WALKING TOGETHER

TOWARDS A STRONGER, MORE INTEGRATED SUBSTANCE USE SUPPORT NETWORK IN THE COMOX VALLEY

Gaps and Strengths Analysis

MARCH 2023

With Gratitude to our Partners:

And Funders:

Authors: Sharon Karsten, PhD; Andrew Mark, PhD; Christopher Hauschildt; Zarya Chelsea Thomas
Design: Sophia Katsanikakis
Cover Photo: Caresse Nadeau

Walk With Me' Team—Comox Valley
Will Garrett-Petts, PhD—Principal Investigator / AVP Research, Thompson Rivers University
Amanda Wager, PhD—Advisor / Canada Research Chair, VIU
Sharon Karsten, PhD—Project Director / Community Engaged Researcher
Barb Whyte—Elder / Traditional Knowledge Keeper
Nadine Bariteau—Creative Director
Sophia Katsanikakis—Communications Coordinator
Christopher Hauschildt—Peer Researcher and Administration Coordinator
Andrew Mark, PhD—Community Engaged Researcher / MITACS Post-Doc
Zarya Chelsea Thomas—Community Engaged Researcher / MITACS Post-Doc
Galen Rigter—Outreach Worker
Holly Taylor—Outreach Worker

Website: www.walkwithme.ca

ETHICS STATEMENT

For the research described in this work, human research ethics approval was obtained from Thompson Rivers University's Office of Research Ethics.

ABSTRACT

The Comox Valley, as with many communities in BC, is being hit with a series of compounding crises including (but not limited to): a global pandemic that has produced new levels of social isolation; a toxic drug supply that is causing fatalities at unprecedented rates; and a housing affordability/ income disparity crisis that leaves many in our community underhoused and living in poverty. In the midst of these crises substance use-related harms are increasing. This research investigates the state of the Comox Valley's Substance Use Support Network through a Gaps and Strengths analysis. It calls upon stakeholders in the community (Service Providers, Peers, Local Government, Community Members) to come together to build on strengths, fill gaps, and create a comprehensive care continuum in support of people who use substances.

LAND ACKNOWLEDGEMENT

We recognize and humbly acknowledge our place on the unceded, traditional territory of the K'ómoks Peoples. We give respect to this land and to those who have been its caretakers since time immemorial.

DEDICATION

This piece is dedicated to those who shared their stories and insights with courage, and to those whose lives have been lost. We honour all whose names have been spoken in memory—whose stories continue to compel us forward in pursuit of transformation. We honour you, and think about you often—especially when we walk.

TABLE OF CONTENTS

LIST OF KEY TERMS

Benzodiazepines	A class of depressant drugs sometimes used for treatment of anxiety; when combined with other drugs, can increase toxicity and propensity for fatality.
Fentanyl	A synthetic opiate, approximately 100 times more potent than morphine and 50 times more potent than heroin.
MAP	Managed Alcohol Program: a program providing a regular dose of alcohol to individuals with alcohol addiction.
Naloxone	A medication that rapidly reverses the effects of a drug poinsoning by opioids.
OAT	Opioid Agonist Therapy: treatment for addiction to opioid drugs such as heroin, oxycodone, hydromorphone, fentanyl, and Percocet. The therapy involves, often, taking opioid agonists methadone (Methadose) or buprenorphine (Suboxone). These medications work to prevent withdrawal and reduce cravings for opioid drugs.
OPS	Overdose Prevention Site: designated sites where drug consumption is witnessed, leading to immediate response in the event of a toxic drug poisoning.
Peer	In this report, people located in the Comox Valley who currently use, or have used, substances, and who have attempted to access substance use support services over the past two years.
Safer Supply	A practice that allows prescribers to give access to maintenance doses of pharmaceutical alternatives to unregulated toxic substances, within a Harm Reduction paradigm.

1 INTRODUCTION: ABOUT THIS REPORT

"Walking Together" is a research and community engagement initiative several years in the making, that investigates the network of services and supports available to People Who Use Substances (Peers) in the Comox Valley. The report aims to:

- Investigate the state of the Substance Use Support Network in the Comox Valley, shining light on strengths and gaps within this system;
- Produce recommendations leading to the strengthening of this network and to improvements in local service delivery for Peers;
- Raise awareness of endogenous assets that can mobilize towards developing stronger support networks;
- Create opportunities for long-term network-strengthening activities that enable sustained learning and growth.

This report is authored by Walk With Me—a Community-engaged research initiative housed by Comox Valley Art Gallery in partnership with Thompson Rivers University, Vancouver Island University, and North Island College.[i] The Walk With Me team (which includes researchers, Peers, Elders/ Knowledge Keepers, and Outreach Workers) has collaborated with the Comox Valley Community Health Network's Substance Use Strategy Comitee and AVI Health and Community Services to release this report.

Our work consolidates insights gathered from research sessions and presents resulting recommendations. Adhering to the practice of "nothing about us without us," our team's Peer researchers and Elder were involved in every stage of data collection and analysis. This work builds on two recent reports: *Walk With Me Policy Report—Comox Valley* (2021)[1] and the Comox Valley Community Substance Use Strategy Committee's *Phase One Report* (2021).[2] Together these reports present a comprehensive set of considerations and insights related to substance use in the Comox Valley.

Our analysis begins in Chapter 2 with a discussion of the term "substance use" and with an exploration of the ways in which Substance Use Disorder is—in Western and Canadian culture and political frameworks—socially conceived, understood, and discussed. In Chapter 3 we speak to the relevance of this exploration: illuminating key societal, national, provincial, and local trends related to different types of substance use and their impacts. In Chapter 4 we speak to the methodologies we used for this report, setting the stage for Chapter 5, Findings, in

[i] The original title for CVAG's work with Thompson Rivers University was: Cultural Mapping the Opioid Crisis in Kamloops and Comox Valley, BC. The title "Walk With Me" serves as a branch of this larger project. The scope of this Comox Valley-specific project has been altered to examine the Valley's substance use network at-large, including (but not limited to) opioid-based support networks.

which we explore the gaps and strengths evident within the Comox Valley's Substance Use Support Network. In Chapter 6 we present recommendations for strengthening these frameworks. Chapter 7 concludes with a summary of our work and findings.

This report is of relevance to anyone who uses substances in the Comox Valley, participates in these networks, and/or makes decisions related to policy, procedure and funding related to these networks. It is also of relevance to anyone wishing to learn more about the ways in which the Comox Valley Substance Use Support Network functions in this community. By exploring the state of our existing Substance Use Support Network, and by making a series of recommendations, we pursue a vision for community wellness in which people who use substances are supported, included, and valued as members of our community.

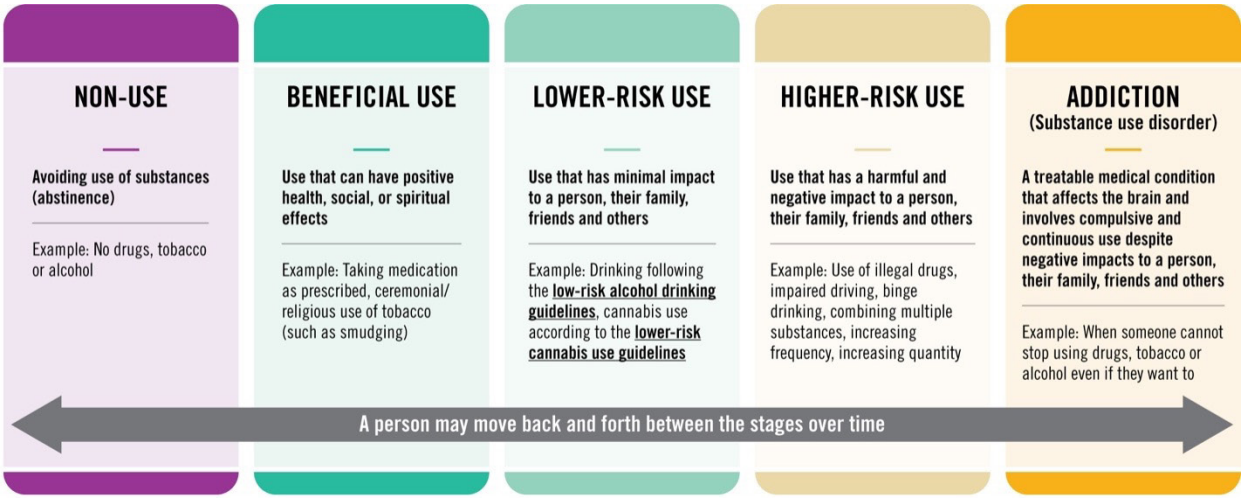
2 CONTEXT

In this chapter, we explore the questions: "What is substance use?" and "How do we think about the role of Substance Use Support Networks?" Here we discuss various ways of understanding Substance Use Disorder through criminal justice, health, and ecological perspectives. We explore the terms "Harm Reduction" and "Recovery," and argue for a support network model in which both types of services are valued as part of a wider care continuum. Our work address notions of "Stigma" and "Cultural Safety" as they exist within this continuum and points to methods for stigma reduction and Cultural Safety enhancement. As a whole, this chapter brings attention to the dominant perspectives, debate, and available data that inform our current Substance Use Support Network, and suggests ways in which this knowledge can inform systems change.

2.1. What is Substance Use?

"Substance use" refers in this report to the use of drugs and/or alcohol and includes substances such as "cigarettes, illegal drugs, prescription drugs, inhalants and solvents."[3] Substance use changes the way we feel; it is deeply embedded in our culturally-constructed habits and has served many different purposes throughout history: "to celebrate successes, help deal with grief and sadness, to mark rites of passage such as graduations and weddings and seek spiritual insight."[4] Substance use can be beneficial and can have positive health, social or spiritual impacts (see Figure 1). Substance use can also entail a level of risk and potential harm. Potential risks and harms vary with substances and their use-context. For instance, much of tobacco's chronic

Figure 1: Substance Use Spectrum



[6]Figure produced by Government of Canada: https://www.canada.ca/en/health-canada/services/substance-use/about-problematic-substance-use.html

harms stem from inhalation of smoke rather than from the drug itself.[5] Harm related to consumption of alcohol can be associated with the place and patterns associated with its use: for example, increased harms associated with drinking and driving. In many instances, harms stem from the composition of substances and their physiological impact. The rise in potency and toxicity within the unregulated drug market in recent years is producing extreme risk for people who use these substances.

A subset of those who use substances are unable to control their use and can be said to have a Substance Use Disorder (SUD). According to the Canadian Government, this term refers to a "treatable medical condition that affects the brain and involves compulsive and continuous use [of substances] despite negative impacts to a person, their family, friends and others."[7] Approximately 21 percent of the Canadian population is projected to struggle with SUD at some point in their lifetime.[8] Substance Use Disorders can range in severity from mild to severe.

While not all people who access Substance Use Support Networks identify as having SUD, many do. When substance use is uncontrolled and damaging to a person's life and relationships, support networks are needed. These networks help those who suffer from SUD to regain balance and control. This can look like stabilization of use (i.e. Managed Alcohol Programs, vaping, Opioid Agonist Therapies, Safer Supply), reduction or removal of reliance on substances (i.e. medical detox, social detox, Alcoholics Anonymous, group therapy, and others), and/or the fulfillment of core human needs which when left unaddressed can lead to a loss of other supports that can feed back into SUD (i.e. housing, family stability, cultural inclusion, mental health supports, and others). A complex array of factors, including social, biological, and systemic feed into SUD.[9, 10]

While SUD impacts people on all levels of the socioeconomic spectrum, a robust literature documents higher rates of SUD amongst people with low socioeconomic status.[11, 12, 13] Stressors associated with poverty impact an individual's capacity to control and manage substance use. Further, certain demographics—including Indigenous people, and men aged 19–59, with strong representation from those working in trades[14, 15, 16]—are disproportionately represented in SUD-related mortality statistics. These statistics draw attention to the ways in which SUD is a product of complex realities involving colonization and racism. They also point to the role that workplace/societal cultures and parameters play in exacerbating SUD. For many, SUD is shrouded in stigma and shame, leading to a reluctance to seek help.

Given these multiple and complex contributing factors and demographics, we advocate for a nuanced spectrum of support—one that holds capacity to address the unique and varied needs and situations of individuals suffering from SUD. The supports that are needed within this spectrum include Harm Reduction and Recovery-based approaches,[17] and also cultural approaches, in addition to supports that address fundamental human needs. Each of these approaches exists within a spectrum of care.[18] When this spectrum of care functions properly, this Substance Use Support Network should meet people where they are at: addressing an individual's unique needs as evident in a particular moment in time.[19]

2.2. How do We Think About Substance Use Support Networks?

Through histories of cultural bias, colonization, and government-lead and funded campaigns of shame and stigma, SUD and associated frameworks of support

occupy a place of deviance and criminality in popular imagination and culture. Canada's history during the first two decades of the twentieth century is shaped, in part, by the attempts of provinces, one after another, to criminalize production and consumption of alcohol. In the end, total prohibition proved unenforceable and contributed to new, lucrative, and dangerous forms of organized crime.[20] The influence of this temperance movement continues today in the persistence of "provincial liquor control boards, restrictions on advertising, and strict rules governing places where alcohol is served."[21] Similar restrictions are in-place in relation to cannabis since being legislated by the *Cannabis Act* in 2018.[22]

The legal framework for Canada's drug control policy was established in the early 1900's—the *Opium Act* and its amendments, which came into force in the early 1900's, listed a range of opiate and stimulant substances as prohibited.[23] In 1969, the Pierre Trudeau Government's Commission of Inquiry into the Non-Medical Use of Drugs recommended a medical, rather than criminal, approach to drug legislation. Unfortunately and in response to the findings of the commission, the government's desire to favour production of criminality over evidence-based solutions became zealous.[24] The War on Drugs rhetoric and legislation championed by the Reagan administration in the United States in the 1980's was taken up in turn by the Mulroney administration in Canada—in the 1987 *Action on Drug Abuse: Canada's Drug Strategy*, which provided significant funding for drug enforcement.[25] In 2007 The Harper Government released the *National Anti-Drug Strategy*, a report that provisioned heavy-handed reliance on law enforcement which exacerbated rather than remediated Canada's drug use issues.[27]

Drug enforcement policy in Canada has also been used to control immigrant and racialized communities. Federal drug-based legislation throughout the 20th century was "often based on moral judgments about specific groups of people and the drugs they were using," rather than on "scientific assessments of their potential for harm."[28] These laws enforced government sanctioned systemic forms of anti-Black, anti-Indigenous and anti-immigrant racism. They increased police and government capacity to criminalize racialized individuals which aided in stripping away their human rights.

In recent years, various levels of government have moved to position SUD as a health, rather than criminal justice, issue. Calls for decriminalization of small amounts of personal possession of unregulated substances have come from the Canada's Chiefs of Police, from BC's Premiers, BC's Medical Health Officer, and from Mayors and Councils. On January 31, 2023, legislation came into force in BC that decriminalized personal possession of small amounts of certain formerly unregulated drugs.[29] BC has also introduced limited Safer Supply programs, which although slow to roll out, are important mechanisms in combatting the toxicity of the drug market.[30]

Substance use-related societal issues involve a history of complex relationships including substance use legislation and enforcement on one hand, and structural/societal forms of racism, stigmatization, and discrimination on another. Moves to both legalize and decriminalize substances today represent progressive responses rooted in evidence-based public health models of legislation. These moves facilitate a balance and management of substance use, and they recognize SUD as a disease rather than a moral, cultural, or criminal failing.

2.3. SUD from an Ecological Lens

Substance use is increasingly understood as an ecological phenomenon—a part of a large system and network of interrelated factors.

Here, SUD is considered not only as a disease but as a symptom of a diseased society—one in which communities are losing capacity to create meaning and belonging for their members. Substance use fills a gap created by the absence of inclusion, belonging, and hope for a better future.

Social determinants of health comprise important considerations within an ecological model. This model recognizes factors related to race, income, education, access to healthy food, and many other variables (and risk factors) that can contribute to SUD.[31] An ecological framework views strengthening support networks as essential to reduce substance use related harms: to mitigate the imbalances in systems that discriminate against people who face significant health determinant injustice. From an ecological perspective, communities grappling with SUD need to strengthen their support networks. To make this change, the spaces and services that present as opportunities for change and improvement must position themselves as spaces and services that promote inclusion, belonging, and hope for the future.

This report, which examines the Comox Valley's Substance Use Support Network, springs from an ecological grounding. We ask how the entities supporting People Who Use Substances in the Valley are working together and within a wider support and community ecology. We look at strengths at-play within this network and at ways in which it can be strengthened.

2.4. Harm Reduction

Health and ecological paradigms alike see Harm Reduction as a key component of a restorative framework designed to counter and reverse rising mortality rates and improve quality of life for Peers. Harm Reduction is defined in this report as an "evidence-based, client-centred approach that seeks to reduce the health and social harms associated with addiction and substance use, without necessarily requiring Peers from abstaining or stopping."[32] This approach includes a series of practices that give Peers options for minimizing harms through non-coercive and non-judgmental strategies. Countering the myth that Harm Reduction "enables" substance use, a growing body of research links Harm Reduction activities with a higher uptake in treatment with no observable growth in usage.[33] Harm Reduction strategies have also been proven to reduce crime and produce stronger health outcomes for Peers.[34] While Canada's history of punitive substance use policy magnifies the harms associated with substance use, Harm Reduction seeks to restore dignity and respect to Peers, and to create supportive frameworks through which individual and communal healing can occur.

Health agencies play an important role in advancing or undermining Harm Reduction principles. Research identifies cultures of stigma prevalent throughout British Columbia's health system which contribute to "poorer quality of care and health outcomes": *In Plain Sight*, a report released by Métis Nation British Columbia,[35] demonstrates that anti-Indigenous racism is systemically embedded within BC's health system and is linked with stereotyping behaviour, in which for instance, Indigenous clients are frequently labelled as drug-seeking, "less worthy of care," "bad parents," "frequent flyers" (presumed to be misusing or over-using the health system), and "less capable." Additional research accomplished by Walk With Me[36] provides vivid examples in which Peers, Indigenous and non-Indigenous, persistently receive sub-standard care and are stigmatized while engaged in the health care system—especially within acute care settings. Work is needed to counter these realities by embedding Harm Reduction principles into our care systems and into the philosophies that underpin how our care systems operate.

2.5. Recovery

The term "Recovery" has at times been juxtaposed against the term "Harm Reduction"—particularly in North America where (unlike in Europe) abstinence has historically played a more central role in substance use treatment practices.[37] Recovery, in our use of the term, refers to a way of addressing SUD through abstinence from (rather than stabilization of) substance use.[38] While for many years Harm Reduction and Recovery have been framed as polar opposites, in which debates were waged arguing the value of either Harm Reduction or Recovery, many now see this juxtaposition as a false dichotomy. Evidence has shown both approaches as important facets within a comprehensive care continuum.[39, 40, 41, 42] Many with SUD move between Recovery and Harm Reduction services at various points in their wellness journey—an important reality to consider when seeking to strengthen the substance use network at-large.

2.6. Stigma

Within health systems, stigmatization occurs on multiple levels simultaneously, including "intrapersonal (i.e. self-stigma), interpersonal (i.e. relations with others), and structural (i.e. discriminatory and/or exclusionary policies, laws, and systems)."[43] If a health system fails to adopt Harm Reduction principles, it can reinforce realities of self-stigma, reduce client willingness to access or pursue help, and perpetuate systemic forms of discrimination, such as through poor quality care standards and a lack of appropriate resource provision.[44, 45] Alternatively, health systems that adopt a Harm Reduction philosophy and practice signal the intent to counter stigmatizing realities and enable those at the heart of the crisis to access inclusive care. BC's Provincial Health Officer, in a widely celebrated report, *Stopping the Harm: Decriminalization of people who use drugs in BC*, calls for a systemic Harm Reduction push within the province's health systems using a "public health Harm Reduction and human-rights-oriented approach."[46] This call has been taken up, to various degrees, by provincial health agencies,[47] and also by the Walk With Me research team which sees the pursuit of Harm Reduction as an important step forward in reversing the rapid rise in substance use mortality.

Island Health, one of BC's five regional health authorities, released its first Harm Reduction Policy in the summer of 2022. This policy is the second (after Vancouver Coastal Health) to be released among BC's health authorities, and it marks a progressive step forward as it formally commits Island Health and its staff to a stance that minimizes "negative health, social and legal impacts associated with…unregulated and regulated substance use, substance use policies, and laws that criminalize People Who Use Drugs."[48] The policy's release is one step of many in the development of systems change.

2.7. Cultural Safety

The practice of Cultural Safety is promoted within health and care systems to combat realities rooted in stigma, racism and colonization. First Nations Health Authority defines Cultural Safety as "an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system." Cultural Safety pursues "an environment free of racism and discrimination, where people feel safe when receiving health care."[49] Cultural Safety recognizes the colonizing histories embedded within established health systems and the ways in which these systems have historically excluded, marginalized, and abused Indigenous peoples. In recent years, numerous health institutions, including the BC Ministry of Health, BC Regional Health Authorities, BC Coroner's Service, and BC Regulators, have formally committed to the development of Cultural Safety principles.[50] These principles can support health systems in better-serving First Nations clients and

challenge the systemic judgements held by systems against People Who Use Substances while recognizing and honouring the humanity of those seeking care.

2.8. Summary

In this chapter, we described the complexity of the terrain in which the Substance Use Support Network in positioned. In what follows, we delve further into existing research which shows how Substance Use Disorders associated with particular substance use consumption trends, related to alcohol, tobacco and cannabis and unregulated drugs, have been addressed on a socio-political level in Canada, BC, and in North Vancouver Island communities.

3 RELEVANCE

We are living in a moment of crisis and change. Social, political, legal, and cultural attitudes towards how our society understands substance use are shifting—though many feel the rate of change is incommensurate with the urgency demanded by the crisis. As our state of crisis worsens, and as people increasingly experience loss and trauma associated with SUD first-hand, the gaps and strengths in our communities' capacities for response become increasingly apparent. These gaps present opportunities for change.

In what follows, we present current data and research related to each of the following four substances use categories—alcohol, tobacco, cannabis, and unregulated drugs (categories for which there exists a level of publicly available local data). Here we show how change is occurring through legislative and community reform—speaking to national, provincial, and local trends.

3.1. Alcohol

Data tells a clear story of escalating alcohol consumption and harm in BC. The University of Victoria's Canadian Institute for Substance Use Research (CISUR) offers two powerful tools for tracking and analyzing change, including a Per-Capita Alcohol Consumption (PCA) trend analyzer tool covering 2002 to 2021,[51] and an Alcohol and Other Drug (AOD) trend analyzer tool that describes premature death and hospitalization in the Province from 2007 to 2019.[52] Between 2002 to 2021, per-capita alcohol consumption in BC increased from approximately 8.2L of pure alcohol to 9.2L per-year. Across the province, alcohol consumption spiked with the COVID 19 Pandemic.[53, 54, 55] Vancouver Island Health Authority (Island Health) has moved from 8.9L to 11.7L, the second highest Provincial Health Authority average for alcohol consumption in the province, a rate consistently above Northern Health (10.7L in 2021) and beneath Interior Health (13.6L in 2021).

We know consumption of alcohol has associated harms. The Comox Valley Local Health Area (CV), where our work in this report is situated, experienced some of the highest reported rates of alcohol related hospitalization in all of BC in 2019 (412.7/100,000, up from 271.9/100,000 in 2015)—a rate that has spiked in tandem with the rest of Vancouver Island. Notably in Northern Vancouver Island, in communities adjacent to the Comox Valley, alcohol-related hospitalization is occurring at absolutely alarming rates: almost double the rate of the Comox Valley—well above Northern and Interior BC which hold much higher average alcohol related harm rates that the rest of the Province's Health Authorities.[56] In neighbouring communities towards Tofino and above Campbell River, there is an extreme and escalating alcohol consumption and associated harm crisis underway.

While increasing alcohol consumption and accompanying negative consequences are unfolding in BC, the Federal Canadian Centre

on Substance Use and Addictions (CCSUA) released new guidelines in January 2023 that promote the health benefits of abstinence from alcohol. This represents a radical shift from their previous guidelines. Researchers from CCSUA now suggest there are elevated health risks for people consuming more than two standard glasses a week—an unprecedented claim.[57] Prior guidelines, only a decade old, recommended less than 10 and 15 drinks per week for women and men respectively to avoid long-term negative health outcomes. Authorities now stand behind substantial studies that refute all ideas that drinking can or should be linked to health benefits.[58] There is also a growing push to attach the kind of cancer-risk labels to alcoholic beverages that are now seen on cigarette packages, and a Bill is currently before Canadian Parliament to affect this change.[59, 60]

3.2. Tobacco

A different situation is playing out with tobacco consumption—tobacco-related morbidity rates in BC, Canada, and North America have declined marginally or held steady over the past decade,[61] and the pandemic does not appear to have significantly altered associated death and hospitalization trends in BC.[62] However, in the Comox Valley, rates of death and hospitalization remain higher than BC's average[63] and, as in the rest of the nation, tobacco-related illnesses remain the leading preventable cause of illness and premature death by a considerably wide margin.[64]

3.3 Cannabis

In contrast to tobacco, much has changed regarding the use of cannabis. There has been a dramatic reduction in the harms caused by criminalization of cannabis use. The national legalization of cannabis in Canada in 2018 correlates to a reduction in harm caused by the criminal justice system for this substance.[65, 66]

When mandatory penalties for possession were still being enforced in 2014, Canadian police were dealing with a cannabis-related and "criminal" incident every 9 minutes.[67] The cost of prohibition was in the billions.[68] The legalization of cannabis has allowed for significant refocus of resources away from criminalization and towards other social concerns. Legalization started with an election promise from the federal Liberal party which took office in 2015 and moved quickly to implement this change. While cannabis associated crime has seen "drastic reduction,"[69] preliminary findings suggest that there are weak if any links between legalization and observable changes with respect to hospitalization, mortality, and illness related to cannabis consumption.[70]

Though a great deal of new studies are forthcoming detailing how cannabis influences health,[71] data regarding mortality is difficult to untangle. We can however observe that in BC, the number of cannabis offences dropped from 17,723 in 2012 to only 8 in 2021 (a drop attributable, perhaps, to legalization through the *Cannabis Act* where illegal non-sanctioned cannabis activities were targeted as a result).[72] Further, the total number of drug offences in the Comox Valley fell by over 50% from 371 in 2012 to 159 in 2020.[73] When considering cannabis use and all observable social harm data, we see that the act of removing cannabis from the criminal justice system correlates to a reduction in crime and with few if any observable changes in health-outcomes so far.[74]

3.4. Illicit Drugs

In contrast to the situation with cannabis, the unregulated and criminalized toxic drug trade has produced a dramatically increased number of hospitalizations, premature deaths, and deaths since 2014, and its impact is not declining in BC.[75, 76, 77] In April

2016 BC's Health Officer declared a public health emergency due in part to the high toxicity of fentanyl in the illicit drug supply. Over 11,390 lives have been lost in BC to the crisis between 2016 and 2022, including over 141 in the Comox Valley.[78] Toxic drug related deaths in the Comox Valley have risen dramatically in recent years—from 11 in 2016 to 37 in 2022.[79]

Decriminalization of illicit street drugs has begun but with far less urgency and speed than the move to regulate cannabis. On January 31st, 2023, Health Canada provided BC with an exemption to the federal *Controlled Drugs and Substances Act* for three years that allows adults to possess very small amounts of opioids, crack and powder cocaine, methamphetamine, and MDMA without criminal charges or seizure.[80] If possession is discovered, individuals are to be supported in reaching out for health and social services for addictions, mental health, and recovery when requested.[81] Even as this small change represents a "too little" and "too late" allowance, and looks nothing like the legalization process accomplished through the *Cannabis Act*,[82] it does mark significant change and an opportunity to expand the measure though continued advocacy and social pressure.

Since 2016, the Province has responded to the toxic drug poisoning crisis by advancing public education, implementing targeted information campaigns, increasing access to trauma and mental health counseling, increasing access to opioid agonist therapies, distributing naloxone kits, increasing toxicological testing of drugs, expanding Harm Reduction services (i.e. establishing toxic drug death prevention services and expanding supervised consumption sites), developing a ministry focused on mental health and addictions, and recently, taking a first small step towards decriminalization. Some of these efforts are substantive, and before the pandemic arose, the data suggests these efforts may have been working to reduce harm; however, while harm has increased through the COVID-19 pandemic, the pandemic has also shown us what real health emergency mobilization looks like. Reflecting on the government's deployment of public health resources in response the pandemic, which has claimed far fewer lives that the toxic drug poisoning crisis in BC (less than half),[83, 84] it is difficult to locate—apart from prejudice, stigma, red-tape, and complaints of complexity—what exactly is preventing more rapid and better supported systemic change. Opportunities exist to build consensus and effect evidence-based decisions: federally, provincially, regionally, and locally in the Comox Valley. We can lead the way.

3.5. Summary

Above-average (within the province) and generally increasing morbidity with respect to all substance use in the Comox Valley speaks to our community's need to strengthen local networks of care and belonging in relation to People Who Use Substances. Evidence points to the need for radical action to support people seeking balance in their relationship with substances. The pursuit of a strong network of care and support services for People Who Use Substances is not only a loical impulse locally, but a growing and deep field of social concern and exploration for society within the context of multiple evolving crises (i.e. housing, public health, and environmental loss).

Harm Reduction, as a movement unfolding within our current economic and environmental climate, and as a response to compounding layers of crisis, is allowing communities like ours to take stock of the ways in which we provide substance use supports and mobilize rapid change.

4 METHODOLOGY

In this chapter, we outline the techniques and strategies we've used to gather data and speak to the research processes and practices we used to develop our recommendations. This chapter sets the stage for Chapter 5, Findings, where we take readers through a series of insights provided by research participants, and Chapter 6, Recommendations, where we consolidate our understanding into actionable goals.

4.1. Definition of "Substance Use Support Network"

In this report, we define the "Comox Valley Substance Use Support Network" broadly as the network of organizations and projects/initiatives working to support People Who Use Substances in the Comox Valley. This definition includes organizations whose work is rooted in Harm Reduction, Recovery, health and mental health services, as well as in the "upstream" areas that have impact on the substance use ecology, including housing, policing, education, and others. When recruiting research participants, we asked community groups to self-identify whether (or not) their services/organizational activities exist as part of this network.

4.2. Definition of "Peers"

The use and intended meaning of the term "Peers" is highly contextualized. In this report, we use "Peers" to signify people located in the Comox Valley who currently use, or have used, substances, and who have attempted to access substance use support services over the past two years. In literature and generally in Harm Reduction discourse, "Peers" can describe People With Lived and Living Experience (PWLLE) of crisis (homelessness, poverty, SUD and more). Calls for and inclusion of "Peers" in power structures, in the context of "nothing about us without us," are about the value, humanity, skills, professionalism, ethics, lived insight, knowledge, and capacities that Peers can uniquely supply for fostering change. The term "Peer" is not mutually exclusive: a Peer may also be a front-line worker, for example, or an Indigenous Traditional Knowledge Keeper.

4.3. Definition of "Cultural Mapping"

Our research practice uses "cultural mapping" as its core methodology. This methodology was developed and brought into research contexts by Indigenous communities and community development proponents in the 1990's and early 2000's.[85,86] Cultural mapping involves deep storytelling and insight-sharing with the aim to produce group-based insights and recommendations. To produce our report, we hosted 16 cultural mapping sessions with small groups. In total, 59 Peers and 25 Service Providers from the Comox Valley participated. Within these sessions, the Walk With Me team, consisting of Community-Engaged Researchers, Elders/Knowledge Keepers, Peers, and Outreach Workers, supported groups of participants

to share their insights through cultural mapping during Peer/Service Provider sessions. To elicit engagement and response to our questions, in each session we brought groups through the following steps:

1. Groups were recruited through public calls for participation, through existing community relationships held by the Walk With Me team and collaborating organizations, and through snowball sampling (referral of participants by other participants).

2. Participants were informed about the nature of the project and engaged in a comprehensive ethics and consent process approved through Thompson Rivers University's Research Ethics Board following Tri-Council research oversight. Groups were supported through Cultural Safety practices and inclusion of Elders/Knowledge Keepers, Peers, and Outreach Workers in session. Participants were offered food and were provided honoraria for their time.

3. Groups were then taken through a draw-talk protocol where they were invited to draw/map particular aspects of the Substance Use Support Network and their experience of it and to speak on-record if they desired to the insights they shared on paper. Peers were asked to share their insights related to the strengths and gaps in the system as they had experienced these over the past two years. Service Providers were asked to share insights related to the "strong" relationships between Service Provider entities and relationships they felt could be strengthened. Both Service Providers and Peers were invited to speak to their insights related to "strengths," "gaps," and "potential solutions."

4. After the mapping exercises, groups were led through semi-structured focus-group interviews where the research team asked participants to speak more deeply to the maps and visual concepts they had shared.

5. To produce the report, we synthesized and cross-referenced the pool of data we gathered using NVivo qualitative software, which was used to code participant insights and locate aggregate nodes of consensus. We also moved through second-stage consent checking (member checking) to ensure participants were comfortable with how their voices appear in this report.

6. Finally, we invited research participants and partners to review and provide feedback and critique a preliminary draft of the report before integrating their suggestions, proofing, and releasing the public copy.

4.4. Public Survey

Complementing the cultural mapping process, our team issued a public survey and recruited Peers in the Comox Valley to participate. The survey contained a range of questions related to the Substance Use Support Network in the Comox Valley (see Appendix A). The Survey received 51 responses. This data presents yet another snapshot of substance use networks in the Comox Valley.

4.5. Participant Demographics

The following participants were involved in this work:

Peers

Peers were involved with both the cultural mapping focus group research sessions and also the public survey dimensions of this research. 59 Comox Valley Peers participated in cultural mapping sessions in the Spring of 2022. Of these, 31 elected to fill out

our optional demographics form. Of these individuals, 16% were under 30, 55% were between 30 and 60, 6% were over 60, and 22% did not supply their age. 39% identified as female, 58% as male, and 3% did not provide identification. 26% were housed, 58% were living outside, 19% were in a tent or outdoor shelter, and 3% were unlisted. 26% of individuals were employed, 61% were unemployed, and 13% did not respond. 6% described their heritage as Indigenous.
For the public survey, 51 Comox Valley Peers participated in the Fall of 2022. The majority of respondents fell between the ages of 30–60 representing 75% of those who answered. 11% of the respondents were young people under the age of 30, and 4% were over 60 years of age. There was a near equal division between those who identified as male and those who identified as female. Of the 51 respondents, slightly more than half (57%) described themselves as unhoused or precariously housed at the time of completing the survey. Approximately 50% of those who responded identified as being BIPOC (Black, Indigenous, People of Colour), with 27% self-identifying as Indigenous, 10% identifying as Black, and 12% identifying as a Person of Colour.

Substance Use Service Providers

24 representatives of Service Providers participated in cultural mapping group sessions hosted in the Fall of 2022. 33% participants were from Island Health, 13% municipal representatives, 50% were from community support organizations, and 4% were physicians.

4.6. Analysis

The Walk With Me team analyzed the qualitative results from the above methods by transcribing audio-recorded conversations, analyzing these using NVivo coding software, and by integrating map drawn insights from Peer sessions. Additional quantitative tools were used to consider the public survey results and the ranked priorities for systems change that Service Providers offered. We utilized the survey and visual outputs to test and confirm our findings. These tools helped us consider areas of alignment and misalignment across a variety of sessions.

5 FINDINGS

The following section reviews key findings emerging from our research—grounded in our team's understanding of the insights shared by participants and in available current data. We support our findings with select first-person insights from our dialogues with Peers and Service Providers. We ask the reader to hold these insights and those who gave their voices to this process with respect. We acknowledge that the act of speaking to these issues can be difficult. We honour the voices of those who contributed to this process with the intent to make change.

5.1. Systems Gaps

The following section speaks to gaps identified by Peers and Service Providers in relation to our local Substance Use Support Network in the Comox Valley. Here, we underscore the areas that are in need of significant attention to strengthen our local care network. Following our analysis of gaps, we move into a second analysis of strengths—areas of the system that are working and could be developed further.

5.1.1. Enormity of Loss

We begin by sharing a sense of the enormity of the loss that Peers in this community shared with our team. Peers spoke to the high death toll they are experiencing in particular as a result of alcohol and drug-related harms:

I've lost probably 100 friends in the last three years.

(Rick Berdaru)

I've seen people die. Right, my good friend died because of fucking ignorance. I'm sorry for swearing. But that's what I gotta say.

(De-identified participant #1)

We've lost what 20…20 friends in the last two, three years? Yeah, a lot. Yeah, I quit counting.

(Jo Moore)

Six months ago, I lost my brother who's 39 to a fentanyl overdose. And I've been struggling with it myself for 5 years now. Since I lost my father, my uncle, my kids, my land.

(Chris Bowie)

The reality of this loss impacts Service Providers and Peers alike:

I became just completely overwhelmed by the amount of loss and deaths, and it was just so frustrating to witness this every day and people that you work with every single day watching their lives spiraling due to the toxicity in the supply…it just seemed to amplify year by year and get worse…

(Galen Rigter—AVI, Outreach)

Peers brought home the magnitude and immediacy of loss they were experiencing to our research team. As we sat and listened to what Peers had to share, many were actively remembering and honouring loved ones who had recently passed:

Lost my sister last week at the age of 35. She had 2 children who are teenagers now.

(Julia)

Just can't seem to stop praying for a friend of mine that just passed away a couple of days ago. I think most of us knew him. Died in the hospital in his sleep. So that was a blessing for him I guess because he was really sick. Anyway, I would like to just have everybody say a prayer for him in your minds, you know.

(Mike)

Witnessing the grief and trauma many Peers experience on a near daily basis was a stark reminder of the need for concentrated efforts towards meaningful change. In one session, participants collectively dedicated their voices and what they shared with us to the memory of someone they had lost that week, recognizing that systems change was needed to prevent deaths such as his and that this report would work towards that end.

5.1.2 Stigma in the System

Alongside issues related to loss, Peers and Service Providers both spoke to the prevalence of substance use stigma within our local healthcare systems. Both Peers and Service Providers felt stigma takes many forms in our network. Some spoke to the ways in which stigma made them feel unacknowledged and unseen: **"ambulance, cops…the way people treat us—we're not invisible."** *(De-identified Participant #1)* Others spoke to the ways in which Service Providers prejudice, pigeonhole, and essentialize Peers:

You could be clean for 20 years, and when you go into the hospital, they treat you just like, you know, [you] crawled out of an alley somewhere, and you haven't touched anything for decades. Anything judgmental is ridiculous.

(De-identified participant #2)

This stigma-based judgement can, according to many, be long-standing and pervasive. A number of Peers reported that once a label of substance use has been applied in the health system, it is difficult to remove.

Peers identified the propensity of some workers within the Comox Valley Substance Use Support Network to identify SUD as an individual failing rather than a structural issue and social responsibility. When health care workers gloss over the role that social

determinants (as reviewed in Chapter 2) and life circumstances (such as trauma) play in generating substance use related harm, health care workers in turn cause harm:

> **I don't think [health care workers] should see it as "we're doing it to ourselves." I just I hate that. The way that they treat us, especially in hospitals.**
>
> *(Jenna Johnson)*

In one Peer's story, stigma took the form of a lack of urgency on the part of Service Providers to afford lifesaving care within a moment of intense personal crisis:

> **My friend decided to do a shot in the passenger seat, and I pulled out of the liquor store and headed back towards home…I drove up to the hospital; there was a couple cops in the emergency room. I kind of parked off to the side, and ran in and I said, "you have to come, like, my friend's overdosed. He's blue at this point. He's dead"…They said, "Oh yeah? Bring him in." Yeah. I said, "He's fucking dead in the car." Like, come on. They walk out there with a wheelchair. And they say, "Okay, put him in." And then they…they want me to get him out of the car and put him in the wheelchair. There was no fucking rush. There was no—it didn't even matter [to them]. It was like, "Just let him fucking die, he's just another junkie, whatever."**
>
> *(De-identified participant #3)*

This harrowing story relays a fundamental lack of regard, on the part of a Service Provider, for the life and humanity of someone who needed emergency help after substance use.

Some identified yet another form of stigma in the practice of Service Providers requiring or seeking "war stories"—stories filled with details of traumatic and extreme suffering and loss—to provide Peers with access to the services they request or in fact require:

> **It's like this contest of suffering. Like, if you're not completely at rock bottom and in your worst possible place in your life…you won't get the help that you deserve. And I don't think that's fair…in that you're forced to relive that deficit story over and over. And just to get heard, you need to end up in a psych ward or…[to] have just terrible, terrible things happen to you. And to me, that's super unjust. Yeah.**
>
> *(Galen Rigter—AVI, Outreach)*

The requirement that Peers tell and re-tell their war stories to gain access to services was seen by several service providers as a structural embodiment of stigma:

> **People will come here and tell their story. And then we're supposed to say, "You need to go next door, make an appointment with their intake nurse." And then they have [to tell] the story [all over] again. So that's another barrier.**
>
> *(De-identified participant #11)*

Others spoke to the system's propensity to deny services based on religious bias:

> **[The treatment facility I attended] was based on…it was Catholic or Christian, a Christian place. And I don't know why [there was no follow up]…it's only in my opinion [that there was no follow up] because I didn't get baptized: when my 90 days was up, they dropped me off in an alley with my bags. No nothing. No. And the whole time I was there, it wasn't: "Have you looked for housing? Have you checked a newspaper? Can I give you a ride anywhere? Can I do anything?" It was completely the program, and no bridge to anything positive after—no housing, no. But the second girl in there got baptized, and they gave her the house that they lived in. They bought a new house and gave her that house. And the third girl in there, she got baptized, and she got help. So that was just another form of stigma, but in a religious aspect.**
>
> *(De-identified participant #4)*

One Service Provider positioned religious bias as having deep and historic roots within the Comox Valley's systems of care, specifically within the Hospital:

> **I've…noticed a huge difference between Campbell River and Courteney [hospitals]. And… the deciding factor is [that the Comox Valley Hospital] was [formerly] St. Joseph's. So it was, you know, a Catholic based hospital for a long time. And I think that held them back…they should be on the same page, Comox Valley and Campbell River; [they've] both [been] open for five years; they should be at the same place. But I think the…past experiences of that administration, and the beliefs of that hospital…have held back the learnings and the opportunities that should be there, especially for the community that needs it so desperately.**
>
> *(De-identified participant #12)*

While the religious affiliation of programs and care systems do not influence stigmatization by default, and while there exists a wide degree of variance in the approaches taken to substance use within faith-based care systems, these insights above show how deep-seated values cultivated through religious affiliation can play a role in dissuading or preventing Peers from accessing services. This is particularly true for Peers that do not subscribe to program beliefs that are integrated into and promoted within service delivery. These insights also underscore how systems of care can be deeply entwined within the "spirit" of institutions and the values and assumptions they espouse.

Peers flagged the need for Peer-based education of Service Provides and systems change leaders as one of many necessary ingredients for destigmatizing care. By improving comprehension of the needs and humanity of people struggling with Substance Use Disorder, Peers are able to promote a more a humanistic understanding of, and enlightened approach to, the crisis:

Education [is needed], not with the focus on changing someone's mind, but enlightening them.

(De-identified participant #10)

We're not invisible. And that's the biggest thing…our voice and our concerns, right…they have to be heard.

(De-identified participant #1)

My solution? Put us in charge. Give us a say. Believe in [us]. Listen…we aren't going away. I'm not, anyway…

(De-identified participant #4)

Let's hope that something good comes from awareness. More people aware.

(De-identified participant #4)

Here we see, then, a profound need for systems change leading to a reduction/ elimination of stigma on intrapersonal, interpersonal, and structural levels. The same call (and identification of stigma and service gaps) is reflected in the personal maps made by Peers, as in Figures 2 and 3. We also see a call for Peers in enabling this change by providing the education necessary to humanize care, and by increasing awareness of the different contexts and life circumstances that are entwined with the emergent crises we face as a community.

Figure 2: Peer Map

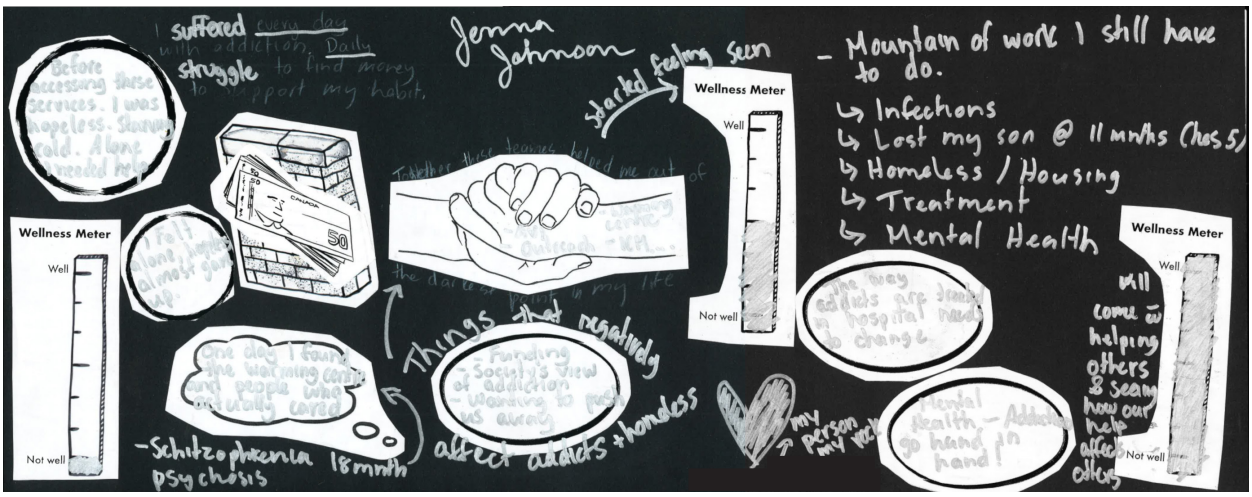
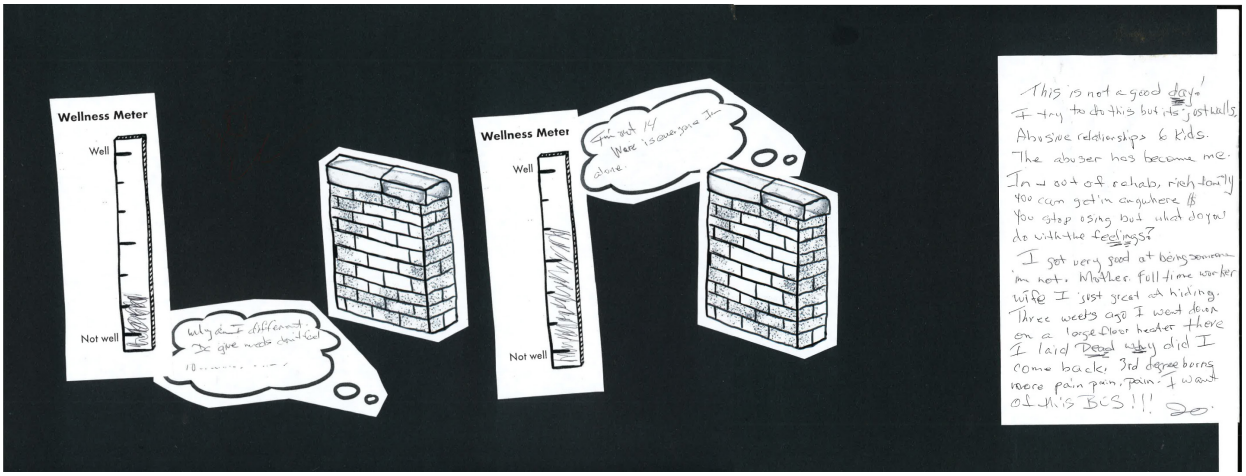


Figure 3: Peer Map



5.1.3 Gaps in Recovery Services

Both Service Providers and Peers spoke to gaps in Recovery and Harm Reduction care systems in the Comox Valley. We define a "Recovery" system as one focusing on reducing and/or eliminating reliance on substances (i.e. moving towards abstinence). We define a Harm Reduction system as one designed to support safe use of substances (i.e. Managed Alcohol Programs, Opioid Agonist Therapy, Overdose Prevention Sites, Safe Supply). In what follows, we illustrate the gaps identified by Peers and Service Providers in our local Harm Reduction and Recovery systems.

Recovery models often include a three-phased approach. The phases are often tailored to individual need and often include the following elements:

a. reducing reliance on substances, often through medical intervention, often over a period of one or two weeks (Medical Detox).

b. stabilizing use or absence of use over a period of weeks or months (often up to 90 days) (Social Detox).

c. maintaining this new level of substance use or sobriety over a long period of time, often years (through Supportive Housing, or other forms of long-term care).[87]

Unique and individualized tactics often enhance and/or compliment these phases. Community and Recovery support networks (i.e. Alcoholics Anonymous, Cocaine Anonymous, Narcotics Anonymous, cultural learning and engagement, community integration and more) play critical roles. While each person's recovery method is unique, many established and evidence-based methods use these critical building blocks within the Recovery process. For some substances (such as alcohol) medical and managed detox can be essential, as rapid unmanaged withdrawal presents significant physical risks. Individuals often struggle to make progress on their recovery goals when these pieces are not in place and working together.

Within the Comox Valley's Substance Use Support Network, research participants identified two key gaps in our local Recovery continuum:

Recovery Gap 1: Lack of local medical detox services

Peers and Service Providers identified a significant (and fundamental) gap in the lack of available medical detox services in the Comox Valley. Although social detox services are available, including at Comox Valley Recovery Centre (CVRC) and Amethyst House, in many cases these services are inaccessible unless an individual has first undertaken medical detox. While research participants acknowledge that the Comox Valley Hospital provides some level of medical detox, those who have accessed this service (or have referred clients) report that the detoxification was often a secondary outcome of patients having been admitted for other primary health concerns. One Outreach Worker observes:

> **[Clients] have [had] to invent something that's wrong with them other than the need to detox just to get…detox for a couple of days. People go to the hospital, feigning injury, you know, complaining about various ailments that may or may not exist in their body, just so that they can remain in hospital while they test them for whatever it is that they've identified.**
>
> *(Galen Rigter—AVI, Outreach)*

Aside from the hospital, Peers seeking medical detox are often referred to facilities in neighbouring cities, notably to Island Health's Clearview Community Medical Detox Centre in Nanaimo. But according to one Service Provider, Peers may need to be referred by a Mental Health and Substance Use Counsellor—a process that is "**difficult because [clients] have to drop in with Mental Health [and Substance Use], or phone, and then they have to call back and get an intake appointment**" *(Eva Hemmerich—Comox Valley Addictions Clinic, Doctor)*, a process which can according to a number of participants, can take up to six weeks.

Given this scenario, it is no wonder that wait times for entry to medical detox represent a prohibitive barrier to service for Peers. Wait times can range from two to three months and even more, taking into account the time between MHSU referral and intake to the detox facility. This prolonged wait time dissuades Peers from accessing the service in many instances. We heard from both Peers and Service Providers that the window in which someone becomes and remains open to medical detox is small—a matter of days, hours, and sometimes minutes. In what follows, Peers speak to the overwhelming challenge of accessing non-local medical detox options under these conditions:

> **I tried [accessing detox]. I talked to one of the workers about it, but it's quite a process; you're put on the list. It takes weeks.**
>
> *(De-identified participant #5)*

> **[Detox] just doesn't happen fast enough. It's very dragged out, and it's like, by the time you get it, you don't want it, or, you know, you're not ready. And it's like, that desire to get better can change really quick, so it should be…quicker to get help.**
>
> *(De-identified participant #6)*

I can't access treatment fast enough. It's always a three or four month wait. And if I still have my phone, it's a different number by [the time they try to reach me].

(De-identified participant #7)

Further, Peers can be dissuaded by additional barriers to accessing medical detox or starting treatment, including the requirement that clients cease smoking while detoxing from alcohol and/or drugs:

I tried that detox center down in Nanaimo…Yeah, I lasted four days there. They won't let you smoke. Which, you know… I'm not here to quit smoking. I'm here to quit drinking.

(Rick Berdaru)

According to several Peers and Service Providers, the transportation needed to access medical detox presents a yet another barrier:

We're asking [clients] to somehow get to Nanaimo safely…intake on their own. There's nobody going down there with them. Maybe they're using Wheels for Wellness, maybe they're taking the InterLink bus…[They] do a week…they're still pretty shaky when they leave at one week. Now [they] need to get back to the community…to intake into CVRC or Amethyst…That's huge, right? That's a big big ask.

(De-identified participant #14).

The travel can be a huge barrier. You know, especially for someone who's maybe using opiates, and they sort of have transportation down if it's Wheels for Wellness, but that becomes a bit of a scenario for a volunteer to potentially have to reverse an overdose.

(De-identified participant #18)

For some, the transition from medical detox in Nanaimo to social detox/treatment in the Comox Valley involves significant risks, especially when services do not align. Outreach Workers expressed frustration to us at having no way of "holding" people in the gap that can appear when they know the potentially challenging conditions in which clients are currently living while they are actively seeking detox away from that environment:

I can say…"hold that thought… stay here for three days"… [because] this person is reaching out right now. And [I can also say]…"too bad, wait a week or two weeks or three weeks, go back and live with all your friends" [in the environment in which substance use is supported].

(Danny O'leary— Island Health, OPS)

Other Service Providers did identify that concerted efforts are made by staff at Clearview and local social detox facilities (CVRC/Amethyst House) to link medical and social detox services:

> **“Oftentimes Clearview can be quite…good. If we tell them that someone has a bed CVRC on this date, they will do what we call, “bed Tetris.” You know, shuffle people around to make a bed available one week prior so that people will have that medical detox piece in time for their social detox… They’ve been quite accommodating in my experience. But again…the transportation, even sometimes getting down there for people and the fact that Clearview does not allow cigarette smoking on site…, these are a lot of the folks who are going into medical detox for alcohol use disorder, right? And cigarette smoking just goes so closely hand in hand, especially I find with the older population. It’s such a deterrent for people; they just won’t go because they can’t smoke.”**
>
> *(De-identified participant #13)*

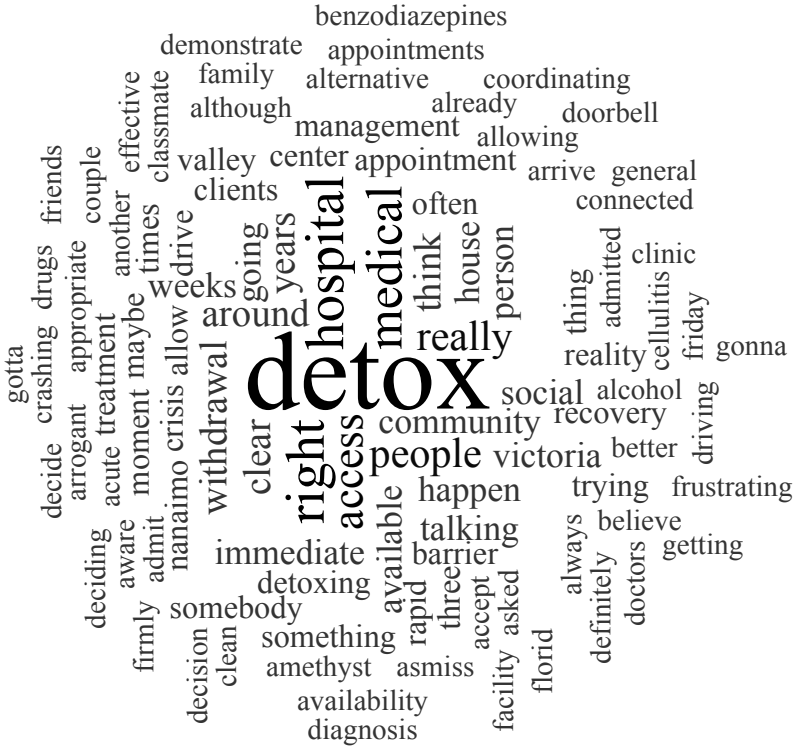
Here we begin to see a picture of the stress points involved in connecting people with what is often the very first step in a person’s recovery journey. For people who smoke, there are additional barriers to recovery.

Interestingly, several Service Providers report that “back door channels” permit some clients to access medical detox more directly by bypassing the required MHSU referral (those who spoke about these channels did not want to be identified). How these back-door channels work, and how they are sustained, remains a mystery. Facing significant systemic barriers, some working within the system are, apparently, finding ways to manufacture unique pathways to recovery for the benefit of their clients. It is distressing to observe that people in need of help require such channels in the first place, and to also recognize that they are not open to everyone.

One final incidental finding demonstrated a contrast in understanding of “detox” between Peers and Service Providers. Our team conducted a word cloud query in NVIVO, where the coded “detox” section was searched to identify secondary 3+ character words connected to this term. This query displays up to 100 words in varying font sizes, where frequently occurring words are in larger fonts (the more frequent, the larger the word). The same query was run separately in Peer and Service Provider data files. Our team discovered a different set of concepts to be associated with each category’s use of this term. As shown in Figure 4, Peers tended to use this term in association with emotive words like “alone,” “depressed,” “demoralizing,” “trying,” “barrier,” and “ghost.” Service Providers tended to use this term in a more clinical context, associated with words like “management,” “appointment,” “admitted,” “allowing,” “diagnosis,” and “decision.” These differences highlight ways in which the experience of detox can be understood in radically different ways. It points to an opportunity, perhaps, to bridge a gap in service provider understanding, so that the human impact and experience of detox are understood on a deeper level.

Peer Query

Service Provider Query



Impact

Beyond an understanding of the importance of a streamlined and rapidly accessible local medical detox service, it is important to understand the impact that the absence of such a service can have within lives of Peers seeking support. The following story, told by a Peer trying to help a friend access medical detox, demonstrates how frustrating the process of seeking help can be for those for whom "back doors" are unavailable:

> **"A friend of mine had gotten kicked out of CVRC [Comox Valley Recovery Centre]. He had relapsed…He was in Nanaimo…I drove down there to pick him up and bring him back up here. And on the drive up, so within the span of, I guess, two hours, he first called the hospital here in the Comox Valley, to see about being able to detox there because he needed to detox. And the nurse there actually said…"I don't know, you have to call Mental Health Substance Use." And so he called Mental Health Substance Use…and they said to "call the hospital," and there was kind of this back and forth…We call back the hospital, got somebody else. And they said, "No, there's no detox here. You have to call Clearview in Nanaimo." He did call Clearview. The lady there again said, "I don't really know; it's about two weeks, approximately two weeks, before we can take you," and so that was kind of that. He called CVRC to ask if he could get back in because he'd only been out for a couple of days. And they said, "No…you're gonna have to get back on the list to…re-apply, but there's people ahead of you now." So they wouldn't take him. And at that point, I think he felt like he had exhausted those options. So he phoned the shelter just to try and get a place to stay for the night because that was the most immediate thing that needed to happen. And so we call the shelter, and they said, "if you get here by…" I think it was, "four o'clock." And it was 3:30. And we weren't going to make it. So he had nowhere to stay for that night. We got into town; it was maybe 5:30. We went to the Travelodge, which was the place to maybe get a place to stay for that night. And, I actually can't remember why…I guess they didn't have space. They didn't have a room available. And that was it."**
>
> *(Sophia Katsanikakis)*

In this account, we see described a series of barriers that prevent an individual from engaging with medical detox, which in turn prevents them from entering other stages of treatment. A significant number of these barriers would be removed or reduced through the provision of a local medical detox centre in the Comox Valley—one large enough to accommodate Peers in the moment they express need for help. Comprehensive integration of medical and social detox would remove further barriers, reducing gaps that prevent people from immediately entering social detox after medical detox.

Recovery Gap 2: Lack of Supportive Housing/Long-Term Care

The transition from social detox/treatment to Recovery-based housing represents another key gap in our local provision of support. Peers and Service Providers both spoke to the profound absence of Supportive Housing in the Comox Valley which is currently restricted to the options available through social detox (often limited to 90 days) and to the limited 6-bed, 6 month, Supportive Housing option available through CVRC for those who have finished their social detox programs. The absence of Supportive Housing feeds a cycle in which Peers regularly engage with detox and treatment but are released without better provision for next steps to recovery, leading to relapse and often re-engagement with detox and treatment:

> **You get the revolving door, right? Or just they relapse, then they come back, and then they relapse, and they come back because there's nowhere… there's nowhere for them to go once they complete their, you know, maximum 90 days. Yeah.**
>
> *(De-identified participant #13)*

> **It's always been known that [when] you need to get somebody into a program they're there for 90 days if they're lucky. And then they just get turned loose. And they go back to what they know because they don't have the support system.**
>
> *(De-identified participant #10)*

> **I think one of the biggest challenges is that we have people who have come [in], whether it's been through supportive Recovery, a residential program or even, you know, at the Travelodge, who have said [to us], "I don't want to use anymore." And our only option coming out of Amethyst House sometimes is the Junction, which is really not helpful for somebody who's made that decision… There's just no dry place or a place where you can continue Recovery on limited income.**
>
> *(Heather Ney—Transition Society, Director)*

> **Other than second stage through CVRC…We have nothing. There's nothing in the Valley that's Recovery-based housing.**
>
> *(De-identified participant #13)*

The larger housing crisis also exacerbates the cycle of relapse and recovery. Many research participants spoke to problems obtaining long-term stable housing:

I'm homeless due to addiction; I managed to stay clean for a year there, and then finding housing has been a real, real issue…seems damn near impossible to find any kind of housing. That makes it especially hard. A bit of a struggle right now.

(De-identified participant #5)

I'm amazed [at rent prices]. Like $1,000 and over [a month], half the people can't afford that.

(De-identified participant #8)

Especially the clients that…are on such a minimal fiscal string that they've got basically the bare minimum and how they're meant to afford places that are $1500–$1600, just at the bottom end, yeah. When what they get is like $1,400 for the PWD or whatever…it is not that much.

(De-identified participant #11)

For people who are living unhoused, processes of detox and recovery can be especially trying.

We're talking about gaps, what a huge gap for our folks when they're in the hospital [or coming out of Recovery program]…like we all know, right? Where are they going to go? What are they going to do?

(De-identified participant #22)

It's incredibly disheartening to see somebody work so hard…for their Recovery for three months with us…put their all into it, and then [be] discharged to the shelter. Not like the shelter isn't great…But when somebody's worked so hard for their Recovery to have nowhere to go afterwards…it is heartbreaking.

(De-identified participant #15)

Apparently, past initiatives have considered a Supportive Housing facility within the Comox Valley:

About 8 years ago, a past coordinator for the CVRC was working on starting 2nd stage housing…They wanted to build a house right across from CVRC…The clients could go there and work or school or volunteer. This fell through, and nothing was started. There's money somewhere; we can do this.

(Danny O'leary—Island Health, OPS)

While people in active substance use have some housing options available, including Travelodge and the Junction, people pursuing abstinence see a need for "dry" housing where they are supported in this aim.

Ideas for Supportive Housing

Service Providers expressed no shortage of ideas for what such a facility could look like. Some spoke to the importance of a "group/family" environment—underscoring this environment as an important component of

Recovery:

> **I would like to see us going back to providing more Supportive Housing in the form of smaller group homes that provide a sense of community and family as well as being mindful that those sharing these homes have similar goals, for example having group homes for people whose goal is abstinence and others for people who are wanting Harm Reduction… more interested in Harm Reduction.**
>
> *(Jennifer Coulombe—Island Health, MHSU Researcher)*

Beyond cultivating group housing, some participants spoke to the importance of involving family members throughout treatment and Supportive Housing in the Recovery journey.

> **I think that the family model is really important because it's about changing habits. [When family members are involved], individuals have a support system when they return home after Recovery.**
>
> *(Barb Whyte—Elder/Traditional Knowledge Keeper)*

Family models were seen as especially relevant within Indigenous treatment contexts:

> **We see ourselves as family… We think of ourselves as family. And on reserves, the families are very tight-knit. Big families live in small houses… That's part of it, the housing piece. Grandparents, mothers, fathers and children all live in one house. So everyone is impacted [by an individual's Substance Use Disorder], and everyone in the family has a role to play in Recovery. How do you break a destructive routine if that routine is still going on with family members when you return from treatment?**
>
> *(Barb Whyte—Elder/Traditional Knowledge Keeper)*

One Participant cited the Kackaamin Family Development Centre in Port Alberni[88] as a notable example of family-based care centre—a non-profit that self-identifies as one of three Indigenous family treatment programs in Canada. The centre was seen by this participant as innovative in its understanding of addiction as a family and community construct and in its foundational reliance on Nuuchah-nulth values to direct and hold its work.

Several Service Providers also spoke to the potentials that farm models afford Supportive Housing:

My dream would be to have a farm where people requiring housing could live and contribute while learning new skills in a supportive environment. It is important that future decisions are made with a climate change lens while strengthening local food security.

(Jennifer Coulombe — Island Health, MHSU Researcher)

The farm model, which often includes social enterprise and work experience components (i.e. through the cultivation and selling of farm produce and artisan goods at markets), is growing in BC. Examples include the Port Alberni Shelter Society's Shelter Farm,[89] and the Mustard Seed's Hope Farm Healing Centre.[90] The implementation of Port Alberni's Shelter Farm was inspired in-part by an internationally renowned Recovery farm in Italy called SanPadrignano—a treatment centre involving a 3–4 year live-in experience in which residents "learn to overcome hardships through honesty, commitment, respect for themselves and for others, and by developing solidarity and interpersonal skills."[91] The centre professes a 72% Recovery rate; residents do not pay for their stay on the farm—they are afforded room and board, work full-time and donate their labour to the upkeep of the program and facility. A 2019 article written by Port Alberni's former Mayor, John Douglas titled Addiction and Therapeutic Recovery Models "*Working Towards a Solution*," considers this model and its implications in detail.[92]

A number of Comox Valley Service Providers feel that a Recovery facility (whether based on a Farm model or otherwise) should be located at a distance from the city centre, in a place where the substance use scene is less accessible. To help break cycles of SUD, many thought it important to offer an environment in which new behaviours and cycles could develop and new forms of resilience could grow.

It is worth noting, as well, an emerging trend in BC (and beyond) to establish tiny home villages in BC (and beyond) for transitional housing. Though research participants did not explicitly identify this concept in our study, some BC municipalities are advancing these solutions. Duncan, Port Alberni (in process),[93] and Victoria[94] already have examples of these villages. Some villages are developed explicitly to support Recovery,[95] while in other cases they are developed to provide housing and services for unhoused populations at-large. Tiny home villages are one of many potential strategies that can help address the need for Supportive Housing.

Clearly there exists an urgent need to bolster both the "front-end" of the continuum (medical detox services) and the "back-end" (Supportive Housing). Without initiatives to improve and create these life-saving services, the Comox Valley Substance Use Support Network will continue to cycle people through potentially endless and expensive processes that involve minimal prospects for success. By failing to provide local medical detox and adequate quantities of Supportive Housing, we are setting people up to fail.

Alternative Recovery Pathway—Privatized Services

Alternatives exist to the public system of Recovery-based care we have just described. Several Peers spoke to their experiences accessing privatized Recovery services such as Edgewood Treatment Centre (Nanaimo) or Cedars (Cobble Hill). Privatized systems often offer a broad spectrum of Recovery-related supports that bring medical detox, social detox, treatment, and Supportive Housing together (a model that could be considered within the Comox Valley's public services sector). However, access to privatized

services often come at an enormous cost. As one Peer notes: "**you have to have like $40,000 sitting around**" *(De-identified participant #21)*. Some feel the privatization of treatment and Recovery facilities creates problems in its own right:

> **[Privatized Facilities] just run like a business. They don't care about the people who are in rehab…Counselors are constantly leaving because they're like, "I'm not actually here to help people anymore. I'm here to just make people feel like they're being helped. So we can get them in and out of the door so we can get more money." And that's fucked up.**
>
> *(De-identified participant #21)*

This focus on financial gain can wreak havoc with the lives of those accessing these systems:

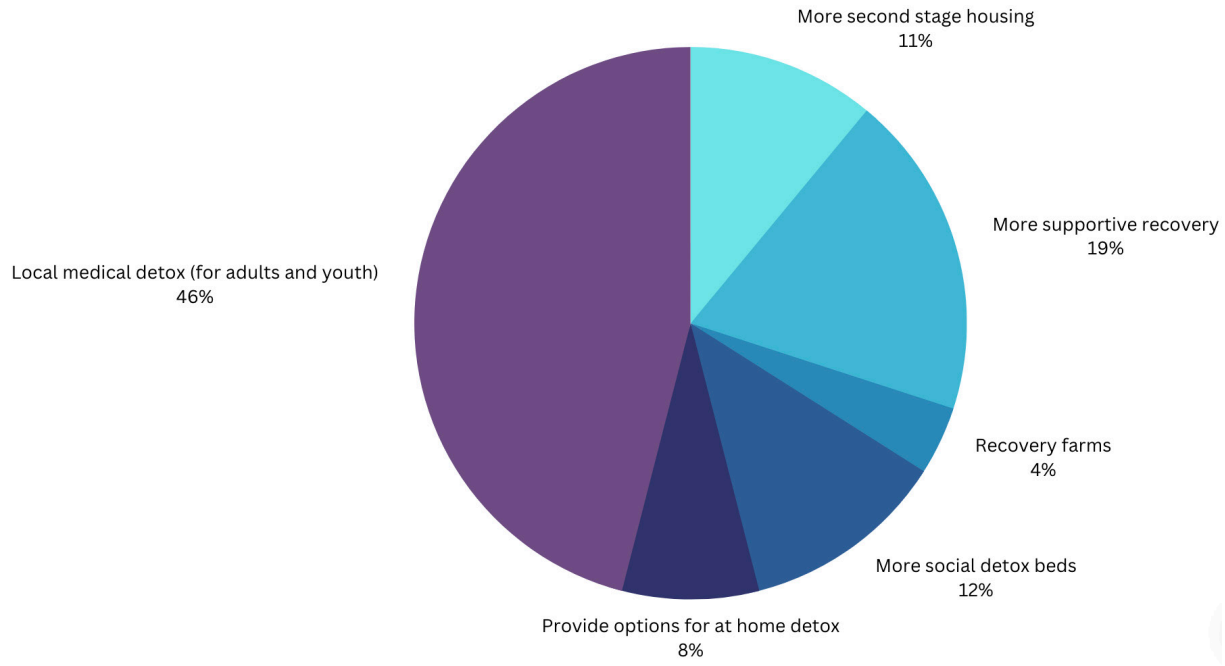
> **[While in a privatized Recovery centre], I was encouraged to sell my house…"Was my life worth saving? You need to sell your house, you need to sell your cars. You need…" It was all about money all the time… "Looks like you're coming up to the end; we really think you need another three months. Well…can't afford three months? Do you have a house? Do you have a car?" We were encouraged constantly, all the time, to sell our shit in order to stay longer…And it was all about, like, "You're worth saving. You're worth it."**
>
> *(De-identified participant #22)*

Not only can privatized services be prohibitively expensive, but their commercial mandates can potentially dehumanize those who access them. While commercial treatment centres may in some cases offer a more cohesive Recovery experience, they clearly come with significant drawbacks and are financially out-of-reach for many.

Summary

In this section we examined a consistent and sustained call made by Peers and Service Providers to fill key gaps in the provision of medical detox and Supportive Housing. Additionally, both groups reported that more work is required to reduce and/or eliminate stigma in the care system at-large—a move that will allow Peers to access services without being shamed or dehumanized. Figure 5, which shows the most urgently-needed solutions selected by service providers across sessions, identifies many of these same gaps and associated solutions, and provides additional support to our gaps analysis. Overall we see significant gaps in the Recovery services system that require urgent attention.

Figure 5: Most Urgently Needed Recovery-Based Solutions Selected by Service Providers Across Sessions



5.1.4 Gaps in Harm Reduction Services

Thus far, we have considered key gaps in Recovery services in the Comox Valley. Again, Recovery and Harm Reduction can occupy points on a spectrum and operate within a wide continuum of potential care. In what follows, we consider gaps in Harm Reduction provision in the Comox Valley.

Our work begins by exploring key gaps that our research participants reported in relation to Managed Alcohol Programs and Safer Supply programs within the Comox Valley. We then look at additional gaps that they flagged in relation to Overdose Prevention Sites and Opioid Agonist Therapy provision. This Harm Reduction analysis, as well as the analysis we've just presented related to Recovery care, will feed into Section 5.1.5, where we zoom out further to explore key gaps in the continuum of care at-large.

Harm Reduction Gap 1: Managed Alcohol Programs

An emerging Harm Reduction tool utilized by health agencies throughout the province involves stabilizing alcohol-based substance use through the prescription of alcohol (in the case of alcohol use disorder). In Island Health, this program is called iMAP (individualized managed alcohol plan). Through this program, Peers are prescribed a maintenance dose of alcohol that attempts to both avoid intoxication and manage cravings. Island Health has, through the COVID-19 pandemic, moved to develop this program across multiple sites, and is working to refine the scope of the program and services. The program, intended to eventually be offered in multiple settings within and outside of Island Health (i.e. acute care, long-term care, Supportive Housing, outpatient, community, NGOs, and others), is in its early days. Work is

needed, according to Island Health, to roll iMAP out within multiple communities and within multiple facets of community.[96]

Several Service Providers spoke to their desire for a more significant and rapidly implemented Managed Alcohol Program in the Comox Valley. These providers (who have asked not to be quoted) spoke to the limited reach and impact of this program and to the need to ensure an adequate dosage level is achieved in prescribing in order to meet client needs.

Harm Reduction Gap 2: Safer Supply and Opioid Agonist Therapy

Peers and Service Providers also expressed additional need for Safer Supply programs. In a landmark move in 2021, the Province of BC released a prescribed Safer Supply policy, the first province in Canada to introduce this public health measure.[97] This policy allows prescribers to give access to maintenance doses of certain unregulated drugs. The policy is designed to reduce client reliance on the toxic drug supply and to be of benefit to individuals using unregulated substances throughout BC. According to the Province:

> **Once fully implemented, People Who Use Drugs and who are at high risk of dying from the toxic illicit drug supply will be able to access alternatives covered by Pharmacare, including a range of opioids and stimulants as determined by programs and prescribers.**[98]

Despite this landmark move, the roll-out of Safer Supply programs has been slow, especially in small communities that lack prescribers with capacity to do this work.

In 2022 the Comox Valley and Campbell River offices of AVI Health and Community Services—a Harm Reduction-based NGO—began working on a Safer Supply program entitled Regulated Access to Drugs (RAD) to provide Safer Supply options to a designated group of clients. This program is a **"federally funded, flexible, community-based Safer Supply project…the goal of which is to save and affirm the lives of People Who Use Drugs by providing safer pharmaceutical alternatives to the currently toxic supply created by criminalization"** *(Galen Rigter—AVI, Outreach)*. The program is staffed by registered nurses, physicians and Outreach Workers, and involves **"observed dosing of transdermal fentanyl patches and sublingual tablets at the program site"** *(Galen Rigter—AVI, Outreach)*. While the program is in its infancy, and while it is client-centred and enables participants to create their own wellness goals, initial results are promising:

> **Participants have shared stories of how the program has impacted how they feel about themselves. The freedom of having the option to access Safe Supply instead of doing actions that put people at risk in order to feel well, is in itself, a massive shift in a person's physical and mental well being. The obsessive pursuit of having enough money or credit on the street to stave off the feelings of withdrawal and/or pain to simply function day to day can be overwhelming. Participants have said that they no longer have to sneak around, constantly putting themselves at risk to maintain a minimum level of pain relief/withdrawal symptoms. [Some participants have reported] improvements in physical ailments such as sleep disorders, stomach/digestion issues, vein care, respiratory problems, abscesses, and mobility. [Other participants have] been positively impacted by the reduction of Benzodiazepine use by accessing Safe Supply versus illicit supply. For many, the presence of Benzo's in the street supply has negatively impacted people in many ways; physical dependence, periods of blackouts/lost time with loss of personal belongings related to these episodes…The program has given a new sense of hope for some and is helping people set goals to better themselves.**
>
> *(Galen Rigter—AVI, Outreach)*

In spite of the seemingly positive role the RAD program is playing in the lives of Peers, it is important to note that the program falls short of meeting demand within the Comox Valley.

> **From a capacity standpoint, the RAD program falls short of meeting the overall need in the North Island. We have lengthy waitlists to onboard participants, and as the information of the program reaches a larger population we can expect even more demand for access. The only solution for this is to be generously re-funded [as current funding is provided only until July, 2023] and staffed for expansion. While we are grateful to now be able to provide this service to the public, it's safe to say that we are late to the starting gate. We have lost many people from preventable deaths while we have waited for these services to be funded. Other, larger communities have seen the benefits of Safe Supply for years, and it falls on both the provincial and federal governments to provide funding to further expand and support Safe Supply programs especially in smaller communities, Indigenous communities, anywhere where people are at risk from a toxic drug supply or who are impacted by chronic pain and opioid use disorder.**
>
> *(Galen Rigter—AVI, Outreach)*

Work is urgently needed to expand services in prescription services for both Managed Alcohol and Safer Supply programs and to educate and support prescribers in understanding and working with clients to administer correct dosage, and to make these services widely available. The failure to move quickly to establish and strengthen these services will perpetuate service gaps that keep people engaged in dangerous high levels of substance use harms.

Harm Reduction Gap 3: Continuum of Care

Additional Harm Reduction improvements were recommended by Peers and Service Providers alike—notably, related to OPS (Overdose Prevention Site) location, hours and services; also to the regulations surrounding Opioid Agonist Therapy provision. These improvements are as follows:

Re-constitution of Overdose Prevention Sites (OPS):

Currently, the Comox Valley has one OPS site in downtown Courtenay—located on the outskirts of the downtown core (several blocks away from 5th Street, and run out of an Island Health clinical facility). Several Service Providers view the location as problematic. They feel the clinical setting and lack of visibility sees the service underutilized. A more central site in the downtown core, in a space offering a community support component, is needed:

> **When the OPS was first set up here…I noticed and seen firsthand that the location wasn't the greatest. Why this location and not at the junction or at the Travelodge?**
>
> *(Danny O'leary—Island Health, OPS)*

> **If we would [position the OPS] near Connect, you know, just a bit more downtown…in that area. It'd be, yeah, it'd be so much busier and just easier for people to access.**
>
> *(De-identified participant #11)*

Several Service Providers recommend the development of an OPS site at the Comox Valley hospital which would allow people to continue using services in hospital without having to leave for maintenance doses of drugs. This would also provide an access point for Peers wanting support in daily witnessing (someone close by to monitor for overdose events).

This suggestion is not without precedent. In 2018, St. Paul's Hospital in Vancouver opened an OPS on site (first Peer-run, and later nurse-run). This move was groundbreaking in allowing patients with opioid use disorder to remain in care for the duration of their treatment while also providing OPS services to the community surrounding the Hospital.[99]

One Service Provider recommended developing a Peer-run OPS:

> **What would ultimately be fantastic is a Peer-run OPS that is actually funded and supported by Island health. So it doesn't have to be that very formal clinical setting like we have.**
>
> *(Shari Dunnet—Comox Valley CAT)*

Expansion of OPS Hours

Peers and Service Providers told us that after-hour OPS Services are needed. The current OPS site operates during the day with service from 9:30 to 3:30pm on weekdays or from 10am to 2pm on weekends.[100] This leaves Peers with less safe options for substance use when the OPS is closed (between 18 and 20 hours a day depending).

Addition of Inhalation to OPS Services

Numerous Service Providers spoke to the need for safe inhalation OPS services in the Valley. Given that inhalation is frequently used for intake of drugs, the absence of this service represents a major gap in service provision:

> **If we can get inhalation that would be key. Because obviously, I keep hearing from our users that people aren't injecting as much. Now it's all inhalation.**
>
> *(De-identified participant #11)*

Several Service Providers note that Island Health does appear to be moving towards adding these services to the existing slate in the Comox Valley. However, it is unclear when this move will occur.

Review of OAT Witnessing Guidelines

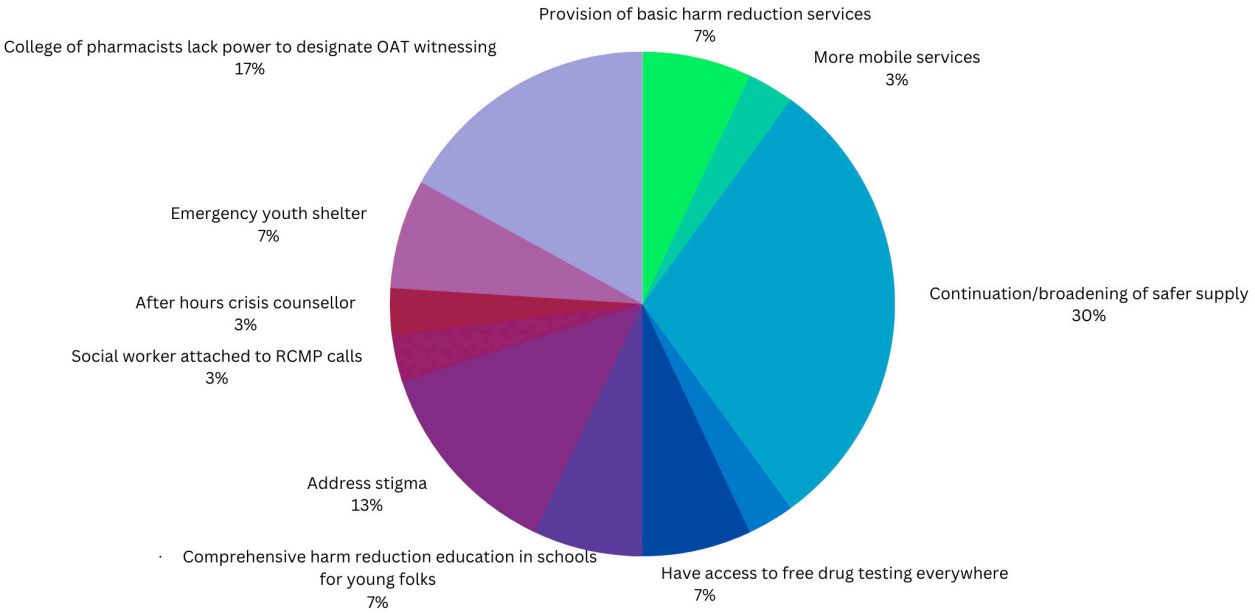
Several Service Providers spoke to the hurdles they encounter in facilitating Opioid Agonist Therapy (OAT)—in particular, at the Travelodge—a hotel used, in part, for transitional housing. Staff working at the Travelodge spoke to the ways in which changes to OAT delivery requirements, developed by the College of Pharmacists of BC, impact their practice:

> **At the Travelodge, we were giving people their OAT, and then the pharmacies were given a note that we could no longer witness OAT. And [the role of witnessing] was… given to a new pharmacy in town. And so that was such a stressful time. Because prescriptions were everywhere. [Previously] we had it totally under control. We knew what we were doing. We had the night staff anyway…When we were witnessing, we were able to provide that [service] anytime of the day…Now if [clients are] not there at 9am, or whatever it is, they lose it for the day… So if that person misses their OAT, they don't get their OAT for the day…So now these folks are falling off their OAT.**
>
> *(De-identified participant #16)*

This comment shows how changes in regulation, such as those made by the College of Pharmacists of BC regarding OAT provision, can have significant impact on the capacity of clients to adhere to a care plan. This story also underscores the importance of empowering community Service Providers, those most directly connected to the lives of clients, with responsibilities that they can reasonably undertake in relation to the provision of OAT and other related services. The absence of such empowerment produces increased barriers to stabilize substance use for Peers. Work is needed to lobby the College of Pharmacists for changes to this procedure.

Figure 6, which shows the most urgently needed solutions selected by service providers across sessions, identifies many of these same gaps and associated solutions.

Figure 6: Most Urgently Needed Harm Reduction-Based Solutions Selected by Service Providers Across Sessions



5.1.5 Gaps in the System at-Large

Beyond gaps in Recovery and Harm Reduction services, Service Providers identify the following fragmentation within the Comox Valley's care system at-large, and they describe the need to develop and coordinate full-spectrum wrap-around services designed to increase accessibility and ease of engagement for clients:

There is a huge, huge need for more comprehensive mental health and substance use services. And I don't mean [just within] Island Health, but a broad spectrum from like, super, super Harm Reduction (broad range of Safer Supply and [an anti-stigma environment where it is] totally okay to get high because it feels good) to abstinence…[to]…detox and treatment and all of those things in between. And [services] accessible in various points in the community, whether that's at a hybrid model, like inside or through hospital or at-home detox.

(De-identified participant #17)

Systems Gap 1: Need for Culturally Safe Services

Several Service Providers flagged a need to develop a stronger and more culturally rooted Harm Reduction and Recovery support system within the Comox Valley's systems of care. This includes facilitation of meaningful land-based practices and connections:

> **I'm thinking specifically of…an Indigenous person and really [someone] you know [who] connects with their culture as a healing modality. What's available to the person unfortunately [are] institutional modalities of treatment. So in an ideal world…we live in such a beautiful landscape. And we have this, there's this amazing resource of nature around us as a healing modality. And so connecting to the land as a solution. Breaking outside. Go outside because that's, I think [that's] where the human spirit…really becomes one.**
>
> *(De-identified participant #18)*

Systems Gap 2: Need for Better Coordination of Services

Some participants spoke to the need for the development of a "map" that would provide access to the range of services available **"not just within Island Health, but [within] all the other different services."** Apparently, this gap is now in the process of being filled:

> **[Eureka Place is] actually working on a resource guide… maybe it's not a hub where people can go physically, but it's a hub where if somebody is looking for some kind of support, they have it laid out simply to be like, "Okay, this is the kind of support I'm looking for, here are the places that I can go to," without getting confused.**
>
> *(Jason Lee John Kirsch—Eureka, Member Support Worker)*

Systems Gap 3: Need for Peer Navigators

In connection with this "map" of Substance Use Support Network Service Providers, research participants identified a strong need for Outreach Workers, preferably Peers, to help connect and guide clients through the local system of care services:

> **We talk about like, you know, having like a patient advocate or somebody who has a kind of a holder of all that information of how the system works with the Peer.**
>
> *(De-identified participant #13)*

> **I think in a dream world, there'd be like a Peer in Emerge [Emergency Department] that could support people.**
>
> *(De-identified participant #18)*

Not just the Emerg but rotating through the hospital. For the in-patients. Yeah, that's huge…To be able to support people admitted.

(Eva Hemmerich—Comox Valley Addictions Clinic, Doctor)

I think it would be great if there was more understanding of the value of [Peer advocates] … it's so valuable to have somebody who's walked in your shoes… it means something … you feel them there, they get things, you don't have to explain everything, and it has so much value.

(Shari Dunnet—Comox Valley CAT)

Many participants felt that Peers were well-placed to be in front-line "navigation" and "connection" roles. Our team also identified the need for Peers to be integrated and on-boarded into leadership and administrative roles as these bodies often set the conditions under which front-line services operate.

Systems Gap 4: Need for a Hub

Building on the theme of "coordination," a number of Service Providers envisioned developing a physical "hub" site that would provide a broad range of coordinated substance use-related services under a single roof:

It would be great if we provided a lower barrier Rapid Access Clinic for those interested in OAT, so they can walk in and obtain treatment right away and you can support people where they are at in that moment.

(Jennifer Coulombe—Island Health, MHSU Researcher)

One provider spoke to the "hub" model in-place at Insite (a supervised injection site in Vancouver) that could be taken up in the Comox Valley:

You walk in, and it's like, you know, a Peer-run kind of entry. There's a supervised injection site/consumption site. So some folks come in with whatever they get off like the street, some people can access their Safer Supply there. And then they can use supervised; they consume on site. And then there's a chill space, Peer-run. And then if they are wanting to connect with detox, it's upstairs. So it's really…meeting people in the moment. Because…really, when those moments happen…(and we've seen historically at AVI many, many times, you know, that's that moment, but… getting somebody connected? It's such a small window). And there's often not something available…I don't know how it plays out in reality at Insite, maybe there is a bit of a wait, but the theory is that people can access right away.

(De-identified participant #17)

Such a vision already exists, apparently, in the historic efforts of Service Providers in the Valley:

> **There was very serious intensive work done in this community around developing like a coordinated, access point for all of the various services in the Valley. And ultimately, what came of that was nothing—because people realize there's no funding for it, and nobody can add that on to what they're already trying to do.**
>
> *(De-identified participant #17)*

Based on this evidence, more capacity, resources, and coordination are needed within the Service Provider network to create a hub and physical centre.

The above suggestions point to ways forward to achieve "in the moment" provision of services. They show a need for greater coordination amongst providers, and for developing a comprehensive wrap-around system of care that is less bureaucratic and overwhelming than the one currently in-place. Work is needed to connect and make our community's fragmented system of care more "whole" and "comprehensive."

Systems Gap 5: Need for Shared Data and Communication Systems

On a practical front, some Service Providers indicated a desire for secure data systems that enable client health information to be shared across the spectrum of care.

> **It'd be great if we had like some kind of easy, breezy communication…information sharing…like a streamline information sharing so that you can talk to people more easily, without needing to be so meta about it.**
>
> *(Participant #19)*

> **We have an internal Island Health charting program that we use, and a lot of our… mental health and substance use teams use it…but pharmacists don't have access to it, and the hospital doesn't use it. [And] community partners…don't use it either.**
>
> *(De-identified participant #13)*

> **The Comox Valley Hospital does…most of their charting on paper, which makes it really difficult for other Island Health agencies or teams to access any information once our people go into hospital we have no… it's like they fall into a black hole. So it's can be quite difficult to get information.**
>
> *(De-identified participant #14)*

While such a system may indeed improve efficiencies (and help mitigate having to tell war stories again and again as described in 5.2.1 in this report), any move towards this goal should, in our view, be balanced against the responsibility each Service Provider has to hold client data and confidentiality "in a good way." Our experience tells us that not all Peers will want their information to be

accessible to all agencies. Should this agenda move forward, we advise the inclusion of Peers in conversations about how such a system would work, and how it could best serve People Who Use Substances.

Systems Gap 6: Need to Address Remote Access

According to Service Providers located on Hornby Island, Denman Island, and in Cumberland, work is needed to address barriers to service access for these more remote communities. These locations suffer from inadequate Harm Reduction and/or Recovery services in different ways; it is worth noting that Hornby and Denman Island have the highest rates of childhood and adult poverty in the Comox Valley[101]:

> **[Other than Comox Valley Street Outreach, and Caravan which] come up [to Cumberland] once in a while but [have] no connection [to the] Village office or other service providers in town that I know of…we really have zero services…in the Village itself, and zero Service Providers… including dedicated police. We have Island Health operating out of, I think it's called the Health Center. It's the Cumberland Lodge. And there is a pharmacy, there used to be a lab, but it's been closed. But…there's nothing for mental health or addictions at all…So essentially, those people get pushed out of our community.**
>
> *(Vickey Brown—Councilor now Mayor, Cumberland)*

> **I would say Harm Reduction is…just not taught enough [on Denman and Hornby]. Like, it's just not…the young people aren't getting educated. I'm usually…the first one to talk about it. So there's no Harm Reduction outreach for kids in school…It doesn't need to be in schools, but everything happens in schools.**
>
> *(De-identified participant #19)*

Service Providers working in Cumberland and on Hornby and Denman Islands spoke to difficulties they have in transporting Peers to and from services in-town:

> **Because we have a number of [Cumberland] youth who come and access services and groups and whatnot, where we're running into huge challenges for them is the busses trying to get home after [going] to Cumberland. So we're using staff or just transporting them back and forth. But I was really, really shocked at how much of a barrier the transit system to Cumberland is for young people to access services.**
>
> *(Angie Prescott—John Howard)*

Normally, I don't work on Fridays, because there's no school that day, but there's been two of the last four Fridays, where our adult MHSU worker has done incredible work locally to get a person ready to go somewhere… and there's no driver and the person…can't just have a volunteer with them. They need someone with more experience. And so I drove to town those two Fridays; that's normally my day off with my kids.

(Meredith McEvoy—Program Manager, Adult Mental Health and Substance Use, Hornby & Denman Community Health Care Society)

Here, then, we see flagged a need for more mental health and addiction services in these remote communities, and for transportation solutions to be developed that enable Peers from these remote communities to access in-town services.

Systems Gap 7: Need to Address Tensions in our Ecology of Care

During our sessions with Peers and Service Providers, it became clear that tensions and power imbalances exist within our local Service Provider ecology. We identified a need to disrupt these dynamics and to create space for coordination and collaboration amongst diverse entities. In particular, tension was seen to exist between Island Health and Community providers (a discrepancy flagged by a number of Community Providers across multiple sessions). This tension was tied, according to some, to wage differentials—to the fact that Island Health staff are perceived to be better-paid than staff in community service organizations (though in many cases, workers in Island Health were seen to be trained in community). It was tied as well to a type of elitism associated with Island Health staff seen to negatively impact the capacity of the service network at large to function (participants providing these insights opted not to be quoted). When asked to elaborate, one community worker described this elitism as involving, in part, a sense of protectionism:

There is like this, almost like protectionism that happens around, you know, these are our clients and our people, and they sort of do this little bit. So it doesn't feel as collaborative as sometimes I might like it to be.

(De-identified participant #18)

Another community provider noted that the tension **"impacts clients more than it impacts us."** *(De-identified participant #15)* When asked to elaborate, this Service Provider observed that these tensions have very real impacts on clients' lives:

When we're spending time fighting with each other around who's supposed to do what, and who's the leader of what, and what we're supposed to do, and who's the boss of who, clients are waiting to be served. And that's frustrating. Because in the end of the day…I don't care what somebody else thinks of me, or [who thinks they are] better than me or not; I'm quite happy in what I do and where I'm at…What bothers me is the people waiting for service while we're going back and forth on who is supposed to do what…let's just do it. Let's just work together. We're serving the same population of people, literally the same people. So let's just serve them.

(De-identified participant #15)

Further, community providers spoke to Island Health's limited capacity, due to its operation as a large institution, to tailor services to meet individual needs: "**I think a strength for community services is that we have more flexibility than [Island Health]…I recognize the constraints that Island Health has put upon themselves**." *(De-identified participant #10)* This attribute of flexibility represents a contrast to the rigidity of Island Health's processes—and can be an additional cause for stress.

Peers also spoke to these tensions, referencing them in relation to the care system as a whole:

One of the biggest problems I see today is that when you got multiple groups and multiple people and multiple, you got Island Health working…with the ICMT team…and then the ACT team and all these different teams that start up because they don't like the way that the other team works or the other team has guidelines that the other team doesn't believe, you know, it's not right. Like, it's essentially there, it's essentially just a battle for money in that way, because now you guys are just battling for the funding to do the helping. You know, it's like…"Pick Me Pick Me"…"I/ we can help the best"…and it's gross.

(De-identified participant #9)

These observations are eye-opening. They call for a leveling of hierarchies of power in substance use support work, and for an elevation of cultures of collaboration and collective innovation. In particular, work is needed to bring Island Health and Community providers together in respectful conversation to carve out more streamlined pathways for the benefit of clients—outside the urgency of client service provision.

You know, I feel like we need to come together more and support each other…in a positive way.

(Diana Merten—
Transition Society, Outreach)

If we could just work a little bit closely together to serve the population of people that we serve, we could do a lot better.

(De-identified participant #15)

Given histories of power dynamics and discrepancies, it may be valuable to bring in third-party entities to facilitate dialogue and planning—with the aim of creating new collaborations and pathways forward.

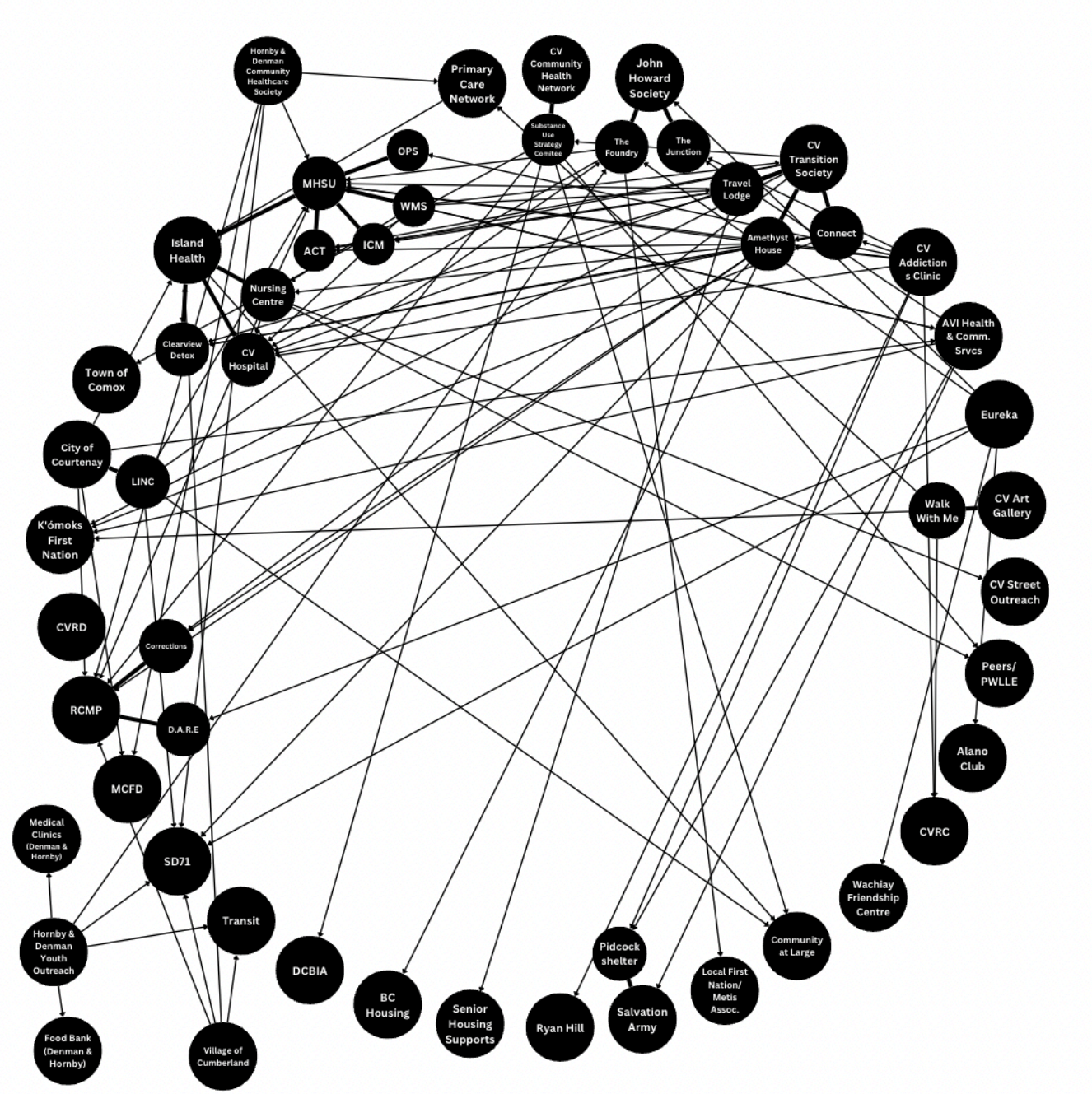
Systems Gap 8: Need / Opportunity to Boost Cross-Sector Collaboration

In seeking to better-understand the web of connections at-play within the local Substance Use Support Network, we asked Service Providers, as part of the cultural mapping process, to identify up to five "strong connections" at-play between a particular organization, project or initiative with which each individual participant was affiliated, and up to five "connections that could be strengthened". Figure 7 draws attention to "connections that could be strengthened" (strong connections" are identified in Section 5.2). It is worth noting that participants could, if desired, identify a particular connection as both "strong" and "could be strengthened" (i.e. could express the desire for strong connections to be further strengthened).

In analyzing this figure, we note, first, the flurry of "could be strengthened" lines running between Island Health services and non-profit entities such as John Howard Society, CV Transition Society and AVI Health and Community Services. This flurry, it seems, speaks to a desire from both sides for greater connection between Island Health and key community-based service infrastructures. We note, as well, the desire expressed by a number of participants for stronger connections to be developed with SD71, RCMP, K'ómoks First Nation, Clearview, North Island Hospital and Island Health Mental Health and Substance Use (the top-six identified connections). We find interesting the range of identities and mandates represented within this group.

From these observations, we see a need and opportunity to both develop stronger Island Health / Community Service Agency connections, and to develop connections with entities not always seen as "dominant players" within the substance use ecology. This second point speaks, it seems, to a need to recognize change-potential as stemming from multiple, and often unexpected, places.

Figure 7: Connections That Could be Strengthened—Service Providers



Primary Care Network (2)
Substance Use Strategy Comittee (1)
John Howard (1)
Foundry (3)
Junction (2)
CVTS (1)
Travel Lodge (1)
Amethyst House (2)
Connect (1)
AVI (2)
CVSO (1)
Peers/PWLLE (2)
Community at Large (3)

Local First Nation/ Metis Assoc. (1)
Wachiay (1)
Alano Club (1)
CVRC (2)
Salvation Army (1)
Pidcack Shelter (2)
Ryan Hill (1)
Dawn to Dawn (1)
BC Housing (1)
BIA (1)
Transit (2)
SD71 (6)
MCFD (2)

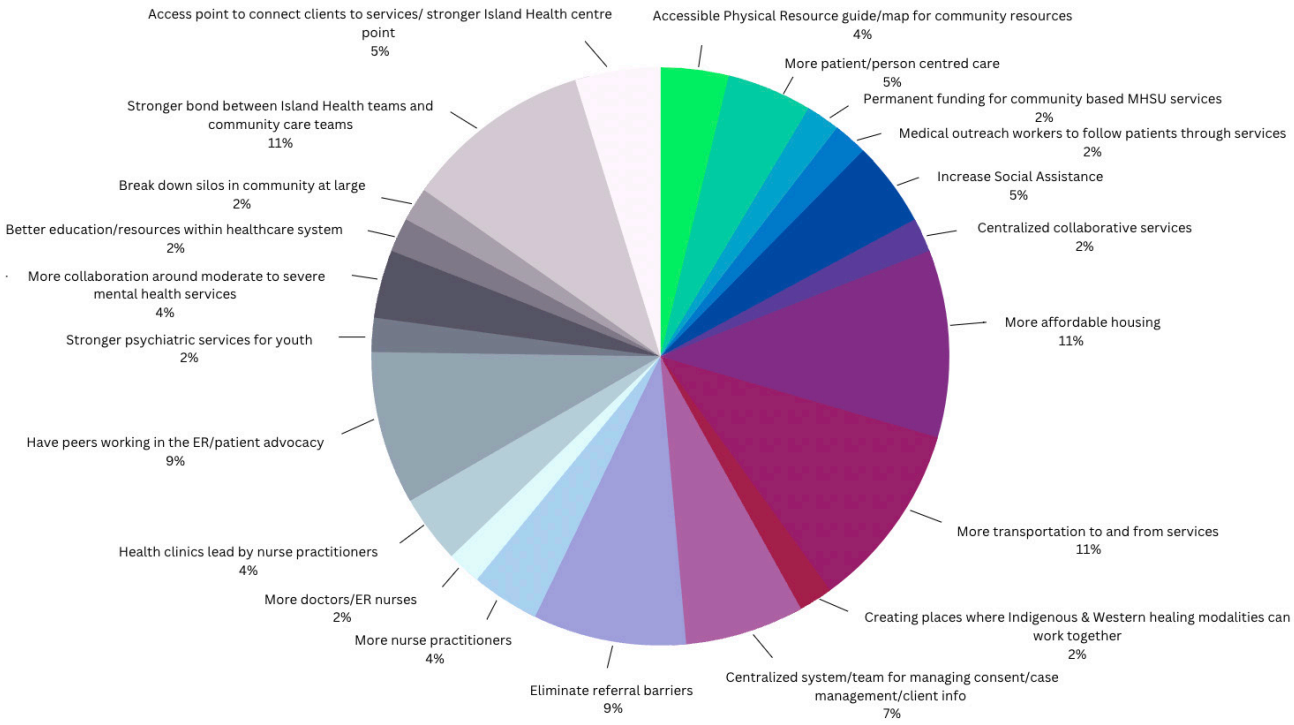
RCMP (6)
D.A.R.E (1)
Corrections (2)
K'ómoks First Nation (4)
Comox (1)
Island Health (2)
Clearview Detox (4)
North Island Hospital (7)
Nursing Centre (2)
MHSU (8)
ICM (1)
ACT (3)
OPS (1)

Summary

This section illuminates key service gaps in the Comox Valley Substance Use Support Network as identified by Peers and Service Providers. Included here is a need to create a local medical detox centre, develop Supportive Housing options, bolster Managed Alcohol Programs and Safer Supply programs, create a services hub, expand and re-position OPS services, expand delivery options for OAT services, ensure the existence of Culturally Safe services, strengthen services and transportation for remote communities, and enhance connectivity and collaboration between Service Providers—especially between Island Health and Community groups. Figure 8 which identifies the highest-rated urgently needed "systems-based" solutions selected by service providers across sessions, identifies many of these same gaps and associated solutions.

Closing these gaps will require concerted effort and investment. This said, the urgency of this moment, and the alternative posed by a broken system, which involves a tremendous human and fiscal cost, demands of us that we do this work now. We must come together to repair our fragmented systems and create new and collaborative ways forward.

Figure 8: Most Urgently Needed Systems-Based Solutions Selected by Service Providers Across Sessions



5.2. Systems Strengths

In what follows, we switch our focus from "systems gaps" to look at "systems strengths." These we present to encourage continued support and development of "things that are working well." This section is significantly shorter than the "gaps analysis," which is an anticipated outcome given the pressure our community is under to find new ways forward amid multiple crises. It often feels as if we are trying to mend the holes in our figurative boat instead of acknowledging the wind in the sails that moves us forward. We sometimes forget to recognize that some of our boat remains intact. We need to honour and investigate the parts of the support system that are functioning.

We wish to acknowledge the mapping work of the Comox Valley Community Action Team (CAT), which recently undertook a community conversation that looked at gaps and strengths in the community of services. In this entity's work, a long list of organizations and initiatives were identified as representing strengths within our network (see Appendix B). This list, as well as the list of service organizations identified in the Comox Valley Community Health Network's Substance Use Strategy's *Phase One Report*,[102] speak to a breadth and diversity of support services that are working together in the Comox Valley as part of the Substance Use Support Network.

Many research participants spoke to a potential for innovation through collaboration in our network despite the tensions identified in this report between some Service Provider groups. For some, innovation potential stems from a supportive political and community climate:

I do feel like we actually could have some shifts happen here. We do have some great people and all kinds of positions. And as I said, I think having the elected officials that are understanding this at a quite a solid level is huge as well. So, yeah, I actually have a fair amount of hope that things can improve here.

(Shari Dunnet—Comox Valley, CAT)

Many of the people and organizations in this network are working from a heart-based commitment and perspective, which is a strength:

At the community-based services level, just…there's so many amazing people. And we develop personal relationships. These are people with big hearts, you know.

(Meredith McEvoy—Program Manager, Adult Mental Health and Substance Use, Hornby & Denman Community Health Care Society)

I think in smaller communities…people get more creative to try and do as much as they can with…smaller resources…but in a way, it's a good thing.

(De-identified participant #10)

We are willing to…think outside the box. Yeah, just doing what needs to get done.

(De-identified participant #18)

One Service Provider spoke to the energetic advocacy and visioning power at-play within this community:

This community, at least I can say…has shown incredible capacity to come together to vision together. And to like, get loud and noisy and make things happen. You have some really, really, like strong spicy advocates out there who will like take on if they hear politicians are in town, like they show up and they make sure they're heard. And yeah, we put some really amazing champions in our community that know how to make things happen, and they're not the people you would think they are.

(Angie Prescott—John Howard)

These words convey an opening, unique to this moment, in which there exists a significant amount of both political and community will to find solutions and pathways forward. We understand the Comox Valley as well positioned within our region to make change.

Peer engagement in system

A number of examples were given of the empathy, compassion and solidarity through Peer engagement that are being fostered within our existing network:

Social detox and CVRC…yeah, like every guy that's in there, and maybe they're there for a week, three weeks a month, six months in or whatever, right? This mixture of guys. They're all so empathetic and compassionate to that person coming in. They'll say, "We felt just like you did, you know, a few months ago, it'll get better." And the person says "Yeah, you're right." They know. And they hang in there, because they're not alone.

(Danny O'leary—Island Health, OPS)

So we've got another team. It's called the IHOST, which is our outreach support team. And they're just so they're new team, but they're just employing four Peers. Yeah, huge because how are we supposed to fix the problem without you know, the insight of the people that are living it.

(De-identified participant #11)

Again, Peers [are working] on the front lines [through] Comox Valley Street Outreach, Community Cares [Peer Outreach]. Definitely the new IHOST team.

(Shari Dunnet—Comox Valley CAT)

Peer involvement in the Comox Valley care network has increased in recent years—a trend many Peers recognize as significant.

Indigenous-led Harm Reduction

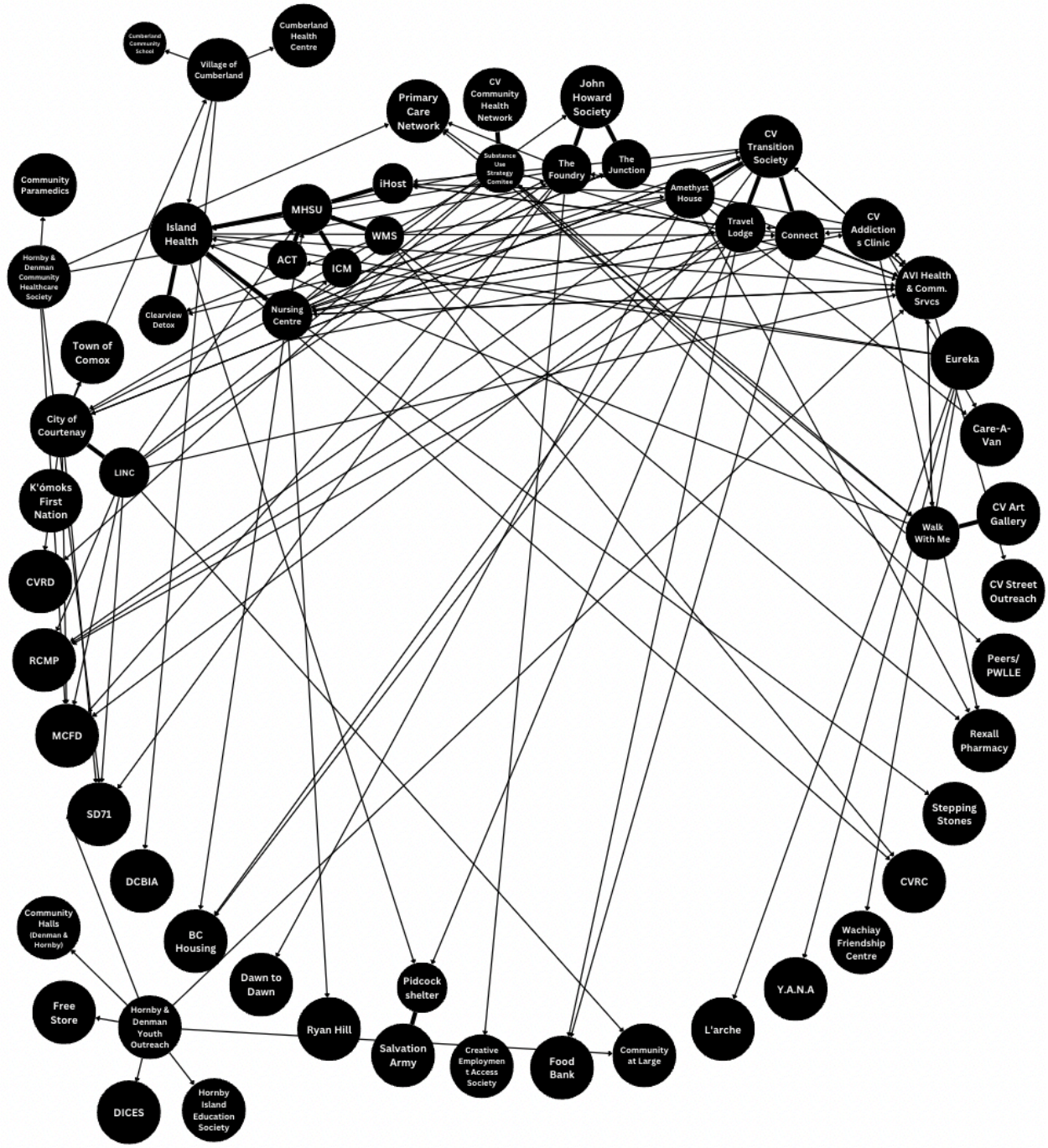
Several providers pointed to the significant number of Indigenous organizations and Elders involved in the Substance Use Support Network as a core strength:

> **Like IWSS, and their program Unbroken Chain, and Sassaman Society….Wachiay. Yeah, of course. So there's many more organizations that were mentioned, as well as Elders, I think Elders actually are a huge strength. We've had more Elders involved in our events we've put on and some very important learnings, and I just think Elders have a really great, great place for helping in this on a really deep level.**
>
> *(Shari Dunnet— Comox Valley CAT)*

Strength in Island Health/ Community Connections

Another set of strengths can be found in the "strong connections" identified by service providers as part of our cultural mapping process. As a sequel to the "connections that could be strengthened" (see Figure 7), we present Figure 9, which shows the connections Service Providers identified as strong (again, by identifying a particular organization, project or initiative with which an individual participant was affiliated, and up to five "connections considered strong" between this entity and other organizations/ projects or initiatives). Interesting to note, again, was the flurry of "strong connection" lines indicated between Island Health and community service agencies, including John Howard Society, CV Transition Society and AVI (as a similar level of activity between these exists in Figure 7, it appears that many of these connections are seen both as strong, and as needing to be strengthened). Also interesting are the organizations/ entities identified in this process for whom a high number of strong relationships was identified, including: AVI, Island Health, Nursing Centre, CVTS, MCFD and Primary Care Network. Within this group, in comparison to the most-identified group outlined in Figure 7, we see, perhaps, a more obvious connectivity between entities working in traditionally-acknowledged substance use fields. We see fewer "unconventional" connections identified (as in the highly tagged organizations/identified in Figure 7). This juxtaposition recognizes, perhaps, a need to both honour and build on existing Island Health/ Community partnerships (through organizations that have been working in substance use frameworks for many years), while at the same time leaving room for unconventional players to have agency. Sometimes, it seems, powerful change potentials can come from the periphery.

Figure 9: Strong Connections—Service Providers



Primary Care Network (4)
SUSC (2)
John Howard (1)
Foundry (3)
Junction (1)

CVTS (4)
Travel Lodge (2)
Amethyst House (1)
Connect (2)
L'Arche (1)
Y.A.N.A (1)
Care-A-Van (2)
Walk With Me (2)
CVSO (1)
Peers/PWLLE (1)
Community at Large (2)
Wachiay (1)
Creative Employment Access Society (1)
Food Bank (2)
Rexall (3)
Stepping Stones (1)

CVRC (2)
Pidcack Shelter (2)
Ryan Hill (1)
Dawn to Dawn (1)
BC Housing (3)
BIA (1)

SD71 (5)
MCFD (5)
RCMP (4)
CVRD (2)
Comox (1)
Courtenay (2)
CV Addictions Clinic (2)

AVI (7)

Island Health (4)
VIHA (2)
Clearview Detox (2)

Nursing Centre (4)
MHSU (3)
iHost (4)
ICM (1)
ACT (1)

The Foundry Centre as a Collaborative Model

Our team observed that the Foundry Centre represents an excellent model and collaborative success story for the Comox Valley. New to our community, beginning in 2022, the Foundry established a youth-based service centre offering "young people 12–24 access to mental health and substance use support, primary care, Peer support and social services."[103] Foundry spaces exist in a number of BC communities—the Comox Valley space, hosted by the John Howard Society of North Island, "unites multiple partner organizations to address the health and wellness needs of young people…" and serves as an innovative collaborative model.[104]

As a model, we were struck by the Foundry's capacity to bring together and leverage partnerships. The story of the Foundry's development is useful for envisioning the type of multi-agency, multi-sectoral collaboration that holds relevance for our community as we work to create new pathways forward towards collaborative models for adults, as well as youth, in the Comox Valley:

> **"[The Foundry] came out of a Comox Valley table, identifying that this community needed a…response to the mental health and substance use and general health needs of young people. And so John Howard North Island, which also operates Foundry in Campbell River, stepped forward to be the lead agency. We competed with 45 other communities around the province. And we're one of six communities selected…This community successfully opened a foundry back in June. So we're fairly new. Having said that, I mean, I think part of the reason our community was selected was because of some of the strong relationships that we have…I've spent the last 19 years working in Youth Justice, Youth Mental Health, Youth Substance Use. And so in order for us to make Foundry work…we have really strong partnership with the Ministry for Children and Family Development, both with our partners in Child Youth Mental Health, as well as our partners in guardianship and protection and adoption and your services. We have a really strong relationship with the School District. The School District has welcomed our programs into the schools in what I feel as a somewhat progressive way…The schools have also been extremely generous in finding space for us to be able to have some of our substance use counselors be on site, a regular morning, afternoon or full day, a week so that we can reduce barriers for people accessing services…The Primary Care Network and Division of Family Practice…we now have nine physicians…providing primary care at Foundry…[including] addictions medicine specialists…we have psychiatry…that super low barrier, high access supported wraparound programming is great."**
>
> *(Angie Prescott—John Howard)*

“We've started a relationship with Island Health and public health. So the sexual health clinic is running out of Foundry Tuesdays and Thursday afternoons, which has just been lovely to have them in there…because their public health nurses are also in our schools. It's a really awesome bridging…they're seeing young people in the schools; they can also speak to them about like, hey, "like have you been to Foundry and I'm there Tuesday, why don't you pop in and see me?"…And then Creative Employment Access Society actually have guest staff. They have staff who are youth employment specialists who are working full time at a foundry, helping offer our Foundry Works programs so that young people can come in and have access to support and implementation. So those are just some of the great relationships and partnerships, we're trying to put our…energy towards.”

(Angie Prescott—John Howard)

Apart from the Foundry, John Howard Society also operates a "second stage supported Recovery housing program for youth in the Comox Valley" called Level Up:

So we have a 10 bed facility. So five of the beds are funded through ministry of family development, those are for young people who are transitioning out of ministry care into youth agreements. The other five beds are funded by Island Health, and there are second stage supported Recovery…So we went to Island Health…And just kind of put it on their radar… kept saying: "Hey, I've got these five beds that could be used, like, here we go." And so then as soon as the money was available through the province, [Island Health] was able to say, "Okay, we know what we want it for in the Valley. We've got this opportunity to have these five beds."

(Angie Prescott—John Howard)

Several insights emerge by recognizing the gains that Foundry and Level Up have accomplished. First, we see the power of deep and long-standing inter-sectoral relationships—between community service entities (i.e. John Howard Society), government (i.e. Ministers), Island Health, school districts, physicians, mental health workers, employment agencies, and others in creating a model that works for youth in this community. This story details significant "social capital" and the "coming together" of diverse entities to accomplish a shared vision. We also see value in the way a hub provides many services to youth in a single place. As a model, the Foundry may not translate easily into the world of adult substance use services. John Howard staff working to develop the Foundry observe that developing collaborative services and transition environments for older youth (those closer to adulthood) is more difficult:

[We're] not finding that those relationships, those invitations, those opportunities are happening as seamlessly as they did with some of our youth serving partners.

(Angie Prescott—John Howard)

This comment may suggest increased levels of stigma at-play in adult service provision and populations than in youth. Further, the model described above has notable limits:

> **We are not intended to be providing services for moderate to severe presentation with mental health…So we're going to be resourcing, we're going to be supporting with basic in-the-moment needs…We don't have capacity to do that sort of treatment and intervention at that moderate to severe level—that that still belongs with our folks at the hospital… at the Wellness Center…at adult mental health.**
>
> *(Angie Prescott—John Howard)*

Recognizing these limits, we were inspired by many components of this model. We believe models of deep-rooted connection and relationship-building are key to building capacity and bringing multi-sectoral collaborative projects of this nature together.

Endogenous Wisdom

Our team observed substantial endogenous wisdom and innovative ideas that are held in our community of care. We already have a plethora of very experienced experts, ideas, models, and change-initiatives that, combined with creative dialogue and collaborative good will, could rapidly inform a stronger system of support. Our next key task, it seems, is to collectively activate these ideas and engage in processes of radical collaboration.

5.3. Summary

As a whole, the full picture of strengths and gaps documented here describe a significantly broken system—one that is perpetually failing Peers that seek help. Our Recovery systems lack sufficient medical detox and Supportive Housing. Our Harm Reduction systems lack appropriate and sufficient Managed Alcohol, Safer Supply, OPS, and OAT services. Stigma is prevalent within our system, and Cultural Safety supports need improvement. Evidence shows that our system is providing much less than the "bare minimum", and as a result, Peers are falling through the cracks.

This said, numerous strengths are evident within the Substance Use Support Network—endogenous assets that grow to usher in a new and stronger network. We recognize the links identified between this network and our forward-thinking local political landscape. The Comox Valley is developing strong Peer engagement practices, enhancing Indigenous representation within the network, and has demonstrable innovative collaborative change models and ideas. If we chose, we can leverage these assets to "move the dial forward" in filling gaps.

6 RECOMMENDATIONS/ WALKING TOGETHER

We've titled our recommendations section to echo our report's call to action: "Walking Together." If there were one recommendation we heard that encompasses and transcends all others, it would be this: the need to walk together. We must step out of our silos. We must mend our broken system. This work can and will only happen when we start working creatively, imaginatively, and compassionately, together.

In each of the following recommendations, we draw on our research findings to point to areas where coordinated efforts can help achieve tangible goals. A coordinating entity and role (or multiple coordinating entities/roles) are needed to do this work. Whether this role is accomplished by a consultant, research group, community circle / collaborative, or some combination thereof, those coordinating must favour collective action and have:

1. A deep commitment to working relationally across community and service lines;

2. A strong and deep knowledge of the local substance use continuum and support network;

3. The capacity to facilitate conversations that leads to direct and immanent change-modelling in a strategic and action-oriented way.

This role also requires a commitment to eliminating stigma and adhering to Cultural Safety principals. Peers must be included as leaders in this work (including as coordinating entities). It is important that this entity (or entities) continue with this work until the identified gaps have been filled.

The following questions are central to this work:

- How can we reduce gaps in services as a community?

- How can we reduce deaths and stigma and improve quality of life for People Who Use Substances?

- How can we bring our collective knowledge together to create systems innovations and change?

We also ask: **who is responsible to make this change?** At the local community level, evidence shows that the harms associated with substance use are worsening. This reality involves a complex set of variables which necessitate a multi-faceted response. Given this reality, any meaningful solution will require leaders, organizations, community groups, and individuals to work together towards common ends.

Change agents include: leaders of local community service organizations, managers and front-line workers at Island Health; Peer groups working in the Comox Valley area; Indigenous leaders; politicians and staff from Courtenay, Comox, Cumberland, Comox Valley Regional District and K'ómoks

First Nation; community downstream and upstream Service Providers (i.e. housing, mental health supports, education); local RCMP; and Peers—including their family members and allies. We believe that many more actors exist who will self-identify as having change agency after reading this report.

In the following section, we outline the primary recommendations stemming from our research. While we identify actors who are responsible for making change, we also acknowledge the limits of our understanding related to the jurisdiction and potential involvement of local, provincial, and federal systems and agencies. We ask those with power within these systems to engage as creative, willing, and collaborative partners—imagining ways in which their agency can be applied towards the development of solutions.

1 Create and Implement Medical Detox Service in the Comox Valley

Key to this table: Island Health, Comox Valley Transition Society, Comox Valley Recovery Centre, Community Recovery and Harm Reduction Service Providers, Addictions Medicine Physicians, Medical Health Officer, Local Government, Peers, Indigenous Voices.

Acknowledging: The damage enacted by the lack of an established local medical detox service, including the damage suffered by Peers in transitioning to and from an out-of-town service, and the harms produced through the extensive wait-times in place for Peers to access this service, we recommend a coordinating entity to bring together key players to chart a direction forward. Key questions include:

How many medical detox beds are needed?

How will these be funded?

How can immediate, low barrier, on-demand medical detox be made available to people seeking this service (including options for people who smoke)?

How can the barrier of long referral wait-times be reduced?

How can the gap in transition from medical detox to social detox be closed?

Is there potential to implement a stronger medical detox program at the Comox Valley Hospital?

How can a wider "hub" of community services integrate medical detox options?

Stakeholders should aim to produce concrete results (i.e: detox beds with low-barrier entry) within as short a time frame as possible.

2 Create and Implement a Recovery-Based Supportive Housing Service

Key to this table: Island Health, Comox Valley Transition Society, Comox Valley Recovery Centre, Community Recovery and Harm Reduction Service Providers, Dawn to Dawn Action on Homelessness Society, Addictions Medicine Physicians, Medical Health Officer, Local Government, Peers, Indigenous Voices, Funders (i.e. BC Housing and others).

Acknowledging: The lack of Supportive Housing in the Comox Valley, and the damage suffered by Peers who are cycling through patterns of medical and social detox without a sufficient transitional housing option to stabilize their progress, we recommend a coordinating entity bring together key players to chart a direction forward. Key questions include:

How many Supportive Housing units are needed (now and in projecting into the future)?

How will these units be funded?

How long should Supportive Housing be provided to those needing it?

Should Recovery-based Supportive Housing be developed as a stand-alone entity with links to medical and social detox programs?

Should Supportive Housing include social detox programs? And/or, should Supportive Housing be developed as part of a multi-staged subsidized treatment program or centre (i.e. a program that includes medical/social detox and Supportive Housing as 3-stage components of a live-in residential program)?

How will people be transitioned into and out of Supportive Housing towards long-term housing?

What services and support infrastructures should be integrated into a Supportive Housing initiative?

What models should be used for Supportive Housing (i.e. Group-Based? Family-Centred? Farm-Based? Culturally Driven? Tiny Home Village?)

How might Supportive Housing options integrate within a wider "hub" of community services?

Stakeholders should aim to produce Supportive Housing units that address the service needs of people in Recovery.

3 Expand Managed Alcohol Program Services

Key to this table: Island Health, Comox Valley Hospital, AVI Health and Community Services, Community Harm Reduction Service Providers, Addictions Medicine Physicians, Medical Health Officer, Local Government, Peers, Indigenous Voices, Funders.

Acknowledging: The important role Managed Alcohol Programs play both in enabling inpatient care, and in helping to stabilize alcohol use in community, we recommend a coordinating entity to bring together key players to chart a direction forward. Key questions include:

How can patients help inform their dosing norms?

How can Managed Alcohol Programs be developed in accordance with a Patient-led approach?

How can Managed Alcohol Programs be developed in-hospital and in-community?

How can acute care, long-term care, Supportive Housing, outpatient, community, NGOs, and others collaborate to develop a Managed Alcohol Program that serves the entire Comox Valley?

What services and support infrastructures should be integrated into a Managed Alcohol Program initiative?

How can this model be funded?

Stakeholders should aim to produce tangible results (i.e. an expanded Managed Alcohol Program) in short order.

4 Expand Safer Supply Services

Key to this table: AVI Health and Community Services, Island Health, Community Harm Reduction Service Providers, Addictions Medicine Physicians, Local Government, Medical Health Officer, Peers, Indigenous Voices, Funders.

Acknowledging: The important role Safer Supply programs play in reducing reliance on toxic drugs, and in helping to stabilize use, we recommend a coordinating entity to bring together key players to chart a direction forward. Key questions include:

How can our community support the Safer Supply work that AVI Health and Community Services is providing in the Comox Valley?

How can this program, under AVI's direction, be expanded to meet community need?

What services and support infrastructures should be integrated into an expanded Safer Supply program?

How can this expansion be funded?

This work should aim to produce tangible results (i.e. an expanded Safer Supply program) that honours and builds on the pioneering work being done by AVI Health and Community Services.

5 Relocate and Expand Overdose Prevention Site (OPS) and Services

Key to this table: Island Health, AVI Health and Community Services, Local Government, Community Harm Reduction Service Providers, Medical Health Officer, Peers, Indigenous Voices, Funders.

Acknowledging: The important role OPS Services play in reducing reliance on toxic drugs, and helping to stabilize use, we recommend a coordinating entity to bring together key players to chart a direction forward. Key questions include:

Where should OPS services be located? (i.e. closer to services like Connect and Travelodge? In community? At the Comox Valley Hospital?)

How might the hours of OPS be expanded?

How might inhalation services be included?

What additional services and support infrastructures should be integrated into an OPS program?

How might this expansion be funded?

This work should aim to produce tangible results (i.e. an expanded/ relocated OPS Service).

6 Pursue Improvements in Opioid Agonist Therapy (OAT) Delivery

Key to this table: Comox Valley Transition Society / Travelodge, College of Pharmacists of BC, Local OAT providing pharmacists, Community Harm Reduction Service Providers, Medical Health Officer, Peers, Indigenous Voices, Funders.

Acknowledging: The important role OAT programs play in stabilizing substance use, and the need to ensure availability of OAT services and support staff who can witness OAT consumption, we recommend a coordinating entity to bring together key players to chart a direction forward. Key questions include:

How can barriers to OAT witnessing be reduced?

How can the responsibility for OAT supervision be addressed in such a way as to honour and utilize the strong links at-play between Community Service Providers and Peers while still maintaining safety in providing OAT supervision responsibly?

How might we attract more OAT providers to the Comox Valley?

Should the College of Pharmacists of BC be approached for changes to OAT witnessing protocols?

This work should aim to produce changes, leading to more comprehensive and accessible OAT delivery practices in the Valley.

7 Pursue a Series of Network Improvements

Key to this table: Entire Service Network, Peers, Indigenous Voices.

Acknowledging: A series of improvements has been identified as necessary to make our care network run more effectively, we recommend that a coordinating entity bring together network stakeholders throughout the system to chart a direction forward. Key questions include:

How can agencies work together efficiently and collaboratively leading to better coordination of services?

How can an inter-agency communication and client data-sharing system be developed in such a way as to give Peers power over their information? Who will be responsible for the consent process, and how will it work? Is such a system worth recommending? (i.e. do the benefits to Peers of having a system that shares their data with multiple providers thereby allowing for a streamlining of services outweigh the potential risks associated with a loss of privacy in relation to personal data)?

How can Island Health and community providers work together respectfully, and with clarity around roles and responsibilities?

How can Peers become involved on front-line navigation and leadership levels in shaping the development of the Network?

This work should aim to produce tangible changes in the communication channels, effectiveness and efficiency of our system, and should work to address the power imbalances expressed between Island Health and community Service Providers—creating a stronger network of collaboration.

8 Create a Services Hub

Key to this table: Entire Service Network, Peers, Indigenous Voices, Funders, Local Government.

Acknowledging: The value of a single point of access centre that provides primary care, addictions medicine care, mental health care, access to a wide range of community services including medical and social detox, Peer Navigators, employment opportunities, and others, we recommend a coordinating entity to bring together network stakeholders throughout the system to chart a direction forward. Key questions include:

How can such a centre be designed, developed and built?

How can a strategically beneficial group of services be brought together in the centre?

What partnerships are needed to make such a centre happen?

What funding sources can be utilized to make such a centre happen?

This work should aim to produce a brick and mortar services centre designed to provide an amalgamation of services in one place, and access to navigators who can link clients to a wide range of services both inside and outside of the building.

9 Pursue Service and Transportation Improvements for Remote Places, and Places Without Strong Transit Systems (Hornby and Denman Islands, Cumberland, and Others)

Key to this table: Hornby and Denman Community Health Care Society, City of Cumberland, BC Transit/Comox Valley, Wheels for Wellness, Island Health, Medical Health Officer, Peers, Indigenous Voices, Funders.

Acknowledging: The difficulties involved in the transportation of Peers from the more remote regions of the Comox Valley to in-town services, we recommend that a coordinating entity bring together key players to chart a direction forward. A key question is as follows:

What do improvements in both service delivery and transportation look like for Peers in these regions?

This work should aim to produce results that include stronger Harm Reduction and Recovery program delivery in remote places within the Comox Valley, and stronger transportation systems that support the linkages between Peers and in town services.

10 Address the Need for Culturally Safe Services

Key to this table: Elders/Knowledge Keepers, Indigenous Organizations, Indigenous Peers and Leaders, Service Providers, K'ómoks First Nation, Island Health.

Acknowledging: The need expressed for culturally safe services, we recommend a coordinating entity bring together key players to chart a direction forward. Key questions include:

How can Cultural Safety principles be brought into existing services?

What new services are needed that honour the teachings of Cultural Leaders and show respect for Indigenous ways of knowing and healing?

This work should be guided by local Elders/Knowledge Keepers and should honour territory and teachings.

11 Work to Reduce/Eliminate Stigma in the System

Key to this table: Entire Service Provider Network, Peers, Local Government.

Acknowledging: The expressed need to develop services that are safe for Peers, and that are premised upon an atmosphere of respect, we recommend a coordinating entity to bring together key players to chart a direction forward. Key questions include:

How can anti-stigma training be included in the work of our Service Provider Network and its constituent organizations?

What education, information and/or staff development programs are needed within the Service Provider Network to reduce/eliminate stigma?

How can Service Providers work together across the network to advance this work?

This work should be guided by local Peer leaders.

Summary:

These recommendations provide pathways forward, and together create a framework for further dialogue leading to action. The dialogues called for in this slate are urgent and necessary to advance the effectiveness of our Substance Use Support Network. By working through these conversations, and by pursuing the necessary collaborations, relationships, funding, and actions to make the recommendations a reality, we believe a significant systems shift can happen.

7 CONCLUSION

We live in a time of crisis, wherein multiple and compounding forces are contributing to the fragmentation of our communities. In the midst of these crises, substance use-related harms are growing. Work is urgently needed to shore up our Substance Use Support Network—to strengthen our continuum of care and by extension, our community's capacity for wellness.

There are many reasons why we must take action now. From a human rights standpoint, the act of strengthening our Substance Use Support Network is important to our shared humanity and in our ability to function as a community. This act is also important from an efficiency standpoint, as countless dollars are expended within a system that is not functioning well. By spending money to create strong health and wellness outcomes, we can repair the leaks in our boat, and can begin to chart our way forward.

The time to act is now. Our existing Substance Use Support Network, broken as it is, has strong political allies, strong Peer engagement, and a pool of creative thinkers with a wealth of experience that could be innovatively applied. In moving forward, we need to work together, dream big, and make transformative change happen. We must stop working in silos and begin to think of each of our organizations as parts of a whole. Walking together we are stronger.

APPENDIXES

Appendix A: Survey

Objectives

To enhance our comprehension of substance use in the Comox Valley, we offered an anonymous survey for data collection in addition to other methods. We recognize the sensitivity and need for confidentiality that surrounds this largely stigmatized dimension of life for PWLLE of substance use, and through our survey, we invited participants to anonymously respond to a questionnaire using an online platform. The data presented within this section represents the experiences of 51 people actively using substances in the Comox Valley who responded to a range of questions focusing on types of substances used and access to addictions and social services within the Comox Valley in terms of specific services accessed, frequency of access, and quality of services received.

Findings

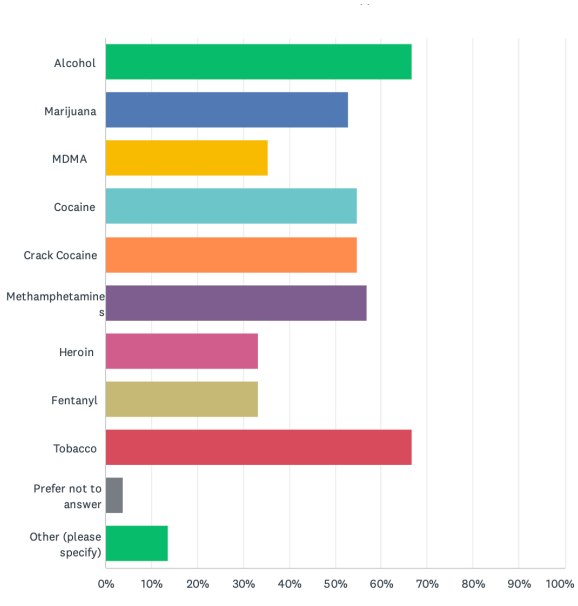
Respondent Demographics

The majority of respondents fell between the ages of 30–60 representing 74.5% of those who answered. Approximately 11% of the respondents were youth under the age of 30, and approximately 4% were over 60 years of age. There was a near equal division between those who identified as male and those who identified as female. Of the 51 respondents more than half (56.87%) described themselves as unhoused or precariously housed at the time of completing the survey. Approximately 50% of those who responded identified as being BIPOC (Black, Indigenous, People of Colour), with 27.45% of that self-identifying as Indigenous, 9.8% identifying as Black, and 11.76% identifying as a Person of Colour.

Substance Usage Responses

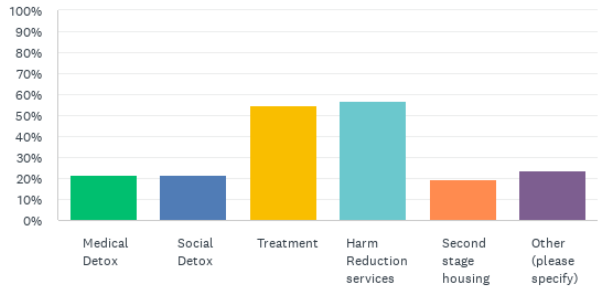
In terms of the specific substances used as reported by survey respondents as being used in the past two years, there were 9 substances primarily identified.

Chart 1. Substance Use Over Past Two Years



As the chart indicates, the substances with the highest reported use are alcohol and tobacco which are both government regulated. This reporting is supported by available data on hospitalization rates and deaths in Comox Valley. The first and highest reported illicit substances being used are methamphetamines, at nearly 57% of all respondents reporting use. Our findings also support the claim that our sample uses many different substances in a simultaneous or overlapping manner. Both cocaine and crack cocaine showed frequent use with approximately 55% people reporting. Heroin, Fentanyl and MDMA have slightly lower percentages of reported use, each at approximately 35% of respondents reporting use. It is notable that aggregate Province wide data from the BC Coroner's Service suggests that fentanyl deaths are far outpacing other substances—even if reported use fentanyl may be lower than the use of other drugs in our survey results.

Chart 2. Substance Use Services Accessed in the last two years



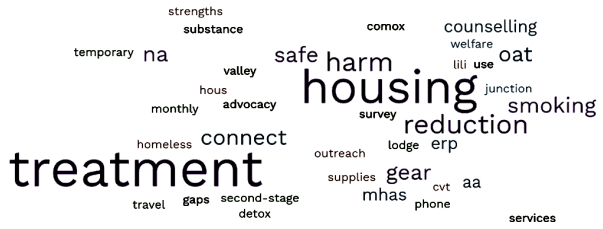
More than half of the respondents have attempted to access treatment and Harm Reduction services over the past two years. When asked to consider one service at a time, the majority of respondents (81.63%) indicated that they were able to access the service on their first attempt to do so. Of the approximately 16.33% of respondents who indicated that they were unable to access the service they attempted, there were varied reasons for why this was the case. One respondent noted "no room for me," where others mentioned housing precarity or a lack of desire to quit using substances.

In terms of specific services accessed in the Comox Valley in the past two years, respondents reported a wide range of services. Question 13 asked the question "What service provider have you approached for help?" and invited respondents to focus on one service provider at a time. In terms of frequency of services approached, Comox Valley Transition Society (CVTS), AVI Health and Community Services, Mental Health and Addiction Services (MHAS), Comox Valley Addiction Centre (CVAC), Comox Valley Recovery Centre, and Narcotics/Alcoholics Anonymous (NA/AA) were among the top reported services approached with more than 5 respondents naming one of these service providers. The CVTS, has several services housed under its umbrella which explains why it received the highest reported frequency of approaches at 19 respondents in total. As a model for frequency of access and use, we note that the CVTS operates like a hub—with the kind of centralized substance use service provision we suggest the Comox Valley should pursue whenever possible. Following closely behind CVTS with 12 respondents having reporting are MHAS and NA/AA, with 7 respondents and AVI with 6 respondents reporting.

Chart 3. Word Cloud of Service Organizations Approached in the Comox Valley Over the Past Two Years

In Question 14, we asked respondents to answer, "Which service did you try to access?" As illustrated in the word cloud above the most repeated answers include treatment, housing and Harm Reduction as the primary services that were accessed through the above-mentioned service providers. There is strong correlation between these findings from our survey participants, people who are using substances in the Comox Valley, and the top priorities for action that our service providers identified in our focus groups with them. Many services fall under the category of treatment and are offered by multiple service providers in the Valley. CVTS houses many programs under its service provision umbrella which includes Amethyst House, a withdrawal and recovery house that was reported as being accessed by 6 respondents in total. Additionally, the CVRC was reported as being accessed by 11 respondents over the past two years. In terms of housing, CVTS provides services through the Connect Warming Centre, reported by 11 respondents, and Lilli House, a women's transitional house reported by 1 respondent. In terms of Harm Reduction services, AVI was reported by 7 respondents and Unbroken Chain was mentioned by 5 respondents.

Chart 4. Word Cloud of Specific Services Accessed Through Substance use Service Providers



Respondent Evaluations of Services Accessed

In terms of overall ratings of helpfulness of each service identified within the survey, 41.67% of respondents felt that they found their services super helpful, 33.33% said the services were very helpful, 16.67% said the services were somewhat helpful, and approximately 13% said that the services were not helpful. Of those who stated that the services were not helpful, we invited an explanation. One participant offered:

> **It would have been, but there was an issue where the first counselling I was I assigned to, we connected well and I felt comfortable so when she said I could call in again and request her I trusted that. The office then sabotaged that from happening and I withdrew service requests.**

Another spoke of being disqualified from accessing group therapies because they received individual counselling services through First Nations Health Authority:

> **I was unable to use their services which would have been beneficial to me and my recovery. I could not join because I had counseling through FNHA so I did not need an individual counselor through mental health which excluded me from these group therapies.**

Furthermore, the durational range of time between expressed need for the service and actual delivery of service was between: immediate service access, to weeks, months, over a year, and finally to never gaining access after trying. Of the 48 respondents, 21 said that they received access to services almost immediately or within week. 15 said within weeks to under 3 months. 5 said between 3 months and 1 year. 3 reported over a 1 year, and 3 reported that they still had not received access since expressing a need for services.

Strengths of Services Provided

When asked in Question 19 about what parts of the service worked, respondents shared a range of responses, with many stating that the services were optimal in their totality. While others spoke about more specific aspects of the services—mentioning the general ability to connect and gain support from staff through counselling and group therapy—others spoke about receiving housing as a result of the services accessed as being the best part of the service, unsurprisingly. Those satisfied cited safe supplies, knowledgeable staff, and overall improvement of health, such as described by one respondent, **"My health has improved—stability—nutrition. I can start my life."**

Weaknesses of Services Provided

In Question 20, we asked the respondents to tell us about the parts of the services that were not working for them. Of the 49 respondents to answer this question, almost half stated that there was nothing to report and that the services worked as well and as they expected. Of those who did respond that parts of the service that did not work, some common themes included: time/hours and availability of services and program rules as in the example provided by one respondent:

> **We are not allowed guests at night. We have to apply to have guests pre-approved each time. No guests after 7pm–8am Staff only check on people if requested.**

Recommendations for Changes to Services

In Question 21, we asked respondents to expand upon the weaknesses in service delivery they identified to make suggestions about what they would change about how the services they accessed could work. It was our hope to gain some understanding about the potential gaps that exist within the substance use service provision in the Comox Valley. Of the 48 people who answered, 18 responded with no recommended changes needed. However, there were several notable suggestions. Approximately 10 respondents requested an increase the hours and availability for services offered. Other recommendations included increasing staffing and funding for services, improvements to client care and relationship building with staff, housing access and services pertaining to securing safe and affordable housing, and coordination between service providers to create better wraparound services and connections, as identified by this responded who said:

> **It would help if the nursing centre worked or coordinated to other agencies in order to find support for the prescriptions they provide.**

In Question 22 we asked if service users felt sufficiently connected to the next relevant service following their experience, to which the majority of respondents indicated that they did, indeed, feel their needs were met. However, several respondents also indicated that the services were not adequately connected. One person mentioned not having appointments scheduled close enough together and another indicated a lack of support to connect with adequate financial assistance. Furthermore, one respondent said they had to do their own research to connect with other services as they were not supported to do this.

Limitations

It is important to consider the limitations of this survey questionnaire as a data collection method and to view its findings within the context of all the research methods we

have used to make recommendations in this report. As respondents were invited to participate and offered an honoraria, it is possible that some responded with the simplest possible answers, and their evaluations of the services described in our survey should be understood in this light. Respondents were invited to reflect on each service individually and only 5 of 48 respondents took the opportunity to reflect upon more than one substance use service. It is difficult to capture the full context of each respondents' answer through this questionnaire, and this is why we conducted in-person cultural mapping groups with People Who Use Drugs in the Comox Valley to understand the larger picture of the substance use services gaps and strengths.

Conclusions

This questionnaire offers a glimpse into the ongoing substance use strategies within the Comox Valley, and in examining this data set in exclusion from our other methods, we were left with questions that are considered in the body of the report:

1. What barriers do service providers face if and when they attempt to work and collaborate together to provide a more seamless experience for substance use services users?

2. Why is it so difficult to access housing for PWLLE in the Comox Valley?

3. How can we improve program hours and availability for substance use services in the Comox Valley?

APPENDIX B

This Asset Map was produced by the Comox Valley Community Action Team (CAT) in November 2021. The CAT brings together a diverse range of community stakeholders as a team focused on developing and implementing local action-oriented strategies to respond to the needs of those most at risk, prevent further toxic drug poisoning deaths, reduce stigma, and better coordinate access to supports, treatment, Harm Reduction and recovery services for people in our community who use substances and their families. Through the course of three CAT meetings, 40 individuals involved in the CAT (including Peers, Service providers, Indigenous organizations, local Health Authorities, local elected officials, family members and others), participated in small group conversations to identify the strengths and weakness in our local community support systems. This list shares the strengths identified in these conversations. It has been amended to exclude personal names.

Note: Several of the items identified as strengths were also identified as weaknesses and vice versa.

November 2021
Comox Valley Community Action Team (CAT)
Strong Local Organizations and Initiatives Asset List

Public and Government Institutions

- Government
    - Supportive Elected Government Representatives—Local, Provincial, and Federal
    - Mayor and Council, CVRD, MLA, MP
    - K'ómoks First Nation

- Island Health
    - Mental Health and Substance Use (MHSU)
    - Public Health
    - Nursing Centre
    - Hospital, Addictions Medicine Department
    - Intensive Case Management Team (ICM)
    - Assertive Community Treatment Team (ACT)
    - Overdose Prevention Site (currently located at Island Health, previously at AVI Health & Community Services)

- Resources/Initiatives
    - Ambulance
    - Drug Alerts (multiple agencies: Island Health/AVI)
    - Naloxone Kits (MHSU and other local distributors)
    - Income Assistance Outreach
    - Physicians who participate in Outreach (Travelodge and Connect)
    - Mail-in drug testing
    - Nasal Naloxone access (free for Indigenous, First Nations)
    - Take-home testing strips (through Island Health, FNHA and peer project/outreach)
    - Local advocates for decriminalization

- Shared Services
    - Withdrawal Management
    - Primary Care Network
    - Peer Experts (within agencies, within CAT, and on frontlines)

- Education
    - North Island College
    - Nursing Programs
    - Overdose Response Training
    - Comox Valley Lifelong Learning Centre (computer access, literacy support)
    - School District Nurses

Community Organizations and Initiatives

- Community Action Team (CAT)
- Comox Valley Street Outreach (with support from the CAT and AVI)
- Substance Use Strategy Committee
- Walk With Me
- Connect Warming Centre
- AVI Health and Community Services
    - AVI Outreach Team (*note: federal funding contract ended March 2022, this team not currently funded)
- Moms Stop the Harm
- Comox Valley Transition Society
- Comox Valley Additions Clinic
- Comox Valley Family Services Association
- Homelessness Response Team meetings and Frontline Check-ins
- John Howard
    - The Junction
    - The Foundry (at time of asset mapping, The Foundry was soon to open)
- Care-a-Van
- Hornby & Denman Community Health Care Society
- Comox Valley Helping Hands
- Food Bank
- Sunday Station
- Soup Kitchen/St. George's
- St John the Divine
- Travelodge Team

Indigenous/First Nations Institutions and Supports

- Kómoks First Nation (KFN)
- Unbroken Chain, Youth Outreach
- Wachiay Friendship Centre
- Kwakiutl District Council (KDC Health)
- Indigenous Women's Sharing Society (IWSS)
- Upper Island Women of Native Ancestry (UIWONA)

- Sassaman Society
- First Nations Health Authority (FNHA)
- Indigenous Wellness Advocates (PCN)
- KUU-US Crisis Line Society
- MIKI'SWI Métis Association
- Cultural Ceremonies, Knowledge, Teaching, Elders
- Cultural Safety

Communication Technologies

- Brave & Lifeguard apps
- 1-888# (virtual safe consumption) 24/7 LOVE
- Testing strips (*only semi-reliable)
- Zoom meetings/networking
- Social media campaigns (CV Street Outreach, Unbroken Chain, etc.)

Businesses

- Comox Valley Dodge Dealership

REFERENCES

1. Sharon Karsten, "'Walk With Me' Uncovering the Human Dimensions of the Drug Poisoning Crisis in Small B.C. Communities. Policy Report – Comox Valley.," 2021, https://www.walkwithme.ca/publications.
2. Comox Valley Substance and Use Strategy Commitee, "Community Substance Use Strategy: Phase One Report," 2021, https://www.courtenay.ca/assets/Community/Community~Drug~Use~Strategy/CV_%20Community%20Substance%20Use%20Strategy%20Phase%201%20Report.pdf.
3. HealthLinkBC, "Mental Health & Substance Use," accessed February 7, 2023, https://www.healthlinkbc.ca/mental-health-substance-use/substance-use.
4. Trudy Norman and Dan Reist, "Understanding Substance Use: A Health Promotive Perspective" (Canadian Institute for Substance Use Research, 2022), https://www.heretohelp.bc.ca/infosheet/understanding-substance-use-a-health-promotion-perspective#people.
5. Norman and Reist.
6. Government of Canada, "Substance Use Spectrum" (Government of Canada), accessed February 14, 2023, https://www.canada.ca/content/dam/hc-sc/documents/services/publications/substance-use-spectrum-infographic/pub-eng.pdf.
7. Health Canada, "Substance Use Spectrum" (Health Canada, 2022), https://www.canada.ca/en/health-canada/services/publications/healthy-living/substance-use-spectrum-infographic.html.
8. Canadian Mental Health Association, "Substance Use and Addiction" (Canadian Mental Health Association, Ontario, 2023), https://ontario.cmha.ca/addiction-and-substance-use-and-addiction/.
9. Jeremy Mennis, Gerald J. Stahler, and Michael J. Mason, "Risky Substance Use Environments and Addiction: A New Frontier for Environmental Justice Research," International Journal of Environmental Research and Public Health 13, no. 6 (2016): 607, https://doi.org/10.3390/ijerph13060607.
10. Hortensia Amaro et al., "Social Vulnerabilities for Substance Use: Stressors, Socially Toxic Environments, and Discrimination and Racism," Neuropharmacology 188, no. Journal Article (2021): 108518–108518, https://doi.org/10.1016/j.neuropharm.2021.108518.
11. Mhd. Wasem Mhd. Wasem Alsabbagh et al., "Original Quantitative Research - Stepping up to the Canadian Opioid Crisis: A Longitudinal Analysis of the Correlation between Socioeconomic Status and Population Rates of Opioid-Related Mortality, Hospitalization and Emergency Department Visits (2000–2017)," Health Promotion and Chronic Disease Prevention in Canada 42, no. 6 (2022): 229–37, https://doi.org/10.24095/hpcdp.42.6.01.
12. Megan E. Patrick et al., "Socioeconomic Status and Substance Use Among Young Adults: A Comparison Across Constructs and Drugs," Journal of Studies on Alcohol and Drugs 73, no. 5 (September 2012): 772–82, https://doi.org/10.15288/jsad.2012.73.772.
13. Canadian Centre on Substance Abuse, "Systems Approach Workbook: Socioeconomic Determinants of Health," Systems Approach Workbook: Socioeconomic Determinants of Health (Ottawa, ON: Canadian Centre on Substance Abuse, April 2014), https://www.ccsa.ca/sites/default/files/2019-04/CCSA-Systems-Approach-Socioeconomic-Determinants-2014-en.pdf.
14. Vancouver Island Construction Association, "BUILDING HOPE: MEN IN THE TRADES AND SUBSTANCE USE," 2022, https://www.vicabc.ca/news/building-hope-men-in-the-trades-and-substance-use/.
15. British Columbia Centre on Substance Use, "Provincial Guideline for the Clinical Management of High-Risk Drinking and Alcohol Use Disorder" (British Columbia Centre on Substance Use, 2019), https://www.bccsu.ca/wp-content/uploads/2021/01/AUD-Guideline.pdf.
16. First Nations Health Authority Public Health Response, "Toxic Drug Crisis Events and Deaths and FNHA's Response: COMMUNITY SITUATION REPORT: March 2022," 2022, https://www.fnha.ca/Documents/FNHA-Toxic-Drug-Poisonings-Community-Situation-Report-March-2022.pdf.
17. National Harm Reduction Coalition, "Principles of Harm Reduction," accessed February 7, 2023, https://harmreduction.org/about-us/principles-of-harm-reduction/.
18. Natalie Baker, "Abstinence vs. Harm Reduction in Addiction Recovery" (American Addiction Centers, 2022), https://recovery.org/abstinence-vs-harm-reduction-in-addiction-recovery/.

19. Mary Bartram, "'It's Really About Wellbeing': A Canadian Investigation of Harm Reduction as a Bridge Between Mental Health and Addiction Recovery," International Journal of Mental Health and Addiction 19, no. 5 (October 2021): 1497–1510, https://doi.org/10.1007/s11469-020-00239-7.
20. Matthew Bellamy, "Beer Wars" (Canada's History, 2016), https://www.canadashistory.ca/explore/arts-culture-society/beer-wars.
21. Bellamy.
22. Government of Canada, "Taking Stock of Progress: Cannabis Legalization and Regulation in Canada," 2022, https://www.canada.ca/en/health-canada/programs/engaging-cannabis-legalization-regulation-canada-taking-stock-progress/document.html.
23. Diane Riley, "Drugs and Drug Policy in Canada: A Brief Review & Commentary" (Canadian Foundation for Drug Policy & International Harm Reduction Association), accessed February 7, 2023, https://sencanada.ca/en/content/sen/committee/362/ille/rep/rep-nov98-e.
24. Liora Salter and Melvyn Green, "Royal Commission on the Non-Medical Use of Drugs," The Canadian Encyclopedia, 2006, https://www.thecanadianencyclopedia.ca/en/article/royal-commission-on-the-non-medical-use-of-drugs.
25. Riley, "Drugs and Drug Policy in Canada: A Brief Review & Commentary."
26. Government of Canada, "The New Canadian Drugs and Substances Strategy: Backgrounder," 2016, https://www.canada.ca/en/health-canada/news/2016/12/new-canadian-drugs-substances-strategy.html.
27. Todd Gordon, "Neoliberalism, Racism, and the War on Drugs in Canada," Social Justice (San Francisco, Calif.) 33, no. 1 (103) (2006): 59–78, https://go.exlibris.link/4KZbKW6r.
28. Toronto Public Health, "QUICK FACTS: MYTHS ABOUT SUBSTANCE USE" (Toronto Public Health, 2018), https://www.toronto.ca/wp-content/uploads/2018/05/9114-Myths-About-Substance-Use.pdf.
29. Province of British Columbia, "Decriminalizing People Who Use Drugs in B.C.," 2023, https://www2.gov.bc.ca/gov/content/overdose/decriminalization.
30. Province of British Columbia, "B.C. Introduces New Prescribed Safer Supply Policy, a Canadian First" (Province of British Columbia, Mental Health and Addictions, 2021), https://news.gov.bc.ca/releases/2021MMHA0035-001375.
31. Minnesota Department of Health, "Social Determinants of Substance Use & Overdose Prevention" (Minnesota Department of Health, 2022), https://www.health.state.mn.us/communities/opioids/prevention/socialdeterminants.html.
32. Canadian Mental Health Association, "Harm Reduction," 2022, https://ontario.cmha.ca/harm-reduction/.
33. Canadian Drug Policy Coalition, "Evidence Around Harm Reduction and Health-Based Drug Policies," 2022, https://www.drugpolicy.ca/resources/evidence/.
34. Canadian Drug Policy Coalition, "Evidence Around Harm Reduction and Health-Based Drug Policies," 2022, https://www.drugpolicy.ca/resources/evidence/.
35. Métis Nation British Columbia, "In Plain Sight: Addressing Indigenous-Specific Racism and Discrimination in B.C. Health Care," 2020, https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Summary-Report.pdf.
36. Sharon Karsten, "'Walk With Me' Uncovering the Human Dimensions of the Drug Poisoning Crisis in Small B.C. Communities. Policy Report – Comox Valley," 2021, https://www.walkwithme.ca/publications.
37. Chris O'Leary et al., "PROTOCOL: The Effectiveness of Abstinence-based and Harm Reduction-based Interventions in Reducing Problematic Substance Use in Adults Who Are Experiencing Severe and Multiple Disadvantage Homelessness: A Systematic Review and Meta-analysis," Campbell Systematic Reviews 18, no. 3 (September 2022), https://doi.org/10.1002/cl2.1246.
38. Recovery Research Institute, "What Is Recovery?" (Recovery Research Institute), accessed February 19, 2023, https://www.recoveryanswers.org/recovery-101/.
39. Alberta Health Services Harm Reduction Services Team, "Harm Reduction: Recovery-Oriented Care" (Alberta Health Services, 2019), https://www.albertahealthservices.ca/assets/info/hrs/if-hrs-recovery-oriented-care.pdf.
40. Chris McBain, "Stop Polarizing the Debate. It Took Both Harm Reduction and Drug Treatment to Save Me.," CBC News, 2023, https://www.cbc.ca/news/canada/calgary/the-way-out-polarized-debate-makes-no-sense-opinion-1.6746857.
41. Benjamin F. Henwood, Deborah K. Padgett, and Emmy Tiderington, "Provider Views of Harm Reduction Versus Abstinence Policies Within Homeless Services for Dually Diagnosed Adults," The Journal of Behavioral Health Services & Research 41, no. 1 (January 2014): 80–89, https://doi.org/10.1007/s11414-013-9318-2.
42. Canadian Drug Policy Coalition, "Evidence Around Harm Reduction and Public Health-Based Drug Policies" (Simon Fraser University, 2023), https://drugpolicy.ca/resources/evidence/.
43. Stephanie Knaak, Ed Mantler, and Andrew Szeto, "Mental Illness-Related Stigma in Healthcare: Barriers to Access and Care and Evidence-Based Solutions," Healthcare Management Forum 30, no. 2 (March 2017): 111–16, https://doi.org/10.1177/0840470416679413.
44. Stephanie Knaak, Ed Mantler, and Andrew Szeto, "Mental Illness-Related Stigma in Healthcare: Barriers to Access and Care and Evidence-Based Solutions," Healthcare Management Forum 30, no. 2 (March 2017): 111–16, https://doi.org/10.1177/0840470416679413.

45. Bonnie Henry et al., "Stopping the Harm: Decriminalizaiton of People Who Use Drugs in BC. Provincial Health Officer's Special Report" (British Columbia, Office of the Provincial Health Officer, 2019), https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/special-reports/stopping-the-harm-report.pdf.
46. Henry et al.
47. Chief Public Health Officer, "Addressing Stigma: Towards a More Inclusive Health System" (Ottawa, ON: Public Health Agency of Canada, 2019), https://www.canada.ca/en/public-health/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/addressing-stigma-toward-more-inclusive-health-system.htm.
48. Island Health, "Update Bulletin: Special Edition Harm Reduction – Substance Use Policy" (Island Health, 2022), https://medicalstaff.islandhealth.ca/sites/default/files/news/harm-reduction-newsletter-sept-2022.pdf.pdf.
49. First Nations Health Authority, "Cultural Safety and Humility" (First Nations Health Authority), accessed February 27, 2023, https://www.fnha.ca/wellness/wellness-and-the-first-nations-health-authority/cultural-safety-and-humility.
50. First Nations Health Authority.
51. Canadian Institute for Substance Use Research, "Per Capita Alcohol (PCA) Consumption in the Province of British Columbia (BC): Interactive Data Visualization Tool" (University of Victoria, 2023), http://aodtool.cfar.uvic.ca/.
52. Canadian Institute for Substance Use Research, "Alcohol and Other Drug (AOD) Trend Analyzer: Interactive Data Visualization Tool," 2022, http://aodtool.cisur.uvic.ca/.
53. University of Victoria, "Alcohol Consumption in BC Higher than Ever" (Human and Social Development, 2021), https://www.uvic.ca/news/topics/2021+alcohol-consumption-bc+media-release#:~:text=At%209.32%20litres%20(L)%20of,started%20monitoring%20it%20in%202001.
54. University of Victoria, "Alcohol Consumption: Annual Alcohol Consumption in BC" (Canadian Institute for Substance Use Research, 2022), https://www.uvic.ca/research/centres/cisur/stats/alcohol/index.php.
55. Office of the Provincial Health Officer, "Problematic Alcohol Use: Examining the Societal Consequences of the Covid-19 Pandemic" (BC Centre for Disease Control, 2021), http://www.bccdc.ca/Health-Professionals-Site/Documents/societal_consequences/Problem_Alcohol_Use.pdf.
56. Canadian Institute for Substance Use Research, "Alcohol and Other Drug (AOD) Trend Analyzer: Interactive Data Visualization Tool."
57. Canadian Centre on Substance Use and Addiction, "Canada's Guidance on Alcohol and Health" (Canadian Centre on Substance Use and Addiction, 2023), https://ccsa.ca/canadas-guidance-alcohol-and-health.
58. Megan DeLaire, "What You Should Know about Canada's New Alcohol Guidelines," CTV News, 2023, https://www.ctvnews.ca/health/what-you-should-know-about-canada-s-new-alcohol-guidelines-1.6239499.
59. Ted Raymond, "Cancer Warning Labels on Alcohol Would Not Reinvent Wheel, Senator Says," CTV News, 2022, https://ottawa.ctvnews.ca/cancer-warning-labels-on-alcohol-would-not-reinvent-wheel-senator-says-1.6151152#:~:text=The%20bill%2C%20called%20%E2%80%9CAn%20Act,the%20development%20of%20fatal%20cancers.
60. Patrick Brazeau, "An Act to Amend the Food and Drugs Act (Warning Label on Alcoholic Beverages)," Pub. L. No. S-254, accessed February 7, 2023, https://www.parl.ca/legisinfo/en/bill/44-1/s-254.
61. Nerea Almeda and Irene Gómez-Gómez, "The Impact of the COVID-19 Pandemic on Smoking Consumption: A Systematic Review of Longitudinal Studies," Frontiers in Psychiatry 13 (July 12, 2022): 941575, https://doi.org/10.3389/fpsyt.2022.941575.
62. Canadian Institute for Substance Use Research, "Alcohol and Other Drug (AOD) Trend Analyzer: Interactive Data Visualization Tool."
63. Canadian Institute for Substance Use Research.
64. Department of Health, "Canada Gazette, Part I, Volume 156, Number 24: Regulations Amending the Tobacco Products Regulations (Plain and Standardized Appearance)" (Government of Canada, 2022), https://canadagazette.gc.ca/rp-pr/p1/2022/2022-06-11/html/reg5-eng.html.
65. Research and Statistics Division, "JustFacts: Cannabis Crime Statistics in Canada, 2020" (Government of Canada, 2022), https://www.justice.gc.ca/eng/rp-pr/jr/jf-pf/2022/pdf/RSD_JF2022_Cannabis-related-crime-statistics2020-en.pdf.
66. University of Northern British Columbia, "Study Finds Reduction in Youth Cannabis Offences after Legalization" (University of Northern British Columbia, 2021), https://www2.unbc.ca/newsroom/unbc-stories/study-finds-reduction-youth-cannabis-offences-after-legalization.
67. Joanne Levasseur, Jacques Marcoux, and Kubinec, Vera-Lynn, "Police Report a Pot Possession Incident Every 9 Minutes in Canada: Incidents up 30% since Stephen Harper Government Elected in 2006," CBC News, 2015, https://www.cbc.ca/news/canada/manitoba/pot-possession-incidents-1.3247653.
68. Peter Jaworski, "The Price of Pot Prohibition: THE ECONOMIC COSTS OF CANADA'S WAR AGAINST CANNABIS," C2C Journal, 2009, https://c2cjournal.ca/2009/07/the-price-of-pot-prohibition/#:~:text=Maintaining%20prohibition%20of%20marihuana%20costs,million%20in%20law%20enforcement%20costs.
69. Akwasi Owusu-Bempah et al., "Impact of Cannabis Legalization on Youth Contact with the Criminal Justice System" (Canadian Centre on Substance Use and Addiction, 2021), https://ccsa.ca/sites/default/files/2021-11/CCSA-Impact-Cannabis-

Legalization-Youth-Criminal-Justice-System-2021-en.pdf.

70. Canadian Centre on Substance Use and Addiction, "Research (Cannabis)" (Canadian Centre on Substance Use and Addiction), accessed February 7, 2023, https://www.ccsa.ca/research-cannabis.
71. Canadian Centre on Substance Use and Addiction.
72. Ministry of Public Safety and Solicitor General Policing and Security Branch, "British Columbia Regional District Crime Trends, 2012-2021" (Province of British Columbia, 2022), https://www2.gov.bc.ca/assets/gov/law-crime-and-justice/criminal-justice/police/publications/statistics/bc-regional-district-crime-trends-2012-2021.pdf.
73. Ministry of Public Safety and Solicitor General Policing and Security Branch.
74. Public Safety and Solicitor General, "Expanded Delivery Options Increase Access to Legal Cannabis" (Province of British Columbia, 2022), https://news.gov.bc.ca/releases/2022PSSG0047-001079.
75. CBC News, "As B.C. Marks Another 2,272 Toxic Drug Deaths, Addictions Doctor Tells Families: 'I Am so Sorry,'" 2023, https://www.cbc.ca/news/canada/british-columbia/2022-toxic-drug-deaths-bc-1.6731772.
76. BC Centre for Disease Control, "Unregulated Drug Poisoning Emergency Dashboard," accessed February 9, 2023, http://www.bccdc.ca/health-professionals/data-reports/substance-use-harm-reduction-dashboard.
77. BC Coroners Service, "Illicit Drug Toxicity Deaths in BC" (Province of British Columbia, 2023), https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/illicit-drug.pdf.
78. BC Centre for Disease Control, "Unregulated Drug Poisoning Emergency Dashboard."
79. BC Centre for Disease Control.
80. Province of British Columbia, "Decriminalizing People Who Use Drugs in B.C."
81. Mental Health and Addictions, "B.C. Receives Exemption to Decriminalize Possession of Some Illegal Drugs for Personal Use" (Province of British Columbia, 2022), https://news.gov.bc.ca/releases/2022MMHA0029-000850.
82. Mental Health and Addictions.
83. Ben Nelms, "COVID-19 Hospitalizations Rise for First Time This Year While ICU Numbers Drop 40 per Cent.," CBC News, February 16, 2023, https://www.cbc.ca/news/canada/british-columbia/covid-19-weekly-report-feb-16-1.6751470.
84. Ben Nelms, "B.C. Recorded 211 Toxic Drug Deaths—Almost 7 a Day—in January, Coroner Reports," CBC News, March 7, 2023, https://www.cbc.ca/news/canada/british-columbia/bc-toxic-drugs-deaths-january-2023-1.6770643.
85. P Poole, "Cultural Mapping and Indigenous Peoples: A Report for UNESCO," 2003, http://www.iapad.org/wp-content/uploads/2015/07/cultural_mapping.pdf.
86. Creative City Network of Canada, "Cultural Mapping Toolkit," accessed March 13, 2023, https://www.creativecity.ca/product/cultural-mapping-toolkit/.
87. Last Door, "Recovery Path" (Last Door), accessed February 19, 2023, https://lastdoor.org/drive/uploads/2020/04/45-day-banner_2.png.
88. Kackaamin Family Development Centre, "Kackaamin Family Development Centre," 2023, https://www.kackaamin.org/about-kackaamin.
89. The Port Alberni Shelter Society, "Shelter Farm," accessed February 23, 2023, https://portalbernishelter.com/shelter-farm/.
90. The Mustard Seed Street Church, "Hope Farm Healing Centre" (The Mustard Seed Street Church, 2023), https://mustardseed.ca/ministries/hope-farm-healing-centre/.
91. The Port Alberni Shelter Society, "THERAPY RECOVERY MODEL: WORKING TOWARDS SOLUTIONS," accessed February 19, 2023, https://portalbernishelter.com/therapy-recovery-model-working-towards-solutions/.
92. John Douglas, "Addiction and Therapeutic Recovery Models: 'Working Towards a Solution'" (Port Alberni Shelter Society, 2019), https://portalbernishelter.com/wp-content/uploads/2019/12/TherpeuticCommunityReport1.pdf.
93. Justin McElroy, "The Story of Tiny Homes, Intertwined Problems, and One B.C. Municipality.," CBC News, 2022, https://www.cbc.ca/news/canada/british-columbia/duncan-tiny-homes-bc-municipalities-1.6582177.
94. Greater Victoria Coalition to end Homelessness, "Caledonia Tiny Homes Village" (Greater Victoria Coalition to end Homelessness, 2022), https://victoriahomelessness.ca/tinyhomes/.
95. "Tiny Home Village to Be Built for Recovering Addicts." (KOBI-TV NBC5, 2021), https://www.youtube.com/watch?v=PdRzgoXjb8E.
96. "CMAPS CoP: Island Health: Individualized Managed Alcohol Plan (IMAP)" (University of Victoria, Canadian Institute for Substance Use Research, 2022), https://www.youtube.com/watch?v=-aTpInYA3SA.
97. Province of British Columbia, "B.C. Introduces New Prescribed Safer Supply Policy, a Canadian First."
98. Province of British Columbia.
99. CATIE, "Overdose Prevention Site at St. Paul's Hospital" (Public Health Agency of Canada, 2019), https://www.catie.ca/programming-connection/overdose-prevention-site-at-st-pauls-hospital.

100. Island Health, “Comox Valley – Island Health: Harm Reduction Services” (Island Health, 2023), https://www.islandhealth.ca/our-locations/overdose-prevention-supervised-consumption-locations/comox-valley-island-health.

101. Comox Valley Community Foundation, “Comox Valley’s Vital Signs 2018 Detailed Data and Source Report,” 2018, https://cvcfoundation.org/wp-content/uploads/2021/12/Comox-Valley-Vital-Signs-Source-Report.pdf.

102. COMOX VALLEY COMMUNITY SUBSTANCE and USE STRATEGY COMMITTEE, “COMMUNITY SUBSTANCE USE STRATEGY: PHASE ONE REPORT.”

103. Foundry Comox Valley, “Foundry: Where Wellness Takes Shape” (Foundry Comox Valley), accessed February 19, 2023, https://foundrybc.ca/comoxvalley/. Foundry Comox Valley.

104. Foundry Comox Valley, “Foundry: Where Wellness Takes Shape” (Foundry Comox Valley), accessed February 19, 2023, https://foundrybc.ca/comoxvalley/. Foundry Comox Valley.