Comparing Models for Addiction Services

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Comparing Models of Addiction Services

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Abstract

A comparative analysis of harm reduction and abstinence addiction treatment programs focusing on Peterborough City and County, Kawartha Lakes, Haliburton County, and Northumberland County has not been done. The present study researched previous studies in the field of addiction services, identifying the available services in the specified regions, surveying those services, and compiling data to determine the gaps in the current services to make future recommendations. This work is critical to addiction service research because substance use is a significant area of concern in the research area and across Canada. The study will aid in the identification and implementation of services needed in the four counties to reduce addiction and indirectly keep addiction-related offenders away from the criminal justice system. A literature review of harm reduction and abstinence was conducted using on-line portals. A questionnaire containing service details, client statistics, and gaps in services was administered to the available service providers and front line services including youth services and hospitals. Results show that individuals face many barriers when dealing with their addictions which include stigma, transportation, financial issues, and wait times for service. The current distribution of services is mostly harm reduction- compared to abstinence-based services but both serve equal males and females. The most prominent substance use is with alcohol, cannabis, and opioids. The significant gaps that currently exist are a lack of communication between services, a lack of funding for additional services, and a lack of residential detoxification centers and addiction supportive housing units.

Acknowledgements

I would firstly like to thank Sharon Beaucage-Johnson for accepting me into the Community-Based Research Course and introducing me to this project. I have learned valuable research skills, communication skills, and problem-solving skills. I also enjoyed working with the communities of Peterborough, Kawartha Lakes, Haliburton, and Northumberland, and I found the community-based atmosphere very rewarding.

Secondly, I would like to thank John Marris of the Trent Community Research Centre for always giving me feedback on my work and keeping me on track with my deadlines for the project through e-mail and in-person meetings.

Thirdly, I would like to thank Dave Jarvis for allowing me to take on this particular project. The project itself has been a lot of hard work but it has also been very rewarding. I hope that this paper helps to make positive changes in the addiction services field and the communities of Kawartha Lakes, Peterborough, Northumberland, and Haliburton.

Fourthly, I would like to thank all those who took the time to respond to my e-mails and phone calls, those who took time to physically meet with me to discuss my research, and those who took the time to fill out my questionnaires and surveys. Without your responses this paper would not have been possible.

Lastly, I would like to thank my family. My parents, Stephen and Krista Emino, have helped me persevere throughout the year in the ups and the downs. They have kept me motivated and pushed me to work my hardest on this project. Also to be thanked is my brother Steven Brewer who passed away from a drug overdose in 2007. He was the person who got me interested in addiction and helping people and through this report I hope to help many people in the future who are dealing with addictions.

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Key Terms

AA – Alcoholics Anonymous, international fellowship of men and women who have had a drinking problem; it is a nonprofessional, self-supporting, multiracial, apolitical abstinence-based addiction treatment program available almost everywhere (1)

Abstinence - the practice of not doing or having something that is wanted or enjoyable; the practice of abstaining from something such as drugs or alcohol (2)

Addiction - any behaviour that is out of control in some way; characterized by craving, loss of control of amount or frequency of use, compulsion to use, and use despite the consequences it might have (3)

Alcohol - depressant drug which slows down the parts of the brain that affect thinking and behaviour as well as breathing and heart rate (4)

Alcohol Detoxification - processes to prevent alcohol withdrawal in individuals with alcohol dependence (5)

Alcohol Swab - used by people who use drugs to clean an injection site before injection (6)

Alcohol Swab Distribution Programs - programs that facilitate the use of sterile alcohol swabs for each injection to reduce the transmission of Human Immunodeficiency Virus (HIV), Hepatitis C Virus (HCV), and bacterial pathogens (6)

Ascorbic Acid - a form of Vitamin C which is acid-based and in powder form; it also helps to dissolve crack cocaine or heroin into a water solution (6)

Ascorbic Acid Distribution Programs - programs that facilitate the use of ascorbic acid to dissolve drugs instead of lemon juice to help reduce damage to veins and bacterial/fungal infection (6)

CJS - criminal justice system; set of agencies and processes established by governments to control crime and impose penalties on those who violate laws (7)

Concurrent Disorder - co-occurring addiction and mental health problems; may be active at the same time or at different times and symptoms may vary in intensity and form over time (8)

Cooker - container used for mixing and heating a drug so that what once was a powder can be injected (6)

Cooker Distribution Programs - programs that facilitate the use of a sterile cooker for each injection and aims to reduce the transmission of HIV, HCV, and other pathogens (6)

Detoxification (Detox) - removal of toxic substances from a living organism such as humans (9)

Drug - any chemical substance that has biological effects on the body (10)

Drug Detoxification - processes to reduce or relieve withdrawal symptoms in drug addicted individuals (11)

Fentanyl - an opioid medication, usually in patch form, used to treat pain (12)

Filter - used on the tips of needles to prevent un-dissolved particles of drug or other debris from entering the blood system; usually replaced by cigarette filters, cotton wool, or tampons (6)

Filter Distribution Programs - programs that facilitate the use of a sterile filter for each injection and aims to reduce the transmission of HIV, HCV, Hepatitis B Virus (HBV), and other pathogens (6)

Front Line Service – a service that is run by the government to provide services directly to members of the public; examples are hospitals and youth services. (13)

Front Line Worker - individual who directly provides services where they are most needed; examples of front line workers are nurses, school teachers/workers, paramedics (13)

Harm Reduction - practice or strategy that reduces the harms individuals face because of their problematic use of substances (6)

HBV - Hepatitis B virus; causes the infectious illness of the liver, Hepatitis B, which results in vomiting, jaundice, liver inflammation, and sometimes death; it is spread mostly through blood to blood contact through injections (6)

HCV - Hepatitis C virus; causes the infectious disease of the liver, Hepatitis C, which results in liver failure or liver cancer; it is spread mostly through blood to blood contact through injections (6)

HIV - human immunodeficiency virus; it causes acquired immunodeficiency syndrome (AIDS) where the immune system progressively fails; it is spread mostly through transfer of blood, semen, vaginal fluid, or breast milk (6)

HSJCC - Human Service and Justice Coordinating Committee; aims to address the pressure mental health clients place on the correction and court services (14)

Methadone - opioid medication that reduces withdrawal symptoms in people addicted to heroin or other narcotic drugs (6)

Methadone Distribution Programs - programs that facilitate the dispensing of methadone to aid individuals in the reduction of other narcotic drug usage (6)

Mortality - refers to the number of deaths within a population (15)

Morbidity - refers to the incidence of illness in a population (16)

NA - Narcotics Anonymous; international fellowship of men and women who have had a drug problem; it is a nonprofessional, self-supporting, multiracial, apolitical, religious abstinence-based addiction treatment program available almost everywhere (17)

Needle + Syringe Distribution Programs - programs that facilitate the use of a sterile needle and syringe for each injection and aim to reduce the transmission of HIV, HCV, HBV, and other pathogens (6)

Opiates - a group of drugs, including morphine and heroin, that are used for treating pain; they are highly addictive (18)

Overdose - the ingestion or application of a drug in quantities greater than the recommended dose which may result in toxic effects or death (19)

Tourniquet - ties that individuals use to tie off the vein and increase blood flow to the vein and facilitate injections (6)

Tourniquet Distribution - programs that facilitate the use of a clean tourniquet for each injection and reduce the potential for contamination of tourniquets with bacteria (6)

Introduction

From the 2012 Health Canada "Canadian Alcohol and Drug Use Monitoring Survey", 90.1% of Ontario citizens have admitted to consuming alcohol for their whole lifetime and of those, 14.5% exceeds chronic alcohol use (20). Chronic use is defined as drinking no more than 3 (for women) or 4 (for men) drinks during one occasion, drinking no more than 15 drinks per week, and "planning non-drinking days to avoid developing a habit" (20). The percentage of chronic alcohol users has increased from 2011 to 2012 (20). Not only is substance use prominent in Ontario, but mental health conditions and concurrent disorders are as well (21,22). The Centre for Addiction and Mental Health (CAMH) shows through their research that at least 20% of individuals in Canada who have a mental health condition will also have a concurrent substance use condition (21). CAMH found that every year, one in five individuals within Canada will experience either a mental health or substance use condition (21). Finally, according to the 2013/14 Fourcast Mental Health and Addictions Report, the most prominent substance abuse is alcohol, marijuana, and prescription opioids (23). Addiction services have been developed throughout the world to cope with addictions but the statistics show increased instead of decreased substance use.

Addiction services aim to help individuals manage or recover from their drug, alcohol, or other addiction issues. The two main models of addiction services are harm reduction and abstinence (24,25,26,27,28,29). Harm reduction and abstinence models have different underlying principles and intended audiences, but the two models exist on a continuum (26). The continuum for addiction services means that someone may begin treatment for their substance abuse using a harm reduction approach but further delve into treatment using an abstinence approach or vice versa (26). A continuum of addiction services can also mean that abstinence is a method within

harm reduction (26). Harm reduction is a strategy that aims to reduce harms such as disease, infection, or death that results from substance abuse (6, 24). Abstinence is a strategy where substance use is completely stopped in order to treat substance abuse (2, 24).

Harm reduction methods began around 1960 when society realized that drugs and alcohol have adverse effects and that these effects could not be faced alone (30,31,32,33). From the 1980s on, the presence of illicit drugs such as heroin or other illegal drugs had a dramatic effect on the increase of HIV and other viral infections (32). Currently, these viral infections are of concern in areas of high drug use (29,30,31). Harm reduction can be beneficial in cases where individuals are not physically or mentally ready to completely refrain from substance use and it also aids in the prevention of harmful events associated with substance use such as the contraction of HIV, HCV, HBV, or other pathogens (24,25,28,30).

Abstinence-based addiction services were first developed in the 1940s in the United States and have been around for some time in Canada as well (24,34,35). There are two well-known organizations that follow this model, Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) (35). Abstinence-based approaches can be beneficial for those individuals both mentally and physically willing to completely eliminate substance use from their lives (24,25,26,28,34). Abstinence-based approaches not only reduce the transmission of viral infections, but eliminates them completely because drug use is no longer existent (34).

My host for the project is Human Service and Justice Coordinating Committee (HSJCC). The HSJCC coordinates services and resources for people with mental health conditions, addictions, and developmental disabilities who are involved, or are in danger of becoming involved, with the criminal justice system (14). The regional HSJCC includes the areas of Peterborough, Kawartha Lakes, Haliburton, and Northumberland and the committee consists of police officers, mental

health services, court representatives, community members, and other service providers (14). HSJCC aims to address the pressures that mental health clients place on the correction and court services by identifying policy issues, making recommendations to government ministries, and creating solutions to systemic problems (14). The HSJCC needed further research in the area of addiction services because substance use and abuse are important issues within Ontario and this research will help identify gaps within the current services and how treatment can be improved in the future.

Previous research in the field of addiction services has demonstrated that there are two main approaches, harm reduction and abstinence. The purpose of this project was to compare and contrast the main models of addiction services: harm reduction and abstinence. It was my responsibility to research what different models of addiction services are available, what those models consist of, and what should be available. This project was necessary for Peterborough City and County, the City of Kawartha Lakes, Haliburton County, and Northumberland County because substance use and addiction has been identified by many studies as a major area of concern in Ontario (20,21,22). I looked at the four counties because the HSJCC was specifically interested in these areas. The HSJCC was also interested in how youth relate to abstinence-based addiction services. Youth make up a significant portion of substance users within Ontario (20,21). Therefore, it is critical to identify effective ways to manage and treat addictions within the youth population. My research will examine how effective abstinence-based approaches are in relation to youth populations (36,37,38,39). Assessing the effectiveness of these programs will be based on previous studies and research that evaluate relapse rates, types of addictions treated, and specific abstinence-based treatment factors such as number of meetings attended by the participant and presence or absence of a sponsor (36,37,38,39).

My research aimed to answer four main questions. 1) What are the differences between harm reduction and abstinence treatment programs? 2) What programs are available in the four counties? 3) What programs are needed in these areas? 4) How do younger people relate to 12-step programs like AA or NA? My research will help fill in the gaps that exist for comparative evaluations of these approaches and their specific applications in the four counties. The success of addiction services programs are to help prevent addiction, help battle addiction, and to indirectly help keep addiction-related offenders away from the criminal justice system. This study will aid in the identification and implementation of services needed in the four counties to aid those suffering from addiction and concurrent disorders.

To make the comparison between harm reduction- and abstinence-based approaches, I first researched what each model encompassed, their strengths and weaknesses, the types of individuals they would be most effective for, and examples of each model. I also researched abstinence-based approaches specifically and their effectiveness within youth populations. I then identified services offered in the four counties and retrieved data from those services by handing out questionnaires and conducting interviews. Next I combined all of my literature research with the questionnaire responses to both quantitatively and qualitatively compare harm reduction- and abstinence-based approaches. Finally, I used all of this information to evaluate what services should be offered in the four counties and why.

Methods

Firstly, I conducted an extensive literature review to determine what different models of addiction services exist currently. The internet-based platforms for my research were Google Scholar, PubMed, Web of Science, and Scholars Portal. I chose these platforms because I had free direct access to them through my Trent University account and they also contained the widest selection of old and new articles. The keywords used for searches on these platforms were "harm reduction", "abstinence", "continuum", "alcohol", "drugs", "Ontario", "Canada", and "youth". My host said that harm reduction and abstinence were the main models of addiction services. I confirmed this by searching for "addiction service model" in the search engines listed above. The majority of the articles from this search consisted of either harm reduction or abstinence models. For each model, I located definitions, history of the development and use of the model, principles of the model, pros and cons of the model, intended users of the model, statistics associated with the model, examples of the model, and best practices for methods within each model. Specifically for abstinence, one aspect of the project was to determine how youth relate to 12-step programs, like AA and NA; I used the same platforms listed above to locate research articles.

I also researched the geographic boundaries of the project which included Peterborough City and County, City of Kawartha Lakes, Northumberland County, and Haliburton County. I did this through a Google search of each of the four areas listed to obtain a general idea of the cities and areas located in each county. I compared this to the Central East Local Health Integration Network (LHIN) map of the above mentioned counties (40). Knowing the geographic boundaries is important to completely understand what treatment programs and services fall into the areas and also provides information on the boundaries from which clients might be coming from.

Once I fully understood the major models that encompassed addiction services, the next step was researching what harm reduction- and abstinence-based addiction services were available in Peterborough City and County, City of Kawartha Lakes, Northumberland County, and Haliburton County. I did this with a Google search of the key terms 'harm reduction', 'abstinence', 'Peterborough', "City of Kawartha Lakes', 'Haliburton', and 'Northumberland'. From my Google search, I identified seven addiction service organizations in Peterborough, five in Kawartha Lakes, six in Northumberland County, and four in Haliburton. The complete list of addiction services located and contacted can be found in Appendix A. The complete list of front line services located and contacted can be found in Appendix B. An expansion to the geographic location is the Pinewood Centre in Oshawa, Ontario; however no other organizations were contacted in Oshawa or other areas of Ontario. I added the Pinewood Centre because my host asked me to include this in my research; the Pinewood Centre is the nearest residential detox program to the four counties.

The next step in the project included an extensive evaluation of harm reduction and abstinence. Part of the evaluation included determining what front line services in the communities referred individuals to, either harm reduction- or abstinence-based services. Therefore, I researched what front line organizations/services were offered in Peterborough City and County, City of Kawartha Lakes, Northumberland County, and Haliburton County. I located the different organizations by searching the 2009 Central East LHIN Addictions Environmental Scan (22). I gathered a list of organization names from the Environmental Scan and then located contact information, from a Google search, eleven in Peterborough, eight in Kawartha Lakes, three in Northumberland County, and two in Haliburton. The complete list of front line organizations located and contacted can be found in Appendix B. I determined which individuals

would be best suited for this research by examining their job titles to see if it was addictions- or mental health-related. I recorded available e-mail addresses, phone numbers, and addresses.

Before contacting the organizations, I developed the e-mail introduction and questionnaire template that I would send to each of the front line workers and addiction services organizations. The purpose of the e-mail introduction was to explain myself and the research I was conducting. The e-mail introduction can be found in Appendix C. The e-mail introduction was also used when calling organizations to introduce myself, my affiliations and my research. I developed three different questionnaire templates which included one for addiction services, one for front line workers, and an additional on-line survey for front line workers. The on-line survey was created using the free version of Survey Monkey and I created the template by following instructions on the website itself. I used Survey Monkey to create the on-line survey because it had a free trial version and it allowed services to directly access the survey through their work or personal computers. I decided to do multiple questionnaire platforms to allow organizations to easily access whichever is better for them and I gave organizations the option to complete answers in-person, by e-mail, over the phone, or on-line. The purpose of the questionnaire was to determine what services are currently offered, the demographic of clients who are using the available services, and where these services are lacking. Appendix D is the addiction services survey. Appendix E is the written front line worker survey and also represents the questions from the on-line front line worker survey created using Survey Monkey.

After creating the questionnaires for my research and getting them approved by my professor, host supervisor, and Community-Based Education representative, I initiated contact with the organizations on November 3rd, 2014. I continued to send out responses until December 22nd, 2014. I started receiving responses immediately after sending out requests on November 3rd,

2014 and continued to do so until the cut-off date of January 31st. A list of organizations I received responses back from can be seen in Appendix F.

From my literature review of harm reduction and abstinence and the responses received from addiction services and front line organizations, I compiled a comparative evaluation of harm reduction and abstinence. In addition, I made recommendations for services or aspects of services that should be available in the four counties I examined. The evaluation first examined the total number of people served, not-for-profit versus for-profit, and characteristics of addiction services such as gaps and barriers for accessing them. Next, the evaluation examined the characteristics of the clients such as age, gender, nature of dependency, the presence or absence of a concurrent disorder, and regularity of visits. All graphs and charts were created using Microsoft Excel whereas tables were created using Microsoft Word.

Quantitative data were evaluated using means and standard deviations calculated using Microsoft Excel. Means are what are represented in the graphs for all the quantitative data which show the average answers for addiction service providers and front line services. Standard deviations are represented in the graphs by error bars which show the total variation between questionnaire responses; in other words, the lowest and highest responses and everything in-between are represented by the standard deviation. Sample calculations for mean and standard deviation can be found in Appendix T.

Results

I contacted 43 organizations (addiction services and front line services) and I received responses back from 14 organizations. Not all organizations answered all of the questions on the questionnaire. The raw data for the project can be seen through Appendices F-S. Some analyses focus on combined results for addiction services and front line services whereas other analyses break down results into addiction services and front line services. The following qualitative and quantitative data, along with an extensive literature review, allowed for a direct comparison to be made for addiction services.

The appendices can be broken down into sections of information. 1) Appendices A and B list both the addiction services and front line services that I contacted and surveyed. 2) Appendix C shows the template that I used to reach out to the various services. 3) Appendices D and E include the templates for the questionnaires I handed out to services through either e-mail, in-person interviews, phone interviews, or on-line. 4) Appendices F-S show raw data from each interview or questionnaire response; the formats of the responses are one of: transcribed interview, written responses to the questions, or internet responses. 5) Appendix T shows sample calculations for mean and standard deviations; these calculations were used frequently to generate the graphs in the results sections. All values used to generate graphs were compiled from all of the responses in Appendices F-S and means and standard deviations were calculated to demonstrate a more generalized representation of addiction services and front line services.

Means and standard deviations found separately for addiction services and front line services are in Figure 1. Addiction services generally serve generally fairly equal amounts of males and females but slightly more males. Front line services serve more females than males; data in Figure 1 for front line services represent total clients not just clients with addictions. Means and

standard deviations found separately for addiction services and front line services are in Figure 2. Addiction services generally serve individuals aged between 19-50. Front line services generally serve individuals aged 0-30. The major overlap for the age category for both addiction services and front line services is 19-30 years old.

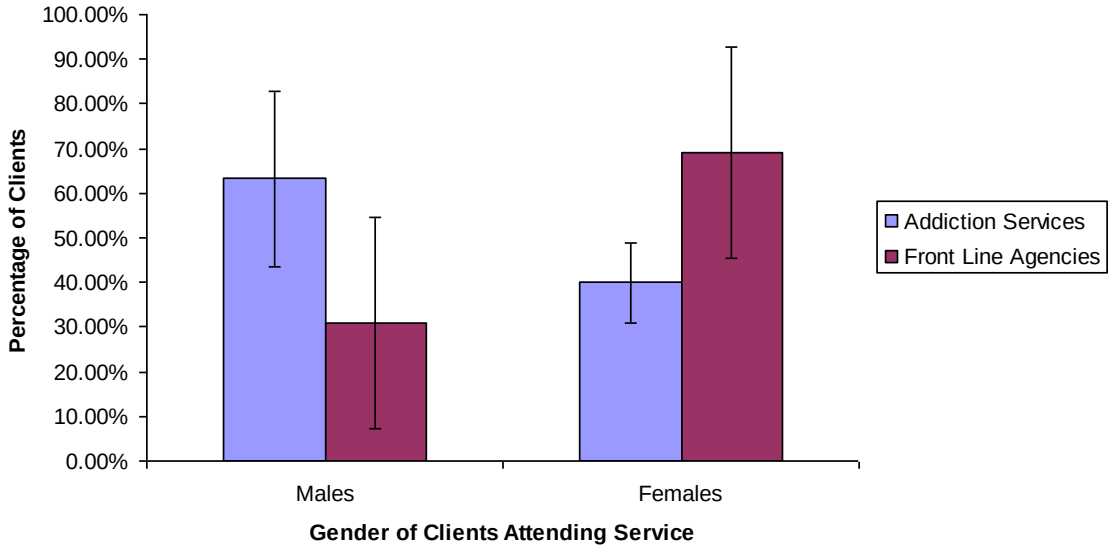

Figure 1: Means and standard deviations for percentages of males and females attending both addiction services and front line services. The percentages for front line service males and females are excluding 4 surveys that indicated unknown. Three of the unknown surveys indicated more males than females whereas the fourth unknown survey indicated more females than males.

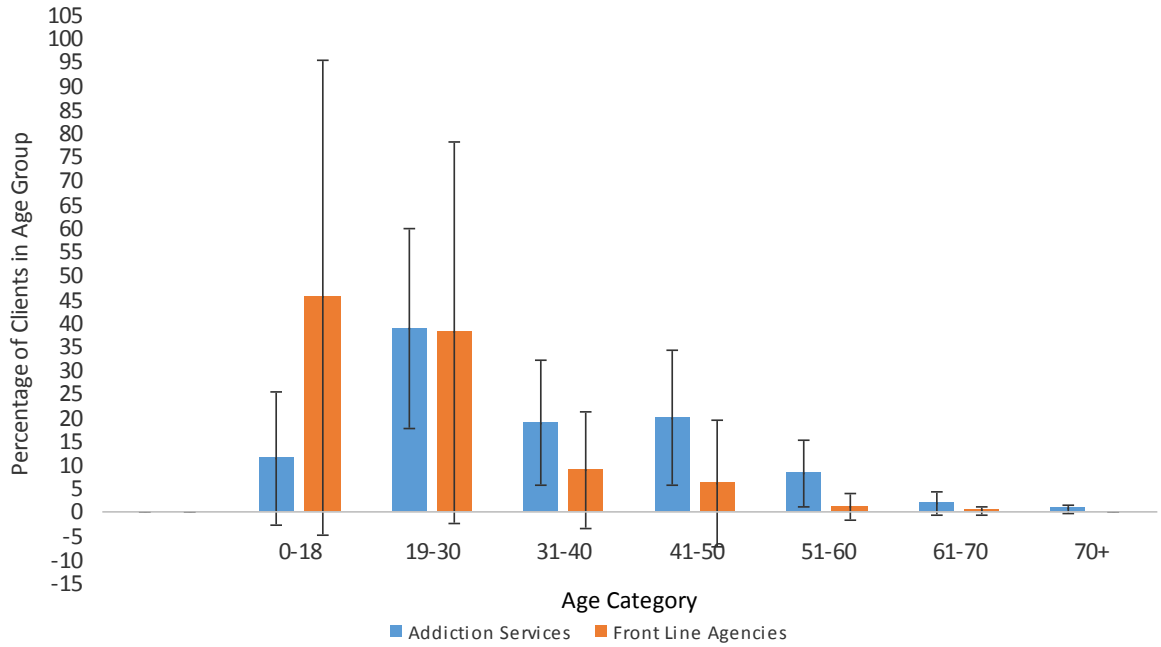

Figure 2: Means and standard deviations for percentages of various age categories attending both addiction services and front line services. Two of the addiction services surveys did not indicate age percentages. Three of the front line service surveys did not indicate age percentages.

Figure 3 represents the number of front line services that serve clients with addictions. Two services indicated that they serve between 61-70% of clients with addictions. Two services indicated that they serve between 0-10% of clients with addictions. One service indicated that they serve between 21-30%. Three front line services did not answer this section of the questionnaire. Figure 4 represents the number of both front line services and addiction services that serve clients with concurrent disorders. Front line services report that they serve anywhere from 0-90% of individuals with concurrent disorders. Addiction services report that they serve mostly between 51-60% of individuals with concurrent disorders but it ranges from 21-30% and 61-70%.

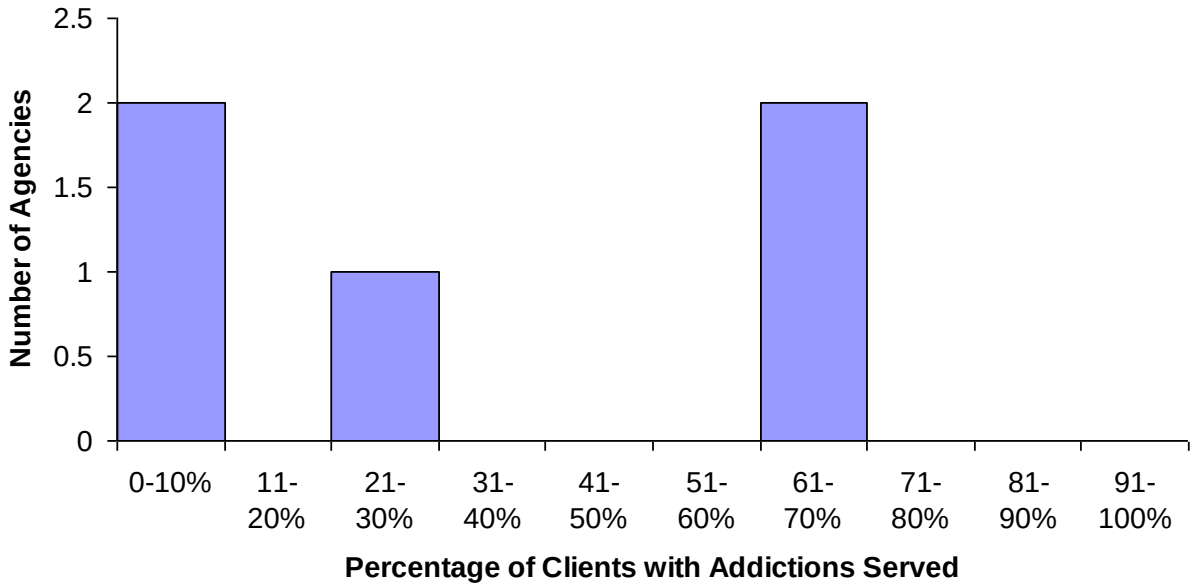

Figure 3: Number of front line services that indicated serving various percentages of clients with addiction

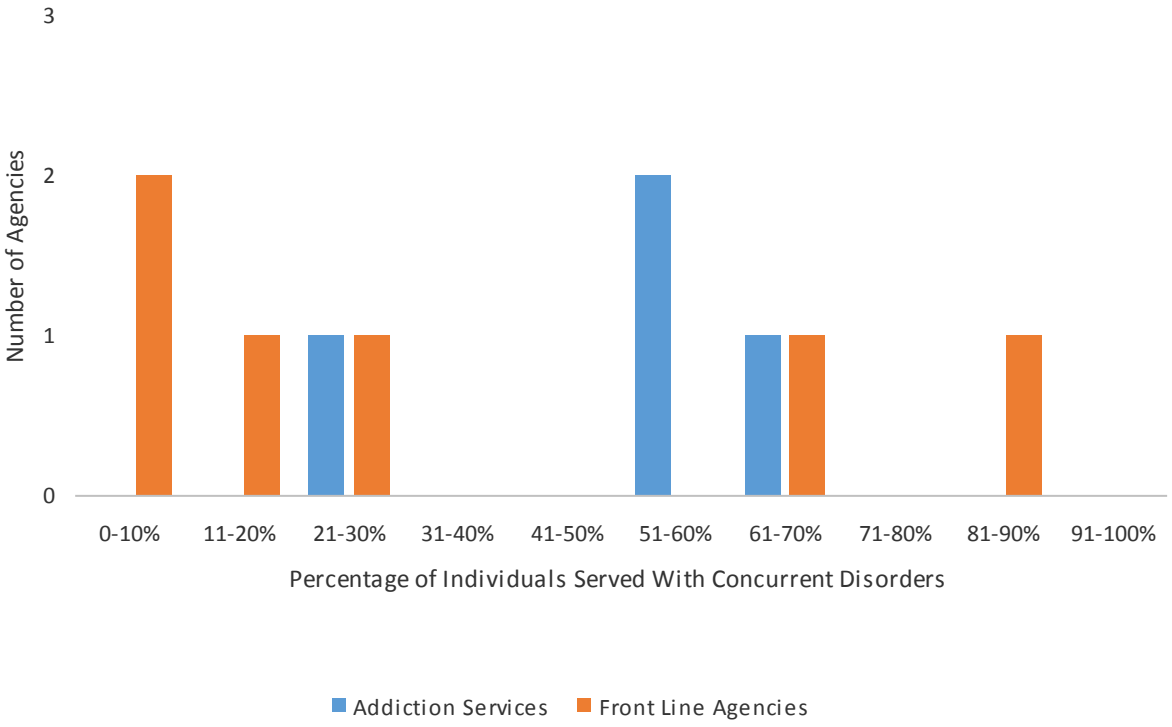

Figure 4: Number of front line services and addiction services that indicated serving various percentages of clients with concurrent disorders

The addiction services and front line services presented several barriers when accessing addiction services. Each service presented at least one barrier. The barriers identified by addiction services and front line services can be seen in Figure 5. The most prominent barrier was transportation. Other barriers that were identified as significant by the services include wait times and the stigma of having an addiction. Lack of motivation to reach out to services and financial issues were not identified by as many services but were still presented as issues. The denial of having an addiction is a barrier to receiving help for their addiction as well as no inpatient treatment, a lack of communication between services, the inability of clients to take time off work or school to attend services, a lack of pharmacies to dispense methadone, and the issue of services refusing individuals in jail with appointments. The latter barriers are less frequently identified by addiction services and front line services.

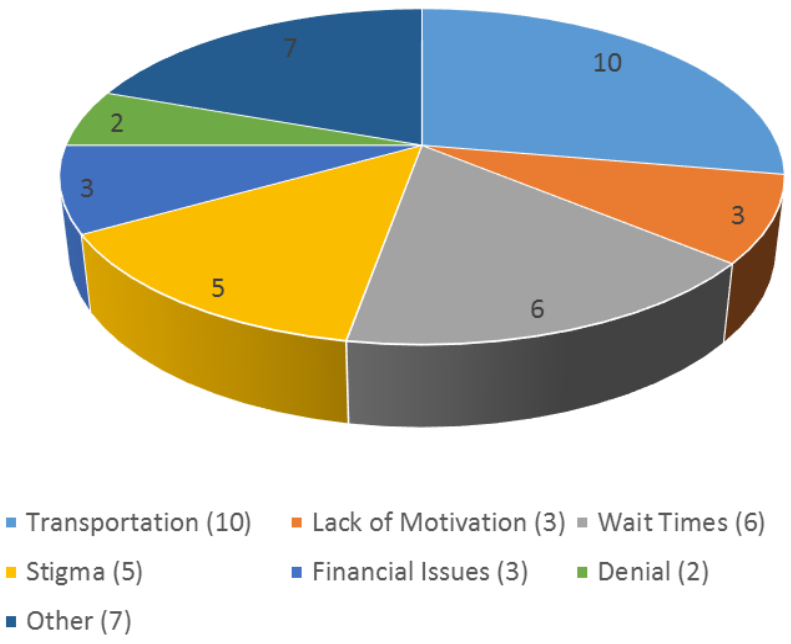

Figure 5: Barriers for individuals attempting to access addiction services. Other includes a lack of pharmacies that dispense methadone, no inpatient treatment, a lack of communication between services, a lack of job or school flexibility to attend services, and services refusing appointments for individuals in jail.

The addiction services and front line services presented the nature of dependencies for those utilizing the services available. Each agency or service presented at least one type of dependency. The nature of dependencies are represented in Figure 6. The most noteworthy dependencies are alcohol and marijuana. The next most mentioned dependencies are opiates and prescription medications. Fentanyl and other drugs are least mentioned by services. Finally, one agency reported that individuals are mostly multi-drug users and did not specify the exact dependencies.

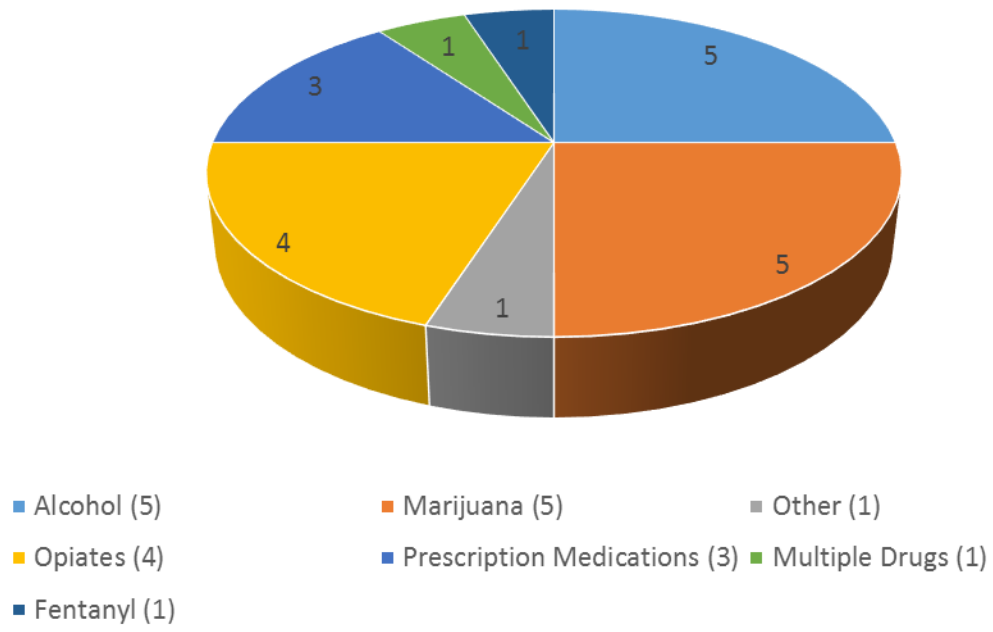

Figure 6: Nature of dependencies for individuals attending front line services and addiction services. Other includes other drugs not listed but drug types were not specified by the service. Multiple drugs indicate that the users are using more than one drug. The drugs could be those listed in other categories, but the data was presented as "multiple drug users".
abstinence - principles

A summary of the gaps of current services (Appendices F-S) can be broken down into gaps identified by addiction services and gaps identified by front line services. Addiction services

identified a lack of communication between services, a lack of funding, and a general lack of resources as gaps in the current services. Addiction services also suggested that the four counties should have local withdrawal management programs, supportive housing units for those with addiction, more outreach workers, and an expansion of FourCAST. FourCAST provides community addiction treatment programs including addiction supportive housing, counseling, withdrawal management programs, and more in the four counties. Front line services mainly identified the lack of a residential detox program in the four counties as well as a lack of preventative and educational programs. For youth battling addiction, several front line services suggested that parental involvement is lacking and that education programs need to reach out to not only youth but parents or other family members. Throughout the majority of questionnaire responses, most services identified lack of communication, lack of funding, and lack of a residential detox program as major gaps in the current services.

Figure 7 represents the number of front line services that indicated where they would send individuals if those individuals came in with addictions. The most referrals were to FourCAST. Equal amounts of referrals were to PARN, AA, and methadone clinics. Other less-referred to addiction services include Trent University counselling centre, CMHA, NA, and Al Anon.

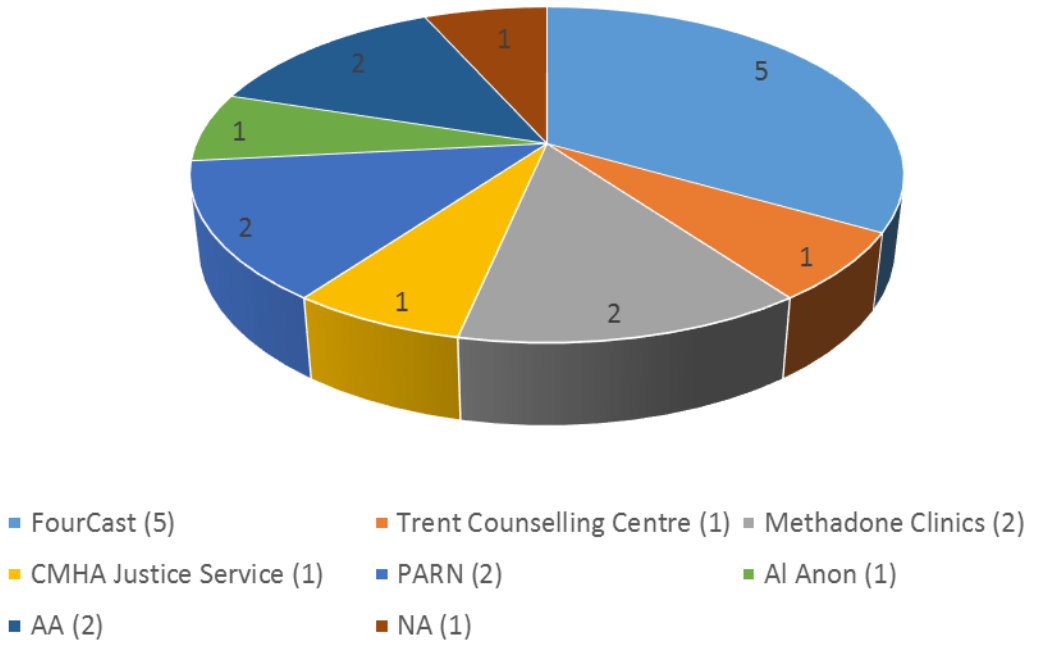

Figure 7: Number of front line services who refer individuals to various addiction services.

There are several other noteworthy results from Appendices F-S. Firstly, most addiction services and front line services are free whereas methadone clinics and Partners in Pregnancy Clinic (PIPC) are OHIP funded. When front line services were asked if sobriety was required for treatment or service, responses were mostly no. Finally, when I asked addiction services and front line services what services should be offered in the four counties, there were several answers. The most popular response was that the four counties need a residential detox program for males and females, more government cooperation, more outreach workers to support preventative and educational programs, more flexible locations, and satellite offices located surrounding the main areas of Peterborough, Kawartha Lakes, Haliburton, and Northumberland.

Results from my literature review can be broken down into abstinence and harm reduction methods. For each model, results can be further divided by pros, cons, method types, best practices, intended users of the service, and principles. The literature review also specifically

examined if connections exist between youth populations, abstinence-based services, and treatment effectiveness.

Abstinence-based addiction service approaches have a number of guiding principles in common (34,35,41,42). 1) Addiction is a disease which has no definite cure but it can be controlled. The concept behind this first principle is that the individual is no longer feeling guilty or stigmatized about their addiction. 2) The focus for abstinence is based on the addiction and the individual. 3) Therapists who are involved in abstinence programs control who is or is not ready for treatment. 4) The counselling style used in abstinence-based approaches is the confrontational style. Confrontational counselling is used to break through an individual's denial of addiction. 5) Success is based on levels of abstinence from the substances causing addiction and how many meetings the individual attends. 6) Addiction is a progressive disease and will cause death unless abstinence is continued (34.35.41.42).

Pros and cons to using abstinence-based addiction services exist (35.41.42.43). Abstinence, or completely removing substance use, completely reduces the risk of contracting HIV, HCV, HBV, or other illnesses/diseases associated with unsafe drug use. Scheduled group meetings provide individuals with a sense of community and belonging which may lead to increased success. Individual success may also be attributed to each participant receiving a sponsor which they can confide in. Even though abstinence aims to remove substance use, cons for the model do exist. Abstinence-based methods usually have high relapse rates and low success rates but rates depend on a complexity of factors (41,43-47). Another con for abstinence is no blame is put on the individual for addiction problems, just solely that addiction is a disease. This means that the individual might not necessarily hold any responsibility for their addiction. There does not appear to be any non-religious abstinence programs, only NA and AA, and this is significant

because not every individual will be comfortable with attending religious or spiritual-based programs. Finally, the abstinence-based approaches are a "one size fits all" type of approach where it is not flexible or adaptable to those who do not want to use the spiritual aspect of the program; sometimes individuals are presented with unattainable personal goals which also contributes to low success rates (35,41-47).

Abstinence-based addiction service methods are not intended for all types of individuals (35,41,42). Abstinence is intended for those who are ready to discontinue drug or alcohol use completely and is beneficial for individuals who need group/community support and want to delve into the spiritual aspect of the program. Individuals who are not ready to completely remove substance use from their lives would not be best suited to abstinence-based programs (35,41,42).

The two main methods of abstinence-based addiction services include 12-step programs such as AA and NA (41,42). AA focuses on abstinence from alcohol whereas NA focuses on abstinence from drugs (41,42). Groh et al. examined the effects of involvement in the AA 12-step program and the overall odds of abstinence for individuals (41). Groh et al. found that more involvement at meetings and other 12-step functions increased the odds of individual abstinence (41). Another study, conducted by Peyrot, found similar results for NA programs (42). Stewart et al. examined meeting attendance, residential treatment attendance, and the outcomes of abstinence which indicated that AA and NA can support the benefits of residential treatment programs (47).

Harm reduction-based addiction service approaches have a number of guiding principles in common (32,33,48,49). 1) Some level of substance use is expected and inevitable which should be expected in a society. 2) Values are based on dignity, compassion, and acceptance of

individual's decision to use or not use drugs or alcohol. 3) The extent of substance use is not as important as the harms that the substance are causing. 4) Methods are cost-effective and evidence-based; methods are researched thoroughly before putting them into use to ensure cost effectiveness for not only organizations but participants as well. 5) Harm reduction does not require complete abstinence but may lead to that. 6) Methods complement preventative approaches and aim to induce incremental changes instead of complete substance removal (32,33,48,49).

Pros and cons exist for harm reduction-based approaches just as they do for abstinence-based approaches (48,49). One positive aspect of harm reduction methods is that the methods reduce HIV, HCV, HBV, and other illness/disease transmission due to unsafe drug use. Another positive aspect of harm reduction is that evidence shows no further increases in substance use occur just incremental decreases. Harm reduction helps prevent drug overdoses and deaths by providing a safe environment for controlled substance use. Harm reduction offers individuals a gradual change in substance use instead of stopping use all at once. Even though harm reduction has several effective methods for reducing harms associated with addiction, there are some cons. Harm reduction methods indirectly encourages drug use and sends the message that drug use is okay as long as it is done safely. Finally, there is a high possibility that individuals will get stuck in their substance use instead of continuously decreasing substance use (48,49).

Various harm reduction-based programs exist and the best practices have already been extensively researched (6). One example of a harm reduction program is needle and syringe distribution and exchange (6,50,20). Other programs include cooker distribution centres, filter distribution centres, ascorbic acid distribution centres, sterile water and alcohol swab distribution centres, tourniquet distribution centres, opioid overdose and safe drug use education programs,

and methadone maintenance clinics (6). All of these programs aim to facilitate safe drug use and to prevent the harms associated with unsafe drug use (6).

The intended users of harm reduction programs are those not suitable for abstinence-based approaches (32,33,49). Individuals who may not want to discontinue drug or alcohol use completely or may not want to be in intensive treatment are suitable candidates for harm reduction programs. Also suited for harm reduction are those individuals that are at high risks for HIV, HCV, HBV, and other illnesses/diseases easily transmitted through unsafe drug use. Mostly all individuals are suited for harm reduction approaches because programs can be individually tailored to suit a variety of needs whereas abstinence approaches are fairly constant leaving little room for individual treatment (24).

Several studies have been conducted to examine how the youth population responds to abstinence-based 12 step programs such as NA and AA (36,37,38,39). Kelly and Myers found that several benefits of AA/NA to youth exist; the benefits include local accessible meetings, no cost, and the programs offer a group atmosphere (36). Abrantes et al. conducted an 8-year study which investigated effectiveness of 12 step programs for adolescent addiction recovery (38). Abrantes et al. found that attendance declined over the 8 year period but attendance depended on severity of the addiction individuals were recovering (38). Kelly and Urbanoski conducted similar studies and found that adolescents who attended more meetings, more regularly, had a greater level of abstinence compared to those who did not attend meetings or participate in the 12-step program (39). Several barriers do however exist to youth accessing abstinence-based 12 step programs. Firstly, younger individuals are less likely to have as severe addictions as adults (38). Secondly, youth may not be comfortable with spiritual or religious emphases in the

programs (38). Thirdly, youth would be largely outnumbered by adult members within the program, contributing to discomfort attending meetings (36).

Discussion

Four questions were answered by my research. Firstly, the research examined what differences exist between harm reduction and abstinence treatment programs. Secondly, programs in the four counties were identified. Thirdly, gaps in the current services were brought forth. Lastly, potential correlations between youth and 12-step abstinence programs were evaluated. These questions were answered through an extensive literature review of harm reduction and abstinence, identification of programs available in the four counties, and surveys to learn more about the current services and what is lacking.

Through the literature review of harm reduction and abstinence treatment programs, no method reigned better than the other. Harm reduction and abstinence can be thought of as a continuum where abstinence is included as a method of harm reduction and the two models really should be viewed as one method, just different stages. As previously noted, each stage has pros and cons but the pros and cons will depend on the individual seeking treatment. Harm reduction methods are more suited to individuals who are not willing or able to completely remove substance use but just want to get on an incremental plan to achieve abstinence at some point in their life. Abstinence methods are more suited to individuals who are either ready to start removing substance use right away or individuals throughout their harm reduction journeys that are at the stage for complete abstinence. The method/stage will depend on the person, how far along they are in addiction recovery, and their attitude of where they want to be.

The second and third research questions were answered through identification of available services, the demographic of clients using the current services, and areas where the current services are lacking. Results from the surveys of addiction services indicate that there is no significant difference in genders accessing treatment for addictions. Several studies demonstrate

results that are consistent with this study and the studies show that there is no significant difference in genders accessing addiction services (52-54). No significant differences between genders for attendance at addiction services indicates that gender has no effect on the initiation or completion of treatment, barriers to accessing services are similar for males and females, and the types of services used does not vary between genders. When developing new addiction services and programs, gender of clients does not need to be taken into account because results of previous studies and the current study indicates gender does not significantly affect the service type (harm reduction or abstinence) the individual attends.

Surveys of front line services including youth services and hospitals indicate that there are slightly more females than males identifying addiction issues but this is due to a skew of the data because of certain services only serving females. Front line service survey responses for the gender question are unexpected because previous research indicates a fairly equal ratio of males to females attending addiction services. One explanation for why there are more females than males is because the mean of all the front line service surveys was used. When looking at the individual surveys, results show more an equal balance of males and females. One exception to this is the PIPC survey where only females are served.

Results from both addiction services and front line services demonstrate that the most prominent age group attending services is 19-30 years old which is in accordance with past research (55). According to a 2012 Statistics Canada study, individuals aged 15-24 are more likely to experience a substance use disorder (55). Overlap exists for the ages 19-24 between front line service questionnaires and addiction service questionnaires which indicates that individuals of those ages are at a higher risk of using drugs or alcohol than individuals outside of those ages. Age should be taken into account when adapting current services or developing new

services because certain age groups have been identified as more vulnerable than others. The 19-30 age group may need more intensive, interactive, and guided services compared to older age groups seeking treatment.

A noteworthy observation can be seen in Appendix N within the CHIMO youth agency interview. CHIMO stated younger and younger participants are utilizing services and these participants are no longer starting drug use with marijuana but prescription medications. Several issues arise from this alarming observation. Children are beginning drug use at younger ages than previously recorded by CHIMO. Drug use is now more harmful within the youth age group than previously indicated. Aspects of future services should be allocated to dealing with solely children under 18, focusing more on pre-teens aged 10-13, to provide them with preventative and educational programs to avoid drug use.

Front line services were asked approximately how many individuals are served with addictions. Answers varied significantly between services but the two main answers were 0-10% and 61-70% individuals with addictions served. Some services indicated that a lot of individuals they served had addictions whereas others indicated serving few to no individuals with addiction. No direct correlations can be made between what results were obtained and the number of individuals who have addictions. However, these results lead to the discussion of why certain front line services are coming into contact with addiction clients whereas others do not. One possibility of why certain services do deal with addiction clients is because of geographical area; some services are out of reach for some clients versus other clients. Depending on the level or length of transportation required to get to that service, some addictions clients may not be able to access that particular service. Another possibility is social reasons; some services may serve different classes of individuals making those with addictions feel out of place or uncomfortable

entering certain services. Research does show that addiction is a prominent issue in Ontario (21,22,23). Results from this aspect of the survey are futile because of the variation between front line service responses. More questionnaires would need to be collected to achieve more accurate results on clients served with addictions by front line services.

Both front line services and addiction services were asked to approximate the number of individuals served with concurrent disorders. Front line service responses varied from 0-90% but addiction service responses were mostly 51-60% thus implying that approximately half of individuals with addictions has an accompanying mental health condition as well. Even though a significant portion of the research was not spent on concurrent disorders, through the above percentages and opinions throughout Appendices F-S it can be concluded that concurrent disorders must be considered when developing services and programs. Interestingly, several services suggested that if individuals want to treat or manage their mental health condition, the individual must first overcome addictions before being allowed admittance into mental health condition services. A more efficient way to manage concurrent disorders would be to create a program/service where individuals can manage both addictions and mental health conditions in one area which would eliminate several barriers for the client. Barriers that concurrent disorder treatment centres could potentially eliminate are transportation costs to several locations for treatment and a reduced stigma for either the individual's mental health condition or addiction.

Results from addiction services and front line services indicate that some substances are more frequently encountered than others. The most-used substances, as identified by addiction services and front line services, are alcohol and marijuana. Expected results for this question were that multiple drugs would constitute a high percentage for the nature of dependency but only one agency, the Central East Correctional Centre, identified multiple drug use as an issue.

FourCAST addiction and mental health reports conclude that the most prominent nature of dependencies are alcohol, marijuana, and prescription medications (23). My results are consistent with those in other studies and reports. New services should be tailored to specifically deal with the most prominent nature of dependencies including alcohol and opiates; the current services are fairly evenly distributed to accomplish this but most of the services for opiate addictions are solely harm reduction-based approaches. Future services could be developed to also encompass abstinence-based approaches for opiate addictions.

Front line services usually do not do any sort of addiction treatment, except outpatient treatment, and respond by referring individuals to an addiction service. Over half of the front line services reported that they send individuals to FourCAST to treat addictions. Other answers for referral included methadone clinics, AA, NA, Peterborough Aids Resource Network (PARN), CMHA, Al Anon, and the Trent University Counselling Centre. No prior research, other than the Central East LHIN Addictions Environmental Scan conducted in 2009, has been conducted in this area within the four counties (22). The Central East LHIN Scan found that front line services referred individuals to FourCAST, Pinewood, methadone clinics, residential treatment centres outside of the four counties, AA, NA, counsellors, psychologists, and the Children's Aid Society, just to name a few (22). A lot of overlap exists between the study conducted in 2009 and the current study, but the most prominent connection is the referral of individuals to FourCAST.

Evident from these results is the fact that FourCAST is the most well-known, most used service in the four counties. Other services are not receiving the optimal number of clients in comparison to FourCAST which may indicate several issues. Firstly, FourCAST is overcapacity and needs more funds for expansion to accommodate more clients. Secondly, services other than FourCAST could accommodate more individuals but may not be offering the right services to

bring people to the service. Thirdly, funds may not be appropriately allocated to the services that are busier which may contribute to a lack of resources where they are most needed.

One of the main parts of this study was to determine what barriers individuals face when accessing addiction services. The most significant barrier for individuals, according to the service providers, is transportation, followed by long wait times, the stigma of having an addition, financial issues, lack of motivation to receive treatment, denial that addiction problems exist, and other barriers. Other barriers include no inpatient treatment, a lack of communication between services, the inability of clients to take time off work or school to attend services, a lack of pharmacies to dispense methadone, and the issue of services refusing individuals in jail with appointments; these barriers are far less identified by service providers. The Central East LHIN Addictions Environmental Scan conducted in 2009 surveyed the same areas and asked similar questions to addiction services and front line services (22). Results of the Environmental Scan from 2009 found similar results to those in this study indicating that what barriers existed in 2009 for clients have still not been addressed six years later.

The barriers mentioned by the service providers were expected; for example, transportation in rural areas like Peterborough County, Northumberland County, Haliburton County, and the boundaries of the City of Kawartha Lakes will always be a barrier to receiving service because transit is usually only available right in the city, leaving those outside the city without vehicles unable to travel to and from the service. A major barrier that needs to be considered when developing new services is transportation. Having services in the cities within the four counties is important because that is where the majority of clients live, but it might be beneficial to develop a service that is closer to those on the outskirts of town.

Stigma, denial, and motivation to attend services are immense barriers and should be taken into consideration when marketing new services. For individuals to attend an addiction service for treatment, individuals want to feel safe and that they will not be judged for having an addiction. Individuals also want to go where support and motivation are parts of treatment to ensure relapse rates are lowered. Having services that add a counselling component along with normal addiction treatment might increase the number of individuals willing to open up to treatment and may increase rates of success.

Another significant portion of this study was to determine where current addiction services are lacking and to identify what gaps should be addressed during the creation of new services and programs. Gaps identified by addiction services include lack of communication, funding, and resources, no supportive housing units or local withdrawal management programs, more outreach workers are needed, and FourCAST should be expanded. Gaps identified by front line services include lack of communication, funding, and resources, lack of a residential detox program, and a lack of preventative and educational programs. The Central East LHIN Addictions Environmental Scan identified similar issues as well as no access to family physicians, limited partnership with methadone clinics, and a lack of psychiatrists (22).

In 2009, and now identified in 2015, the lack of residential detox programs in the four counties is a significant gap in the available services. Individuals can go to services for appointments, but nothing currently exists in the four counties where individuals can stay a couple weeks or a couple months to fully detox. The most important change or addition to the current services that needs to happen is the creation of a residential detox program in one or more of the four counties. Further research would need to be done to determine if the program

should be only in one county or all four counties and the best practices for a residential detox program.

The literature review of the relationship between youth and abstinence-based addiction treatment programs revealed several interesting points. Firstly, research shows that youth face various age-specific barriers when trying to access AA or NA meetings. Secondly, AA and NA has been shown to provide youth with success for abstinence depending on how many meetings the youth attend, how the youth can deal with barriers, and the continued support after abstinence has been accomplished. From the compilation of research, several suggestions exist for how AA and NA programs can be made more accessible to youth. Future AA and NA programs could be structured to encourage youth to attend meetings by making a separate meeting for solely youths to take away the uncomfortable feeling of older individuals being present. AA and NA programs could also be developed to exclude the religious/spiritual component to make abstinence more appealing to those not comfortable with that part of the program.

The current study also bears some limitations, which need to be considered when viewing the data. Results are also hampered by small sample sizes. Even though many surveys were sent out, only 14 responses were received back which limits making generalized conclusions. This study lacks data from the clients of the services. With information from the clients, more specific conclusions could have been made regarding nature of dependencies and barriers to receiving service. When working with workers in addiction services, bias cannot be ruled out because individuals are very knowledgeable on addictions and personal opinions cannot be avoided in these situations. Although several limitations exist, results of the current study contribute sound data and recommendations for future services to help combat addiction.

Several areas of future research have been identified. Most importantly, further investigation of the aspects of residential detox programs should be conducted. Residential detox programs were presented as a major gap in the current services. Future studies should examine other residential detox programs in Ontario and Canada to evaluate best practices to aid in the initiation of an effective program. Another interesting area of research is youth and addiction services. Youth and addiction services were briefly examined in this study but further research could examine education and preventative programs for youth and their parents as well as on-line apps to aid in-person services. Society is very internet-savvy now and introducing on-line ways to aid individuals battling addictions might be more effective than other forms of supportive treatment. Finally, further research on concurrent disorders and how they should be addressed within services. The current study did not examine in-detail concurrent disorders, but did identify that concurrent disorders are a major issue in the four counties; individuals battling addictions usually had a mental health condition accompanying their addiction.

In conclusion, there are a lot of harm reduction-based services in the four counties compared to abstinence-based services. Overall, many barriers that individuals face may prevent them from receiving service or may make it more difficult to attend services. Gaps in the current services can be easily addressed for the development of future services to ensure that not only individuals are receiving the help they need but also that resources and funding are being allocated appropriately to the right services.

Summary of Results & Discussion

- Fairly equal ratio of males to females using services
- Most prominent age group is 19-30
- Barriers to service: transportation, stigma, lack of motivation, denial, financial issues, long wait times, lack of pharmacies that dispense methadone, no inpatient treatment, a lack of communication between services, a lack of job or school flexibility to attend services, and services refusing appointments for individuals in jail
- Nature of Dependencies: Alcohol, Marijuana, Prescription Medications, Opiates, Fentanyl, Multiple Drugs, Other
- Most referrals from front line services to: Fourcast
- Other referrals to: AA, Al Anon, CMHA, PARN, NA, Methadone Clinics, Trent Counselling Center
- 100% of questionnaires indicated the need for a residential detox program in the area

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Appendices

Appendix A - List of Addiction Services Located and Contacted

Peterborough County and City

1. ACT Peterborough (Addiction Center Toronto in Peterborough) - methadone clinic
   - 226 Charlotte St, Peterborough, ON, K9J 2T8, P: 705-740-0228 F: 705-740-0223

2. First Step Clinic - methadone clinic
   - 191 Simcoe St, Peterborough, ON, K9H 2H6, P: 705-876-1000

3. OATC (Ontario Addiction Treatment Center) - methadone clinic
   - 215 Sherbrooke St, Peterborough, ON, K9J 2N2, P: 705-748-0995 F: 705-748-5946

4. FourCAST (addiction services - mostly harm reduction methods + counselling + referrals to other programs, 12 week concurrent disorder group)
   - 200-130 Hunter St W, Peterborough, ON, K9H 2K8 P: 705-876-1292 F: 705-876-9125, fourcast@fourcast.ca
   - Youth Programs, Community Withdrawal Management, Community Treatment, Adult Programs, Substance Abuse Support with Housing

5. Narcotics Anonymous (ORSCNA) - NA
   - 175 Murray St, Peterborough, ON, K9H 2S7 P:1-888-811-3887

6. Alcoholics Anonymous (Kawartha District 86) - AA
   - 625 Cameron St, Peterborough, ON, K9J 3Z9 P: 705-745-6111

7. PRHC - inpatient services - address addictions or overdependence intervention as indicated/warranted

City of Kawartha Lakes County

1. FourCAST (addiction services - mostly harm reduction methods+ counselling + referrals to other programs, 12 week concurrent disorder group)
   - 2-86 Russell St W, Queen's Square Plaza. Lindsay, ON, K9V6A5 P: 705-878-5547 F: 705-878-8401, fourcast@fourcast.ca

2. OATC (Ontario Addiction Treatment Center) - methadone clinic
   - 40 Lindsay St S, Lindsay, ON, K9V 2L8, P: 705-324-5553 F: 705-324-7184

3. Narcotics Anonymous (ORSCNA) - NA
   - 10 Angeline St N (Ross Memorial Hospital), Lindsay, ON P:1-888-811-3887
   - 35 Lindsay St S, Lindsay, ON P: 1-888-811-3887

4. Alcoholics Anonymous - AA - district 82
   - 36 Wellington St, Lindsay, ON, K9V 3N3 P: 705-324-9900

5. RMH - (ross memorial hospital) - inpatient services - address addictions or overdependence intervention as indicated/warranted

Northumberland County

1. FourCAST (addiction services - mostly harm reduction methods + counselling + referrals to other programs, 12 week concurrent disorder group)
   - c/o Lakeshore Counselling, 975 Elgin St, Cobourg, ON, K9A 4K9 P: 905-377-9111 F: 905-377-9392, fourcast@fourcast.ca

2. FourCAST (addiction services - mostly harm reduction methods+ counselling + referrals to other programs, 12 week concurrent disorder group)
   - c/o Campbellford Memorial Hospital, 146 Oliver Rd Room 246, Campbellford, ON, K0L 1L0 P: 705-653-3352 F: 705-653-1584, fourcast@fourcast.ca

3. Bayly Healthcare Consultants Methadone Clinic - methadone clinic
   - 5-541 William St, Cobourg, ON, K9A 3A4 P: 905-377-0005

4. Change Health Care - Cobourg Clinic - methadone clinic
   - 1000 Depalma Dr, Cobourg, ON, K9A 5W6 P: 905-373-4494

5. Alcoholics Anonymous - AA - district 30
   - Cobourg, Campbellford,etc.. , ON, P: 1-866-951-3711

6. Narcotics Anonymous (ORSCNA) - NA
   - 50 Bridge St W, Campbellford, ON P:1-888-811-3887
   - 1000 Depalma Dr, Cobourg, ON P: 1-888-811-3887

Haliburton County

1. FourCAST (addiction services - mostly harm reduction methods+ counselling + referrals to other programs, 12 week concurrent disorder group)
   - 101-5 IGA Rd, PO BOX 929, Minden, ON, K0M 2K0 P: 705-286-4077 F: 705-286-2871, fourcast@fourcast.ca

2. OATC (Ontario Addiction Treatment Center) - methadone clinic
   - 211 Highland St, Haliburton, ON, K0M 1S0, P: 705-455-9900 F: 705-445-9901

3. Alcoholics Anonymous - AA - district 82
   - Haliburton, ON P: 705-324-9900 **same district as Lindsay

4. Narcotics Anonymous (ORSCNA) - NA

- 7199 Gelert Rd, Haliburton, ON P:1-888-811-3887

Oshawa

1. Pinewood Centre of Oshawa
   - 300 Centre St S, Oshawa, ON, L1H 4B2 P: 905-723-8195

Appendix B - List of Front Line Services Located and Contacted

Peterborough County and City

1. Trent University Wellness Centre
   - 1600 West Bank Dr, Peterborough, ON, K9J 7B8, P: 705-748-1481

2. John Howard Society
   - 305 Stewart St, Peterborough, ON, K9J 3N2, P: 705-743-8331

3. Kawartha Pine Ridge District School Board
   - 1994 Fisher Dr, Peterborough, ON, K9J 6X6, P: 705-742-9773

4. Peterborough Social Planning Council
   - 360 George St N, Peterborough, ON, K9H 7E7

5. Partners in Pregnancy Clinic
   - 170 Simcoe St, Peterborough, ON, K9H 2H7 P: 705-741-1191

6. PRHC
   - 1 Hospital Dr, Peterborough, ON, K9J 7G6 P: 705-743-2121

7. Peterborough AIDS Resource Network (PARN)
   - 159 King St Suite 302, Peterborough, ON, K9J 2R8 P: 705-749-9110

8. Schizophrenia Society of Ontario
   - 466 George St N, Peterborough, ON, K9J 8S1 P:705-749-1753

9. Peterborough Social Services
   - 178 Charlotte St, Peterborough, ON, K9J 8S1 P: 705-748-8830

10. Kinark
   - 380 Armour Rd, Peterborough, ON, K9H 7L7 P: 705-742-3803

11. CMHA
   - 466 George St N, Peterborough, ON, K9H 3R7

City of Kawartha Lakes County

1. CHIMO Youth & Family Services
   - 227 Kent St W, Lindsay, ON, K9V 2Z1 P: 705-324-3300

2. Fleming College (Frost Campus)
   - P: 705-878-9304

3. John Howard Society
   - 31 Peel St, Lindsay, ON, K9V 3L9 P: 705-328-0472

4. OPP (Kawartha Lakes)
   - 21 Angeline St N, Lindsay, ON, K9V 5B7

5. Kawartha Lakes Police Service
   - 6 Victoria Ave N, Lindsay, ON, K9V 4E5 P: 705-324-5252

6. A Place Called Home (APCH)
   - 64 Lindsay St S, Lindsay, ON, K9V 2M2 P: 705-328-0905

Northumberland County

1. Broken Arrow Residential Treatment Services (BARTS)
   - 210 Willmott St Unit 5B, Cobourg, ON, K9A 4K2 P: 905-377-0490

2. OPP (Cobourg)
   - 107 King St W, Cobourg, ON, K9A 2M4 P: 905-372-2243

Haliburton County

1. OPP (Haliburton)
   - 12598 Hwy 35, Minden, ON, K0M 2K0 P: 705-286-1431

Appendix C - E-mail/Phone Introduction

Hello,

My name is Olivia Emino and I am a student at Trent University in Peterborough, ON, pursuing a Bachelor of Science in Forensic Science. As part of my final year of study, I am working alongside the Human Service and Justice Coordinating Committee (HSJCC) and the Trent Centre for Community-Based Education on a project that explores different models of addiction service. This work includes looking at harm reduction and abstinence approaches; determining potential ways to measure the effectiveness of these models; and identifying programs available throughout Peterborough, Kawartha Lakes, Haliburton, and Northumberland Counties. To research currently available addiction services, it would be immensely helpful to learn more about your specific organization.

Thank you for your time and consideration in contributing to my research. If you have any questions or concerns about my research or the above questions please feel free to contact me using the information below. This research project is time sensitive so I am requesting a response by the beginning of December but preferably, before, in the next couple of weeks. If you are interested in receiving a copy of the final research report feel free to let me know and I would be happy to share a copy or copies of it with you in May 2015.

Regards,

Olivia Emino

Email: oliviaemino@trentu.ca

Phone: 705-875-076

Appendix D - Addictions Services Survey

1. Organization Name and Regional Location:
2. Give a brief overview of the facility's purpose and goals:
3. State your job title and specific role within the facility:
4. Is the facility not-for-profit or for-profit?
5. Is the service paid for or free for the participants, check the applicable answer.

_____ Free _____ Paid _____ Other

Describe if "other":

6. What is the total number of individuals you serve:

7. What is the percentage of men and women served:

	Approximate Percentage Served
Male	
Female	

8. What is the percentage of age groups served:

Age Group	0-18	19-30	31-40	41-50	51-60	61-70	70 +
Approximate Percentage Served							

9. What is the percentage of individuals with addictions served:

	Less than 10%	10-20%	21-30%	31-40%	41-50%	51-60%	61-70%	71-80%	81-90%	91-100%
Individuals with Addictions Served										

11. What is the nature of dependency for the participants you serve and approximate percentages of each: (ie: alcohol, narcotics, marijuana, etc...)

12. What is the percentage of individuals with concurrent disorders served:

	Less than 10%	10-20%	21-30%	31-40%	41-50%	51-60%	61-70%	71-80%	81-90%	91-100%
Individuals with Concurrent Disorders Served										

13. What is the percentage of participants and their amount of visits:

Regularity of Visits	Greater than 1 visit per day	1 visit per day	At least 1 visit per week	At least 1 visit every two weeks	At least 1 visit per month	At least 1 visit every 4 months	At least 1 visit per year
Percentage of Participants							

14. Are there statistics for your service regarding relapse rates of participants? If so - do you have any that you can share with me?

15. What are the barriers for clients when accessing addiction services? (ie: transportation - no vehicle or bus service, wait times, finances, etc...)

16. Is sobriety of the participant required for initial treatment/service?

17. Does your organization do outreach in the community?

18. Are there any additional addiction services that should be offered in your area?

19. What are the gaps that need to be addressed for future addiction services/programs?

20. What trends or changes do you believe there will be in the future of addiction services?

Appendix E - Managers of FLW Organizations Survey/On-line Questions

1. Name your place of work:

2. Give a brief overview of the facility's purpose and goals:

3. State your title and specific role within the facility:

4. Answer the following questions regarding the population you serve:

	Approximate Percentage Served
Male	
Female	

Age Group	0-18	19-30	31-40	41-50	51-60	61-70	70 +
Approximate Percentage Served							

	Less than 10%	10-20%	21-30%	31-40%	41-50%	51-60%	61-70%	71-80%	81-90%	91-100%
Estimate of Individuals with Addictions Served										

	Less than 10%	10-20%	21-30%	31-40%	41-50%	51-60%	61-70%	71-80%	81-90%	91-100%
Estimate of Individuals with Concurrent Disorders Served										

5. Where do you send individuals if you are not an addiction service?
6. What are the barriers for clients when accessing addiction services? (ie: wait times, transportation, finances, etc..)
7. Are there any additional addiction services that should be offered?
8. What are the gaps that need to be addressed for future addiction services/programs?

Appendix F - ACT Peterborough Questionnaire Response

Survey

1. Organization Name and Regional Location: ACT- Peterborough

2. Give a brief overview of the facility's purpose and goals:
treatment for opiate addiction
3. State your job title and specific role within the facility:
Charge Nurse- health teaching, vaccines, blood work, support staff in reception, oraganize procedures across 9 clinics
4. Is the facility not-for-profit or for-profit?
For-profit
5. Is the service paid for or free for the participants, check the applicable answer.

_____ Free _____ Paid X- Other

Describe if "other": OHIP Funded

6. What is the total number of individuals you serve: 430 patients

7. What is the percentage of men and women served:

	Approximate Percentage Served
Male	60%
Female	40%

8. What is the percentage of age groups served:

Age Group	0-18	19-30	31-40	41-50	51-60	61-70	70 +
Approximate Percentage Served	11%	25%	25%	30%	13%	5%	1%

9. What is the percentage of individuals with addictions served: N/A

	Less than 10%	10-20%	21-30%	31-40%	41-50%	51-60%	61-70%	71-80%	81-90%	91-100%
Individuals with Addictions Served										

11. What is the nature of dependency for the participants you serve and approximate percentages of each: (ie: alcohol, narcotics, marijuana, etc...)

Opiate addiction only

12. What is the percentage of individuals with concurrent disorders served: N/A

	Less than 10%	10-20%	21-30%	31-40%	41-50%	51-60%	61-70%	71-80%	81-90%	91-100%
Individuals with Concurrent Disorders Served										

13. What is the percentage of participants and their amount of visits: N/A

Regularity of Visits	Greater than 1 visit per day	1 visit per day	At least 1 visit per week	At least 1 visit every two weeks	At least 1 visit per month	At least 1 visit every 4 months	At least 1 visit per year
Percentage of Participants							

14. Are there statistics for your service regarding relapse rates of participants? If so - do you have any that you can share with me?

_____
_____
_____

15. What are the barriers for clients when accessing addiction services? (ie: transportation - no vehicle or bus service, wait times, finances, etc...)
ALL THE ABOVE

16. Is sobriety of the participant required for initial treatment/service?
_____ NO

17. Does your organization do outreach in the community?
NO

18. Are there any additional addiction services that should be offered in your area?
Detox Centres
In Patient Treatment Centres

19. What are the gaps that need to be addressed for future addiction services/programs?
More preventative, education, job opportunity to reduce boredom which is a trigger, physician education on opiate abuse, more accessibility to in patient treatment centres

20. What trends or changes do you believe there will be in the future of addiction services?
We will be dealing with more poly drug users due to fluctuation and demand of street supplies.

Appendix G - Central East Correctional Centre Questionnaire Response

Survey

6. Organization Name and Regional Location: _____Central East Correctional Centre_____

7. Give a brief overview of the facility's purpose and goals: _____We incarcerate males and females who are in conflict with the law.

8. State your job title and specific role within the facility: __Addiction Counsellor in the Programs Department_____

9. Is the facility not-for-profit or for-profit? ____Neither, it is a government facility._____

10. Is the service paid for or free for the participants, check the applicable answer.

__X__ Free _____ Paid _____ Other

Describe if "other":

_____
_____

6. What is the total number of individuals you serve: __Per year? In 2014 I met with 241 new clients plus had an additional 248 individual counselling sessions. _____

7. What is the percentage of men and women served:

	Approximate Percentage Served
Male	100%, I don't work with women
Female	

8. What is the percentage of age groups served: **We do not keep records of ages, I would have to look up each person.**

Age Group	0-18	19-30	31-40	41-50	51-60	61-70	70 +
Approximate Percentage Served		**majority**					

9. What is the percentage of individuals with addictions served:

	Less than 10%	10-20%	21-30%	31-40%	41-50%	51-60%	61-70%	71-80%	81-90%	91-100%
Individuals with Addictions Served	5								95	

11. What is the nature of dependency for the participants you serve and approximate percentages of each: (ie: alcohol, narcotics, marijuana, etc...)

_Our clients use all of these all the time. They are poly users,

_____

_____

12. What is the percentage of individuals with concurrent disorders served:

	Less than 10%	10-20%	21-30%	31-40%	41-50%	51-60%	61-70%	71-80%	81-90%	91-100%
Individuals with Concurrent Disorders Served							70%			

13. What is the percentage of participants and their amount of visits: **What do you mean by visits? They aren't visiting, they're in jail here. It varies too much.**

Regularity of Visits	Greater than 1 visit per day	1 visit per day	At least 1 visit per week	At least 1 visit every two weeks	At least 1 visit per month	At least 1 visit every 4 months	At least 1 visit per year
Percentage of Participants							

14. Are there statistics for your service regarding relapse rates of participants? If so - do you have any that you can share with me?

_____We don't have exact stats, many come back to jail but that does not mean they have relapsed, it means they have broken the law.

_____

_____

_____

_____
____

15. What are the barriers for clients when accessing addiction services? (ie: transportation - no vehicle or bus service, wait times, finances, etc...)
_____They are provided intakes, assessment, referral, the biggest barriers are waiting lists and agencies refusing to make appointments for people in jail.
_____
_____

16. Is sobriety of the participant required for initial treatment/service?
No, we use a harm reduction model but we are client-centred, if abstinence is their goal, we support them.
_____
_____

17. Does your organization do outreach in the community?
_____
_____Yes, we are in regular contact with community agencies and resources.
_____
_____

18. Are there any additional addiction services that should be offered in your area?
_____
__Yes, tere is no residential treatment in the Peterborough or Kawartha Lakes area for males or females.
_____
_____

19. What are the gaps that need to be addressed for future addiction services/programs?
_____
There is no withdrawal management services (detox) and there are no residential treatment options or recovery homes. There is only one show in town and that's Fourcast.
_____
_____

20. What trends or changes do you believe there will be in the future of addiction services?
_____We need to start listening to what the addicts need instead of thinking we know what's good for them. We need to get back to grassroots and general care for people. We need outreach and we need options. PARN does have needle exchange, which is great. _

Appendix H - CMHA Online Questionnaire Response

- **Collector:** Web Link 1 (Web Link)
- **Started:** Monday, December 15, 2014 3:52:15 PM
- **Last Modified:** Monday, December 15, 2014 4:01:55 PM
- **Time Spent:** 00:09:40
- **IP Address:** 76.75.126.50

PAGE 2: Organization Information

Q1: Organization

- **Name** Kelly Robinson
- **Organization Name** Lynx Early Psychosis Intervention Team - Canadian Mental Health Association, HKPR
- **Organization's Purpose and Goals** To provide community mental health services - Lynx provides early psychosis intervention services for people age 14-35
- **Your Title in the Organization** Clinical Program Manager
- **Your Role in the Organization** To provide coordination and clinical supervision to staff from 7 agencies in 5 communities

Q2: Which of the following describe the availability of the service to individuals?

- Free

PAGE 3: Information on the Population Served

Q3: What is the approximate percentage of males and females that you serve?

- **Male** 61-70%
- **Female** 31-40%

Q4: What is the approximate percentage of individuals you serve in each age group?

- **0-18 years old** 21-30%
- **19-30 years old** 61-70%

Q5: What is the approximate percentages of individuals served with the following:

- **Individuals with Addictions** 51-60%
- **Individuals with Concurrent Disorders** 51-60%

Q6: Rank the number of individuals by their nature of dependency (ie: alcohol, prescription medications, opiates, marijuana, tobacco) and include approximate percentages.

- **1** marijuana
- **2** alcohol
- **3** opiates
- **4** prescription medications

PAGE 4: Referrals

Q7: Are there any screening tools/techniques available for potential addiction individuals? (ie: blood test, breath test, etc...)

Blood test

Q8: Where do you send individuals if you are not an addiction service?

Our team has developed its capacity to provide services to people with concurrent disorders as it is a significant component of their difficulties and inextricably linked to their mental health conditions. We do offer referrals to our local addictions services agency (4CAST) and when we believe the person's needs require such service, we strongly encourage them to make the connection and will support them in doing so. Our agency works closely with 4CAST.

PAGE 5: Barriers and Gaps
Q9: What are the barriers for clients when accessing addiction services? (ie: wait time, no vehicle, costs, etc...)

Do not recognize the difficulty caused by addictions Reluctance to seek service from another agency or an additional agency Wait times Lack of transportation Fear of stigma

Q10: What are the gaps that need to be addressed for future addiction services/programs?

provide funding for transportation youth-friendly service trauma-informed services shorter wait times

Appendix I - CMHA Questionnaire Response

Survey

11. Name your place of work: _Community Court Kawartha Lakes Survey completed by CMHA HKPR Justice Service Worker and Assistant Crown Attorney

2. Give a brief overview of the facility's purpose and goals: _Community Court in Kawartha Lakes was developed to:

I. Deal with persons with mental health issues (including developmental delay, acquired brain injury, and concurrent disorder) who are facing charges under the Criminal Code of Canada
2. Help those in conflict with the law by providing and referring them for treatment and/or support
3. Lessen the anxiety of the courtroom experience by focusing on recovery and rehabilitation

3 State your title and specific role within the facility: CMHA HKPR Justice Service Worker. Support clients involved in the Criminal Justice System. Assistant Crown Attorney assigned to the Community Court in Kawartha Lakes.

4Answer the following questions regarding the population you serve:

	Approximate Percentage Served
Male	50%
Female	50%

Age Group	0-18	19-30	31-40	41-50	51-60	61-70	70 +
Approximate Percentage Served	2%	30%	30%	30%	6%	2%	

	Less than 10%	10-20%	21-30%	31-40%	41-50%	51-60%	61-70%	71-80%	81-90%	91-100%
Estimate of Individuals with Addictions Served							x			

	Less than 10%	10-20%	21-30%	31-40%	41-50%	51-60%	61-70%	71-80%	81-90%	91-100%

Estimate of Individuals with Concurrent Disorders Served							x			

5. Where do you send individuals if you are not an addiction service? To Four County Addiction Service Team (FourCAST) CMHA Justice Service Workers have training with addictions.

6. What are the barriers for clients when accessing addiction services? (ie: wait times, transportation, finances, etc..)
Transportation – Big Geographical area need more satellite offices or outreach workers.

There are agreements made with FourCAST and the Community Court that any client involved in the Community Court will not be put on a waitlist. CMHA HKPR Lindsay Branch and FourCAST meet quarterly to make sure clients are receive the best service possible while involved in the Community Court.

7. Are there any additional addiction services that should be offered? More satellite offices or outreach workers. After care groups for clients that have completed a residential treatment program. Addiction supportive housing units.

8. What are the gaps that need to be addressed for future addiction services/programs? Local withdraw management center or outreach withdraw management workers. Supportive housing units for addiction. Outreach workers.

Appendix J - Northumberland Hills Hospital Questionnaire Response

Survey

12. Organization Name and Regional Location: ____Northumberland Hills Hospital Community Mental Health Services Cobourg_____

13. Give a brief overview of the facility's purpose and goals: _____Offer community based mental health services to Northumberland County – includes counselling, case management, housing support, early psychosis intervention, ACTT, and crisis

14. State your job title and specific role within the facility: ___Crisis Clinician – offer crisis services in the community and out of the emergency department at the hospital

15. Is the facility not-for-profit or for-profit? __not for profit

16. Is the service paid for or free for the participants, check the applicable answer.

__x___ Free _____ Paid _____ Other

6. What is the total number of individuals you serve: __approx 25-30 per month _____

7. What is the percentage of men and women served:

	Approximate Percentage Served
Male	50
Female	50

8. What is the percentage of age groups served:

Age Group	0-18	19-30	31-40	41-50	51-60	61-70	70 +
Approximate Percentage Served	15	30	20	20	15		

9. What is the percentage of individuals with addictions served:

	Less than 10%	10-20%	21-30%	31-40%	41-50%	51-60%	61-70%	71-80%	81-90%	91-100%

Individuals with Addictions Served						x				

11. What is the nature of dependency for the participants you serve and approximate percentages of each: (ie: alcohol, narcotics, marijuana, etc...)

_____alcohol_- 25%_____marijuana 65%
_other drug use _10%_____

12. What is the percentage of individuals with concurrent disorders served:

	Less than 10%	10-20%	21-30%	31-40%	41-50%	51-60%	61-70%	71-80%	81-90%	91-100%
Individuals with Concurrent Disorders Served						x				

13. What is the percentage of participants and their amount of visits: **- in my position, I often only seen people once when they are in crisis**

Regularity of Visits	Greater than 1 visit per day	1 visit per day	At least 1 visit per week	At least 1 visit every two weeks	At least 1 visit per month	At least 1 visit every 4 months	At least 1 visit per year
Percentage of Participants							

14. Are there statistics for your service regarding relapse rates of participants? If so - do you have any that you can share with me? - no

15. What are the barriers for clients when accessing addiction services? (ie: transportation - no vehicle or bus service, wait times, finances, etc...)

_____transportation

16. Is sobriety of the participant required for initial treatment/service?

_____No_

17. Does your organization do outreach in the community?

_____Yes_____

18. Are there any additional addiction services that should be offered in your area?

_____

We have FourCAST in our community – more outreach would be beneficial

19. What are the gaps that need to be addressed for future addiction services/programs?

_____

__No local detox or residential facility in the area

20. What trends or changes do you believe there will be in the future of addiction services?

Appendix K -Trent Wellness Centre Online Questionnaire Response

November 19th, 2014 - Ruth Walker - Survey Monkey Response

Q1: Organization

- **Name**Ruth Walker
- **Organization Name**Trent University Student Health Services
- **Organization's Purpose and Goals**To provide primary health care services for Trent University students
- **Your Title in the Organization**Clinical Team Leader
- **Your Role in the Organization**Responsible for co-ordination of clinical functions for Health Services and the development of campus-wide health promotion activities.

Q2: Which of the following describe the availability of the service to individuals?

- Costs Money But Is Covered By Insurance
- **Other (please specify)**There are some fee for service services provided at our clinic.

PAGE 3: Information on the Population Served

Q3: What is the approximate percentage of males and females that you serve?

- **Male**21-30%
- **Female**71-80%

Q4: What is the approximate percentage of individuals you serve in each age group?

- **0-18 years old**10-20%
- **19-30 years old**71-80%
- **31-40 years old**Less than 10%

Q5: What is the approximate percentages of individuals served with the following:

- **Individuals with Addictions**Less than 10%
- **Individuals with Concurrent Disorders**Less than 10%

Q6: Rank the number of individuals by their nature of dependency (ie: alcohol, prescription medications, opiates, marijuana, tobacco) and include approximate percentages.

- **1**Unknown
- **2**Unknown
- **3**Unknown
- **4**Unknown
- **5**Unknown
- **6**Unknown

PAGE 4: Referrals

Q7: Are there any screening tools/techniques available for potential addiction individuals? (ie: blood test, breath test, etc...)

Blood tests

Q8: Where do you send individuals if you are not an addiction service?

Fourcast Trent Counseling Centre Alcoholics Anonymous Narcotics Anonymous

PAGE 5: Barriers and Gaps

Q9: What are the barriers for clients when accessing addiction services? (ie: wait time, no vehicle, costs, etc...)

Wait times. Need services sooner Finances for rehabilitation therapy - treatment facilities Transportation Stigma and labeling Cost of phychologists

Q10: What are the gaps that need to be addressed for future addiction services/programs?

Public funding for inpatient, rehabilitation therapy/treatment facilities. Clients returning to environments that make it difficult for them to avoid substances - so other determinants of health, like housing.

Appendix L -Trent Wellness Centre Transcribed Questionnaire Response

O- Olivia speaking, interviewer S- Director speaking, interviewee

O - Do you mind if I record this?
S - Yes that's fine. So, uh, the student wellness centre was created about two and a half years ago and it was uh motivated by the need to be more integrated in the care we provide students, so both counselling services, student health services, and student accessibility services have about 30% of our students in common and prior to becoming integrated something could be happening with a student seeing a doctor and physician in health services, something different could be happening with that same student in counselling, and something different could be happening with that student in accessibility services, so we brought the three units together. Counselling and student accessibility services have a shared database and our students when they register with us sign off that this information is shared but health services is a separate database because it is different information, it is an electronic medical record database but we do have access to the database and the information over at the health services on a need to know basis, so we will only go look at it if we need to for a particular reason. So a big part of the work that we are doing here is trying to create a ____ hierarchy in comparison to the top down hierarchy. So you can see the crisis coordinator, educator, and director are in the middle of the hierarchy because we are not assigned to any one department, we work for all three departments. Uh, we are looking to expand the center to bring more people into the center of the circle so you aren't working for any one department but for all three. But what we have found is that is has been a very effective model of service delivery and helping students, particularly students in crisis, or students that uh just are high users of the services - there is a high continuity of care as a result of being integrated. We are a group of 30 people and we represent 11 different disciplines so it is quite a dynamic interdisciplinary team.
O - So, there are quite a few students who use all three services?
S - Yes about 30% of our population use all three. It really is amazing.
O - So, obviously it would be mostly just students, do you get anyone that comes in from the public or is it just students?
S - Just students. We are funded a little bit differently but the student accessibility services are funded by something called targeted funding by the ministry. So instead of the ministry giving the money to the university and then the university giving the money to this office, the ministry gives it straight to this office to ensure that the money that is allocated for us, gets to us. Health services is all funded by students. Counselling services is funded by operating funds from the university and funds from the students so it is a shared funding model that we have that is very effective, when one pot is tight we can pull from other pots to sustain ourselves. That model we talk about of the services goals, we are operating under a biopsychosocial model. So you can see, there is student health services which is predominantly biological, counselling services which is predominantly psychological, and student accessibility services which is predominantly social. But we overlap in all of those areas and that is the world health organization introduced notion of biopsychosocial model meaning integrative care and our primary goal is health and wellness and meet the holistic needs of our students and not to get stuck in any one of our models. So, a student may come to us, and say cause that did an on-line survey that they are suffering from depression, and uh I understand that SSRIs are a good way to treat depression. We will say well yes they are, but do you exercise? What's your diet like? How do you manage your leisure time?

O - Right, so just other factors.
S - Those are the things you need to be doing before you start popping the pill. However, there are some students that come and they are already at that stage where they probably wouldn't be able to claw back too quickly, so, uh, a little energy from an SSRI would be a good thing. So that's kind of our model. So my title?
O - Yes, so, you are the director of the wellness centre?
S - Yes, director of the student wellness centre.
O - Do you keep any statistics on uh the types of people who are coming in?
S - Yes we do keep stats. I have printed off our board report which is brief because it has to be, from last year which talks about the presenting issues at health services from a percentage standpoint and the number of student visits so you get to see those stats as well and this is from disability services and the students there that are registered with us, and this is the reason for referral to the counselling centre. So, I just thought I'd give you all of this information for you to refer to. It is not published but it is in our board report. You can figure out how to source that as an unpublished document. We don't do a male female breakdown.
O - Most places don't, I have noticed that.
S - Yes, however I guess the university would in terms of students enrolled, they could probably run a report. Traditionally it has been skewed around 63% towards females at Trent so that is roughly where we are at. Our clinical population at the counselling centre would probably be skewed even more than that, maybe 75%, because females students are more likely to come approach with counselling support than male students. Though, certainly, in the last 30 years I have been doing this work we find more and more males now approaching us. The stigma for males seeking mental health support has been reduced and hopefully will continue to be reduced with more and more male symposiums and acknowledging that he needs to look after himself as well.
O - Yeah, I have noticed that as well so it's normally more females.
S - So age we don't really track. So obviously the majority of our students are in the 19-30 age group, I'd probably say around 85% are falling right in here. What would the first year students be?
O - Yeah, so the first year students would be 17 or 18.
S - So, if I have to guess 0-18 would be 20%, 19-30 would be 70%, and the rest would be a total of 10%. So that's roughly. When we're talking about the number of individuals or percentage of individuals with addictions that's also sort of difficult because we are not simply doing addictions, we do a full range of, well when we do our presenting issues form we look at the top three issues. But, I mean, when we say issues, we mean significant issues in terms of mental health. We have a lot of students abusing marijuana, we have many students abusing alcohol. What we would say in terms of use, misuse, and abuse, there are a huge number of students in the misuse category. The actual number of students in the abuse category is actually quite small. So if we are doing a social norm campaign we will say you know, 90% of students get up for their morning classes. There is a much smaller percentage of students that are consistently missing it because they are hung over. But the whole idea of social norm campaigns, which we do run in terms of prevention and education, is that this isn't the norm folks. So when you feel the peer pressure to go out and engage in this activity, recognize that this isn't the norm and most people are not doing this. Most people are healthy. Most people are having a controlled number of drinks, ya know, not abusing, recreationally using, and occasionally misusing because of inexperience. So our first year students when they first come into residence, we get a bit of a

surge of students that have partied but really sort of misuse in their first month, and end up in trouble, really sick, and sometimes in the hospital. So there are a few scares in that regard but most individuals, again even that is a small number compared to the number of students who come and want to go wild, ya know very few that go wild actually end up in hospital, they are smart enough and have friends that help them out.
O - So the percentage is still very low?
S - Yes. it is still a very low number, but the number of mis-users is very high. Right, so the people who are drinking beyond 8 drinks a week, and people who are, I don't think there is any sort of use category around marijuana use, but in mind there could be a use category, but we are not supposed to sanction marijuana as an acceptable drug. But realistically speaking, to me it is acceptable for someone to be smoking, ya know, a couple times a month or whatever at a party here and there, at an opportune time to have some fun. But what we find is that there is a much larger portion of students who are regular users, who are smoking several times a week which may be considered misuse, and daily users are abusers. So that's how I see it. Recreational users are a couple times a month, mis-users are definitely smoking once a week for sure, and abusers are smoking everyday. We don't have numbers on that, but we definitely have a high number of students who do. See, counselling models when we look at substance abuse, at this age group, we're saying we'll work with you while you're still using substances but once you get beyond this age group it's we are not working with you until you deal with your substance abuse
O - So right now it's more of a harm reduction approach?
S - Yes absolutely. We have no abstinence model here. AA is the abstinence model. AA has been on campus here, I don't know if they are currently but uh AA has been on campus. So, uh, it's hard to pin down these numbers because I don't know. Most of the percentages are probably concurrent. So, what do we do with students with substance abuse issues. So, if they are mis-using, we do harm reduction and talk to them about harm reduction. We're doing stages of change in terms of readiness and try to get an understanding of that. We'll do some motivational interviewing with them in terms of engaging them in that process of change. For students who are abusers, then we'll encourage them to go to Fourcast.
O - So, that's mostly where you would send people then, Fourcast?
S - Yep, if they are going to specifically look at drug and alcohol counselling and we are saying that nothing else will be able to happen until that is controlled then that is where they go.
O - So, first you try and manage it here, and if that doesn't work you send them to Fourcast?
S - Well first we assess it here, and we figure what stage they are at, in terms of level of use and abuse and readiness for change and what are the other concurrent issues and whether the concurrent diagnosable or not. What are the underlying issues that bring them to self medicate, then we might be able to do that but if we are feeling like its so engraved and all we'd be dealing with is a dry drunk at best, then we are going to say no and you need to go and get sobriety and you need to get a harm reduction plan in place, ya know, it's serious. So, and that's the same for narcotics as well. There is a segment of the population that is abusing narcotics, so you should talk about that in your study. Even in terms of the Peterborough community, opiate use has been on the rise even in the past ten years like dramatically with the availability of drugs that were not as available previously that now are. Oxy is really easy to get a hold of now and inexpensive, pop a pill and you're flying high as a kite, and it is very addictive.
O - So, there is a lot of students on campus using drugs, you just don't have an accurate percentage of those students?

S - We don't, we see them but that is not the issue we are dealing with. It's through this issue that we may start to address that issue but primarily we are dealing with other issues in terms of student success and wellness. It is still the youth model, where you don't say you need to abstain. That is a very parental message. We say you need to do harm reduction and we need to talk about what is bothering you. Yeah, so that's sort of the model we use. We do have, and continue to use, the ECHUG screener. ECHUG is an online alcohol screener. There is also a sister program called ETOKE for smoking.
O - So, what are some barriers that you see that students have for even just coming here? Is there a lot of wait times for the students here?
S - Historically, depending on when you approach us, there is a wait time for service. Relative to the community it is pretty responsive. It might take two weeks to get in here whereas in the community it might take eight weeks, so two weeks is pretty good. During our busiest time at the counselling centre, we'll have a three week wait. So far this year, we've been doing really well, we have about a week and a half wait. We also have an evening clinic to see students.
O - Is it busier when students are coming back in September?
S - We're busy all the time, we just fill up really quickly. Counsellors are seeing students on a day to day basis so we have a line up in September getting people into counselling but the waitlist doesn't build until usually November because that's when we're starting to see people and starting to build a case load and haven't moved people on yet. So that's when the schedule starts getting tight for in-takes.
O - So, are there any other barriers?
S - It's interesting, substance abuse disorder is not considered to be a disability. So, you don't get access to accessibility services for substance abuse issues. You might have been diagnosed for a concurrent mood disorder but not if you have been diagnosed for a substance abuse disorder. But there is also new legislation that just came out about accessibility in the workplace. They are now starting to say that you do actually need to accommodate employees with substance abuse disorder, meaning what I think you're really accommodating is their treatment. So, if they want to be treated, you need to be flexible in terms of their time away from work to seek treatment. So if they need to be gone for twenty-eight days to go to rehab, then they need to go to groups, counselling, or whatever the case may be then they need to be able to accommodate that. So, those standards are kind of changing. The approach that I have always taken around accommodating students, so like leniency, so you know we have academic consideration advocacy that we do for students that get into difficulties with their academics because of mental health issues - substance abuse doesn't figure in. So, the idea is that you can't come to us and say you didn't write your exam because you were drunk and didn't wake up - too bad so sad. The philosophy around that is very much from a family systems perspective - you don't save the person from their consequences, the person needs to face their consequences and the implications of their choices even though one could say it wasn't a choice at some point, but they still need to face it in order for it to hit reality and for change to occur.
O - In your opinion, do you think there should be any other types of programs available to specifically the students?
S - We do a lot of prevention and education with the community around substance abuse, proper use, and healthy use. So there is a big educational component that needs to go on. I think we still need to do social norm campaigns. I don't think taking a punitive approach is really very effective, especially in this age group. People party and they need to learn from their experiences. I personally would like to see a dry residence. I would like students to be able to

make the choice and say they don't want to be in that environment because a) I'm recovering b) I'm just not into it or c) for religious reasons. I've always suggested a dry residence. I don't think being controlling around alcohol works either, Queen's [university] has tried a dry frosh week and it just goes in the ground. I would rather it be out in the open so if someone does get into trouble we are there to help them as opposed to hiding it or not wanting to report it because the trouble with getting in trouble is that you can die. We have had people with extremely high blood alcohol levels. The toxicology realms of it are remarkable.
O - What are the gaps that currently exist for addiction services?
S - There are some significant gaps when it comes to the community services that are available to really meet the need of a population where we know there is a lot of mis-users and students - a percent of the population is at risk. The services that we have downtown at Fourcast actually need to be expanded upon. Many mental health services or addiction services are under a lot of pressures and stress so that's what we need - more resources to actually meet the needs. They have a model they have developed as a result of that demand, so you start becoming more limited in what you can offer students, you do group intakes instead of individual intakes, and different things to almost try and weed out who's ready and who's not ready.
O - So, just more services?
S - Yeah, I think addictions cost the economy a lot of money so it would be good to properly fund preventative secondary and post-secondary communities so you have enough resources to meet the needs. There is huge gaps when it comes to individuals who need residential treatment.
O - There is nothing in the four counties area.
S - Yes, nothing close and the waitlists are huge, it may be up to a year.
O - Thank you for your time.

Appendix M - AA Peterborough Transcribed Questionnaire Response

O- Olivia speaking, interviewer G- Sponsor of AA speaking, interviewee

O - Do you mind if I record this?
G - No, go ahead.
O - So, does this location have a district number?
G - Yes, we are district 86.
O - 86, okay, perfect and that is just for Peterborough?
G - Yes.
O - If you can just give a brief overview of the purposes and goals.
G - The purpose of this building?
O - Yes.
G - This is the office of Alcoholics Anonymous, we have our library and our archives. We provide the support for medallions and chips that are given out at all the groups. All the groups in the area use this location. We also have an archives group, so that if anyone is having a group anniversary so it is something they can use with their meetings.
O - So what is the purpose of Alcoholics Anonymous in general?
G - The purpose of Alcoholics Anonymous is sobriety and total abstinence.
O - And your job role is like a counsellor?
G - No, I am a member, I am no different then anybody else. Um, I usually just work one day a week. But I have long term sobriety and have worked the steps many times in my life. I have held many positions at the table. Many of the workers here are male, but they like to have at least one female so that women can identify and relate to.
O - So there is no fee to coming here at all?
G - We all pay the price.
O - But there is no money cost?
G - No, no fee.
O - Do you have any idea of the number of people who are coming here on a daily basis? Are there some people who come everyday or at least one day a week?
G - Well, you see, this is our, when we meet. Every year we have the number of meetings in our area. There are at least two meetings in this building every day, afternoon and evening.
O - And some people are coming to all of those?
G - Yes. We recommend anybody who is just starting at AA, 90 meetings in 90 days.
O - Any idea, just a rough number, of people who come to this specific location?
G - A rough idea would be at least 100 a day.
O - Are most of those males or females? Is there a fairly even distribution?
G - At one time it was more males than females, but now it is about half and half.
O - What is the approximate age groups? Is there a minimum age you have to be to come here?
G - No, no age restrictions, we have teenagers all the way to people in their 80s and 90s.
O - So the average age would be?
G - I would say in their late 40s.
O - Do you have people now who are coming as teenagers?
G - Yes we do.
O - So, the only dependency you deal with at AA is alcohol?

G - Yes, there are other groups for different things, gamblers anonymous, narcotics anonymous, but our main purpose is alcohol. You will find most people who have one addiction have many and when you work through the steps and you see your defects in character. You can recognize anything you like but it is illegal and moral value you're there.
O - Is there any barriers that people have when they're trying to come here.? Transportation?
G - No because if someone is calling here and needs a ride, this is where they call, and what I do is ask what part of the city they're in, and we have different coverage for different times. We have a whole schedule, we have 21 groups. So, if someone calls in and they want to go to a meeting and it happens to be a Sunday night, that would be the North End group or the meeting down here which is the Liberty Group. So I find out which one they want to go to then I have over here a book with all the group listings and the group member's numbers and then I go through calling them. I do not give out numbers to people when they call in, that's what anonymity is all about. So, I take the number of the person who calls, and then what I do when I get that number, I call the member of Alcoholics Anonymous and give them that number so that they can. Anonymity is the spiritual foundation and I will not break anyone's anonymity. There is a lot of shame with people first coming in, to realizing who you are and what's going on, so therefore you look at that and we have to be very careful that we don't push people away. We want them to come and we want them to hear. We only make suggestions. We don't tell an alcoholic to do anything. It is the nature of the beast. It is the nature of the personality of the alcoholic. We have slogans, and one of the slogans is keep an open mind. We ask anyone who comes in to open their minds because if you can change your thinking, and that's what has to be changed, that will bring a different attitude and as you change and things start to change in your life you start to become grateful. That's the principle of love. We work through love. We will help anyone at anytime, and we will go anywhere. I have been called to the hospital at 4 in the morning, but I have been given so much. What we do is we have a program called bridging the gap and that's between treatment. When a person is ready to come out of treatment, if we're working it right, we will get a phone call from the treatment center to say that so and so is being released on such a such a date. So what we do is we get their phone number, we call them, and we give them what we call temporary sponsorship. That is, someone will take them out and take them to all the meetings and we insist that the one thing that works in AA is a) you identify, b) find a group and sponsor and c) start to work the program. That basically takes you 90 days and that's why we say 90 meetings in 90 days. Then you decide whether you go back out, you've saved a little money and you want to go on a bender, and you go on a bender.
O - So emotions are a big barrier then?
G - Oh yes.
O - Is there anything that would help you to do more with the services here, like is there anything that is missing?
G - I wish we had more cooperation out of the services that have been set up by the government.
O - Is there a lot of support from the community?
G - No. We are self supported. The only requirement for membership is the desire to stop drinking. You don't even have to be sober. I have brought people who are drinking. But once the seed is planted, the drinking is really screwed up. So eventually down the road they will come in. It is really nice to see someone who has struggled and nice to watch them change. That is the twelve steps and there are twelve traditions within those steps. So, this is a spiritual program and that is not what counsellors deal with.
O - So how are you funded here?

G - No funding at all. We have what is known as the seventh tradition at each meeting, a basket is put down and put around. We pay rent, we don't own this building, but we pay rent to the church. Members pay one dollar for coffee.
O - Is there any other general comments you have?
G - I told you this was a spiritual program and I don't want that to be confused with religion. It says it's the God of our understanding, but our basic program has been based upon the Bible and that's because it originally came out of the Oxford movement. The first one hundred members who were deemed hopeless and could not recover actually found they could. If people are younger, they usually go back to school; they become very usefully and helpfully whole and they serve in their community.
O - Is there anyone coming in that are dealing with concurrent disorders?
G - Yes, we have every kind. Schizophrenia, manic episodes, depression. Most of us, with alcohol, do have mood swings. We have people who are slower than others. But this program works because it is based on love.
O - Approximately how many?
G - A quarter [25%]. We also work with the professional community. We only deal with one thing and that's alcohol and I'm not an authority on it either. I can see things and can suggest further counselling. The huge part of this program is becoming honest with yourself and who you are and accepting it.
O - I think the biggest surprise about Alcoholics Anonymous for me is that you provide transportation.
G - Yeah I mean sometimes we take people to detox. I have had people call me and I can call and see if they have beds at Fourcast.
O - So you do referrals?
G - Yes, but I have to be comfortable that that is what that person wants, I mean it is that person's decision. I usually choose a place that is far enough outside of Peterborough that they can't turn around and come back right away.
O - So, sometimes you do send people to Fourcast?
G - Usually people are taken to emergency and they meet with the doctors there who are in charge of that type of thing. If they need to be helped, they meet with the crisis doctors and the crisis doctors make the decision. Like I said, I don't like how the system is set up because they don't call us unless it's some of the older doctors that I used to work with over the years. But we are not the first call. Detox is great but it is only going to sober them up and sending them to rehab for twenty one days is the same environment. What do you do with the person when they come back with the same situation that they left. Sure they do well in rehab but how are they going to do when they get back. That's why I call it bridging the gap -that's where our treatment services come in, we walk with the person; it doesn't matter what education you have because it is an insidious disease, it is inside of you. There is no cure. It is like diabetes, you have to take your medicine.
O - So, do you get a lot of people coming in from rehab?
G -Yes a lot.
O - Thank you so much for your time.

Appendix N - CHIMO Transcribed Questionnaire Response

O- Olivia speaking, interviewer S-CHIMO worker speaking, interviewee

O- So if you just want to state your name and where you work.
S- Okay So I am Stephanie Anderson I am the clinical supervisor of children and Chimo family services in Lindsay and Kawartha Lakes.
O- So what do you do here just as an overview.
S- We are a children's mental health agency and we work with parents and clients any where between 0 and 18 years old.
O- okay
S- We do group therapy, individual therapy, parenting support groups, walk in
O- Pretty much everything
S- Pretty much
O- what is the approximate male to female ratio, any idea
S- it really kind of varies based on the age of the clients. We have a lot of males between 8-13
O- okay
S- and we have much more males than females
O- interesting, any reason for that?
S- ah, mostly we get alot of referrals from parents and schools about externalizing behaviours in sort of that 8 year old category and once they hit 12 they have the right to decline service
O- oh okay then
S- we are a voluntary agency so there is some stigmatism around adolescent therapy so they don't want to come
O- okay yes for sure
S- for females we get a lot of internalizing issues
O- interesting
S- and that comes in shifts
O- So it is different. So max of 18 years
S- yes
O- ah yes. Any idea of an estimate of those coming in with addictions?
S- um, don't tend to get a lot of addiction issues as the main presenting at start
O- right
S- um, but a lot of times it might be there in the background
O- right
S- so in terms of statistics it might be pretty small
O- Mhm, yes right, so less than10% probably
S- yes less than 10% definitely
O- and any idea what those are like alcohol and marijuana
S- yes drugs lot of marijuana
O- right mhm
S- We do have some other recreational use in terms of prescription medications
O- right
S- it is a very small percentage
O- yes

S- what we do generally speaking as an agency what we do if we have an addiction issue as their main presenting concern we refer them to Fourcast
O- always to Fourcast
S- yes for sure in this community always
O- it is not just in this community I've noticed the same in Peterborough and all the other communities as well
S- oh did you
O- yes that is very interesting. So no consideration to any abstinence program like AA or NA or anything like that?
S- no
O- so what are the barriers for people wanting to access the services here?
S- transportation
O- are people coming here from Haliburton as well
S- no
O- okay, so people are coming here from just Lindsey?
S- so, Lindsey we go as far as Kirkfield
O- so pretty far then
S- yes we go as far as Durham, Beaverton, Port Barrie
O- so definitely transportation is an issue and is it like a free services
S- yes it is free service. We are funded by the ministry
O- any other barriers that you can think of for people going to Fourcast other than transportation?
S- transportation is definitely the main one because we are centrally located.
O- right
S- other barriers tend to be flexibility and scheduling. Do not want to affect school attendance. There are only so many after school appointments available.
O- right and stigma of course definitely a huge thing
S- right
O- so do you think there are any other addiction services that should be offered even just in Lindsey area?
S- it would be great to have some more that were flexible in location
O- um, any thoughts on like a residence detox program, not necessarily for the people you are in contact with but just anyone
S- we have two residential programs that are geared towards mental health so they are for adolescents aged 12-18. They are at our Kirkfield location.
O- oh yes, I wouldn't have come into contact with that because it is outside my location.
S- so we have to decline, our physiatrist addresses any addictions before they come in.
O- so sobriety is needed to be accepted in this. So there is some sort of residence program then. Any other gaps that you think should be addressed for the addiction services.
S- I think, we find it starting earlier and earlier so literally across the street we have a middle school grade 7-8 and it is starting. Having services available for them and the awareness piece for parents as to what to be on the look out for.
O- right
S- they are starting with prescription medication. They are not starting with pot and marijuana anymore.
O- right so more heavy
S- comes to access , it is in their medicine cabinets. It is much more accessible

O- do you think it would be beneficial to have more programs and information available for children at a younger age?
S- for sure and to get more information home to the parents.
O- so yes that needs to improve for sure
S- parent engagement is key
O- right. I'm hearing more about younger ages. Other agencies deal with older adolescents. That pretty much answers all my questions. Do you have anything else you wanna throw out there?
S- what are you hoping to accomplish with the research.
O- well, I am looking at Peterborough, Kawartha Lakes, Haliburton as well as Northumberland so it's a big area so I am just kind of surveying what is out there now and I am coming to you guys and other front line workers just to see where you are sending people and what I find is mostly Fourcast. Basically just to see what should be in the these areas. There was an environmental scan done in 2008/2009 so just an extension of that to provide a little updated information. Getting some ideas for what should be available. It is pretty much the same thing a residence detox centre because the nearest one is in Oshawa. People definitely want something like that in Peterborough County.
S- that would be great.
O- so hopefully maybe some changes will come from this. But, it will be done in May.
S- okay
O- so, I can definitely provided you a copy
S- that would be great
O- I have been offering that to everyone. That pretty much answers everything. I don't-want to bog people down. Think that's it.
S- okay
O- great thank you so much

Appendix O - Kawartha Lakes Police Transcribed Questionnaire Response

O- Olivia speaking, interviewer J- Chief speaking, interviewee

O - Do you mind if I record this?
J - That's fine.
O - So, I guess first if you just want to give an overview of what the police station does on a day to day basis.
J - Sure, we service a community of about 25,000 part of the total community of Kawartha Lakes. We have the area of Lindsay and a former township of OPS, so a little bit of rural and urban and what we do, classically, is that we serve and protect. We respond to routine calls for service and we try to educate and prevent crimes from occurring. Although here is no really good academic study, about 80% of our time is spent on non-criminal activity, but obviously 20% of our time is spent on criminal activity.
O - Do you keep any statistics on the population you serve, like number of males and females?
J - I don't have that, but off the top of my head I would say it is comparative to the Statistics Canada. I'm not sure if its 51% female, 49% males. Stats Canada, as you're doing some research, they have some pretty good demographic information, I don't track it myself.
O - So you're coming into contact with a lot of individuals with addictions I assume?
J - Yep.
O - Is it more alcohol, more drugs?
J - A good question, I haven't looked at more alcohol, more drug. I just know that we respond to all of it. Alcohol, typically with us, shows up with impaired driving offences, fights in bars, domestic violence, drunks occasionally that we pick up off the street in the downtown area. Alcohol tends to spur on fights in the downtown area or in a domestic situation at home that we respond to. Alcohol has always been there. Drugs are another thing that is of particular interest to me, I've had 32 years of policing, is the misuse of prescription medications has become a significant problem. Fentanyl is one of the big ones of course we are dealing with on a frequent basis. That's how addiction manifest itself in my environment, it tends to be we are reacting to crimes. Often, what I've described as careless, poorly planned, unsophisticated crimes of people who are simply desperate to feed their addictions.
O - Is there any specific places you send people who are dealing with who have addictions? Do you recommend places?
J - Well, I'll mention it now. One of my sergeants is actively involved with a few different groups - one dealing with overdose, one dealing with fentanyl, one involved with safe needle exchange, and those types of things. He might be a good person for you to deal with. As a police chief, I don't have direction to staff to make recommendations on addiction, specifically we know about areas in our community that we can support people, suggest people go to, but really unfortunately we are in the business of, when they come to our attention, it's usually because of a criminal charge laid. Whether that's the best approach or not, it is our responsibility once a crime has been committed and then leave it for the criminal justice system to determine whether that person through their resources or their probation or diversionary methods to help that person with their addictions

O - What are the barriers for, not clients in this case, but people who are accessing addiction services?
J - One of the barriers I guess is the, well I'm sure there are access issues, stigma issues for the person reaching out, and just their own personal motivation to reach out for help. I'm sure every addict doesn't want to be an addict and there's a whole lot of shame there and so how do they get the help they need and where is rock bottom for them. The barriers that I can see are, a lot simply, the motivation of the individual being prepared to reach out.
O - Are there any additional services you think should be offered? I guess this question would be better directed for the Sergeant.
J - Yes I agree.
O - Do you think that there are any gaps in the services? Just gaps in the addiction services that are offered now?
J - Well I would say yes. But it's one of those, as technology is evolving, addictions are evolving as to what drug is being used and how it is being misused. Fentanyl is a prime example of this. Although I suspect those patches have been around for five or more years but the thought of someone taking a discarded fentanyl patch and cutting it up and smoking it was not on our radar at all. So, I think from the addictions folks, we try to look at how we could eliminate some of the precursors or creation of meth and then you take some steps in there and all of a sudden there is another drug that is being used. So, I think from the addiction folks issues, and you in your academic background, will have a better understanding of how addiction may simply just be addiction. But it's the source of the product that is being used, I'm sure they're having some challenges keeping on top of that. You talk about needle exchange and all of those things, but now we're talking about patch for patch exchange programs or fentanyl. How do you close those gaps when it is in every evolving marketplace.
O - I think that's pretty much all then. Thank you for taking some time out of your busy day.

Appendix P - Kawartha Lakes Police Transcribed Questionnaire Response 2

O- Olivia speaking, interviewer T-Sergeant speaking, interviewee

O- so if you would state your name and position
T- okay I am a sergeant with the city of Kawartha Lakes Police Service. My name is Terry Cox.
O- perfect, I don't know where to start, there is so much I want to ask you.
T- well why don't I kind of start
O- sure
T- with respect to how I got involved in this and hopefully that can lead into your questions and of course your questionnaire as well.
O- sure
T- as I articulated in your questionnaire my role here has nothing to do with overdose prevention, nothing at all. I am what we call here an administrative sergeant responsible for addressing the media. I am responsible for building and fleet maintenance. I am responsible for equipment purchases, training, that sort of thing. Overdose prevention has nothing to do with my role here, but it kinda goes back, the majority of my career. I have been policing 25 years and the majority has been drug enforcement. And when I say drugs I do mean enforcement nothing to do with overdose prevention and that side of it. 20 years ago there wasn't any talk of that really with respect to community partnership. It was just strictly enforcement and that's all it was. I got into that mentality young into my career and it wasn't till about 3-4 years ago when the overdose prevention role started and the wheels started turning that I started to see that maybe there is a place for this. Maybe if we concentrated a little more with overdose prevention we wouldn't have to concentrate as much on the enforcement and then at the same time we would be bettering people's lives and improving our community
O- right
T- we don't have a whole lot of buy in with that yet from a law enforcement prospective and like I said that wheel just started rolling with me about 3years ago. I have always had an interest in drug enforcement as I indicated. About 3 years ago I got asked to participate in a provincial initiative called Prescription Drug Drop Off. Have you heard of that at all?
O- no, I am not from Ontario so I don't know a whole lot about what is going on here yet.
T- oh, where are you from?
O- Nova Scotia, I moved here a couple years ago so I am still learning
T- got ya. So what that provincial initiative is a drug amnesty a prescription drug amnesty whereby the community is encouraged to empty their medicine cabinets of expired and excess prescription drugs in an effort to get it off the street and keep it away from youth. I started 3 years ago and I jumped into it with a passion, I put a lot of time and effort into it. Not only the initiative itself but the whole education and awareness surrounding it. I have been doing it annually ever since. This year has been the most successful year. What I mean about successful not only quantity but type.
O- right
T- like the amount of fentanyl we had turned in was fantastic. Hydromorphone, another serious, serious addictive drug the quantity of it is how I am labelling this years initiative as our most productive yet. Getting back to the prescription drug drop off I started this initiative to work with community partners. I started to put a whole lot of time into the awareness of the initiative itself. I tried to put an education spin on it as well.

O- right
T- this got me then involved with our health unit, got me involved with some other community groups with respect to overdose prevention.
O- okay
T- of course 3 years ago you are dealing with an officer that had blinders on with respect to drugs, it was strictly enforcement that is what I keyed in for 20 years. Old habits especially with old dogs are tough to break. I am finally starting to open up and starting to see how the overdose prevention program can be effective in our community. I started to work with the drug overdose prevention program in the community group that we were just starting to role here in the Kawartha Lakes and it was spurred on be the health unit
O- okay then
T- I am going to back track on that we have been successful. The initial goal of that was to look at overdose prevention and the implementation of naloxone. That was our initial goal when we first formed up to look at whether we could utilize that in this zone in Lindsey and Kawartha Lakes.
O- right
T- we are still kind of rolling with that. I guess what is kind of happening with that is that we got meeting as a group and we started identifying areas of concern and kind of naloxone got of to the side a little bit. What we have been instrumental in doing since this all started was we started working over a year ago with fentanyl patch for patch program and as you can imagine it was a slow moving process. It was a fair bit of work but we finally got that launched in October this year which was fantastic. From there we started the needle exchange. We used to have a needle exchange 24/7. As I indicated earlier part of my role here is media I basically know what our calls for service are. Any calls for service directed to the media I have to dig through every day. I started to notice a trend that this particular year we are responding for many calls to service for discarded needle and syringes all over town. I am thinking we gotta do something about that. I started to go back and look at the statistics Olivia. I pulled up some stats from ten years ago like 2004 and comparing to 2013/2014 regarding our calls for service for discarded needles and syringes. We went from like 18 calls for services in 2013 just to pick up syringes to 31 in 2014.
O- oh wow
T- and that doesn't include the number of phone calls that I took from our parks and recreation City of Kawartha Lakes Rec in relation to discarded. That is from our public park flower beds. That is huge. Let's get that drop box up and rolling. That is what we are currently working on now is that 24/7 drop box. In a nutshell that is what I have been doing for the last 3 years.
O- wow
T- and that is over and above my normal duties and responsibilities. And again it's not in my job description. It is just something that I have taken an interest in and working towards and for the last 2 years we the city of Kawartha Lakes are making a presentation on different community issues and one of those issues is addiction. Whether it be drug, alcohol, gambling and they have labelled this presentations or group of presentations "Shifting The Lens" the name of the program. They have been conducting them at the library.
O- oh, okay
T- it is open to the public, it is video taped, it is actually on YouTube if you wanted to view it for your your report.
O- okay

T- I have been asked to speak at the last two events in relation to addictions. There are other group members on the panel. There is Fourcast, a member from family healthy team, a member Ross Memorial Hospital, a member from PARN. There is a presentation and a number of questions and the community gets involved that way. So in addition to those other things I have been busy with Shifting The Lens presentations also. Did I spur any thoughts?
O- I have a question about the needle exchange drop box. Is that something that would be located here at the station or just in the community?
T- as you can imagine police have a certain stigma with those suffering with substance abuse issues.
O- right
T- if you were to place it here you would not have anyone using it. They are not going show up here right. Ideally our syringes are found in the downtown core. So our struggle is to try and find a suitable location for this. If we try and speak with private business owners downtown we are going to get push back from them, because they don't want that type of cliental around their properties.
O- right
T- we could get some pushback from the city public from a public relation stand point. They may want to promote tourism. They want to promote a safe and healthy community. I'm not sure how receptive they will be in placing a drop box on public grounds or a city owned building. We are still tossing around some ideas for the location but certainly not here. It would not be effective here.
O- definitely. I think that answers all my questions. We can go to the survey now.
T- certainly, I have it right here. When I started to fill this out, I get to here addictions is about 65%-35%. Then it gets difficult for me as a law enforcement agent to answer some of these questions.
O- yes
T- so I wanted to get some feed back from you and maybe go through it together. I'm not sure where you are going with this and how I can assist you.
O- sure. The whole point of these is to get the demographic that you are dealing with. Like mostly I am trying to get a sense from the frontline workers how many people in general are coming in not for service dealing with addiction services but they have addiction issues. That is what that survey is. It is hard question because I'm sure you don't keep statistics on each individual case that comes in.
T- no right
O- it would pretty much be an approximate value like 50% coming in or calls you are dealing with that relate to addictions.
T- yes I see what you are after now. very difficult for me to put a number on that. When I do give you a number keep in mind it is just an opinion a number off the top my head. Umm I am gonna say maybe as high as 65%.
O- okay. Give or take a little. That sounds reasonable.
T- the reason why we have somebody in here on a criminal offence is because there is a motive of some sort. The motive being financial or to fuel an addiction. I will suggest that 65% or higher the motive is to fuel an addiction.
O- okay mental health issues
T- going to be totally honest with you I looked at concurrent disorders and I didn't know what they were.

O- yeah most people don't. That is a big thing that our project is addressing because the more people I go and talk to the more i see that people may have addiction problems but they also have schizophrenia, anxiety
T- absolutely, I see where you going. That's going to be a very high number. Oh dear, umm I have no medical experience to back this up. This is only from me seeing this from 20+ years of drug enforcement. Especially cannabis, we all may have some mental health issues that are buried deep inside and haven't manifested yet. What I really see is cannabis manifesting the mental health issues. Huge, huge, I am going to say possibly as high as 85% deal with side mental health issues in some capacity. So that's huge.
O- for sure
T- for what ever reason the drugs reveal it.
O- I think there is some medical information to back that up
T- the majority of people with addiction issues have that side issue. Was it the addiction that brought it out, was it the substance itself that manifested those symptoms? It is pretty overwhelming that the majority of people have something on the side.
O- approximate age groups? Like is there more youth? And like just not people with addictions just in general
T- you know I would say we deal with an age group the most often say 20-35.
O- okay, the majority of people you deal with percentage
T- oh I am going high I will say 80% of the people we deal with for addiction related issues are between 20-35.
O- okay that works for sure. That's good for those questions. What services are available in this area? I know Fourcast
T- I know there is PARN representative here I think Friday's One day a week and he works out of the methadone clinic on Lindsey Street South but again only one day a week. Other than Fourcast I don't know but again not really my field of expertise. I am slowly learning of these community groups in the last 2-3 years. I am not familiar with any others.
O- I believe that it is just Fourcast. There are some side groups that don't directly deal with addictions
T- have you made an effort to contact Fourcast
O- oh yes, I contacted Donna Rogers she is the head person at Fourcast. My host Dave Jarvis he is with the Human Service and Justice Coordinator. We have made several attempts at that. From what I hear there is somewhat of a lack in communication between methadone clinics and Fourcast. They are the only organization I haven't been able to touch base with.
T- I know they are swamped and as far as I know they only have two workers. Have you spoken with the ones here.
O- I was hoping to speak with someone from Peterborough. They are the main addictions service. There is a lot of political stuff going as well which makes it harder to get in touch with them.
T- another organization that is really an advocate for overdose prevention is a place called APCH. It is like a homeless shelter.a particular employee of APCH named Nicole Bryant, she is huge in our overdose prevention program here.
O- any barriers people may encounter? I know you see a lot of people coming here, maybe some can't drive?
T- I don't really know enough about addiction work to articulate what and why. I don't think I'm educated enough to properly answer that to assist you

O- okay sure that's fine
T- I don't want to break my confidentiality with my contact at Fourcast so she wouldn't reveal that information to me.
O- the next question are there any services you think would be beneficial to the area?For example a residence detox centre, the nearest is in Oshawa. Do you think one should be here or maybe in the Peterborough area?
T- in my conversations with one of the local Fourcast workers she has told me her stats with respect to how many people she deals with on a yearly basis for drugs and then she categorizes it and it is huge. They have two councillors here in town and PARN. Some of the work they do is incredible and their passion is second to none. Other than that in our community we have absolutely nothing. Yes I certainly believe we need more assistance. But where do we draw the line. We need it in addictions but we also need it in mental health so where does the money come from? How do we finance all these services that we need. Two councillors at Fourcast is not enough for what they deal with. We don't have a detox centre and I'm not experienced to properly articulate all the services provided. We used to have a short term detox in Lindsey but we don't anymore.
O- how long ago was that?
T- I wanna say close to 15 years ago and I think it was offered at the hospital but we don't have it now. The issue I wanna make is we don't have anything and the closest would be Oshawa. Do we need it, absolutely. Would we be able to utilize it effectively, I firmly believe that in partnership with PARN and Fourcast. Where would funding come from and how do we get it? And how do we pick what is most important addictions issues/ mental health
O- that is the idea with the concurrent disorders centres. That is something we are looking into combing the two. What about AA?
T- we do have AA here, absolutely
O- what about NA
T- I don't know as much about NA. I have actually attended a few AA meetings to support acquaintances. There is several in Lindsey, Oakwood, Omemme. It is very popular here.
O- interesting
T- I can't speak to NA
O- it's not as well Known. I think there is one here I have an address but haven't been able to reach anyone. They don't have local numbers. They have a #1-800 and you dial into certain areas.
T- the last AA meeting I was at might be 2-3 years ago. I attended in Oakwood 10 minutes outside Lindsey and overwhelmed, it was incredible. It's strong and Very effective. We have several here in Lindsey.
O- I think that pretty much covers it for that part of it. Any opinions on harm reductions verses abstinence methods.
T- again I'm not knowledgeable to answer that. My old school days would be abstinence would be the ultimate thing. Ummm my mind is being opened if yo you will to The topic of harm reduction and allowing that. Vancouver is rolling the carpet out for that. They are the first and the biggest in Canada I think. Am I right?
O- yeah I'm pretty sure from what research I have done.
T- I was fortunate enough to work the winter Olympic in 2010 and working with the members of the Vancouver police city service I got to hear a lot of their stories. What a difference in mentality here then there in comparison to abstinence here there it is more harm reduction. I'm

not sure if I agree with all of it. I'm slowly starting to see from a health perspective and from saving lives perspective the benefits of harm reduction.
O- yeah they definitely both have positives and negatives.
T- being a police officer I would have to argue that abstinence is the way to go. Then again that's, the police officer and old school thinking and I am 50
O- this isn't a research question just an interest. You are involved in many things and am sure you have lot of opinions
T- I understand the importance of walking the political line, so to speak. I do what I can to stay impartial
O- I would love to hear more about all those programs. There isn't that much available in Peterborough.
T- well Peterborough is trying to put a group together, like just now like we have. They already have the fentanyl patch. They are looking at establishing a committee right now to do the same thing we are doing. And doing the needle exchange program. Kerri Kightley is in Peterborough police station. She is knowledgable on the types of programs.
O- I don't get a lot of contact with the police side of it
T- she is not an officer she works out of the Peterborough Drug Strategy Office in the Police Station. Her phone #876-1122 ext. 292.
O- definitely have heard of her. Will make a note of that.
T- anything else that you can think of?
O- no, that pretty much covers it. That's great
T- I don't know if there is anyone in the Peterborough police station working on this. Is it just this area?
O- yes Peterborough, Kawartha Lakes, Northumberland and Haliburton. It is very widespread. The project started out with those plus Durham and Scarborough, but we had to narrow it down a little. That is more of a masters program.
T- I don't know anyone doing the same in those areas.
O- I talked briefly to the chief in Coburg and he referred me to another officer but he wasn't knowledgeable on the subject.
T- for Northumberland I can point you to the Haliburton/Kawartha Pineridge District Health Unit which includes Northumberland. contact manager communicable disease control Shawn Woods #1-866-888-4577 ext. 1290
O- do you have any contacts for the Ross Memorial Hospital? The crisis manager that would have attended the Shifting the Lens
T- yes, Lisa Knoester email: lknoeste@rmh.org . another gentleman that would be a huge assistance to you would be Wayne Ducker he manages the needle exchange in Peterborough and one day here in Lindsey on Fridays. His email address is wayne@harmreductionworks.ca. He is a huge advocate of harm reduction. He is currently on our needle drop box here. When the time comes if you get chance. I work with a great girl here with Fourcast
O- the issue that I was having initially was I was told by my host that I want allowed to talk to specific workers. I could speak to her and maybe she could ask. I feel like it is not getting communicated that I want to talk to the workers. That would be so useful.
T- if you want to pursue that avenue down the road by all means get in touch.
O- maybe in January I will be in touch. I am getting a little late now.
T- you go to Trent?
O- yes, the report will be done in May. I can send you a copy

T- I would be interested to see it
O- of course it may be useful for the programs you are involved in.
T- I don't have a lot of experience with harm reduction so some questions I found hard to answer. I really don't know, for me it has been absence all along. That's part of my job. I would love to read your report. after January my contact will change it will be # 515. My role is changing to supervising our criminal investigations.
O- congratulations
T- I still would like to maintain our prevention initiatives
O- I am very interested in what you are doing and if for some reason you ever need help with anything I am definitely around. At Trent I am taking Forensic Science and specifically I want to go in toxicology so it is kind of at the other end of the spectrum. I am exploring all options to that. am doing pharmacology for the science behind all of it but this project is really helping to see other end of that.
T- I realize you are in Peterborough and appreciate the offer and would love to have on board win some of the stuff we do and I do appreciate the fact you would have to drive here.
O- well driving to Nova Scotia is a bigger task, so the drive to Lindsay isn't to bad!!

Appendix Q - OATC Peterborough Transcribed Questionnaire Response

O- Olivia speaking, interviewer L- OATC worker speaking, interviewee

O - So, if you just want to state your name and title here at OATC.
L - Sure, my name is Laura Lunn and my position is a clinical case manager and addictions counsellor.
O - If you can just give a brief overview of what you do here.
L - What we do at the clinic?
O - Yes.
L -So we provide treatment for opiate addictions by prescribing either methadone or suboxone.
O - So it's mostly just methadone?
L - Yes mostly.
O - Is there a fee for people coming here?
L - So, the services are covered by OHIP, the medication itself, for people who have drug plans, are mostly covered by the drug plans. However if they don't have a drug plan they have to pay. Just like any other medication.
O - What's the total number of people who come here?
L -265
O - And most people are coming on a daily basis?
L - We have a lot of clients who come once a week, I would say more of that.
O - And males versus females?
L - It's about even. I was surprised, when I was doing my counts, I thought there would be more men but it's pretty even.
O - And what about age groups?
L - So I put down the majority into between 30-50. Then I did around 30% for 19-30. 30% for 31-40 and 30% for 41-50. We do have some older people as well, we have some seniors who are up to 70+
O - But very few?
L - Yeah very few.
O - And is there anyone who comes in under the age of 18?
L - Not currently. To do that, we either need a parental signature approval or if someone doesn't have that or are unable to get that then they need to see two separate physicians before their first visit and then they can qualify to start.
O - So not currently anyone under 18.
L -No we don't currently have anyone under 18 right nw.
O - So the nature of dependency is mostly..?
L - We only deal with opiate addictions and obviously some of our clients have other addictions but the primary focus is opiates.
O - Does anyone come in with concurrent disorders?
L - Yes
O - What types of disorders?
L -Pretty much everything from anxiety, depression to schizophrenia, bipolar. So we pretty much see it all.
O - So mostly people are coming in one time per week.

L - The majority, like 60%. 40% come in once a day. 50-53% comes in once a week. 5% of people come in every two weeks and then 2% have visits every once per four months and that is for pain patients - they don't have to be seen as often.
O - Do you have any statistics available that I could have?
L - I don't unfortunately.
O - What are some of the barriers for clients when they are accessing the services here?
L - Transportation is huge. Pharmacies dispensing methadone. There are only 4 pharmacies in Peterborough who can receive it. So if we have clients who live in Bridgenorth, Lakefield, Curve Lake, they have to come to Peterborough. They don't have anything out there for them. So it's quite a drive.
O - Is there a big wait time to get an appointment?
L - No, not here. So, I actually had a new person come in this morning and I saw them right then and they're seeing the doctor in a week so it's not too bad. We like t try and get them in within 48 hours whenever possible. But one of our physicians is away this week so that kind of shortens the availability.
O - Are people coming in who are really embarrassed? Like is there a stigma?
L - Stigma is huge. A lot of people when they come in during their intake with me, they say they wish they came earlier. They are just worried what people will say and how people will view them.
O - Is sobriety needed for someone initially coming in?
L -No, not at all. Someone could be on the program their whole life and still be using.
O - Do you think there are any other services that should be offered here in Peterborough?
L - Maybe rehab centers. The closest would be Oshawa and waitlists are very long. That is the hard thing, when people are ready to go to treatment but they have to wait six months or more and then by that point its just...
O - So some sort of rehab center?
L - Yes.
O - So, obviously you're more harm reduction, what are the benefits of harm reduction.
L -It can be a lot less scary for people. Abstinence can be quite scary to think you'll never use again or you can't when it's very difficult to quit. So harm reduction is nice, it gives them a nice secure place to come and talk about what's going on. We try to move them along in terms of change, but if that's not where they're at they know that's okay. Whatever they want to do is whatever we want to do, is basically what we tell them.
O - Well, I think that's it. Thank you for your time.

Appendix R - PIPC Transcribed Questionnaire Response

O- Olivia speaking, interviewer P- PIPC worker speaking, interviewee

O - Do you mind if I record this?
P - Sure go ahead.
O - So, if you can just state your role and just give a brief overview of what you do here on a day to day basis.
P - So, I'm a social worker at Partners in Pregnancy Clinic. We see women for their prenatal care and up to six weeks after, we do some newborn care as well, breastfeeding support which helps. Any woman can come here for their prenatal care - they can get a self referral or get referred from their family doctor. Women that get referred to me are anything that you can imagine - so I do see a lot of teens, do a lot of child protection work and advocacy, but I see women with addictions, I see women with homelessness, poverty, mental health issues - depression, anxiety, trauma, relationship problems, workplace stress, almost anything you can imagine that a woman expecting might face. Oh, and we also do some loss work so stillbirth and miscarriage.
O - So, most people pay through insurance?
P - It's all through OHIP, because we're a family health team, so long as they OHIP all the services are covered. I should probably mention, we are the only clinic of it's kind in Ontario. So there are other prenatal clinics but they're usually funded through a hospital, so a hospital decides to set aside so many funds for that, but we're solely funded by family health teams - so from the ministry of health.
O - Any idea what the total number of woman you serve is?
P - So we do around 500 deliveries a year which works out to about 40 due dates a month.
O -So obviously all females and no males here.
P - Yes, women if their childbearing years. It's kind of an interesting population.
O - Would the most frequent be in their 30s?
P - Yeah, I means 20s or 30s its hard to say.
O - Do you have any statistics that you could e-mail me later?
P - Yes definitely.
O - So, the approximate percents of women coming in with addictions?
P -Let me go back to my stats because we do keep stats on reason for referral.
O - So, more generally, what is the nature of dependency that women are coming in with?
P - Huge percentage of our population uses marijuana, they don't feel like they have an addiction, but they are like daily marijuana users. It's so common now that it's barely a blip on our radar. The marijuana use is completely widespread. So pregnancy is a really interesting time where women usually give up a lot of their addictions pretty easily because they realize they have a baby on board. So we see a lot of women who are smoking marijuana daily, like chronically, then get pregnant, and claim to most use during their pregnancy but probably go right back to it post-partum. So marijuana is definitely by far the most common. We see quite a few women on methadone now who were struggling with opiate addictions in the past. And they are at different points in the program, some of them are at the top level of their program for like years and some of them get on methadone as soon as they find out they're pregnant. I don't feel like our stats are anywhere near accurate on alcohol use. Alcohol use during pregnancy is so shunned, that nobody admits to it. We might get maybe two clients a year that admit to drinking during their pregnancy. When you think about alcohol rates and alcohol use, especially in this

community, our smoking rates and alcohol rates in Peterborough are really high compared to the rest of the province. We're definitely seeing the smoking rates, a lot of women do admit to smoking, and it seems to be a little more socially acceptable than alcohol use but yeah, we did have some women, so with the whole oxys being off the market and harder to get, we have had some women experimenting with fentanyl before being pregnant, now not too many get into it while being pregnant.
O - And concurrent disorders?
P - It's very rare. Even people with mental health issues, they seem pretty stable during their pregnancy for whatever reason. We don't get too many identifying with that. We just don't focus on it as much. We do have a lot of depression and anxiety, and people that I feel, like with the marijuana, a lot of people are self-medicating for those types of things, and ADHD. And not so much the pregnant moms but their partners. I have a lot of women, they say their partner smokes weed every day, but I don't want him to quit because he's awful when he's not smoking. Because of the nausea and vomiting in pregnancy, and then the difficulty in sleep, a lot of people are really reluctant to give up marijuana when they are pregnant and then there's this whole urban legend that it's natural and some of them feel like it's better to smoke weed because it gives me an appetite and that is better for my baby. They'd rather smoke marijuana then take diclectin and some of the other more medical forms of treating the nausea and vomiting.
O - So how many times does a woman come in and see you during the course of her pregnancy?
P - It varies. I see women up to biweekly, and pregnancy is 40 weeks. So some women I see quite frequently. Some women only wan to come in for their prenatal appointments. So, when a woman is first pregnant she comes in once a month for a prenatal visit and they can see a social worker at that time. Then once they get up to thirty weeks, they come in biweekly for prenatal and then from 35-40 weeks they come in weekly. So depending on the patient, it varies. In general, we don't see people for more than ten months at a time. We're completely voluntary, so you don't have to meet with a social worker.
O - What are the barriers for people when they are accessing addiction services? So like where do you refer people to?
P - Fourcast
O - It's always Fourcast?
P - Yes usually or the methadone clinics. So, there's a few barriers I see. I always have to check this, and it might have changed by now but for the longest time Fourcast didn't have a consulting psychiatrist so that's a huge barrier to me. A barrier with the methadone clinics is that we don't have good communication.
O - Do you ever refer people to programs like AA or NA?
P - Not often, I talk about it sometimes.
O - What are your thoughts on it?
P - I've definitely seen people have success with it. I think people do benefit from professional help and I think the ideal situation would be both. It's definitely a peer-support model. It isn't my first line of care. What I do refer more to, that's similar to AA is Al Anon. I have a lot of clients that their partners are dealing with addictions or parents with addictions, and it's really impacting them. Pregnancy is a really interesting time, it's a moment in time where women stop and kind of take stock of their life. They have this reminder that "I'm not going to let my brother treat me like that or I'm not going to put up with my father's raging alcoholism, or my partner's chronic gambling problem" and they start to try and deal with it before the baby comes so it creates all this stress. So, I have lots of people who come to me with that kind of stuff and then I will

suggest Al Anon for them. I think the peer support model works best if they're also seeing a professional because I think a lot of things happen within AA, NA, and Al Anon, there are boundaries, relationships get started. That stuff is not always bad but I think it's good to have an objective professional support.
O - So it's mostly just harm reduction you'd be referring people for?
P - Yeah, and sometimes if they are refusing to go to Fourcast I will do some of that myself. I'm by no means an addictions counsellor or therapist but another barrier I should add is that our clients have so many appointments. Some women have to meet with their OW, they have prenatal appointments, they have to meet with children's aid, they sometimes have to meet with a lawyer if they're dealing with children's aid stuff or if they're going through a separation.
O - Just too many appointments?
P - Yeah, so sometimes I'll take on that piece of work, I'm not an expert but I do know about harm reduction, stages of change model, motivational interviewing. I do have training in those thing. So, I figure obviously best practice would be to send them to Fourcast because they can really get the best support there, but if I can do even little bits of it while they're coming here anyways - like we're kind of a one stop shop, so they have to come for prenatal care. So if I can do even a little bit of work like lay the groundwork so once they have their baby and aren't coming here anymore, they might have more time for appointments and might be more open to Fourcast or something.
O - Is transportation a big issue?
P - A little bit, I think our location is really helpful. I would say in other counties you named for sure.
O - Do you have a lot of people from outside of Peterborough coming here?
P - If we do, it's usually because they have good transportation options. So yes, we'll have people from Campbellford, Norwood, Havelock, sometimes Apsley way. We definitely have some clients missing appointments due to transportation issues.
O - Any other barriers?
P - Just beds, and getting into places, and that we don't have any residential programs here. It can be really scary for people to leave the city.
O - So, do you think it would be beneficial to have a residential program here in Peterborough?
P - Sure definitely.
O - Does anyone come in that isn't sober at the time of their appointment?
P - Sure.
O - And that's not an issue? Like do you turn people away?
P - It depends on their level. I don't know what the doctors would do, but I would still continue the appointment.
O - Any additional addiction services that should be offered?
P -Definitely a residential program, as well as a program that meshes addictions and mental health issues together.
O - So gaps are kind of like addiction services not offered, are there are more gaps?
P - Just more communication between the services.
O - So, any further comments?
P - The Nalaxone program, I think it is a huge one for pregnant women. Pregnant women, and women who have had babies, are at one of the highest risk for overdosing because if you look at the risk - a change in body weight, lack of sleep, break in use (a lot of women stop using during pregnancy and go back to what they were using ten months earlier), and stress. I try to promote it

to my patients. Of course they say they will never use again but they are at a really high risk to use again. So, I think it is an important program that we need to keep spreading word about, because I heard a lot of young moms who have overdosed. Sometimes, I try to sell it like I know you're not going to use again, I educate them about their risk, and say even if you are not going to use again, what about your partner or the "junkies" you hang out with, because they call their friends "junkies".
O - Thank you so much for your time.

Appendix S- Kinark Questionnaire Response

Survey

6. Name your place of work: _____ KINARK

7. Give a brief overview of the facility's purpose and goals: ___ Children's Mental Health Services

8. State your title and specific role within the facility: _____ Lead Manager- manage family intervention
9. Answer the following questions regarding the population you serve:

	Approximate Percentage Served
Male	-
Female	-

Age Group	0-18	19-30	31-40	41-50	51-60	61-70	70 +
Approximate Percentage Served	100%						

	Less than 10%	10-20%	21-30%	31-40%	41-50%	51-60%	61-70%	71-80%	81-90%	91-100%
Estimate of Individuals with Addictions Served			25%							

	Less than 10%	10-20%	21-30%	31-40%	41-50%	51-60%	61-70%	71-80%	81-90%	91-100%

Estimate of Individuals with Concurrent Disorders Served		X								

5. Where do you send individuals if you are not an addiction service? FourCAST

6. What are the barriers for clients when accessing addiction services? (ie: wait times, transportation, finances, etc..)
Wait times, transportation, stigma, geographic isolation, lack of motivation, denial, no inpatient treatment in Peterborough

7. Are there any additional addiction services that should be offered? Inpatient and detox

8. What are the gaps that need to be addressed for future addiction services/programs? Same as above

Appendix T- Sample Mean and Standard Deviation Calculations

Sample Calculation for Mean

$$\bar{x} = \frac{x_1 + x_2 + x_3 + ... + x_i}{n}$$

where $\bar{x}$ = mean

x_1, x_2, x_3, x_i = value for each of the questionnaires

n = total number of questionnaires

Ie: We have four trials of data with results of 1, 2, 3, 4

$\bar{x}$ = 1+2+3+4 / 4 = 2.5

Sample Calculation for Standard Deviation

$$s = \frac{\sqrt{\Sigma(x- \bar{x})^2}}{n-1}$$

where s= standard deviation

x = value for each questionnaire

$\bar{x}$ = mean

n= total number of questionnaires

Ie: We have four trials of data with results of 1,2,3,4 and in the previous example we calculated the mean to be 2.5

$$s = \frac{\sqrt{(1-2.5)^2 + (2-2.5)^2 + (3-2.5)^2 + (4-2.5)^2}}{4-1}$$

s = 1.29