



Summary Report: THE OTTAWA SUMMIT on Opioids, Substance Use and Mental Health

February 2019

Research conducted by The Strategic Counsel

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The Ottawa Summit on Opioids, Substance Use and Mental Health

A Comprehensive Mental Health and Substance Use – Focus on Opioids – Strategy is being developed. In support of this strategy, OPH engaged The Strategic Counsel (TSC) to undertake an in-depth consultation with over 25 external organizations and agencies in this field. In collaboration with the Community Addictions Peer Support Association (CAPSA), OPH received questionnaires from individuals in or seeking recovery for problematic substance use, their family members and peers. OPH also conducted interviews with clients using OPH’s supervised consumption site. The consultations produced a detailed series of key findings and suggested next steps for consideration.

Following this initial consultation, OPH and The Royal organized The Ottawa Summit, which brought together almost 200 participants with varying perspectives and expertise to discuss issues and ideas for action. The Summit focused on three main themes – preventing stigma and problematic substance use, emerging harm reduction initiatives and collaborating and integrating across the system.

The Ottawa Summit took a workshop approach, where participants were actively involved in each activity throughout the day, including a series of guest speaker panels, table discussions, expert panel discussions, and participant voting. At the culmination of the Summit, 9 priorities for action (under three broad themes) and a series of comprehensive next steps were identified.

PRIORITIES FOR ACTION

Preventing stigma and problematic substance use

- 1. Develop a stigma and prevention strategy that includes social engagement and acknowledges and addresses the effects of trauma, housing, and adverse childhood experiences
- 2. Implement broad public and stakeholder education on mental health and substance use that addresses stigma and language to shift public and professional opinion
- 3. Create a collaborative table across systems to advance a mental health and substance use strategy across sectors and lifespan that is designed with vulnerable populations and people with lived experience

Emerging harm reduction initiatives that can reduce harms associated with opioid use

- 4. Increase access and funding to opioid addiction treatment and managed opioid programs
- 5. Establish a call to action for allied systems level partners to integrate harm reduction practices and philosophy in their services
- 6. Expand accessibility and diversity of harm reduction services

Collaborating and integrating across the system to increase access and uptake of services

- 7. Create a funding model that encourages comprehensive, collaborative, integrated, and client-focused care (one-stop shop)
- 8. People with lived experience, including family members, should be integrated into the design and delivery of all services
- 9. Collaborating across the system should be required to address stigma, looking at existing evidence-informed models

NEXT STEPS



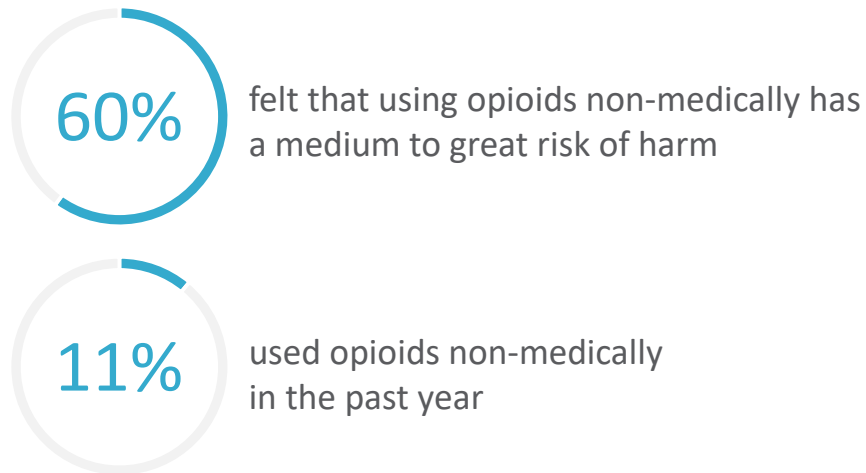
- > Conduct further analysis of findings from the Summit
- > Continue to consult stakeholders to validate findings from the Summit and identify gaps
- > Incorporate the top ideas for action in collaborative work plans, with relevant stakeholders

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SETTING THE CONTEXT

Quick Facts About Opioid Use in Ottawa

In 2017, among Grade 7-12 students in Ottawa:¹



Young people with problematic opioid use experience a high burden of mental illness and polysubstance use, as well as, greater severity of use and hazardous use.²

In 2017, in Ottawa:³

- **1 in 10** residents had an opioid pain prescription
- **4,390** people received high daily dose opioid therapy for pain
- **10,421** naloxone kits were distributed through pharmacies

Other relevant data:

- **3,641** referrals for addiction services (12% opioid specific) were made by Service Access to Recovery, a treatment referral service, between July 2017 and December 2018⁴
- **36,146** supervised consumption site (SCS) visits between July and December 2018 (21% of Ottawa Public Health [OPH] SCS visits during this period were among clients who reported being on opioid agonist therapy, a safe dispensing therapy to treat opioid use disorder)⁵

Quick Facts About Opioid Use in Ottawa

The spectrum of substance use, across the lifespan, ranges from low to high complexity



Emergency Department (ED) Visits⁶

- Those aged 30-34 are at highest risk of an opioid overdose ED visit
- In 2017, 16% of unintentional opioid ED visits were by someone who had an opioid ED visit in the past year

Hospitalizations⁷

- Unintentional opioid drug overdose hospitalizations exceeded overdoses from all other drugs combined (e.g., cocaine, barbiturates, amphetamines)
- Those aged 65 and older are most at risk for opioid-related hospitalization

64 opioid related fatalities⁸, of which⁹:

- 47% were 25-45 years old
- 41% were 45-64 years old
- 68% were men
- 88% were white
- 17% were homeless
- 50% were alone at the time of incident
- 45% had evidence of injection
- 71% were due to fentanyl
- 74% naloxone was not used

A Comprehensive Mental Health and Substance Use – Focus on Opioids – Strategy is being developed.

As input to the development of the strategy, and in advance of **The Ottawa Summit**, a consultation was undertaken to seek feedback from external organizations, agencies and people with lived experience to:

- Gauge the current state of mental health and substance use in Ottawa
- Assess views and ongoing relevance of the four pillar approach – prevention, treatment, harm reduction and enforcement
- Obtain feedback on a proposed thematic approach for the strategy
- Determine ways in which stakeholders could contribute to the development and implementation of the strategy
- Understand potential challenges to implementation

The consultation took place throughout December 2018 and January 2019.

Over 70 stakeholders shared their views through a combination of in-depth telephone and face-to-face interviews, as well as self-administered questionnaires. Stakeholders included:

- Community health and resource centres
- Educators: school boards
- Emergency medicine/acute care
- First responders: paramedics
- Hospitals
- Law enforcement: police
- Mental health agencies
- Peer workers
- People with lived experience
- Primary care physicians (including sole providers)



26 interviews with organizations and agencies were undertaken by The Strategic Counsel.



In collaboration with Community Addictions Peer Support Association (CAPSA), OPH received questionnaire responses from 39 individuals in or seeking recovery for problematic substance use, their family members and peers. OPH also conducted 10 interviews with clients using OPH's supervised consumption site.

Moving Forward – Thoughts and Considerations

Findings from the consultation* identified several areas of common ground which were viewed by stakeholders as key to moving forward and achieving progress.

*The full report is titled *Comprehensive Mental Health and Substance Use – Focus on Opioids Strategy: Findings from Consultation*

Work to engage elected officials and their staff

Ensure commitment, clear leadership, sustained attention and funding

Improve access to treatment and counselling

Work towards increasing capacity to address mental health and substance use simultaneously. Support a system that provides more timely/immediate access and longer-term follow-up. Treatment plans should address the intersection of issues – financial security, housing, etc. – in an integrated manner

Enhance system-wide collaboration between partners/stakeholders across the community

Create and maintain an inventory of the full range of programs and services available so that stakeholders can effectively assist their clients in navigating opioid-related resources in the community; bring stakeholders and partners together at regular intervals

Address the illicit drug supply

Addressing the illicit supply is as important as addressing the ‘demand’

Focus on awareness-raising and public education

Create broader and more targeted education focusing on the impact and those affected by problematic substance use, symptoms of addiction and overdose, where to obtain and how to use naloxone kits

Reduce stigma

Less focus on abstinence, more focus on harm reduction strategies and setting realistic goals

Continue to involve people with lived experience

Engage those at the center of the crisis to be part of the dialogue to identify the issues and the solutions

Identify key metrics to evaluate progress

Set realistic targets, track and share data

The Ottawa Summit was a joint initiative between Ottawa Public Health and The Royal.

These items were discussed in 3 panel discussions:

1. Preventing stigma and problematic substance use
2. Emerging harm reduction initiatives
3. Collaborating and integrating across the system

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OVERVIEW OF SUMMIT PROCEEDINGS

THE OTTAWA SUMMIT on Opioids, Substance Use and Mental Health was held on Thursday, February 7, 2019.

Ottawa Public Health and The Royal co-chaired the event.

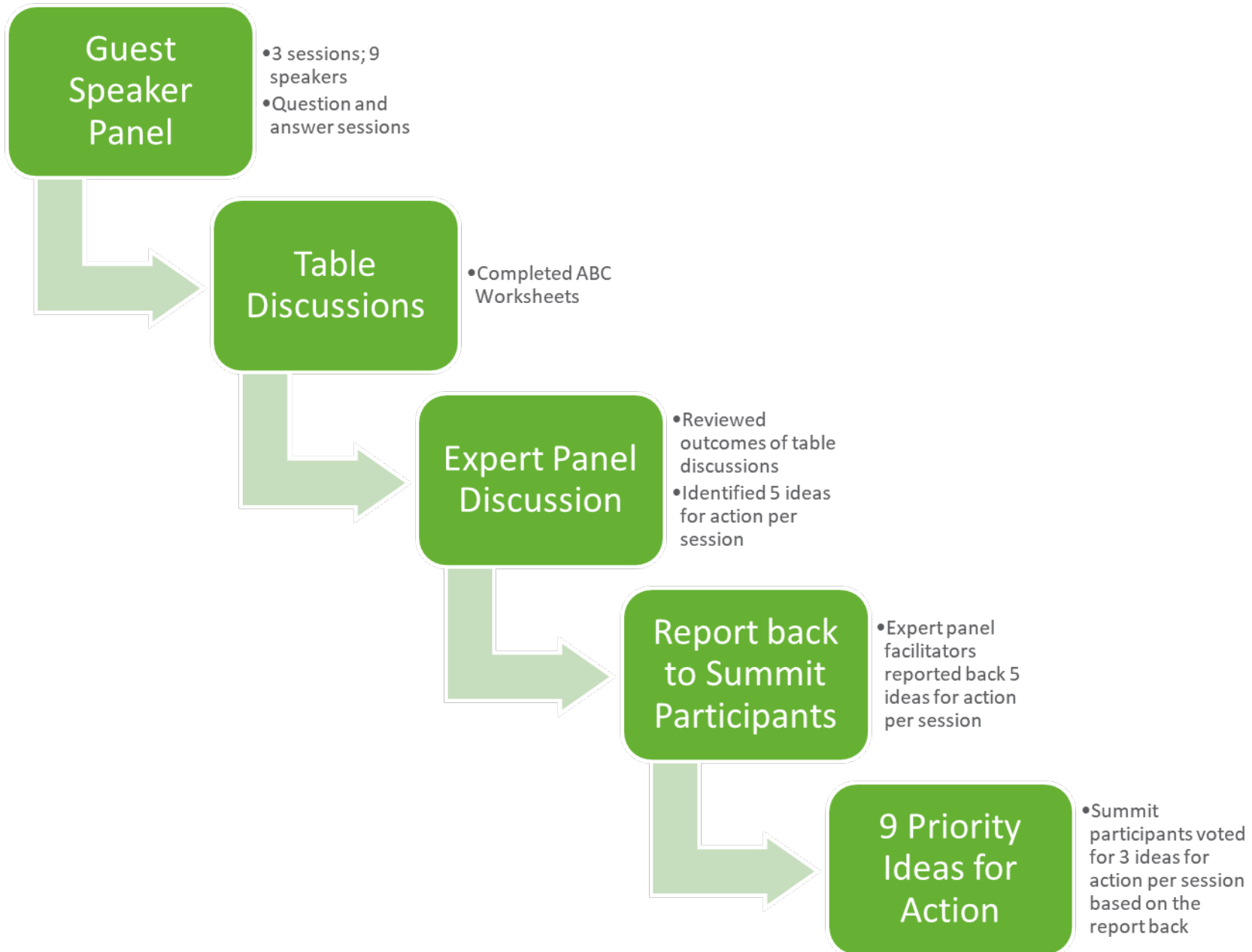


The day-long event brought together almost **200 participants** to share their perspectives and discuss ideas to prevent problematic substance use and promote mental health in Ottawa.*

Participants reflected a cross-section of community organizations, agencies and individuals engaged on this issue:

- Community-based agencies
- Educators
- First responders
- Law enforcement
- Medical and allied health professionals
- Mental health professionals
- Peer support workers
- People with lived experience and advocates
- Researchers

*A complete agenda of the day and list of participants can be found in the Appendix.



Guest Speaker Panel

The day was built around **three plenary sessions** highlighting key themes based on the consultations with those with lived experience.

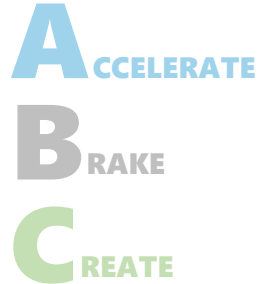
1 Preventing stigma and problematic substance use Guest Speaker Panel: Dr. Kim Hellemans Professor and Chair of the Department of Neuroscience Carleton University Angela Slobodian Acting Director of Wellness at the Ottawa Police Service and Vice-Chair, CAPSA Dr. Lisa Bromley Family Physician and Medical Director of The Ottawa Hospital, Substance Use Program	SESSION 2 Emerging harm reduction initiatives that can reduce harms associated with opioid use Guest Speaker Panel: Mark Barnes Pharmacist and Owner of Respect Rx Pharmacy Sean LeBlanc Peer Outreach Worker and Founder of Drug Users Advocacy League (DUAL) Rob Boyd Director of Oasis, Sandy Hill CHC	SESSION 3 Collaborating and integrating across the system to increase access and uptake of services Guest Speaker Panel: Dr. Jeff Turnbull Medical Director, Ottawa Inner City Health Gord Garner Executive Director, CAPSA Dr. Kim Corace Director of Clinical Programming and Research, Substance Use and Concurrent Disorders Program, The Royal and Associate Professor, Psychiatry, University of Ottawa
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Each plenary session was followed by a question and answer session, engaging Summit participants. The questions can be found in the Appendix of the report. Ottawa Public Health facilitated compiling the speakers’ responses to the questions following the Summit.

Table Discussions

After each panel discussion, participants identified ideas for action through round table discussions (4-8 participants per table).

Each table was provided with 1 ABC worksheet per panel discussion (3 in total). Participants were asked to identify ideas for action relating to the panel topic under each of the following categories:



EXAMPLE OF ABC WORKSHEET*

The Ottawa Summit on Opioids, Substance Use and Mental Health
Ideas for Action – Preventing stigma and problematic substance use

What could we speed up/do more of? Accelerate	
What could we stop doing? Brake	
What could we start doing? Create	
Longer term actions	

*Instructions to participants regarding the Small Group Table Discussions can be found in the Appendix. The ABC Worksheet was adapted from www.idenk.com.

Expert panels identified 5 ideas for action and Summit participants identified the top 3 actions by voting.

Expert panels reviewed the actions to identify the top 5 ideas for action that could be achieved in 12-18 months. The top ideas for action, within each theme, were reported back to Summit participants. All Summit participants then identified their priority ideas for action by voting.

The following process was undertaken with the expert panels:

- 

An expert panel reviewed and validated the themed action items from the table discussions (ABC worksheets) that were summarized by the support team.
- 

The moderator took the expert panel members through a facilitated discussion to review and compare all themed options.
- 

Each member of the expert panel was given 3 green (positive) and 3 red (negative) dots to vote on the themes. Members discussed why they placed their dots on specific themes.
The results of the dot exercise is shown in the next section.
- 

From this, the expert panel formulated actions which led to the 5 ideas for action from each session.
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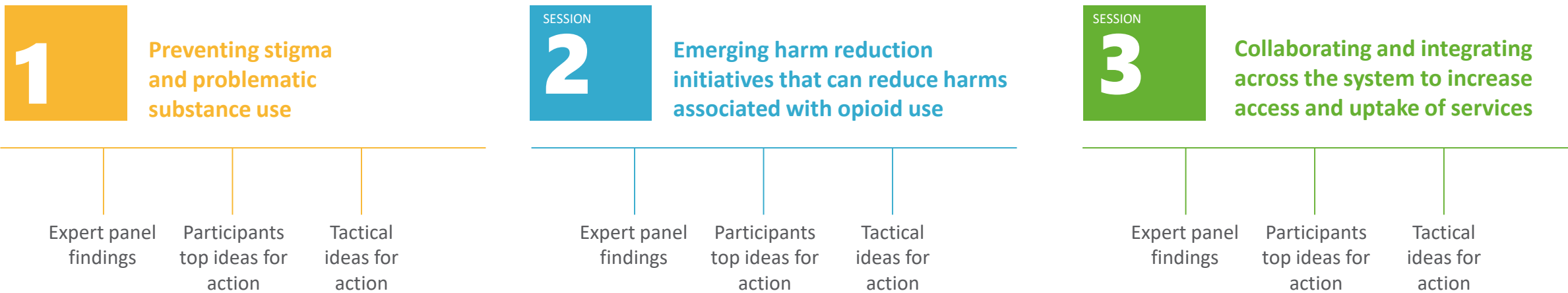
The actions were brought back to the participants to vote for their 'top 3 priorities' among the 5 actions presented. Voting took place using Menti, a conference polling technology, where participants could vote on their mobile phone.
The results of the voting exercise is shown in the Key Findings section.

3

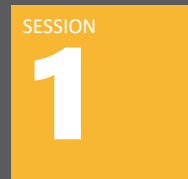
KEY FINDINGS

Key Findings: Overview

The findings are outlined in this section across the three key themes.



KEY FINDINGS



Preventing stigma
and problematic
substance use

1

Preventing stigma and problematic substance use

Expert panel findings
Participants top ideas for action
Tactical ideas for action

Expert Panel Findings

Based on the identified actions from the Summit participants, the expert panel identified education as a key area for action. More education is needed, including education that addresses stigmatizing language. Efforts need to be made towards mental health promotion and substance use prevention, while also creating more stakeholder education.

A ACCELERATE

What could we speed up/do more of?

- Education across sector and lifespan (8)
- Address stigma and language (8)
- Decriminalize use (7)

B BRAKE

What could we stop doing?

- Stop working in silos (6)

Longer term actions include:

- Care models
- Decriminalization
- Education
- Integration
- Housing
- Political action

C CREATE

What could we start doing?

- Promotion and awareness of mental health and substance use (4)
- Stakeholder education across sectors(3)

Expert Panel 1:

Moderator: Esther Moghadam, OPH

Participants:

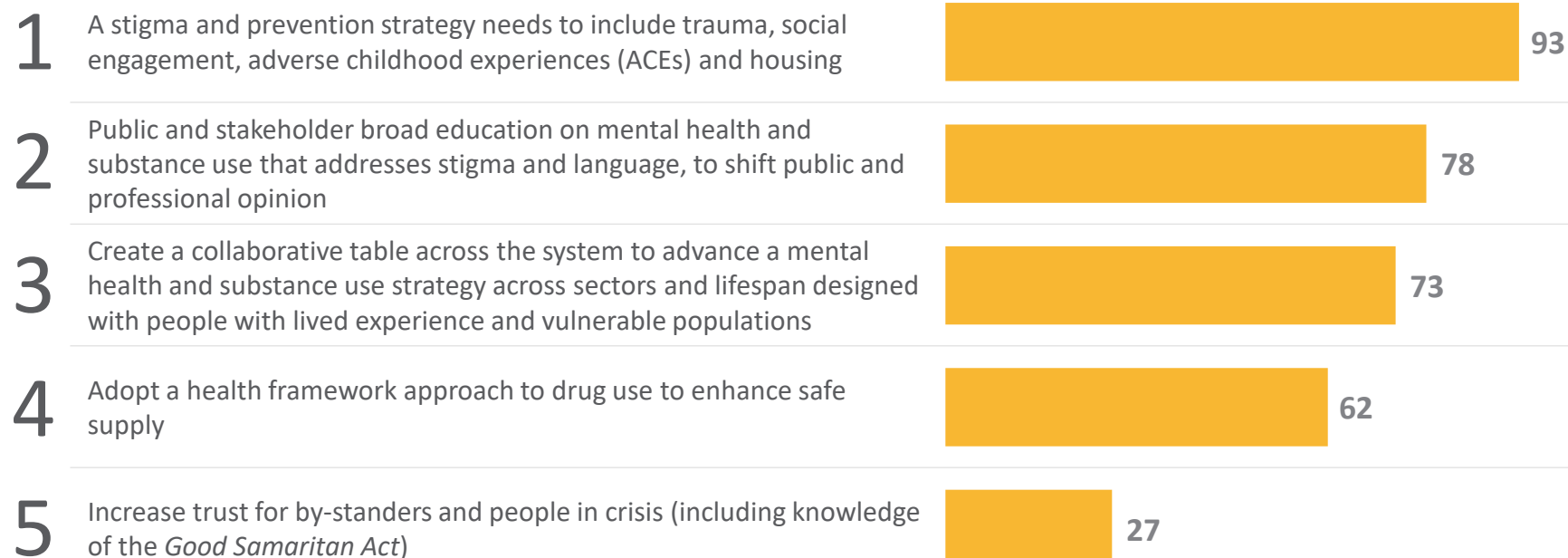
1. Steve Bell, Ottawa Police Service
2. Petra Duschner, OCDSB
3. Gord Garner, CAPSA
4. Ben Leikin, OPH
5. Joanne Lowe, YSB
6. Ann-Michelle McNulty, CECCE
7. Elizabeth Paquette, OCSB
8. Chantal Wade, CECCE

(#) Indicates the number of green dots each theme received.

*A complete table of ABC worksheets from the Small Group Table Discussions can be found in the Appendix.

Participants Top Ideas for Action

The top-ranked 'action item' for this theme is the development of a stigma and prevention strategy which would need to include trauma, social engagement, adverse childhood experiences (ACEs) and housing.



Numbers shown represent the total votes for each action item/recommendation

1

Preventing stigma and problematic substance use

Expert panel findings

Participants top ideas for action

Tactical ideas for action

Ideas for Action: Public and Stakeholder Education

What should we be doing more of? (ABC Worksheet)

- **Public education** across the lifespan, with an emphasis on addressing stigma and language
- **Stakeholder education** across sectors

What did participants think was most important? (Voting exercise)



- 1 A stigma and prevention strategy needs to include trauma, social engagement, adverse childhood experiences (ACEs) and housing
- 2 Implement broad public and stakeholder education on mental health and substance use that addresses stigma and language to shift public and professional opinion

What does this mean?

Public and stakeholder education should be evidence-informed, including the science of addiction, and focus on:

- Social determinants of health
- Infant and early childhood mental health
- The disease model of addiction (versus the moral model)
- Acknowledging concurrent disorders
- Stigma reduction
- Normalizing appropriate language and reduce stereotypes ('us' vs. 'them')
- Supporting conversation

How can we achieve this?

Education needs to be targeted and can be delivered through multiple channels:

- Mainstream anti-stigma campaigns (similar to mental health campaigns)
- Embed within the school health curriculum (demystifying drug use, empowering youth with problem solving skills and strategies)
- People with lived experience and peer workers can support program development and act as system navigators in hospitals
- Capacity building: training to identify the signs and symptoms of substance use disorder, sensitivity training, and trauma informed-care

Who should we focus on educating? In which settings?

Public:

- Youth (and their parents) – at a young age and continuously
- Families and caregivers
- Minority groups (newcomers, marginalized communities)
- Media

Stakeholders:

- Health care professionals (doctors, nurses)
- First responders (police, paramedics)
- Community leaders
- Politicians
- Regulators

- Schools
- Family services
- Supportive housing
- Workplaces

Expert panel
findingsParticipants
top ideas for
actionTactical
ideas for
action

Ideas for Action: Mental Health and Substance Use Strategy

What should we be doing more of? (ABC Worksheet)

- Increased collaboration to address **mental health and substance use**

What did participants think was most important? (Voting exercise)



- 3** Create a collaborative table across systems to advance a mental health and substance use strategy across sectors and lifespan that is designed with vulnerable populations and people with lived experience

How can we achieve this?

- Integrate the prevention and treatment of mental health and substance use disorders through holistic care models and integrated programs
- Advocate for funding models that promote intersectional integration of mental health and substance use disorders
- Provide better navigation of the mental health and substance use system and eliminate the redundancies (over assessment is viewed as a barrier)
- Streamline the emergency system for users

Expert panel
findingsParticipants
top ideas for
actionTactical
ideas for
action

Ideas for Action: Decriminalization

What should we be doing more of? (ABC Worksheet)

- Decriminalizing use

What did participants think was most important? (Voting exercise)



- Adopt a health framework approach to drug use to enhance safe supply
- Increase trust for by-standers and people in crisis (including knowledge of the Good Samaritan Act)

How can we achieve this?

- Explore drug policy reform
- Start the conversation about decriminalization and the effects to the system
- Address the illicit drug supply to establish a less harmful supply
- Seek alternatives to discipline and an abstinence only approach

KEY FINDINGS

SESSION

2

Emerging harm reduction
initiatives that can reduce harms
associated with opioid use

Expert panel findings

Participants top ideas for action

Tactical ideas for action

Expert Panel Findings

Based on the identified ideas for action from the Summit participants, the expert panel identified integrating harm reduction services into different settings as a key area for action. Addressing harm reduction focuses on providing more access to harm reduction services and alternatives. This can be achieved by bringing harm reduction services into different settings and providing more opportunities for peer involvement.

A ACCELERATE

What could we speed up/do more of?

- Increase access to Opioid Agonist Therapy (OAT) and Managed Opioid Programs (MOP) (4)
- Access to and integration of harm reduction services (4)

B BRAKE

What could we stop doing?

- Stop criminalization (of use)¹ (4)
- Stop using abstinence based models (2)
- Stop barriers to service (2)

C CREATE

What could we start doing?

- New and emerging harm reduction expansions (4)
- Embedding harm reduction into other existing settings (i.e. primary care, hospitals, detention centres, etc.) (2)
- Health promotion messaging¹ (2)
- Start providing additional opportunities for peer involvement³ (2)

Longer term actions include:

- Addressing the Social Determinants of Health
- Cross agency collaboration
- Decriminalization
- Funding
- Holistic approaches
- Justice system
- Information on system navigation

Expert Panel 2:

Moderator: Andrew Hendriks, OPH

Participants:

1. Tamara Chipperfield, Centretown CHC
2. Luc Cormier, Sandy Hill CHC
3. Catherine Hacksel, Ottawa Inner City Health
4. Anne Marie Hopkins, Ottawa Inner City Health
5. Christine Lalonde, Centretown CHC
6. Kira Mandryk, OPH
7. Carole Sinclair, Somerset West CHC

¹Also an action item (A, B, or C) in Session 1.

³Also an action item (A, B, or C) in Session 3.

(#) Indicates the number of green dots each theme received.

*A complete table of ABC worksheets from the Small Group Table Discussions can be found in the Appendix.

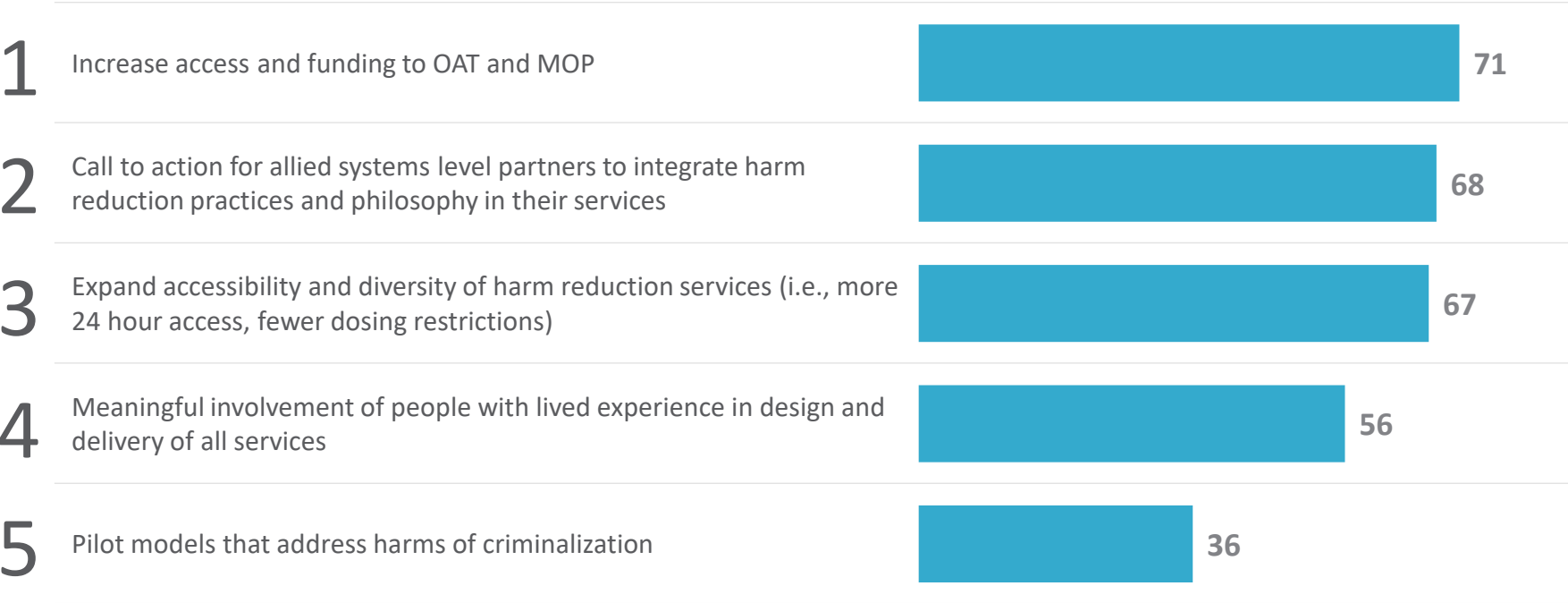
2

Emerging harm reduction initiatives that can reduce harms associated with opioid use



Participants Top Ideas for Action

Voting on this theme resulted in three items being closely identified as top priorities: increased access to opioid agonist therapy (OAT) and managed opioid programs (MOP), call to action to integrate harm reduction practices and philosophy in services offered by allied systems level partners, and expanded access to harm reduction services.



Numbers shown represent the total votes for each action item/recommendation

Expert panel findings

Participants top ideas for action

Tactical ideas for action

Ideas for Action: Increase Access to Harm Reduction Services

What should we be doing more of? (ABC Worksheet)

- Increased access to harm reduction services, including OAT and MOP

What did participants think was most important? (Voting exercise)



- 1 Increase access and funding to OAT and MOP
- 2
- 3 Expand accessibility and diversity of harm reduction services (i.e., more 24 hour access, fewer dosing restrictions)

How can we achieve this?

- Provide publicly funded access to:
 - Naloxone kits (i.e. mail-order kits, vending machines)
 - Fentanyl test strips
- Provide 24-hour safe access to services, such as supervised consumption sites (SCS)
- Provide more MOP spaces and hubs for pharmaceutical medications (i.e. hydromorphone)
- Expand access to services in rural and sub-urban areas
- Reduce restrictions on prescribing opioid replacements (i.e. methadone), including age limits
- Continue to research substitution therapies and fund trials to increase harm reduction options
- Provide better navigation of harm reduction services offered city-wide (i.e. a searchable electronic database)

*Item 2 is included on the following page.

2

Emerging harm reduction initiatives that can reduce harms associated with opioid use

Expert panel findings

Participants top ideas for action

Tactical ideas for action

Ideas for Action: Integrate Harm Reduction into Existing Settings

What could we start doing? (ABC Worksheet)

- Embed harm reduction into existing care settings in place of abstinence-based models

What did participants think was most important? (Voting exercise)



- 2 Call to action for allied systems level partners to integrate harm reduction practices and philosophy in their services

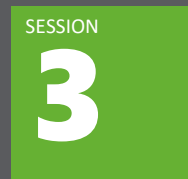
How can we achieve this?

- Create community based advisory committees to coordinate and implement harm reduction services across different sectors
- Include peers to help normalize the conversation that harm reduction is part of treatment and break down abstinence based approaches in these new settings
- Provide a single “fast track” source in which all settings can refer patients to (such as an “Opioid Emergency Department”)
- Incorporate naloxone training into existing programs (i.e. through First Aid/CPR courses)
- Allow police to be a part of the solution in providing harm reduction services to those in need (naloxone kits, etc.)
- Better inform the community (i.e. parents, families and care givers) on the harm reduction services available

In which settings should harm reduction services be implemented?

- General primary care (medical offices, walk-in clinics) – physicians, psychologists, prescribers, pharmacists, front line workers
- Hospitals (specifically emergency rooms)
- Detention centres
- Law enforcement (police and by-law)
- Schools (middle schools, high schools, post-secondary)
- Youth programs
- Supportive housing, finance, social services

KEY FINDINGS



Collaborating and integrating
across the system to increase
access and uptake of services

3

Collaborating and integrating across the system to increase access and uptake of services

Expert panel findings

Participants top ideas for action

Tactical ideas for action

Expert Panel Findings

Based on the identified actions from the Summit participants, the expert panel identified a need for equitable services and an acknowledgement that stigma is present within the current system as key ideas for action. There needs to be equitable services through a “one-door” service approach, while creating a mutually beneficial model that allows for collaborative, client-focused care. Stigma can be addressed by continuing to include people with lived experience and peer advocates in ongoing conversations to set priorities and drive effective strategy implementation.

A ACCELERATE

What could we speed up/do more of?

- Engaging people with lived experience ² (7)

B BRAKE

What could we stop doing?

- Stop avoiding the issue of stigma ¹ (4)

C CREATE

What could we start doing?

- Providing more equitable services:
 - A “one stop walk-in” (8): The ability for a person to access the services they need at one point of contact, instead of being required to make multiple points of contact in the system
 - A funding model that encourages comprehensive, collaborative, client-focused care (8)
- Shared resources (2)

Longer term actions include:

- Upstream approaches (policy), i.e. Icelandic model
- Appropriate use of resources and equitable distribution
- Client-focused care
- Build people’s capacity to help themselves
- Community-driven partnerships
- Joint funding proposals from agencies
- Establishing system navigator/liaison roles
- Flexible “basket of services”
- Technology to integrate services
- Address Social Determinants of Health
- Emergency funding and housing for people entering recovery

Expert Panel 2:

Moderator: Dr. Kim Corace, The Royal

Participants:

1. Dr. Trevor Arnason, OPH
2. Andrew Berthelet, CAPSA Board Member
3. Louise Bradley, MHCC
4. Johanne Levesque, Rideauwood Addiction and Family Services
5. Rita Notarandrea, CCSA
6. Melissa McFadden, Queensway Carleton Hospital
7. Dr. Sinthu Suntharalingam, CHEO
8. Steve Vachon, Service Access to Recovery
9. Dr. Melanie Willows, The Royal

¹Also an action item (A, B, or C) in Session 1.

²Also an action item (A, B, or C) in Session 2.

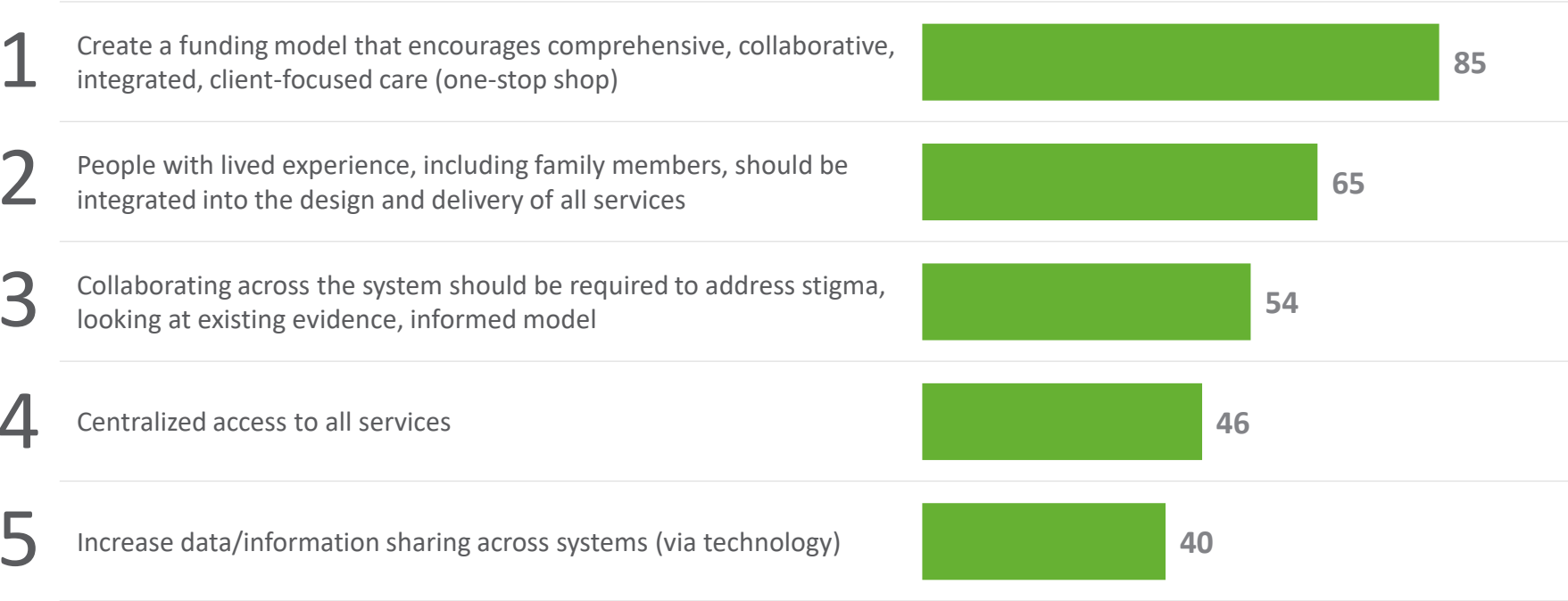
(#) Indicates the number of green dots each theme received.

*A complete table of ABC worksheets from the Small Group Table Discussions can be found in the Appendix.



Participants Top Ideas for Action

Based on the number of votes by participants, the top-ranked ‘action item’ for this theme is the creation of a funding model to promote collaboration and integration, specifically in a way that offers client-focused, one-stop care.



Numbers shown represent the total votes for each action item/recommendation

3

Collaborating and integrating across the system to increase access and uptake of services

Expert panel findings

Participants top ideas for action

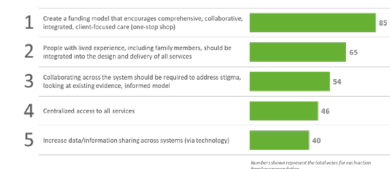
Tactical ideas for action

Ideas for Action: Integration of People with Lived Experience/Peers

What could we start doing? (ABC Worksheet)

- Establish equitable services through integration (“one-stop shop”) and funding models that encourage comprehensive, collaborative, client-centered care

What did participants think was most important? (Voting exercise)



- Create a funding model that encourages comprehensive, collaborative, integrated, and client-focused care (one-stop shop)
- Collaborating across the system should be required to address stigma, using existing evidence-informed models
- Centralized access to all services
- Increase data/information sharing across systems (via technology)

What does this mean?

- Create multiple points of entry
- Stop working in silos and institutions
- Adopt an integrated approach that includes all parties in the individual’s circle of care (team)
- Create a barrier-free system
- Take a holistic approach
- More transformational change rather than incremental change
- A redesigned system through greater involvement of people with lived experience
- Build a person’s ‘recovery capital’

How can we achieve this?

System Redesign

- Pilot programs
- Create a vision of the optimal integrated system
- Identify organizational gaps
- Shift away from institutions/make it more community-focused
- Public-private partnerships
- Co-design of programs
- Create interdisciplinary teams trained to identify different levels of risk
- More involvement of peers in schools for prevention/early identification
- Clearer referral pathways
- Allow third party support for referral or access to programs
- Promote community services (211)
- Employment solutions, housing solutions, sense of purpose

IT/Communication

- Technology to integrate services
- Technology innovation
- Develop a secure/safe information portal
- Easier sharing of medical history
- Promote community services (211)
- Better inter-agency communication
- Knowledge exchange of available services
- E-Health hubs

Funding & Accountability

- More short-term financial support
- Funding incentives and rewards for collaboration
- Create a shared funding model
- Accountability for consistency of care

*Item 2 is included on the following page.

3

Collaborating and integrating across the system to increase access and uptake of services

Expert panel findings

Participants top ideas for action

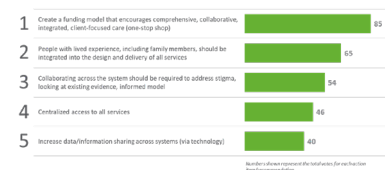
Tactical ideas for action

Ideas for Action: Integration of People with Lived Experience/Peers

What should we be doing more of? (ABC Worksheet)

- Expanding opportunities for peer involvement and engaging those with lived experience

What did participants think was most important? (Voting exercise)



- 2 People with lived experience, including their family, should be integrated into the design and delivery of services

What does this mean?

- Continue to actively involve peers and people with lived experience as part of the ongoing discussion
- Change societal ideas and beliefs around addiction and mental health

How can we achieve this?

- Peer-led discussions, education, movies, video, art, advertising campaigns
- Include peers on the care team
- Develop peer positions in all organizations to reduce stigma and increase understanding of client expectations
- Create the ability through stigma reduction for people already working in prevention, harm reduction, treatment and enforcement to bring their lived and living experience to their job skills

4

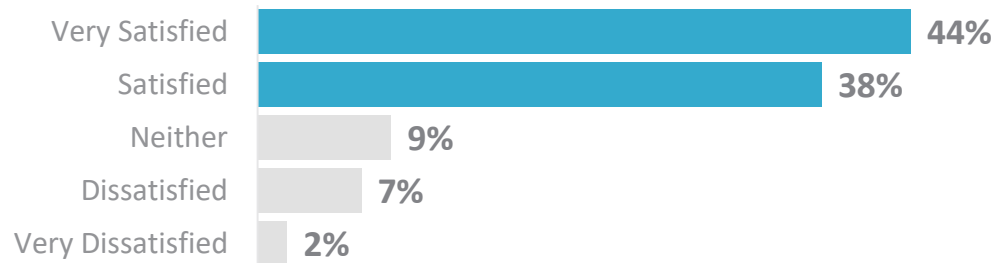
PARTICIPANT EVALUATION



Participants were asked to complete an evaluation in print or online following the Summit. Most were satisfied with the event, specifically the panel discussions, involvement of people with lived experience, opportunities for cross-collaboration and participation, and the focus on action.

Satisfaction with The Summit

(n=85)



Several areas stood out as being of particular **value** for participants, including:

- Quality, caliber and variety of the guest speakers
- Involvement of people with lived experiences and peers
- Ability to network and collaborate with others at table discussions
- Focus on decisions – summarizing the feedback and actions at the end of the day
- Cross-section of attendees and number of stakeholders engaged
- Opportunity to provide input and participate (voting)
- Themes discussed



Participants also highlighted **areas for improvement**, going forward:

Taking Action

- Identify clear next steps, including an action plan, timelines and accountabilities
- More time dedicated to asking questions, group discussions, prioritization of actions
- Focus on solutions: less talk – more action
- More participation from those who can influence policy change

Collaboration

- More involvement of people with lived experience in the development phase
- Ensuring a variety of organizations and sectors at each table
- Continue working as a community and move towards collective agreement
- Commit to continuing the dialogue

New Ideas

- More learning about new research, innovation and programs

5

NEXT STEPS

Next Steps

1

Conduct further analysis of findings from the Summit

- Identify proposed actions and opportunities arising from the discussions
- Incorporate the key findings within The Comprehensive Mental Health and Substance Use – Focus on Opioids – Strategy

2

Continue to consult stakeholders to validate findings from the Summit and identify gaps

- Seek opportunities to expand engagement and outreach to a broader spectrum of stakeholders
- Identify opportunities for ongoing collaboration and information/idea sharing
- Identify gaps:
 - What tools/resources is our community missing?
 - What other stakeholders need to be engaged?
 - What other mechanisms can our community employ to encourage cross-sectoral collaboration?

3

Incorporate the top ideas for action in collaborative work plans, with relevant stakeholders

- In consultation with stakeholders, identify opportunities to work collectively to further address mental health and substance use in the short and long-term
- Include people with lived experience in planning and implementation; ensure they are engaged to drive the work and priorities

6

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A

APPENDIX

THE OTTAWA SUMMIT

on Opioids, Substance Use and Mental Health

Thursday, February 7, 2019

8:00 AM to 4:00 PM

RA Centre, 2451 Riverside Dr., Ottawa

#theottawasummit

Agenda

Time	Activity
8:00 am	Registration Opens – Clark Hall <i>Light breakfast and refreshments (provided)</i>
8:30 am	Welcoming remarks
8:45 am	Opening Remarks <i>Hon. Lisa MacLeod, Minister of Children, Community and Social Services, Minister Responsible for Women's Issues</i>
8:55 am	Opening Remarks <i>Councillor Keith Egli, Chair, Ottawa Board of Health</i>
9:05 am	Context Setting <i>Dr. Vera Etches, Medical Officer of Health, Ottawa Public Health Dr. Joanne Bezzubetz, President and CEO, The Royal</i>
9:10 am	Session 1: Preventing stigma and problematic substance use <i>Welcome: Dr. Vera Etches</i> <u>Guest Speakers:</u> ➤ <i>Dr. Kim Hellemans, Professor and Chair of the Department of Neuroscience at Carleton University</i> ➤ <i>Angela Slobodian, Acting Director of Wellness at the Ottawa Police Service, Vice-Chair, Community Addictions Peer Support Association</i> ➤ <i>Dr. Lisa Bromley, Family Physician and Medical Director of The Ottawa Hospital Substance Use Program</i> <i>Moderated by: Dr. Rebecca Jesseman, Director of Policy, Canadian Centre on Substance Use and Addiction</i>
10:10 am	Networking Opportunity and Nutrition Break

10:20 am	Session 2: Emerging harm reduction initiatives that can reduce harms association with opioid use <i>Welcome: Dr. Joanne Bezzubetz</i> <u><i>Guest Speakers:</i></u> ➤ <i>Mark Barnes, Pharmacist and Owner of Respect Rx Pharmacy</i> ➤ <i>Sean LeBlanc, Peer Outreach Worker and Founder of Drug Users Advocacy League (DUAL)</i> ➤ <i>Rob Boyd, Director of Oasis, Sandy Hill Community Health Centre</i> <i>Moderated by: Wendy Muckle, Executive Director, Ottawa Inner City Health</i>
11:20 am	Session 3: Collaborating and integrating across the system to increase access and uptake of services <i>Welcome: Dr. Joanne Bezzubetz</i> <u><i>Guest Speakers:</i></u> ➤ <i>Dr. Jeff Turnbull, Medical Director, Ottawa Inner City Health</i> ➤ <i>Gord Garner, Executive Director, Community Addictions Peer support Association (CAPSA)</i> ➤ <i>Dr. Kim Corace, Director of Clinical Programming and Research, Substance Use and Concurrent Disorders Program, The Royal; Associate Professor, Psychiatry, University of Ottawa</i> <i>Moderated by: Dr. Melanie Willows, Clinical Director, Substance Use and Concurrent Disorders Program, The Royal; Assistant Professor, Department of Family Medicine, University of Ottawa</i>
12:20 pm	Lunch (provided) <i>Soup, salads and sandwich buffet</i>
1:20 pm	Priorities for Action ▪ <i>Panel report back</i> ▪ <i>Outline areas of consensus</i> ▪ <i>Online voting on actions</i>
3:30 pm	Closing Remarks <i>Scott McLean, Chair, Board of Trustees, The Royal</i> Moving Forward into 2019 <i>Dr. Vera Etches and Dr. Joanne Bezzubetz</i>

We honour the Algonquin Anishinabe people, on whose unceded traditional territory the City of Ottawa is located. OPH extends this respect to all First Nations, Inuit and Métis peoples, their ancestors, their Elders, and their valuable past and present contributions to this land. OPH recognizes the impact and legacy of colonization and ongoing systemic racism on the health and well-being of First Nations, Inuit and Métis peoples, and is strongly committed to public health actions that promote reconciliation and the health of First Nations, Inuit and Métis people and communities.

PARTICIPATING ORGANIZATIONS THE OTTAWA SUMMIT

AIDS Committee of Ottawa
Amethyst Women's Addiction Centre
The Centre for Addiction and Mental Health (CAMH)
Canadian Armed Forces
Canadian Centre on Substance Use and Addiction (CCSA)
Community Addictions Peer Support Association (CAPSA)
Carleton University
Le Centre d'intervention et de prévention en toxicomanie de l'Outaouais (CIPTO)
Carlington Community Health Centre (CHC)
Centretown Community Health Centre
Champlain Local Health Integration Network (LHIN)
Centre intégré de santé et des services sociaux de l'Outaouais (CISSS)
Conseil des écoles catholiques du Centre-Est (CECCE)

Conseil des écoles publiques de l'Est de l'Ontario (CEPEO)
Dave Smith Youth Treatment Centre
Drug User Advocacy League (DUAL)
Eastern Ontario Health Unit
Leeds, Grenville & Lanark District Health Unit
Maison Fraternité
MAX Ottawa
Mental Health Commission of Canada (MHCC)
Hôpital Montfort
Montfort Renaissance
Nepean, Rideau & Osgoode Community Resource Centre
Office of the Chief Coroner for Ontario
Ottawa Carleton District School Board (OCDSB)
Ottawa Catholic School Board (OCSB)
Ottawa Inner City Health
Ottawa Paramedic Service
Ottawa Police Service

Ottawa Public Health (OPH)
Overdose Prevention Ottawa
Public Prosecution Service of Canada
Queensway Carleton Hospital (QCH)
Royal Canadian Mounted Police (RCMP)
Recovery Canada
Recovery Ottawa
Respect Rx Pharmasave
Rideau-Rockcliffe Community Resource Centre
Rideauwood Addiction and Family Services
Sandy Hill Community Health Centre
Somerset West Community Health Centre
South East Ottawa Community Health Centre
The Elizabeth Fry Society
The Ottawa Hospital
The Royal
Tungasuvvingat Inuit
University of Ottawa
Youth Services Bureau (YSB)

The Ottawa Summit

Questions & Answers

Following the Ottawa Summit, Ottawa Public Health facilitated the process to obtain answers to additional questions that were not addressed at the Summit. Panelists graciously provided answers to the following questions.

- 1. Q: Can the brain that has changed due to trauma ever change back to a “normal” neural pattern or will the person have to live with the adaptations to circumvent those neural changes?**

A: This is difficult to answer. The memory of the trauma is more or less permanent, however, the emotional valence associated with the trauma can be altered (reduced); this is what is observed with some therapy. Because behaviour/emotions/cognitions are altered, we can assume the brain is altered as well.

- 2. Q: Considering what we know about trauma and the neuro responses to problematic substance use, why is there so little public understanding and in-turn, appropriate and evidence based treatment options?**

A: I think it is gaining traction – see [“The Brain Story.”](#) This does highlight the challenge of translating the basic science into policy.

- 3. Q: So if it is genetics and environment – why do doctors and lawyers become addicts?**

A: Psychosocial factors are also important to consider.

- 4. Q: Is there evidence supporting substance use disorders as both a disease and a disorder? Does it matter which word we use?**

A: Yes. There is evidence for both, but people do disagree on whether to say it is a disorder or disease defined as a condition that impairs function and has specific signs/symptoms, whereas disorder is a only a disturbance of function. Across drug classes, there are brain regions/functions that are disturbed, and there are signs /symptoms that seem to be common across all substances. However, as stated, not all agree with this and some suggest that “addiction is a disorder of a person, embedded in a social context.” (Levy, 2013)

- 5. Q: The system feeds the stigma. For example – programs have criteria’s in place, and the person has to meet these to access the program. How can we change the system to prevent stigma?**

A: I completely agree. To quote from Andre Picard from the Globe and Mail on Feb 27, “care is system-driven and not patient-centered.” This is because the system has been designed that way. The system performs perfectly well and exactly as it was designed to do. Programs get designed, mandated or funded to address pieces of the whole, not from the user’s perspective of “come as you are.” The answer is to hold politicians and funders accountable to design a patient-centered system. The flip side is dilution of expertise and inefficiency. Not all parts of the system can be all things to all people all of the time. Users of

the system eventually need to get connected with the services and programs that serve them the best. We need to build into the system intelligent and creative ways for users of the system to get welcomed (no “wrong door” to enter the system), then quickly get connected to the right service that meets their needs. Again, I believe this can be done by ensuring accountability from the system creators to the system users. Networked/ interconnected design, not silos.

6. Q: About half the people in this room have lived experiences or work directly with people who do. We understand stigma. How can we influence change in the institutions we work in or work with?

A: Show up and speak up. Be visible. Own the illness. Why should addiction be any different from heart disease or cancer? Anyone who has a health issue comes by it honestly. Addiction is something a person can have but does not have to define who you are. Do not allow the external stigma you encounter to become internalized. Be proud. Know your worth. It can be exhausting to combat stigma. Acknowledge that speaking up can come at a cost. Support one another. Pick your battles. For those who work with people with addiction, be allies. You have privilege compared to people who are living with addiction. Speak up on their behalf.

7. Q: How can we work form within large organizations to promote a harm-reduction philosophy? For example, the Ottawa Hospital?

A: Education and knowledge of harm reduction is important, as is education and knowledge on substance use and substance use disorders more broadly. In fact, education should be mandatory for health providers. But, while education and knowledge is necessary, it is not sufficient. It is really about reconceptualising and shifting views about substance use and addiction. And of course, breaking down systemic and structural barriers as well as stigma. Health care institutions and health professional care about their patients. Therefore, it is about finding similar goals (i.e., patient safety) and seeing how harm reduction principles can help meet these goals. In addition, internal “champions” and people with lived experience are also key to moving this forward. Working with colleagues across sectors (i.e., public health, mental health/addiction) is also important. Finally, many best practice guidelines and quality standards (i.e., HQO OUD quality standards) can be helpful in moving forward.

8. Q: How could we create a treatment model that is both client-centered with harm reduction at the core, and at the same time, navigating care for clients who are triggered and who’s goal is abstinence and possible safety concerns?

A: Harm reduction and abstinence are not mutually exclusive. Safety and harm reduction should be part of all treatment provided. This requires a shift in philosophies of providers and agencies so that they can see the value to their clients of adopting a harm reduction approach. Talking about how to use safely and reduce risks does not promote people to use drugs. In fact, not adopting this philosophy puts clients in danger when they leave abstinence-based programs (or even while they are participating in abstinence based programs). It also contributes to feelings of shame and failure. There are numerous examples of services across Canada that have successfully integrated harm reduction into their programming and services and remain respectful, supportive, and helpful to clients’ abstinence goals. I encourage you to meaningfully engage clients and families into the development and implementation of new services.

9. Q: Is there a non-medical treatment for ADHD?

A: There is some evidence for non-pharmacological treatment (i.e., CBT) of ADHD in adults. A recent Cochrane review (Lopez et al 2018) showed some evidence from low-quality studies that CBT may improve ADHD symptoms in the short-term. This review also showed additional benefit of combining CBT with pharmacological treatment. There is a paucity of long-term data and of high-quality studies which limit the strength of the findings and recommendations. Further research and evaluation in this area is needed.

10. Q: How do we help institutions listen to people who use drugs and follow advice that makes them uncomfortable?

A: Reduce stigma, educate, Also people who use drugs or support people using drugs need to stop yelling and begin speaking to institutions, and start producing evidence that makes sense to the institutions. Get funding into the conversation, start moving in increments instead of demanding massive change, Understand that institutions like ships take time to turn and respect the process. Get off a moral platform and assume good intentions of the existing programs (let us not throw it all out, but find advocates within the system not just from the outside) and engage peers with systems change experience.

11. Q: If you could “blue sky” a plan of an integrated approach to addiction – could you describe what it would look like for a teenager, someone who is homeless or someone living with mental health issues?

A: Youth

That, prevention would have educated preteens and teens on brain story/ACE studies and indicators of problematic or substance use disorders. They would have been taught various pathways and positive outcomes for most people who experience harms from substance use and/or substances disorder and that there were supports to go.

That, teenagers would have a different modality of treatment in general, informed by adolescent experience and outcomes (for example, lived and living), where outcomes and services would be informed by typical pathways while remaining individually flexible. Their levels of service would increase with difficulties, not decreasing and would be based on ACE informed and trauma informed perspectives. Where suffering should be treated as such, and not as failure or client blaming.

That, in urban areas, there would be consideration given to education centres where there was a focus on concurrent disorder and mental health and substance use disorder. There is much to be learned from some schools in the US, that are focused on well-being and education, and in these key areas where populations are sufficient to support

That, online resources for mental health and substance use disorders across the continuum of the spectrum are readily available to all. This would include an “exploration” piece of what is my relationship to substances like compared to others and compared to a general health (harm-free) model. Similar to Carleton University’s “Don’t Know” and Algonquin College “Umbrella” project, “Breaking Free on Line” has a new excellent public health perspective on substance use, as well as self-directed moderation models volumes on well-being that has defined by the person using the system.

Homeless

To begin, this is such misleading heading. There is a complex population who are without homes. We can get well off tracked in providing individual care by using all assumptions that come to mind and thinking of it as a definition of circumstances rather than what brought the condition into being. Keep in mind that for some, homelessness is a safety behavior and a healthy choice. That they are indeed better off now than where they were before. When we approach this demographic (especially youth) we miss their decision to be safer and all that entails including self-determination and perseverance. We are actually declaring them a failure when they have actually experienced a success.

One cannot support the homeless unless we support the individual in front of us (who is without a home) and try to understand why and to ask them what they need. They are still people who live somewhere. We do not see their home because we do not recognize it as a home. It could be an air vent, a doorway or a dumpster. We have to provide care that meets the needs of people living in varying circumstances. It must go without judgement and with the mindset that our expectations cannot be imposed to them, especially to those who have received support in the past and their needs were not met.

We need to provide unconditional care with increased services for those most difficult to reticence or to utilize them similar to what we do for palliative clients.

We have been so caught up in maintaining individual rights that we have lost some our social responsibilities. As foolish as it may sound, we need to develop a system that is designed for those struggling to access the system. We continue to blame clients for not using the system effectively instead of empathizing with people who are unable to use the system it was designed for.

“Triage, Triage, Triage.” Every point of contact needs to have a triage-focused approach and to identify what is needed now, that the client’s voice is heard and that they are engaged in their care.

I have a caveat I wish to make clear here. In my active substance use disorder and suicidal ideation, I was often not the best advocate for the help I needed, because I didn’t know what help I needed. There is a lot to be said about client centered service, however part of that has to include being aware that the client may not be well. Keep in mind that information and input from professional researches and evidence-based models may be perceived and implemented as demands and instructions.

All the people I know with a substance use disorders, all experienced a time in their life when all they wanted was to not run out of substances, to be left alone and to not be bothered by anyone. That voice cannot be the voice that sets our health care policy as that is the voice of the illness.

Mental Health

I have no idea why we don’t have an open-door hospital setting for mental health that is continuum based. I always hear people say that a reason people call the crisis line every day, was just to have someone to speak to. So I say yes, imagine a life where you can call a number and can speak to someone, and not because it is a crisis situation.

That, we would embed peers into the professional setting to engage them in social aspects and peer activities. As such, establish a new bridge of experience with peers at the hospital that may lead to outside areas of engagement.

That, there would be peer support for people with suicidal thoughts or decisions. For example, the South Western Ontario Bridge building has to go past the peers and into the general community. Where people

are not separated and defined by their struggles, but instead, we need to look for engagement strategies for the broader society to promote inclusion.

12. Q: As someone who has worked with individuals with substance use and mental health issues for almost 30 years; discussions regarding non-compartmentalization and no-silos has been taking place for decades. How does the change happen, and do we just keep on talking?

A: Moving to an integrated system of service provision is transformational and very difficult. I believe it happens through changes in funding and governance. We are starting to see evidence of this emerging provincially through integrated healthcare providers. We have to work with a mental health and addictions community to work closely with the acute care sector as well as relevant social services.

13. Q: What do we know (from other jurisdictions and countries) about what actually works to achieve collaborative, cross-sectoral health care systems? What is the first step we can take?

A: There is considerable evidence relating to the effectiveness of inter-and intra-sectoral initiatives. Different networks or collaborative have been developed in Europe and Scandinavia. In Canada, the Saskatchewan hub model is a good example.

14. Q: If what we are doing is not working (I agree), what do you propose would work?

A: I believe that we should move to programmatic management as opposed to Sector specific management. An integrated mental health and addictions strategy that focusses on the continuum with its own governance and funding strategy would be most effective.

15. Q: How can collaboration be supported when we are so overwhelmed with what is in front of us everyday? How?

A: When faced with the day-to-day crises that we all experience and the lack of appropriate resources to do the required tasks before us, it is very hard to plan constructively for the future. Nevertheless, we have to carve off some time and resources to plan for a better system, as the one that we currently work with is ineffective.

Small group table discussions

General Instructions

For this part of the summit, you will work at your tables to explore ideas for action after each of the three morning sessions. On your table, you will find the **Accelerate-Brake-Create (ABC)** worksheets. You will have a total of **20 minutes** to discuss and prioritize your ideas after each session.

Please choose a group member at the table to be the:

- a) Facilitator – This person will aid the discussion
- b) Recorder – This person will record the ideas onto the ABC worksheet

You are not required to report your ideas to the audience. The worksheets will be collected at the end of each session and given to the Expert Advisory Panel members. The panel will review your responses and provide the top recommendations for action back to the audience this afternoon.

Activity

1. Spend one or two minutes thinking about the speakers you have just heard and reflect on your experience and knowledge.

2. Locate the ABC worksheet for the corresponding session:

Session 1 - Preventing Stigma and Problematic Substance Use (**Green**)

Session 2 - Emerging harm reduction initiatives that can reduce harms associated with opioid use (**Yellow**)

Session 3 - Collaborating and integrating across the system to increase access and uptake of services (**Purple**)

3. The FACILITATOR will guide the discussion by starting with the first volunteer and moving around the table to discuss ideas for action in each area: “accelerate,” “brake” or “create.”
4. Narrow the ideas down to **a maximum of two** for **each area** and have the RECORDER note them on the worksheet in two concise sentences under each area.

Expert Panel Discussion #1: Preventing Stigma and Problematic Substance Use

Each member of the expert panel was given 3 green (positive +) and 3 red (negative -) dots to vote on the themes from the ABC exercise. Results showing the placement of these dots are shown using symbols (+/-) next to each statement below.

Accelerate (A)	Brake (B)	Create (C)	Long term
Education Across Sector and Lifespan + + + + + + + + Embed info into school curriculum Share more info regarding neurological changes Specific evidence based programs Involve peers and lived experiences Continuous early education	Working in Silos + + + + + + Stop separating mental health & addiction Stop silos between mental health and substance use disorder Stop repeating stereotypes Mass media and talking about drugs will make people/kids use drugs Slogans Criminalization Criminalization of a medical problem	Stigma Family focused centre Comprehensive strategies to pain management Look holistically and acknowledge concurrent disorders Keep mothers and babies together Stabilize families Holistic Care + Programs holistic approach concurrent support Treatment approaches with the skills in mental health and substance use	Integration Medical Community see all mental health and integrate Integrate treatments – mental health and substance use Streamline emergency system so substance use clients don't sit in waiting room in withdrawal Clinicians – understand basic needs of client care (i.e. trauma) Cross sectional holistic models of care and integrated services Focus on infant and early childhood mental health

Accelerate (A)	Brake (B)	Create (C)	Long term
Target specific age groups across sectors and across lifespan: Youth Trauma informed Parents, families Professionals (health care) First responders Capacity building Stigma reduction Education Across Sector and Lifespan + + + + + + + + Embed info into school curriculum Share more info regarding neurological changes Specific evidence based programs Involve peers and lived experiences Continuous early education	Discontinue police attending overdose calls - - Stop arresting people for anything drug related Working in Silos + + + + + + Stop separating mental health & addiction Stop silos between mental health and substance use disorder Stop repeating stereotypes Mass media and talking about drugs will make people/kids use drugs Slogans Criminalization Criminalization of a medical problem Discontinue police attending overdose calls - -	Upstream Approaches Social housing Stigma Family focused centre Comprehensive strategies to pain management Look holistically and acknowledge concurrent disorders Keep mothers and babies together Stabilize families Holistic Care + Programs holistic approach concurrent support Treatment approaches with the skills in mental health and substance use	Housing Supportive housing Integration Medical Community see all mental health and integrate Integrate treatments – mental health and substance use Streamline emergency system so substance use clients don't sit in waiting room in withdrawal Clinicians – understand basic needs of client care (i.e. trauma) Cross sectional holistic models of care and integrated services Focus on infant and early childhood mental health Housing Supportive housing

Accelerate (A)	Brake (B)	Create (C)	Long term
Target specific age groups across sectors and across lifespan: Youth Trauma informed Parents, families Professionals (health care) First responders Capacity building Stigma reduction Support conversations Evidence informed & science of addiction Sensitivity training Faces and voices Promote/increase awareness/understanding of mental health and substance use Educate younger through family services and schools Specific evidence based programs Include lived experience community in education and show case their experience and peer support	Stop arresting people for anything drug related Apprehensive of children whose parent use drugs Stop abstinence only approach Stop Short-term Solutions Stop doing same thing “Bandage” short term solutions and trying to fix people Stop doing ineffective things Barriers to Care + Fragmented Care Lack of holistic care Redundancies (i.e. assessment) High threshold for methadone treatment Current models support stigma Example – must meet criteria to enter care Specialized care centres	Upstream Approaches Social housing Empower problem solving Harm reduction Housing Models of Care Trauma informed care and practitioner education Partnership CHS Education Link to service Better Accessibility at daycare and schools System of peer navigation in hospitals and long term access to support and seamless transitions Comprehensive service Targeted services for pregnant moms who use drugs Funding Create more funding	Care Models Free medical detox Day detox Make PEP treatment easier to access ALT teams for substance use Decriminalization Address supply Alternatives to discipline Funding Education Develop training re: signs and symptoms of addiction (similar to Asist and SafeTalk) Focus on prevention, early identification, harm reduction, education on strategies to deal with mental health. Education at younger ages More harm reduction and mental health education in schools Public and organizational campaigning

Accelerate (A)	Brake (B)	Create (C)	Long term
Address Stigma & Language ++ +++++ Discuss Mental Health (including addiction) openly Consider the language of public education Non stigmatizing Plain language Trauma informed Use/normalize appropriate language Change language Awareness of alternate languages Open conversations Stop stigma in workplace Stop rewarding people for coming into work when they are not well. Stop using stigmatizing language Stop self-blame Address stigma early in schools	Funding Stop cutting funding to housing	Stakeholder Education +++ Hold each other accountable Transparency among professionals Public Education Include people with lived experience to school boards - - - - - - - - Shift from “you’re in trouble” in schools to “here’s support” Harm reduction info to younger children - - - - - Start conversations younger Reach out to minority groups who may not see themselves in the conversation Media	Education audiences Professionals Education system School Curriculum Culture Newcomers Sense of com/belonging Political Action Federal Government Community level Develop a strategy to review implementation to allow for changes and adaptations

Accelerate (A)	Brake (B)	Create (C)	Long term
Stop being a bystander, say something if inappropriate language Modelling good language, similar to mental health. Change our language Beyond substance use and emphasize care, compassion empathy at an early age and with care environment Systems Approach, Upstream Approaches, SDOH Housing, Employment, Trauma + Specific groups with specific needs (hospitals, police, politicians) Address & housing Talk about stigma to everyone Housing Upstream approach Problem solving strategies		Create more promotion and awareness of mental health and substance use + + + + Substance use campaign for children, youth and parents Bust myths Start conversations Mandatory curriculum in controlled environment Public campaigns – focused on lived experience from all backgrounds Anti-stigma kindness	

Accelerate (A)	Brake (B)	Create (C)	Long term
SDOH Fund political action Government buy in and funding for substance use and stigma Decriminalization + + + + + + - Decriminalization policies, legalize drugs Safe Drug Supply			

Expert Panel Discussion #2: Emerging Harm Reduction Initiatives that Can Reduce Harms Associated with Opioid Use

Each member of the expert panel was given 3 green (positive +) and 3 red (negative -) dots to vote on the themes from the ABC exercise. Results showing the placement of these dots are shown using symbols (+/-) next to each statement below.

Accelerate (A)	Brake (B)	Create (C)	Long term
Funding: + • Funding • Funding peer based projects • Research for evidence based info to inform policy makers /professionals funding for research	Stop Stigma: - • Stop promoting “Just say no” • Stop saying “Stop using” • Stigmatizing • Stop – judgement against people who access services (stigma) • Stigmatizing people • Stop stigma & funding for conferences • Hospital taking addiction seriously • Decrease stigma and therefore decrease use in private residences • Stop focusing on opioid crisis – drug policy – stop blaming	Imbedding Harm Reduction in Other Existing Settings: ++ • Create intersectoral round table/communication strategy – work together • Fentanyl strips – make available to public • Harm reduction in detention centres and hospitals • Have more services provide harm reduction supplies ie general primary care • More holistic care providing more HR services • Rural/suburban access to SCS • Harm reduction services accessible in rural areas/suburbs • Mail order naxalone kits – kits available in public spaces like defibrillator and fire extinguisher	Decriminalization: • Drug consumer for Prime Minister • Legalize all drugs • Anything policy • Influence drug policy • Drug policy reform • All policy changes already discussed • De-regulate opioids/stimulants as controlled drugs • Change drug policy – decriminalize • decriminalization
Integration of Harm Reduction: ++ • Stop change language “harm reduction is treatment” • Integrate harm reduction into everyday life • More services within the justice system • Supportive housing, finance, social services	Stop Criminalization: ++++ • Stop criminalization • Criminalizing people who use drugs • stop criminalizing medication to ensure controlled but free access • stop being punitive if urine samples come back dirty	Hours for Access: + • 24 hr access to SCS and OAT services • 24/7 clinic based solutions • Evenings/weekends for OST, more flexibility	Funding: • Funding • New funding formulas

Accelerate (A)	Brake (B)	Create (C)	Long term
• Sectors approach – collective impact • “health Hubs” – integrated access to care where you live • Training education for law enforcement re their potential contribution to harm • Assuming police are only there to arrest/charge people – they can play a constructive role in this issue • Not linear – a continuum • Better housing – affordable • Providing support and resources • More mental health services • Harm reduction is not failure • Redefine recovery • Public awareness of harm reduction instead of abstinence			
Education: • Practice standards for SCS/front line service workers • Education of Drs and psychologists on harm reduction • Educate opioid prescribers • education	Stop silos: • over-medicalizing substance use • eliminate barriers to referrals • public system is fraud • segmenting health care • stop separating services • stop silos in addictions/mental health • stop compartmentalizing recovery • limiting treatment options for people • no one size fits all • stop accepting that one treatment model fits everyone • reduce barriers between caregivers	More models for consumption sites: • SIS=more inclusive for everyone i.e. professionals • Safe place to use that is peer run • Safer smoking spaces • Create more models for consumption – mobile – exam room	More Info (education) how to navigate the system: • Refute the moral model of addiction • Training better and evaluations • Education and awareness • Inform and engage general public b/c they will influence/impede policy reform • Live electronic searchable information about city-wide services for mental health/addiction /housing etc.

Accelerate (A)	Brake (B)	Create (C)	Long term
Decriminalization: ++ • Lobbying advocate for policy change • Legalize drug and sale like alcohol and cannabis • Drug policy reform – decriminalization • Legalize all drugs • Decriminalization	Stop barriers to services: ++ • remove age limits • decrease restrictions around methadone Rxing • reducing barriers to naxalone access • no more barriers around SCS	New and Emerging Harm Reduction Expansions: ++++ • create fast track lane outside of current structures public system i.e. opioid emerg dept • evidence based treatment • more evidence informed interventions • access to injectable opioids • start researching stimulant Tx needs i.e. substitution therapy • hubs for treatment • expand access to Mop • do better than RAAM – great start but needs more than current system	Social Determinants of Health: • more counselling – address root causes • supportive housing • respond to larger social issues – homelessness, mental health, poverty etc.
Client Centre Care: • Not a one size fits all for people • Target families rather than people who use drugs • Develop a personalized plan for those who wish to access support services of harm reduction facility • Put client in the middle – trust them – they are the experts in their own health	Stop abstinence based models: ++ • stop viewing harm reduction and abstinence as separate entities, view as continuum • stop thinking abstinence/sobriety is ultimate goal for people who use drugs • stop thinking harm reduction is step to abstinence • stop funding programs who require abstinence	More Opportunities for Peers: ++ • peer exchange for HR + naxalone distribution • incorporate lived experience • peers should be paid for their work • community advisory committee of HR service users for SCS • incorporate lived experience	Holistic Approach: • more holistic view of person • need to acknowledge alcohol in convo
Access to Harm Reduction services: ++ • include nax training in first aid/cpr • Naxalone dispensed at bars/stores • Timely access to HR services • Install more needle drop boxes • Increase rural service access • Access to more CTS across city • SC sites within RHTs and PC settings		Health Promotion Messaging: ++ • integrate HR in all sectors – schools/justice/health • shifting focus of recovery • common understanding of harm reduction • educate parents when children are young • strong messaging if safe drugs are distributed	More Collaboration Across Agencies: • Develop a city-wide strategy/more collaboration with existing services • Common goal across agencies vs. each agency having separate goals • More collaborative approach between agencies • Sustained response • Community outreach

Accelerate (A)	Brake (B)	Create (C)	Long term
• Increase access to naxalone – increase doses per kit with no age limits etc • More fentanyl test strips • Increase access to HR supplies • HR services tailored to specific population i.e. sex workers that use drugs etc • More naxalone kits • Naxalone in schools and other places • More naxalone and quick call to 911		• educate on what is harm reduction, what that treatment looks like • clarity on how to navigate services	
Access to OST & MOP: ++++++ • Increase PH care confidence to prescribe opioid replacement therapy • Safe drug programs in all settings – free but controlled • MOP spaces • Access to pharmaceuticals • Root causes to treating addiction • More efforts on prevention • Advocate for access to right drugs for injectable opioid • Support pharmacies to prescribe opioids • Cleaner drug supply • Liberal guidelines for prescribing • Short term for controlled opioid distribution • Expand access to safe drug supply • Pharmaceutical grade opioids • Free and safe access to safe medications • Access to pharm stimulant treatment			Justice System: • Court order drug treatment offer • Criminal justice system is too absolute

Accelerate (A)	Brake (B)	Create (C)	Long term
• More options for treatment • More options for OST • MOP access • More MOP • Treatment MOP			
Peer Support: +++ • Peer support within SCS, emergency rooms, exchange programs • More peer programs • Peer Network city-wide • Encourage safer use through buddy system • Peer support in checking in on users for OD prevention			

Expert Panel Discussion #3: Collaborating and Integrating across the System to Increase Access and Uptake of Services

Each member of the expert panel was given 3 green (positive +) and 3 red (negative -) dots to vote on the themes from the ABC exercise. Results showing the placement of these dots are shown using symbols (+/-) next to each statement below.

Accelerate (A)	Brake (B)	Create (C)	Long term
Increase Housing + - Affordable housing options - Involve	Stop silos + - Turning people away (stop) - Stop spending money to get programs, work together - Break down silos. - Stop threatening mental health and addiction as silos - Stop separating mental health addiction services - Don't work in silos - Get rid of silos - Stop silos	Drug Court Make better use of drug court	Upstream/policy - Policy changes - Mental Health not solved with a pill - Housing provision - Address determinants of health
Increase Employment Increase employment program	Stop Barriers Access to Care + - Increase outcomes (not outputs) - Organizational driven services development - Decrease eligibility criteria - Start action - Barrier to care - Stop one issue per visit - Stop telling people they need to be well for treatment. - Don't fit all people into PSMS categories prior to treat. - No solution solutions	Integration - Knowledge exchange of available services - Understand gaps to enable collaboration - Get out of silos - Multiple point of entry - Integrate pairs in clinics to support internal discussion - Multiple point of entry - Work better day to day as one	Integration - Integrated treatment - Interdisciplinary teams - Interdisciplinary teams - Increase collaboration - Work with the system don't create a new system

Accelerate (A)	Brake (B)	Create (C)	Long term
	• Create safe space • Need to change how services are provided • Risk adverse • Stop fear people afraid of losing kids if they access help • Don't dismiss valid health concerns	• Co-assigning of progress • Integration • Integrated approach buy in • De-stigmatization of invisible disabilities + • Shared resources ++	• Technology to support integration
Reduce Silos • Bring services to where people are housed (supporting housing) • Housing first approach ++	Stop Excuses • Stop excuses for why we can't do something • Find more excuses	Account • Account and consistency	Meet People Where They Are • Expert +allow for multiple relapse • Increase people's capacity to help themselves • Develop peer position in all organisations to reduce stigma +increase understanding of client expectations
Key Messages • Key messages ie" nothing about us without us" - • Sell long terms benefits • Demystify " get clean first" attitude • Bringing care to where people are at	Stop Stigma • Stop promoting idea that drug use is one class • Change in ideas+ beliefs about addictions • Perpetuate stigma • Stop avoiding issue of stigma ++++ • Stop using peers as tokens	Innovate • Think outside the box • Pilot new approach • More transformational (rather than incremental) • Allow for 3rd party support • Build person's recovery capital • Move way from Institution	• Equitable Resource Distribution • System Navigator or liaison • Community driven partnerships • Navigation basket of services (identifiable + flexible)

Accelerate (A)	Brake (B)	Create (C)	Long term
			• Spread power equally: (not just small groups) • Use resources appropriately • Those not homeless get similar services as CMHA workers • No more “squeaky wheel gets the oil”
Community-Based Services • More community based service access • Increase services • Increase ROSC + • View holistically • Barrier free system • Clearer referral pathways • Whole treatment program • Shared funding model to prevent limited services • Not acute condition • More mental health professionals • Faster community engagement		Equitable services • One number to access services + a place • Recovery Capital • One stop walk-in stop +++++++ • Seamless Care pathways (reciprocal) • Create funding model that encourages integrative comprehensive collaboration care (client focused) (“one stop shop”) +++++++	

Accelerate (A)	Brake (B)	Create (C)	Long term
Data/Info-Sharing • Accessible service information • Increase info-sharing+ • Increase info-sharing (i.e. data portal) + • Intra-Agency community • Integrated services • Computer access to needs services		Increase Funding • Funds +rapid services to those not eligible for CMHA • Increase funding processes + - - - • Increase capacity and funding • Increase funding to services • Funding incentives • Sharing resources*	
Lived Experience • Engage people with lived experience ++++++ • Increase involvement of people with lived experience + • Ask “What I can do to help” • Increase Peer Support • Include lived experience • Give weight to people with experience • Compensation for people with lived experience, involve them)		Peers • Offer peer support and gate openers • Peer support/Additional capacity • Include peers on service teams	

Accelerate (A)	Brake (B)	Create (C)	Long term
• Increase involvement of peers in schools for prevention + early intervention			
		Listen to the client • Treat the symptoms • Listen to the client • A pre-designed system through greater involvement (PLEE)	
		E-health • E-health hubs	