board of Health urges the Government of Ontario to act on the recommendations from the Children Count Task Force.

Yours truly,

Denis Doyle, Chair
KFL&A Board of Health

Copy to: The Honourable Christine Elliott, Minister of Health and Long-Term Care, Deputy Premier
The Honourable Lisa Thompson, Minister of Education
The Honourable Lisa MacLeod, Minister of Children, Community and Social Services and Minister Responsible for Women's Issues
Ian Arthur, MPP Kingston and the Islands
Randy Hillier, MPP Lanark-Frontenac-Kingston
Daryl Kramp, MPP Hastings-Lennox and Addington
Loretta Ryan, Association of Local Public Health Agencies
Ontario Boards of Health

Ontario

Ministry of Health and Long-Term Care

Office of Chief Medical Officer of Health, Public Health
393 University Avenue, 21st Floor
Toronto ON M5G 2M2

Telephone: (416) 212-3831
Facsimile: (416) 325-8412

Ministère de la Santé et des Soins de longue durée

Bureau du médecin hygiéniste en chef, santé publique
393 avenue University, 21e étage
Toronto ON M5G 2M2

Téléphone: (416) 212-3831
Télécopieur: (416) 325-8412

April 29, 2019

TO: Chairpersons, Boards of Health
Medical Officers of Health, Public Health Units
Chief Executive Officers, Public Health Units

RE: Public Health Modernization

As you are aware, the Ontario government released its Budget on April 11, 2019. The government is taking a comprehensive approach to modernize Ontario's health care system which includes a coordinated public health sector that is nimble, resilient, efficient, and responsible to the province's evolving health needs and priorities.

While the broader health care system undergoes transformation, a clear opportunity has emerged for us to transform and strengthen the role of public health and its connectedness to communities. Modernizing and streamlining the role of public health units across the province will better coordinate access to health promotion and disease prevention programs at the local level, ensuring that Ontario's families stay safe and healthy.

As you know well, public health is a uniquely placed sector that must evolve to better meet ever-changing community needs. To that end, the Ministry of Health and Long-Term Care (the "ministry") has been working to define what a more resilient, modernized public health sector will look like, and also how it can contribute to the patient experience and better align to the new Ontario Health Agency, local Ontario Health teams, and the health system at large.

Notably, with respect to the public health sector, the ministry is proposing the following:

- Changing the cost-sharing arrangement with municipalities that would reflect an increased role for municipalities within a modernized public health system beginning 2019-20. The ministry will graduate the cost-sharing changes slowly over the next 3 years and will vary the final ratios by population size of the new Regional Public Health Entities. This is being done to recognize the variation across the province (i.e., geography, disbursement of populations, etc.). The cost-sharing changes, which will also apply to all 100% provincial programs funded by MOHLTC (except for the unorganized territories grant provided to northern public health units, and the new seniors dental program) are planned as follows:

  - **2019-20 (April 1, 2019):** 60% (provincial) / 40% (municipal) for Toronto; and, 70% (provincial) / 30% (municipal) for all other public health units.
  - **2020-21 (April 1, 2020):** 60% (provincial) / 40% (municipal) for the Toronto Regional Public Health Entity; and, 70% (provincial) / 30% (municipal) for all other Regional Public Health Entities.
  - **End State 2021-22 (April 1, 2021):** 50% (provincial) / 50% (municipal) for the Toronto Regional Public Health Entity; 60% (provincial) / 40% (municipal) for 6 larger Regional Public Health Entities with populations over 1 million; and, 70% (provincial) / 30% (municipal) for 3 smaller Regional Public Health Entities with populations under 1 million.

- Creating 10 Regional Public Health Entities, governed by autonomous boards of health, with strong municipal and provincial representation. Realigning the public health sector at a regional level provides for enhanced system capacity, consistent service delivery and greater coordination to support health system planning. The role of municipalities are core aspects of public health that the ministry wants to preserve in this new model and will do so by maintaining a local public health presence in communities.

- Modernizing Public Health Ontario to reflect changes in the health and public health landscape.

- Introducing a comprehensive, publicly-funded dental care program for low-income seniors. The program aims to prevent chronic disease, reduce infections, and improve quality of life, while reducing burden on the health care system.

It is important to note that the $200 million annual provincial savings target identified in the 2019 Ontario budget (by 2021-22) incorporates provincial savings related to the cost-sharing change, as well as savings from the proposed creation of 10 Regional Public Health Entities.

As mitigation, and to support boards of health experiencing challenges during transition, the Ministry of Health and Long-Term Care will consider providing one-time funding to help mitigate financial impacts on municipalities and consider exceptions or “waivers” for some aspects of the Ontario Public Health Standards on a board by board basis. Implementation of these exceptions will ensure that critical public health (health protection and health promotion) programs and services are maintained for the protection for the public’s health.

The proposed changes in both structure and cost-sharing are premised on the fact that essential public health program and service levels would be maintained and will remain local. The Ministry of Health and Long-Term Care will work with boards of health and public health units to manage any potential reductions in budgets, including encouraging public health units to look for administrative efficiencies rather than reductions to direct service delivery.

As a first step, we will be arranging calls with each of the Health Units over the next week to discuss the Annual Business Plan and Budget Submissions you have submitted, discuss the planned changes for this year and related mitigation opportunities, and ensure this next phase of planning supports your local needs and priorities.

Further details on the 2019 Ontario Budget can be found on the government's website at: http://budget.ontario.ca/2019/contents.html.

As previously noted, there is a significant role for public health to play within the larger health care system and it will continue to be a valued partner. I look forward to your input and collaboration as we work to modernize the public health sector.

Thank you for your ongoing support as the ministry continues to build a modern, sustainable and integrated health care system that meets the needs of Ontarians.

Sincerely,

Original signed by

David C. Williams, MD, MHSc, FRCPC
Chief Medical Officer of Health

c: Business Administrators, Public Health Units
Executive Director, Association of Municipalities of Ontario
City Manager, City of Toronto
Executive Director, Association of Local Public Health Agencies

---------- Forwarded message ----------
From: "**Brian Lester**" <BLester@hivaidsconnection.ca>
Date: Fri, May 3, 2019 at 12:05 PM -0400
Subject: RHAC Position Statement - Sex Work

Dear Community Partner/Supporter;

Regional HIV/AIDS Connection (RHAC) board of directors would like to announce the release of our organization's position statement on sex work. The statement is also posted on our website at http://www.hivaidsconnection.ca/get-facts/publications - on this page you will see the Sex Work statement document link.

Over a two year period, the board of directors consulted with a range of stakeholders, in addition to reviewing evidence-based research to inform our position. This consultation/education included; persons with lived experience, those who advocate from an abolitionist position, individuals and organizations that oppose the criminalization of sex work and those concerned about the conflation of sex work and human trafficking.

We fully acknowledge there are many perspectives and responses to this complex issue. RHAC has taken a position that aligns with our organization's harm reduction philosophy. Our position recognizes that criminalization of sex work continues to place individuals at greater risk and harm (including HIV transmission risk and STIs acquisition) and creates barriers to access health care and other supports.

RHAC is a sex positive, evidence-informed agency committed to harm reduction practices that positively impact those living with, at risk for, or affected by HIV/AIDS and Hepatitis C. It is with this foundation that we believe that sex work is real work and that we support the decriminalization of sex work. This recognition is made knowing that sex work, as with all forms of labour, is influenced by the social forces of capitalism, colonialism and patriarchy and those involved can experience violence and exploitation. However, the act of exchanging sexual services for money (or other similar transactions) is not inherently violent or oppressive.

Respectfully,

Brian Lester
Executive Director

Brian Lester
Executive Director
519-434-1601 Ext. 243
blester@hivaidsconnection.ca

www.hivaidsconnection.ca @HIVAIDSConnect
Serving Perth, Huron, Oxford, Lambeth, Elgin and Middlesex counties.