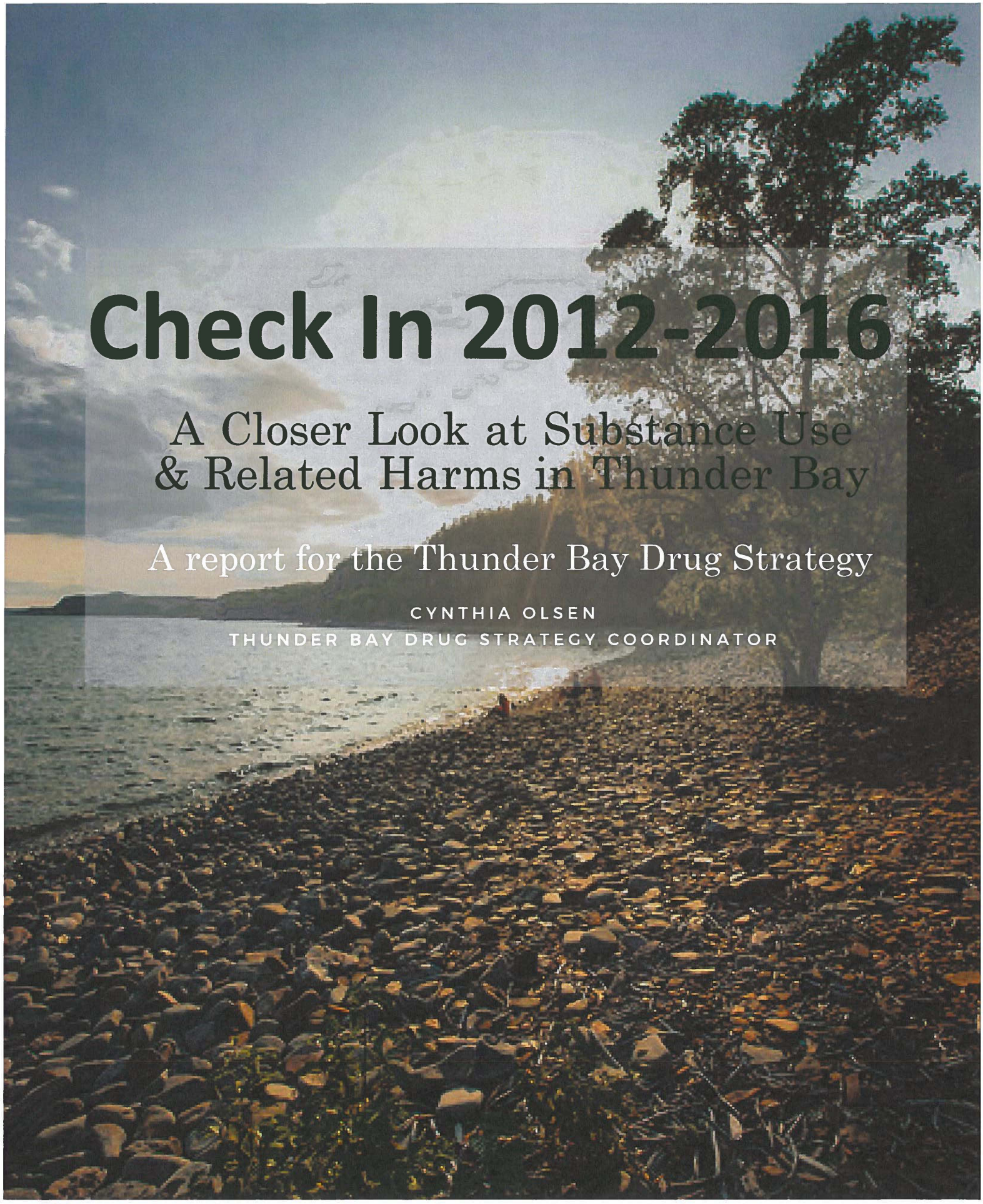

Check In 2012-2016

A Closer Look at Substance Use & Related Harms in Thunder Bay

A report for the Thunder Bay Drug Strategy

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THUNDER BAY Drug Strategy

October 2017

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SCOPE & LIMITATIONS

The purpose of this report is for the Drug Strategy Implementation Panel, Community Partnership, and Working Group Members to review the current status of substance related harms in Thunder Bay, as well as the broader context of substance use and drug policy internationally, within Canada and particular provinces. The goal in reviewing this information is to help re-evaluate the existing recommendations contained in *Roadmap for Change (March 2011)* and determine new recommendations based on this environmental scan. The intention is to provide as current and accurate information as possible to initiate an informed dialogue amongst the Implementation Panel to assist in determining our strategic priorities. In 2010, a report was completed by Stephanie Hendrickson "*An Environmental Scan of Thunder Bay: Issues, Impacts, and Interconnections of Substance Use. A background paper prepared for the Thunder Bay Drug Strategy Project*"[1] and was significant in informing the development of the official Drug Strategy for the City of Thunder Bay.

This report will attempt to update similar information as that captured in Ms. Hendrickson's report. It is important to note that while this report aims to be as complete as possible, it is difficult to determine what information is most relevant and what information can be reasonably left out. There is a wide range of literature available that provides information on particular substances, pathways to addiction, terminology and theories on substance use, however that information is beyond the scope of this report. For the context of this report, the term substance use will be used to describe all psychoactive substances (legal and illegal, including alcohol) and will refer to a range of use from beneficial to problematic.

This report will aim to provide a very brief synopsis of the international and national/provincial context of substance use, and will largely focus on data pertaining to Thunder Bay specifically. All attempts were made to gather the most up to date information as possible, and several years of data for comparison where possible. It is important to note that where local data was unavailable, or where this writer did not know where or how to access local level data, provincial or national data was used. Some data not provided in this report may be available locally, however due to time constraints this information was not gathered, or may be a pending request. These data sets, should the Drug Strategy membership see as valuable for future reports, can be accessed and updated in future versions of this report. It is the intent of this writer that this document be a "living" document which can be updated regularly (annually or biennially) to assist with future evaluation efforts of the municipal drug strategy, as well as for future strategic planning efforts.

Many thanks to all those who forwarded me information for inclusion, and to the Working Group Advisory Committee who took time to review this report. Thanks also goes out to Stephanie Hendrickson for the original environmental scan which provided this writer with guidance and a framework for this report.

Cynthia Olsen
Drug Strategy Coordinator

INTRODUCTION

The Thunder Bay Drug Strategy was developed as a result of extensive community consultation and research and was accepted through a formal motion of Council as the official Drug Strategy of the City on April 11, 2011. The Thunder Bay Drug Strategy sets direction for a collaborative and cohesive manner to address substance use issues and related problems primarily in the City of Thunder Bay, but also in partnership with the region of Northwestern Ontario.

The Drug Strategy Implementation Panel is comprised of agency representatives, municipal leaders and community members with diverse perspectives and backgrounds. The Panel has developed implementation plans and determined priorities based on the actions contained in the Thunder Bay Drug Strategy document, *"Roadmap for Change" (March 2011)*. The implementation plan is a comprehensive approach to substance use issues based on integration of our five pillars; prevention, treatment, harm reduction, enforcement and housing.

This report will provide a brief examination of some significant drug policy reforms across the globe, as well as those recently occurring in Canada. It will also look at the coordinated efforts of the Municipal Drug Strategy Coordinators Network of Ontario, the only province to have a network of municipal drug strategies. It is important to consider this landscape of drug policy when making considerations for areas of advocacy work that the Drug Strategy should focus on.

A brief history on the development of the Thunder Bay Drug Strategy will be provided, which includes details about the Community Partnership that provides funding for Drug Strategy initiatives, the current structure of the panel and working groups, and the recommendations that had been identified as priorities for implementation over the past five years.

The prevalence, burdens and risk factors for the top three most commonly used substances in Canada; alcohol, marijuana and opioids will be highlighted. It is also important to recognize that the federal government has made a commitment to introduce legislation to legalize marijuana by 2017, and public consultations are underway in that regard. The Drug Strategy membership will need to keep abreast of this significant shift in drug policy in Canada as the government moves toward legalization. Next, this report will examine the burdens associated with substance use, and provide local data as it relates to substance related morbidity and mortality. It will also provide some information relevant to two identified priority risk populations – substance-involved youth and substance-involved pregnant and/or parenting women.

Finally, this report will provide available local data on initiatives/programs/services under each of our five pillars of enforcement, prevention, treatment, harm reduction, and housing. All of which, is intended to inform a dialogue around the future efforts of the Drug Strategy Implementation Panel and Working Groups.

GLOBAL DRUG POLICY

International Context

Globally, there is momentum in reshaping the approach to drugs and drug related issues. It is now being recognized that international policy has had too much focus on prohibition and the use of criminal law on complex social issues. Global leaders are now calling on countries to shift their response to a public health and human rights approach to substances and related issues. Some significant drug policy reforms across the globe include:

- Portugal decriminalized all drugs (2001)[2]
- Uruguay legalized marijuana (2013)[3]
- Recreational marijuana fully legalized in Oregon (2014), Colorado (2012), Washington (2012) and Alaska (2014), the District of Columbia (2015), and 3 cities in the United States[4]
- Barak Obama called for the end of mandatory minimum sentences for non-violent drug offences (2015)[5]
- United Nations General Assembly Special Session on the World Drug Problem - discussed international recommendations, including the decriminalization of marijuana, universal access to controlled medicines, criminal justice system reforms including elimination of mandatory minimum jail sentences and abolition of the death penalty and acknowledging marijuana's medical use (2016)[6]

National Context

National Anti-Drug Strategy (2007)

Replacing Canada's former four-pillar Drug Strategy in 2007, the National Anti-Drug Strategy has only three specific areas of focus: enforcement, prevention, and treatment. The recognition of substance use as primarily a health issue was lost, and has been criticized for lacking a focus on reducing the harms caused by substance use. It also moved away from addressing the underlying factors associated with substance use, and places more emphasis on illicit drug operations to reduce the growth in supply and demand. This narrowing of focus excluded alcohol, prescription drugs or other legal substances such as solvents. In 2013, however, the strategy was expanded to include prescription drug use.

With an overall budget of approximately $513.4 million, the enforcement action plan of the national strategy accounts for 40% of this budget, while the treatment action plan accounts for 37% and the prevention action plan accounts for 23%. There was a frozen allocation of an additional $67.7 million set aside for the four components under the Mandatory Minimum Penalties.[7]

Nationally, there is hope that the newly elected government will update the national strategy and reinstate the harm reduction pillar, and broaden the scope to include recommendations that also address the harms associated with alcohol, prescription medications and other legal substances.

Safer Streets and Communities Act

In 2009, the conservative government at the time, put forward a bill aimed at imposing mandatory minimum sentences for serious drug offences, and increasing the maximum penalty for cannabis production, as well as reschedule certain substances from the Controlled Drugs and Substances Act. This bill died with the proroguing of parliament in December of that year, but the conservatives were intent on reintroducing the bill at a later date.

In September 2011, Bill C-10[8] the Safe Streets and Communities Act (also known as the omnibus bill) was reintroduced and was passed in March 2012. The Act aims to amend the Controlled Drugs and Substances Act, and introduced mandatory minimum sentences, increased the penalty for marijuana production, and moved some substances from Schedule III to Schedule I.

Controlled Drugs and Substances Act (CDSA)

The Government of Canada announced its commitment to developing a new framework to legalize, regulate and restrict access to marijuana in the 2015 Speech from the Throne. The Minister of Justice and Attorney General of Canada, with support from the Minister of Public Safety and Emergency Preparedness and the Minister of Health, has created a Task Force on Marijuana Legalization and Regulation. The Task Force has prepared a discussion paper[9] to assist with consultations to support a focused dialogue with stakeholders and the public. The paper outlines the following key issues where the government is seeking advice and input:

- Minimizing harms of use
- Establishing a safe and responsible production system
- Designing an appropriate distribution system
- Enforcing public safety and protection
- Accessing marijuana for medical purposes.

The task force will present its advice on the design of a new framework for the legalization and regulation of marijuana in Canada in November 2016.

Marijuana is currently listed as a Schedule II substance of the CDSA. This means that possession, production and trafficking of marijuana are illegal. It has been prohibited in Canada since the 1920s. Legal access to medical marijuana is regulated through the Marihuana for Medical Purposes Regulations (MMPR).

Municipal Drug Strategy Coordinators Network of Ontario

Established in 2008, the Municipal Drug Strategy Co-Coordinators' Network of Ontario (MDSCNO) aims to bring together municipalities across Ontario working toward reducing substance related harms to learn from one another, and to join together in advocacy work.[10] Participating members represent over 155 municipalities, counties, townships, regions and First Nations throughout Ontario with a combined population of more than 7 million people.[11] It is the only provincial network of municipal drug strategies in Canada.

Members of the MDSCNO co-ordinate integrated municipal or regionally-based drug strategies and have a wide-range of expertise on issues of substance use. Members work in multi-sectoral initiatives that aim to reduce the harms of alcohol and other drugs, including prescription medications. Strategies are tailored to each community, and are based on the integrated components (or pillars) of prevention, harm reduction, treatment and enforcement/justice. Some municipalities have opted to add a fifth pillar of housing, as an area of strategic importance to the work undertaken in their given locale.

Thunder Bay Drug Strategy has been an active member of the MDSCNO since 2011.

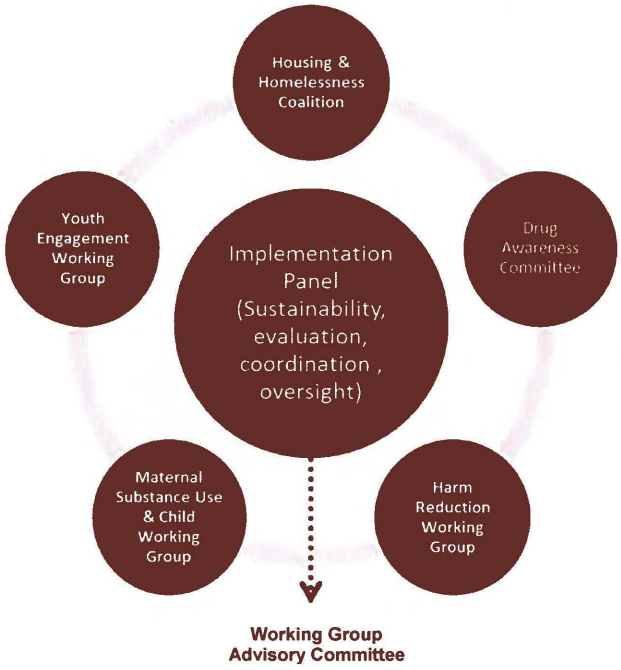
Municipal Context

Endorsed by City Council in 2011, the Thunder Bay Drug Strategy is the official community plan to address substance related harms. It provides a comprehensive approach to substance use issues integrating our five pillars which include prevention, treatment, enforcement, harm reduction and housing.

In 2012, the Steering Committee spent time determining priority actions that could realistically be achieved and selected 21 recommendations to implement over a three year period (2012-2014). The Steering Committee updated the terms of reference and became an Implementation Panel. A "Community Partnership" was established to support the funding of the Drug Strategy. The City of Thunder Bay became the host of the municipal drug strategy, and contributed 50-60% of the funding for the program. Members of the Community Partnership provided the remaining 40-50% of funding and included the following: Thunder Bay Regional Health Sciences Centre, St. Joseph`s Care Group, Thunder Bay Police Service, Thunder Bay District Health Unit, Fort William First Nation, Superior North EMS and one time funding was received from Thunder Bay District Social Services Administration Board.

In 2014, the Implementation Panel reevaluated its priorities and determined an implementation plan for another three-year term (2015-2017). Simultaneously, the Community Partnership was renewed with several of the same partners and includes the following: Thunder Bay Regional Health Sciences Centre, St. Joseph`s Care Group, Thunder Bay Police Services, Thunder Bay District Health Unit, Superior North EMS and one time funding was received from North West Local Health Integration Network.

In order to implement the selected recommendations, the Panel developed a number of working groups or connected with pre-existing coalitions or committees to act as a working group for the Drug Strategy. The following is the current Implementation Structure:



For a complete list of recommendations identified as priority by the Implementation Panel for the first two 3-year terms, please see Appendix A.

SUBSTANCE USE IN CANADA

The most commonly used substances (other than tobacco) in Canada are alcohol, marijuana and opioids. This next section will examine information related to the prevalence of use, the burdens of use, and the specific risk factors associated with each substance. Where possible, information in this section will draw upon research with local level data.

Alcohol

Prevalence

In 2015, the Thunder Bay District Health Unit released a community report[12] showing elevated levels and patterns of alcohol use in Thunder Bay District compared to the province. These elevated levels continue to increase, with over half (59%) of adults 19 and over in Thunder Bay District reporting drinking in excess of the Low Risk Alcohol Drinking Guidelines (LRADG) in 2013-14, up from nearly half (48.2%) in 2011-12. This is significantly higher than the provincial average of 42.6% in 2013-14.[13] Heavy drinking rates are also elevated among adults in Thunder Bay District, with one in four (26.2%) self-reporting heavy drinking in 2013-14, up from one in five (20%) in 2011-12. This is significantly higher than the provincial rate of 16.6% in 2013-14.[14] Men are more likely than women to report exceeding the LRADG and heavy drinking, however it is important to note that levels of in-risk drinking among women are on the rise, with women catching up to their male counterparts.

Students in grades 7-12 in Northern Ontario are more likely to report using alcohol in the past year, binge drinking in the past month, hazardous/harmful drinking, drunkenness before grade 9, and operating off-road vehicles after consuming alcohol compared to the rest of Ontario. Even though rates of drinking and driving have reduced since 2009, 4% of students with a license in grades 10-12 report driving after consuming alcohol at least once in the past year.[15] Over half (54.8%) of post-secondary students in Ontario who consume alcohol, report adverse consequences due to their drinking in the past year. These consequences include risky sexual activity, suicidal ideation and injury.[16]

Burdens

Evidence indicates that alcohol is increasingly shown to be the substance causing the most individual and social harms and is a significant source of health risks in Thunder Bay. The World Health Organization recognizes that there is an increased risk to harm of self or others with the presence of alcohol. Risky drinking is associated with injuries, assaults, impaired driving, alcohol poisoning, and risky sexual behaviour. Nearly 25% of all deaths and 40% of all car crashes on Ontario roads involve alcohol.[17]

Over 65 diseases and conditions are related to alcohol, and it is also a known risk factor for cancer.[18] It is second only to tobacco as a significant risk factor for disease, disability and death. There is evidence on the connection between moderate levels of use of alcohol to the development of health issues such as stroke, heart disease, high blood pressure, diabetes, mental health problems, liver disease and digestive problems. Social harms associated with alcohol, such as public disorder, family problems, physical and sexual violence, financial problems, and work/school related problems are significant. In Ontario, one in three adults report experiencing second-hand effects from someone else's drinking.[19]

Risk Factors

Much like other substances, there are multiple and complex factors that increase an individual's risk of harm from the use of alcohol. Individuals who face barriers to the social determinants of health are disproportionally affected by harms related to alcohol. Although research shows that those with lower incomes overall drink less and are even more likely to abstain from alcohol use, they are more likely to experience alcohol-related health problems and even death. Researchers also identify particular groups who experience a disproportionate amount of harms than others, such as youth (15-24) and those who identify as LGBTQ2S+; women; Aboriginal people; people with inadequate housing/income/employment; older adults; workers in industrial/blue-collar occupations; people diagnosed with a mental health condition; people who use other substances; and incarcerated individuals.[20]

Marijuana

Prevalence

According to a 2012 report from the United Nations Office on Drugs and Crime (UNDOC), it is estimated that approximately 200M people worldwide reported using marijuana at least once in that same year.[21] Even though marijuana is prohibited, it remains the most commonly used illegal substance in the world, including in Canada. It ranks second to alcohol in its use as a recreational drug. Approximately 11% of Canadians 15 years of age and over reported using marijuana at least once in 2013 – in more detail this data shows that 25% of youth (15-24) reported use in that same year, in comparison to 8% of adults (25+).[22]

Burdens

Enforcement

Marijuana is reported to be the most trafficked drug in the world, and in Canada, organized crime acquires an estimated $7B annually on its illegal trade. Of the 657 organized crime groups reported to be operating in Canada in 2015, over half are either known or suspected to be involved in the illegal marijuana market.[23] Marijuana possession represented more than half of all police-reported drug offences in 2014. Of the 57,314 reported marijuana possession drug offences, 22,223 resulted in charges that year.[24] It is believed that the majority of illicit market marijuana in Canada is domestically produced. Health Canada reported that in 2013 over 39 metric tonnes and over 800,000 plants were requested to be destroyed by law enforcement.[25] Marijuana also represents one of the top three drugs seized between 2007 and 2012 with Canada's Border Services Agency. Drug-impaired driving, which includes marijuana, has increased from 2% in 2011 to 3% in 2013.[26] Because marijuana affects coordination, response time, and concentration, there are particular concerns for driving while under the influence. Research shows that driving after marijuana use increases the chance of being responsible for a collision, and that combining marijuana with other substances such as alcohol also increases the dangers of driving. [27]

Health and Social

Studies indicate that there is a relationship between dose/frequency of use during adolescence and negative health and social outcomes: reduced cognitive functioning, educational attainment, longer-term personal disadvantage and marijuana dependence.[28] Individuals who use marijuana daily have a higher risk for negative outcomes. Because of the critical time for brain development during adolescence, youth are more vulnerable to the adverse health effects of marijuana use.[29] Less clear is the association between mental health risks and marijuana use. Short-term effects can include loss of short-term memory, difficulty with focus and concentration, loss of motor coordination and poor reaction time, sleepiness, dizziness and fatigue.[30] It can also include risk of psychotic episodes, paranoia/anxiety, panic attacks, perceptual distortions, disorientation and confusion.[31] Some studies indicate that long-term effects of marijuana use can lead to higher risk for developing psychosis or schizophrenia – more particularly for individuals who have personal or family history of these illnesses, who started using marijuana at a younger age, who use a few times a week to daily, and who have used for months or years.[32] Marijuana also increases the risk for cancer, lung and heart problems. There are also adverse health outcomes for babies who have been exposed to marijuana in utero.[33]

Risk Factors

Age of initiating use
Frequency and duration of use
Amount and potency of substance
Actions while intoxicated
Health status – including medical, personal, and family health history

Opioids

Prevalence

According to the International Narcotics Control Board, Canada has the second highest per capita consumption of prescription opioids, next to the United States.[34] High levels of prescribing opioid medications in Canada, and in particular Ontario, has led to a "widely acknowledged" public health crisis. In 2012, OxyContin was discontinued and was replaced by OxyNeo, which was intended to be a more tamper resistant formulation. In the same year, Health Canada approved the introduction of generic OxyContin, while the Food and Drug Administration in the United States declined to approve it. There has been some observed reduction in oxycodone prescribing, however there has also been an increase in prescribing of other strong opioids in Canada. Data suggests that Canada leads the world in prescriptions for hydromorphone, and is second to the United States in oxycodone prescriptions.

According to a 2015 report prepared by the Canadian Centre on Substance Abuse, the following data describes past year use of prescription opioids in Canada:[35]

- The rate of past-year use of opioid pain relievers among the general population (age 15+) dropped from 21.6% in 2008 to 14.9% in 2013. The report does note methodological differences in the prevalence estimates between the two studies cited, and suggests comparing the data should be done with caution.
- The rate of past-year use of opioid pain relievers in 2013 among youth (age 15-24) did not differ from the rate of past year use of adults (age 25+): 14.8% vs. 14.9% respectively.
- The rate of past-year use of opioid pain relievers in 2013 for seniors (age 65+) was 16.2%
- When comparing past-year use of opioid pain relievers based on gender, 2013 data indicates that females are slightly higher (15.7%) compared to males (14.0%).

According to the same 2015 report, the following data describes past-year prevalence of misuse of opioids in Canada:[36]

- Among the general population who use opioid pain relievers (age 15+), 2.3% reported abusing them. This represents approximately 0.3% of the total population in Canada. This is down from 2012 where 5% of the general population who use opioid pain relievers (or 0.9% of the total population of Canada). The report does note methodological differences in the prevalence estimates between the two studies cited, and suggests comparing the data should be done with caution.
- In 2013, the rate of abuse of pain relievers among youth aged 15-19 who use opioids was 5.8%.
    - Students – 1.5% of Canadian students (grade 7-9) and 2.5% of Canadian students (grade 10-12) reported past-year use of pain relievers to get high and for non-medical purposes in 2012-2013.
    - 6.4% of post-secondary students had used opioid pain relievers that were not prescribed to them in 2013.
    - 12.4% of students in grades 7-12 reported using a prescription opioid pain reliever not for medical purposes in 2013.
- First Nations: 4.7% of First Nations (age 18+) either living on-reserve or in northern First Nations communities across Canada reported past year use of prescription opioids (including morphine, methadone and codeine) without a prescription or illicit opioids (heroin) between 2008 and 2010.
    - 1.3% of First Nations youth (age 12-17) reported past year use of prescription opioids without a prescription.
    -

It is important to look at the prevalence of both use and misuse of opioids because the risk for overdose and other burdens is not isolated to illicit or non-medical use of opioids.

Burdens

Hospital Visits

Emergency room visits in Ontario related to narcotic withdrawal, overdose, intoxication, mental health issues and other related diagnoses increased by almost 250% from fiscal year 2006 to fiscal year 2011.[37]

Individuals on high doses of opioids were 21-42% more likely than those on lower doses of opioids to have a visit to the emergency department due to road trauma between 2003 and 2011.[38]

According to a 2016 report by the Ontario Drug Policy Research Network on opioid prescribing and opioid related hospital visits in Ontario, Thunder Bay District has among the highest rates of both opioid prescriptions and opioid-related deaths in Ontario.[39] Opioid-related morbidity and mortality is due in large part to the use of opioids to treat chronic non-cancer pain, and more specifically to those between 15-64 years of age.[40] Thunder Bay ranks highest in Ontario for prescribing rates, and is significantly higher than the provincial average, and approximately 15,000 per 1000 higher than Manitoulin and Rainy River.[41] Thunder Bay is third for opioid toxicity hospital admissions next to Rainy River and Algoma for individuals aged 15-64.[42] Thunder Bay is tied for second for hospital admissions for those aged 65 and over.[43] Thunder Bay ranks third for opioid toxicity emergency department visits among those aged 15-64, next to Manitoulin and Peterborough.[44] For opioid toxicity emergency department visits among those 65 and over, Thunder Bay ranks 10th out of 49 counties studied.[45]

In 2015, there were 1648 individuals receiving methadone in Thunder Bay, across seven clinics, or through an authorized prescriber.[46] In fact, methadone is generally the first-line of medication assisted treatment for opioid addiction in Canada. However, the provinces are under pressure to improve access to Suboxone.[47] In Ontario, there were 127 deaths due to methadone in 2013, which represented the leading cause of opioid toxicity next to oxycodone (122) and fentanyl (117).[48] Suboxone is considered much safer than methadone and the shift to increasing access could result in a significant decrease to overdose deaths. It must be noted that the majority of methadone deaths are not individuals receiving opioid replacement treatment.

In 2016 the federal government made changes to the regulations of the opioid antidote naloxone, and in the spring, Ontario developed the Naloxone Pharmacy Program. Individuals at risk, as well as family and friends can access naloxone overdose kits free of charge, as well as the training to administer, from Ontario pharmacies. As of September 8, 2016 there were 17 participating pharmacies in Thunder Bay.

Neonatal Abstinence Syndrome (NAS)

3.8 babies out of 1000 births were born to women who used opioids during pregnancy and were diagnosed with NAS. The rate of NAS has increased in Ontario to 5.1 per 1000 live births in 2011-2012 from 0.9 per 1000 live births in 2002-2003.[49]

Risk Factors

Research indicates that there are four factors that significantly contribute to an increase in opioid dependence for patients receiving prescription opioids:[50]
Younger age (less than 65)
Major depression
Psychotropic medication
Pain impairment

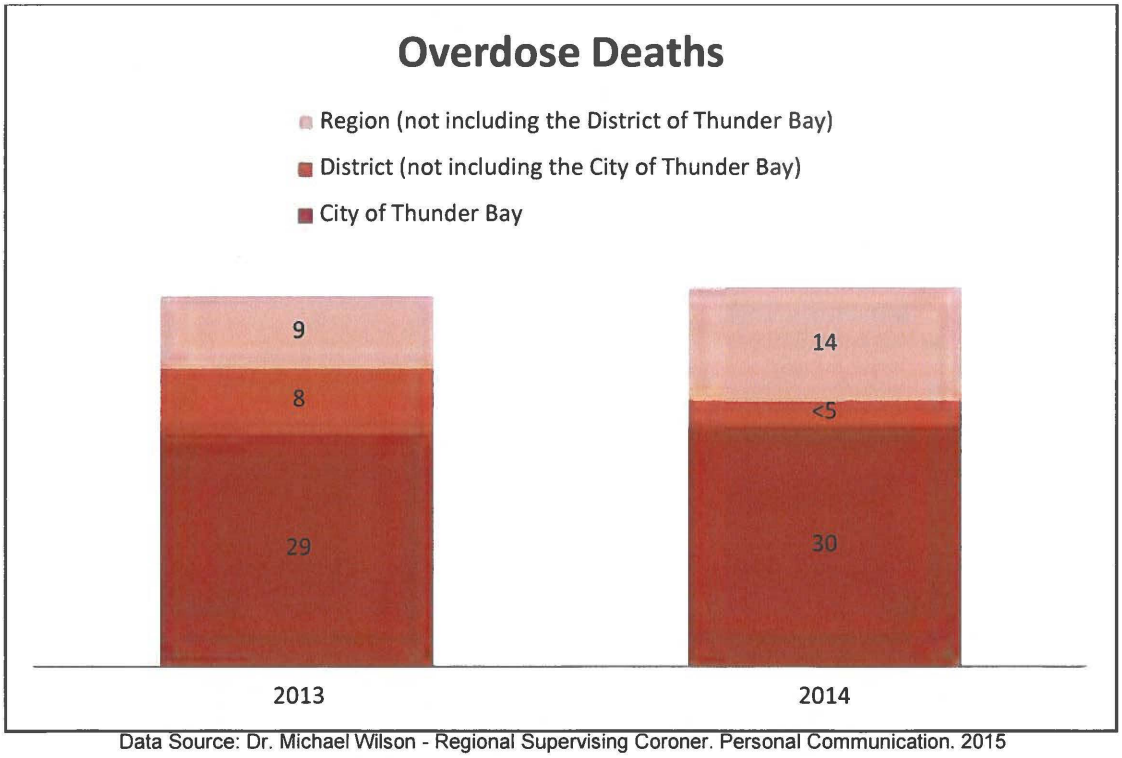
BURDENS OF SUBSTANCE USE

The burden of substance use (including legal and illegal drugs, and alcohol) is generally measured in years of life lived with disability (YLDs), years of life lost (YLLs), and disability-adjusted life years (DALYs). According to the World Health Organization, neuropsychiatric illnesses contribute the most to the global burden of disease, and within that category, substance use disorders account for the second largest proportion of this burden after depression.[51] Moreover, in higher-income countries, alcohol and illicit drugs are among the 10 highest risk factors for DALYs.[52] The use of alcohol, legal and illegal drugs poses substantial risk to the health, social well-being, and financial health to individuals, families and communities. It is estimated that, worldwide, 2 billion people use alcohol, 1.3 billion people smoke cigarettes, and 185 million people use drugs.[53]

In Thunder Bay, some of the burdens we collect data on are substance related mortality, emergency medical service calls related to alcohol intoxication and overdose (fatal and non-fatal), as well as presentations to the emergency department for mental health or substance use related issues. We also capture the rates of Hepatitis C, largely borne from injection drug use, as well as the rates for HIV.

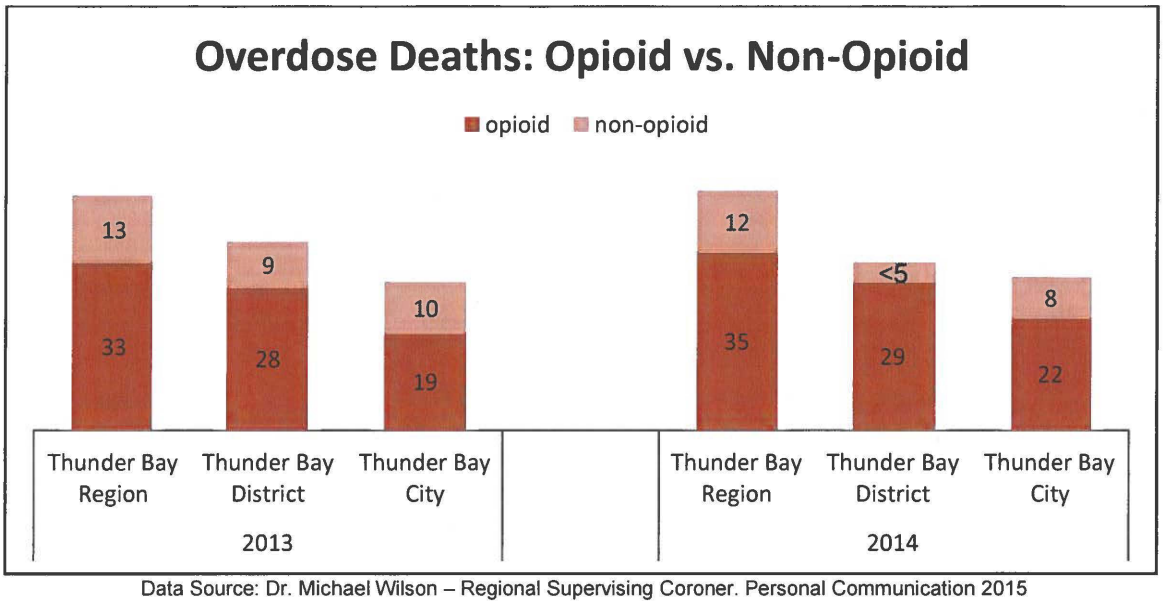
Overdose

According to the Regional Supervising Coroner, Dr. Michael Wilson, there were a total of 46 drug or drug *and* alcohol related deaths in the Region in 2013, 29 of which occurred in the city of Thunder Bay.[54] Preliminary data for 2014 indicates that there were a total of 47 overdose deaths in the Region, 30 of which occurred in Thunder Bay.[55] Thunder Bay Region comprises the districts of Thunder Bay, Kenora, and Rainy River and encompasses the area from White River to the Manitoba border and from Lake Superior to Hudson Bay.



Data Source: Dr. Michael Wilson - Regional Supervising Coroner. Personal Communication. 2015

Based on data provided from Dr. Michael Wilson, overdose deaths due to opioid drug toxicity and overdose deaths due to alcohol *and* opioid toxicity exceed those related to other drug toxicity with and without alcohol. Opioids implicated in overdose deaths in the City of Thunder bay are codeine, fentanyl, hydromorphone, methadone, morphine, and oxycodone. There have been no heroin implicated deaths.



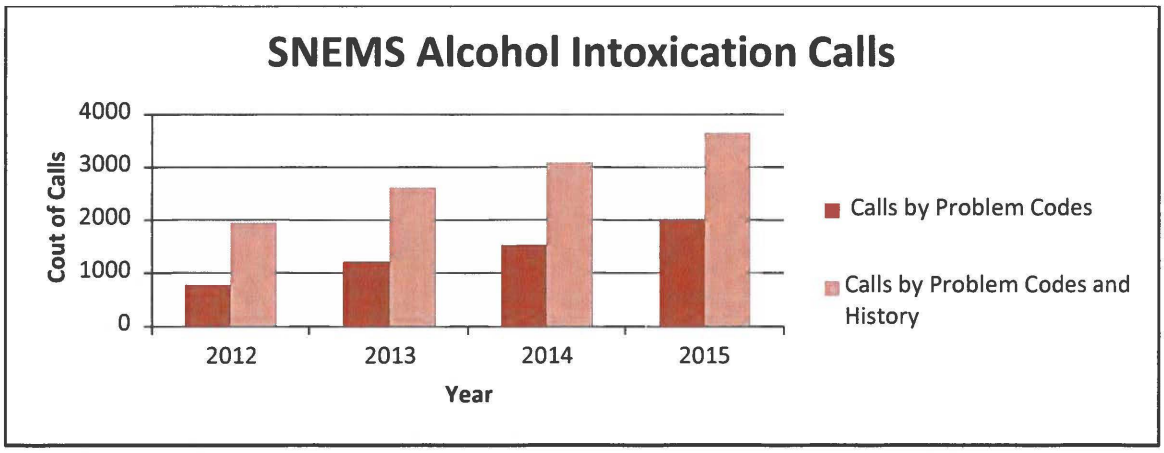
Data Source: Dr. Michael Wilson – Regional Supervising Coroner. Personal Communication 2015

Overdose deaths recorded by the coroner reflect both unintentional and intentional overdose. Between 2014 and 2015, there were 70 deaths combined that were Accidents, 12 were Suicides, and less than 5 were Undetermined (could not distinguish as Suicide or Accident).[56]

Deaths due to alcohol alone represent a large number of overdoses; however this data was not accessed. Further, deaths related to other types of alcohol such as methanol, propanol and ethylene glycol (non-beverage alcohols) are classified separately and only represent a small number of deaths over the past few years.

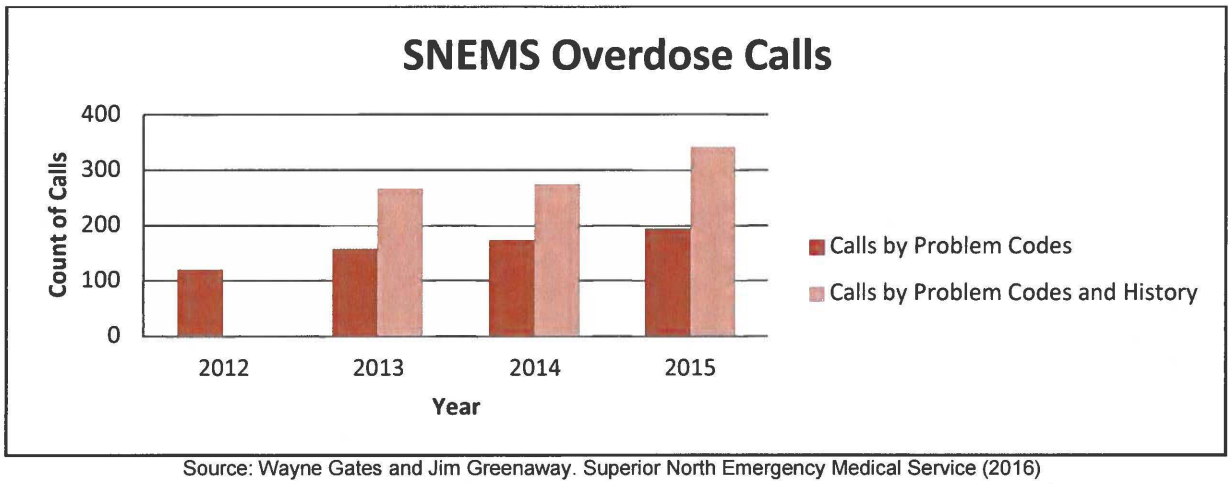
Emergency Medical Service Alcohol and Overdose Related Calls

The following information is related to Emergency Medical Services (EMS) calls specific to patients within the city limits of Thunder Bay. Calls to EMS are significantly increasing for alcohol intoxication since 2012. Problem Codes are those which are recorded at the time of the call to EMS. When using incident history, which is a short narrative taken by the paramedic attending the scene, numbers increase for total amount of calls where alcohol consumption has led to the medical condition that resulted in calling EMS (e.g. trauma, altered consciousness).



Source: Wayne Gates and Jim Greenaway. Superior North Emergency Medical Service (2016)

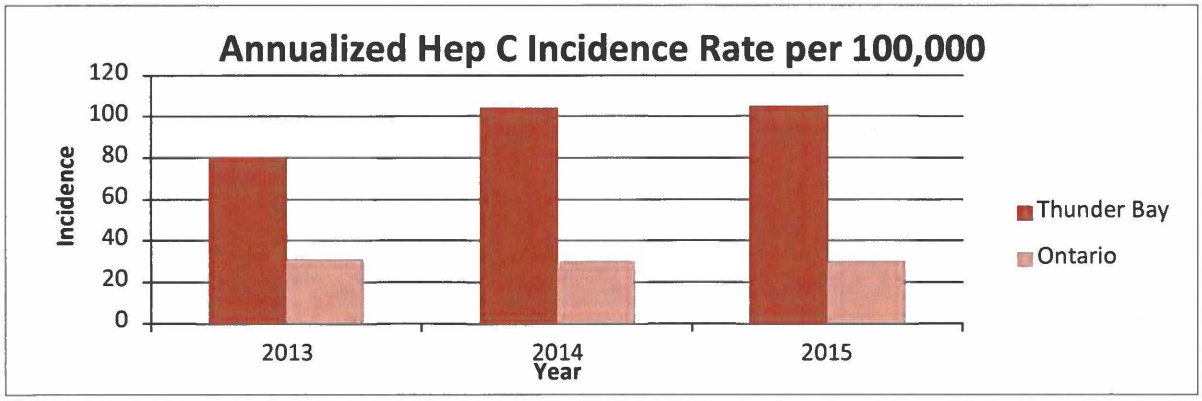
Calls to EMS in relation to drug overdose have slightly increased from 2012 to 2015. When using problem codes or drug overdose underlying problem codes recorded by the attending paramedic, the type of illicit drugs indicated are as follows: cocaine (32%), marijuana (24%), morphine (14%), and methadone (9%).[57] This represents almost 80% of all illicit substance overdose calls to EMS.[58] It is important to note that overdose calls related to marijuana usually had another substance, such as alcohol, implicated in the call. EMS indicated that this data is likely an underrepresentation of the actual call volume, and attempted to do a second analysis of calls, broadening the search terms used as well as expanded search area to include incident history and remark section of the Ambulance Call Report.[59] This second analysis reveals that, in fact, drug overdose related calls are higher than the first analysis indicated. This second analysis also revealed that central nervous system (CNS) stimulants are the primary reason for calls when looked at independently, and are responsible for 33% of the calls.[60] However, opioids independently represent 20% of the calls, and opioids combined with other substances represent 16% of the calls.[61] When examined in this way, opioids – either alone, or combined with other substances, actually represent the leading cause (36%) for drug overdose related EMS calls for service in 2015.[62]



Source: Wayne Gates and Jim Greenaway. Superior North Emergency Medical Service (2016)

Hepatitis C

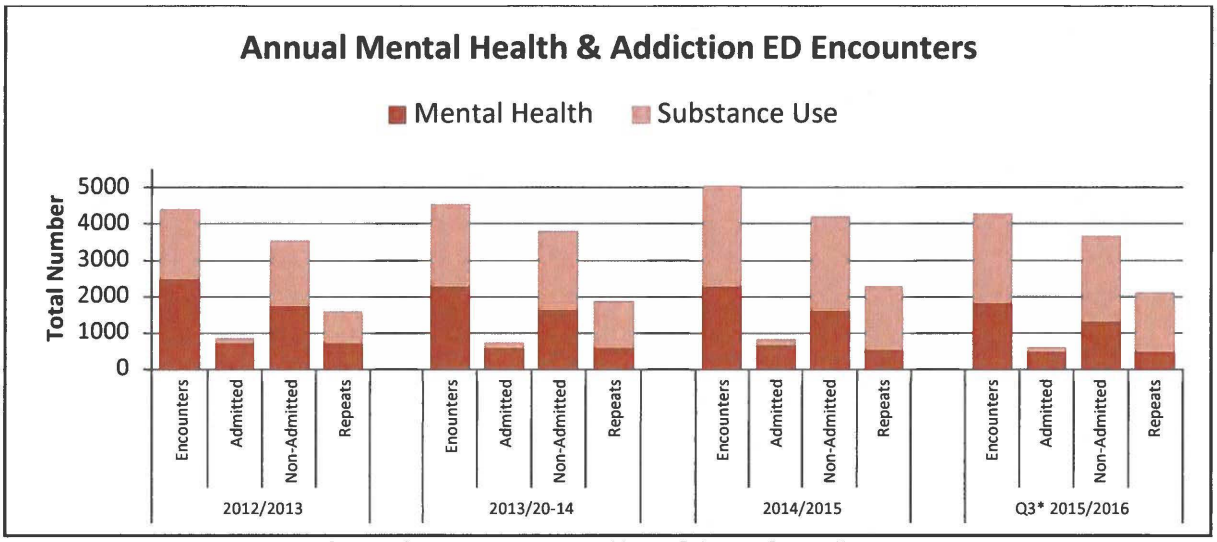
Hepatitis C (Hep C) is a virus that attacks the liver and is spread through blood-to-blood contact. There are an estimated 170million people worldwide who are infected, including an estimated 250,000 in Canada.[63] Injection drug use is high risk, and sharing snorting/smoking equipment is considered moderate risk for contracting Hep C. Compared to the annualized incidence rate per 100,000 for Ontario, Thunder Bay has a significantly higher rate of Hep C than that of the rest of the province.[64] It is often identified as the community with the second highest rate of Hep C in Ontario.



Source: Thunder Bay District Health Unit (2016)

Mental Health and Addiction Related Emergency Department Visits

According to the Thunder Bay Regional Health Sciences Centre (TBRHSC), overall mental health encounters at the emergency department are down since 2012/2013; however they have been increasing for the past two fiscal years and were projected to be approximately 2400 by the final quarter of 2015/2016.[65] Substance use related emergency department visits at TBRHSC have been increasing since 2012/2013, and were projected to reach approximately 5700 by the final quarter of 2015/2016.[66] Of note is that 70% of substance use patients, and 80% of mental health patients are new to the system from year to year.[67] More individuals presenting at the emergency department for mental health are admitted than those presenting for substance use. More individuals presenting to the emergency department with substance use related concerns versus individuals presenting with mental health related concerns have repeat visits, as well as more repeat visits within 30 days of their previous visit. The rate of repeat and 30-day repeat visits for substance use patients have continued to increase since 2012/2013. Presentations for mental and behavioural disorders due to use of alcohol, acute intoxication ranks 11 among the top 20 emergency department diagnoses for 2014/2015.[68]



Source: Thunder Bay Regional Health Sciences Centre (2016)

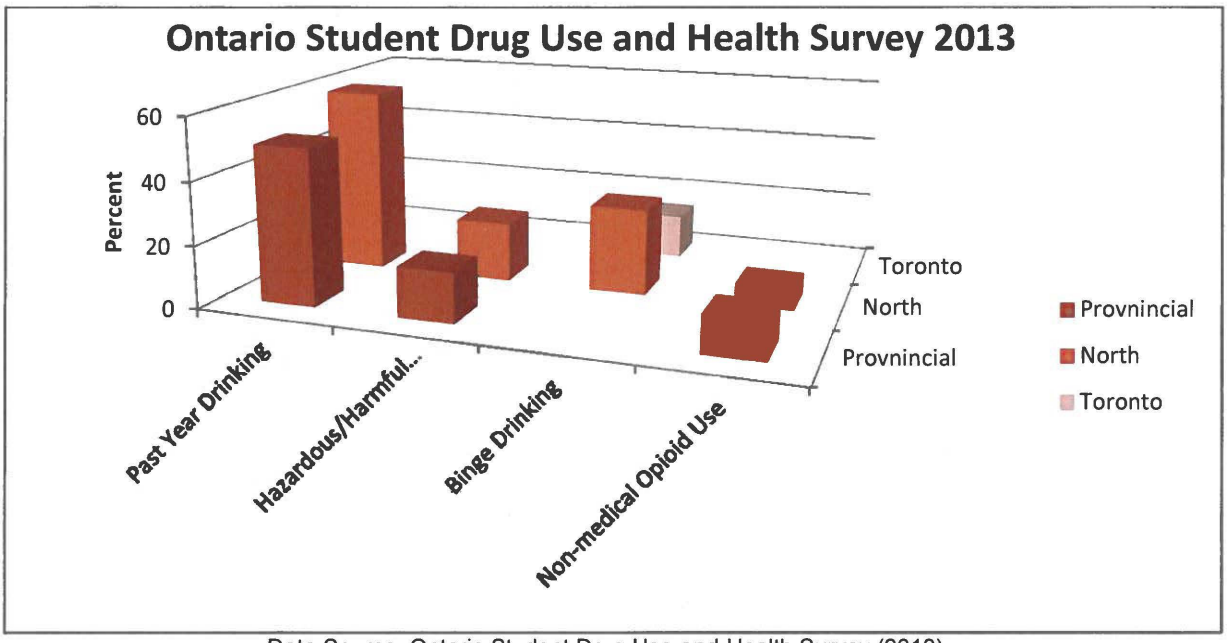
Interpreting these data is difficult. Anecdotally, members of the Drug Strategy Implementation Panel posit several factors that may be contributing to the increasing numbers. In 2013, there was a policy change provincially that saw the former $28 weekly benefit (Personal Needs Allowance) for individuals who were homeless replaced with a new benefit (Basic Needs Allowance) that increased the amount of benefit to $230 to be paid in a lump sum monthly. With this change, there were concerns voiced by members of the Drug Strategy Implementation Panel that the increase in funds provided all at once would lead to behaviours such as binge use of substances among some of those impacted by the change. Findings from data analyzed and reported on in briefing notes completed by the Northwest Local Health Integration Network suggest that the policy change has likely contributed to increased emergency department visits due to substance use in Thunder Bay.[69] According to the Mental Health Surveillance Report (March 2016), mental health and substance use related emergency department visits across Ontario have been increasing annually as well. Other factors which may be contributing to the increase in numbers are a lack of resources to support people with complex needs, migration inward to Thunder Bay with the suggestion that our population data is off by approximately 20%, as well as an impact due to the amount of primary care closures over the past couple of years.

PRIORITY POPULATIONS & SUBSTANCE USE

It is widely recognized that some populations are more at risk than others. The Thunder Bay Drug Strategy has identified two groups in particular that are priority in the work that it does; substance involved youth, and substance-involved pregnant and/or parenting women. The following section provides a snapshot of information relevant to each group.

Youth

According to the Ontario School Drug Use and Health Survey (2013), Northern Ontario students are more likely to drink alcohol and binge drink than the provincial counterparts.[70] They are also less likely to use prescription opioids non-medically, and their reported past year use has decreased since a previous survey completed in 2009.[71]



Data Source: Ontario Student Drug Use and Health Survey (2013)

Pregnant and/or Parenting Women

In 2011, it was reported that 18% of mothers who deliver at TBRHSC report using substances (narcotics, methadone, prescription drugs, alcohol) during pregnancy. Newborns that develop dependence in utero related to their mother's substance use, is a condition called Neonatal Abstinence Syndrome (NAS). Infants born with NAS require high levels of care and accounted for 20% of the admissions to the Neonatal Intensive Care Unit.[72]

In 2014, 15.7% of women who delivered at TBRHSC reported "drug and substance" exposure during pregnancy.[73] During that same time period, 14% of newborns admitted to the TBRHSC NICU had NAS.[74] This represented 6% of all births during this period.[75] It is important to note that not all babies born with NAS symptoms are admitted to the NICU.

In 2015, it was reported that 15.8% of women who delivered at TBRHSC reported "drug and substance" exposure during pregnancy.[76] During that same time period, 12% of newborns admitted to the TBRHSC NICU had NAS.[77] This represented 5.7% of all births during this period.[78]

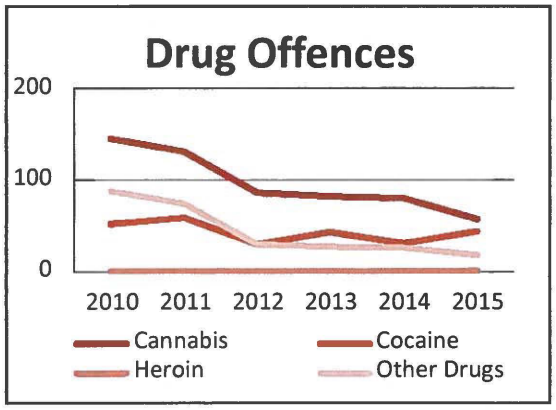
ENFORCEMENT PILLAR

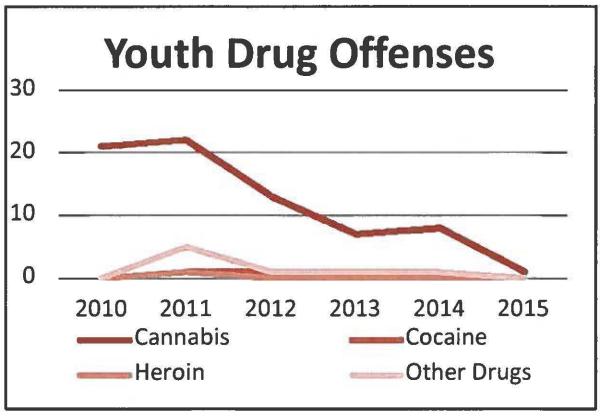
It is important to consider the association between crime and substance use as one of the most significant areas of risk under the Enforcement Pillar. Internationally and nationally, criminological researchers have established a strong connection between the use of alcohol and drugs and crime. However, it is important to note that it is not possible to draw definitive conclusions on the direction of this relationship. Research has identified three theoretical models originally developed to explain the drug-violence link in the United States.[79] The relationship is complex and these models propose a framework to understanding the link:

a) Psychopharmacological Link (also known as Use-related Crime) – this model suggests that it is the effects of certain substances on the individual using them that impacts the criminal behavior. Substances that produce effects such as decreasing judgment and self-control, creating paranoia or distorting perceptions are implicated here. Research suggests that alcohol, PCP, cocaine, amphetamines and barbiturates are more strongly associated with violence. Whereas, cannabis and heroin are linked to a lower use of violence to resolve disputes.
b) Economic-compulsive Link (also known as Economic-related Crime) – this model suggests that, in order to support one's drug habit, individuals commit crimes to obtain money to pay for the substance of choice. Crimes implicated here are prostitution, theft, fraud, robbery, and break and enter, to name a few.
c) System Link (also known as System-related Crime) – this model suggests that it is the illegality of the drug world that is the driving force on criminal behaviour. This model identifies production, trafficking, transportation of drugs, as well as violence related to the production and sale of, such as a turf war.

It is important to note that there is a large body of data that shows that most people who use drugs illegally will never become regular users, and even fewer will develop drug addiction. And that many people who use drugs illegally will commit no other kinds of crimes, and many people who commit crimes never use illegal drugs.

Drug Offences





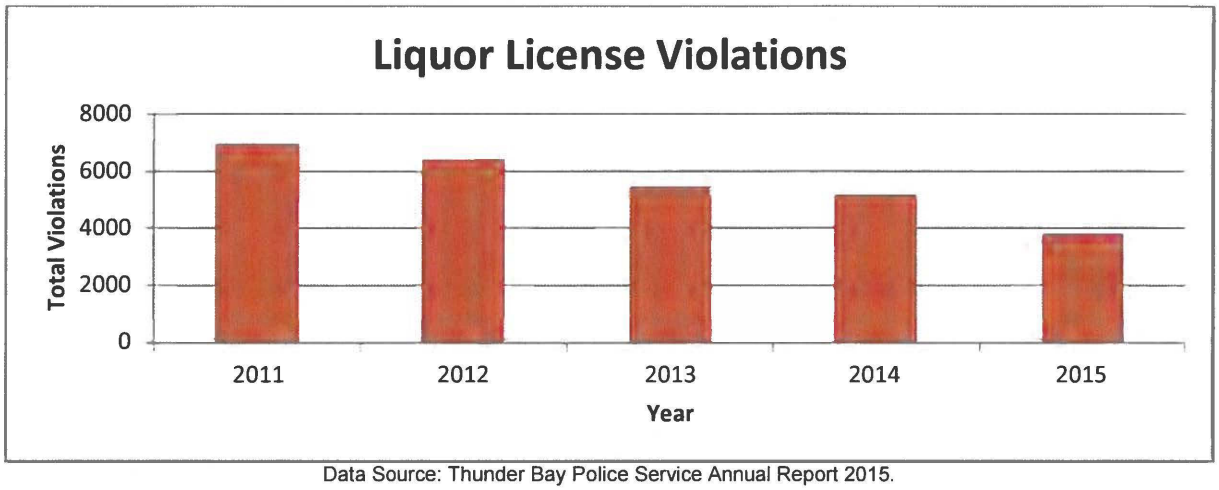
Data Source: Thunder Bay Police Service Annual Report 2015.

As previously outlined in the section on Marijuana, Thunder Bay follows the same trend nationally, in that cannabis accounts for the majority of drug offences. Overall, total drug offences are trending downward for both the general population, and for youth drug offences.[80] What is not described in this data is the breakdown between the various types of drug offences: possession, trafficking, production, etc. However, according to the Thunder Bay Police, most of the police-reported drug offences are for possession for the purpose of trafficking and simple possession. We also do not have data that shows the number of other crimes (based on type) where substances, particularly alcohol, were involved. For homicides and

incidents of significant violence, generally alcohol was a contributing factor and often the people involved are known to each other. This same generalization cannot be made in the context of domestic violence.

Liquor Licence Violations

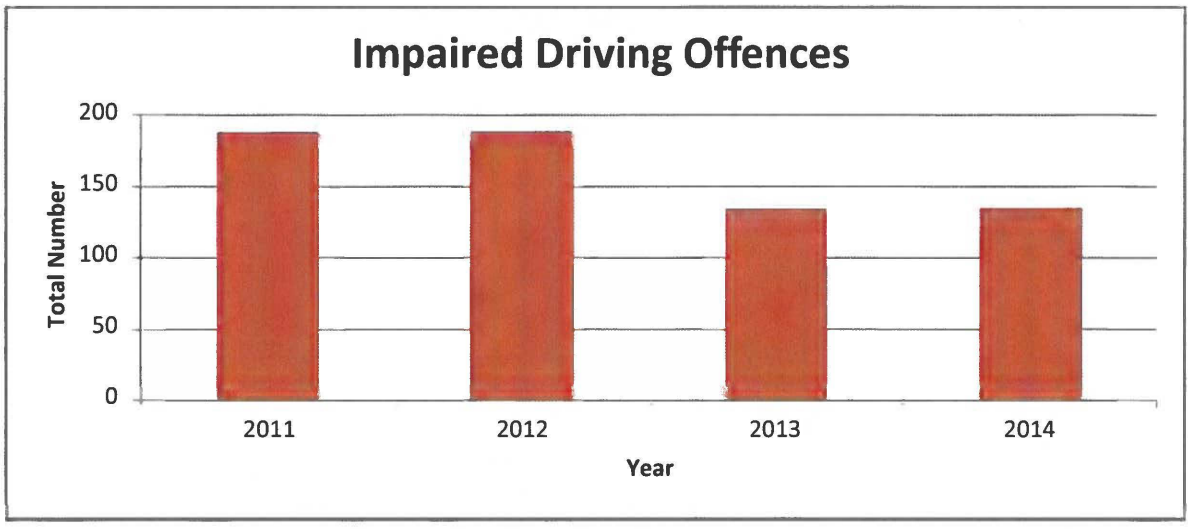
Total liquor license violations are on a downward trend, and this includes public intoxication arrests. While this is promising, the rate of arrest for public intoxication is still one of the highest in Ontario, and the reduction in violations, according to the Thunder Bay Police Service, is due more so to an increase in alternatives (other than arrest and charges) available in the community. This includes the improved access to Balmoral Centre Withdrawal Management Program, and the implementation of Shelter House's Street Outreach Services (SOS) Program.



Data Source: Thunder Bay Police Service Annual Report 2015.

Impaired Driving

Impaired driving offences include operating motorized vehicles such as cars, trucks, boats, snowmobiles and off-road vehicles while under the influence of drugs or alcohol. According to a 2015 Statistics Canada report, police reported impaired driving has declined for four years in a row in Canada.[81] Alcohol is involved in nearly all (96%) of police reported impaired driving incidents. The remaining 4% involved drugs.[82] While the overall rate has decreased, drug-impaired driving has increased, however the rate still remains low in comparison to alcohol-impaired driving. In Thunder Bay, impaired driving offences in 2013 and 2014 have declined significantly since 2011 and 2012.[83]



Data Source: Thunder Bay Police Service Annual Report 2014

PREVENTION PILLAR

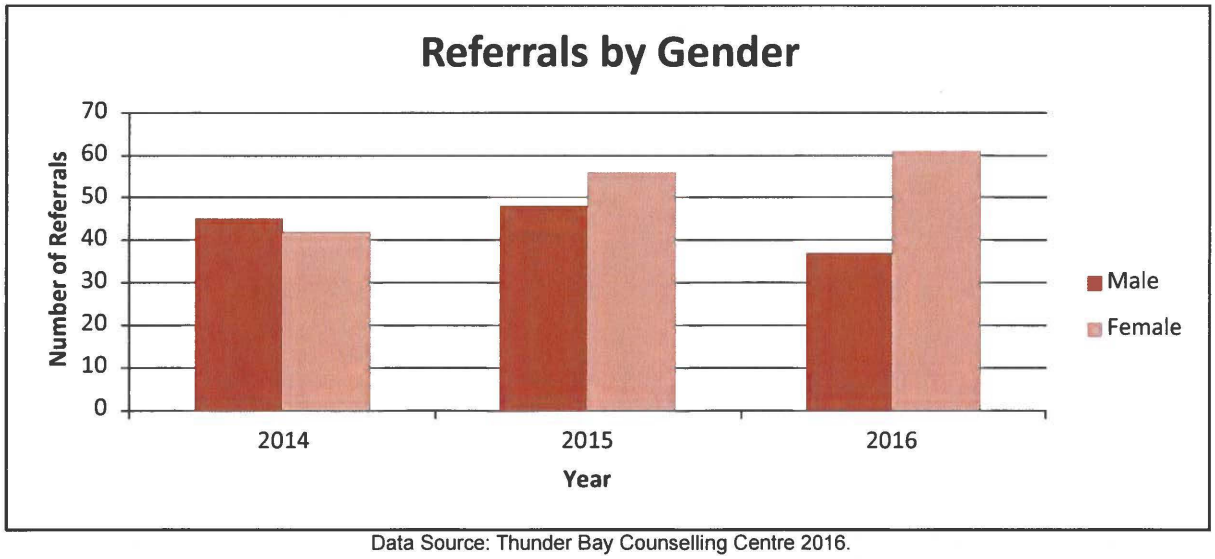
Education and awareness initiatives are often the cornerstone for the Prevention Pillar. They can involve providing information on the harms related to substance use, promoting an understanding about complex reasons why people use substances, and providing tools, skills and resources to prevent addiction. Interventions are often offered to targeted groups, and are based on evidence to have an impact on preventing or delaying the onset of substance use.

SNAP® (Stop Now and Plan)

Dilico Anishinabek Family Care has been successful in their application to facilitate the SNAP® program in Thunder Bay, in partnership with Children's Centre Thunder Bay.[84] They have developed a community resource manual for parents. SNAP® is an evidence based intervention prevention program aimed at youth between the ages of 6-12 who are identified as high risk. The program offers training to youth to improve self-control and problem solving skills with the aim of keeping youth in school and out of trouble.[85]

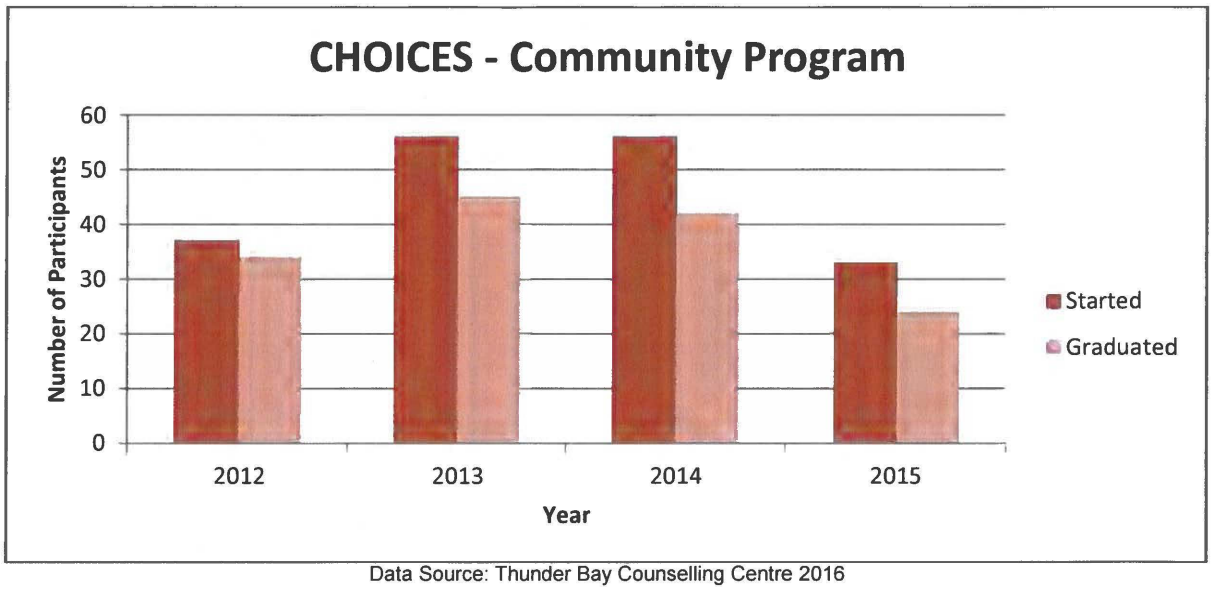
CHOICES Program

In Thunder Bay, the CHOICES Program is intended for young people aged 12-17 who may be experiencing difficulties at home, school or in the community which places them at greater risk for substance related harms. The program is facilitated through the Thunder Bay Counselling Centre in partnership with both Children's Centre Thunder Bay and the Sister Margaret Smith Centre. CHOICES is a 10-week evidence based intervention prevention program that is free and offers social skills, life skills, decision making skills, self-esteem enhancement opportunities and substance use education. Sessions are led by a volunteer base of community mentors who provide guidance and support to the youth to promote making positive choices in life.

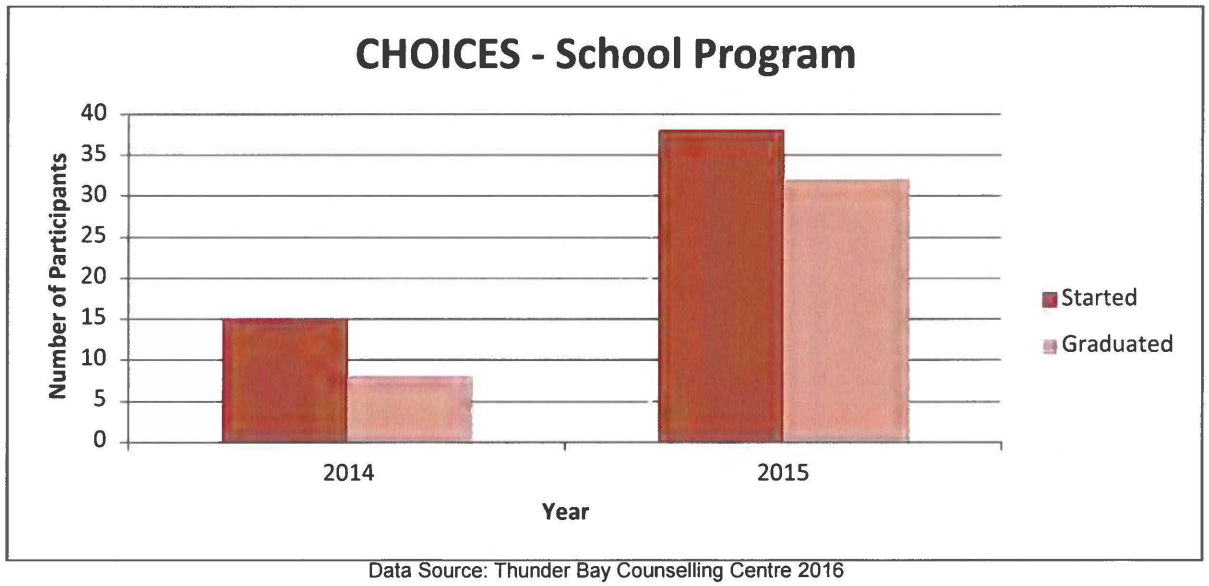


Data Source: Thunder Bay Counselling Centre 2016.

Referrals to the program can come from family members, organizations involved with the youth or family, from the school system or from the youth themselves. Not all youth referred to the program will start the program, as some don't follow up (respond, call back, or engage) with the program. Very few do not meet criteria, and the coordinator indicates that this represents a very small number in all the years the program has been running.[86] Some youth who are considered high risk have been accepted into the program if they demonstrate commitment to attending the sessions.



Data Source: Thunder Bay Counselling Centre 2016



Data Source: Thunder Bay Counselling Centre 2016

In 2014, the CHOICES Program expanded into the school system at one school, and in 2015 it further expanded to include 4 schools. This resulted in fewer intakes for the community program in the same year, and a dramatic increase in intakes in the school program from 2014 to 2015.[87] The community program is offered at Thunder Bay Counselling Centre. Graduation rates are quite high for the youth starting this program and averages at approximately 80% over the years for the community program.[88] It is too early to determine the average graduation rate in the school program.

Buffalo Riders Program

Twenty staff at Dilico Anishinabek Family Care have been trained in "Buffalo Riders" which is a program that icreases community capacity to offer youth with early and brief interventions and supports to assist in reducing substance using behaviour.[89]

TREATMENT PILLAR

Residential treatment is often the most known intervention under the treatment pillar. However, there exists a continuum of services and interventions in Thunder Bay that provide support to individuals with substance use issues who wish to make changes in their lives. These options can include withdrawal management, counselling, medical care, pre and post treatment supports, and case management services.

Thunder Bay Counselling Centre

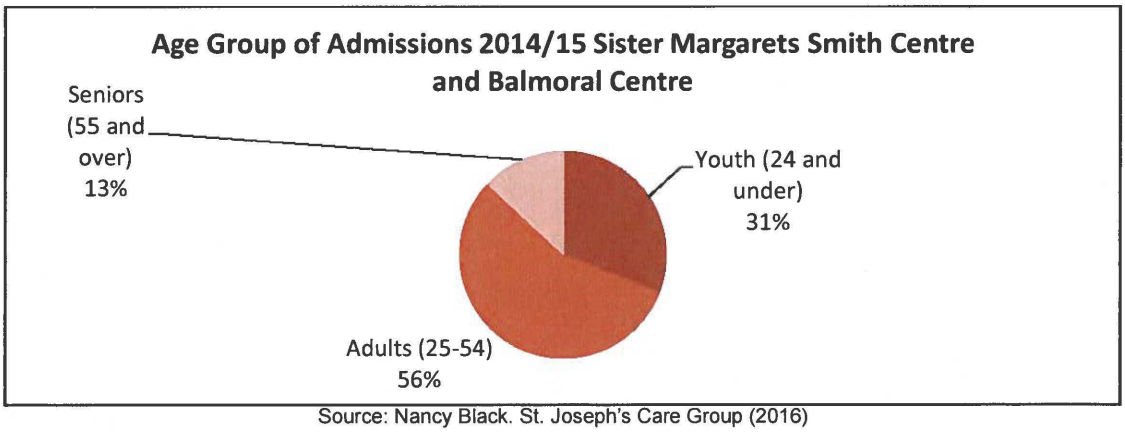
In 2014/15 a total of 946 individuals participated in community treatment at Thunder Bay Counselling Centre.[90] In that same time frame, 223 individuals were involved in case management services.[91]

Dilico Anishinabek Family Care

Annually, the residential addictions program receives approximately 700 referrals per year, and they can provide service to approximately 250 individuals per year. Dilico Anishinabek Family Care also offers pretreatment and after care services in the city and in the district of Thunder Bay.[92]

St. Joseph's Care Group

In 2014/15, a total of 4,769 individuals received services through a range of programs crossing the continuum of care located at Sister Margaret Smith Centre and Balmoral Centre of St. Joseph's Care Group.[93] Youth 24 years of age and under accounted for 31%, adults between 25 and 54 years of age accounted for the majority of clients served at 56%, and 13% were over 55 years of age.[94]



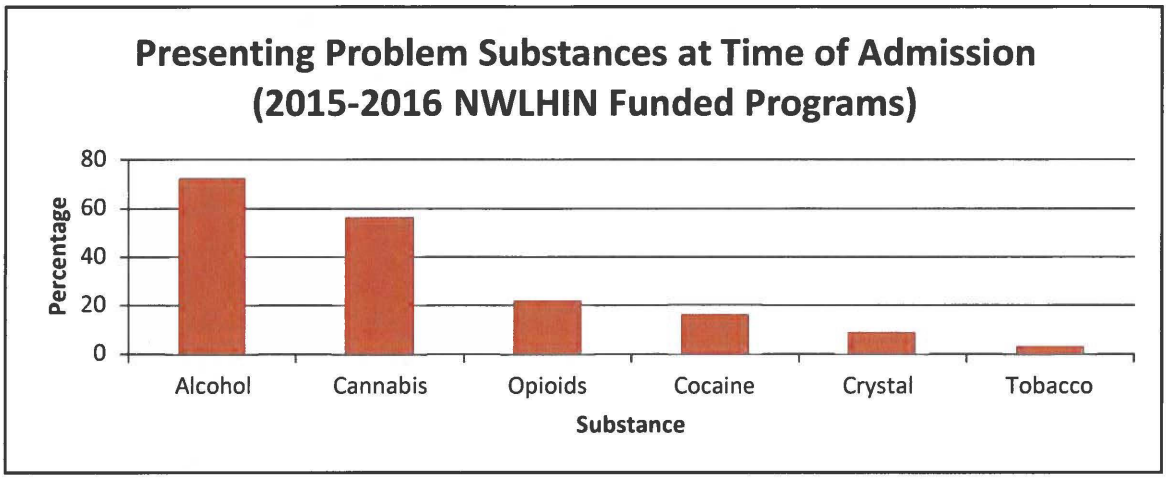
Source: Nancy Black. St. Joseph's Care Group (2016)

In 2012, it was reported that Balmoral Centre served 1300 people and turned away another 1000 annually due to capacity issues.[95] In 2013, Balmoral Centre received funding from the North West LHIN for a two-year pilot project to enhance services at Balmoral Centre. The funding provided allowed for Balmoral Centre to fully utilize all 22 beds at the facility for crisis management and stabilization through the creation of a level 3 medically supported withdrawal management program. Prior to this, the 7 beds allocated for crisis management were consistently at over capacity (119%) and caused a bottleneck for accessing services.[96] Funding for the enhanced withdrawal management services became permanent in 2015. As a result of the enhancements, the 2014/2015 year saw 2,573 admissions, which reflects an increase of 94% over the total admissions (1,326) for 2012/13, and an overall reduction of 54% in declined admissions for the same time period.[97] In 2015/2016 there were a total of 2,616 admissions, which reflects an increase of 100% over the total admissions since 2012/2013 for the same reporting period.[98] Despite this success, the number of clients who are turned away due to capacity issues has grown substantially each year, reaching 1,301 (754 males; 547 females) in 2015/2016.[99]

Some of the same factors described in the section on burdens, anecdotally can be an attributed to the increased amount of intakes as well as the substantial rise in declined admissions due to capacity issues.

Northwest Local Health Integration Network

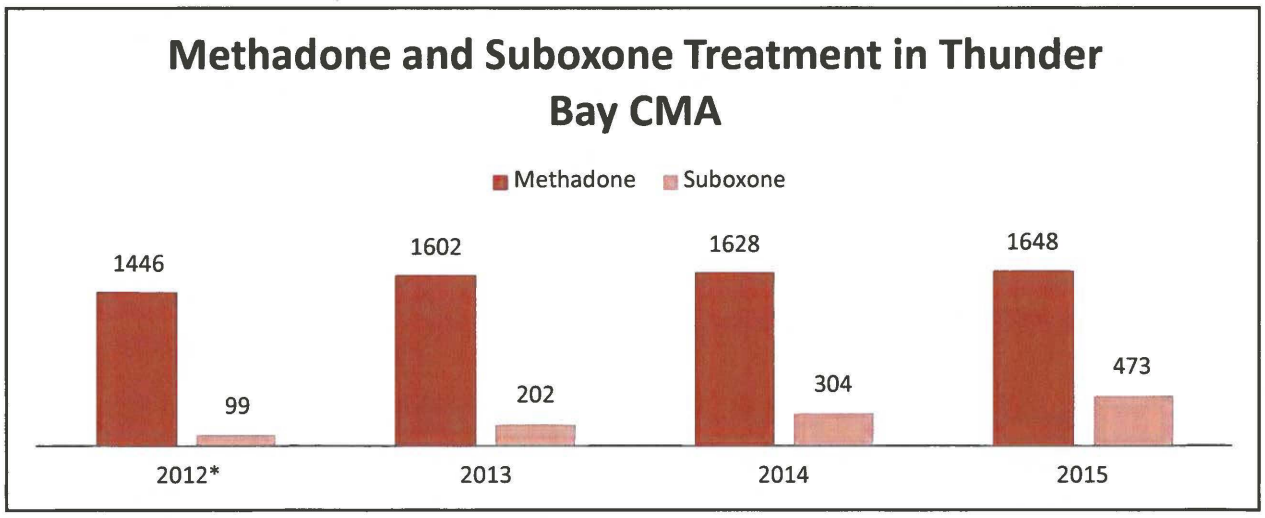
According to the Northwest Local Health Integration Network (NWLHIN), for all NWLHIN funded substance use programs in 2015-2016, the majority of admissions are youth (40.8%), followed by adults (33.4%), then seniors (16.6%).[100] Approximately 2.9% of admissions are for individuals under 16 years of age.[101] Slightly more males are admitted than females to the NWLHIN substance use programs. The top three presenting problem substances at time of admission are alcohol, cannabis and opioids. Data also shows that 29% of inbound referral sources are self-referrals, followed by 6% by the legal system (police and other), 5% are referred by family or friends, and another 5% are referred by hospital and psychiatric services in hospital.[102]



Data Source: Northwest Local Health Integration Network (2016)

Opioid Replacement Therapy

Thunder Bay District has the highest rate of opioid maintenance therapy users in 2015 in all of Ontario.[103] According to the Health Analytics Branch of the Ministry of Health and Long Term Care, records from the Narcotics Monitoring System for individuals with an Ontario Health Card indicate that the number of individuals receiving methadone remains relatively stable over the past four years. On the other hand, the number of individuals receiving Suboxone has increased substantially over the same period.[104]



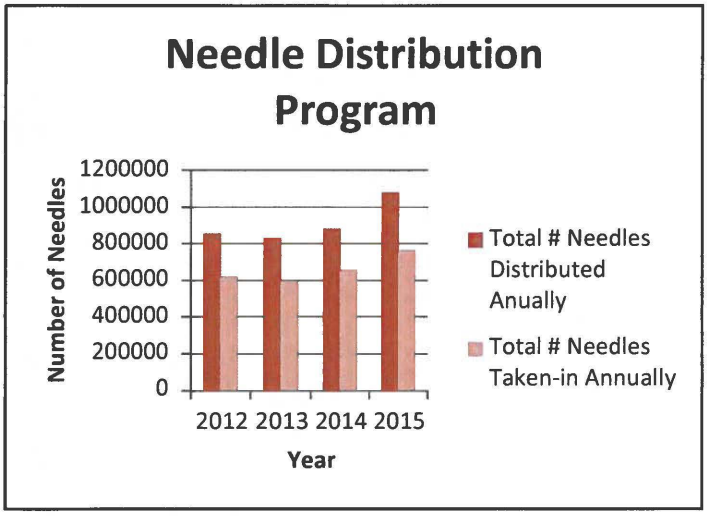
Data Source: Ministry of Health and Long Term Care, Health Analytics Branch (2016)

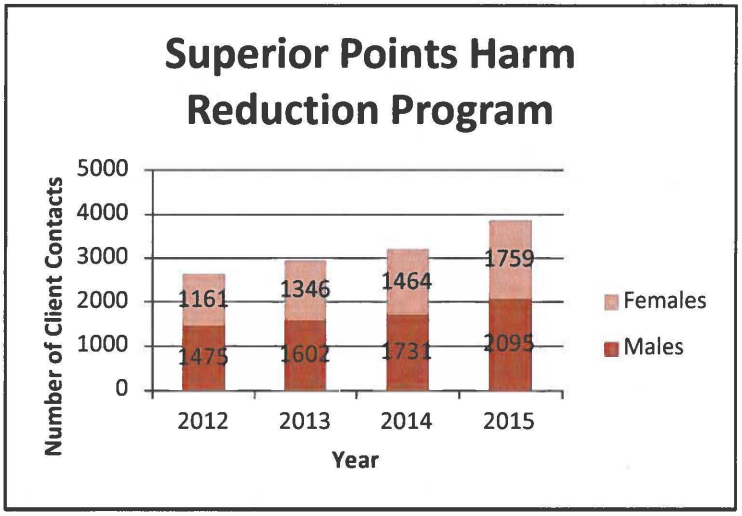
HARM REDUCTION PILLAR

Harm reduction refers to non-judgmental, person-centred interventions, including programs and policies, which aim to reduce the adverse health, social, and economic costs that may arise from the use of legal and illegal substances, and can include (but does not require) abstinence. It is widely accepted by many groups, including the World Health Organization and Canadian Centre on Substance Abuse, as an evidence-based approach to addressing substance related harms.

Superior Points Harm Reduction Program

The Superior Points Harm Reduction (Superior Points) program provides clean needles and harm reduction services through outreach services which are free and confidential. The needle distribution program has seen an upward trend in the amount of needles distributed annually, as well as an increase in number of annual client contacts. Recorded client contacts do not represent unique clients as Superior Points is an anonymous program and therefore does not collect unique client information as a requirement for accessing services. Over a two year period, Superior Points has increased satellite sites from approximately 7 to 15 in the City and District.[105] It is important to note that one of the local sites, which is responsible for about 1/3 of the distribution in smaller amounts, plus most of the district sites, are unable to provide number of client contacts or any information regarding demographics.[106] This indicates that the number of client contacts is greatly underreported and is likely significantly higher.





Data Source: Superior Points Harm Reduction Program (2016)

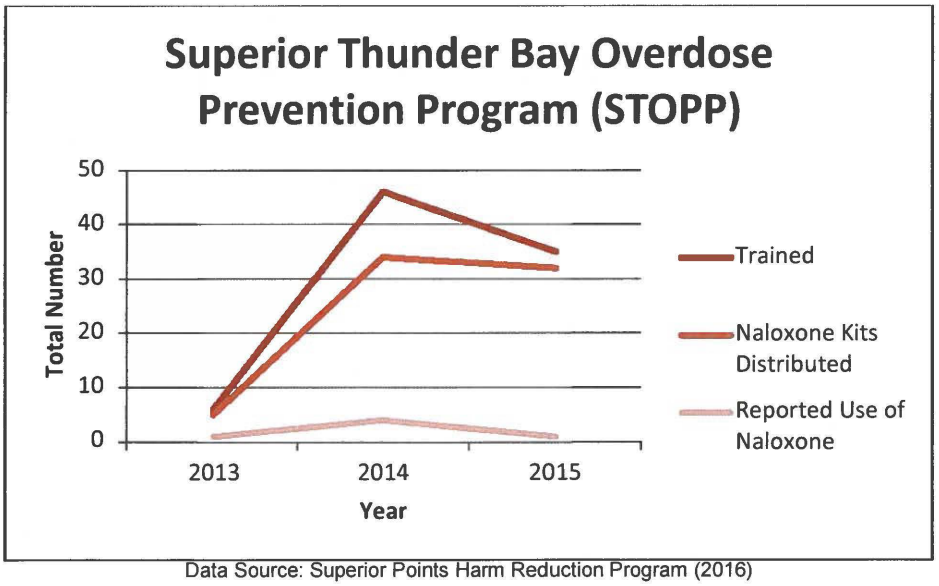
While both data sets are trending upward, these numbers are not a good indicator for the level of substance use or injection drug use in Thunder Bay. The numbers are unable to tell us, for example, if drug use has increased, if there has been a shift in route of administration (i.e. inhalation to injection) amongst those who are accessing services. They also do not tell us if the distribution of needles is reaching more unique people, if those accessing are using them for their personal use, or providing harm reduction equipment to their peers either locally or in remote regions.

Safer Inhalation Program

Approximately 20,000 – 30,000 safer inhalation kits are distributed on a weekly basis.[107] Information is not currently collected on the intended use of the kits; however, anecdotally there are reports that the inhalation kits are being used for tobacco from discarded cigarette butts and for marijuana. Attempts are being made to begin to collect this information to further assess the use of safer inhalation kits. With the rate of distribution of the inhalation kits, it has been difficult to keep up with the demand.

Superior Thunder Bay Overdose Prevention Program

The Superior Thunder Bay Overdose Prevention Program (STOPP) was launched in the summer of 2013. In that year, there were a small number of individuals trained on overdose prevention, fewer received a kit with naloxone, and there was one reported use of naloxone. 2014 was the first full year the program ran in the community, and there were 46 individuals trained, 34 individuals received a kit with naloxone, and there were 4 reports of using naloxone.[108] In 2015, there were 35 individuals trained on overdose prevention, 32 individuals received kits, and there was one reported use of naloxone.[109] Efforts have been made to build relationships with organizations serving at risk clientele to offer overdose prevention training on-site, and to-date, the program is offered at Shelter House, and the four Ontario Addiction Treatment Centres located in Thunder Bay.[110] In 2017, STOPP will be provided with the nasal formulation of naloxone for distribution.



Data Source: Superior Points Harm Reduction Program (2016)

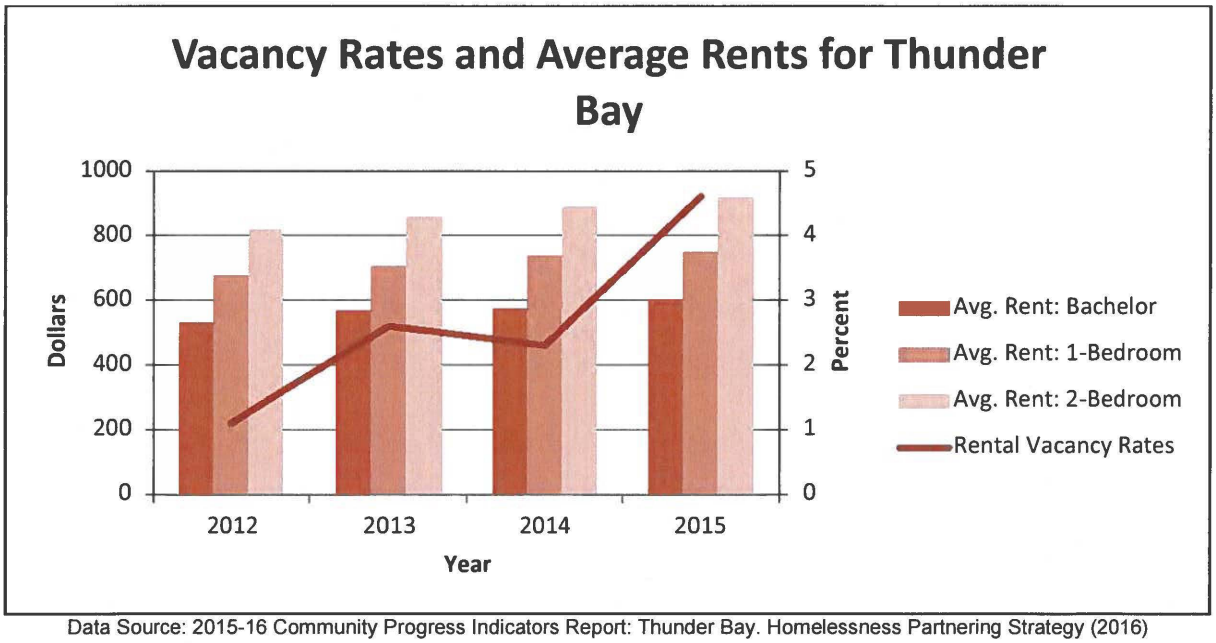
HOUSING PILLAR

Adequate housing refers to housing that, according to residents, does not require any major repairs. ***Suitable housing***, according to National Occupancy Standard (NOS) requirements, has enough bedrooms for the size and make-up of the household. To be ***affordable***, means that a household spends less than 30% of before-tax income on housing. ***Core housing need*** is when a household does not meet one or more of the adequacy, suitability or affordability standards and the household spends more than 30% (***severe housing need***: 50%) of its before-tax income to secure housing.

Vacancy Rates and Average Rent

According to the Homelessness Partnering Strategy 2015-16 Community Progress Indicators Report for Thunder Bay, rental vacancy rates have risen from 1.1% in 2012 to 4.6% in 2015.[111] Average rents in 2012 for Bachelor ($531), 1-Bedroom ($676) and 2-Bedroom ($818) have risen to $603, $749 and $917 respectively in 2015.[112]

In 2011, it was identified that approximately 5,265 households (or 10.5%) were in core housing need, and 4% were in severe housing need.[113]

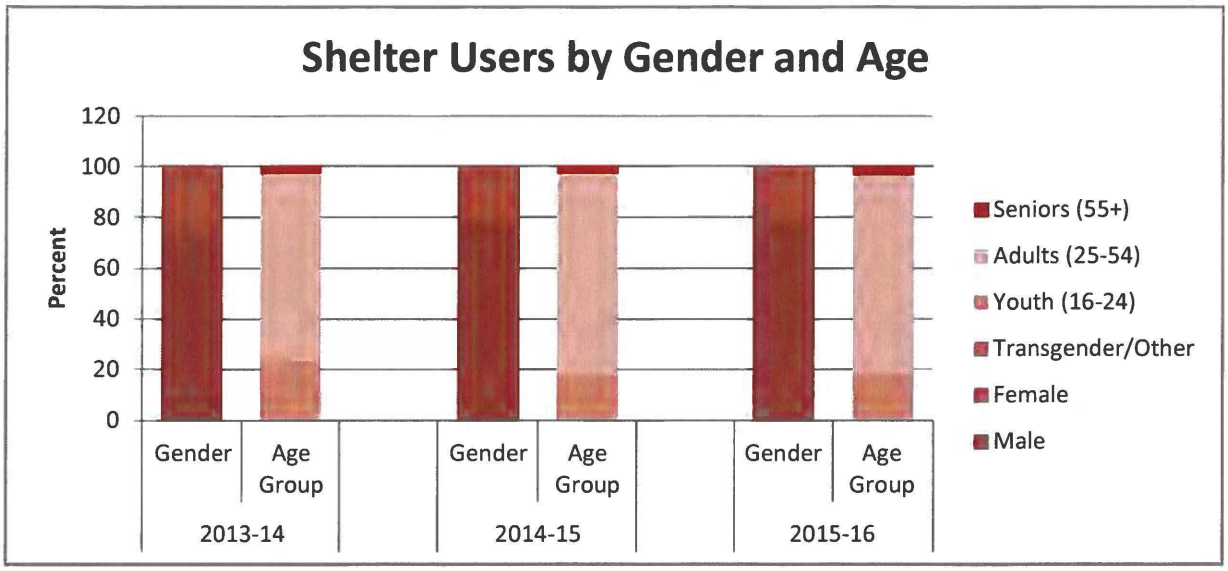


Data Source: 2015-16 Community Progress Indicators Report: Thunder Bay. Homelessness Partnering Strategy (2016)

Emergency Shelter Use in Thunder Bay 2015-16

Someone is said to be a ***chronic shelter*** user if they have stayed at a shelter for 180 nights or more in the past year.[114] Someone is said to be an ***episodic shelter*** user if they have had 3 or more episodes of homelessness in the past year.[115] One homeless episode can be a single stay or multiple stays at a shelter separated by less than 30 days.[116] A new episode begins if after 30 days a user returns to a shelter.

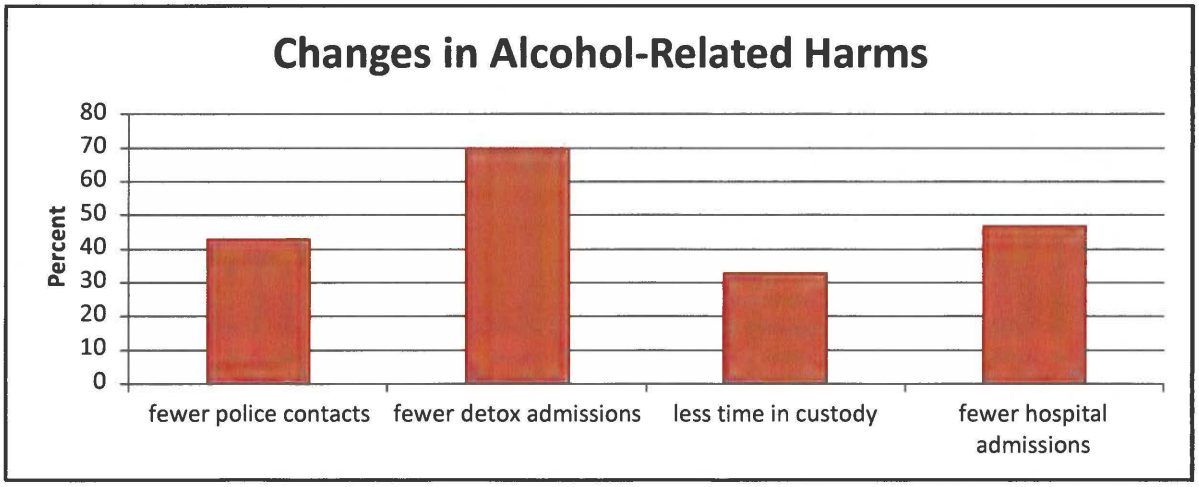
In 2015-16 there were 1300 unique shelter users in Thunder Bay.[117] Thirty-three were identified as chronic and 167 were identified as episodic.[118] Data represents users of Shelter House and Salvation Army. Data is not collected through the Homeless Individuals and Families Information System (HIFIS) from other shelters, such as Beendigen or Faye Peterson. More males are accessing the shelter system. It is important to note that the Salvation Army is a men's residence, and Shelter House has limited beds available to females. Adults make up close to 79% of the shelter population, youth close to 18%.[119] A very small number of shelter users are seniors (around 3%).[120] This may be due in large-part to the reduced life expectancy of homeless individuals.



Data Source: Homelessness Partnering Strategy 2015-16 Community Progress Indicators Report for Thunder Bay (2016)

Managed Alcohol Program – Kwae Kii Win Centre (KKW)

The KKW Centre continues to offer support and accommodation to 15 men and women who have experienced long-term homelessness and chronic and severe problems related to alcohol use. The Housing & Homelessness Coalition Community Advisory Board supports this program through HPS funding from Service Canada. The City of Thunder Bay approved one time increase in funding for Shelter House to continue to operate the program while they look for other funding.



Data Source: CARBC (2016)

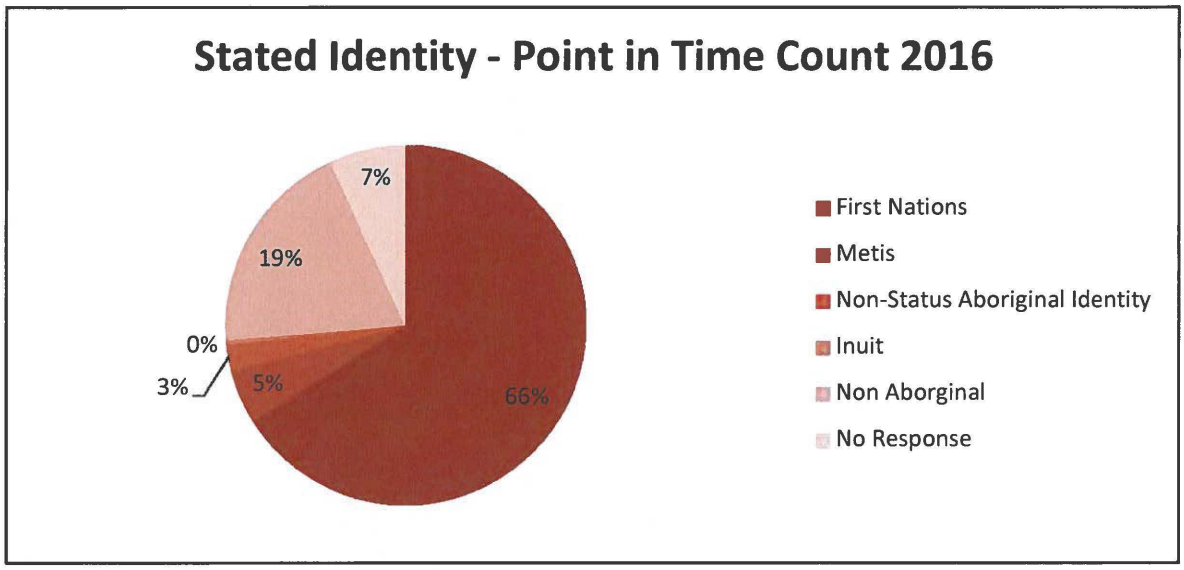
KKW is one of about 12 managed alcohol programs across Canada, but there is still little research about their long-term impacts. Research that has been conducted suggests that participating in the managed alcohol program is associated with several positive outcomes, such as fewer hospital admissions, fewer police contacts leading to custody, fewer detox admissions, less frequent use of non-beverage alcohol (such as mouthwash or rubbing alcohol), and improved scores on liver function tests. Participants in the program were also more likely to report improvements in their quality of life, such as maintaining housing and experiencing increased safety. Shelter House continues to seek financial support to sustain this important program.

SOS – Street Outreach Services

The SOS program helps people who are street involved and/or publicly intoxicated find the help they need such as shelter, food or withdrawal services. The project began in 2013/14 as a pilot to address what was anticipated to be a harsh winter and the rising admissions to the local shelter. In the first 4 months of the project (December 27, 2013 to April 27, 2014), the SOS team provided 948 transports. The project did not receive funding to start again until December 2014, and from that time until March 2015, the SOS teams provided 1620 transports.[121] The SOS teams provided 6670 transports for people between April 2015 and March 2016.[122] SOS helps alleviate pressure on emergency responders and ensures people get access to services that best meet their needs. The City of Thunder Bay approved one time increase in funding for Shelter House to continue to operate the program while they look for other funding. Shelter House continues to seek financial support for long-term sustainability of the SOS program.

Point in Time Count 2016

According to the first biennial Point in Time Count (PiT Count) conducted in Thunder Bay (2016), 289 individuals were surveyed over a 24-hour period and identified as being homeless.[123]



Data Source: Lakehead Social Planning Council (2016)

There were 213 homeless people who stated they were of Aboriginal identity, which represents approximately 74% of those surveyed for the PiT Count.[124] Of those individuals surveyed, 168 people indicated they had been homeless for 6 months or more in the past year, and 101 people identified that they had been homeless 3 or more times in the past year.[125] Over 80% reported that addiction or substance use was the main reason for housing loss – followed by family conflict and eviction or job loss.[126] The next local PiT Count will take place in 2018. In conjunction with the PiT Count, Thunder Bay was the first community in Canada to conduct the 20,000 Homes Campaign (20K) Registry. Where the PiT Count is an anonymous count, 20K is a registry of named individuals in Thunder Bay who are homeless. Based on their answers to the survey questions, they are ranked based on acuity of risk. Nationally, the goal is to house 20,000 homeless individuals by July 2018.[127] Preliminary work has begun to coordinate efforts to house individuals on the 20K Registry list in Thunder Bay.

Appendix A – TBDS Selected Priority Recommendations 2012-2017

X = Panel identified priority action for implementation

#	Recommendation	2012-2014	2015-2017
1.1	Create a comprehensive Drug Strategy Implementation Plan	x	x
1.3	Ensure Drug Strategy is included in the City strategic plan.	x	
1.4	Seek funding partnerships and opportunities to initiate a Centre of Excellence for Addiction Studies in Thunder Bay.	x	
3.1	Advocate for the development of a Federal housing Strategy that includes funding for social housing.	x	x
3.7	Allocate sustainable operational funding to local emergency shelters based on adherence to shelter standards that promote acceptance and inclusion of persons who use substances.	x	x
3.13	Create a personal identification (ID) storage program for vulnerable populations.		
3.14	Create housing options that follow the Housing First philosophy	x	x
4.24	Advocate to the Province of Ontario to increase funding for the Ontario Works Addiction Services Initiative (ASI) (delivered through the DSSAB) to ensure that program capacity meets community need.		
5.1	Support school boards and families to begin drug education based on supporting positive social and behavioural development at earlier ages.	x	x
5.2	Conduct an environmental scan to identify resources and gaps in parenting supports and programming for families.	x	
5.3	Provide caregivers with access to current and evidence-based information and education about how to delay or prevent their children from using substances.	x	x
5.11	Encourage schools and school boards to develop evidence-based alcohol and substance use policies that utilize a restorative justice framework.	x	
5.12	Conduct an environmental scan of programming and campaigns designed for post-secondary students.	x	x
5.13	Improve the range of treatment options for youth to expand and enhance off-site, school, community-based and early onset approaches.	x	x
5.14	Create a working group to investigate the provision of harm reduction services for youth.	x	
5.15	Examine the feasibility of creating a pool of available and screened trustees for youth that access social assistance allowances.	x	
5.16	Create an inter-agency neonatal substance use working group to develop strategies for supporting pregnant women, new mothers who use substances and their infants to improve family outcomes.	x	
6.1	Compile current community programs and services that provide system navigators, case management providers, and street outreach positions.	x	x
6.2	Expand crisis response services to address various types of addiction-related crises.	x	
6.8	Form a working group to examine the implementation of overdose prevention such as the provision of Naloxone, overdose education and institution of a medical amnesty program.	x	

#	Recommendation	2012-2014	2015-2017
6.9	Advocate that publicly funded and insured insurance cover the cost of suboxone as a treatment option for detoxification and harm reduction for opiate dependency.	x	
6.10	Improve access to safe inhalation kits.		x
6.13	Advocate and support access to specialized emergency services for people with mental health and addictions issues.	x	x
6.14	Form a working group to determine the fit and feasibility of a supervised consumption site.		x
6.18	Educate the community about methadone maintenance therapy (MMT) and the principles of harm reduction.	x	
6.20	Promote basic training about harm reduction, addictions and IV drug use to professionals that interact with community members.		x
6.21	Increase "one-stop" access to primary care, basic preventative health services, harm reduction services and addictions and mental health screening system entry points at accessible or mobile sites.		x
6.22	Expand and diversify needle exchange services by advocating and supporting needle exchange services at primary health care clinics, hospitals, pharmacies and non-profit groups.		x
7.2	Increase the availability of suitable childcare initiatives to support caregivers' access to treatment services.		x
7.9	Create a common, shared process that integrates treatment, social services and other systems to facilitate access and provide more collaborative case management.		x
7.10	Request that the Northwest LHIN, in partnership with Northwestern Ontario service providers, review the Mental Health and Addictions system in Northwestern Ontario for improved system access and navigation.		x
8.2	Increase education to the community about how to safely dispose of needles.	x	
8.4	Provide more needle disposal bins at key sites, including not-for-profit housing complexes.	x	
8.12	Provide public education about substances, substance use, and legislation about substance use including impaired driving and promote local helping resources.	x	x
8.13	Examine the feasibility of partnership programs that match clinical resource teams with enforcement teams to improve health outcomes for people who use substances.	x	x

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