



# **Experiences of Delivering and Accessing Opioid- Related Services in Oxford County**

Working Together to Meet People's Unique  
Needs

Situational Assessment Report  
Southwestern Public Health  
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## Authors

**Laura Gibbs, M.Sc., MPH**

Public Health Planner

Foundational Standards

Southwestern Public Health

**Elizabeth Urbantke, MD, CCFP(EM),**

**FCFP**

Master of Public Health Student

Foundational Standards

Southwestern Public Health

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# Summary

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In response to the nation-wide opioid crisis, Southwestern Public Health (Public Health) conducted a situational assessment to understand the accessibility and coordination of opioid-related services in Oxford County. We wanted to know what services exist and what services might be missing. We also wanted to learn about what makes it easier and harder to deliver and access these services. Our findings will inform the opioid-related strategic directions of a local drug strategy for Oxford County.

We found 114 unique services in Oxford County for people who use opioids, people at risk of using opioids in the future and their loved ones. Despite the appearance of many services, organizations and service planners should be aware of five potential gaps in:

- services located in rural municipalities and available online and/or by phone
- services for people in recovery from opioid use
- services falling under the justice pillar
- medical detox facilities
- chronic pain management

Service providers report that they are constantly working on collaboration. Collaboration is facilitated by an existing close-knit network with a lot of strong connections between organizations. Although this network structure can make it easier to coordinate services and build trust, it may also make it harder to work together in new ways and implement flexible, creative solutions to problems.

People with experience accessing these services told us that services in Oxford County are not meeting their unique needs because their lived experiences are not understood. They feel restricted by others' decisions and must fight for what they and their loved ones need. As a result, they often must make difficult choices between their opioid-related and other needs.

The Oxford County drug strategy and opioid-related service providers should consider how to leverage Oxford County's assets – namely, the number of services available, number and strength of relationships among organizations and first-hand expertise of potential service users – to overcome these challenges and reduce opioid-related harms in Oxford County.

# Experiences of Delivering and Accessing Opioid-Related Services in Oxford County

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## Background and Rationale

Canada is currently experiencing a public health crisis<sup>1</sup> related to the use of opioids such as fentanyl, heroin, methadone, codeine and hydromorphone. Over the past 14 years, opioid-related deaths and emergency department visits in Ontario have doubled. Prescribing practices, the introduction of synthetic opioids and addiction and mental health concerns all contribute to the negative population health impacts.<sup>2</sup> The Ontario Ministry of Health and Long-Term Care's (Ministry) opioid strategy includes investments in data collection and surveillance, education for patients and training for prescribers and dispensers, improved substance use and harm reduction services.<sup>3</sup> As part of this strategy, the Ministry provided all local public health units in Ontario with funding to enhance harm reduction programming. Health units must use the funding for three initiatives:

1. local opioid response
2. naloxone distribution
3. opioid overdose early warning and surveillance<sup>4</sup>

Under the first initiative, local opioid response, health units must conduct a situational assessment that identifies local opioid-related challenges and issues and that informs the development of a drug strategy or a local overdose response plan.<sup>4</sup> This assessment aims to build on the previous population health assessment, research and situational assessment work conducted by the former Oxford County Public Health and others to address the Ministry's requirements. In May 2018, Oxford County Public Health merged with Elgin St. Thomas Public Health to form a new organization called Southwestern Public Health (Public Health). Although Southwestern Public Health serves the communities of Oxford County, Elgin County and the City of St. Thomas, this assessment is focused on the situation in Oxford County only.

## What We Already Know

In Oxford County, 400 to 1200 residents may be at risk of experiencing harms related to opioid and other substance misuse. Opioid-related deaths have increased slightly since 2005, with seven deaths (6.2 per 100,000 population) of Oxford County residents attributed to opioid use in 2016. Women in Oxford County experience higher rates of opioid-related hospitalization than men (26.4 versus 10.7 per 100,000 population), especially among those aged 45 to 65 years (63.6 per 100,000).<sup>2</sup>

Among people eligible for the Ontario Drug Benefit (ODB)<sup>a</sup>, 6,002 Oxford County residents used prescription opioids in 2015 and this rate was slightly higher than that of Ontario (2,080 vs 2,054 per 10,000 ODB eligible people). Just under three per cent (i.e., 182 people) were prescribed high strength opioids, placing Oxford County as the seventh-highest prescribing county in Ontario for high strength opioids.<sup>2,5</sup> However, it should be noted that the age distribution of the population was not accounted for in these analyses. The high proportion of older adults (i.e., 65 years old or older) in Oxford County may contribute to the high prescribing rates.<sup>2</sup>

In the 12 months between October 2016 and September 2017, 378 people who reside in Oxford County were admitted at least once to a Ministry-funded substance use service which is a slight decrease from the previous year. Of these residents, 65% were male and 71% were between 25 and 54 years old. After alcohol (28.5%), prescription opioids were the second-most common presenting problem substance (13.3%, tied for second with cannabis) among clients of substance use services with new admissions in this time period; 8.9% of people with new admissions reported using prescription opioids in the past year.<sup>2</sup>

A previous assessment of the accessibility of mental health services in Oxford County revealed over 200 services available to children, youth and families with mental health concerns. However, these services were concentrated in the three most populous municipalities (Woodstock, Tillsonburg and Ingersoll), making it more difficult for residents of the mainly rural municipalities to access services. Information about the mental health services in Oxford County was difficult to find and was inconsistent across four information sources. A discourse analysis of newspaper articles and reports published by local organizations revealed that socially established understandings construct mental health services in Oxford County to be of good

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<sup>a</sup> ODB is available to Ontario residents who: are 65 years and older, qualify due to low income or have high drug costs relative to income or receive disability support, home care or live in long-term care

quality, but the services lack the capacity to meet demand and are unacceptable among youth. Stigma is understood to be a barrier to accessing mental health services. Based on these findings, service providers were encouraged to seek innovative approaches to service delivery to improve equitable access – especially in rural areas.<sup>6</sup> A mental health needs assessment of children, youth and families in Woodstock revealed that residents want to feel safe and free from stress when accessing services. At these ideal services, they want to be able to do the things *they* want to do, rather than what others want them to do. Woodstock residents reported that they want people to accept them for who they are and help them in ways that they want to be supported.<sup>7</sup>

## Purpose and Research Questions

Based on our knowledge of opioid use and related harms in Oxford County and building on the work related to local mental health service needs, this situational assessment focused on the accessibility and delivery of opioid-related services in Oxford County. In this report we use the term, “opioid-related services,” to refer to both services and programs in Oxford County that support people who currently use licit and/or illicit opioids, people in recovery from opioid use, people at risk of using opioids and loved ones of people who use opioids.

The purpose of this situational assessment was to inform the opioid-related strategic directions of a drug strategy for Oxford County. The situational assessment did not aim to suggest specific interventions that could be employed by organizations or committees; potential interventions will be researched and assessed at a later date as part of the development of the broader drug strategy. Drug strategies in other Ontario jurisdictions<sup>8</sup>, as well as the Canadian Drugs and Substances Strategy<sup>9</sup> use a four pillar approach: prevention, treatment, harm reduction and justice/enforcement. Accordingly, our assessment focused on services that fall under these four pillars.

This assessment answered the following questions:

1. What gaps in services and programming exist in Oxford County for people who use and are at risk of using opioids and loved ones of people who use opioids?

2. What barriers and facilitators to coordinated service and program delivery exist in Oxford County?
3. What barriers and facilitators to accessing services and programs exist in Oxford County for people who use opioids and are at risk of using opioids and loved ones of people who use opioids?

Secondary research questions, indicators and data sources are listed in the evaluation matrix (Appendix A).

## Methods

This assessment used a mixed methods, cross-sectional design and attempted to collect data from all eight municipalities in Oxford County. The study protocol was reviewed and approved by the Public Health Ontario Ethics Review Board (File # 2017-068.02). Data collection and analysis were carried out simultaneously from February to May 2018. A full description of the assessment methods can be found in our Technical Appendix.<sup>b</sup>

The assessment had three components:

1. service inventory
2. network relationships
3. lived experiences

## Service Inventory

A service inventory was created to understand the service landscape. We combined service data from a previous environmental scan of mental health services in Oxford County conducted in early 2017<sup>6</sup> with additional opioid-related services identified by Public Health staff to create an initial inventory of 99 services. We reviewed the data previously collected for accuracy and

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<sup>b</sup> Gibbs L. Experiences of Delivering and Accessing Opioid-Related Services in Oxford County: Technical Appendix. Woodstock, ON: Southwestern Public Health; 2018.



sought missing or new service information from organization websites and the SouthWesthealthline.ca database. To fill in remaining information gaps that could not be found on the organizations' websites or SouthWesthealthline.ca, we contacted the organization providing the service via phone or email and asked for additional information and clarification.

To be included in the final inventory, services had to meet the following criteria:

- physically located in Oxford County or provide a phone or online service to Oxford County residents
- target one of the assessment's populations of interest (i.e., provide a service to them *because* of their status as a population of interest)
- address opioid use, its consequences or risk factors<sup>c</sup> for opioid use
- not restricted to rostered patients of a family physician, family health team, nurse practitioner-led clinic or community health centre
- not offered by a committee or coalition
- not limited to dispensing opioid prescriptions

The service information was entered into Microsoft Excel and pivot tables were used to calculate the number of services that addressed each category of interest and cross-tabulate frequencies across multiple categories (Appendix A).

## Network Relationships

We conducted two mapping sessions with service providers from 15 opioid stakeholder organizations: one with decision makers and one with front-line staff. In these sessions, participants were asked to broadly describe their overall relationship with each of the other 14 organizations (if they had one), then provide specific examples of how they work together. Then, participants categorized each example of working together as one of the following types of relationships:

- **networking:** exchanging information for mutual benefit

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<sup>c</sup> Risk factors include: a history of trauma or abuse, experiencing chronic pain, homelessness, living in poverty, being a teenager or older adult and a personal or family history of addiction.<sup>10</sup>

- **coordinating:** exchanging information for mutual benefit and altering activities towards a common purpose
- **cooperating:** exchanging information, altering activities and sharing resources for mutual benefit and towards a common purpose
- **collaborating:** exchanging information, altering activities, sharing resources and enhancing the capacity of another organization for mutual benefit and towards a common purpose<sup>11</sup>

Using these examples, participants then identified the type of relationship they most frequently engaged in with each of the other organizations. On a large piece of paper, the participants drew arrows depicting these relationships between circles representing each organization. The resulting pictures produced two network maps: one of the relationships among decision makers and one of the relationships among front-line staff.

The data from these sessions were combined and entered into a social network analysis software program to produce an overall map of the relationships between the 15 opioid stakeholder organizations in Oxford County. The organizations were anonymized to protect the identity of the mapping session participants. We used the software's built-in analysis tools to determine:

- the number of relationships in total
- the number of each type of relationship
- the density of the network (i.e., the ratio of the number of actual relationships to the number of possible relationships)
- the importance of each organization within the network (i.e., degree, closeness and betweenness centrality)
- the number and member organizations of smaller groups within the network (i.e., clique census)

## Lived Experiences

We collected data about two types of lived experiences: delivering opioid-related services and accessing opioid-related services. For the experience of delivering services, we held two focus groups with service providers who attended the mapping sessions: one with decision makers

and one with front-line staff. These participants were asked to share stories about collaborating with other organizations to provide opioid-related services and describe the challenges and successes of these stories. For the experience of accessing services, we conducted interviews with people who had accessed or tried to access opioid-related services in Oxford County. In these interviews we asked participants to describe what it is like to use services, challenges they face and what makes it easier to use services.

Participants were given an ID code that reflected which type of experience they were discussing and their enrollment in the assessment. Decision makers received a code that began with DM and front-line staff received a code that began with FL. People who were currently using opioids received codes that began with CUI (currently using illicit opioids) or CUL (currently using licit opioids); people who used to use opioids were given codes that began with FUI or FUL. Loved ones' ID codes began with L and the ID codes for people who were at risk of using opioids began with R. For example, CUI-1 was provided to the first enrolled participant who identified as currently using illicit opioids. Because most interview participants identified with multiple categories of experience, their ID codes were based on the category that fit best with how they initially presented their experience to the project lead and the order in which they enrolled in the study.

Focus groups and interviews were audio recorded and transcribed verbatim. We conducted a phenomenological thematic analysis of the data to describe the essence of the experience (i.e., the concept that underlies all experiences) and essential themes (i.e., concepts that, if removed from the experience, would change its meaning).<sup>12,13</sup> The draft themes were shared with select participants to determine if they resonated with their experiences.

# Findings

## Service Inventory

We found 114 unique services in Oxford County that are provided by 47 individual organizations and 3 collaborative groups of organizations (i.e., 2 or more organizations working together to provide the service). The overall characteristics of the services are found in Table 1 of Appendix B. Most services targeted youth (107 services), people at risk of using opioids (58) and people currently using illicit opioids (52); 14 services targeted only females and no services targeted only males. Prevention (61) and treatment (42) were the most common pillars represented in the service inventory. Services were most often offered in Woodstock (81), Ingersoll (50) and Tillsonburg (44); only one service was available online and eight were available by phone.

**Overall, Oxford County appears to have services that address all four pillars and target residents across the lifespan; every municipality has at least one service.**

Based on the overall counts and cross-tabulations of service characteristics by municipality, target population and age (Tables 2-4, Appendix B), service planners should be aware of low numbers of:

- services located in rural municipalities (i.e., outside of Woodstock, Ingersoll and Tillsonburg) and available online or by phone
- services for people in recovery from opioid use
- services falling under the justice pillar – particularly for friends and family and people in recovery

Although there were other categories with small numbers of services, these were expected. For example, there is likely little need for justice-related services for people who use licit opioids because their status as “licit” removes the threat of legal trouble because of their use. Similarly, we would expect there to be fewer services for children, as this group is the least likely to use opioids and some risk factors for opioid use are more prevalent later in life (e.g., experiencing chronic pain).

## Network Relationships

Figure 1 depicts the network map created by combining the decision maker and front-line staff data. The thickness of the lines represent the strength of the relationship, with networking being the thinnest line, followed by coordinating, cooperating and collaborating, respectively. The size of the shape with the organization ID represents how important the organization is to the network, based on how many other organizations it is connected to (i.e., the degree centrality score); larger shapes represent more important organizations.<sup>d</sup>

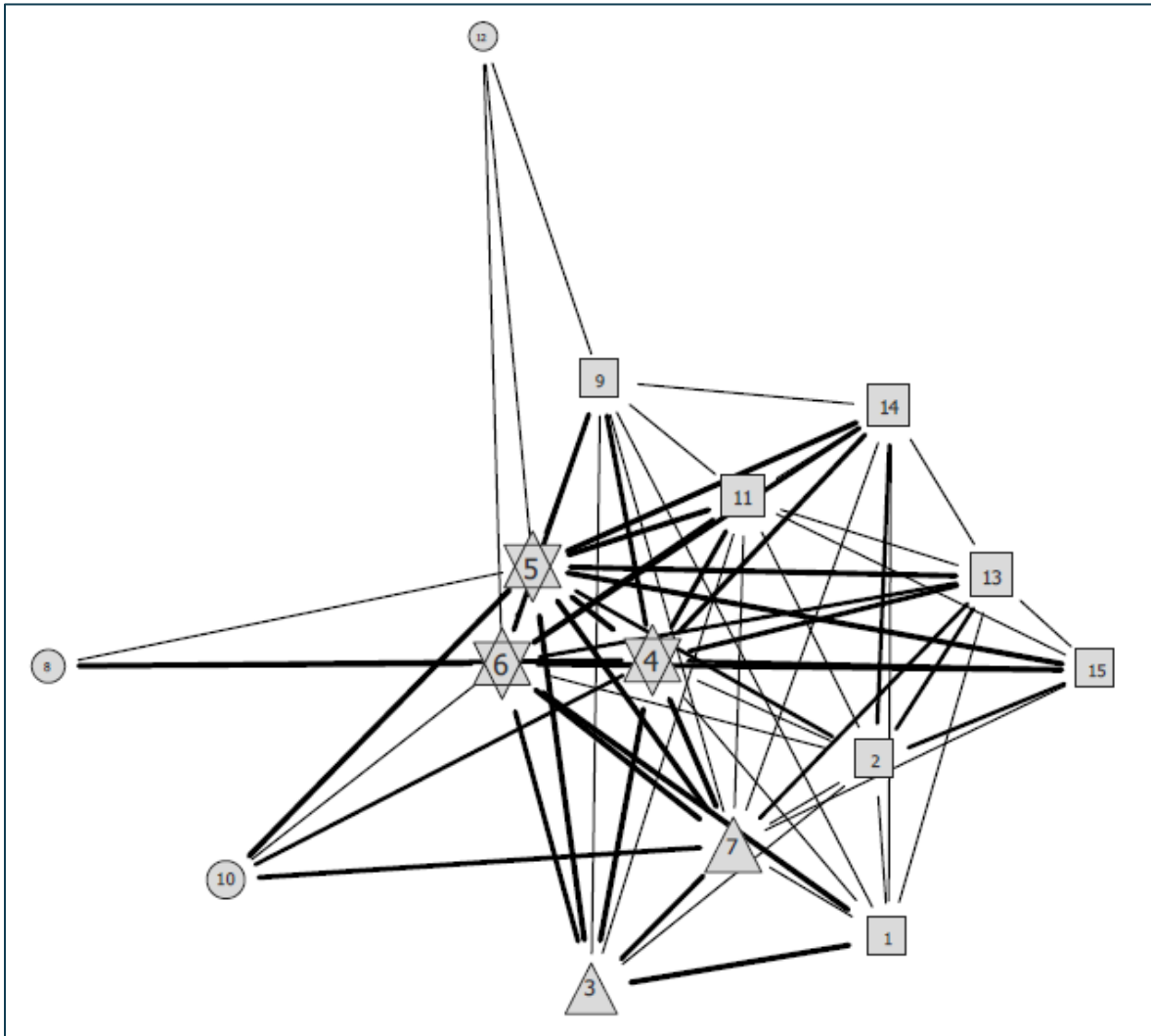
The map has a total of 66 relationships between organizations, with 30 (45.5%) of those relationships described as networking, 9 (13.6%) described as coordinating, 13 (19.7%) described as cooperating and 14 (21.2%) described as collaborating. The network has a density of 0.63; this means that 63% of the total possible relationships between the 15 network organizations exist. Organizations 4, 5 and 6 had high importance scores for degree (how many relationships they have), betweenness (how many organizations they can connect to each other) and closeness centrality (how few “steps” it takes for them to reach all the other organizations).

**Organizations who provide opioid-related services in Oxford County form a close-knit network with many strong relationships between them. If the three core organizations are lost from the network, its structure is fundamentally changed. The peripheral organizations are at risk of becoming isolated if they lose their connections to the core and involved organizations.**

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<sup>d</sup> We applied the Fruchterman-Reingold force-directed model to the map data to produce the image. This model treats each node as if it is a charged particle, repelling all nodes and attracting those next to it. The result is a visual where the distances between nodes are in a “minimal energy state.”<sup>14</sup>

**Figure 1. Network map (Fruchterman-Reingold model) of relationships among opioid stakeholders, by degree centrality and category, Oxford County**



**Legend:** Stars = core organizations; Triangles = involved organizations; Squares = supportive organizations; circles = peripheral organizations

The two sets of participants – decision makers and front-line staff – created similar maps, with a few notable differences. For example, the front-line staff participants identified more relationships overall than the decision maker participants. Decision makers identified a fairly even split across the four relationship types, but the front-line staff described more networking and collaborating relationships than coordinating and cooperating. The front-line staff also identified three networking relationships with Organization 12, but the decision makers described this organization as an isolate with no connections to the rest of the network. Focus group participants attributed these network discrepancies to the different roles the two groups of

participants fulfill: front-line staff work to find support for individual clients by regularly connecting with other organizations, which allows them to have more frequent and varied types of contact with all organizations in the network. Decision makers, on the other hand, form relationships with organizations that share similar mandates and collaborate with them in larger-scale initiatives.

The organizations were grouped according to their importance scores (Table 5, Appendix C), position in the network map and the qualitative examples provided by participants. Four categories of similar organizations, resembling a common public health stakeholder analysis framework<sup>15</sup>, emerged from the network analysis: core, involved, supportive and peripheral. Core organizations (i.e., 4, 5 and 6) had high degree, closeness and centrality scores and both decision maker and front-line staff participants described strong collaborative relationships with these organizations. When the three core organizations are removed from the network, it becomes less centralized and less dense. Organization 12 also becomes an isolate in this new network structure (Figure 2, Appendix C). The two involved organizations (i.e., 3 and 7) had relationships with the other organizations, but these relationships were not as strong as those of the core organizations.

Supportive organizations (i.e., 1, 2, 9, 11, 13, 14 and 15) were the most numerous in the network. These organizations have lower centrality scores than the involved organizations and generally have weaker ties to the rest of the network. Among this group, Organization 1, Organization 2 and Organization 9 were each represented at only one mapping session and the remaining members of the group were not represented at either session.

Finally, the peripheral organizations (i.e., 8, 10 and 12) are those organizations with the lowest centrality scores and are located the farthest distance from the centre of the map. These organizations have fewer and generally weaker relationships with the rest of the organizations in the network. Peripheral organizations risk becoming isolates if their connections to the core and involved organizations are lost.

# Lived Experiences

## Delivering opioid-related services

We held one focus group with decision makers (three participants) and one focus group with front-line staff (four participants). One of the decision maker participants did not attend a network mapping session. We conducted member-checking with one decision maker participant and one front-line staff participant; both participants agreed the findings presented below resonated with their experiences.

**The essence of the participants' experience of delivering opioid-related services is that both decision makers and front-line staff are always working on collaboration. They do this by building trust and evolving into a new way of working together.**

### Essence of the experience: We are always working on collaboration

For both the front-line staff and decision maker focus group participants, the essence of the experience of delivering coordinated opioid services was that they were always working on collaboration and collaborative relationships.

...you can't just sit there once and let it [the collaborative relationship] stay there because then it becomes stagnant and it's really not as effective, right. So they are always needing to be reassessed and tweaked and I hate this word, but like massaged for the current situation [FL-3].

You can't just do it just once and then expect it to be good forever [DM-1].

Through the process of working on collaboration, participants sought to overcome barriers and exploit facilitators to reach this goal. Participants in both groups reported that they were constantly trying to build and maintain relationships to ensure the collaborators have a common goal or underlying philosophy. At least one decision maker participant said that it is still too early



to tell if her partners have a common goal because it's still unclear if potential partners are aware of opioid-related harms in Oxford County.

I think it [a common goal] might still be coming. I'm not sure we're at a place where Oxford County is like "Oh, yeah, we have a significant you know, problem with opiate dependency or opiate use." We've got needle exchange, but it's probably still a little bit quiet.... So, um, I think there – it's still going to come and we're still going to have to address that by having a very unified vision – a shared vision – from everybody who's a part of the solution because it [we need] all those four pillars [treatment, prevention, harm reduction and enforcement/justice]. We have to be unified... [DM-3].

And I think having the same philosophy, so even when you're working with a worker with a similar philosophy of addiction or of the reasons, the root causes of opiate use or how to prevent that. Like those philosophies, root philosophies, if they can be the same in a community that would be really helpful and you're all coming from that same philosophy [FL-1].

Although both sets of participants shared this experience of constantly working on collaboration, *how* they worked on collaboration differed. The front-line staff described working at two levels: with individual clients to improve their well-being and on changing the health-care system. Facilitators to service delivery, in relation to front-line staff's work with individual clients, include a passion for the work and the client population. On the other hand, this group reported that compassion fatigue among front-line workers is a barrier to service delivery. These same participants reported having to work with their counterparts at other organizations to "blur the lines" by accepting clients who would normally not be enrolled in a service at that moment or by changing how the service is delivered; they do this to help meet the clients' needs.

... you know if you're sending that person to the person that you know on the other end, I find that a bit easier and I can reach out directly to that person. I know that's not the right process though, so you are almost skirting the proper process in order to get somebody in with somebody you know and trust on the other end [FL-5].

The front-line staff said that rigid adherence to rules and policies was a barrier to getting clients the help they need because the window in which a client was willing and ready to access a service was limited. By blurring the lines to get clients into a service, they suggest that the client has the potential for a better outcome.

Front-line staff also attempt to collaborate at the system level by moving creative service delivery models forward so that lines do not have to be blurred to provide services to individual clients. The length of time it takes for the system to change is a barrier to this type of work, but their passion for change and their clients' well-being helps them to persist and do the hard work required.

So, we look at things creatively and looking at the evidence and... we can approach things in creative ways. We can find really interesting and new solutions, so what if we could have a hub with one service provider every day, that was their office, like follow business models, too. Sometimes business models will do shared office spaces, that's kind of a new thing. So, there could be some creative solutions if we take off that idea that we all have to be in our own physical building [FL-1].

I think both of those tables [Oxford Addiction Treatment Strategy and Situation Table], I don't know exactly who—brought about by some creative, I'm guessing front-line people, and they had the support of... their executives to make it happen and try it and see [FL-5].

Decision makers work more at the organizational level, but the results of their collaborative efforts often impact the system level. They described how this work on collaboration has been about changing organizations' approaches to addressing the opioid crisis, altering preconceptions and bringing new collaborators on board:

I just see so many other players that weren't historically collaborators collaborating now. Like [Oxford County] Housing really coming on board with stuff, I mean they're at every meeting now, like they're at Situation Table and housing is a huge problem here, so I just love that they are collaborating and being very slow to evict [DM-1].

We had a bad history in some communities just because of our old management, um. And it does – like it does have a huge impact on trying to get communities – like some communities just don't want to work with you. So trying to change.... Trying to go in with an unbiased opinion about the organizations [DM-2].

Whereas the front-line participants talked about flexibility at the client level as a facilitator, the decision maker participants talked about flexibility at an organizational level. Decision makers talked about accepting differences in how partner organizations implement the same service.

For example, one participant described a situation where they were trying to convince their partner of the benefits of providing multiple appointments to their clients in rural areas while maintaining the one-off approach provided by the partners in larger municipalities. For decision makers, the work of collaborating is facilitated by having “passion for making things better and for collaborating” [DM-1] and a history of collaborating with an organization. When these characteristics are present, the decision maker participants described innovative and successful partnerships that overcame obstacles. One participant described a situation in which most of the individual collaborators left their organizations, but the organizations’ history of working together allowed them to re-form the partnership with a renewed vision and a new set of collaborators.

The decision makers saw the expectations of their funders as a driver of collaboration: “... many funding applications and grant proposals, you won’t even be considered if you’re not collaborating” [DM-3]. These expectations meant that they had to work on collaborative relationships from early in the lifecycle of a service or program. However, the participants did describe it as a double-edged sword: the competition for scarce funding and time resources were also described as barriers to working collaboratively.

I just think it’s... healthcare is busy right now and it’s getting busier and busier. And so, if you don’t already have meetings scheduled where you can problem solve or check out, you know, whatever’s happened, it takes a while to get back to it and to fit it into the schedules of everyone who needs to be there.... healthcare is also incredibly competitive right now and so that eats away at all those base things that make a good collaboration because there’s resources at stake [DM-3].

The drivers of collaboration for front-line participants were more personal: they saw themselves working collaboratively to keep people alive, with less concern about the expectations of funders compared to the decision makers. The nature of their role in the organization facilitated this unique experience.

One of my biggest things is, you know, keeping people alive. That’s what drives my work every day is just trying to keep people alive. So, if we can have a coordinated service, I think our likelihood of doing that is going to increase [FL-3].

... because we have the clients’ face in our mind. Decision makers don’t see that client’s face, they see the numbers and the stats and everything that comes out of that, but we have a face to the name and it’s more personal [FL-6].

The two sets of participants also discussed different pathways for working on collaboration. For the front-line participants, the most prominent pathway starts with the clients, flows to the front-line worker and then to the decision makers to formalize or authorize changes. However, they did acknowledge that collaboration needs to be worked on in both directions (i.e., bottom-up and top-down) to be effective.

Decision makers, on the other hand, described the pathway as flowing from the funding organization, to decision makers who design a delivery model or service which is then implemented by front-line workers: “I think a lot of the collaboration at this stage, um, I think it starts at leadership and then it filters down” [DM-1].

Both sets of participants said that this work on collaboration is as hard as – and sometimes harder – than just doing it yourself. In the end, though, both groups understood that the work was worth it because it created something better than what could be created by one organization on its own. Part of the hard work is on resolving conflict and putting aside traditional boundaries, which can be made easier with the help of effective group facilitation:

I think because everybody brings their own value set and their own level of expertise and experience to the table... and we might be coming at things from different angles, so as long as we're respectful then we can really accomplish wonderful things working together [FL-3].

[When] there's conflict or misunderstandings you need to sort of address stuff in a timely way. You need to go to the source, you need to not jump to conclusions, get all your exercise jumping to conclusions [DM-3].

... if you have a good facilitator or somebody that's really good at group dynamics and stuff you can really accomplish a lot. [FL-5]

Time itself was described by both front-line staff and decision makers as a barrier to working on collaboration. The front-line participants described how the lag time between the work and the results made it difficult to sustain motivation and momentum for collaboration. The decision makers talked about how it was important to invest time and energy, but the amount of time they are able to invest in collaborative work was limited and was linked to funding.

... people want immediate outcomes. Some of these things are going to take years and years and years, so if we try to shift to prevention and true prevention, it might be 20

years before you see the outcomes of that intervention for a child.... So [we should be] trying to find patience in the system to give some of the interventions a chance to actually make a difference [FL-1].

So [budgets are] gonna limit how many new things and how much time we can put into future collaborations. Like certainly the willingness is there, but you can only be stretched just so far [DM-1].

Always working on collaboration underlies all the participants' experiences of delivering coordinated opioid-related services. Within that work, participants described two key components – building trust and evolving into a new way of working – that are essential to working on collaboration. If these two components are not present, the experience of delivering coordinated opioid-related services changes. One decision maker participant shared an anecdote that illustrates the link between these components and the essence of the experience particularly well. She described how people at her organization had to work on their collaborative relationships after a change to the organization's service delivery model broke down trust and prevented them from working with partners in a new way.

... if you change the way you do service, sometimes it's really hard to [keep the relationship going]. And even when you provide education, like "this is the way we're doing it now" – people still want to hold you in the "We know you've always done it this way. We want you to stay that way. You know, you were reliable to do this – that's what we want you to do." And that's very hard to change. I find sometimes you can do education session after education session with the same people and they're still going "No – do this [what you did before]." So that stuff's hard. Just the amount of time. You just can't rush through this. Sometimes we want to because there's – the money's here now, let's do this collaboration now, let's get moving on it. But you can't skip over those early steps as much as you might want to [DM-1].

### **Essential theme: We are building trust**

Participants in both the front-line and decision maker groups described building trust as an essential component of working on collaboration when delivering coordinated opioid-related services. According to the participants, without trust there was no way to move forward in a collaborative relationship. The participants talked about needing to build three kinds of trust:

- partners' trust in each other
- managers' trust in front-line staff
- clients' trust in the system

Participants talked about building trust by respecting organizational differences and having an open mind about each organization's approach to the problem or service. Sometimes, conflict tests the trust built between partners. In these situations, they said it's best to address issues in a timely way and "Sometimes you duke it out" [DM-3]. One participant used the analogy of "a potluck where everybody brings and contributes something to the meal" [DM-3] to describe the collaborative process. Each partner contributes unique ingredients and the others trust that everyone will bring what is needed to create "something new – a service that's greater than what you can provide alone" [DM-1]. Preconceptions about organizations' motives and historical relationships with the community are barriers to building trust.

A lot of people come in [with] blinders on [thinking], "this organization can't do anything, so why are we having them?" But they can have a lot of great things to bring in [DM-2].

I think having trust in the people that [are] around the table, as well too. Like knowing that putting your ego aside... and looking at the problem and not the people sitting around the table.... Everyone is trying to work together looking at how you can best help them [FL-6].

Front-line participants discussed their need to feel trusted by the decision makers. Specifically, they said that front-line staff should have the "professional trust" of their supervisors to identify issues and allow them to creatively address those issues to provide effective and timely services. Without that trust, front-line participants said their work on collaborating with their counterparts at other organizations and their ability to do their job was negatively impacted.

...the executives [need to] have enough confidence in their front-line staff...that they can be autonomous and run with what needs to be done and look at what's going on and they trust that they're going to work within their social [work] and college parameters and regulations and all of that and be ethical minded individuals, but still be creative and work for the people in community...Because it's that [going] back up the ladder [to ask permission] constantly that just delays everything, right [FL-3].

Finally, both sets of participants insisted that part of working on collaboration was to build the clients' trust that the system would be able to help them. When participants worked on collaboration, clients get the services they need, when they need them and in the way they want to be helped. When collaboration falters, clients have no reason to believe it will be better the next time and may disengage from the service.

...working with somebody who doesn't have a lot of patience for those barriers and the system – and we've had system failures in the past and [clients] don't really trust systems – that can be really hard to try and keep them engaged and keep going [FL-1].

To facilitate building clients' trust in the system, participants said it was important to involve people with lived experience in the service planning process: "Just making sure the patients or the people utilizing the service are involved is a big thing that I've come across on my travels" [DM-2]. Front-line staff said they found that being empathetic allows the clients to continue trusting even when the system fails them.

### **Essential theme: We are evolving into a new way of working together**

In addition to working on building trust, participants told us that working on collaboration meant evolving into a new way of working that is different from the ways they traditionally deliver programs and services. This evolution is facilitated by and results in increased: willingness to collaborate among potential partners, involvement of non-traditional partners, innovation in service delivery and frequency of collaboration. A prominent example provided by both sets of participants was their collaborative partnerships with police forces and other partners in the justice system.

I feel there's a bit of a shift in the policing world where they are maybe starting to get that it's a little bit not black and white...and realizing that they can't arrest their way out of addiction and mental health concerns. Now, I think at the high level, there is some understanding. I don't know that it's trickling down to the front-lines quite yet – for some it is – but that makes me feel a bit hopeful that things are changing maybe in that world and I feel like good collaboration has helped with that [FL-5].

[There is] a lot more interest from police to collaborate with us. The justice system [is] reaching out to us and saying “Let’s make a drug treatment court here”... that’s pretty big. Oxford County’s tiny to have a drug treatment court [DM-1].

The front-line participants also identified physicians as a new partner. Although these relationships are still evolving, the participants reported already seeing benefits to both the individual clients and their own understanding of opioid use and its consequences.

I think even the collaboration between [the] medical field and addictions mental health [has improved]. Like the [continuous care plans]... they are bringing different minds and different perspectives together and I think that’s actually a really positive thing because I don’t have a medical mind. I have a [different kind of] mind, right, so then hearing the medical piece of things and the risks of things, or how a medical professional even looks at a situation, I think is actually really positive.... it keeps me open minded around, okay, these are other things that I’ve never considered before and having the willingness for medical professionals to sit at these tables on these [continuous care] plans or just in the community plan of any sort is... I think it’s a wonderful thing because having a psychiatrist on board that understands concurrent disorders [is good]. It’s so difficult [to get them on board], but as soon as you have one on board, it can make so many differences in that person’s life [FL-6].

When the way of working together evolves, partners start changing their organizational philosophies and practices, too. One participant in the decision maker group gave the example of how she noticed that Oxford County’s Housing department has changed their eviction practices and now actively seeks to prevent people from being evicted from their subsidized units.

Both sets of participants described stigma and conservatism as barriers to the evolution. They had to work hard to overcome others’ prejudice towards people who use opioids, fear of talking about opioid use and political climates that do not support best practices, such as harm reduction. One decision maker participant described how she was trying to get providers to offer dental services in her facilities to improve access for her organization’s clients because they do not feel comfortable with other services or models.

It’s just about working around the problems... bring in dental care or something – that’s something that I’m working on now. But you can figure it out. A lot of collaboration and



partnerships [are needed] to bring in these services so patients don't have to deal with that stigma or aren't stigmatized [DM-2].

Although both sets of participants discussed the evolution of new ways of working together, their experiences of how much this way of working has evolved differed. For decision maker participants, the new way of working together can already be seen; it is embedded in the system's culture and is expanding. One participant described how the new way of working together among organizations who participate in the Oxford Addiction Treatment Strategy led to the normalization of collaboration for services across sectors. For this group, the impetus for evolution was funding expectations: most funding organizations require evidence of collaboration from the outset of every new venture.

And it's been driven by funders.... many funding applications and grant proposals, you won't even be considered if you're not collaborating [DM-3].

And you better have talked to people beforehand and got their input. And you better have your letters of support with it... so the systems have to be right from the start, when you're building a service, has to be more than yourself.... you have to collaborate right from the beginning [DM-1].

On the other hand, front-line participants described a slower evolution. Although there has been movement towards a new way of working together, these participants said they are not yet where they need to be. The reason for this shift was also described differently than the decision makers. For front-line staff, the opioid crisis is the impetus for evolution and is facilitating investment of resources in interventions that produce more immediate outcomes, such as increasing naloxone distribution to reduce deaths due to overdoses. Although they agreed the investment was important and necessary, they also saw it as a barrier to addressing the root causes of addiction, creating effective systems-level change and implementing upstream interventions to prevent addictions in the first place. They also spoke of their fears that when the crisis period has passed, so will resource investments. For front-line staff, a new way of working together means collaborating on long-term preventive strategies – not just treatment and harm reduction.

And I think we put so much, as a community, so much effort into the situation table, but the unfortunate part is people have to get to acutely elevated risk before they get there. Why aren't we helping them before they get there [FL-5]?

And we had talked about having medical [professionals] on board, [but] education and school board should also be on board, too, because that's working at the preventative stage [FL-3].

Yeah, we need to keep working at [prevention], too. Don't forget that with the crisis, because that's one thing [with] crises is you put all your money into the crisis to deal with that, but then we forget about this next group [FL-1].

## Accessing opioid-related services

We conducted five interviews with people with experience of accessing opioid-related services; one interview had two participants, for a total of six participants. Two people (CUI-1 and CUI-2) scheduled interviews, but cancelled the appointments prior to the consent process and after receiving participant ID codes. All but two participants identified with multiple experience categories and all four categories (currently using opioids, in recovery, at risk and loved ones) were represented in the final sample. We conducted member-checking with two participants and both agreed that the themes presented below resonated with their experiences.

**The essence of the interview participants' experiences was that the services in Oxford County do not meet their unique needs. There were four essential elements that contributed to this gap: their lived experiences aren't understood, they have to fight for what is needed, they are restricted because of others' decisions and they have to make very difficult choices.**

### **Essence of the experience: These services are not for me**

The interview participants all described experiences of not being able to find or access services that met their unique needs. This theme permeated through their overall narratives and within each anecdote, making it the essence of the experience of accessing opioid-related services in Oxford County. At the beginning of the interviews the participants – even the ones who identified as a loved one of someone who uses opioids – often focused their experiences on trying to access treatment services. As a result, the participants started by asserting that there were no services available or their experience was limited to one particular service.

[My experiences using opioid-related services] are pretty non-existent really. I mean we have our methadone clinic and that's pretty much about it. I mean we don't have any type of outreach services that I know of here in town and most of it you have to be directed to London to use services there [CUL-1].

Like other than methadone I just – I don't know. I didn't think there was any other thing [FUI-1].

The participants equated a lack of services available for their specific needs to a lack of services overall. After further probing and conversation, the participants started to broaden their view of the service landscape in Oxford County to include non-treatment services and services they had tried to access but found ineffective or unacceptable. One participant described how they were not aware of what could be available outside of what was offered through their union representation at work.

I have not heard from my union rep once going through this with [Fiancé]. And they know me and they know I work there and they know I'm his fiancée.... So, no, they've been absolutely no help and no support whatsoever for me and the kids. There's nothing they could do really. Even if they did get a hold of me, and what would they do for me and the kids really [L-3]?

Another participant talked about the limited availability of treatment programs:

I didn't, couldn't find any [services] for my stepdaughter. Not that she would participate in for any length of time. You know there was... Children's Aid involved.... and nobody seemed to be able to make her go and do anything... counselling just wasn't enough for her and she had to go to a treatment program as far as I was concerned and she never got anything. I still see that around today when I talk to people. There's really no spots in treatment programs that aren't months away [L-1].

Some participants knew that services should be available to help them but found that the organizations who provided them were not willing to do so. The participants described being rejected or ignored and being told by service providers that "it wasn't their job" [L-2] to help them. For others, it was their relationship to opioids that they felt prevented them from receiving appropriate services; for example, the fact that they were addicted to opioids and not alcohol made it more difficult to receive treatment. In contrast, one participant who reported having

chronic pain described how she could not get help from subsidized housing workers because she did not have an addiction.

It's just like they tried to tell me that my neighbour next door was an alcoholic therefore he had a disability and they had to put up with it and I said, "No you don't!".... An addiction makes you take that substance, right, but I do not believe that it makes you play your stereo 24/7, right, and I said... "My disability trumps my neighbour's disability because I did not choose this. I'm not having fun, I'm in a hell of a flare up because I haven't slept in three days because of him." You know, and I have no pain management – any real pain management – to deal with it and no one should have to go without sleep for three days [R-1].

Another participant described how, despite reducing his methadone dose, he did not qualify for rehabilitation that would be covered by his benefits and would have to pay for a different service out-of-pocket.

And then I got to the point I was at 100 milligrams [of methadone] and I wanted to go to withdrawal – I mean rehab, but you can't even get into a rehab unless you're on 30 milligrams.... Unless you pay for medical detox which costs \$10,000 [FUI-1].

Participants learned quickly that the opioid-related services that were offered to them would not meet their specific needs. Most participants described knowing within a few visits to counsellors or psychiatrists that the service would be ineffective. Others described searching online for reviews and asking people about their personal experience before trying to access particular services so that they could understand if it was even worth trying. One participant said he knew as soon as he entered a building that the services they offered would not meet his needs.

Now, we do have a community place here in town, but that's more for mental health I think than anything.... Woodstock being such a small town, I walked by it and one day I just walked in.... I was given a date to see a counsellor there and there was – I didn't even attend actually after that – I just, as I looked around, I just figured this place wasn't for me. It was more of a hangout for people—somewhere for people to go during the day because, you know, a lot of people that are on disability or Ontario Works they are trying to fill their day with something. So, it's people, they hang out, they play cards, they have a newspaper there, they can read, they have coffee. So, I mean it is a good – it's a good

thing that they do have there as like a drop-in centre so to speak, but I didn't really get the feeling that it was anything to do with drug abuse or people in crisis [CUL-1].

Previous experiences with a particular organization informed our participants' expectations about their future interactions with that organization. These experiences could be both positive and negative, but the participants' narratives often emphasized their negative experiences with services. The participants spoke about losing trust in both particular organizations (e.g., police services and methadone clinics) and types of services (e.g., counselling and the Ontario Disability Support Program) as a result of their previous interactions – even if these interactions were not related to their opioid concerns. One participant had negative experiences with so many services that she could not even justify asking her son to try them.

You only allow yourself to be disappointed so many times. Let's say after the experiences I've had, I would never go back to those services. I would never, ever in my lifetime ask my son to put his faith in those services [L-2].

However, this same participant described an overall positive experience with one particular service that, despite it not meeting all of her needs, she would continue to access if she needed some help: "I would never go beyond [Alcoholics Anonymous]. And I'm not saying that they are a cure-all either, I'm just saying that they are the only ones who have not betrayed my faith in the system" [L-2]. For another participant, a positive experience accessing a service in another context led him to believe it could fill a service gap in Oxford County:

I mean that's a perfect area for what you would need for a medical detox.... Like that would be the perfect candidate of an area, size. The way they have that psychiatric ward set up would be perfect for a medical detox. If people knew that they had an area where they could go and they know that it's not going to be a good time or it's going to be a rough go, but if they knew that at least they could have food available, they could have liquids available, nurse, doctor, sedatives if needed, sleep sedatives if needed, you know, all those types of things that were there. I think you'd have people trying it out [CUL-1].

In contrast to their experiences with actual services, participants described their ideal services as flexible and tailored, with care plans that address multiple needs beyond physical health. These services would be well-known, easy to find and offered to people without them having to ask for more support. Participants also described being able to interact with compassionate and

empathetic service providers in the course of accessing an ideal service. These components of ideal services address the four essential ways in which the currently available services do not meet their unique needs: their lived experiences are not understood, they are fighting for what is needed, they are restricted by others' decisions and they have to make difficult choices. Those four essential themes are described below.

### **Essential theme: My lived experience is not understood**

For our participants, their lived experience – what it feels like, how exhausting it is, the struggle involved, what is important to them – related to opioids is not understood by service providers. In some cases, participants reported that providers had an academic or theoretical understanding of living with addiction or chronic pain, loving someone with an addiction and the consequences of opioid use; however, they felt these types of understandings were inadequate and negatively affected how well they connected to service providers.

Interviewer: What do you think you would need to see or hear or feel in order to say “I have a connection with that person”?

FUI-1: Maybe if I could feel that they knew what I was actually talking about and not just went to school for it.

L-3: I think that's a big thing. I do, honestly. That's a big thing.... I want somebody that's gone through stuff, not just read about it.

FUI-1: I think that – the girl who I see, I don't know, she was like 22 and I was just – it just didn't seem like she knew. She didn't have very much life experience.

Trusting that the provider knows what you're going through was important to participants. They talked about how being familiar with the provider and having a sense of trust that they “walked the walk” made it easier to reach out in the first place. When participants connected with providers or the other clients in a support group, they talked about feeling that there was greater empathy and compassion in the service: “...they give you hope that there's a better tomorrow. They have been down the road you have been down, so there's familiarity and the fact that they are a few steps ahead of you, gives you strength” [L-2].

Although participants' stories most often reflected negative experiences, the participants did describe some positive experiences where they had a good connection with the service and its providers. One participant's description of taking custody of his grandson illustrates the difference made in the experience when their lived experience is understood by providers particularly well. As he spoke about the attention paid to his unique situation by one organization, his body language became more relaxed and the tone of his voice became more upbeat than when he was describing his earlier interactions with two other organizations.

What happened was that the circumstances with her [stepdaughter's] children were at a point we had to do something, so we ended up calling the police and telling them about it. You know, looking for some options. And they said, "Well go get the kids. Go take the kids, you know. If you need any help, well give us a ring." That's what we did. Children's Aid got involved. It would have been nice to have some support when that was going on. Cause we weren't told anything like that – not that I am aware of anyway.... We ended up with the youngest, the baby, [and the] two older kids went to their fathers' houses. Now the one [boy's situation] that was alright, but then we took the oldest boy to get him to his dad in London and you know I walked in there one day and the guy's girlfriend is on the couch and she's passed out. Yeah. I [said], "What's going [on]...?" "Oh she takes these pills for this car accident she was in and blah, blah, blah..." Yeah, ok. Cause the [Oxford] Children's Aid didn't want anything to do with that. That was London's problem. So there was nothing we could even do for that one. And for us we didn't really get any support from the [Children's Aid Society] at all. We got a subsidized daycare spot and that was it... which was a big help of course.... I gotta say they were really fantastic at the daycare.... They just gave him [grandson] a lot of extra attention and you know that sort of thing. Kept an eye out for mommy dearest [in case she came to the daycare]. It was registered day care. I dropped him off in the morning and picked him up at night.... I didn't have to change my schedule around, no [L-1].

The participants also talked about how this lack of understanding was reflected in what supports or treatments the services offered and to whom they were offered. Services planned without the understanding of the lived experience were described as missing essential components that would make them more effective. Similarly, the eligibility criteria for services or benefits from those services did not take into account the lived experience of potential clients.

See methadone may – or suboxone may – may like cover the withdrawal, but for people like me that are an intravenous user that you [are] also addicted to that ritual, as well, you know. So, it's only half the battle and you are only covering up the withdrawals, you're not actually getting a chance to have – you know, to deal with the inner problems with the person, right. Obviously, for most people, you know, are starting to use opiates that are not doctor prescribed or overuse, there's more underlying problems than anything else, you know [CUL-1].

... you were supposed to get, at the time, you were supposed to get a one hundred dollar—I don't know, it was a hundred dollars for trying to work for something, right. I'm still waiting.... It's not like I don't spend money when I try to work, right, like you know, I keep my eye out at the second-hand shops for business clothes, right, because I mean like at my age the business clothes I wore when I finished working are not what you wear today, right. So, I try and dress nice if I'm gonna go and [work] and, you know, I'd have to go and buy brand new high heels and, you know, like not high heels, but you know, little heels, right. You know, stuff like that that I have to be presentable right, you know I have to go and get hair dye and dye my hair. I go and spend the money and that's what that hundred bucks was supposed to be about, right. And then the gas to get there and then the parking I incurred. It's supposed to offset those expenses and I never see that money... [R-1].

Participants reported that the ultimate result of not having their lived experiences understood was that they had to face stigma and discrimination – from providers and the broader community. They told stories about being denied services because of their opioid use or their chronic conditions that require opioid prescriptions. In one interview, the participant described how both she and her son experienced the stigma of opioid addiction from one group in particular:

Alcoholics do not like drug addicts. So, either you have to lie about your addiction. I mean I don't mean about having an addiction, but you swap out words, okay, instead of clean you say sober even though alcoholics tend to also use drugs, you have to use the alcoholic terminology.... Alcoholics are accepted, they are seen as people with an illness or a disease. Drug addicts are seen as low lifes, losers who, well, they deserve what they get. I'm not saying anything bad about the [Alcoholics Anonymous] here or – it's just the culture. For instance, my dad's an alcoholic.... you show up at his door a new



[Alcoholics Anonymous] member, he will take you in, he will embrace you. He will walk you through the twelve steps. He will go pick you up and drive you to meetings and introduce you to other people who you may have things in common with. But he calls his grandson a druggie.... I am accepted as part of the [Alcoholics Anonymous] community because I have a father who is an alcoholic.... I wouldn't be able to relate [as a mother of a drug addict] [L-2].

The participants also talked about how the stigma of opioid use extends beyond services. They describe feeling alone in their experiences in the community. Some participants reported that their familial relationships were strained. Others shared that they would not know who to talk to because the shame and stigma attached to opioid use kept others silent about their experiences.

There's a real quiet thing going on about this. I think at first you don't want to admit that your kid's in a situation with drugs that is way out of hand and, you know, getting by that part is difficult enough to tell somebody.... probably because it's sort of looked down as some kind of failing or what have you [L-1].

The silence and strained relationships made it difficult for the participants to receive social support and also limited the amount of information and advice about services available to them. Participants described situations in which it was easier for them to find information about other substance use services and related support, such as treatment for alcohol addiction and how to get medical marijuana; they attributed this ease to the greater social acceptance of using alcohol and marijuana.

### **Essential theme: I have to fight for what is needed**

Because opioid-related services in Oxford County do not meet the participants' unique needs, they are constantly having to advocate for themselves and others. They described this advocacy like a fight or battle: at times advancing and then retreating, playing both offence and defence. Their participation in this study was in itself an example of this advocacy; all participants expressed during the interview or the screening calls that they wanted to make things better for themselves and/or people like them. They talked about investing different amounts of effort depending on the severity or urgency of the need and the likelihood of

success. The participants advocate for three things: access to services for themselves, access to services for others and availability of different types of services.

The participants described several times in which they had to advocate for access to services that would address their needs. They fought to be able to get a service they needed, such as additional money from the Ontario Disability Support Program, and to have services delivered in a particular way.

There was some type of [support] group. I never went though, I have to be honest with you. Just that because of being on disability, it's really hard for them to give me medical travel, like as much—like you really have to fight [tooth] and nail to get any type of extra money from disability [CUL-1].

It's always fraught with – they don't want you to do it [taper your methadone dose]. You know what I mean. Like “Oh, you wait a week,” or you know, “Maybe you can next week.” It's always something with him [the doctor].... It's been me telling them every week I want to drop [my methadone dose]. And he's been doing it. So, I've dropped five [milligrams] pretty much every week for months [FUI-1].

Sometimes the participants described situations where they had to fight to gain access to a service or benefit they had been denied; they had to argue with service providers and provide documentation that proved they were eligible for the service. Other times, they fought for a particular service or benefit that was not initially offered to them. In one case, a participant described a situation where he had to fight against his doctor's common practice of and reputation for providing opioids. He described his successful advocacy in the situation below as “stepping aside from a bullet.”

I'd go for a doctor's appointment and the waiting room is lined up out to the door. You know what the hell is going on here? If I was going in because I had a pinched nerve in my neck, the first thing he offered me was pills. I don't want any damn pills. I want some physio or something [L-1].

All participants talked about advocating for other people, but participants who identified as loved ones spoke of advocating for others more than they spoke about advocating for themselves. They were advocating for their children, grandchildren, neighbours, significant others and friends, but they were also advocating for people they did not know personally. Two of the loved

ones who participated described first fighting for services for loved ones over 10 years ago; this fight never ended, though, as they talked about currently fighting for friends' needs and for better services for everyone. Because of their lived experience, they knew the importance of fighting for others and made it clear in the interviews that services need to better serve everyone.

Because I do believe, you know, Woodstock does have a problem with a lot of people accessing that Food Bank. We do have a lot of people living under par here in town, under the poverty level, you know.... people that have opiate problems are going to spend their money to feel better as opposed to eating. So, I mean I'm not saying that we should give food to people that are not doing the proper things, but I mean if, you know, if you are trying to do the right thing it's hard to survive when you're on disability or Ontario Works. I don't even know how they do that, I don't know how they live on that. Like I find – I'm going to be going back to work hopefully in the next couple of weeks here again – so, but just being on disability for the time I've been, I don't know how people do it. You could only probably live in a room if you want to eat. If I had an apartment like this I couldn't eat and that's basically what was going on, you know [CUL-1].

This fight requires significant investments of time and energy from the participants – of which they sometimes do not have enough. They describe having to pick and choose when they fight, what they fight for and how hard they fight. One participant used the skills and knowledge she acquired in her former job to help her with these decisions:

My last job was as an assistant [working in a government office].... That was my job, right. Only I don't have the energy to take this to – a lot of these things – to the level that it needs to go, right.... I have a very good idea of what is acceptable and unacceptable [R-1].

The participants talked about how the fighting sometimes becomes so exhausting and disappointing at times that it's just easier to give up. Most participants described giving up on a particular fight, such as trying to get the police to arrest a drug dealer or trying to get approval from their employer to provide paid time off for rehab. However, one participant described how the fight to get her son access to the right services became so consuming that she had to give up on finding help altogether. Years ago, she was fighting so hard to get her son access to the

right services that it became a “lifestyle,” but she talked about how her lifestyle is now one of waiting for bad news.

I’m to the point now where I’m just waiting to find out if my son ends up dead.... About two years ago, when I started preparing myself for that knock on the door or the phone call, it was horrible. Now, it’s just a waiting game. I hope it never comes, but [in] reality, it probably will.... It’s a lifestyle of resigning yourself to the fact that eventually his luck will run out. He’ll end up with a bad fix – something with the fentanyl or carfentanil in it – and he’ll end up dropping dead in some back alley way. So, we just wait [L-2].

### Essential theme: I’m restricted because of others’ decisions

Decisions made by service providers and organizations restricted if, when, where and how the participants could access services, contributing to their experiences of services not meeting their unique needs. The decision about whether or not the participants could receive a service or benefit was the most common example participants provided of being restricted by others’ decisions. Other people are literally deciding that the services are not for *them*. The participants were noticeably frustrated when they talked about being restricted in the specific services they could access. Participants reported that the restrictions were sometimes explicitly stated, but other times the restrictions were implied.

I called and I was pretty much signed up to go [to a medical detox] and then the doctor at work wouldn’t let me do it. But then he runs the clinic in London, a methadone clinic in London, but he’s a [Employer] doctor. So, that’s probably a little bit of a conflict of interest for him. I was already off [work], but he wouldn’t approve for me to be paid while I go [to detox].... There’s – we have a [Employee Assistance Program] rep at work and he just deals with addictions. But again, it’s just – you talk to people and they – you hear, “Oh, I went to Homewood” and then he says “Oh, you can’t go to Homewood. You have to go here [a different facility]” [FUI-1].

... it was very hard for me to get into [the Ontario Disability Support Program in] Woodstock – and my mom lived here – and they try to push you out of town. They try to push you to London to live, they don’t want you here on disability or Ontario Works. They try to... it seemed to me that they tried to push me to London to live as opposed to

Woodstock either because they don't have the services or they don't have the capacity to hold me here. I don't know, but it was very tough for me to get in here [CUL-1].

Policies of income support services, like Ontario Works and the Ontario Disability Support Program, were discussed by multiple participants. In these cases, the policies and criteria for how much money a person can get restricted participants' financial security and access to treatment. Some participants also talked about how those policies limited their ability to access additional income supports, such as student loans.

Beyond the participants' eligibility for services, other people and organizations decide how and when they are able to access service. For example, one participant shared that he was restricted to accessing private physiotherapy for an injury because the hospital who hosted the publicly-funded clinic decided to shut it down and direct patients to the private clinic in the same building. The participants also explained how others' timelines and policies meant they often had to wait to get what they needed, which put their health at risk. They talked about how some health concerns require care from specific professionals, but that the waitlists for these professionals are so long, by the time they become available it's too late.

Yeah, it all comes back to doctors are having to prescribe opioids and people who don't have doctors are having to buy them over the counter and take, you know, to equal a Tylenol 3, you know, a normal Tylenol 3 dosage, you have to take like between 4 and 8 Tylenol 1s which then you have way too much Tylenol. You have the right amount of codeine for the pain management, but you have way too much Tylenol destroying your kidneys. So, it's like I'm knowledgeable about what I'm doing to my body, I'm just faced with the reality of gee, do I want to get up today [R-1].

Well, so it's basically if you need to see a psychiatrist, it takes about eight months. So, if you're suicidal, by the time you see the psychiatrist you're not suicidal any more. You're like – just stuff like that, right. When I really needed to see him, I couldn't [FUI-1].

Loved ones of people who use opioids were restricted by the services their loved ones were willing and able to access. If a loved one could or would not access services, our participants described having limited options to support them. In one case, a participant tried to convince someone to help him get a mutual friend to seek treatment for his opioid use, but the effectiveness of his efforts to help his friend were limited by the other person's apathy.

I talked to the guy he's living with right now and I said, "You got to get him into something before he ends up dead. Like, he's not going to sleep on your couch forever, [we] gotta do something with him. Get him over to detox for a little while and get him straightened up a bit and talk some sense into him a little bit maybe. Just keep pushing a little bit, just a little bit at a time, you know."... Well frankly buddy doesn't seem all that interested in pushing him on it. So we gotta do something you know.... [He said,] "Nope not my problem, not going to do that." Man, pretty cold when it's your friend [L-1].

The participants talked about how the restrictions they faced did not align with their lived experiences or the research they had done. In some cases, the participants reported that the restrictions resulting from other people's and organizations' decisions violated their rights. Participants also talked about the long-term and far-reaching consequences of these decisions and how, in some cases, it impacted the future accessibility of services. For example, one participant related her difficulty accessing pain management services and the broader opioid crisis to a report that discussed opioid prescriptions.

I've done the research, you know, and it's—there's so much illegal drugs coming into Canada and being produced in Canada and McMaster [University] did not record or research how much was illegal drugs and which was legal drugs when they found out about this opioid epidemic okay, you know, they're saying doctors wrote too many prescriptions, it was their fault.... chronic non-cancer [pain] patients are the problem. They didn't look at that there is so much fentanyl being produced here. They didn't look at that, you can buy these huge pill presses, right, and bring them into Canada through our customs and it is legal to purchase them and then you can set it up in your house and you can start manufacturing. The raw components are being brought in from China and, again, I've researched all this, right. I've gone to reliable sources.... They decided ahead of time, chronic pain non-cancer patients were the problem and doctors were the problem and they weren't looking at anything like that Canada is not putting research dollars into chronic non-cancer pain conditions like chronic fatigue syndrome, fibromyalgia. The research is just not being done... [R-1].

Another participant recounted how she was almost evicted because of others' decisions:

They [police] actually almost had me evicted.... they were at my door guns a-blazing when they thought my son was maybe visiting me. Yes, it didn't make for very good

relationships with other tenants in the building nor did my superintendent, at the time, like me very much [because] of course they didn't know what was going on other than cruisers, police. Ah, yeah, I was almost living under the bridge with Johnny [L-2].

### **Essential theme: I have to make very difficult choices**

The final essential theme of the participants' experiences is that they have to make very difficult choices in order to be able to access services; as a result, the services are not meeting their unique needs because they have to sacrifice some needs to meet others. In particular, the participants described how they had to choose between meeting their opioid-related needs and their other needs. For example, participants described having to choose between:

- continuing to use opioids and being able to engage in their daily activities
- accessing treatment services and supporting their families
- living in the municipality of their choice and being able to access the necessary health and social services

The participants seemed to be very aware of the trade-offs they were making when trying to access services. When they talked about the choices, their stories included elements of prioritization: figuring out what was more important to them in both the short- and long-term. Two participants, who were in a romantic relationship and participated in the interview together, described how they each had to choose what was more important: his rehabilitation and connection to a support system or their family's financial security and emotional health.

You know, it sounds – it almost sounds like prison. Like rehab sounds like prison to me. And that's what scared... me, too. It's like don't make [it] like a punishment for people. Like you have to surrender your cell phone. You can't call home. You can't leave.... It's not going to work for some people – especially with anxiety and stuff. And even mine was going to be paid for and it was, you know, like – I don't think I could do it. I don't know.... That separation would have put me over the edge, just knowing I couldn't see my kids for seven weeks.... The hardest part would have been not being able to support my family while I'm gone. That's the hardest part [FUI-1].

I think I told him he has to do whatever he has to do. You got to do it. Go.... we would make it work. We would find a way, right. Don't really have any other option but to make

it work. We're lucky enough that at least I have a good income. I have the opportunity – we were working Saturdays at the time. I could pick up, you know, [extra] shifts to cover the bills for a few weeks. So, we would have made it work. I would have made it work. But it's, you know, then he's gone for seven weeks and I'm working every single day, then I'm not seeing the kids either. So, then now your whole family is not together ever. So, but you do what you have to do. But yeah, definitely a decision for both of us that we had to talk about and figure out [L-3].

Participants also explained how the social environment and physical layout of services contributed to these difficult choices. In particular, they talked about how they or their loved ones had to expose themselves to people who were actively using opioids and other drugs or with whom they had previously used opioids. This exposure acted as an actual or potential trigger and threatened their recovery, health and well-being.

And other doctors and methadone [should be available]. I think the Ontario government now is – I don't know if it's [the] Ontario or Canadian government – is trying to set up more doctors ready to have methadone or suboxone instead of having just one place, like a methadone clinic. Because this way [is] getting a bunch of addicts together there, too. I found it's easier – you know, I can find more drugs going to a methadone clinic... [CUL-1].

We have been through – we have been to Steps Rehab in Toronto. Wonderful service, but six weeks in, out, he, unfortunately, came back here and about three weeks later he was back to using. There's no supports [in Oxford County]. I mean we went to – we've been to the Ranch twice, wonderful service. He came out looking healthy, feeling healthy, emotionally ready to go, ready to pick up the pieces and start his life again. Came back here. Twice to the Ranch, twice coming back here [and relapsing] [L-2].

As demonstrated in the comments above, the participants said these choices were impossible to make – so much so, that they became non-choices. As L-3 said above, “you do what you have to do” to get at least some of your needs met. For some participants, these non-choices include using a service even if it's not ideal because it's the only thing they know is available in Oxford County. Participants who had lived or travelled outside Oxford County compared services they found here to those they accessed in other counties to illustrate these non-choices.



... we only have an Inn Out of the Cold [shelter] here which is only for colder months<sup>e</sup>, you know, from October to maybe April. We don't have any types of services for all year round and usually places like, you know, in London we have the Centre of Hope and London's Men's Mission. We have Unity Project. All those places are front-line services that are able and to help with people that have opiate or other drug problems. You know, like those are—which, you know, in the Men's Mission they have—you are provided a counsellor and you are able to speak with them with your problems and help you to move on with your life, so to speak [CUL-1].

Other participants described how their social and family obligations took precedence in any choice. For one participant, seeking support from the Children's Aid Society to help him take custody of his stepdaughter's child was an inevitable choice because the child needed to be in a safe environment. Another participant described how she made the decision to not eat well so that she could provide healthy foods for her young daughter when her income support services were insufficient to meet all their needs.

I would be going to my doctor and my doctor would be saying, I don't know what to do to help you because [Ontario Disability Support Program] won't cover vitamins and you have malnutrition because you are feeding your child all the food. So, I had malnutrition for years, now I have severe osteoporosis and I mean severe, I'm like an 80-year old woman [R-1].

The participants talked about the significant and long-lasting consequences of these choices. The consequences affected them financially, socially and physically. Participants described losing relationships, having to alter their plans for the future and cuts to their income.

You know it's a unique situation when you're in your middle years and you're taking care of a little kid. Like you're confronted with some things that aren't very good here. Your retirement plan might just have gone to hell [L-1].

Like he was... off [work] on [Benefit] being paid, but to continue his [Benefit] and continue getting paid, the doctor had to approve it. And [the doctor] wouldn't allow it, so

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<sup>e</sup> After this interview was completed, Inn Out of the Cold announced that it received additional funding from Oxford County Council and would be open year-round:  
<http://www.woodstocksentinelreview.com/2018/04/30/the-shelter-formerly-known-as-inn-out-of-the-cold-will-now-be-known-as-the-inn-of-woodstock>

he could have gone, but unpaid [leave of absence]. At the time, but then losing that income too and you're already putting \$10,000 out of your pocket to go to... medical detox as it is. It's crazy [L-3].

The participants also talked about having to make sacrifices to their own health as part of these choices. Using licit opioids (e.g., methadone, over-the-counter drugs) was sometimes a way to feel better, physically. Participants talked about having to choose to access clinics and pharmacies in order to be able to function and get through the day. However, for one participant the choice to stop accessing a methadone clinic and its prescriptions was a way to feel better in the long-term.

But I got off of it seven years ago. I've gotten off it twice. The first time, like eight years ago and I got off it. I was off it for two weeks and I just took one pill and then the second time the same thing. Got off it. I was off it for three months. Took one pill.... And each time I went – I went by ones. One milligram pretty much to get off. And doing it at by one milligram is not too bad. But it just takes forever.... Well no matter what, even if – when I'm at a stable dose, I feel like shit. So, I start going through withdrawal around four in the afternoon, no matter what. So, I got to the point where I'm like – I might as well feel like, you know, extra shit and get off of it, then just feel like a little bit of shit [FUI-1].

In one interview, the participant talked about how long wait lists and policies about opioid prescriptions led some people – including herself – to make a choice with permanent consequences.

The other thing is they are committing suicide. I mean and I did research on the internet about that. There have been many suicides in Canada since that [policy about prescribing opioids] went into effect and there are people that are disabled in chronic pain, their opioids were reduced to the point where they could no longer tolerate life and so they opted to save up a bunch of opioids or buy them illegally and they committed suicide.... Also, we now have an assisted dying program for Canada which you are probably aware of, right. Disabled people are applying and they're not applying because they are at end of life, they're applying because the pain is intolerable with the opioids that they're getting and I applied and I was turned down. I was in excruciating pain, there was nowhere to turn [R-1].

# Discussion

Although there are several ways to assess accessibility to services, this assessment focused on three dimensions: physical access or availability, affordability and acceptability.<sup>16,17</sup> Our results

**Despite the appearance of comprehensive opioid-related services in Oxford County, it may still be difficult for people to access them easily and meaningfully.**

revealed that Oxford County appears to have services available under each pillar of the four-pillar approach to drug strategies: prevention, treatment, harm reduction and justice. These services are available across the lifespan and for people with

different opioid-related needs including people who are currently using, in recovery, at risk for future use and who love someone who uses opioids. However, these services are concentrated in the larger municipalities of Woodstock, Ingersoll and Tillsonburg. In addition to the specific gaps of medical detox facilities and chronic pain management services, future service planning should be aware of the low numbers of services available in rural municipalities, services available online or by phone, recovery services and justice-related services. These findings align with a 2017 assessment of mental health services in Oxford County, which found that people in rural municipalities may have poorer physical access to and decreased affordability of services.<sup>6</sup> In line with the previous study, our participants identified that, despite their availability, some services were harder to afford due to the costs associated with travel and time off work. Medical detox and pain management services were both mentioned by participants as particularly difficult to afford because they could not access those services within Oxford County.

Acceptability of services includes whether the service meets the cultural and social needs of the user and the perceived appropriateness of the service's characteristics.<sup>16,17</sup> Despite seemingly good physical access to a variety of services, the essence of our interview participants' experiences was that local opioid-related services are not meeting their unique needs. These findings echo those of previous local assessments. Together, these assessments demonstrate that acceptability is a key issue affecting accessibility of mental health and addiction services in Oxford County. When our participants try to access services, they do not feel like they belong there or that the services will be able to help them. In an assessment of mental health and well-being needs, children, youth and families in Woodstock said they need to be able to go places – including services – where they can feel socially, emotionally and physically safe. These places

are considered safe when the people using the services are supported by people who know what they are going through and how they like to be supported.<sup>7</sup> Youth attending United Way Oxford's Community Conversations sessions also described their need to feel valued and included in their communities and to have services that match their personal interests.<sup>18</sup> Similarly, two previous assessments found that the stigma surrounding mental health concerns and suicide made it unacceptable for participants to seek help from services.<sup>6,19</sup> All five assessments identified the need of (potential) service users to be understood by providers and to have services tailored to the individual for them to be considered accessible.

In our study, the participants' experiences of poor alignment of the services' offerings to their needs and the inflexibility of these services means that they must choose between meeting their opioid-related needs and their other health and wellbeing needs. These choices have significant and long-lasting impacts on them and their loved ones because they may delay getting needed care or result in financial and emotional hardships. Both sets of participants – people who deliver services and people who access services – described the rigidity of services as having a negative impact on service delivery and access. Flexible, open spaces that provide unstructured, informal and autonomous activities were previously identified by children, youth and families as necessary to meeting mental health and well-being needs of Woodstock residents.<sup>7</sup> Another assessment suggested that involvement of youth in the development stage of service planning could help to address the disconnect between what services offer and what service users need.<sup>6</sup>

Our analysis of the network relationships between organizations demonstrates that the ability of service provider organizations to address concerns about acceptability of services will be impacted by the way these organizations work with each other. The network of opioid stakeholder organizations in Oxford County is dense, with all organizations connected to at least one other organization in the network. This structure can facilitate some coordination of services, because there are lots of opportunities to share information; however, it may also impede changes to behaviours, attitudes and social norms within the broader network.<sup>20,21</sup> The smaller groups (cliques) within the networks may change quickly, but the spread of that change across the network may be slower.<sup>22</sup> Communication between cliques and to those organizations who do not belong to a clique is important to effectively spreading change that starts within a clique. Establishing clear and formalized communication channels between collaborative mental health working groups has previously been identified as a need in Oxford

County.<sup>6</sup> Organizations with high betweenness centrality could act as bridges between these groups.

When networks are concentrated – or centralized – around a few members, these members can coordinate activities for the network. However, if those central members are removed, then the network may not be able to continue to function.<sup>22</sup> The network examined in this assessment has three core organizations who could fulfill this central hub

**The network structure of organizations who provide opioid-related services in Oxford County can help coordinate activities, but it might make it difficult to find new ways of working together and implement flexible, creative solutions to problems.**

role, but as described above, the network structure would change significantly if they are removed from it. Removal of peripheral network members, by contrast, would not affect the overall network structure, but it may remove opportunities for connections with other networks and innovation because they are less influenced by the core organizations.<sup>22</sup> Therefore, it is important for service providers in this network, as part of their work on collaboration, to sustain the current contact with the peripheral organizations in the network without necessarily increasing the strength or number of relationships between them and the rest of the network. By doing so, the network may be able to achieve the creativity and flexibility that the service providers seek as they work on collaboration.

Knowing the names of the core organizations is not necessary to ensuring the sustainability of the network. Instead, stakeholder organizations should try to maintain at least a networking relationship with those organizations they already collaborate with and look for opportunities to elevate the importance of organizations who are regularly involved, but may not lead, new collaborative activities. In doing so, the network is protected from structural change by decentralizing some activities and still has an opportunity to innovate with peripheral organizations.

# Conclusions

This assessment revealed that, although there are several opioid-related services available in Oxford County, there are challenges accessing these services and coordinating their delivery across organizations. In particular, service providers' perceived poor understanding of the lived experience of people who may access services makes it difficult for them to feel like they belong and will be helped by the services they are trying access. Flexibility in service delivery and eligibility can address these concerns and the barriers to collaboration identified by service providers. The Oxford County drug strategy and opioid-related service providers should consider how to leverage Oxford County's assets – namely, the number of services available, number and strength of relationships among organizations and first-hand expertise of potential service users – to overcome these challenges and reduce opioid-related harms in Oxford County.

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## Appendix A – Evaluation Matrix

Question	Indicators	Data Sources
<b>1. What gaps in services and programming exist in Oxford County for people who use and are at risk of using opioids and loved ones of people who use opioids?</b>		
1a. What services exist in Oxford County?	List of services and organizations	Environmental scan
1b. What are the characteristics of each service offered in Oxford County?	<p># targeting or serving each of the following subgroups:</p> <p><b>Target population</b></p> <ul style="list-style-type: none"> <li>- People who currently use illicit opioids</li> <li>- People who currently use licit opioids</li> <li>- People who are at risk of using opioids</li> <li>- People who are in recovery from opioid use</li> <li>- Friends and family of people who use opioids</li> </ul> <p><b>Gender</b></p> <ul style="list-style-type: none"> <li>- Males only</li> <li>- Females only</li> <li>- Any gender</li> </ul> <p><b>Age</b></p> <ul style="list-style-type: none"> <li>- Children (0-12 years)</li> <li>- Youth (13-25 years)</li> <li>- Adults (26-64 years)</li> <li>- Older adults (65+ years)</li> </ul> <p># providing service in each of the following municipalities/ formats:</p>	Websites, SouthWesthealthline.ca, email and phone follow-up



Question	Indicators	Data Sources
<b>2. What barriers and facilitators to coordinated service and program delivery exist in Oxford County?</b>		
2a. How do key organizations interact with each other?	Social network maps identifying relationships between organizations: - networking - coordinating - cooperating - collaborating	Participatory mapping
2b. What are essential themes of service providers' experiences of coordinated service and program delivery?	Essence of the experience and essential themes of the experience from service providers' data	Focus groups, narratives
2c. How might the service network structure influence these facilitators and barriers to coordinated service and program delivery?	Aspects of the network structure: - central actors - peripheral actors - isolates - clusters/cliques	Network maps
<b>3. What barriers and facilitators to accessing services and programs exist in Oxford County for people who use and are at risk of using opioids and loved ones of people who use opioids?</b>		
3a. What are essential themes of peoples' lived experiences accessing services and programs in Oxford County?	Essence of the experience and essential themes of people with lived experience's data	Interviews, narratives
3b. How might the service network structure influence these facilitators and barriers to accessing programs and services?	Aspects of the network structure: - central actors - peripheral actors - isolates - clusters/cliques	Network maps

## Appendix B – Service Characteristics

**Table 1. Overall characteristics of opioid-related services in Oxford County**

Category	Characteristic	Number of Services*
<b>Municipality/format</b>	Blandford-Blenheim	17
	East Zorra-Tavistock	18
	Ingersoll	50
	Norwich	18
	South-West Oxford	16
	Tillsonburg	44
	Woodstock	81
	Zorra	18
	Online	1
	By phone	8
<b>Age</b>	Children (0-12 years)	45
	Youth (13-25 years)	107
	Adults (36-64 years)	90
	Older Adults (65+ years)	76
<b>Gender</b>	Males only	0
	Females only	14
	Any gender	101
<b>Target population</b>	Currently use illicit opioids	52
	Currently use licit opioids	20
	At risk of using opioids	58
	In recovery from opioid use	12
	Friends and family of people who use opioids	19
<b>Drug strategy pillar</b>	Prevention	61
	Treatment	42
	Justice	10

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\* Category totals do not add up to 114 because services may have more than one characteristic within each category (e.g., they may be offered in multiple municipalities or include both treatment and prevention activities)

**Table 2. Opioid-related services in Oxford County, characteristics by municipality/format**

		BB	EZT	Ing	Nor	SWO	Till	Wdstk	Zorra	Phone	Web
<b>Age</b>	Children	11	11	19	11	11	19	31	11	1	5
	Youth	16	17	49	17	15	43	75	17	1	8
	Adults	12	13	38	12	11	33	61	13	1	6
	Older adults	12	13	34	12	11	29	48	13	1	5
<b>Target population</b>	Currently use illicit	7	8	24	8	7	20	27	7	1	5
	Currently use licit	4	4	10	4	4	7	10	4	0	1
	At risk of using opioids	10	10	28	10	9	25	51	11	1	5
	In recovery from opioid use	3	4	8	3	3	7	8	3	1	3
	Friends and family of people who use opioids	3	3	7	4	3	5	12	3	1	3
<b>Drug strategy pillar</b>	Prevention	10	11	28	10	9	25	52	11	1	6
	Treatment	7	8	21	7	7	18	22	7	1	3
	Justice	1	1	6	1	1	6	8	1	0	1
	Harm reduction	4	4	13	5	4	10	18	4	1	4

**Legend:** BB = Blandford-Blenheim; EZT = East Zorra-Tavistock; Ing = Ingersoll; Nor = Norwich; SWO = South-West Oxford; Till = Tillsonburg; Wdstk = Woodstock; Web = Online

**Table 3. Opioid-related services in Oxford County, characteristics by target population**

		Currently use illicit opioids	Currently use licit opioids	At risk of using opioids	In recovery from opioid use	Friends and family
<b>Age</b>	Children	27	5	22	5	5
	Youth	52	19	54	12	18
	Adults	48	19	39	11	19
	Older adults	47	20	25	11	17
<b>Drug strategy pillar</b>	Prevention			54	11	5
	Treatment	34	20			
	Justice	7	0	3	0	1
	Harm reduction	21	8	7	7	17

**Note:** Black cells indicate relationships that cannot exist.

**Table 4. Opioid-related services in Oxford County, characteristics by age**

Drug strategy pillar	Children	Youth	Adults	Older adults
<b>Prevention</b>	20	57	45	31
<b>Treatment</b>	21	41	40	40
<b>Justice</b>	7	10	6	6
<b>Harm reduction</b>	7	28	27	26

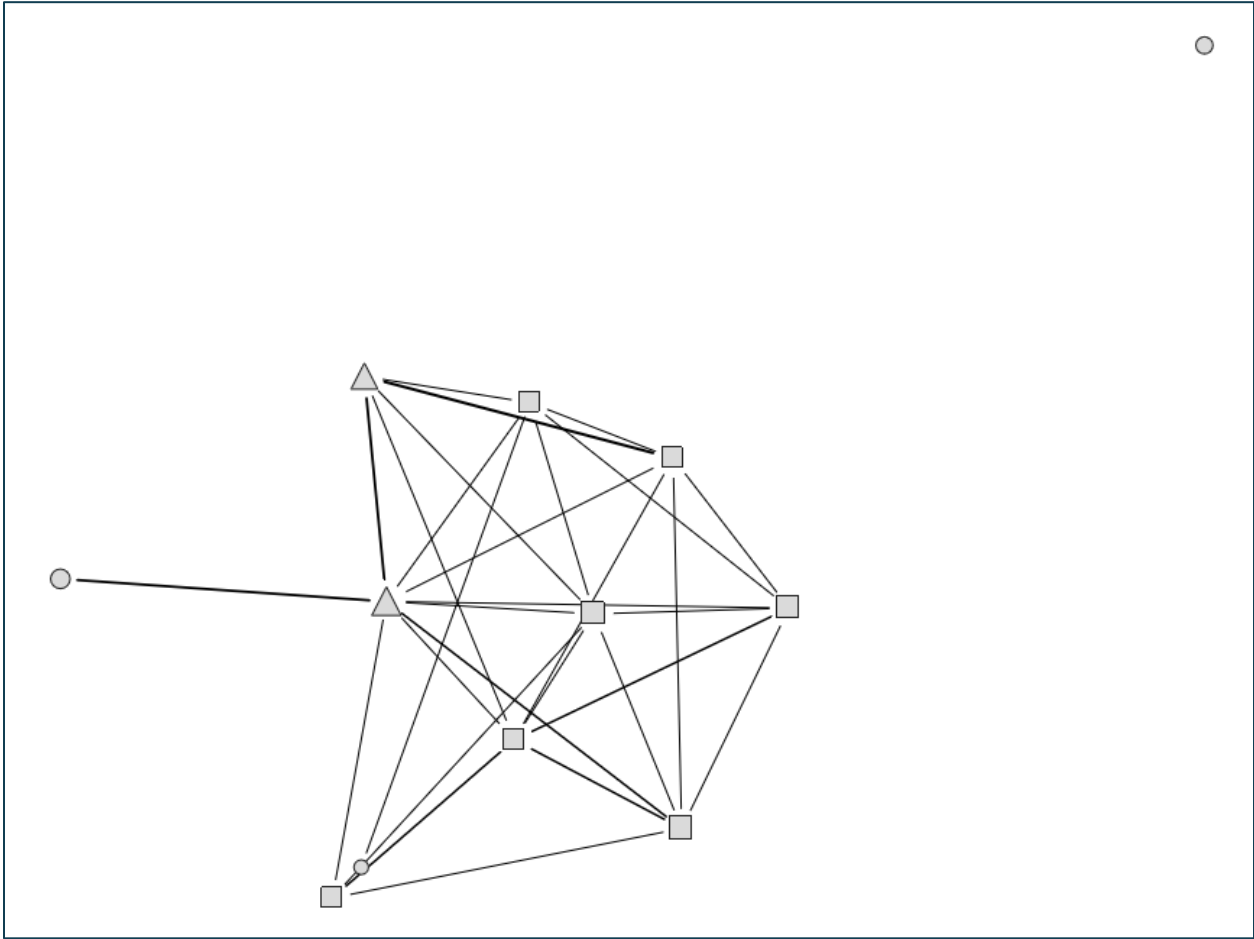


## Appendix C – Network Characteristics

**Table 5. Degree, closeness and betweenness centrality scores, opioid network organizations, Oxford County**

Organization ID	Degree Centrality	Closeness Centrality	Betweenness Centrality
1	14.000	0.039	3.000
2	14.000	0.050	35.500
3	21.000	0.063	65.750
4	36.000	0.121	174.850
5	39.000	0.109	124.617
6	37.000	0.095	38.917
7	26.000	0.064	7.900
8	7.000	0.061	0.000
9	13.000	0.055	0.000
10	10.000	0.052	0.000
11	17.000	0.046	0.000
12	3.000	0.041	0.000
13	17.000	0.056	6.400
14	17.000	0.048	6.400
15	15.000	0.044	6.800

**Figure 2. Network map (Kamada-Kawai model) of relationships among opioid stakeholders after removing core organizations, by degree centrality and category, Oxford County**



**Legend:** Triangles = involved organizations; Squares = supportive organizations; circles = peripheral organizations

**Table 6. Clique census, opioid network, Oxford County**

<b>Clique Number</b>	<b>Member Organizations</b>
1	12, 5, 9
2	12, 6, 5
3	6, 5, 4, 10
4	7, 5, 4, 10
5	3, 1, 7, 9
6	3, 2, 1, 7
7	13, 2, 1, 7
8	14, 1, 7, 9
9	14, 2, 1, 7
10	7, 6, 5, 4, 10
11	14, 13, 2, 1, 7
12	3, 2, 7, 5, 4, 11
13	13, 2, 7, 5, 4, 11
14	14, 2, 7, 5, 4, 11
15	14, 13, 2, 7, 5, 4, 11



**Southwestern Public Health**

[www.swpublichealth.ca](http://www.swpublichealth.ca)

**St. Thomas Site**

1230 Talbot Street

St. Thomas, ON N5P 1G9

**Woodstock Site**

410 Buller Street

Woodstock, ON N4S 4N2