CORPORATION OF THE CITY OF COURTENAY
COUNCIL MEETING AGENDA

Date: October 18, 2021
Time: 4:00 p.m.
Location: City Hall Council Chambers

We respectfully acknowledge that the land on which we gather is the unceded traditional territory of the K'ómoks First Nation

AMENDED AGENDA

K'OMOKS FIRST NATION ACKNOWLEDGEMENT

Pages

1. ADOPTION OF MINUTES

1.1. Adopt October 4th, 2021 Regular Council meeting minutes 7

2. INTRODUCTION OF LATE ITEMS

3. DELEGATIONS

3.1. 'Walk With Me' (WWM) - Independent Research Project, Thompson Rivers University in partnership with Comox Valley Art Gallery

Presentation by:

- Sharon Karsten, Co-Investigator/Project Director, WWM
- Barb Whyte, Elder/Traditional Knowledge Keeper, WWM
- Sam Franey, Community Engagement Coordinator, WWM
- Sarah Delaney-Spindler, North Island Manager, AVI Health & Community Services

3.1.1. 'Walk With Me' (WWM) Policy Report 13

3.2. Comox Valley Transition Society (CVTS) - Connect Shelter (685 Cliffe Avenue) Update

Presentation by:

- Heather Ney, Executive Director, CVTS
- Deb Praine, Program Coordinator, CVTS

4. STAFF REPORTS/PRESENTATIONS

4.1. Recreation, Culture and Community Services

4.1.1. Report back on Phase One of the Community Substance Use Strategy and Request from Comox Valley Community Health Network (CVCHN) for Continued Support 137

Presentation by:

- Lindsay McGinn, Facilitator, CVCHN
- Evan Jolicoeur, Report Consultant
- Patti Alvarado - Unbroken Chain, Indigenous Harm Reduction Program
- Ally Reeder - Unbroken Chain, Indigenous Harm Reduction Program

4.1.2. 685 Cliffe Avenue (Connect Shelter) - Form of Agreement and Shelter Services 197

4.2. Development Services

4.2.1. Zoning Amendment Bylaw No. 3021 to Allow for a Secondary Suite at 2099 Hawk Drive 205

4.2.2. Development Variance Permit No. 2103 for 3202, 3212, 3216, 3220, 3224, 3228, 3232, 3248, 3258 and 3304 Klanawa Crescent 217

5. EXTERNAL REPORTS AND CORRESPONDENCE FOR INFORMATION

5.1. Comox Valley Council of Canadians RE: BC Climate Emergency Campaign 281

5.2. Comox Valley RCMP Quarter 2 Report - July 01, 2021-September 30, 2021 285

6. INTERNAL REPORTS AND CORRESPONDENCE FOR INFORMATION

6.1. Briefing Note - 5th Street Bridge Rehabilitation Project Update 289

7. REPORTS/UPDATES FROM COUNCIL MEMBERS INCLUDING REPORTS FROM COMMITTEES

7.1. Councillor Cole-Hamilton

7.2. Councillor Frisch

7.3. Councillor Hillian

7.4. Councillor McCollum

7.5. Councillor Morin

7.6. Councillor Theos

7.7. Mayor Wells

8. RESOLUTIONS OF COUNCIL

8.1. In Camera Meeting

That a Special In-Camera meeting closed to the public will be held October 18th, 2021 at the conclusion of the Regular Council Meeting pursuant to the following sub-sections of the *Community Charter*:

- 90 (1) (c) labour relations or other employee relations;
- 90 (1) (d) the security of the property of the municipality;
- 90 (1) (i) the receipt of advice that is subject to solicitor-client privilege, including communications necessary for that purpose;
- 90 (1) (k) negotiations and related discussions respecting the proposed provision of a municipal service that are at their preliminary stages and that, in the view of the council, could reasonably be expected to harm the interests of the municipality if they were held in public;
- 90 (1) (l) discussions with municipal officers and employees respecting municipal objectives, measures and progress reports for the purposes of preparing an annual report under section 98 [annual municipal report];
- 90 (2) (b) the consideration of information received and held in confidence relating to negotiations between the municipality and a provincial government or the federal government or both, or between a provincial government or the federal government or both and a third party;
- 90 (2) (d) a matter that, under another enactment, is such that the public must be excluded from the meeting.

9. UNFINISHED BUSINESS

10. NOTICE OF MOTION

11. NEW BUSINESS

11.1. Motion to Move Location of Council Meetings

Suggested motion:

"THAT the following regularly scheduled Council meetings take place in the Civic Room at the Comox Valley Regional District (CVRD) administrative office building located at 770 Harmston Avenue, Courtenay:

- *October 25th, 2021; November 1st, 2021; November 15th, 2021; November 29th, 2021; December 6th, 2021; and, December 20th, 2021."*

12. BYLAWS

12.1. For First and Second Reading

12.2. For Final Adoption

13. ADJOURNMENT

Minutes of a Regular Council Meeting

Meeting #: **R18/2021**
Date: **October 4, 2021**
Time: **4:01 pm**
Location: **City Hall Council Chambers and via video/audio conference**

Attending:
Acting Mayor: **W. Cole-Hamilton**
Councillors: **D. Frisch**
D. Hillian
W. Morin
M. Theos
Regrets: **B. Wells**
M. McCollum

Staff: **G. Garbutt, CAO**
C. Davidson, Director of Engineering Services, via video/audio conference
J. Nelson, Director of Financial Services, via video/audio conference
K. O'Connell, Director of Corporate Support Services, via video/audio conference
M. Fitzgerald, Manager of Development Planning, via video/audio conference
R. Wyka, Manager of Finance, via video/audio conference
N. Borecky, Manager of Information Systems, via video/audio conference
R. Matthews, Executive Assistant/Deputy Corporate Officer, via video/audio conference
E. Gavelin, Network Technician, via video/audio conference

The Acting Mayor respectfully acknowledged the lands on which the meeting was conducted is the unceded traditional territory of the K'ómoks First Nation.

1. ADOPTION OF MINUTES

1.1 Adopt September 27th, 2021 Regular Council meeting minutes (0570-03)

Moved By Theos
Seconded By Frisch

THAT the September 27th, 2021 Regular Council meeting minutes be adopted.
Carried

2. INTRODUCTION OF LATE ITEMS

3. DELEGATIONS

4. STAFF REPORTS/PRESENTATIONS

4.1 Development Services

4.1.1 Updated Proposal - Zoning Amendment Bylaw No. 3017 - 801 Ryan Road (3360-20-2011)

Rachel Ricard, Development Manager; Kris Mailman, CEO; and Trevor Dickie, Vice President of Real Estate Development, Broadstreet Properties Ltd., presented information regarding the updated proposal for the rezoning application for 801 Ryan Road.

Moved By Frisch
Seconded By Morin

THAT the October 4th, 2021 staff report "Updated Proposal - Zoning Amendment Bylaw No. 3017 - 801 Ryan Road" be received for information.
Carried

Moved By Hillian
Seconded By Frisch

THAT based on the October 4th, 2021 staff report "Updated Proposal - Zoning Amendment Bylaw No. 3017 - 801 Ryan Road" and the September 7th, 2021 staff report "Zoning Amendment Bylaw No. 3017 - 801 Ryan Road" Council approve OPTION 1 and complete the following steps:

1. THAT Council give First and Second Readings of Zoning Amendment Bylaw No. 3017, 2021;
2. THAT Council direct staff to schedule and advertise a statutory Public Hearing with respect to the above referenced bylaw; and,
3. THAT Final Reading of the bylaw be withheld pending the registration of Section 219 covenant and Housing Agreement.

Carried

4.2 Financial Services

4.2.1 Audit Service Plan for Year Ending December 31, 2021 (1680-01)

Moved By Frisch
Seconded By Hillian

THAT based on the October 4th, 2021 staff report "Audit Service Plan for Year Ending December 31, 2021", Council approve OPTION 1 to receive the Audit Service Plan for the year ending December 31, 2021.
Carried

5. EXTERNAL REPORTS AND CORRESPONDENCE FOR INFORMATION

6. INTERNAL REPORTS AND CORRESPONDENCE FOR INFORMATION

7. REPORTS/UPDATES FROM COUNCIL MEMBERS INCLUDING REPORTS FROM COMMITTEES

7.1 Councillor Cole-Hamilton

Councillor Cole-Hamilton reviewed his attendance at the following event:

- National Day of Truth and Reconciliation's *Spirit Walk* in downtown Courtenay

7.2 Councillor Hillian

Councillor Hillian participated in the following events in September:

- Naloxone Training course
- Meeting with Comox Valley Coalition to End Homelessness (CVCEH)
- UBCM Provincial Minister meetings (4 total) as part of the virtual 2021 UBCM Convention
- Comox Strathcona Waste Management Board meeting
- CVRD Coastal Flood Adaptation workshop
- 17th Street Bike Lane Design - Coffee and Learn with staff
- Comox Valley Community Justice Centre Committee meeting
- Comox Valley Project Watershed Fundraising event
- CVRD Strategic Planning sessions
- Virtual 2021 UBCM Convention
- Comox Valley Sewage Commission Agenda Review meeting

- Comox Valley Community Justice Centre Board meeting
- City of Courtenay Strategic Planning session with staff
- Comox Valley Water Treatment Plant opening ceremony
- Comox Valley Sewage Commission meeting
- Comox Valley Water Committee meeting
- CVRD Board meeting
- Meeting with Dianne Hawkins, CEO, Comox Valley Chamber of Commerce
- National Day of Truth and Reconciliation's *Spirit Walk* in downtown Courtenay

Councillor Hillian brought to Council's attention the Regional Poverty Reduction Assessment and Strategy report on the October 5th, 2021 CVRD Board's agenda.

Councillor Hillian shared that the Vancouver Island Regional Library (VIRL) Board's new Executive Director, Ben Hyman, has been connected with the Comox Valley Accessibility Committee regarding the anticipated renovations to the washroom facilities at the VIRL Courtenay branch.

7.3 Councillor Theos

Councillor Theos reviewed his attendance at the following event:

- Vancouver Island Regional Library (VIRL) Board meeting where the Board was introduced to the new Executive Director, Ben Hyman

8. RESOLUTIONS OF COUNCIL

8.1 In Camera Meeting

Moved By Morin
Seconded By Frisch

THAT a Special In-Camera meeting closed to the public will be held October 4th, 2021 at the conclusion of the Regular Council Meeting pursuant to the following sub-sections of the *Community Charter*:

- 90 (1) (k) negotiations and related discussions respecting the proposed provision of a municipal service that are at their preliminary stages and that, in the view of the council, could reasonably be expected to harm the interests of the municipality if they were held in public.

Carried

9. UNFINISHED BUSINESS

10. NOTICE OF MOTION

11. NEW BUSINESS

12. BYLAWS

12.1 For First and Second Reading

12.1.1 Zoning Amendment Bylaw No. 3017, 2021 (801 Ryan Road)

Moved By Frisch
Seconded By Morin

THAT "Zoning Amendment Bylaw No. 3017, 2021" pass first and second reading.
Carried

12.2 For Final Adoption

12.2.1 Development Application Procedures Amendment Bylaw No. 3052, 2021

Moved By Hillian
Seconded By Theos

THAT "Development Application Procedures Amendment Bylaw No. 3052, 2021" be finally adopted.
Carried

13. ADJOURNMENT

Moved By Frisch
Seconded By Morin

THAT the meeting now adjourn at 4:37 p.m.
Carried

CERTIFIED CORRECT

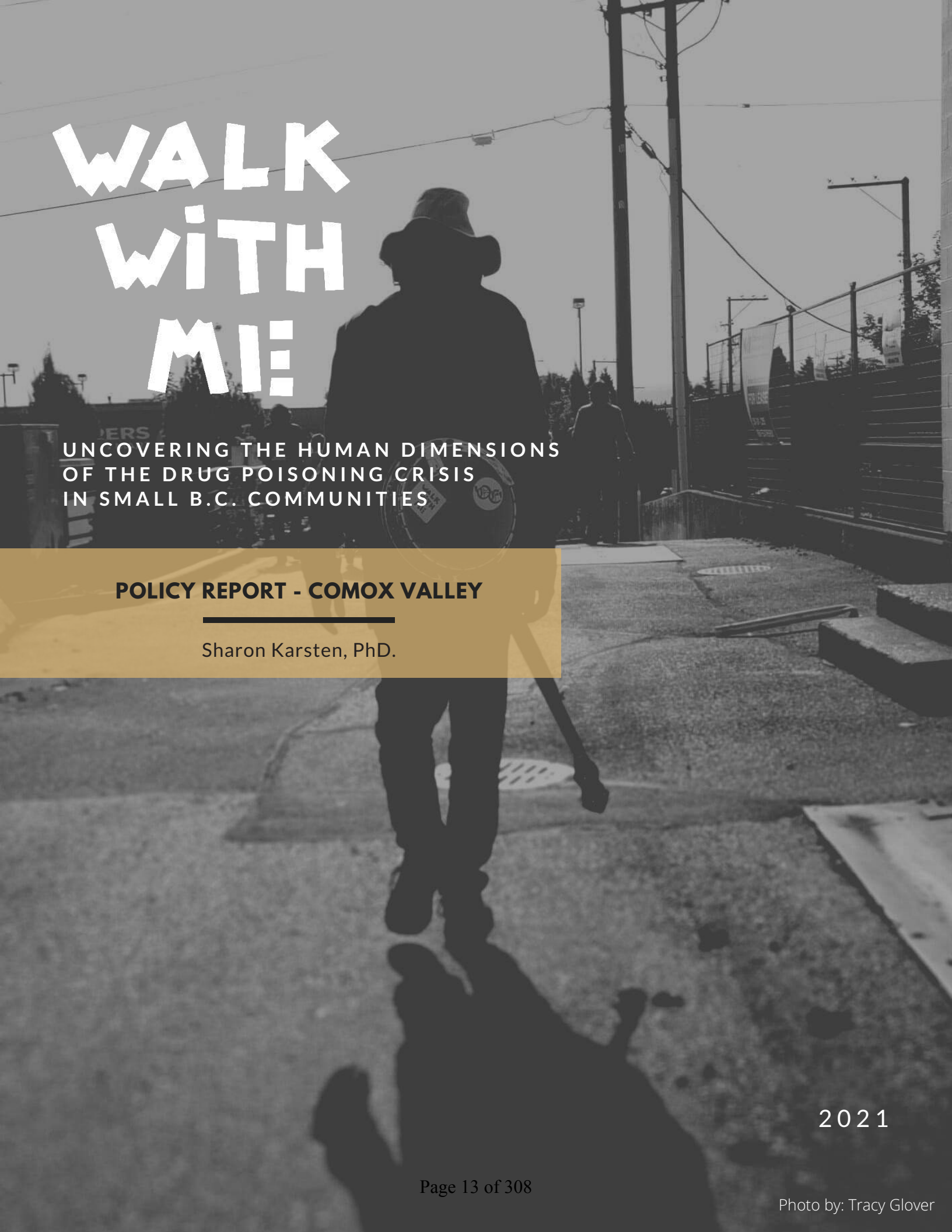
_____

Deputy Corporate Officer

Adopted this 18th day of October, 2021

_____

Mayor



WALK WITH ME

UNCOVERING THE HUMAN DIMENSIONS OF THE DRUG POISONING CRISIS IN SMALL B.C. COMMUNITIES

POLICY REPORT - COMOX VALLEY

Sharon Karsten, PhD.

2021

Photo by: Tracy Glover

With Gratitude to our Partners:

And Funders:

'Walk With Me' Team - Comox Valley

Will Garrett-Petts, PhD - Principal Investigator / AVP Research, Thompson Rivers University
Amanda Wager, PhD - NVIVO Advisor / Canada Research Chair, VIU
Sharon Karsten, PhD - Project Director/Community Engaged Researcher
Barb Whyte - Elder/Traditional Knowledge Keeper
Nadine Bariteau - Creative Director
Sam Franey - Community Engagement Director
Sophia Katsanikakis - Communications Coordinator
Patti Alvarado - Outreach Worker
Galen Rigter - Outreach Worker
Holly Taylor - Outreach Worker
Sara Gifford - Outreach Worker

Report Design:
Sophia Katsanikakis, Haley Tomlin

Website:
www.walkwithme.ca

LAND ACKNOWLEDGEMENT

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

We acknowledge, as well, the teachings we have received from K'ómoks Elder and Traditional Knowledge Keeper Barb Whyte, descendent of the Pentlatch People, who has provided guidance at every step in the journey. Our hands are raised in gratitude.

ABSTRACT

Since labelled a provincial emergency in 2016, the toxic drug poisoning crisis in B.C. has claimed over 7,000 lives. Government, health and community service providers alike have struggled to find solutions to the crisis, developing numerous interventions aimed to reduce deaths, harm and stigma. Despite these efforts, toxic drug poisoning deaths have continued to climb, with 2020 enacting the most fatalities ever. 'Walk With Me' is a research and community action project, developed in the Comox Valley and Kamloops, B.C. as a partnership between Comox Valley Art Gallery, Thompson Rivers University and AVI Health & Community Services, that aims to develop humanistic, and systems-based solutions to this crisis. The project brings people impacted by the crisis together for story- and insight-sharing, and disseminates key findings outward – to policy-makers, systems leaders and community members at-large. The project foregrounds the wisdom of people experiencing the crisis (people with lived experience, their family members and front-line workers). In centering lived experience, the project illuminates ways forward for community and systems transformation.

ETHICS STATEMENT

The author, whose name appears on the title page of this work, has obtained, for the research described in this work, human research ethics approval from Thompson Rivers University's Office of Research Ethics

Keywords

toxic drug poisoning crisis
systems change
stigma reduction
policy
community action

DEDICATION

This piece is dedicated to all who shared their stories with courage, and to those whose lives have been lost. We remember our much-missed collaborators Brooke Mills, Evan Mayoh, and Myles - friends tragically taken even as we worked together for change. We honour, as well, all whose names have been spoken in memory – whose stories continue to compel us forward in pursuit of transformation.

We honour you, and think about you often – especially when we walk.

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

LIST OF KEY TERMS

AVI	AVI Health and Community Services – Harm Reduction Agency
Carfentanil	Synthetic opiate
Fentanyl	Synthetic opiate
PWLLE	People with lived/living experience of drug use
Naloxone	Medication used to counter effects of toxic drug poisoning
OAT	Opioid Agonist Therapy: treatment for addiction to opioids such as heroin, oxycodone, hydromorphone, fentanyl, and percocet. The therapy involves taking opioid agonists methadone (Methadose) or buprenorphine (Suboxone). These medications work to prevent withdrawal and reduce cravings for opioids.
OPS	Overdose Prevention Site: designated sites where drug consumption is witnessed, leading to immediate response in the event of a toxic drug poisoning.
Stimulant	Drugs that tend to temporarily increase energy (rather than relax, as is often the case with heroin and other opioids), including cocaine and methamphetamines.
TRU	Thompson Rivers University
Unbroken Chain	Indigenous Harm Reduction Program through Indigenous Women's Sharing Society
VIHA	Vancouver Island Health Authority
W-18	Illegal synthetic opioid more potent than fentanyl.

17,602

Number of apparent opioid toxicity deaths in Canada between January 2016 and June 2020. [1]

6,743

Number of illicit toxicity drug deaths in BC between January, 2016 and November, 2020. [2]

86.8%

Percentage of Illicit Drug Toxicity Deaths, 2017 – 2020, in which illicit fentanyl and analogues were identified as relevant to death. [3]

1 ABOUT 'WALK WITH ME'

'Walk With Me' has been developed in response to a crisis that has blindsided municipal governments and communities, large and small, across the country. The crisis has had a heavy impact in BC. Since it was labeled a provincial emergency in 2016, illicit drug toxicity deaths have totalled over 7,000. For governments, communities, front-line workers, families and people with lived and living experience, the crisis can feel insurmountable. This project, developed by research and community teams in Kamloops, Comox Valley and Campbell River, B.C., brings together diverse stakeholders to re-frame the crisis through a process of cultural mapping, and to imagine new ways forward.

The project asks, as its central research question: **How can community-based cultural mapping surrounding the toxic drug poisoning crisis help reduce deaths, stigma and harm, improve social cohesion and create systems change for populations facing the crisis first-hand in small and rural communities?** We wanted to understand how this crisis was playing out uniquely in B.C.'s small communities, and shine light on the stories of human loss, crisis and resilience emerging through it. By bearing witness to these and asking others to do the same, and by putting forward policy recommendations emerging from those at the heart of the crisis, we aim to create the conditions for lasting change.

1.1. Why examine the crisis in small communities?

Despite their differences in history, economic stability, social networks, etc., small communities share a common challenge in addressing the health and social welfare needs of their most vulnerable citizens. Such communities are frequently unable to provide the kinds of social, health and economic supports provided in large urban centres. This lack of support is often felt most by those who are socially and economically marginalized, or otherwise require different considerations than the general population. Vulnerable populations are often, within small communities, physically removed from services which are often centralized in downtown cores – leading to challenges for service providers to reach people in ways that are nimble and strategic.

Frequently, small communities are also lacking key elements within a 'spectra' of care. When crises arise, for instance as related to pandemics, forest fires, floods, etc. the resident vulnerable population becomes further affected, displaced and dispersed – leading to even more profound issues of care.

1.2. Why use Cultural Mapping as a core methodology?

Cultural mapping, a community-engaged research methodology, can help small communities make visible the lived and living experience of people facing crises first-hand – and can chart needed connectivity between people with lived/living experience (PWLLE), family members and frontline social service providers; and between these groups and police, government, policy-makers and the broader public. Throughout the last 30 years, the phenomenon of cultural mapping has gained international currency as an instrument of collective knowledge building, communal expression, empowerment and community identity formation. Through cultural mapping, verbal story and insight sharing is combined with artistic sharing to foster understanding about lived realities. Our main mode of mapping in this project occurs through a draw-talk protocol, wherein participants draw about their lived experience, and speak to their drawings, engaging with the researchers in semi-structured interviews. This methodology is adaptive, and foregrounds the communication preferences of participants, who have at-times used other mediums than drawing, including music and photography, or story sharing on its own, to communicate elements of their lived experience.

1.3. What role does art play?

Arts-based investigative frameworks have, in recent years, been readily embraced by health researchers, especially those looking at the social determinants of health by using techniques such as photovoice. Yet in spite of these developments, arts-based, humanities-oriented research approaches addressing multifaceted issues like the toxic drug poisoning crisis remain rare. Some excellent work on 'journey mapping' of the crisis has produced powerful initial results and provides a kind of proof of concept for our work.[4] But where such approaches also solicit community input, they tend not to emphasize individual voices and experiences. Instead of foregrounding unique stories and maps from locals, such mapping has consolidated viewpoints and employed a single graphic facilitator, reflecting the work of skilled note-takers and artists visually representing the broad strokes of oral exchanges, typically in workshop and seminar settings. What tends to get lost are the individual voices, the individual

records and layers - the mappings - of lived experience. The act of bringing PWLLE and their representations of experience into a community-wide dialogue enables, we believe, a powerful evolution of our communities' potential to develop meaningful solutions to the crisis.

1.4. How is the project structured?

This project has been developed by Dr. Will Garrett-Petts, Principal Investigator (AVP Research, Thompson Rivers University), and Dr. Sharon Karsten (Research Director, Comox Valley Art Gallery), Co-Investigator. Thompson Rivers University (TRU) serves as the managing partner, and the Comox Valley Art Gallery (CVAG) as community partner, along with AVI Health and Community Services.

At the core of the project is an Advisory Team that includes participants from Comox Valley, Campbell River and Kamloops, B.C. This group, consisting of municipal managers, health/service providers and PWLLE, have worked with Garrett-Petts and Karsten to develop this project, in parallel, within these small communities. While each community adapts the project in response to its own unique needs and opportunities, the three communities together, through this research team, benefit from cross-community analysis, sharing and learning. Insights from each localized project are shared through the research team, leading to dynamic, cross-community sharing, and collaborative growth.

We gratefully acknowledge the funding received from: Island Health, BC Arts Council, SPARC BC and Vancouver Foundation.

1.5. What are the project's objectives?

To enable new ways of thinking about the toxic drug poisoning crisis as it is played out within these communities, and within small B.C. cities generally – leading to systemic forms of change.

To explore the lived and felt reality of the crisis alongside statistical/empirical data, and in relation to cartographic representations of place – honouring the humanity of those at the heart of the crisis.

To develop insights surrounding the crisis leading to the design of progressive change and transformation.

To create innovative arts-based research models pertaining to the crisis that are participatory—produced through multi-level community agency.

1.6. How has the Comox Valley Project Unfolded?

The Comox Valley project has been in 'active research' mode since 2019, when Karsten began hosting research sessions with PWLLE, their family members, and front-line workers. Alongside a staff team that includes K'ómoks Elder and Traditional Knowledge Keeper Barb Whyte, Outreach Workers (and AVI Health and Community Services Staff) Galen Rigter, Sarah Gifford, Holly Taylor and Sarah Delaney-Spindler, Outreach Worker (and coordinator of Unbroken Chain Indigenous Harm Reduction program) Patti Alvarado, Artist and Creative Director Nadine Bariteau and PWLLE Sam Franey (Community Engagement Director) and Sophia Katsanikakis (Communications Coordinator). Karsten began meeting regularly with groups of PWLLE – hosting research sessions at the Comox Valley Art Gallery. Each session was hosted with food, and involved an ethics presentation (and the completion of consent protocols); participants were invited to draw and/or speak to the lived experience of the crisis, responding to the core research question: How has the toxic drug poisoning crisis impacted you and your community? Participants engaged in dialogue with the research team, and were asked to elaborate on parts of their drawings, stories or insights. The Research Team held these sessions with commitment to respect for those at the heart of this crisis, through trauma-informed practice, and with cultural safety protocols.

The audio interviews were recorded, transcribed, and coded using NVIVO data analysis platform. They were also converted into a series of 'audio walks' – experiential audio journeys that formed the basis of community engagement events and sharing circles, and informed the final report.

1.7. How has the Comox Valley Community Engaged in Walk With Me?

Between September and December, 2020, the Research Team hosted community engagement forums in the Comox Valley Art Gallery's main gallery space, and outside on its Plaza. Attendees were invited to view the art produced in the project within the Gallery space, and engage in guided audio walks. These walks led groups of up to 25 participants on 40-minute walking journeys that left from, and returned to, the Gallery's Outdoor Plaza. Participants walked through parks, under bridges, and through alleyways, while listening to the audio stories and insights gifted to the project by PWLLE, family members and front-line workers. Upon returning to the Gallery, participants were provided with food, and hosted in a Sharing Circle hosted by Elder/Traditional Knowledge Keeper Barb Whyte and the research team.

Outreach support and community resources were made available throughout the entirety of the project. Throughout this period, the Walk With Me team hosted over 32 Sharing Circles with members of the public, engaging with over 500 participants – including local government, community, and health authority stakeholders, as well as PWLLE and members of the general public.

1.8. How has this report been developed and structured?

This report, titled the 'Walk With Me: COMOX VALLEY – POLICY REPORT', draws upon the insights emerging from the research accomplished in the Comox Valley project – with PWLLE, family members and front-line workers. The report includes, in addition to this Introduction (Chapter 1: About Walk With Me), a Literature Review (Chapter 2: The Toxic Drug Poisoning Crisis - Context), Findings (Chapter 3), Recommendations (Chapter 4) and Conclusion (Chapter 5). Together, these offer a snapshot of the crisis' impact in the Comox Valley, and shine light on potential pathways forward in reducing deaths, stigma and harm, improving social cohesion and creating systems change in support of people at the heart of the crisis.

1.9. Summary

The 'Walk With Me' project is a multi-sectoral, community-engaged research project, designed to create systems change in small B.C. communities, as related to the toxic drug poisoning crisis. The 'Walk With Me' team invites readers to receive this report with an open mind and open heart – and to work together towards the catalyzation of long-term, meaningful change.

2 TOXIC DRUG POISONING CRISIS - CONTEXT

2.1. History

In April of 2016, the province's Health Officer, responding to rising numbers of drug poisoning deaths within British Columbia, declared a public health emergency under the Public Health Act – a designation that has continued into the present.[5] In comparison with other provinces, BC has consistently, in recent years, shown the highest per-capita rates of apparent illicit drug toxicity deaths[a].[1,6,7,8,9,10] Between 2016 and 2020, over 6,500 people died in BC as a result of the drug poisoning crisis; drug poisoning deaths for this period were higher than unnatural deaths from other common causes, including suicide, motor vehicle incident and homicide[b].[2] Between April and November, 2020, the number of deaths in BC resulting from drug poisoning (1,279) was almost triple the number of deaths resulting from COVID-19 (432).[11] The Province's move to label the drug poisoning crisis a provincial emergency was a first in BC and Canada, and triggered a multi-faceted intervention aimed to save lives and reduce harm for people who use drugs.[5]Elements of this intervention include: public education, targeted information campaigns, connection with people with lived and living experience, increased access to treatment for opioid use disorder, distribution of naloxone to reverse drug poisonings, passage of legislative changes, increased toxicological testing of drugs, expansion of harm reduction services (ie: the establishment of drug poisoning prevention services and expansion of supervised consumption sites), the development of a ministry focused on mental health and addictions, etc.[5] These interventions are claimed by the Province "to have averted 60

[a] Figures from 2017-2020 show BC as having the highest per-capita drug poisoning rate. It is worth noting that drug poisoning reporting in BC up until 2017 included only deaths due to opioid drug poisoning, and in 2018 the reporting was altered to include drug poisonings due to all illicit substances. This differs from most provinces, which continued to calculate only opioid-related deaths (except for Quebec who undertook this same reporting shift in 2018). Even before this shift was made, BC's per-capita drug poisoning numbers were remarkably high in comparison to other provinces.

[b] Comparative data not yet available for 2020

percent of all possible drug poisoning deaths since the declaration of the public health emergency".[5] And yet, while these have purportedly helped mitigate the death toll, drug poisoning deaths have continued to rise.

An exception to this trend occurred in 2019, as the province's illicit drug toxicity death number fell for the first time since 2012.[3] Attributable, perhaps, to these multiple interventions, the 2019 death toll in B.C. showed a 36% reduction in comparison to the previous year - with total illicit toxicity deaths falling to 984 (2019) from 1,549 (2018).[12] Yet the onslaught of the COVID-19 pandemic appears to have counteracted this reversal, with drug poisoning levels having more than doubled in April through November, 2020, in comparison to the same timespan in 2019.[12] Indeed, the 2020 total for provincial illicit toxicity deaths has exceeded the total in any prior year, with the pandemic being identified by numerous experts, including BC's chief coroner Lisa Lapointe, as having significantly exacerbated the crisis.[11]

2.2. Impact

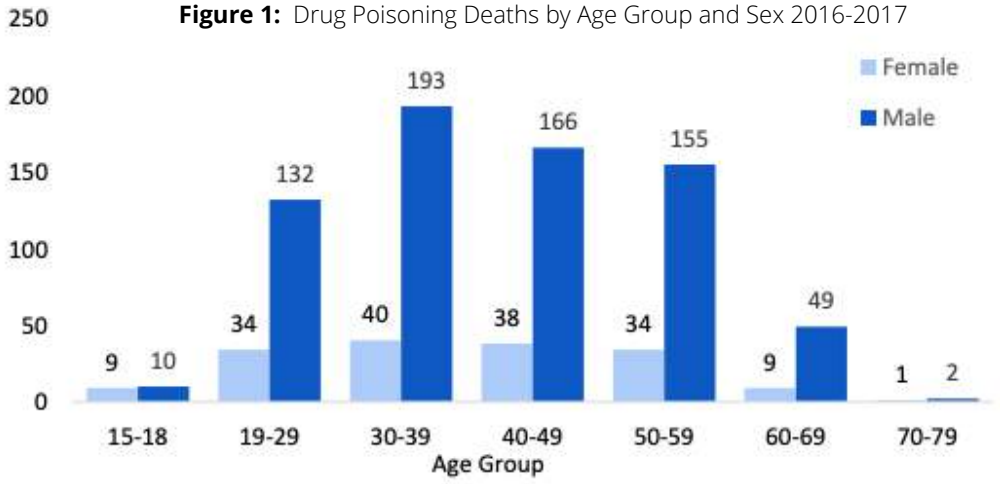
What we know about the way in which this crisis is unfolding provincially and locally is both informed and limited by the data collected by the Province, Vancouver Island Health Authority, First Nations Health Authority, the BC Coroners Service, BC Centre for Disease Control and other health, government and community service agencies. In what follows, we walk through some of the key statistics that have emerged since the crisis was labeled a provincial emergency, with emphasis placed on the most recent numbers.

2.2.1. Who is Most Impacted by this Crisis? (Demographics/ Characteristics)

The question of 'who is most impacted?' is significant, as the response holds the potential to inform our understanding of the crisis, shape public policy and systems change strategies, and inform community action. The following section highlights key demographic-based statistics that have emerged since the onslaught of the crisis in 2016.

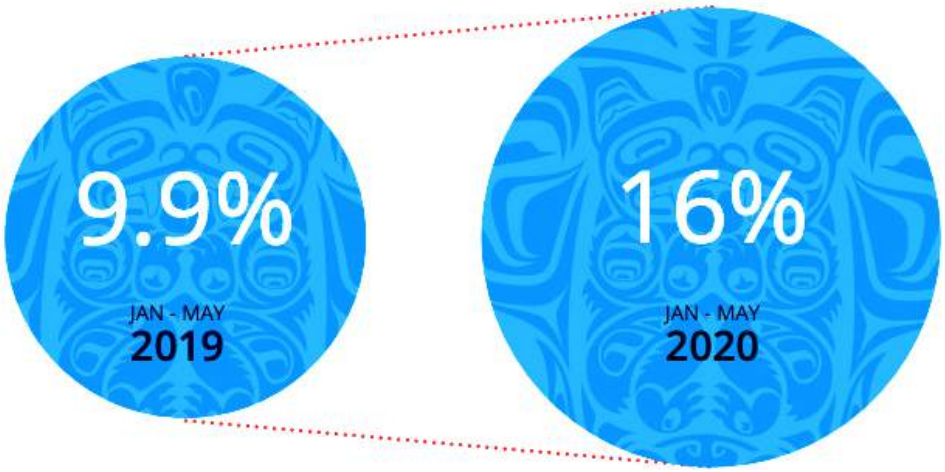
The crisis disproportionately impacts middle-aged men. In 2021 (up to January 31), 70% of those dying of drug poisoning in BC were between ages 30 and 59. Males accounted for 83% of deaths. Similar figures are reported for 2016 - 2020. [14] *(See figure 1)*

Figure 1: Drug Poisoning Deaths by Age Group and Sex 2016-2017



The crisis disproportionately impacts Indigenous People. 16% of drug poisoning deaths in BC between January and May 2020 were First Nations people. This number was 9% in 2019. Both numbers are significant, as First Nations represent 3.3% of the province's population.[14] *(See figure 2)*

Figure 2: First Nations Toxic Drug Deaths 2019 - 2020



Recognizing the crisis' disproportionate impact on men, Indigenous women are significantly represented in drug poisoning statistics. While the drug poisoning crisis at-large in B.C. disproportionately affects men, First Nations women died from drug poisoning at 8.7 times the rate of other women in B.C.[13] *(See figure 3)*

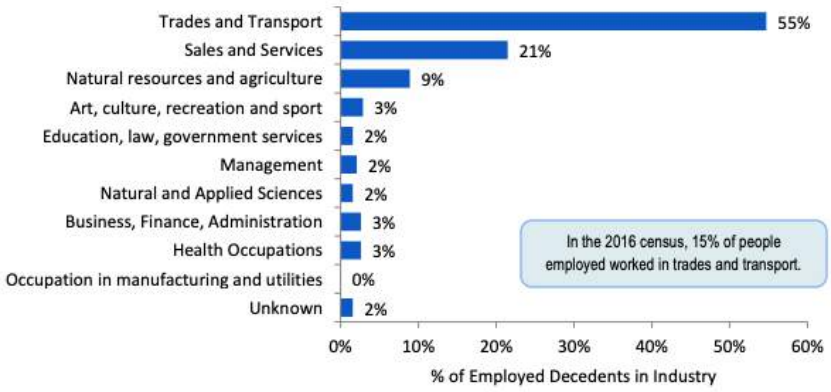
Figure 3: Drug Poisoning Rate for Indigenous Women 2019

8.7x

First Nations women died from overdose at 8.7 times the rate of other women in BC in 2019.

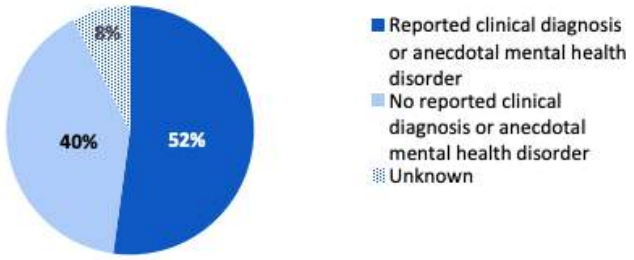
The crisis disproportionately impacts people who are unemployed, as well as people in the trades and transportation industries. A study of 872 drug poisoning deaths in BC from 2016 & 2017 shows that most people who took poisoned drugs were unemployed (51%). Of those employed, 55% were employed in the trades and transport industry.[14] *(See figure 4)*

Figure 4: Toxic Drug Deaths by Industry of Work 2016 - 2017



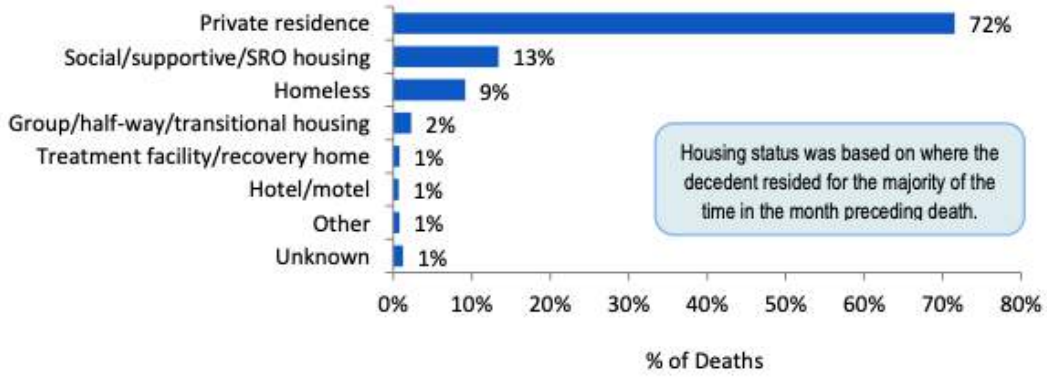
The crisis disproportionately impacts people who are grappling with pain and mental health issues. The same study shows 79% of drug poisoning death victims had contact with health services in the year preceding death (690/872). Over half (56%) had contact for pain-related issues (389/690). More than half of the cohort (455/872) (52%) were reported to have had a clinical diagnosis or anecdotal evidence of a mental health disorder.[14] (*See figure 5)*

Figure 5: Drug Poisoning Deaths and Reported Mental Health Disorders 2016 - 2017



Most drug poisoning victims live in private residences. The above-mentioned study from 2016 & 2017 shows 72% of drug poisoning death victims as having lived (and died from drug poisoning) in private residences, thirteen percent as having lived in social/supportive/single room occupancy (SRO) housing, and 9% as having lived unhoused.[14] *(See figure 6)*

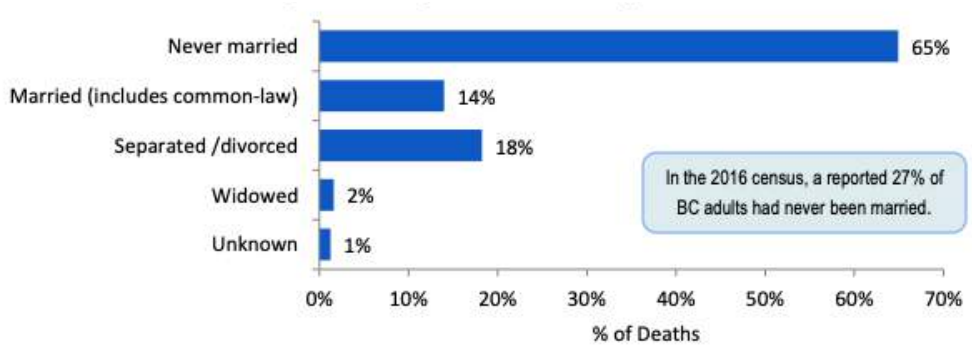
Figure 6: Drug Poisoning Deaths by Decedent Housing



Note: SRO housing = single room occupancy housing

Most drug poisoning victims are not married. Sixty-Five percent of drug poisoning victims in the study had never been married.[14] *(See figure 7)*

Figure 7: Drug Poisoning Deaths by Marital Status 2016 - 2017



Most drug poisoning victims use drugs alone, rather than with other people. The majority of drug poisoning victims (69%) had used their drugs alone.[14]

Drug poisonings increase during income assistance payment week. A British Columbia Coroners Service Report analyzing data in 2019 & 2020 shows the daily average of drug poisoning deaths in the province as having risen from 4.2 to 5.4 in the four days following income assistance payment day (Weds – Sun).[14]

These statistics help form a demographic profile of drug poisoning crisis victims that, though limited in scope, nonetheless helps to inform understanding. From them, we understand this crisis as most severely impacting middle-aged men and Indigenous peoples, notably Indigenous women. We also see the crisis' inordinate impact on those with pain management and mental health issues. And we observe an inverse correlation between drug poisoning rates and income, recognizing a higher rate of drug poisoning amongst those who are unemployed, and accessing income assistance.

While presenting a demographic profile of those most impacted by the crisis, it is important to note that these statistics do not adequately portray the full picture. We know that people from all walks of life have been impacted by this crisis – including people from high- and middle-income backgrounds, women, people in a wide range of professions including doctors, police officers, etc. Recognizing this fact, it is requested that readers receive these statistics with awareness that they tell a part of, rather than the full, story.

2.2.2. Where is this crisis unfolding? (Rural vs Urban drug poisoning Rates)

The question 'where is this crisis unfolding?' is important, as it informs our understanding of it's 'on the ground' impact.

While many see the drug poisoning crisis as predominantly confined to large urban centres, this is not, in fact, the case. Opioid use and drug poisoning rates in small cities and towns is growing, and in some cases surpassing rates in large urban centres. According to a national study by Canadian Institute for Health Information with data from 2017, "opioid poisoning hospitalization rates in smaller communities were more than double those in Canada's largest cities".[15] Another report, produced as part of the BC Rural and Indigenous Overdose Action Exchange shows that between 2016 and 2019, small and mid-sized BC communities "made up between 23-27% of all paramedics attended drug poisoning events".[16]And a recent study by BC Emergency Health Services shows that although urban centres in BC witnessed the deadliest effects of the crisis in 2020, rural and remote areas also witnessed significant spikes in drug poisoning calls to 911. Some of the highest increases in drug poisoning calls, it should be noted, were found on the BC coast and in small cities on Vancouver Island.[17,18] These statistics challenge a common view that the drug poisoning crisis is most significantly impacting large urban centres.

2.2.3. How is the drug poisoning crisis unfolding in Vancouver Island Health Authority, and in the North Island Service Delivery Area?

Between 2016 (the year in which the drug poisoning crisis was designated a provincial health emergency) and 2020, Island Health recorded 1,078 illicit toxicity deaths.[2] This figure represents the third-highest death rate recorded amongst BC's Health Authorities, following behind Fraser Health Authority (2,247) and Vancouver Coastal Health Authority (1,934), and leading (narrowly) Interior Health (1,071) and Northern Health Authority (415).[2] Island Health is divided into three distinct Health Service Delivery Areas (HSDA), including South Vancouver Island (including Greater Victoria, the Saanich Peninsula and the Southern Gulf Islands), Central Vancouver Island (including Greater Nanaimo, Cowichan Valley, Oceanside and Alberni/Clayoquot) and North Vancouver Island (Including Comox Valley, Greater Campbell River and Vancouver Island North and West) (Island Health, n.d). Again drawing on stats from 2016 through 2020, we see that the majority of drug poisoning deaths have occurred in South Vancouver Island HSDA (515) , followed by the Central Vancouver Island HSDA (404), and North Vancouver Island HSDA (154).[2, 19, 20]

When examining drug toxicity deaths as occurring at a rate (per 100,000 people), we see the highest illicit drug toxicity death rates, between 2016 and 2020 as occurring within Central Vancouver Island (27.4), followed by South Vancouver Island (24.6), and North Vancouver Island (23.5)[c].[2] In this snapshot, Central Vancouver Island is seen as the HSDA most affected by the crisis – with South Vancouver Island and North Vancouver Island rates closely aligned.

This data is significant, as it shows the impact of the crisis as higher in the small cities of Nanaimo and Duncan and their surrounding areas, than in the large city of Victoria and its surrounding areas. It also shows the area occupied by the smaller cities of the Comox Valley and Campbell River as witnessing drug poisoning rates similar to the area occupied by Victoria and area. While North Vancouver Island HSDA can be seen to have escaped the worst of the crisis, between 2016 and 2021, as measured in both numbers and rates of illicit toxicity deaths, it has nonetheless suffered a substantial blow.[2] Furthermore, Illicit Toxicity Death Rates for Island Health at-large increased between January and May, 2021.[21] North Vancouver Island, as well as the other Service Areas, are now classified in the highest 'rate' category, suffering more than 30 deaths per 100,000 people.[21]

[c] *Numbers average of Drug Toxicity Death Rates by Health Services Delivery Area from 2016-2020. P.17.*

2.2.4. How is the Crisis unfolding in the Comox Valley?

Within North Vancouver Island HSDA, drug poisonings are concentrated in the Comox Valley Local Health Area (Comox Valley), and Greater Campbell River Local Health Area (Campbell River). Of the 154 illicit drug toxicity deaths that occurred in the North Island HSDA between 2016 and 2020, 68 occurred within the Comox Valley, and 77 in Campbell River. In 2020, 13 illicit drug toxicity deaths occurred within Comox Valley, and 15 in Campbell River. In terms of number of deaths, we see the two communities, Comox Valley and Campbell River, as having similar numbers of drug poisoning, with Campbell river leading slightly. These numbers have remained relatively consistent in both areas over the 2016-2020 time period.

When examined in rates versus numbers, the rate (per 100,000 people) of drug poisoning deaths in Comox Valley between the years 2016 and 2020 (18.8) is significantly lower than that in Campbell River for the same time period (33.2). The fact that Campbell River has a lower population than the Comox Valley reveals a significant difference between the communities in their per-capita drug poisoning rates. From this vantage-point, Campbell River can be seen, between the years 2016 – 2020, to have been more severely impacted by the crisis than the Comox Valley. (Island Health, personal communication, March 12, 2021).

However, while Campbell River has shown higher numbers and rates of drug poisoning between 2016 and 2020, a recent shift is observed. In 2020, paramedic attended illegal drug poisoning events in the Comox Valley rose by 50% to 173, exceeding Campbell River's 162.20 Furthermore, in the first five months of 2021 (January – May), the City of Courtenay witnessed the same number of drug poisonings as it had through the entirety of the previous year (2020) – 12, versus Campbell River's 7.9 This trend shows the Comox Valley, and Courtenay in particular, as having recently surpassed Campbell River as a site for toxic drug poisoning numbers.

We also know from data provided by Island Health that a higher percentage of drug poisonings in the Comox Valley, between 2016 and 2020 have happened in private residences (74% versus 62% in Campbell River, and 61% in Island Health at-large). It is difficult to know the reason for this difference… it might signify a stronger culture of shame and 'closed door' use of drugs in the Comox Valley versus Campbell River; it could also represent a stronger culture of use amongst people who reside in homes versus, for instance, those living unhoused (Island Health, personal communication, March 12, 2021).

Such analysis should recognize the dangers of conceiving of drug poisoning rates as indicative of the full scope of the crisis. It is common for people with opioid use disorder to have multiple morbidity factors, and their deaths to be classified in ways other than as 'illicit drug toxicity'. Furthermore, while these numbers help to inform our understanding, it is important to recognize that the drug poisoning crisis cannot be fully understood through numeric representation. This is a human crisis, one that while producing some statistical markers, cannot be adequately expressed or understood through statistics alone.

2.3. What are Key Contributing Factors?

The drug poisoning crisis, it should be said, has been precipitated by a 'perfect storm' that includes an increase in toxic supply of drugs, over-prescription of opioid-based pain medication, criminalization of drugs, the COVID-19 Pandemic, and the rise, throughout Western Society and globally, in social dissonance factors such as unemployment, housing unaffordability and income disparity. These factors, coupled with ongoing stigma, racism, erosion of mental health supports and erosion of education supports, have been seen to have created a landscape in which the drug poisoning crisis was fostered and enabled. In what follows, we walk through this landscape, with an aim to sketch broadly the context in which this crisis was enabled to take hold.

2.3.1. Increase in Toxic Supply / Provision of Safe Supply

The rise of fentanyl as a dominant street drug has played a significant role in the rise in drug poisoning deaths. Fentanyl, a synthetic opioid that is roughly 100 times more potent than morphine and 50 times more potent than heroin, is legally used and distributed in pharmaceutical practice;[22] and is also made and distributed illegally, through various supply channels - notably through China, with significant levels of drug trafficking occurring online.[23] Drugs ordered online from outside the country are distributed, often, through decoy packages sent by mail or courier in small quantities to evade detection by Canada Border Services Agency[d].[24] Fentanyl traffickers range from organized crime operations to lone operators. Once the drug is in the country, it is diluted by clandestine labs, cut with fillers (such as powdered sugar,

[d] Canada's Border Services Agency currently requires a supplier's permission to open packages weighing less than 30 grams.

baby powder or antihistamines), and mixed with other drugs such as heroin, or packed into pills which are often made to look like OxyContin.[25] According to Edmonton physician Hakique Virani: "A kilogram of pure fentanyl powder costs $12,500. A kilo is enough to make 1,000,000 tablets. Each tab sells for $20 in major cities, for total proceeds of $20-million. In smaller markets, the street price is as high as $80".[25]

Toxicity in the supply of fentanyl stems from its frequent manufacture in sub-standard labs, its mixture with other toxic substances, and its high level of potency. Drug Poisoning Alerts issued by Health Authorities have become common in B.C.[26] It is often the case that a 'bad batch' of fentanyl-containing drugs can be seen moving from large urban centres outward into neighbouring small centres and beyond.[27, 28] Over the past 9 years in BC, there has been a substantial increase in the proportion of apparent illicit drug toxicity deaths in which fentanyl has been detected. While this rate stood at 4% in 2012, by 2020 it had increased to a staggering 83%[e].[12] Post-mortem toxicology results released by BC Coroners Service (p.6) suggest that there has been a greater concentration of fentanyl in the illicit drug market between April and November, 2020, compared with previous months in 2020. From April to November, 2020, approximately 13% of cases had extreme fentanyl concentrations as compared to 8% from Jan 2020 to Mar 2020". The closure of borders brought about by the onslaught of COVID-19 pandemic has complicated these drug supply chains, and is seen widely to have resulted in increased toxicity of supply.[29]

While a dramatic increase in quantities of imported fentanyl has played a key role in the rise in drug poisoning deaths throughout the past 5 years, it is important to note that new, even more dangerous illicit street drugs have entered the scene, and are also now playing a role. Of note is a rise in recent years in carfentanil and W18, both of which are more powerful than fentanyl, and carry a high risk of drug poisoning.[30] Methamphetamine use is also on the rise in B.C.- a stimulant that has been regularly cut with fentanyl and other toxic substances.[3] Similarly, benzodiazepines (commonly prescribed to treat anxiety and depression) are being increasingly distributed on the street, and added in problematic ways to fentanyl and other drugs, resulting in increased toxicity of supply.[31]

2.3.2. Safe Supply

In March, 2020, in response to the rise in toxic drug supply witnessed concurrent with the onslaught of

[e] Data for January to November, 2020

COVID-19, BC's then Minister of Mental Health and Addictions Judy Darcy announced new guidelines for prescribers aimed to support drug users with 'safe supply'.[32] These guidelines, which allowed certain eligible populations of drug users to access prescription drugs from limited classes of health professionals, were designed to help stem the risk of increased toxicity death brought about by the pandemic.[33] In September, 2020, these guidelines were expanded, under a pandemic-related public health order from provincial health officer Dr. Bonnie Henry, to provide safe supply access to nearly all people who access the street drug supply – again with intent to counteract the rise in drug toxicity attributed to the pandemic.[34, 35] The new guidelines also allow for registered nurses and psychiatric nurses to prescribe controlled substances. In July, 2021, the province expanded safe supply regulation further, making it permanent rather than a pandemic measure, and offering more opioid options for consumption, including fentanyl patches.[36] While this move is seen by many as a step forward, the fact that this roll-out relies on existing clinical programs to provide safe supply is seen by some to limit its effectiveness. Many physicians are hesitant to prescribe safe supply, and many drug users are dissuaded from accessing such supply in clinical settings. Reliance on clinical programs can be costly, and potentially leaves out rural, remote and Indigenous communities. Furthermore, the new safe supply legislation leaves out stimulants, and does not address the needs of 'casual' users.[37] In spite of the Province's landmark initiatives taken in the roll-out of safe supply, this work has encountered various 'bottlenecks' – resulting from a complex array of issues, such as under-resourcing, and the construction of new protocols and systems, as well as from complications stemming from the need to accommodate of a wide range of drug users, including those in rural and urban locations, those using opioids and stimulants, and those using chronically and casually. These challenges are not entirely unexpected given that "B.C. will be the first province or territory in Canada to pursue safer supply so aggressively".[38] BC's new addictions minister Sheila Malcolmson has committed publicly to the enablement of safe supply programs across the province as a priority – though the realization of this ideal remains to be seen.

2.3.3. Opioid Agonist Therapy

Safe supply, it should be said, comprises a layer of response to the drug poisoning crisis, and can be seen as an extension of Opioid Agonist Therapy – a treatment strategy that has been in-place within B.C. for many years (since 1959), and that involves prescription of opioid agonists such as methadone (Methodose) and buprenorphine

(Suboxone) – long-acting opioid drugs provided in daily doses used to replace shorter-acting opioids such as heroin, oxycodone and fentanyl.[39] OAT has, for many years, been considered the first line of treatment for Opioid Use Disorder. In BC, the College of Physicians and Surgeons of British Columbia (CPSBC) oversees OAT guidelines; it tracks and monitors patients and physicians, and mandates the concurrent treatment of mental health and addictions.[39]

OAT has been shown to reduce opioid-related morbidity and mortality, with its protective effect increasing as synthetic opioids such as fentanyl become more dominant in the illicit drug supply.[40] Indeed, a recent meta-analysis demonstrated that retention in OAT is associated with two to three times lower all-cause and drug poisoning related mortality in people with Opioid Use Disorder.[41] However, significant barriers to uptake and retention exist.[42] Various of these have been attributed to the quality of OAT service provision. A study conducted by Beamish et al., documents a recent attempt by the BC Institute for Healthcare Improvement's Breakthrough Series Collaborative to, over a period of 18 months, from September, 2017 to December, 2018, improve quality of care in OAT provision in service teams located predominantly in Vancouver - in-line with a series of evidence-based change recommendations. This study showed that particular improvements to quality of OAT delivery, incorporating best practices guidelines, can positively impact uptake and retention of this service.[41] Additional clinical guidelines produced by the Canadian Research Initiative in Substance Misuse advocate an expansion of OAT services to include injectable opioids, arguing this expansion serves as a necessary evolution of OAT, and as a treatment mechanism holding capacity to increase retention rates, and reduction in street opioid use.[43] Recognizing the role OAT plays in preventing drug poisoning amidst a rise in toxic drug supply, work is needed to systemically upgrade service delivery systems throughout the province so as to increase the quality, and therefore effectiveness, of OAT.

It is worth noting that OAT (and by extension safe supply) roll-out often happens differently in large urban centres versus in small cities and rural locales. Best practice guidelines for OAT advocate a 'continuity of care' between a multidisciplinary teams of service providers, including "physicians, nurses, substance use counsellors (with specific methadone expertise), social workers, probation officers, community mental health liaison workers, etc.".[44] In large urban centres, the integration of such 'wrap-around' support services is often more fluid than in small, due to the paucity [in small/rural centres] of health professionals and services…".[39] Furthermore, OAT delivery in Canada is

tied to contingency management strategies that allow for an increasing number of doses to be taken home by patients. 'Carry privileges' are increased "based on appointment attendance and consistently negative urine screens for opioids, stimulants, and other substances". For OAT clients in rural/remote locations, barriers exist as related to travel and regular access to OAT clinics and physicians, as well as to the wrap-around services identified above. These same challenges facing systems of OAT provision are present in the roll-out of safe supply. While OAT and safe supply are strategies often championed for their capacity to counterbalance the rising toxicity of the street drug supply, barriers currently exist that limit their effectiveness.

2.3.4. Over-Prescription of Opioid-Based Pain Medication

These fragmentations in Canada's response to toxic supply have been compounded, it should be said, by the medical institutions' enablement of increased opioid dependency through prescription. On a global scale, Canada ranks "second only to the US in per capita consumption of prescription opioids".[45] The situation in Canada can be attributed, in-part, to a liberal approach to the prescription of pain medication.[39] National clinical practice guidelines published during the early days of the crisis, the Canadian Guideline for Effective Use of Opioids for Chronic Non-Cancer Pain offered few parameters to prescribing physicians: "Many of the recommendations were nonspecific and almost all supported the prescribing of opioids; the guideline provided few suggestions about when not to prescribe".[46, 47] Between 2010 and 2014, Opioid prescribing across Canada increased steadily by 24%, with 21.7 million prescriptions dispensed nationally in 2014.[39] This increase in prescription rates resulted in a 'massive swell' in opioid dependency.

As regulatory bodies began coming to terms with the damage associated with rising opioid dependency, various measures were enacted to address the crisis. The 2017 update to Canada's national clinical practice guidelines, Canadian Guideline for Effective Use of Opioids for Chronic Non-Cancer Pain differs from its 2010 counterpart, in that it introduces restrictive opioid prescribing guidelines (Jones et al., 2020) including recommendations to enter into "opioid prescription modalities slowly, with short durations of use and a maximum dose".[47, 48, 49] Other regulatory initiatives accomplished by Canadian governments (provincial and federal), included reformulating long-lasting oxycodone into a 'tamper-deterrent form' to address concerns related to misuse of OxyContin… and developing/expanding provincial prescription monitoring programs with

enhanced prescriber education. Various of these regulatory responses, it should be said, have been fragmented, given that key elements of health regulations and policy have provincial (vs. national) oversight.[48]

In spite of this fragmentation, government initiatives to restrict opioid prescription were at least somewhat effective in curtailing the practice. From 2016 to 2017, the total quantity of opioids dispensed in Canada decreased by more than 10% and the number of prescriptions for opioids fell by more than 400,000, the first decline seen since 2012.[50] However, by adding deterrents to opioid prescription practices, the measures were also seen to increase demand for toxic street supply, as regular opioid users denied pharmaceutical supply were in many cases compelled to seek illicit supply from the street.[51]

Here, then, we see a multitude of systemic factors driving individuals towards dangerous substances, including: changes in the illicit drug market's production practices that resulted in increased toxicity of street supply; bottlenecks in government response mechanisms (OAT and safe supply) designed to provide pharmaceutical alternatives to illicit street supply, and a history of opioid over-prescription that, coupled with consequent efforts to restrict and regulate prescription, cultivated displaced opioid dependency and increased demand for (toxic) street supply.

2.3.5. Criminalization

Compounding these issues is the ongoing criminalization, within Canada, the U.S. and numerous nations globally, of people who use drugs. In what follows, I provide a brief history of the legislative and strategic framework that has enabled continued criminalization of illicit substances.

The legal framework for Canada's drug control policy was established in the early 1900's - the Opium Act of 1908 enacted the first drug prohibition, as well as alcohol, tobacco and medicine regulations.[52] This act is seen widely to have been developed as part of a state-wide attempt to control non-British immigrant populations, and to uphold a white bourgeois order.[55] In 1911, The Opium and Drug Act added other opiates and cocaine to the list of prohibited substances; and in 1923, cannabis was added.[52] The ban on alcohol and tobacco was repealed by most provinces during the 1920's, as prohibition was seen as unsustainable and costly.

In 1969, Pierre Trudeau's government ordered an investigation into drug law reform. The resulting Commission of Inquiry into the Non-Medical Use of Drugs (also called the LeDain

Commission), recommended, in its final report to Cabinet in 1973 a repeal of the criminalization of cannabis, no increase in penalties for other drug offences, and in relation to those dependent on opioids, an emphasis on "treatment and medical management rather than criminal sanctions".[54] Yet in spite of these counter-prohibition recommendations, the government's approach to drug legislation and enforcement was to become increasingly zealous following the commission's report, and indeed throughout the latter half of the 20th century and into the first decade and a half of the 21st.

Part of this prohibitionist impulse can be attributed to the War on Drugs. In 1986, shortly after U.S. President Ronald Reagan had popularized this concept and made into a policy issue, Canada's Prime Minister Brian Mulroney declared, counter to evidence and popular sentiment, that "drug abuse has become an epidemic that undermines our economic as well as social fabric".[53] In 1987, the government announced the *Action on Drug Abuse: Canada's Drug Strategy* – which "brought $210 million in new funding" into play in the nation's fight against drugs – a substantial portion of which was targeted toward enforcement.[52, 55] In 1996, the Controlled Drugs and Substances Act was passed - a soundly prohibitionist piece of legislation that "expanded the net of prohibition further still".[52] And in 2007, the Harper government released the National Anti-Drug Strategy, which removed the harm reduction pillar of the nation's drug strategy, and emphasized "busting drug users [rather] than helping them".[56, 57] This framework of increasingly prohibitionist legislation led to a situation, in 2017, in which drug arrests in Canada totaled over 90,500 - over 72% of which were for drug possession.[58]

The heavy-handed reliance on law enforcement enacted through the War on Drugs rhetoric was seen to have exacerbated rather than have remediated Canada's drug issues. Its punitive approach to people who use substances resulted in the allotment, for possession and trafficking of banned narcotics, of some of the most severe penalties in the country's criminal code - "surpassed only by offences such as assault or murder".[59] Further, the war on drugs was seen to allow police "far broader enforcement powers in even a minor drug case than they have in a murder, arson, rape, or other serious criminal investigation".[60] The increasing harshness of the penalties enacted for drug possession and trafficking, coupled with a stark increase in the police's enforcement power, contributed to a situation in which Canada's legal protections of civil liberties were eroded, as well as its protection of human rights.[52] Additionally, the criminal justice costs

attributable to substance grew significantly between 2007 and 2017 (for policing, courts and correctional services) … in 2017, these costs were estimated at over $9 billion.[61, 62]

It is worth observing that this punitive approach to drug enforcement policy did not apply to all citizens equally. Todd Gordon traces the federal government's evolving drug laws and legislative frameworks throughout the 20th century and into the 21st, as aligned with attempts to control non-British immigrant and racialized communities.[59] "Drug enforcement [he argues] became an excuse for the police, in their pursuit of the production of bourgeois order, to intervene in and assert their control in communities, on the streets, and in public spaces – regardless of whether those being targeted were actually violating drug laws". The Drug Policy Steering Committee for Toronto Public Health adds weight to this argument, noting that the federal government's drug laws developed throughout the 20th century were "often based on moral judgments about specific groups of people and the drugs they were using (e.g. Asian immigrants who consumed opium)", rather than on "scientific assessments of their potential for harm".[58] These laws were seen to enforce systemic forms of anti-Black, anti-Indigenous and anti-Immigrant racism. Various studies, such as The Impact of Mandatory Minimum Penalties (MMP) on Indigenous, Black and Other Visible Minorities produced by the Department of Justice Canada support this assertion.[63] Drawing on data from 2007/08 to 2016/17, this research shows drug-related acts as comprising "75% of all offences punishable by an MMP (Mandatory Minimum Penalty) for which offenders were admitted to federal custody"[f]. It shows Black, Indigenous and visible minority offenders as comprising 39% of the offenders punishable by an MMP – a number that far exceeds this same group's 23.4% representation in the general population.[63] Another Vancouver-based study, drawing on statistics from 2020, observes "Black and Indigenous people [as] dramatically overrepresented in drug charges recommended by the Vancouver police".[64] Yet another study, accomplished by the Office of the Correctional Investigator with data from 2017, shows "54% of Black women in federal prisons [as] serving sentences for drug-related offences".[64] While many factors can be seen to have influenced this over-representation of visible minorities in the criminal justice system (including the systemic racism

[f] MMP's are legislated sentencing floors wherein the minimum punishment is predetermined by law. These were implemented, in-part, through the Controlled Drugs and Substances Act; in 2007, Justice Minister Rob Nicholson introduced a bill that placed mandatory minimum penalties for those who commit offences.

intertwined with the nation's criminal justice system at-large), the above-mentioned discrimination enacted through Canada's punitive drug laws most certainly played a role.

Throughout the 90's and into the 2,000's, nations around the world began to desert the war on drugs, recognizing the harms enacted by these policies – including, in addition to human rights violations, the "spread of infections (e.g. HIV)..., damaged environments and prisons filled with drug offenders convicted of simple possession".[52] While international commitment to this 'war' was waning, Canada continued, up until 2016/2017, to develop and enforce thoroughly prohibitions drug laws.

It should be said that at various points throughout this time-period, Canada's solidly prohibitionist stance would be publically, politically and legally challenged, and would cede to various 'allowances'. Such an allowance occurred in 2003, when Health Canada under the Liberal Government, granted the Vancouver Health Authority a limited exemption from Canada's drug possession and trafficking laws under the *Controlled Substances Act*, towards the opening of North America's first safe injection facility in Vancouver – InSite.[65] Another allowance is found in the government's efforts in 2016 and 2017 to allow for, and streamline, exemptions to the Controlled Drugs and Substances *Act* for overdose prevention sites.[66] These allowances, when positioned against the backdrop of over a century of prohibitionist legislation, appear, arguably, as the first 'trickles' in what would become a river of public and political pressure pushing towards decriminalization, and in some cases, legalization, of personal possession of illicit substances.

The movement towards decriminalization began to pick up speed 2016, when the Government of Canada announced a new *Canadian Drugs and Substances Strategy*, in which harm reduction was reinstated as a major pillar of national drug policy (after having been removed in the Harper government's 2006 National Anti-Drug Strategy).[66] Then, in 2017, the *Good Samaritan Drug Overdose Act* became law, providing protection to people who witness drug poisonings "so that they can seek help, and ultimately save lives".[67] In 2018, in a landmark move, the Justin Trudeau government through the federal *Cannabis Act* made cannabis legal for both recreational and medicinal purposes – making Canada only the second country globally to accomplish this move (after Uruguay), and the first G7 economy (excluding a number US states that have done so outside of US federal jurisdiction).[68] Yet another key anti-prohibitionist step was taken by the federal government in its recent (2021) development of Bill C-22 – an Act to Amend the Criminal Code and

the Controlled Drugs and Substances Act - submitted for First Reading to the House of Commons on February 18, 2021. Among other things, this bill aims to "repeal certain mandatory minimum penalties (including those instated by the Harper government); allow for a greater use of conditional sentences and establish diversion measures for simple drug possession offences".[69]

These moves by the Trudeau government towards an anti-prohibitionist stance towards illicit substances mark a stark contrast to the staunch prohibitionist stance taken by the previous governments, and by governments throughout the 20th Century and into the 21st. Yet positioned as they are against the backdrop of a crisis that has ravaged the nation, taking over 17,000 lives through drug poisoning throughout the past five years , they are seen by many as 'too little, too late'.[1]

2.3.6. Failure to Decriminalize

Over the past five years, calls have arisen from multiple sectors for the federal government to do more, and move faster, in pursuit of decriminalization. This term holds a range of different meanings, however, common to all of them is the notion that "personal use and possession of drugs is allowed, but production and sale is illegal".[70] Within a decriminalization framework, drug use is positioned as a public health issue rather than as a criminal justice issue. Decriminalization embodies a harm reduction approach, in which people with substance use disorder are enabled to access relevant services in an environment free from the kinds of stigmatization that comes from association with criminalized activity. Under this framework, people found by police to be in possession of small amounts of illicit substances for personal use are enabled to access services, and are supported with community resources, rather than being criminally prosecuted.

A small group of nations who have successfully decriminalized illicit substances are often referenced as beacons in the pursuit of decriminalization. Portugal, through its 'radical' decriminalization drug policy enacted in 2001, is seen to have enacted "dramatic drops in drug poisonings, HIV infection and drug-related crime".[71] In this model, people with substance use disorder are conceived as patients rather than criminals, and connected with a web of social rehabilitation and health services. Alongside Portugal, Czechia, the Netherlands, and Switzerland are among a small group of countries that have decriminalized drug possession for personal use, and invested, alternatively, in harm reduction strategies. The consensus arising from these models is that "decriminalization works"; and yet, few countries are taking the bold step to make decriminalization a reality.[72]

Among Canada's advocates for decriminalization are an increasing number of high-profile players. Notable initiatives of these include:

2017 (November)

The Canadian Public Health Association report Decriminalization of Personal Use of Psychoactive Substances calls on the Federal Government to "Decriminalize the possession of small quantities of currently illegal psychoactive substances for personal use and provide summary conviction sentencing alternatives, including the use of absolute and conditional discharges".[73]

2019 (April)

BC's Medical Health Officer publishes report Stopping the Harm: Decriminalization of People Who Use Drugs in BC, again advocates for federal decriminalization of personal possession.[5]

2020 (July)

The Canadian Association of Chiefs of Police report Decriminalization for Simple Possession of Illicit Drugs: Exploring Impacts on Public Safety & Policing Special Purpose Committee on the Decriminalization of Illicit Drugs recognizes substance use disorder as a public health issue, and decriminalization for simple possession identified as an effective way to reduce the public health and safety harms associated with substance use.[74]

2020 (July)

BC's Premier John Horgan, who formally asked the federal government to decriminalize possession of illegal drugs for personal use.[75]

2020 (November)

Vancouver's City Council, which passed a motion to formally approach Health Canada in pursuit of a plan to municipally decriminalize the simple possession of drugs. Health Canada agrees to enter into these discussions with the City, currently ongoing.[76]

These individuals/groups and others advocating for decriminalization have, in recent years, exerted considerable pressure on the federal government. Along with skyrocketing toxic drug poisoning fatalities, which are contributing to a shift in public opinion, they are exerting a push against which the federal government is (albeit for many slower than desired) beginning to respond.

Beyond the pursuit of decriminalization, some advocates, such as the Canadian Drug Policy Coalition, through their Regulation Project, are calling for legalization of illicit substances – a move that would see these substances regulated by the federal government in a similar fashion to cannabis, alcohol and tobacco, and made subject to federal production and distribution laws.[77] Proponents of legalization tout its capacity, beyond that of decriminalization, to establish a system of 'regulated purity', enact age restrictions on sales, "prevent large racial disparities because of the wide discretion in charging by prosecutors", and "impact the enormous profits being made from drugs by violent criminal gangs".[78] On the other hand, legalization is critiqued by some for its propensity to increase drug use, and to produce harms similar to those enacted by other regulated substances: "We know that currently legal drugs, such as alcohol and tobacco, are widely consumed and associated with an extensive economic burden to society – made from drugs by violent criminal gangs".[78] On the other hand, legalization is critiqued by some for its propensity to increase drug use, and to produce harms similar to those enacted by other regulated substances: "We know that currently legal drugs, such as alcohol and tobacco, are widely consumed and associated with an extensive economic burden to society – including hospital admissions, alcoholism treatment programs and public nuisance".[79] This argument is difficult to prove, as currently there exists no country that has legalized hard drugs. Given this situation, decriminalization, versus legalization, is often seen as a feasible first step in addressing the drug poisoning crisis from a policy lens.

2.4. Upstream Services - Social Determinants of Health

In addition to 'downstream' approaches to harm reduction commonly cited as solutions to the toxic drug poisoning crisis, including decriminalization and safe supply, harm reduction and recovery services, etc., it is important to identify key social determinants of health, or 'upstream services' that also contribute to the crisis. Factors such as lack of affordable housing, lack of access to quality mental health services, and lack of quality of education, all play a role in exacerbating the crisis. In what follows, we explore these areas, as well

as, more broadly, the effects of 'hypercapitalism' as a way of being, or not being, together. Readers are asked to acknowledge these areas not as a definitive list, but as a starting-point for a systems-based understanding of the crisis.

2.4.1. Housing

The correlation between the drug poisoning crisis and lack of affordable housing has been well documented. In comparison to household income, house prices across Canada have grown rapidly in recent years - increasing 69.1% between 2007 and 2017, while median income increased by only 27.6% over the same time period. Additionally, in the first quarter of 2019, Canada's house price-to-income ratio was among the highest across member nations of the Organization for Economic Co-operation and Development.[80] While Vancouver and Toronto, as global cities, were "the first to catch the bug of extreme housing speculation", the crisis was to spread quickly to smaller cities and towns. "In British Columbia... it is not only Victoria and Kelowna feeling the heat, but [also] places like Nelson [and] the Gulf Islands".[81] In the Comox Valley, the benchmark price of a single family home was, (as of February, 2021), $631,400 – a 78% increase from 5 years prior.[82] Housing affordability has dramatically worsened the Comox Valley, and is contributing to the exacerbation of health determinants, including homelessness, poverty and addiction.

Recognizing the magnitude of our housing crisis, we are inspired by 'Housing First' – a policy approach that recognizes housing as the most important component in making progress on a multitude of social issues – including those related to addiction and mental health. While many municipalities have adopted a housing first philosophy, relatively few have successfully implemented it. Some examples of places where this approach has worked include Helsinki, Finland and Medicine Hat, AB, Canada. This approach has been successfully piloted in Helsinki, Finland, and in Medicine Hat, Canada (AB) – both municipalities dramatically reduced homelessness in recent years by providing unconditional housing for people who needed it. Recognized in this move is the positive role housing plays in stabilizing living situations, and enabling people to seek help. As Juha Kaakinen, one of the key architects of the Helsinki program, observes: "We decided to make the housing unconditional...to say, look, you don't need to solve your problems before you get a home. Instead, a home should be the secure foundation that makes it easier to solve your problems.".[83] While the program is, in its initial stages, expensive, it is ultimately seen to reduce costs related to emergency healthcare, social service and the justice system, saving as much

as €15,000 annually for each person provided with housing.[83] A similar program in Medicine Hat, introduced in 2009, has also led to significant progress - indicated, by "reductions in shelter use, the number of homeless housed and maintaining housing, as well as a number of measures introduced to restructure the Homeless-Serving System".[84] A Housing First policy holds potential, according to many, to stabilize peoples' living situations, enabling them to more fully engage in harm reduction and/or seek treatment and support.

2.4.2. Mental health services

Alongside a lack of access to affordable housing, a lack of access to mental health services constitutes an aggravating factor in the toxic drug poisoning crisis. In 2006, Rural B.C. was acknowledged to suffer from a "severe shortage of mental health services" – a reality recognized again in the Auditor General's Report of 2016.[85, 86]A 2019 BC Coroners Report and report from the Office of the Provincial Health Officer (2019) confirmed this same finding.[87, 88] The Province, it should be acknowledged, has recently, in its 2021 budget, committed to providing $500 million in new funding for "expanded mental health and substance use services", including $152 million for opioid treatment - the largest increase in mental health in the Province's history.[89, 90] This funding acknowledges both the growing gaps in mental health services at-play within the Province, as well as the link between mental health and the toxic drug crisis.

2.4.3. Education

Beyond the issues we've discussed related to housing and mental health, education (or challenges in the provision thereof) is often seen to play a role in exacerbating the toxic drug crisis. It is important to acknowledge here that the Province, simultaneous to suffering the toxic drug poisoning crisis itself, is suffering a crisis in education. Schools in B.C. are chronically underfunded, with the province's current per-student spending average estimated at $1,840 lower than the national average.[91] While funding for public education significantly increased in 2017-18, "government spending on K-12 education as a proportion of total public spending continues to decline".[92] Simultaneously, the "costs of running the public education system have continued to rise and expectations of schools have increased significantly".[93] These fiscal challenges have resulted in the loss of supports for students, including specialist teachers (individuals who provide additional layers of learning and social support, address diverse needs of students and are seen as markers of 'inclusivity') – the number of which has declined drastically in recent years.[94] The lack of learning specialist teachers is acknowledged as "particularly acute in smaller

communities and remote schools". This diminishment of educational support is of relevance to the toxic drug poisoning crisis in several ways. Children and adolescents who grow up in households with drug use may experience adverse consequences, including: "increased risk of mental health problems and drug use; accidental opioid poisoning; increased risk of developing a substance use disorder; and family dissolution that results from parents' incarceration, foster care placement, or loss of parent to an opioid overdose".[95] Given the budgetary crisis outlined above, and the fact that supports for vulnerable students have been eroded, the schools system is, arguably, challenged in its ability to provide adequate support. Further, children and adolescents who face challenges besides those related to the toxic drug crisis, including those stemming from poverty, mental health, etc., also run the risk of being 'left behind' (without the provision of adequate supports), and of developing learning and social deficits that impact them later in life. These children are at greater risk of social destabilization, and of suffering from challenges related to mental health and addiction.

In recent years, the B.C. school system has worked strategically to develop new models of learning – the most recently-developed curriculum placing significant emphasis on core competencies - "sets of intellectual, personal, and social and emotional proficiencies that all students need in order to engage in deep, lifelong learning".[96] Here, teachers are encouraged to enable students to explore and develop social, emotional and behavioural competencies, including such skills as communication, conflict management and self-care. Through this focus, children and adolescents are equipped, perhaps better than before, to activate the tools at their disposal when engaging in adverse life events and trauma.

Acknowledging this shift, we have nonetheless seen, in this section, the challenge faced by the province's school system in nurturing and supporting vulnerable children and adolescents - in the wake of a crisis that is, in many adverse ways, impacting their families. By considering children, adolescents and school support systems in our work, we begin to recognize how systemic this crisis has become.

2.4.4. Hypercapitalism and 'Poverty of the Spirit'

Vancouver-based psychologist Bruce Alexander made headlines in 2008 with his book The Globalization of Addiction: A Study in Poverty of the Spirit.[97] In this piece, written, it should be noted, before the drug poisoning crisis in BC gained official 'crisis' status, Alexander posits the rising proliferation of addiction throughout the 20th century and into the 21st as a symptom of a

society whose obsession with capitalist forms of growth and accumulation has resulted in the erosion of the 'social fabrics' that bind communities, families and societies together. Using Vancouver as a case study, a quintessentially 'globalized' city whose economic foundations have been established on principles of global trade and free-market logics, Alexander shows how the City's notorious struggle with addiction has been spurred by a kind of 'hypercapitalism', in which free-market logics have grown to trump logics rooted in social and ecological health and wellbeing. Such logics, he argues, which are now ubiquitous in cities throughout the globe, and consistently propagated through globalized mass media, are responsible for a mass 'impoverishment of the spirit' – including an impoverishment of community, and of the connections that bind individuals together. His argument posits the need for belonging and collectively-defined purpose as a core human need – one that when not filled results in profound dislocation, and in attempts to 'fill the gap' through alternate means. When market logics are left unchecked, they lead (in addition to ecological devastation) to widespread dislocation, and to the proliferation of addiction as a coping mechanism.

A similar argument is made by physician and well-known addictions specialist Gabor Maté. Like Alexander, Maté posits the roots of addiction as lying in a wider societal context developed through agendas that deny fundamental human needs: "...ultimately I'm saying that illness in this society, by this society I mean neoliberal capitalism, is not an abnormality, but is actually a normal response to an abnormal culture... in the sense of a culture that does not meet human needs".[98] Addiction, mental health struggles, and many forms of physical and emotional distress can, in this view, be seen as a normal response to our failure, as a society, to acknowledge the multidimensionality of human existence. Addiction here is seen to serve as a coping mechanism in the absence of cultures of connectedness, belonging and collective aspiration.

These theorists do recognize, it should be said, the role of human agency in the proliferation of addiction. Both acknowledge individuals as interacting differently within the social contexts they are allotted; some responding to the limits imposed by this framework through the creation of localized networks of connectedness, belonging and collective aspiration; others 'getting by' through engagement with minimally addictive behaviours. But for a portion of the population, the response to this widespread erosion of social fabrics occurs in the form of addictions that play a profound role in people's lives (including drugs and alcohol, but also addictions to shopping, gambling, working, exercise, power, etc.). When allowed to grow unchecked, these serve

to temporarily 'fill the void' left by a society consumed with free-market logic at the expense of human connection. Alexander's response to this widespread social dilemma, it should be said, is not to eliminate the free-market altogether, but rather, to keep the free market in check, ensuring it serves, rather than dominates, the institutions and structures designed to foster human connectedness, belonging and aspiration. Such a goal Alexander sees as foundational to not only addressing the root cause of addiction, but also, to the goal of bringing people together in profound and innovative ways in addressing other key crises endemic to our time.

2.5. Summary

Our exploration thus far has walked through various key dimensions of the drug poisoning crisis as it has unfolded in Canada and B.C. We've acknowledged a dramatic increase in drug poisoning deaths brought about since 2016 when the crisis was, in B.C., labeled a provincial emergency, and have seen how the crisis has unfolded statistically in Island Health, the North Island Health Services Area, and in the Comox Valley and Campbell River Local Health Areas. We've seen how a rise in drug poisoning deaths has been fuelled by a number of factors – increased toxicity of supply brought about by a rise in fentanyl production and distribution; trends in over-prescription of opioids and subsequent attempts to curtail such prescription – an act that drove many to the illegal market; the rise of the Covid-19 Pandemic, and a regulatory environment rooted, throughout the 20th Century and into the 21st, in a firmly prohibitionist stance. We've also acknowledged the development of a slate of counter-measures within Canada broadly, and BC in particular, designed to combat fatal drug poisonings, such as the regulation of safe supply, the enactment of opioid agonist therapy, the enablement of overdose prevention sites and interventions, and in recent years, the relaxation of federal and provincial drug legislation. We've witnessed a growing movement, fuelled by a spike in drug poisonings that has stunned the nation, and championed by key advocates such as B.C.'s Premier and the Canadian Association of Chiefs of Police, who are now advocating for a new federal regulatory paradigm and approach to drug enforcement. And... we've examined, briefly, the role played by the 'social determinants of health', and by 'hypercapitalism, in exacerbating the crisis.

In what follows, we switch gears to examine the impact of the crisis in the Comox Valley. Here we have an opportunity to see 'beyond the numbers'; beyond the statistics, and to look at human stories, and to the human impact. Through this glimpse, we have an opportunity, it seems, to

reassess the ways in which we as a community work together towards supporting those facing the crisis first-hand; and to work towards resolution.

3 FINDINGS

The findings outlined in this report stem from research sessions with over 50 participants in the Comox Valley. Participants met together in group and individual sessions, and engaged in a 'cultural mapping' methodology (see sections 1.2-1.7). Groups of participants, including People With Lived/Living Experience (PWLLE), their family members and front-line workers, were hosted by the research team with food, music and art supplies, taken through an ethics consent process and offered an honoraria for their time. Participants were provided multiple levels of support by members of the research team, including a K'ómoks Elder/Knowledge Keeper, Outreach Workers, Peers, Artists, and a Community-Engaged Researcher, as well as by our partnering social service organization, AVI Health and Community Services. In the sessions, participants were asked to respond to the central research question: "**How has the drug poisoning crisis impacted you and your community?**". The researchers then asked follow-up questions, where participants were asked to speak to the themes and concepts shared through their drawings, or stories. The following chapter outlines key insights emerging from these recorded sessions. These reference many of the concepts outlined in the literature review, and illustrate how the drug poisoning crisis is uniquely impacting the Comox Valley.

3.1. Lived Experience of the Crisis

While many of the concepts and debates stemming from this crisis are applicable to communities at-large, the crisis is, we recognize, uniquely experienced by each community. The following section speaks to the ways in which the crisis is felt within the Comox Valley. The stories come from people located in this place. While we do not claim to represent the full story of this experience, we offer a window based on the insights shared by our participant base. The narrative is seen as a starting-point; more work is needed to evolve our understanding.

Before launching into these findings, it is important to honour and acknowledge the participants who boldly gave their stories and insights.

Our team is honoured to have received these– which were given with immense courage, and with intent to spur change. Our circle has borne witness to these stories/insights, and we ask those who read them to do so with respect – acknowledging the impact of this crisis on individuals and families; and the need to come together in ways that are creative, visionary and compassionate, towards the formation of new ways forward.

3.1.1 Fentanyl and drug mixing: 'A different ballgame"

Across the board, participants spoke to their experience of the crisis as worsening in recent years. The rise of fentanyl was cited by many as a key factor exacerbating the crisis - acknowledged to have contributed substantially to the toxicity of the drug supply. Furthermore, it was seen to have triggered more severe forms of addiction, and to have caused extraordinarily negative physical and psychological consequences for those who use – including a higher rate of drug poisoning, and along with this rate, higher levels of mental and physical damage. Dr. Kindy observes:

The difference from 20 years ago to now is, when people would come see me... when they had Opiate Use Disorder, they had survived their substance use for many years... You could basically do heroin for a long time and function for a long time. And your brain wasn't harmed if you didn't do, like I would say, too much, and overdose. So the patients I would see were usually a bit older. And at that point, they had had enough, and they were ready to come into the program. Now what I'm seeing is late teens, or early 20's, that within two or three years, the consequence of their use is extraordinary. I mean, if you have them on the program for two years... if they continue using, the change you see is scary, to be honest with you. And I think that part is a crisis. And again, we have to remember when those kids overdose, there's a brain injury. You keep overdosing, there's going to be some changes, and those changes, some of them are gonna be permanent. (Dr. A. Kindy, personal communication, September 9, 2020).

The rise in fentanyl and its impact on drug poisoning is seen by Dr. Kindy to have dramatically changed the landscape of addiction in the Valley. In addition to its role in spurring brain damage, Dr. Kindy speaks to the very real forms of physical damage caused by the introduction of this substance:

You know, [under the new scenario], I've had patients doing really well, for a number of years, relapse once, relapse twice and then never see them again. Next time, you know, they're in the hospital getting an amputation. And they're like, 26, right? So it's a different ballgame. (Dr. A. Kindy, personal communication, September 9, 2020).

In addition to this enactment of mental and physical damage, the rise of fentanyl was seen to complicate the

provision of Opioid Agonist Therapy (OAT) – causing a reduction in its effectiveness:

The other thing that I'm seeing in my practice is that if people relapse with heroin, with OAT, it would block the heroin, and often they would come back and they would function. So the harm reduction worked, versus fentanyl, which is a different ballgame… (Dr. A. Kindy, personal communication, September 9, 2020).

Dr Kindy speaks, then, to the onslaught of fentanyl as having profoundly negative implications in relation to the maintenance of OAT.

In addition to the rise of fentanyl on the street market, drug mixing was also seen as an emerging trend whose increased practice is having devastating effects. When asked about the key hurdles at-play in her work treating clients with substance use disorder, Dr. Hemmerich states: "Increasing toxic drug supply with more carfentanil laced with benzos" (Dr. E. Hemmerich, personal communication, August 13, 2020). Dr. Kindy supports this view, noting the mixing of increasingly toxic drugs as causing people to "take a lot longer to get better".

Similar insights were echoed by participants with lived experience, who point to the ways in which new forms of drug mixing are diluting, or diminishing, the effectiveness of dominant drug poisoning prevention strategies such as Naloxone/Narcan.

Say you're an heroin user, and you get heroin with fentanyl in it, but maybe it has Xanax in it as well, because things are just being mixed. You have no idea and then when you try and Narcan someone it doesn't work because there's benzos in their drugs, and like that's what happened to my best friend…. It doesn't matter how many times you Narcan them, they're not coming back. (S. Katsanikakis, personal communication, December 17, 2020)

The mixing of drugs, as noted by Sophia, has contributed significantly to the toxicity of the supply. A PWLLE, Daryll, echoes this sentiment:

Back in the day, nobody knew what [fentanyl] was. You just cut it with something that didn't harm you. And now they're cutting it with stuff that does harm you…. Like this pig dewormer and all this stuff, like why would I want that shit? To put that in someone's dope if they're gonna die from it, or get sick from it, or get something from it. I don't want to do that. It used to be all the sugars, right? … Now they're using more powerful dope that brings back more of the drug than what they put in. How does that make sense?… (Daryll, personal communication, November 5, 2019)

In short, the introduction of fentanyl into the street drug scene in the Valley, coupled with the mixing of drugs, was seen by a number of participants to have evoked profoundly negative consequences for drug users – including severe

consequences for drug users – including severe mental and physical consequences, reduction in effectiveness of OAT, and the need for extended treatment times and strategies.

3.1.2. The experience of drug poisoning

Numerous participants spoke to the impacts of toxic supply by describing, often in vivid detail, their experiences of drug poisoning. These personal experiences may evoke strong emotions; readers are asked to engage with discretion:

> **When I overdosed that time, I just flopped on the ground and started banging my head on the door, and my roommate got me and threw me in the bathtub. And he was like what's happening? Like, what's going on? And I could just make out that it was drugs. And then my girlfriend at the time came, and just the look on her face, I'll never forget how scared she was. And so she took me to the hospital, and they didn't want to take me in emergency. They're like, "Oh, he's fine. Take him". But I was pretty incapacitated. I was messed up. They didn't want to take me. So that was my experience with the stigma in the healthcare system. They were like "No, he's fine. We don't want him here."....You know, I didn't have Narcan or anything like I just, I had this in my system. And you would have thought that that would have learned me, you know, about the poison and how dangerous it is, but it didn't. I think within two weeks I was using again, and I overdosed again...(L. Eaton, personal communication, December 16, 2020).**

Here is described a traumatizing rejection by someone seeking medical assistance in the midst of a drug poisoning. This trauma – defined by a threat of death, of inflicting pain on his loved ones and of rejection, is often-times experienced perpetually by people who use drugs, and can be seen as a kind of 'cloud' that persistently threatens to take that which is most valuable: life, family, community. The following story shows one individual's struggle as he grapples with multiple consecutive drug poisonings:

> **...I O.D'ed... I died. And somebody found me. And I don't know how they did it, but they did... So the door was closed, and the lady pushed the door and it wasn't locked. She walked in and found me dead on my bed. And I was cold as can be, blue as can be she said. It took, I dunno, five Narcan shots at that time, to bring me out and then go to the hospital. Well actually, I never did come to. I came to in the hospital at 5:30 in the morning. And I wasn't breathing, right? They thought I was dead for sure. Thought I was gonna have to go on a breathing apparatus. That's what they thought was the next move... That was the first time I O.D.'ed, and it only took me four more times to get to it. And that was in my room, and the last ones were all in the bush or somewhere, somewhere where nobody even knew I'd be. (Daryll, personal communication, November 5, 2019).**

These harrowing accounts speak to the traumatization that toxic drug poisoning is enacting. To experience drug poisoning, often perpetually, to be turned away from medical help, to be made subject to a continuous supply of poisonous drug supply, and to have experienced a prolonged loss of oxygen... these circumstances are unimaginable, and cause unimaginable levels of trauma and distress – both for the individuals to whom they occur, and for those surrounding them.

3.1.3. The Medical System's Role

While clearly the drug poisoning crisis can be attributed to a rise in potency and complexity of street drugs (and their mixing), many participants highlighted, as well, the role of the medical institution in feeding the crisis. As one participant with lived experience observes

Doctors are the worst drug dealers out there. And they get paid to do it (Trigger, personal communication, March 18, 2019).

Many participants spoke to the role of doctors in 'prescribing' the crisis into its current out-of-control state:

From the hundreds of people I've spoken with on the streets, that are addicted to opiates, you know, 65% of them or more, always have the same story. They were injured or were given Oxycontin or all that stuff. And crazy high amounts – (S. Franey, July 9, 2020).

While much has been said, then, about the threat imposed by the toxic supply of drugs, including of fentanyl, and of the mixing of drugs, it is important to also keep in mind the medical system's role in fuelling this crisis through over-prescription.

3.1.4. Stigma

Stigma was identified by numerous participants as a key barrier preventing drug users from seeking help in the medical health system, and as a regressive form of social behaviour that resulted in people who use drugs feeling isolated and socially denigrated. The term 'stigma' is defined by Webster's Dictionary as "a mark of shame or discredit".[99] It is a Greek word that historically has been used to describe markings or tattoos burned or cut into the skin of criminals, traitors or slaves.[100] This knowledge brings to the world a visceral association with notions of 'outcast', and speaks to the level of disenfranchisement, disdain and 'othering' experienced by the substance using community. The following quote by participant with lived experience, Evan Mayoh, illustrates the power of stigma in 'dehumanizing' the drug using community:

> **"I think, first and foremost, we need to get this dehumanization thing completely eradicated. We need the people who are comfortable, with money and a place to live and all the modern trappings of life, to realize that they are just systematically taking the easy way out. And they're not viewing people as people anymore, the people on the streets, because then they can treat them like the trash that they feel, you know, is that the people strew about."**
>
> **(E. Mayoh, personal communication, October 11, 2019)**

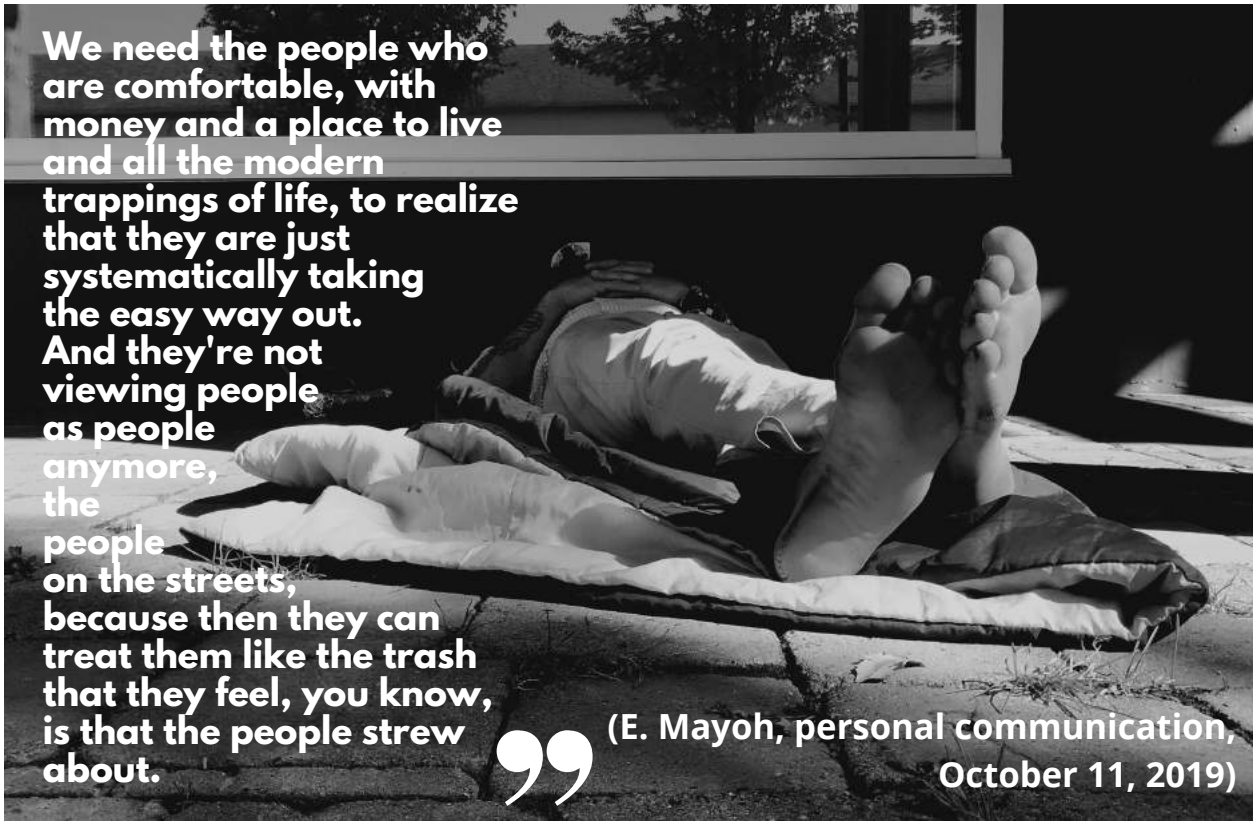


Photo by: Nadine Bariteau

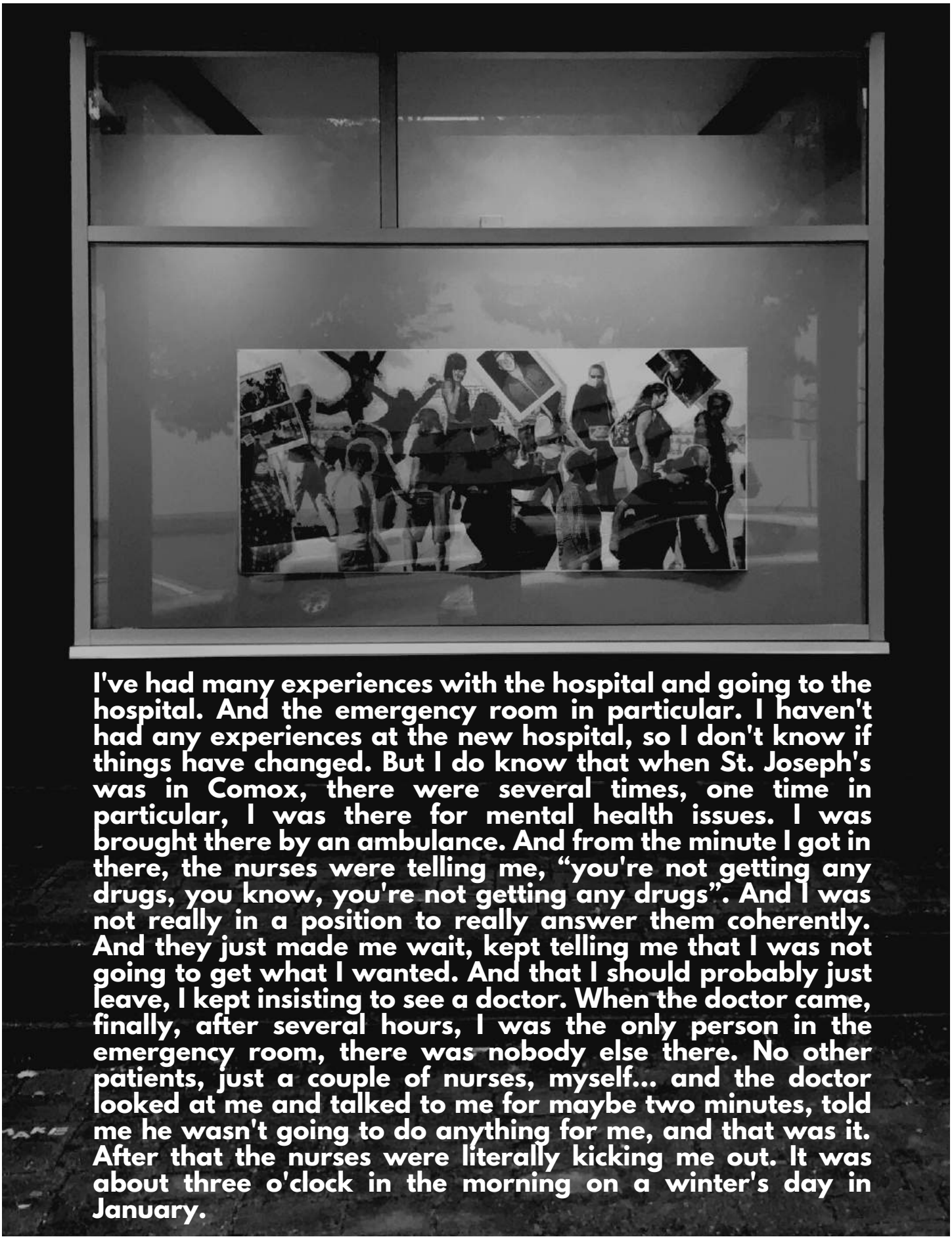
These words provide insight into the strong feelings of rejection and dis-connection imparted to people with lived experience through stigmatization. Through stigma, people are dehumanized, and are treated as unwanted; as 'less than'; as 'trash'.

3.1.5. Stigma in Health Care

This 'dehumanizing' impact of stigma is evident in many different domains – and appears as especially acute in relation to the health care system. Numerous participants spoke of the lengths to which they will go to avoid accessing medical services in response to drug poisoning:

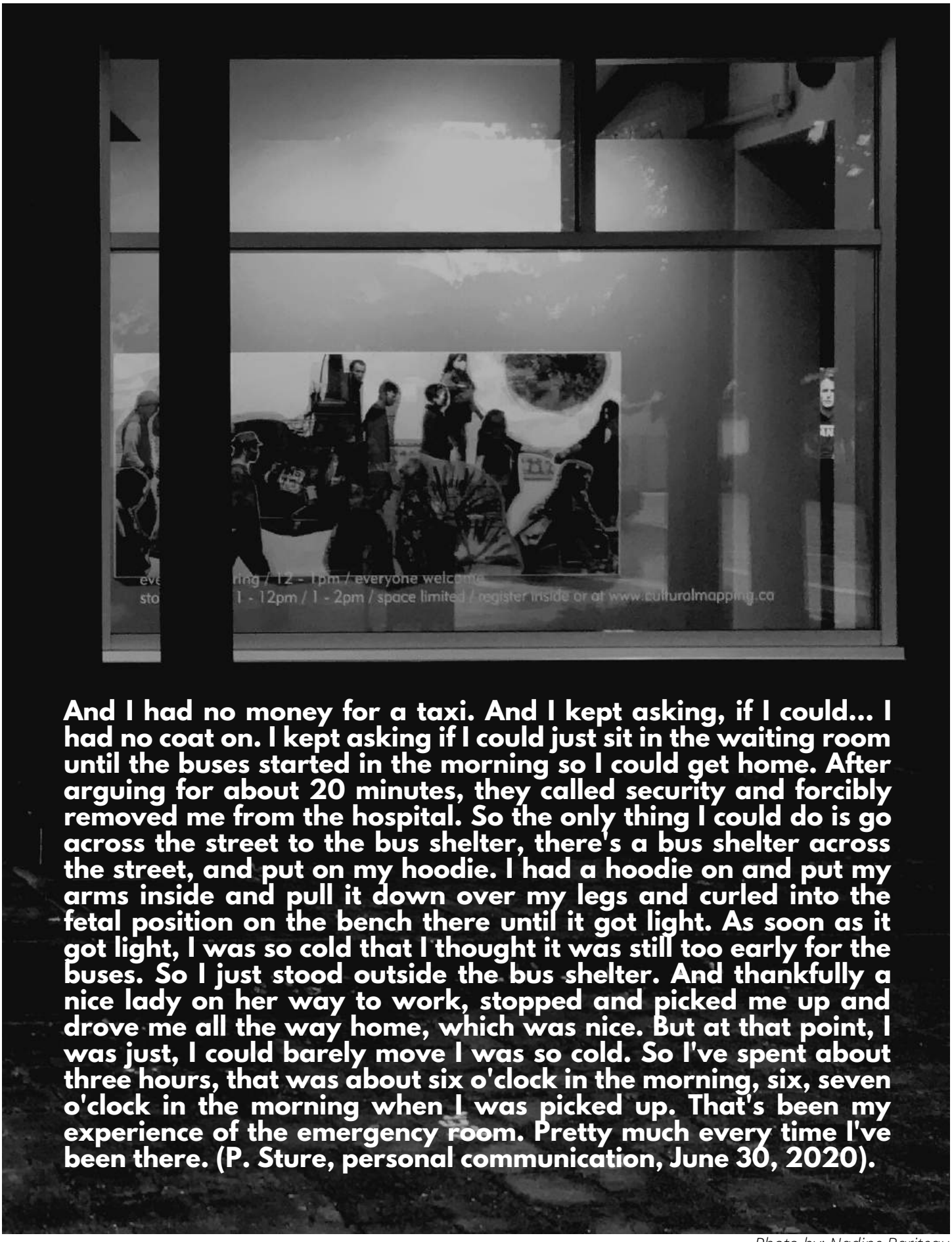
> **There's a lot of times that I've been places, and I feel I've done, you know, 12 Naloxones and we've never called [emergency medical services]. And I've been Naloxoned once myself and we never called it in. A lot of that goes under the radar too. You know, because of stigma, and then you don't want the police and the paramedics coming there to where you're at and stuff like that.... Yeah, it's just like, bring them back, or, if necessary you just keep hitting them, hitting them, hitting them. Like some people have been hit 11 times with Naloxone to bring them back. Finally, they came back. And, you know, a lot of the time, they probably weren't getting CPR while they were getting hit. So there's some brain damage every time, you know? So there's a lot of that going around too, just because of the stigma. (Trigger, personal communication, March 18, 2019).**

Not only are users often afraid to call for help after responding to a drug poisoning, many also hold a strong fear of entering into, and engaging with, hospitals. The following account, which speaks to one participant's experience seeking help in hospital, is similar to many of the stories told by lived experience participants:



I've had many experiences with the hospital and going to the hospital. And the emergency room in particular. I haven't had any experiences at the new hospital, so I don't know if things have changed. But I do know that when St. Joseph's was in Comox, there were several times, one time in particular, I was there for mental health issues. I was brought there by an ambulance. And from the minute I got in there, the nurses were telling me, "you're not getting any drugs, you know, you're not getting any drugs". And I was not really in a position to really answer them coherently. And they just made me wait, kept telling me that I was not going to get what I wanted. And that I should probably just leave, I kept insisting to see a doctor. When the doctor came, finally, after several hours, I was the only person in the emergency room, there was nobody else there. No other patients, just a couple of nurses, myself... and the doctor looked at me and talked to me for maybe two minutes, told me he wasn't going to do anything for me, and that was it. After that the nurses were literally kicking me out. It was about three o'clock in the morning on a winter's day in January.

Photo by: Nadine Bariteau



And I had no money for a taxi. And I kept asking, if I could... I had no coat on. I kept asking if I could just sit in the waiting room until the buses started in the morning so I could get home. After arguing for about 20 minutes, they called security and forcibly removed me from the hospital. So the only thing I could do is go across the street to the bus shelter, there's a bus shelter across the street, and put on my hoodie. I had a hoodie on and put my arms inside and pull it down over my legs and curled into the fetal position on the bench there until it got light. As soon as it got light, I was so cold that I thought it was still too early for the buses. So I just stood outside the bus shelter. And thankfully a nice lady on her way to work, stopped and picked me up and drove me all the way home, which was nice. But at that point, I was just, I could barely move I was so cold. So I've spent about three hours, that was about six o'clock in the morning, six, seven o'clock in the morning when I was picked up. That's been my experience of the emergency room. Pretty much every time I've been there. (P. Sture, personal communication, June 30, 2020).

Photo by: Nadine Bariteau

This story of rejection, and of an apparent lack of concern on the part of the medical system for this individual's wellbeing (as expressed, for instance, in his physical removal from the hospital in the middle of a winter night with no provision for his transportation, physical wellbeing or security), brings to light some stark realizations pertaining to the inherent biases and stigmas ingrained within many such institutions. The hospital (as a construct), and the emergency room in particular, constituted one of the key recurring sites in the Valley identified by participants as a place where power dynamics rooted in stigma were played out. One participant, who had taken an unhoused, using friend to the hospital to address injuries that had been inflicted through an attack, observed the dehumanizing way in which this friend was received within the emergency department:

I will always remember the ways in which the emergency room staff treated [Anonymous PWLLE]. I will remember that forever. And this is somebody who came in bleeding like crazy from his head, and was not offered a gauze until maybe 15 minutes later. I went with him and got him a box of tissues...he was bleeding on their floor. (Anonymous, personal communication, June 30, 2020).

Similarly, the following insight provided by a family member shows how the process of engaging with the hospital as related to a family member's addiction is at times accompanied by instances of shaming on the part of staff:

As we've shared Ryan's story, we've heard people say the treatment they've got from the medical profession, what disrespect they get about their concerns, how they are shamed and blamed if their child comes to the emergency room. And the emergency nurse says: "Well, they are wasting our precious time". And the mom says "If you don't think my child arriving here full of narcotics, and I didn't know about it, isn't an emergency, I don't know what it is". But it's those stories that are heard again and again. (Jennifer Hedican, personal communication, July 14, 2020).

These instances of shaming were often seen to be accompanied, as well, by the provision of sub-standard systems care, such as in the failure to provide a hospital bed, and the hosting patients in the hallway:

I had taken Ryan to the hospital at one point. Because he was sick, in detox. And he wanted Suboxone. And he wanted to feel better, and he wanted to detox. And we sat in the emergency room, six, eight hours. And nobody really came to look at him. He was given a little room to lay down in as he was in pain. On the floor, there was no bed. And they gave us a card and said here, you can contact the nurse at the nursing centre. And she'll return your call in a couple of weeks. And then you can maybe see the doctor up in Campbell River. And that was it. So the

message that's given to the person is "you are not valued". And that was really so unfair, and it is still unfair. (Jennifer Hedican, personal communication, July 14, 2020).

Dr. Kindy speaks to the frequent hosting of substance use patients in the hallway as indicative of the frequent diminishment of addiction in relation to other forms of illness:

I think because of the lack of beds, there's so much acuity that even people with addiction are considered lower on a totem pole... you'll be put in the hallway, which is unacceptable. Right? So that definitely needs to change. (Dr. A. Kindy, personal communication, September 9, 2020).

It is important to note that this provision of sub-standard systems care (ie: denying patients beds, placing them in hallways) was accompanied, in some cases, by stories in which stigma was actively combatted – stories, for instance, in which nurses went out of their way to help. Such interactions were seen, however, as the exception rather than the norm.

On the whole, then, stigma was seen to significantly compromise the front-line health systems' ability to respond to people with substance use disorder. Calls were made by participants for radical improvements to be made in relation to the health care system's treatment and hosting of people who use drugs; Dr. Hemmerich, for instance, speaks to the need for more education to be provided to workers healthcare settings:

People are still being treated poorly in emergency and in hospital with a lot of stigma. And there needs to be so much more education for the healthcare providers, to start to change that. I feel often very upset for my patients, how they've been treated. (Dr. E. Hemmerich, personal communication, August 13, 2020).

Here, then, we see played out, in accounts describing interactions (or lack thereof) with emergency medical and hospital services, the enactment of stigma on multiple systemic levels. The accounts of stigmatization are in many cases so strong that they discourage people from accessing medical services. Work is clearly needed to transform the hospital, along with other health services, into spaces of acceptance for people who use drugs.

3.1.6. Stigma in Policing, Civic Services and the General Public

Stigma was also seen to be present in social systems such as policing and in civic services related to downtown, as well as in a culture of rejection expressed by the general public. Often the references to stigma were related not only to substance use, but to

homelessness:

What I've been going through in the last week is... the system and the stigma behind it, it's horrifying. Walking down the street today. Staggering down the street, and it's not cause of booze, and I got picked up by these RCMP girls. Mean well, I guess. But they also need to keep their jobs. (Anonymous, personal communication, November 2, 2019).

This participant speaks to a kind of routine targeting of people who are non-conforming; people who look or act different; people who 'stagger'. This targeting is seen by some to be part of the ongoing work of the RCMP; as almost a make-work project. Others echo this view:

I spent this morning with the cops. Cut me off in a wheelchair and then blaming me for all the stuff and not recognising I got a broken leg, I'm in a wheelchair (Barry, personal communication, November 2, 2019).

I've experienced, not recently, but in my past, I've experienced years of years of abuse from the police. But yeah, I still hear the same abuses going on. (P. Sture, personal communication, November 2, 2019).

Not only were police often seen to hassle people who use drugs (especially those who also are without homes), they were seen by one participant, at least, as largely unhelpful in pursuing any kind of justice on behalf of those same individuals:

You can be guaranteed that the cops aren't going to lift a damn finger to try and track down somebody who trashed your homeless person camp. Because in their eyes, they're like, well, good, whatever, maybe they'll smarten up or something or go away. (E. Mayoh, personal communication, October 11, 2019).

Here, then, we see articulated an unjust relationship between the participants with lived experience and the police – a relationship characterized by a type of badgering on the part of the police, and by an unwillingness to play a legitimate law enforcement role when needed.

Similar stigmatized interactions to those attached to police were acknowledged in relation to civic services – particularly those located in the downtown core. Participants with lived experience spoke extensively about the difficulties they've had in accessing such fundamental services as water, a washroom and power supply, as well as a place to camp. A reduction in, or retraction of, these services was seen to present a clear message to those who use them:

> **The [washroom] in Lewis is only open for the summer, they already locked it. They never open it in the winter period, because baseball is over.... Yeah, there used to be lots of little hose tap things, but they're systematically removing them, either straight up, or they're taking the little wheels off, or they're putting lockboxes around them, so you can't even get access to water. And it's like, wow, really? Like, I get being really, really vindictive, and you know, shutting down your external outlets, so that, like, we can't even charge our phones. And you know, that's like, 2000 milliamp hours, it's nothing. They keep their business lights on all night, every night. And that's orders of magnitude more energy than, you know, a couple of people plugging their damn phones in for, like, half a charge is gonna ever be on them. So they're removing power outlets, they're locking up the stuff that they threw away because they didn't have a use for and didn't want any longer, and they're taking away water access. And it's like, wow... And then on top of that, they're displacing people constantly. And they're turning the Valley into less and less of a beautiful place in order to do it, because they're ripping out the little nice wild spaces and pockets and stuff that you find scattered around...Is it really worth you know, completely clear cutting the valley's natural beauty in order to get rid of them? .... (E. Mayoh, personal communication, October 11, 2019).**

Participants did show appreciation for the accessibility of several key services: the rec facility showers and the soup kitchen, for instance, were acknowledged by Evan as "pretty decent" (E. Mayoh, personal communication, October 11, 2019). Overall, however, we see a picture emerge wherein civic services are perceived as becoming increasingly inaccessible. The act of limiting and/or diminishing access to public services like washrooms, water, electricity and/or places to camp, sends a clear message to people who use drugs and are unhoused – 'you are not valued; you are not wanted here'.

Finally, participants with lived experience spoke at-length about the stigmatization they received from the general public – often in relation to their perceived homelessness or joblessness. The following quote demonstrates troubling acts of aggression and discrimination enacted by Comox Valley public in relation to people who use drugs and/or are street-involved:

[Anonymous PWLLE] and I were in a tent three weeks short of a year. We got so much flack from people that would know where we were behind Walmart for about eight months. And then we went out to Fanny Bay to a place which was not

good. We went with a landlord that's known notorious for being a slumlord and such. But we took the chance hoping that he'd fulfill you know, the basic necessities, but we didn't even get that. We didn't even have running water. We didn't have windows and such. So we moved on to the pump station. Comox Road. We'd have people drive by honking their horns and calling us awful, awful people and how we were disgusting and we should get a job. And you know, that would make everything right I guess, having a job. (L. Chapados, personal communication, October 20, 2019)

And Evan speaks to a game he plays that demonstrates the extent of the stigma he faces on a daily basis:

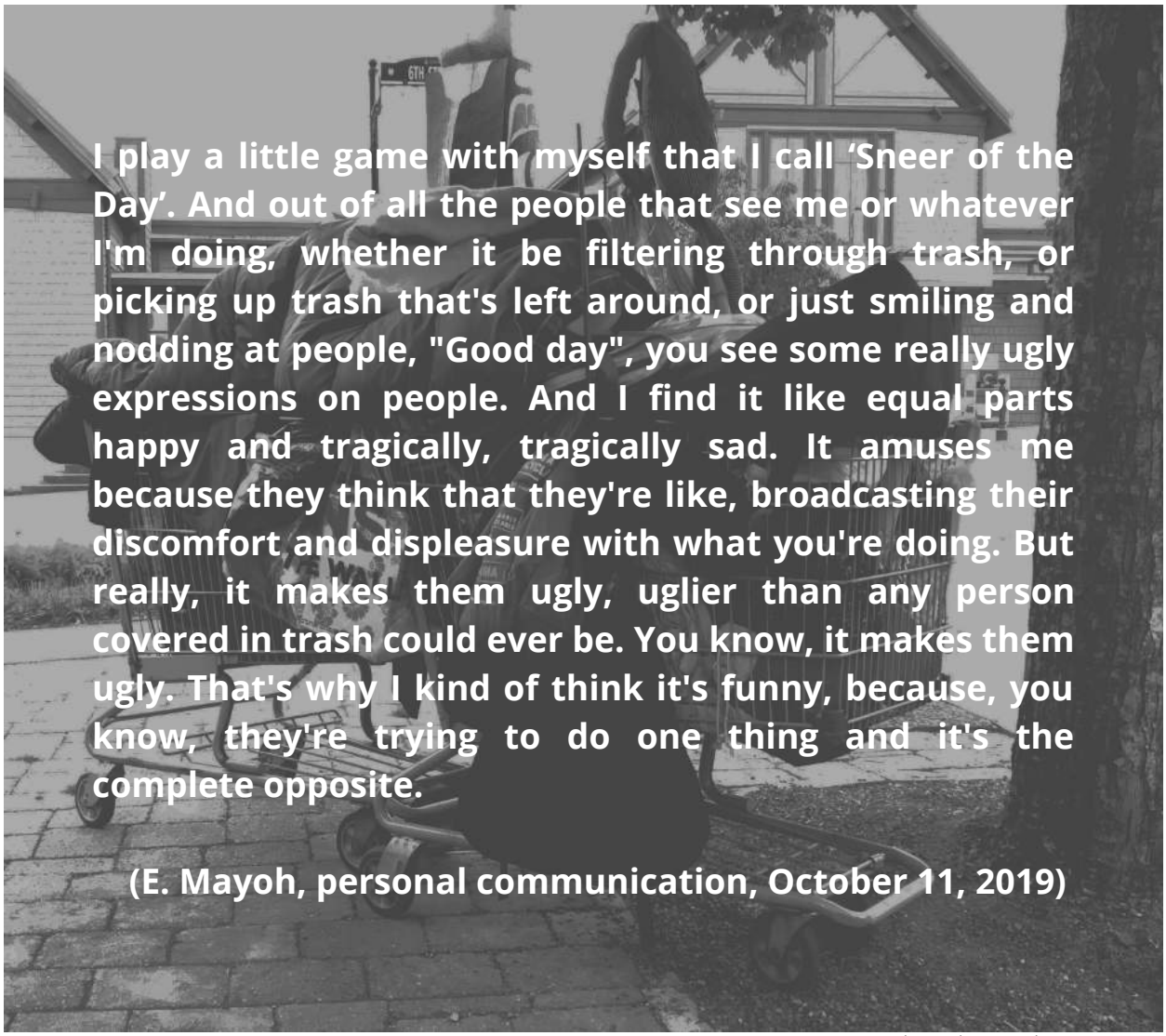


Photo by: Nadine Bariteau

Here then, we see the multiple ways in which people who use drugs and are homeless are stigmatized and dehumanized – within the health-care system, policing, civic services and by the general public – through overt, subtle and systemic acts of discrimination. We've witnessed accounts in which people with lived experience are provided substandard medical care, hassled by police, stripped of access to essential services such as water, and derided, or 'sneered at' by community members – all of which was seen to have profound negative impact on individual and community health and wellness.

3.1.7. Racism

Up to this point, we've received stories of stigma generally, as related to people with lived experience of addiction and homelessness. It is important to note, however, that for many Indigenous participants with lived experience, these acts were often seen to include elements of racism. Many participants spoke at-length to instances of racism they had faced within the medical system, including being denied quality care in hospitals, and dismissed by front-line medical staff as 'drug seeking'. As a participant with lived experience observes:

"Just last weekend, I was told, or I had overheard that I'm there [in hospital] for the drug use. And I'm not, I just want to know what's going on with my body … the racism will never stop. (Anonymous, personal communication, March 8, 2020)

Indigenous participants shared, as well, stories similar to a story shared earlier, of being 'let go' from hospital, often in the middle of the night with no transportation options, often in winter; and of being offered substandard medical service:

This discrimination - having to walk home from the hospital. Asked for cab fare and they said "No, we don't hand those out anymore". And it took us three and a half hours to walk home. My daughter had a back injury. I didn't even have my walker with me. We walked all the way down Ryan Road in the dark, make our way home and it's like, I live at the junction. (Mama Bear, personal communication, March 8, 2020)

This lack of care on the part of the health system, especially as related to the ways in which patients are discharged from hospital, was raised multiple times by Indigenous participants. The risks of uncoordinated and abrupt discharge were seen, by most, to be unacknowledged by those in positions of power. An anonymous outreach worker notes the devastating consequences such release can have for Indigenous Women:

For Indigenous women, when they're put out on the street like that, they put them at great risk. We are in the midst of a crisis involving missing and murdered Indigenous women, and to have women out on the street like that, in the middle of the night is really dangerous. I think there needs to be a lot more cultural training and cultural competency training, when you're going to send somebody out in the street. Know their vulnerabilities and what you're putting them at risk for (Anonymous outreach worker, personal communication, March 8, 2020).

In these accounts we are presented with a system that fails, in many cases, to provide essential care to those who seek it; that compromises human dignity, and that fails to take into consideration the cultural context in which people are seeking care.

3.1.8. Loss of Trust – The Impact of Residential School & Inter-generational Trauma

For many Indigenous participants with lived experience, the stigmatization and racism residing within the present-day medical system was traced back to histories of colonization, including to the legacy of Residential School and its resulting intergenerational trauma. The following account, delivered by Elders who had been forced as children to attend residential school, provides important context:

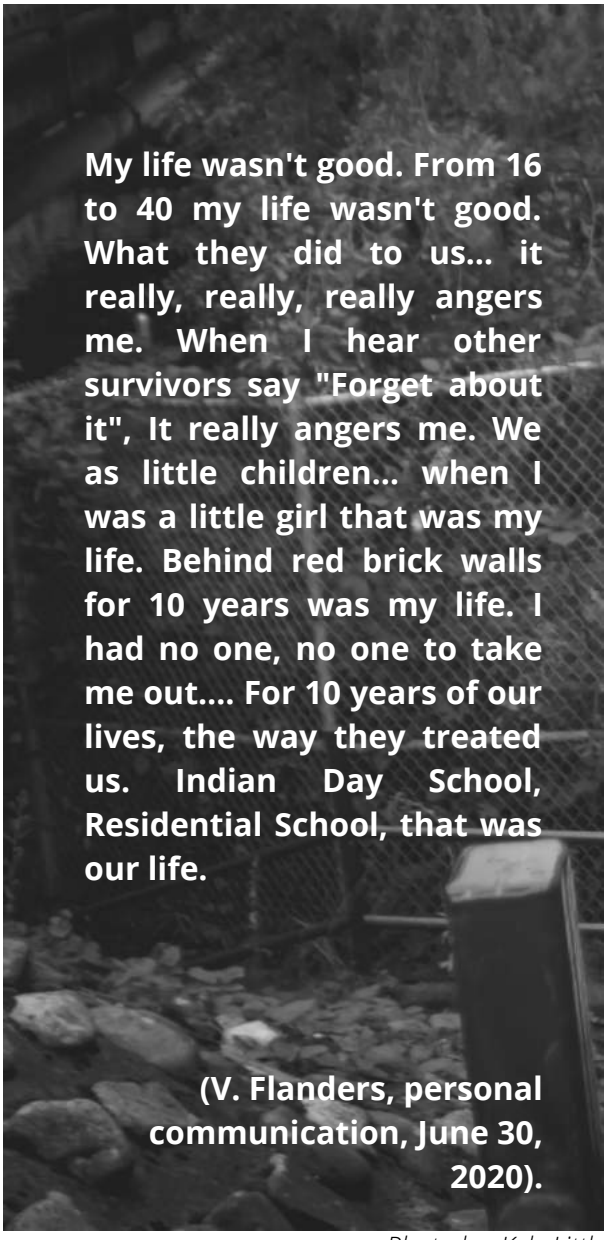


Photo by: Kyle Little

In this account, we are asked to consider the history of oppression brought about by systems of colonization. Such a history has led, in the view of several participants, to a profound distrust in contemporary social, medical and judicial systems:

> **We don't trust them. In the school system, in the hospitals. We don't trust the judges and the lawyers and the cops. We don't trust anybody. The only people we trust is ourselves and they don't seem to get it, because they gotta earn our trust. "Well you've gotta trust me Verna." I said "Never! Never. I will never trust anybody ever". Especially a cop or a doctor or a nurse. They've done wrong to all of us First Nations people, all of us. None of us escaped it. None of us. (V. Wallace, personal communication, June 30, 2020).**

In these powerful words, we see demonstrated the impacts of colonization and dehumanization imposed by Residential School and continuing through generations into the present-day structure of medical and policing systems. In the unthinkable acts of violence and cultural genocide these institutions imposed, we see their systemic production of racism. The trauma inflicted on participants through this legacy was seen by some to enact realities in which depression and dispossession were considered a 'norm', and in which drug dependency was considered a logical escape. As one young participant states:

The thing is, if your natural state of mind is something that's depression, you're gonna want to alter. Alter your brain chemistry and get high and just feel different than depressed. So almost everyone I know has done drugs, or is doing at least something, whether it's drinking, weed or hard shit. (Anonymous, personal communication, March 8, 2020).

Here we are asked to consider the ways in which colonial violence is passed down through generations of families, and in which colonial logics continue to be re-produced within contemporary institutions – whether they be medical institutions, justice institutions, etc. Colonialist histories can here be seen here as implicated in both the distrust held by many Indigenous participants with contemporary health and social systems, and of the racism enacted through these systems.

3.1.9. Cultural Safety, Cultural Knowledge

A response to these systems of colonization and racism as embedded within the health care system is found, according to one participant, in a radical uprooting of existing health care, such that an acknowledgment of the importance of alternative Indigenous ways of healing can occur:

When we go to the doctor, we often don't get offered alternative medications, like different therapies or more holistic, nature-based healing, traditional land-based healing. A lot of times, it's "here to take this pill and go fill this at the pharmacy". There's really very little follow up care. Just check in with your doctor type thing, and they might give you more medication. But I think we need to

look at health in a more holistic way. (Anonymous outreach worker, personal communication, March 8, 2021).

This quest for holism was equated, by some, with the restoration of 'old ways' of healing; ways that have been used by Indigenous communities since time immemorial:

We need to go back to some of the natural healing ways, the old ways, to bring balance. There needs to be balance and healing from all the trauma that people have experienced. So, when we go to the doctor, or we go to the hospital, we need to be offered cultural healing ways, not just a medication. (Anonymous outreach worker, personal communication, March 8, 2021).

Several participants spoke to the medicine wheel as a key symbol of multi-faceted healing – of a kind that takes into consideration not only the physical, but also mental, emotional and spiritual dimensions of a person.

Through these accounts, we begin to understand something about the link between colonial systems of oppression, intergenerational trauma, and the racism encountered by Indigenous participants within present-day medical systems, and in relation to the drug poisoning crisis in particular. We are asked, through these stories, to see addiction not as an 'individual' issue but as one rooted in collective histories of colonialism, oppression and racism.

We are invited, through these accounts, to consider ways in which our biomedical system, whose focus lies primarily in western notions of health, might be altered to accommodate the wisdom of ancient Indigenous healing systems, and of multi-modal understandings of health and wellness – leading to more equitable and compassionate, and less stigmatized and racially-biased, systems of care.

3.1.10. Signs of Change

Against the backdrop of the stigmatization and racism attributed to these systems, some participants offered hope that systems are, slowly, changing. Dr. Kindy speaks to the ways in which the medical system at-large is being re-conceptualized in the wake of the drug poisoning crisis:

What I'm seeing, the big difference from 20 years ago to now, is we're actually treating it [Opioid Use Disorder] as a disease, which I think is fantastic, right? So more resources are applied to try to treat this disease. I think the stigma is still there, but it's being talked about, which I think is a first step to try to get rid of that stigma. And I'm seeing the medical community changing. I mean, there's always people that will not change, because they're so ingrained in their way of being. But what I'm seeing is a lot of the new physicians are being trained in addiction, and they're much more open to the idea that it is a disease. And they're treating, hopefully, people with substance use disorder in a more

respectful way. I'm seeing that more…. And I'm seeing more resources as well put into the system to improve the situation. (Dr. A. Kindy, personal communication, September 9, 2020).

Dr. Hemmerich echoes this hopefulness, pointing to new movement in the healthcare system designed to reduce stigma:

We have a family practice residency program here in the Valley, and we're going to take on residents into our clinic. We have an addiction medicine consult service now at the hospital for the past year. It's also really positive for reducing stigma in hospital to patients (Dr. E. Hemmerich, August 13, 2020).

Some noted that there have been marginal gains in recent years within the healthcare system at large, and within community-driven outreach, in acknowledging and combating racism and stigma, however, most emphasized the need for much more progress to be made.

Programs like Unbroken Chain – Indigenous Women's Sharing Society's Indigenous harm reduction program, were seen to provide a unique model. This program provides culturally-informed ways forward, including harm reduction supports based on Indigenous practices and principles of harm reduction that support the whole community:

We do it in a holistic way. We're meeting people where they're at, building connection is basically the foundation of it, and I think that goes a long way. When people feel supported, they can heal. I haven't seen any other way to do it. (P. Alvarado, personal communication, March 8, 2020).

Acknowledging these 'glimmers of hope', it is clear that much work remains to be done - to re-imagine, and re-develop a response to addiction that embraces multiple ways of knowing and understanding. Such a system must have at its core a fundamental respect for those facing this crisis first-hand, as well as the inclusion of alternative, holistic and culturally-informed healing practices.

3.1.11. Summary

In this section, we've explored multiple ways in which people at the heart of this crisis – people with lived experience, family members and front-line workers, experience the crisis in the Comox Valley. We've received first-hand accounts describing, from various angles, the destructive impact of fentanyl as it has entered into the street drug scene in the Valley; but also the impacts brought about by the 'complexification' of the drug scene through the mixing of drugs. We've received first-hand accounts of drug poisoning, and have learned about the heightened levels of threat and trauma that people who use drugs often live

with on an ongoing basis. Furthermore, we've received stories about ways in which stigma and racism are played out in the Valley – through systems such as health and criminal justice, and as activated within the general public. We've received accounts of the ways in which people are cared for (or not), within these systems – with many speaking to their experiences of care as steeped in stigmatization and inequality. While some glimmers of hope exist, in which health and social systems are being seen to embrace progressive understandings of substance use, much work remains to be done - to combat histories of stigma, oppression and racism, and carve out an approach to addiction that is both trauma-informed and culturally safe.

In what follows, we look at some of the 'big system ideas' that have emerged as solutions to this crisis – including notions of 'decriminalization' and 'safe supply'. We show how participants in the Comox Valley interact with, and think about, these concepts, and how they might be taken up by local systems of change. We then move into a discussion of the landscape of services provided within the Valley (those directly related to addiction) including identifying some key gaps and opportunities within this community's service provision ecology. We augment this analysis with an exploration of the 'upstream' services (those playing a determining, rather than direct, role in addiction). We end, finally, with a series of recommendations that build on the knowledge gained through this research.

3.2. Decriminalization & Legalization

As our province and nation grapples with the drug poisoning crisis in its multifaceted dimensions, many have pointed to the need for policy reform – specifically, for the decriminalization of minor amounts of drugs for personal possession, as a way to make traction on, and reduce the number of deaths enacted by, the crisis. By decriminalizing substances for personal use, the drug poisoning crisis becomes recognized as a public health crisis rather than a criminal justice crisis – an important shift in enabling those most impacted to come forward and seek help. Section 2.3.6 of his report provides a history of this movement towards decriminalization within the Province of B.C. In what follows, I augment this history by outlining some of the key positions held by participants in relation to decriminalization.

The majority of participants in this project, including people with lived experience, family members and front-line workers, supported decriminalization as a viable step forward in addressing the crisis, with many moving a step beyond and advocating for legalization. Indeed,

Barb and Louise
Photo by: Nadine Bariteau

criminalization of substance use was seen as a key generator of stigma – for people who use drugs (generally), and especially for those whose professions require public accountability:

There's a lot of drug addicts that hold full time jobs, quite awesome professions. Nurses, I know a lot of nurses that do a lot of hard drugs, you know, inject them...And I know lawyers and cops, and once the stigma gets dropped, and the fear of it being a criminal thing gets dropped, then you'll see a lot of people come out of the woodworks and admit that they're shooting up, or they're addicted to this drug or that drug. And you wouldn't have expected it, and they were always using by themselves, hiding it from everyone...they're probably more at risk than those on the streets, really. (S. Franey, personal communication, July 9, 2020).

In this view, the decriminalization of substance use would go a long way in mitigating the shame and fear people who use drugs have in relation to seeking help.

A second perceived benefit of decriminalization pertains to the increased influx of funding to be gained towards treatment and harm reduction as a result of the diminishment of criminal prosecution costs:

We need to quit wasting all the tax dollars, the billions that we spent fighting, that changes nothing. And the costs of incarceration. Because there's so many supports, and mental health issues, and homelessness that aren't funded And we spend all that money trying to change something that will never change. (E. Mayoh, October 19, 2019).

Through decriminalization of substances for personal use, not only is money made available to re-allocate into the health of substance users, the net benefits to society are seen as immensely positive. An Anonymous PWLLE states:

In my mind, I think if more drugs were legal, and regulated, I think you could lower the amount of people that are actually becoming addicted. There's countries in the world that have gone that way. And they legalized certain hard drugs, and the amount of people addicted didn't go way up, it went down. And they had better treatment and better mental health care. (Anonymous PWLLE, personal communication, November 9, 2020).

Legalization, specifically, was recognized by participants for its ability to reduce organized crime associated with drug use. Family member John Hedican shows such crime as fuelling the drug poisoning crisis, and positions legalization as a logical response.

I think we need to remove organized crime....Drugs and alcohol are part of life. We need to change how we view that, and how we support it. And we have to talk about the source that is killing thousands and preying on the most vulnerable in our society. And it's organised crime. (J. Hedican, personal communication, July 14, 2020).

A similar view is echoed by Dr. Kindy:

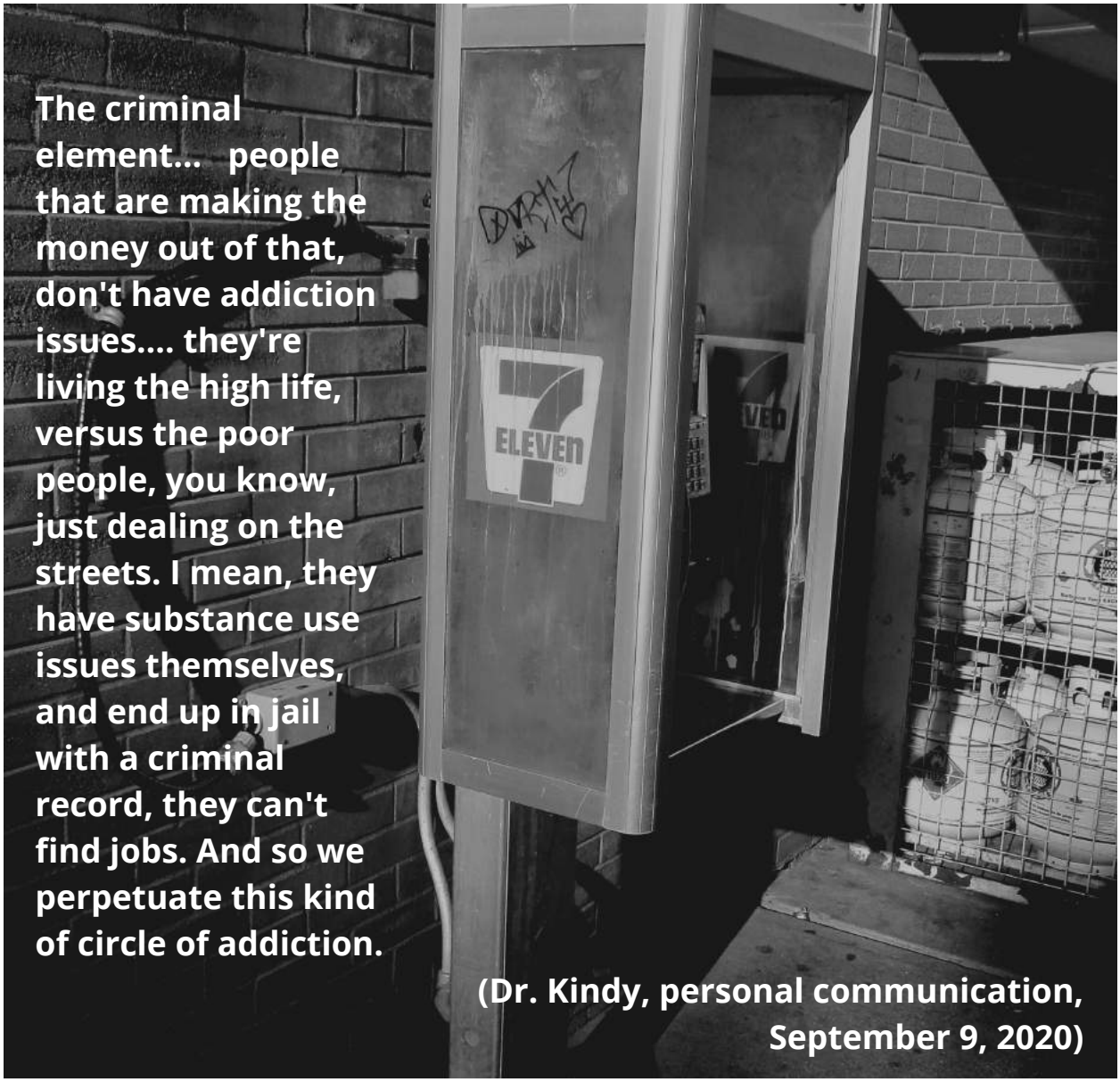


Photo by: Daryll

By legalizing personal drug use, organized crime is essentially 'cut out' of the drug market equation, resulting in more equitable systems of treatment and care. Through this act, the 'circle of addiction' (which allows organized crime agents to benefit from the drug needs of people who are addicted, and often living in poverty), is broken.

This move to decriminalize, and going one step further, to legalize, was positioned by many as the most important action that could be taken in order to save lives:

You know, legalize everything, decriminalize. Provide clean dope, monitored, witnessed, whatever, but start saving lives. (Trigger, personal communication, March 18, 2019).

3.2.1.Summary

Amongst the participant group at-large, decriminalization (and legalization as an extension) was acknowledged as a viable response to the drug poisoning crisis. The act of decriminalizing drugs for personal use was associated with de-stigmatization, and the consequent enablement of people who normally hide their addiction to seek help. Legalization was touted as a way to reduce organized crime, and the kinds of injustices associated with the incarceration of poor people at higher rates than the wealthy. It was championed as a way to enact widespread shifts in our society's conception of people who use drugs.

3.3. Safe Supply

As with 'decriminalization' and 'legalization', 'safe supply' was acknowledged as a logical and necessary response to increased toxicity in the drug supply. As Dr. Wilson observes: "fentanyl in the system has been a game changer as far as killing people. So, clearly, a safe, clean drug supply is critical... without that... we're gonna be faced with ongoing deaths" (Dr. R. Wilson, Personal Communication, September 5, 2020). Not only was safe supply seen as important in keeping people alive, it was also acknowledged as a key factor in enabling people to stabilize their lives to the extent that they could seek treatment

You have got to have that safe supply first. And then once you got the people on the safe supply, then you can talk about weaning them down, getting into programs... It's a lot of effort of pounding the streets to come up with that 20 bucks, four or five times, or how many times a day. You know, it's a lot of work...and a lot of walking across town. From this side of town to that side of town, to this side of town to that side of town. And it takes up just all of your time (P. Sture, personal communication, June 30, 2021).

This stabilizing effect was seen to enable people to move beyond a perpetual search for supply, and into a viable treatment domain.

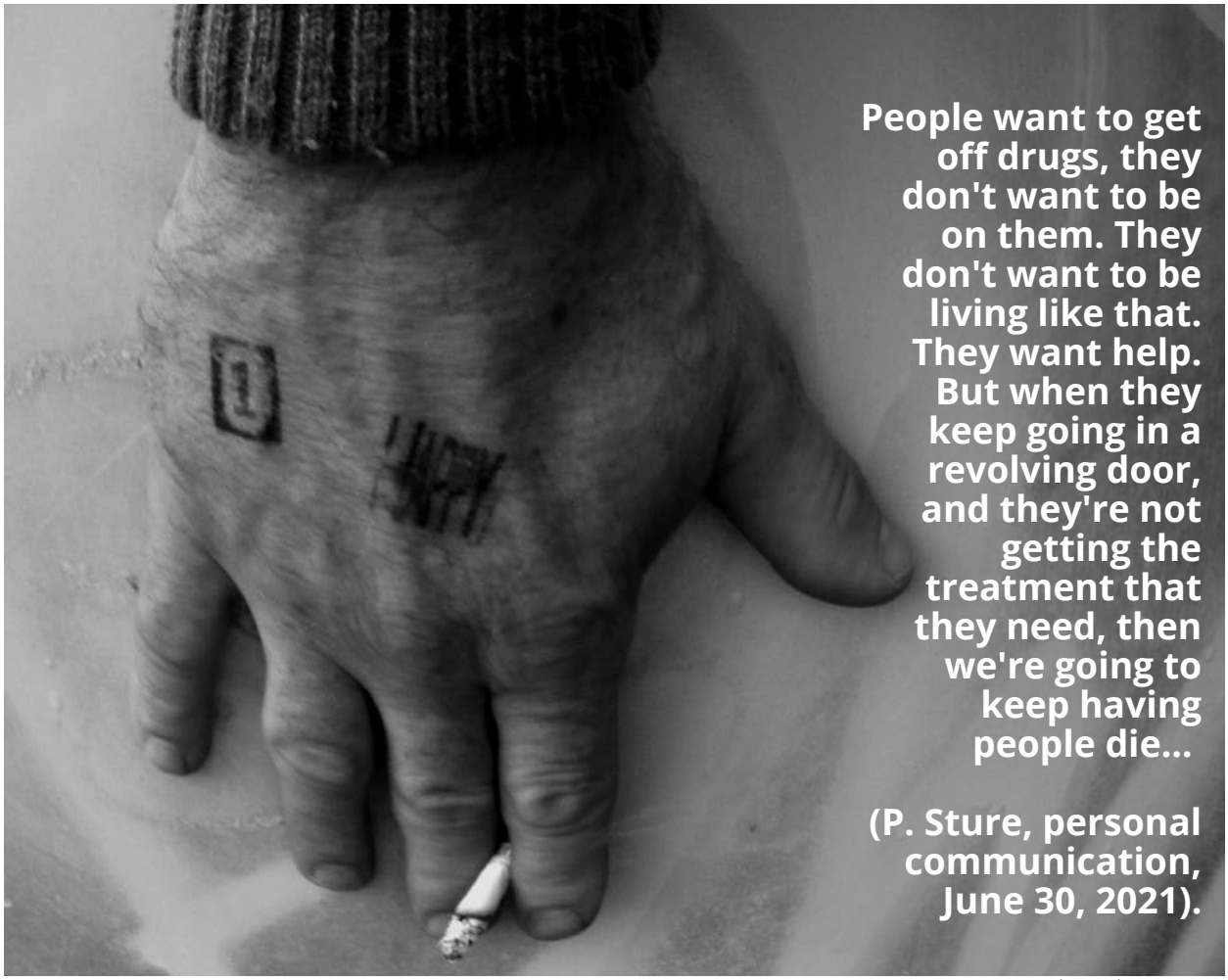


Photo by: Trigger

These comments summarize what many participants feel as a key benefit of safe supply – its ability to save lives by reducing the risk of toxic drug poisoning while at the same time stabilizing users – allowing them to move away from the often-relentless task of seeking drugs through street-based channels, and enabling them to seek help.

3.3.1. Safe Supply - Barriers

While safe supply was widely seen as a necessary agenda in combating rising drug poisoning rates, various participants expressed frustration with the pace at which safe supply is being unrolled in the Comox Valley, and at the hurdles they encountered in accessing it – as well as Opioid Agonist Therapy (OAT):

Sending someone on a wild goose chase, trying to get safe supply or speak with a psychiatrist, psychologist or something, is not good. That's what it feels like if you've ever walked somebody through that process, it's like a wild goose chase. You go from one building to the next and you end up just feeling, you know; you're like a cattle being shot through. It's

ridiculous. It's not effective, and I think that creates trauma in itself. (Anonymous outreach worker, personal communication, March 8, 2021)

Many of these barriers stem, according to an anonymous outreach worker, from the reluctance of local physicians to prescribe safe supply:

A lot of doctors here are really scared about just prescribing freely and so people still need to jump through a lot of hoops. There are a few cases that we've heard of that people are accessing safe supply, but it's not across the board. Not like in other places where people are really able to access safe supply, in a way that's easy, and with not a lot of barriers. But here, it's very tricky. (personal communication, March 8, 2021).

The feeling of 'hoop-jumping' was also echoed, it should be said, in relation to people attempting to access Opioid Agonist Therapy:

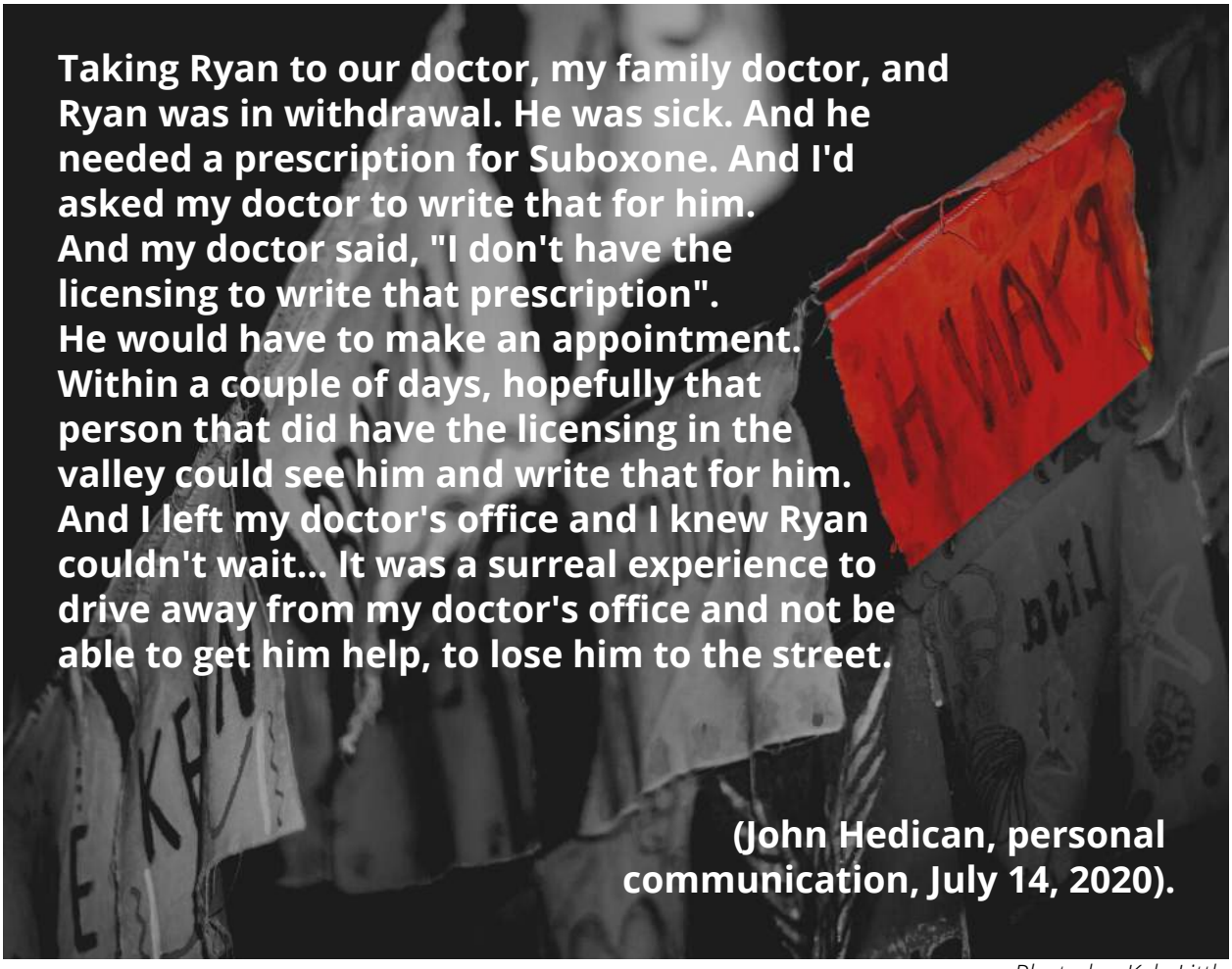


Photo by: Kyle Little

Similarly, a PWLLE speaks (in vivid detail) of the physical experience of withdrawal, and of the frustration she encountered when attempting to access OAT:

> **What they did when I came to the hospital, and I was five days off methadone, no, four days, four and a half days off methadone. And I said I had no way to get to my methadone, and I called them and told them "Hold my prescription. I will be there today". They did not. My doctor was away on vacation. Doctors in Campbell River, they only come here once every two weeks, sometimes once a month..... She therefore could not be reached. So my methadone script was kaput. And doctors as of now do not have the power to rewrite scripts. Only methadone doctors have that power. So I went to the hospital. I was withdrawing off of 80 milligrams of methadone. Severe withdrawal. Puking. Shitting. Shaking cold. It was horrible. My mom was scared. I was scared. They put me in emergency. I was in emergency for four and a half hours. I finally got in to see someone. They said "maybe we can give some Suboxone". The problem is if they put me on Suboxone, then I won't be able to get my methadone script back. And this was on a weekend, and then Monday was also holiday. So I might be able on Tuesdays, that was two days I'd have to wait two days to maybe get a methadone script (B. Mills, personal communication, March 18, 2019).**

These eye-opening accounts speak to both the difficulties people who use drugs face in accessing safe supply, and the barriers placed in front of people who are withdrawing from substances and need immediate access to Opioid Agonist Therapy. In both instances, the medical system is seen as slow to respond to people who need services, and in some cases as enacting systemic barriers for those seeking to 'stabilize' – a situation especially difficult for those withdrawing from drugs and in a state of physical and psychological duress.

While these accounts highlight the need for a more streamlined approach to the prescription of safe supply and OAT, it is worth showing the arguments made by physicians for caution with regards to the prescription of safe supply. Both Dr. Kindy and Dr. Hemmerich point to the history of opioid over-prescription by the medical establishment as cause for caution:

> **It started off with... methadone, that was all that was available. And there was oversight by the College [of Physicians and Surgeons of B.C.]. And maybe for about 10-15 years, prescriptions for pain became a big thing.... so a lot of physicians were prescribing opiates for pain. And some of these patients that were prescribed opiates for pain ended up being dependent on their prescriptions. And the College was overseeing the whole thing. And unfortunately, it wasn't the physicians or Big Pharma that actually came and said, "Hey, we're doing something that's not proper for patients, some patients are actually being harmed with these prescriptions". The College finally went, "Oh, maybe we're not doing the right thing". But their approach was completely wrong. So what the College of Physicians did is, basically... the patients that were getting prescriptions could no longer get prescriptions from their doctors, because the College came down on those doctors. So did the doctors do the right thing to start off with? You know, that's debatable, but at that point, the wrong thing to do was just to stop. And so what happened was people that had dependency on opiates went to the streets...so it magnified the problem.... so suddenly, we had people that had started with heroin. We had people that had prescriptions that ended up going to the streets, and were doing heroin.**
>
> **So now, fast forward to the last, let's say, few years... fentanyl came on. The College basically withdrew from the oversight. So there's no more College monitoring, which I think there's the good and the bad. Meaning that we have to remember that opiates, by themselves, are not safe. And with the nature of addiction, we have to have some monitoring. So if we start prescribing without monitoring, we cause harm... there's a push now to prescribe opiates without monitoring. And part of the issue with that is... you might be able to help a certain segment of the population but then also you're causing a lot of harm. (Dr. A. Kindy, personal communication, Sept 9, 2020).**

The key fear identified by Kindy in this account relates to the harm caused by an approach to prescribing that removes or diminishes oversight for both physicians (by the College) and patients (by their physicians). A similar fear is echoed by Dr. Hemmerich:

Well, I think most doctors are uncomfortable with that responsibility [provision of Safe Supply]...we're barely comfortable. We want to support, we'd rather them take it obviously, than buying carfentanil and overdosing. But yeah, doctors... we used to prescribe opioids, and we were part of the problem getting people addicted, because they were in chronic pain. And we thought nobody should be in pain, opiates take away pain. And then all of the sudden, the College said, 'you cannot prescribe this' and people just, you know, backed away and did not prescribe for their patients, they [patients] ended up using illicit street drugs because they were dependent..... To ask [physicians] to prescribe safe supply to somebody... who is actively using it just seems too dangerous, too risky. (Dr. E. Hemmerich, personal communication, August 13, 2020).

These candid views expressed by physicians provide a window into the rationales by which barriers to safe supply are being constructed, and by which participants are being systematically denied (or sent on a wild goose chase) in pursuit of this service.

To overcome these barriers requires, in Dr. Kindy's view, the development of systems of monitoring and oversight that are attached to safe supply:

I think what needs to happen is we need to set something up where there is monitoring. So it's not just, you know, safe injection sites, but it's also sites that provide medication for injection... You're going to be safer because it won't be contaminated. And if something happens, there's somebody there to help you. I'm totally for that. And if at some point you say, "you know what, I need help, I don't want the needle anymore"... Well, let's do this to help you. (Dr. A. Kindy, Personal Communication, September 9, 2020).

This view of safe supply as expressed by participant physicians, while acknowledging its role as a powerful life-saving strategy within the toxic drug crisis, calls for an approach to its enactment that also includes monitoring – of both physician prescribing and patient consumption practices.

3.3.2. Safe Supply Access

Additional issues, beyond physician hesitancy, were flagged by participants in relation to the roll-out of safe supply. Numerous family members and people with lived experience highlighted the fact that safe supply is available only to a subsection of the using population. Acknowledged here is the fact that a significant portion of people who use drugs do so casually, and are unlikely, given this reality, to access safe supply:

When I hear safe source, people are speaking to the chronic user.

They're not speaking to the adolescent 16 year old kid that's going to try for the first time. They're not speaking to the guy that hasn't seen his buddies, or the gal that hasn't seen her girlfriends. And they bring out a line of coke or whatever they bring out. And they're not speaking to the user that dies, like our son who relapsed, because they're never going to get a prescription. They're not going to do a safe injection site. So I struggle with that. (John Hedican, personal communication, July 14, 2020).

Furthermore, access to safe supply (as well as OAT) was seen as limited largely to opioid users – leaving a large segment of the drug using population underserved:

Heroin is the only substance that has another alternative like methadone. Cocaine doesn't have that, crack doesn't, all these other substances. So unless we address them all, we're not going to help us all. Right? How can we be honest with ourselves if we don't address everything, and everybody that needs support? . (Jennifer Hedican, personal communication, July 14, 2020).

This sentiment was echoed by Sam, who speaks from a personal standpoint about ineligibility for most forms of safe supply:

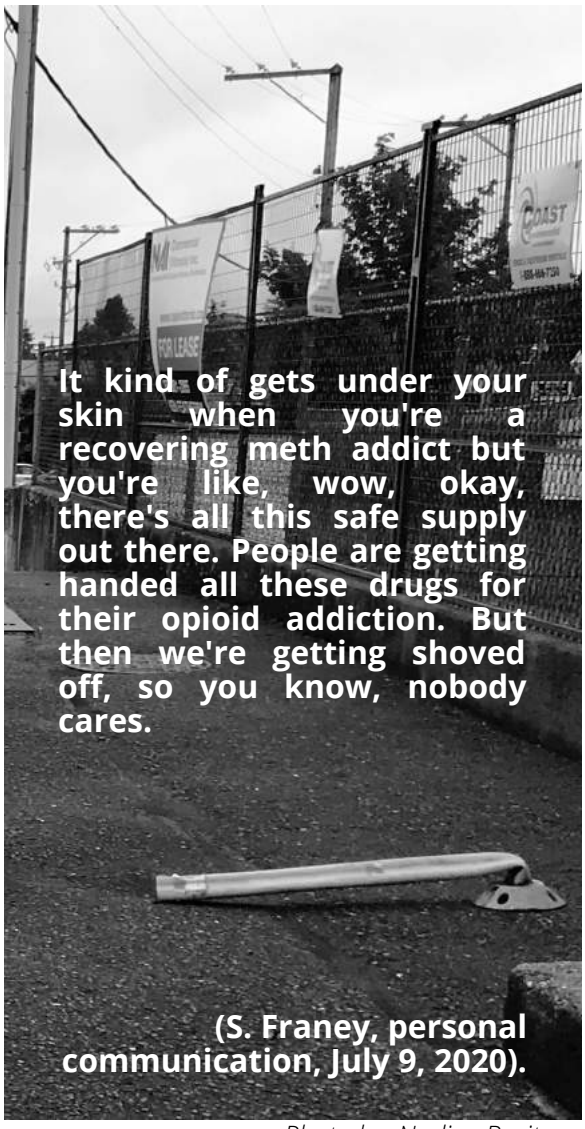


Photo by: Nadine Bariteau

While some physicians are, according to participants, starting to prescribe safe supply in response to addictions other than opioids (such as prescribing Dexedrine or Ritalin for Methamphetamine addiction), these prescribing practices are often

positioned on the 'fringe', rather than in the 'mainstream' of safe supply practice. People who use drugs other than opiates are often left 'in the dark' – unable to access safe supply.

These perspectives, considered as a group, bring to light a number of considerations to be made in the development and implementation of safe supply. They speak to the importance of structuring safe supply in such a way as to reduce the harm it causes through oversight and monitoring. They ask how safe supply/Opioid Agonist Therapy can be made accessible to more people – through increased licensing of physicians, the development of safe supply options for 'casual' users, and the development of prescription options for non-opioid users.

3.3.3. Summary

While safe supply was recognized by many interviewees as an important next-step in addressing the toxic drug supply, and while steps have been made by the provincial government to enable safe supply in the wake of the Covid-19 crisis, participants expressed a number of concerns surrounding the actualization of this concept. Work is needed to decrease the risk of harm caused by safe supply (through increased monitoring and oversight), and to make safe supply more accessible to people at different points of the drug-using spectrum.

3.4. Community Services (Downstream)

Up to this point, we've looked at the lived experience accounts emerging from participants in relation to the drug poisoning crisis as it is played out in the Valley, including at the stigma and racism participants encounter in their interactions with local support systems. We've also examined the views conveyed by participants in relation to the concepts of 'decriminalization', 'legalization' and 'safe supply' – interventions widely positioned as 'solutions' to the drug poisoning crisis. We've recognized a profound need for these interventions – also, however, the need to look closely at the mechanisms by which safe supply (in particular) is delivered so as to increase access, and enable its effectiveness through appropriate levels of monitoring and support.

Building on this discussion, the following section draws attention to a third tier of intervention designed to combat the drug poisoning crisis – identified by the term 'downstream community services'. These are services that have a direct impact on people who use drugs and are geared specifically to work with addiction

Within this category, participant insights have been divided into two distinct sub-

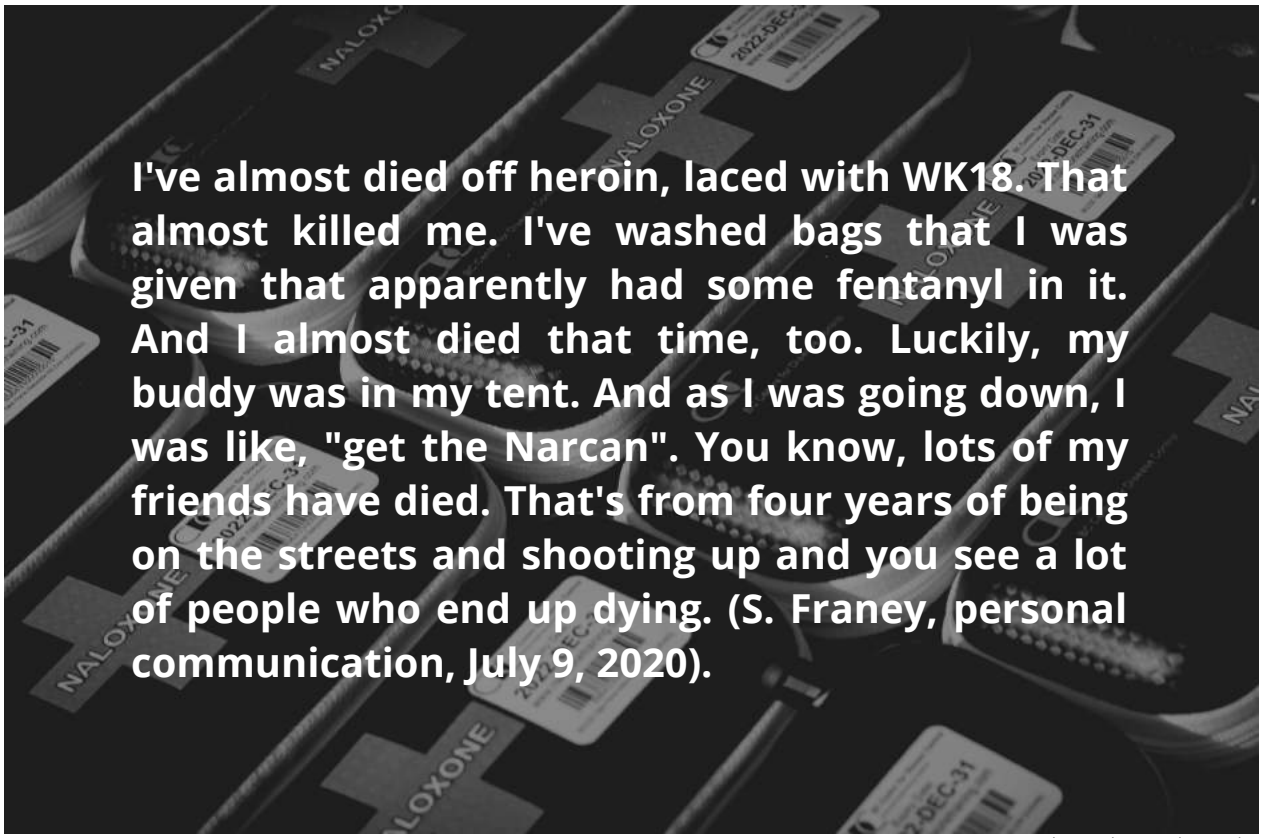
categories: Harm Reduction Services - those that attempt to reduce harm and prevent drug poisoning for people who use drugs; and Recovery Services - those that attempt to support people in reducing or eliminating drug dependency. It should be acknowledged that these categories are distinguished from one another for analytical purposes; in practice, they are often interwoven with one another, and together comprise a spectrum of service.

3.4.1. Harm Reduction Services

Harm Reduction Services are those offering a 'first-line' defence against the risk of drug poisoning. In what follows, we journey through some of the key insights offered by participants in relation to these services.

Narcan

Narcan (also called Naloxone), a drug responsible for reversing drug poisonings, has been distributed throughout the province as part of a provincial strategy to combat the crisis; and is seen as an important front-line strategy by many within the using community. Participants with lived experience provided numerous, often-harrowing and at the same time amazing, accounts in which Narcan had saved their lives.



I've almost died off heroin, laced with WK18. That almost killed me. I've washed bags that I was given that apparently had some fentanyl in it. And I almost died that time, too. Luckily, my buddy was in my tent. And as I was going down, I was like, "get the Narcan". You know, lots of my friends have died. That's from four years of being on the streets and shooting up and you see a lot of people who end up dying. (S. Franey, personal communication, July 9, 2020).

Photo by: Kyle Little

While Narcan as a drug poisoning response strategy was recognized as a key life-saving intervention, many participants cautioned against a reliance on Narcan as a singular solution. Narcan was recognized, for instance, as limited in its capacity to address an increasingly complex spectrum of toxicity as incurred through the mixing of substances. Additionally, it was recognized as limited in its ability to revive the 'whole' person after a drug poisoning. As Dr. Kindy (personal communication, September 9, 2020) states: "Once you've dropped, you've had a lack of oxygen. You've had a brain injury. Yeah, it's not like you get Narcan, you're back to normal". –While Narcan was seen by many as a key harm reduction pillar, many also cautioned against a commitment to Narcan as a singular solution.

Drug Poisoning Response Apps

Drug poisoning response apps were acknowledged by participants as providing an additional layer of protection. In the Valley, two distinct drug poisoning response apps have recently become available. The Lifeguard App, developed by the Lifeguard Digital Health and endorsed by Island health, allows people to signal, via the app, when they are using drugs. A countdown is started; when participants fail to signal responsiveness (via a 'button') prior to the completion of the countdown, emergency medical services (ie: ambulance/paramedics) are dispatched under the assumption that they are overdosing. The BE SAFE App, developed by a Vancouver Co-Op BRAVE, offers a Peer-designed digital drug poisoning prevention service. Users are monitored by phone agents responsible to trigger participant-developed safety plans should they become non-responsive. This system is seen to provide people who use alone with an additional layer of supports:

One of the major reasons why people are dying, is because they use alone. That is the main reason. That's why phone apps like Brave, will be very helpful and more effective than apps which have been previously invented. Because it allows for the community members to also connect, and play an important part in a life-threatening situation. You know, with the Brave App, we no longer have to depend on the first response, which takes 15-20 minutes in the Comox Valley, as some people could get to the scene in only 5-10 minutes (D. Bryzgalski, personal communication, March 8, 2020).

These apps were acknowledged by some participants to provide an important layer of protection – especially for people who are not able or willing to use drugs with others.

Drug Testing

Yet another layer of protection was identified by participants in drug testing. Currently available in the Valley, through

local outreach agencies, are test strips that indicate the presence of fentanyl, carfentanil and benzodiazepines. While these strips were seen as an improvement over nothing, they were also seen to harbour significant limitations – namely, in the fact that they only test for the 'existence' of these substances (ie: yes or no), and not for 'quantity'; also in the fact that they do not test for other harmful substances beyond the ones mentioned. The need for comprehensive drug testing (through, for instance, a mass spectrometer – a testing mechanism that produces a rigorous assessment of drug composition) was flagged by an anonymous outreach worker:

It's a little extra ask, that it be full spectrum testing. Because the types of strips that we have, and the OPS have are just fentanyl or carfentanil or not. So we test dope when people come in, but it only indicates that tiny group. So with full spectrum testing, a person can bring their stuff in and see exactly what it is. And it's just a money thing, like there's no funding or whatnot for it. And those strips that we carry, and we will test - it's like yes or no, but it's not really telling somebody what else it could be. So yeah, I feel that's a really crucial part of the testing. (personal communication, March 5, 2020).

The advantages of full-spectrum testing were acknowledged by multiple participants with lived experience:

Not only is it [full spectrum testing] going to save individual lives, but people are going to start figuring out like, who constantly has an inventory full of stuff that's tainted with things that they didn't warn you about or tell you about (E. Mayoh, personal communication, October 11, 2019).

While the cost of full spectrum testing equipment has been seen as prohibitive in some small and rural communities, the purchase of such equipment for the Comox Valley was recognized as a key pathway forward in reducing drug poisoning deaths. PWLLE Dawid Bryzgalski shows speaks to the new-found need for such testing in an era of toxic supply:

From my experience, in 20+ years of using, we had never heard of "drug testers". I mean sure, they were available and used by doctors and staff at detox, rehab and other clinics, but never for use or dispensed amongst patients. Back then everyone was dropping dead from the purity of the heroin, but now people are dying because of the toxicity in the "street dope", they really haven't got a clue as to exactly what they are shooting into their veins today.' (personal communication, March 8, 2020).

According to Bryzgalski, the failure to implement a comprehensive testing system spells disaster:

If this crisis keeps progressing, is here to stay, and we don't provide our children and youths' in our community with "drug testers", "clean dope", and plenty of great safe injection sites, then we're basically sending them to a "death drop". As one day the "street dope"

will be spiked a little bit too much, and they will "drop", as many, many of my friends died, some in my very presence' (D. Bryzgalski, personal communication, March 8, 2020).

Here, then, we see emerge a call for more comprehensive testing strategies to be implemented; and an acknowledgement of full-spectrum testing, in particular, as an important 'layer' of protection in the wake of rising drug poisoning numbers.

Harm Reduction Service Providers

Participants across the board acknowledged the role of drug poisoning Prevention Sites generally, and the OPS site formerly hosted by AVI (currently hosted by Island Health), in stemming drug poisoning deaths, and in connecting people who use drugs to 'wraparound' services. Participants expressed a desire for more OPS services dispersed throughout the Valley, and for an extension of OPS hours and services:

I love AVI, AVI's a great place, people are great. I think we need those services here. I think it would be great to have an [OPS] tent or, maybe a bus or something. I think to maybe make those hours longer, or put something in on another side of town. Because for a lot of people, they live in different places all over the Valley and to get those harm reduction supplies is hard. I know for me, I live all the way up on Mission Hill. Sometimes if my dealer's over there, I use the same fucking syringe four times in a day because I can't get over here. That's not good. I can't be doing that.... I know [there's a number I can call for mobile service] but sometimes it's after hours or whatever, right? I'm just saying, things to think about right? But I love AVI, it's a great place. (B. Mills, personal communication, March 18, 2019).

Additionally, numerous participants advocated for an extension of AVI's capacity to witness different forms of drug use (other than injection and snorting), including smoking: "You can use AVI but a lot of people can't smoke in there and stuff like that" (Trigger, personal communication, March 18, 2020).

Across the board, AVI was seen as a place where drug users were well-served, and where vital forms of harm reduction were delivered in a compassionate and non-judgemental way. At the time of the interviews, the AVI overdose prevention site was being transitioned to Island Health – a move seen critically by the many participants.

They're threatening to close our OPS in the middle of a crisis, because our numbers aren't great. Numbers vs. people's lives... how many people have to die before we make lasting change? (D. Grimstad, personal communication, June 12, 2019).

Similar sentiments were echoed by Dr Kindy and Dr. Hemmerich:

Well, I personally think that's a tragedy that that safe injection site was closed. Because AVI provides that wraparound service, right? So they provide more than just a safe injection site. There's a place that you can go talk, that you can go get help, that if you need your paperwork done, people will help you, you've got a listening ear. So I don't see the logic of that at all. Like it's beyond me why they would have done that. I think AVI's shown themselves over the years, you know, I hugely admire AVI as an organization. … So I think to close something that is known to work. I don't see the rationale there in a time of crisis, it makes no sense. (Dr. A. Kindy, personal communication, Sept 9, 2020).

AIDS Vancouver Island [now called AVI Health & Community Services] has done an amazing job, and what they did with the OPS and connecting with people, supporting them, and harm reduction supplies. So I think it's a loss. It's a big loss. And where people felt quite accepted and very much at home. So there's big boots to fill, for the new site, but hopefully they'll be able to adjust and make it a similar place. I think the key too is people need to feel comfortable, and trusting. But also we'd need long hours. It has to be, you know, man powered. But still, it's such a small window, really. But it's going to be I think, seven days a week. So that's a start. (Dr. Hemmerich, personal communication, August 13, 2020).

Acknowledging these sentiments, it is important to also acknowledge the continued grassroots work being done by non-profits including (but not limited to) AVI, in supporting people at the heart of this crisis. Outreach Worker Galen Rigter points to the 'invisibility' of this work, and to the fact that it is rarely acknowledged:

The work non-profits are doing… it's incredible. A lot of it will never be seen by the public - [yet] I can only imagine what this world would look like without the amazing work these agencies are doing (personal communication, August 12, 2021).

The effectiveness of this work relies, according to numerous outreach workers, on the ability of grassroots organizations to put in-place staff who identify deeply with the Lived Experience community. Del Grimstad (outreach worker) says: "When we're going out into the using community to try to make an effective change, we really have to make sure we're putting people in-place that understand the community" (D. Grimstad, personal communication, June 12, 2019). Here we find a recognition that many people engaged in active drug use struggle to engage with, and feel safe within, traditional clinical environments, and are more able to accept services delivered through 'grassroots' channels. Additionally, we find a call to provide people who use drugs with wrap-around levels of service simultaneously, and for service that 'meets users where they are".

Coupled with this acknowledgement of AVI's 'grassroots' role is a recognition by

participants of the importance of other harm reduction services in the Valley, including the Health Connections Clinic / Nursing Centre, the Mobile Outreach Unit (formerly operated by AVI, a program that has since been terminated), the Care-a-Van outreach station, and Unbroken Chain – Indigenous Harm Reduction program for the community. Many participants made it clear that these services play an important role in their own personal landscapes, and in a larger harm reduction ecology.

Peer-Led Interventions

Perhaps more notable, even, than the grassroots work of local non-profits, is the work , being accomplished day in and day out by PWLLE - as individuals band together formally and informally to create their own harm-reduction platforms. Outreach Worker Galen Rigter speaks to the importance of these initiatives. While on one hand he sees the Valley's 'formal' Peer-support infrastructure overall as lagging behind those in place in many of the larger urban centres such as Victoria and Vancouver, recent initiatives have kindled his hope that this infrastructure is being developed:

There are some great things happening [in the Valley] currently… [Peers are] out there, getting grants to start their own groups. And when I meet with them, and AVI does our best to support them with equipment and training, they speak to how amazing it feels to give back, to get some new skills, and then to help share those with people… (personal communication, August 14, 2021).

The power of the community's peer support infrastructure is found, it should be said, not only in its ability to enable PWLLE first responders to save lives and reduce harm, but also, in its ability to bring a sense of purpose and pride to those doing this work. Peers supported in their grassroots outreach efforts often, according to Rigter, take great pride in the role they play in mitigating the crisis. The fact that a support network (for the Peer support network) is in place, through such organizations as AVI and the Community Action Team, demonstrates solidarity, and further contributes to a sense of meaning and pride:

It's super empowering. I can physically see a shift in people's swagger…. they're standing upright, they're proud of what they're doing, they're sharing it, the public is behind them. It's great that there's the Community Action Team in town supporting them, offering them what they need (Personal Communication, August 12, 2021).

Aside from supported peer interventions, many PWLE are doing this work independently, or 'under the table'. Jo, for instance, speaks to a 'pop-up' safe injection site that has, from time to time, been informally organized by Peers in the Valley:

We were really getting somewhere with the group that we had going. We had people coming to us. I had people. I live just a little bit out of town and on a weekend I could have up to 15 people show up for different various things. Getting the safe injection sites up is our number one thing I think in the Comox Valley.... If somebody does go down, and we can revive them and send them home, in a good position and stuff, they'll get to trust us (J. Moore, personal communication, March 18, 2019).

Such a site allows PWLLE to transmit to other life-saving information and support:

It sounds condescending, but such simple things about, you know, how to clean your spoon in between usages and stuff. And this one girl says "Oh, I don't clean mine, because it's a build up on this. So I get more and more". And I'm going oh, my god, no, no, no, no, no, you know, and so I showed her the whole scenario of it. I said, "It only takes two extra seconds". "Yeah, but I could get it in me". No, you could kill yourself by doing that, too. But it's the knowledge, right? Get the paperwork out there, get the fliers out there. Talk to the people, you know, go to the tent places. You know, have a couple safe people that could go into the tent cities and be welcomed, right, you know, not go in forceful, or whatever. But be part of the group, and go in and say "Hey, I can bring supplies three times a week. I'll bring in supplies, I'll pick up supplies". We've got people out there that are doing this, but we need more, you know, we need more. (J. Moore, personal communication, March 18 2019).

Here we see a powerful role being assumed by PWLLE in informally organizing and manifesting interventions that impart direct support to those at the heart of this crisis. The importance of such initiatives cannot, according to Rigter, be overstated:

It keeps me up at night to think about what the number of deaths would be if it weren't for what People with Lived Experience / Living Experience are doing on the streets everyday – countless accounts of folks coming to us saying how many people they've saved by administering Narcan or rescue breaths, that kind of thing – the numbers are staggering. And I think that a lot of this stuff is unseen by the general public. There's a whole family of folks out there who are taking care of eachother and they've been doing this forever. And I just feel like they have not been given a platform to either let people know what's happening out on the street, or haven't been given the credit they deserve. (Personal communication, Aug 12, 2021).

These comments speak to the important role peer outreach is playing in the crisis locally, and to the potential for mobilizing peer agency and leadership in the quest for solutions.

Fragility in Harm Reduction Services

While these front-line services were acknowledged as important to the Valley's harm reduction efforts, they were also seen, in the view of several outreach workers, to be fragile; at-risk of

being defunded, or discontinued. Outreach worker Galen speaks to a dramatic reduction in funding for these 'front-line' harm reduction services that has, in his view, occurred recently:

I've only been in the valley for two years, so I'm still finding my way, but in those two years I've been here, seeing the drastic funding cuts to agencies who are essentially front-line, essential service programs, is horrific and terrible… that there's been a dollar amount placed on numbers of people coming through a door or using a service, it's completely unethical and immoral. (G. Rigter, personal communication, November 20, 2020).

It is important to note that while some key programs, such as AVI's mobile outreach unit, have been cut, new programs, such as the Foundry (youth-based harm reduction) and ACT (mobile harm reduction) have been recently introduced. Work is needed to conduct a comprehensive assessment of programs/services in the Valley, with an aim to identify key service gaps.

Across the board, the front-line harm reduction services being offered by such agencies as AVI Health and Community Services, the Nursing Centre and Care-a-van, as well as the services being offered informally by the PWLE community, were seen to play an important role in preventing drug poisoning deaths, and in providing culturally safe services to people who use drugs in the Comox Valley. The expansion of these services, including expansion of the types of witnessed consumption offered, of operating hours, and of services into other areas of town, was seen as a priority. Furthermore, the continued development of 'alternative' and/or 'grassroots' models of harm reduction, including peer-led models, was seen as a priority, in that these models were seen to make harm reduction more accessible to the using community.

Summary

Within this section, we've examined participant conceptions of the 'layers' of downstream services referenced by participants within the Comox Valley – ranging from Narcan distribution to drug poisoning response apps to drug testing to harm reduction programs delivered by service providers. Across the board, participants spoke strongly of the need for services that meet them 'where they are'… services that acknowledge the tension many drug users have in navigating clinical settings and medical systems, and that provide alternative stigma-free spaces in which users are connected with multi-layered supports (including supports for mind, body and spirit) in a non-judgemental way.

3.4.2. Recovery Services & Supports

Beyond harm reduction services and supports, participants offered numerous insights related to recovery services and supports.

Detox

A consensus emerged from participants throughout the project related to the need for more comprehensive detox, treatment and sober living services in the Valley. Here it is important to acknowledge the distinction between medical detox, which involves intervention by qualified medical professionals and is often accomplished in a short time-span; and social detox, which involves a live-in sober living situation for a period of weeks or months coupled with social services and supports. Medical detox is often a precondition for entry into social detox facilities. Two facilities were acknowledged by participants to provide social detox services in the Valley - The Recovery Centre for men and Amethyst House for women. While the hospital was seen to, in certain circumstances, provide medical detox, this option was often seen as limited. The closest medical detox centre was identified by participants as Clearview Community Medical Detox centre in Nanaimo.

Before addressing the recommendations surrounding detox services put forward by participants, it is important to show how traumatic, from a lived experience perspective, the denial of access to detox and rehabilitation services can be.

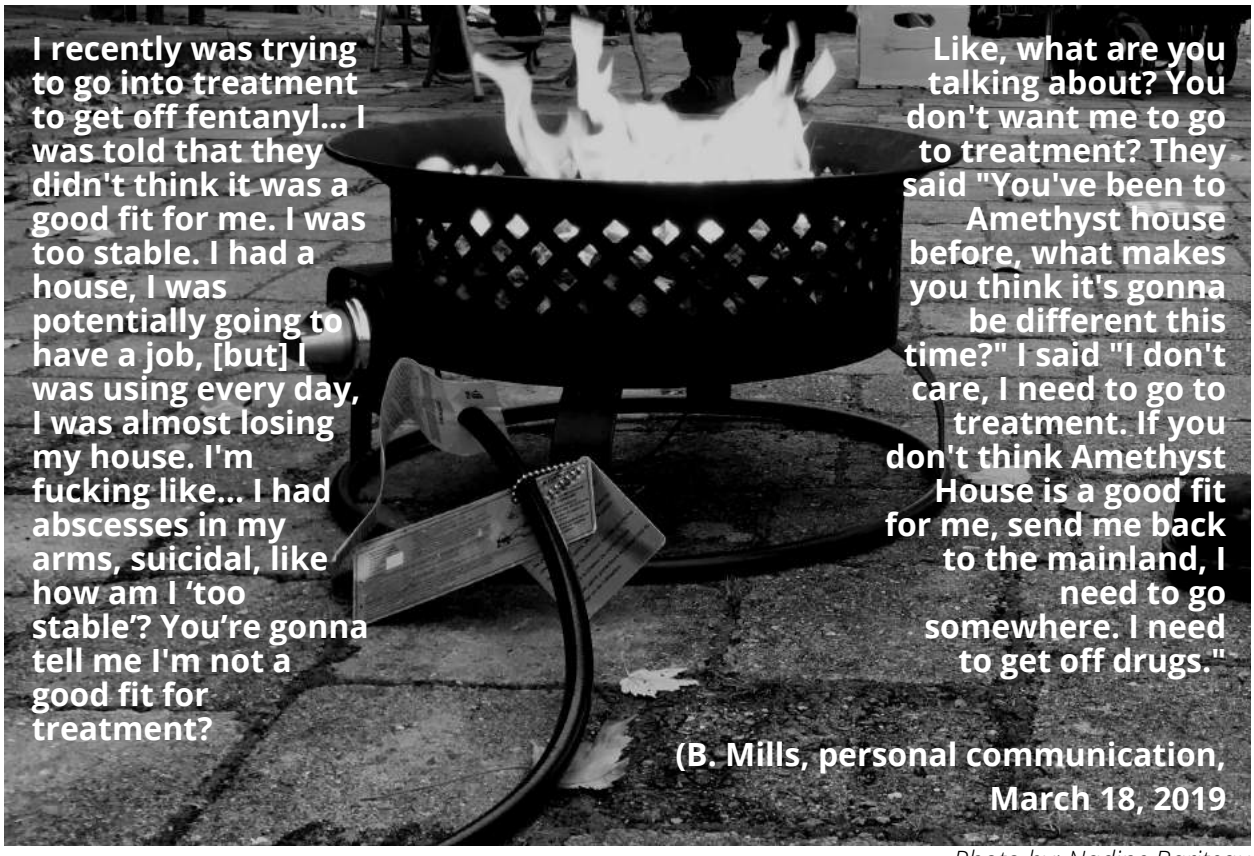


Photo by: Nadine Bariteau

These words ring powerfully; they give a sense of the desperation and anxiety faced by many who have made a decision to come off drugs and are not able to access the appropriate detox services.

Within the Comox Valley, participants identified the absence of medical detox service, as well as a limited number of social detox beds, as a key gap. The slow response time for participants to gain entry to medical (in Nanaimo) and social detox facilities was seen to contribute to this Gap: “we need more treatment, recovery beds for sure. And ideally, a medical detox centre” (Dr. Hemmerich, personal communication, August 13, 2020). Similarly, Dr. Kindy states: “we need to have a way of dealing with addiction where, if there's an opportunity, there's a bed” (Dr. Kindy, personal communication, September 9 2020). An anonymous outreach worker reinforces this same argument: “If we can't get together and find a detox bed and get somebody in the moment doing that, that seems like a major gap in this community” (Personal communication, March 5, 2020), And again, outreach worker Bryan McNicol echoes the this call for immediacy in detox services

It can be two or three weeks, sometimes longer [to access a detox bed]. Yeah, sometimes longer, quite a bit.... You know, it's medical detox these guys need, and we don't have it.. there's such a small window of opportunity with addicts, that they have a brief moment of lucidity, where they go, "I'm done". But you know, give it an hour. Now, maybe not. And that's sad (B. McNicol, personal communication, December 13, 2019).

This call, made by physicians and outreach workers alike for the enablement of quick access to detox services, was echoed by numerous people with lived experience:

People trying to access detox, to get [a detox bed], have to jump through hoops, or know the right person that can get them in, who's going to get them in quicker. And for someone who needs it right then when they're ready, when they're ready that day, it comes down to hours. If they don't get in, you know, in those hours, something could change for them in the next few hours, where they may decide that they don't want to. And if the doors keep going up in their face, the less likely they are to keep trying to go into a detox, and just give up. (S. Katsanikakis, personal communication, December 17, 2020).

Not only are detox services required that are quick to access; but also, services that have, at their core, a commitment to the rights and empowerment of drug users:

Jo: Going to treatment. I found you lose your dignity when you're there.

Anonymous: They make you sign a piece of paper to take your rights away. So everybody gets to do whatever they feel like. You have no choice but to go through..

Jo: ...their system. We didn't get to be where we are at our age without being resilient... Why can't the system allow Miles to do it [detox] the way he wants to do it? He's determined. But there's society going "Oh no, that wouldn't be a safe thing to do". And meanwhile he's dying in front of us. (J. Moore, Anonymous, personal communication, March 18, 2019).

Here, then, we see identified a desperate situation, in which people who have made a decision to come off of drugs are faced with an astounding set of barriers – including lengthy wait times, the need to access services out-of-town, and a lack of fluidity between various detox systems. Some who are able to access detox critique it for its lack of dignity and its propensity to strip people of their identity. In these words lies a strong call to action – for an increase in detox services, a re-formation of detox to better-serve drug user needs (ensuring fundamental respect and dignity), a decrease in wait times, and an effort to better-coordinate services.

Subsidiary Services

While detox services proved a 'hot-button' item amongst participants, it should be noted that conversations around detox were linked with conversations also calling for a range of subsidiary supports – from sobering centres (pre-detox) to sober living centres and culturally-informed aftercare (post-detox).

If they had sobering centres, where they could be safe until they could get in [to detox] and graduate into medical detox if they need it. And then work into some kind of treatment thing, whatever it is. I think they need more treatment beds. But they also, like, we get guys that have been through there four or five times, sometimes more. Some guys have been to like 29 or 30 treatment centres. The big reason that doesn't work, there's no safe place when they get out....Because we tell them to change your playpen, playmates, and then, well, okay, that's great. Where's my new playpen? How do I get away from my playmates? Well, you're gonna gravitate to the things you know, and that's a problem. So it's a big deal. But I mean, if you did it four beds at a time, right? Or eight beds at a time in the valley. .. (B. McNicol, personal communication, December 13, 2019).

This call for a comprehensive spectrum of services surrounding detox is echoed by participants with lived experience and outreach workers alike:

When you come out of that [detox], often times you come out onto the street. Most times that you come out of that, they send you back to the hometown that you came from. So you're coming back onto the street with like 20 bucks in your pocket, or 100 bucks in your pocket which is just enough to buy some drugs... you know, and you're back on the streets with the same old people. So I think a lot of those things fail by not having aftercare....Yeah, you know, sufficient aftercare or plans in place. (Anonymous, June 30, 2021)

An anonymous outreach worker echoes this same sentiment:

There needs to be a variety of aftercare options provided. There's many pathways to recovery. What might work for one person may not be what another person wants to do. Maybe somebody wants to learn their culture and their ceremonies and practice. That needs to be offered to people, not just "here, here, take this card and call this number". We know it needs to be culturally competent when you do the aftercare. It has to be evaluated and assessed thoroughly, not just "okay, let's fill this paperwork out and get you out the door" (personal communication, March 8, 2021).

Another anonymous outreach worker adds to this call for comprehensive aftercare – speaking specifically to the need for sober living. When asked to speak to the needs she sees as most pressing in relation to the Valley's service infrastructure, she outlines a spectrum:

Detox and also sober living, or different stages of housing for people on the other end. And again, not with the expectation that people need to clean up, or get a certain life going. But what about those who we're hearing over and over do want to see that change? This crisis has scared the shit out of them. They're burying all their friends and family and they want out. But we don't always have that moment. (Personal communication, October 14, 2020)

And Dr. Hemmerich speaks to the need for programs that allow participants to form new relationships, and engage in low-barrier employment:

Having a life for people as they go through recovery where they have supportive housing, assisted living to allow them to return to a more healthy normal life, with work/job opportunities… working on farms… low-barrier employment where they can start to recreate their life. Teaching… life skills… a big piece is creating new relationships with people who are not using. You're breaking your bonds, which is huge. (E. Hemmerich, personal communication, August 13, 2020).

Flagged here is the need for a comprehensive, inter-connected chain of services that has capacity to respond quickly (ie: within the same day, often) to the medical and social detox needs of clients, that enables long-term growth and development, and has the ability to meet clients 'where they are' in terms of aftercare. Such a chain would provide a comprehensive, and long-term strategy in place of what now appears as a piecemeal approach to detox and treatment services, and to recovery services at-large – an approach that leaves people seeking treatment vulnerable to gaps in care.

Coordination of Services

Beyond this concern with better-coordination of detox services, the need to better-coordinate harm reduction and recovery services at-large was seen as essential for a reduction in deaths in the Valley. As Megan

Lawrence (outreach worker) observes: "We just cannot seem to get a coherent consensus on moving forward together. It's still very much… our community is fractured, even in the approach of how to support people" (M. Lawrence, personal communication, December 13, 2019). An anonymous outreach worker echoes this same sentiment, and calls for the reconfiguration of services such that they are integrated, and working together fluently: "I'd love to see us all get together and do a better job of having a hub-type environment" (personal communication, March 5, 2020)… This notion of a hub; of a 'coordinated togetherness' is also put forward by Bryan McNicol (outreach worker) who believes it would lead to substantial improvement in the way in which the drug poisoning crisis is addressed in the Valley.

The people who are in the business model, they're looking for cost effectiveness. I understand that, I get that, it bothers me, but I get it. But if they saw that it was really making a change, and if we could get it together more than we are, they'll start saying, yeah, this is working. Because what they have to go on right now is, well, that didn't work. (B. McNicol, personal communication, December 13, 2019).

A similar call is made by Anonymous family member, who speaks to the disjointed landscape of care in which her daughter's calls for help were positioned – a landscape characterized by broken uncoordinated systems. She calls for bold leadership, and for bold imagination in the coordination of a new care paradigm:

Brooke and I had almost every kind of help you could access. I accessed everything. ….But there was no follow up, and no real support for me or her. I… I have been in despair for years…the medical system's broken…. The justice system is very broken. And like I said, I didn't know what in the world you would be able to offer or do. Because it just seemed like there's no one listening. There's no one driving the fucking bus. … It's the lack of imagination that I am sick of. I'm sick of it….Especially the lack of imagination, and the lack of courage (L. Hynes, personal communication, June 11, 2020).

While the coordination of services, and the filling of service gaps, might be dismissed by funders and policy makers [working with a business model] as 'too expensive', it is put forward by outreach workers, physicians and PWLLE alike as a solution that would 'actually work' – a solution that would allow people who use drugs to engage with a comprehensive, coordinated and individual-centred system of sobering, detox, treatment, sober living and aftercare. By investing in such a hub, the Valley would, according to numerous participants, achieve a sustained shift for people who use drugs, and dramatically improve their prospects for health and long-term wellbeing.

Community Integration

One final gap identified by outreach workers in relation to the current harm reduction and recovery systems in the Valley, pertains to the need for 'community integration' spaces for people who use drugs. These are spaces where people who use drugs, and/or people in recovery, are enabled to gather together and with the wider community - cultivating connections, belonging and purpose. Such spaces should, according to an anonymous outreach worker, be hosted by people who understand the concept of 'meeting people where they are', as demonstrated by the work of AVI and Unbroken Chain:

I think AVI and Unbroken Chain do a pretty good job of holding space for people. I think that's what you have to do, is to create a safe space for people so that when they are ready, they will come back. Just having that support and the staff there that are willing to take the time with somebody, and just spend that time unconditionally. Not having an agenda, just being there for them. I think that's a good model, to create safe spaces where people can go and feel welcome. And they're not judged, and they're not treated badly. (personal communication, March 8, 2021).

A similar call is put forward by Galen (outreach worker), who calls for programs where PWLLE can gather and be supported:

Having more social programming where people can get together, that sense of community and belonging... which is what everyone needs to be well is that belonging and acceptance. More programs that are inclusive for folks, and these don't have to be incredibly elaborate programs. They can be as simple as a drawing group, a walking group, a weekly picnic. Getting folks together and saying 'you matter, you're worth something, and you're supported... you're cared for by the community' (G. Rigter, personal communication, March 18, 2019).

The work of AVI and Unbroken Chain provides, perhaps, a model by which such spaces might be developed throughout the Valley, and integrated into a central hub and network.

Summary

In this section, we've examined participant comments in relation to recovery-based services in the Valley, including at the need expressed for more immediate and considered detox services (especially medical detox), and for a wide range of pre- and post-detox services that consider the unique needs of drug users, and that allow for the development of new connections, new relationships and new forms of community contribution. The model being advocated by participants at-large is a holistic one, wherein the multiple pieces of the recovery services and harm reduction landscape are brought

together – the strength of this connection contributing to an overall improvement in the effectiveness of each individual program, and of the system at-large.

3.5. Social Determinants of Health (Upstream)

Tied into these downstream services are social determinant-based 'upstream' services acknowledged by participants as having a powerful role in improving the state of the crisis in the Valley. In what follows, I summarize participant insights in relation to three key 'upstream' service areas: housing, mental health and education. It should be noted that these areas constitute a non-definitive list; additional work is needed to analyze the full spectrum of upstream services, and social determinants of health, and assess their impact on the crisis.

3.5.1. Housing

References to the importance of housing emerged frequently through the research sessions. The fact that housing costs have skyrocketed in recent years, leaving numerous people on the low- and mid- income spectrum without any viable 'place to be', is seen by many to have exacerbated the drug poisoning crisis. Dr. Kindy summarizes this situation, and points to links between housing and Substance Use Disorder:

I can't understand how people can even live in the Comox Valley area anymore. And when I look at the cost of a month of rent, you know, with people's income, it's impossible. And I think that's a huge crisis. That's a huge crisis. And if you have substance use disorder, how can you get better without a roof over your head? I mean, it's impossible. That's basic, you know, food, lodging. So if we can't provide lodging, how are you going to get better? You can go to detox treatment, but then what happens when you come back if you don't have a roof over your head? (Dr. A. Kindy, personal communication, September 9, 2021).

Beyond bricks and mortar notions of housing, various participants advocated for places to camp:

> **In terms of services we're completely lacking anywhere that people can camp reliably without being harassed. Like as long as you can keep it safe and clean then there should be somewhere, anywhere. Preferably like three different locations so that if certain groups don't get along with others, you know, they don't have to be side by side with drama and create some sort of drama vortex and then the whole idea goes down the toilet, it'll turn ugly. And we're not talking about any permanent structures, it'll still be camping. Like there won't be a shanty town building. It's clean, it's not permanent, and it's safe. If you've got a problem with any of these things don't stay here. But otherwise it should be there. Somewhere to go, somewhere to camp while you figure things out. So you don't have to haul around all your shit and you can't go in anywhere without fear of somebody walking off with your stuff. (E. Mayoh, personal communication, October 11, 2019).**

Such places, it was noted, should be located within walking distance to the services accessed by people who use drugs: "There's a number of services within five blocks" (Anonymous outreach worker, November 5, 2019); "if you've got a cluster of services, why are you systematically displacing people further and further away from the services that they need" (E. Mayoh, personal communication, October 11, 2019).

An innovative response to this housing crisis emerged from discussions with Sam Franey, a participant with lived experience with both substance use and homelessness. Sam speaks to a peer-led housing initiative he's in the process of developing:

> **I've just started a non-profit called Comox Valley Unhoused Society. It's about rehabilitating and housing people on the streets and people with mental health and addiction issues...Yeah, the society is to rehabilitate and house people on the streets, especially ones that struggle with mental health and addiction issues. (S. Franey, personal communication, July 9, 2020).**

This initiative, involving the creation of a tiny home community, is one that has been developed through grassroots engagement with the lived experience community: "It comes from four and a half years on the streets, talking to people that need it, and putting together something from their perspective. It's 100% from the voices

that need it to happen for them" (S. Franey, personal communication, July 9, 2020). The concept provides people in recovery with the necessary tools and support to build their own tiny home community, and provides a range of recovery-based supports tailored to meet their individual needs.

Here, then, we see an acknowledgement of the important role housing plays in recovery and harm reduction, a recognition of the dire state of housing affordability in the province and valley, and a grassroots, community-informed solution posed by someone who has lived unhoused for many years.

Mental Health

Numerous participants spoke, as well, to the need for stronger mental health support (generally) as a means to address the drug poisoning crisis. The link between mental health and addiction constituted a continuously emerging theme, with many flagging mental health issues as the core reason for their addiction:

> **My addiction really started when I was 17. And I started to struggle with some mental health issues that I didn't know how to cope with. They weren't anything I had ever experienced before. And my family tried to help by, you know, sending me to psychiatrists and doctors and stuff. But I couldn't handle the pace at which I was, I guess, recovering from that, or dealing with that. And so I turned to drugs. It started with MDMA. And for me, it was like, the first time I used, it was a lot. And I didn't stop, like the next day I use the same amount. And the next day, and the next day, and I didn't...I stayed high. Like, I never really spent any time clean once I started using. And a few months later it progressed to Cocaine. And then Ketamine, and Meth was all mixed in there and stuff just kind of snowballed....I didn't really spend much time sober at all. And that was mostly because when I did stop using I couldn't handle what was going on in my head. And so drugs were really just like a medication, like a solution. It was like my way to feel okay and function in the world. (S. Katsanikakis, personal communication, December 17, 2020).**

Sophia's acknowledgement of the link between drug use and mental health crises was articulated by numerous other participants. Judy Johnson family member speaks to the interconnectedness of these concepts: "Addiction is a part of mental health. And everybody who is addicted has a mental health problem. It's a mental health issue, and that's what we need to address. Just stopping the drug doesn't stop the mental illness"" (personal communication, June 11, 2020).

Similarly, an anonymous PWLLE shows how efforts to improve mental health care have a direct impact on the drug poisoning crisis:

We condemn and stigmatize mental health just like we do addiction.So I think the two are very common, they usually go together. I think if we don't learn to help people cope and provide different treatments, and really invest in mental health support and PTSD recovery, and a lot of things like that, and let people feel like they're supported and that there's not something wrong with them... that's a big part of addressing the overdose crisis. (personal communication, March 8, 2020).

Recognizing the broad call expressed by numerous participants for improved mental health support, a family member speaks specifically to the need for improved monitoring and follow-up within the mental health system, observing the current levels of care and support as inadequate:

I've been involved, heavy with my daughter since she was four years old, when she was diagnosed with all of her stress disorders. And I've dealt with massive counsellors, psych doctors, detox centres, more psych doctors. And I really don't know the answer, because it's not working. And it never worked for [anonymous daughter], at all. And she had more hope given to her, and I worked alongside her, with her, on every one of these things. I was her arm, and there's a lot of information, but it's not going anywhere. And it makes me upset too, that we're heavily prescribing drugs for people with mental illness.... So you have somebody who has mental illness, and they put them on drugs. And then they find a way to self medicate on drugs. And there's nobody following and tracking these kids at all....There is no one really caring for mental health people. That's the issue.... there was no follow up, and no real care. And that makes me really upset because if you want to talk about behaviour modification, and all counselling, and what they said to do, and what I tried to do, all my life with her, it never worked. (L. Hynes, personal communication, June 11, 2020).

These comments provide powerful insight into a key support system seen by many as broken. They speak to a need to re-examine care paradigms, such that those providing mental health care have the time and resources to develop more fulsome understandings of client situations, and more meaningful, long-term and regularized relationships leading to better care outcomes.

Education

A third key social determinant of health identified as having a strong relationship with the drug poisoning crisis is that of education. Judith Conway (family member), advocates for more to be done in schools to equip kids and youth with the tools to communicate with others their mental and physical needs – leading to stronger coping abilities and positive mental health and addiction outcomes. Speaking to the hurdles her son Matthew faced, Judith advocates for stronger, more in-depth teachings around communication, emotional awareness and social negotiation to be provided through the school system and other learning domains:

In describing Matthew's life, I often compare it to a leaky hot water tank. At first, we notice a few drops of water in the pan at the bottom of the tank. Then the drips begin to accumulate and we continue to wipe away the mess until one day the hot water tank bursts and the damage is done, not only to the tank but everything around it. What started as a small leak, turned into a huge, complex and expensive problem. If only we were just talking about faulty tanks. Instead of water damage, we are losing our children. Unless we start early when we see the first signs of a drip we will continue to lose an alarming number of young lives. Depression, anxiety, drug use and mental illness are at an all-time high. Many components, (the internet, stigma, shame, fear, lack of support) contribute to what is happening. I know communication is a key part of the problem and therefore must be a part of the solution. I believe if conversations around mental health are normalized at a young age, we can solve many issues before they become chronic with potentially deadly consequences. This proactive approach needs to be started in schools as early as kindergarten and straight through the teen years. Coping skills, identifying pain, understanding why we act out or why we are angry or frustrated needs to start at a young age. It's also important to identify the needs of self and others and effectively communicate those needs without shame or stigma. If we learn these skills early, we will live in a kinder, more compassionate world and people like my son, Matthew, and thousands of others might still be here today. (Personal communication, June 11, 2020).

Through Judith's words, we hear expressed a need to re-evaluate dominant education strategies, with an aim to better-support children and youth in coming to terms with conflict, mental health issues and difficult social dynamics, and in developing the skills needed to navigate an increasingly complicated world.

Primary school teacher Jen McFarlane agrees with this expressed need, and highlights a recent evolution in the B.C. curriculum that has, in her view, enabled some progress to be made in supporting kids in developing such coping mechanisms:

The BC curriculum has a new element called the core competencies, so we're not teaching content, we're teaching skills. And the idea is they're skills that a child can continue to build and grow throughout their whole time at school, and then use them throughout their life. And the skills are around the areas of creative thinking, critical thinking, communication. But the areas that I love teaching are around personal awareness, and social responsibility. And under the umbrella of personal awareness is like self regulation, and wellbeing, and I love teaching those self regulation skills. And under social responsibility are ideas, like how do you solve a problem in peaceful ways, and valuing diversity is one of the elements of social responsibility… In kindergarten, of course, all of those skills are going to be facilitated by an adult, and modelled. So I'm doing a lot of modelling, or role playing or talking out loud for the child. Like, oh, I'm feeling this way, what's in my toolkit for how I can help myself with this big feeling that I'm having? Or if it's like a conflict with students, they might not have the words or the skills yet for dealing with conflict resolution, and that's not expected yet… So I'm right in there, teaching peaceful methods of conflict resolution, that kind of thing. Or just even how to share space together, and how to be with other people who are having different feelings than you're having…And the idea is as they go through school, they'll gain an independence in those skills. (personal communication, September 5, 2020).

Whether the shift in the B.C. curriculum flagged by McFarlane will result, in the end, in improved outcomes for students in terms of mental health and addiction is yet to be seen (and is difficult to prove definitively). Regardless, the importance of education and training, starting in primary school, in conflict resolution, communication, self-awareness, etc. is worth considering in relation to the toxic drug poisoning crisis, as an absence of these skills is seen to increase individuals' social vulnerability. By supporting people in building these skills at a young age, tools are provided by which to navigate a complex and disjointed system; and, perhaps, to find, or create, meaning and purpose amidst a hyper-capitalist landscape.

3.5.4. Summary

These three 'upstream' services – housing, mental health and education, are all seen to play a key role in tackling the drug poisoning crisis. Each one, when appropriately strategized, resourced and operationalized, holds the potential to offer tools and wisdom necessary, along with the many layers of interventions outlined in Chapter 2, to overcome this crisis. Work is needed to identify elements within each service area that can be further evolved, and to enable appropriate levels of connectedness between these services and others.

While each of these service areas has played a significant role in shaping the drug poisoning crisis, it is important to acknowledge that many additional areas, including service areas related to foster care, child & family care, youth care, and systems related to income and wealth distribution, contribute to this complex and evolving crisis. Work is needed to explore these service areas and their relationship with the toxic drug poisoning crisis in greater depth.

Comox Valley Art Gallery Plaza
Photo by: Nadine Bariteau

Photo by: Kyle Little

Daryll
Photo by: Patrick Dionne

Photo by: Nadine Bariteau

4 RECOMMENDATIONS

Having travelled along a series of pathways examining the toxic drug crisis as it has unfolded in this country, province and region, and having explored the contributions and insights of people in the Comox Valley impacted first-hand, we now take a step back to ask:

- How might the Comox Valley community better-support people at the heart of this crisis?
- How might we reduce deaths, harm and stigma?
- How might we improve social cohesion and create progressive forms of systems change leading to better health and wellness outcomes for people who use, and have used, drugs?

In asking these questions, we also ask: who is responsible for making this change? Clearly the toxic drug poisoning crisis is complex and multi-faceted, necessitating a multi-faceted response. Given this fact, any meaningful solution will almost certainly require multiple leaders, organizations, community groups and individuals to work together towards this common goal.

The most obvious of these includes: federal, provincial and local governments, health authorities, health workers, criminal justice authorities, community downstream and upstream service providers, local businesses (especially in the downtown core), educators and educational leaders and, perhaps less formalized, groups of peers, family members and their allies. We believe that many more actors exist, however, who may self-identify as having change-making agency when reading this report.

In what follows, we outline a series of recommendations stemming from our research. While responsibility for change is suggested, we acknowledge the limits of our knowledge as related to the jurisdiction and potential of local, provincial and national systems and agencies. We ask those with power within these systems to engage as creative partners– imagining ways in which their agency can be applied towards the development of solutions.

Our hope is that readers consider these

recommendations as a concept sketch by which various actions are, in broad terms, defined. It is our collective work to 'fill in the gaps'... to imagine and create meaningful and sustainable solutions so as to end this crisis – by creating pathways leading to a significant shift.

1 Advocate the Federal Government for decriminalization of simple possession

Change Agent: Local Government

Acknowledging:

- The damage enacted nationally (and beyond) through criminalization of drug use, including the ties between criminalization and colonization, racism, and inequitable population control through over-incarceration of BIPOC (Black, Indigenous, People of Colour) populations;
- The growing movement (in B.C., and across Canada) spurred by health and community leaders, including provincial health officers, RCMP, and various levels of government, to recognize decriminalization as a viable 'way forward' in addressing the toxic drug crisis;
- The precedent set by the City of Vancouver, which, in 2020, passed a motion to formally approach Health Canada in pursuit of a plan to municipally decriminalize simple possession of drugs (while at the same time acknowledging the need expressed by many within Vancouver's PWLLE community for greater consultation as related to this advocacy);

We recommend local governments, working with local harm reduction leaders and Island Health, and in meaningful partnership with PWLLE, lobby the federal government for the legal power to decriminalize simple possession of illicit drugs. This recommendation involves asking the federal government for an exemption from the Controlled Substances Act to allow the possession of small amounts of illegal substances within municipal boundaries.

2 Re-commit to the operationalization of safe supply.

Change Agent: Provincial Government, Island Health, Harm Reduction Service Providers, College of Physicians and Surgeons British Columbia.

Acknowledging on one hand:

- The extreme toxicity at-play within the street drug market given the onslaught of fentanyl and its derivatives, as well as the toxicity now occurring through the mixing of street substances;
- The role safe supply can play in saving lives through the provision of clean drugs, while also stabilizing the life situations of people who use drugs;

And on the other:

- The limits surrounding safe supply, including its current lack of accessibility to casual and stimulant users;
- The hesitancy of some physicians to prescribe safe supply given the dangers of unmonitored opioid prescription;
- The propensity for safe supply to do harm if accompanied by a lack of monitoring and oversight;

We recommend Provincial Government, Island Health and Harm Reduction Service Providers urgently pursue the roll-out of safe supply. This includes making safe supply available (as medically/scientifically approved) to people in a streamlined, non-barriered fashion, enabling safe supply for people who use a range of substances (including opioids, but also stimulants); and developing and enacting systems of

monitoring (for instance, through static and mobile OPS sites) as well as physician monitoring (through oversight protocols enacted by the College of Physicians and Surgeons of British Columbia). In small communities located at a distance from large urban centres, work is needed to enact safe supply monitoring protocols in such a way as to eliminate travel barriers for people who use drugs – for example, through the provision of a 24/7 mobile OPS service.

3 Invest in full-spectrum drug testing.

Change Agent: Island Health, Harm Reduction Service Providers, Local Government

Acknowledging:

- The increased toxicity of the street drug supply

We recommend funds be allocated towards a full-spectrum drug testing system within the Comox Valley.

4 Reduce/eliminate stigma and racism within the health and criminal justice systems.

Change Agent: Provincial Government, Island Health, RCMP, Community Leaders.

Acknowledging:

- The stigmatization and racism experienced by participants in their interactions with the health and criminal justice systems – especially in relation to the hospital;
- The under-incorporation, within our current biomedical health system, of holistic frameworks of healing involving mind, body, spirit and emotion as well as collective notions of health found in the terms 'community' and 'belonging';
- The need expressed by participants for holistic, culturally-sensitive approaches to health and wellness;

We recommend Provincial Government, Island Health, RCMP, Community Leaders – take concrete steps towards the reduction/elimination of stigma and racism within the health and criminal justice systems, as well as a pursuit of holistic approaches to health. Such initiatives may include:

- **Inviting PWLLE into leadership roles within the health and criminal justice systems... creating leadership roles for PWLLE in Emergency departments of hospitals; and in policing;**
- **Embracing ongoing cultural safety and anti-sigma training for staff of health and criminal justice institutions;**

- **Developing hospital discharge protocols that enable patients without transportation, especially those released in the middle of the night, to stay safe;**
- **Implementing patient advocacy positions and programs in hospital that foster anti-racism and anti-stigmatization principles;**
- **Receiving and analyzing the feedback of PWLLE in relation to the health care they have received, and hospital care in particular – with an aim to reduce stigma and racism, and to provide high-quality care from a humanistic framework;**
- **Developing hiring practices that actively encourage/preference people committed to an anti-stigma, and anti-racism, stance;**
- **Seeking ongoing guidance and leadership from Elders/Traditional Knowledge Keepers and Cultural Leaders; regarding ways in which to bring Indigenous health and wellness paradigms into hospitals, health care and criminal justice systems;**
- **Investing in strong relationships between health sites (especially hospitals) and community health service providers, both harm reduction and recovery-based, and in commitments to coordinate patient care across these platforms;**
- **Exploring a role for police for in responding to toxic drug poisoning events;**
- **Equipping police with ongoing anti-stigma and anti-racism training;**
- **Developing and funding restorative justice paradigms.**

5 Reduce/Eliminate stigma and racism within the community at-large

Change Agent: Community Leaders

Acknowledging:

- The race and stigma-based injustices suffered by numerous participants at the hands of the general public;
- The principles of equity, diversity and inclusion as core within the pursuit of healthy communities;
- The need to enable understanding and relationship between people who use drugs and the wider community – and to provide opportunities for this group to have value and purpose within - to 'matter to' - the wider community;

We recommend the enactment of anti-stigma and anti-racism learning and development initiatives on all levels of our community – to be championed by community agencies, businesses, schools, governments, health authorities, police, criminal justice systems, 'opinion leaders', etc. S may include:

- **The development of anti-stigma and anti-racism workshops, events, courses, community gatherings, etc;**
- **The inclusion of anti-stigma and anti-racism training in professional development and staff skills enhancement contexts;**

6 Increase the accessibility and connectivity of OPS Services

Change Agent: Island Health, Harm Reduction Service Providers, Local Government

Acknowledging:

- The need expressed by participants for geographically-accessible OPS services that operate 24/7 and facilitate additional forms of drug consumption than those currently available;
- The importance of linking OPS services to a wide range of 'wrap-around services';
- The resistance many participants express to clinical environments;

We recommend Island Health and Harm Reduction Service Providers such as AVI Health and Community Services activate a meaningful and fulsome dialogue with the using community with an aim to develop a comprehensive OPS and Harm Reduction Services paradigm. Solutions may include:

- **Creating a 24/7 mobile service;**
- **Activating several OPS sites throughout the Valley;**
- **Integrating OPS services with a wide range of wrap-around services;**
- **Housing OPS services within community-focused, rather than clinical, environments;**
- **Enabling OPS witnessed consumption of additional methods of drug consumption, including inhalation.**

7 Increase the accessibility and connectivity of Recovery Services

Change Agent: Island Health, Recovery Service Providers, Local Government

Acknowledging:

- The difficulties (expressed in wait times) of participants in gaining access to medical detox platforms, and the frequent need for participants to access these services from out of town;
- The lack of 'streamlined' connectivity apparent between the different facets of the recovery system;
- The lack of long-term sober living rehabilitation support systems, and the importance of such systems, expressed by participants, in enabling people in recovery to maintain sobriety;
- The need for a range of aftercare supports for people in recovery;

We recommend Island Health and Recovery Service Providers activate a meaningful and fulsome dialogue with the PWLLE community, with an aim to develop a comprehensive, immediately accessible and streamlined system. Solutions may include:

- **Development of a medical detox centre in the Comox Valley -one that holds capacity for rapid access;**
- **Development of long-term sober living housing solutions;**
- **Development of aftercare programs that 'meet people where they are', including programs that include cultural safety and support.**

8 Develop a 'Hub'

Change Agent: Island Health, Harm Reduction and Recovery Service Providers, Local Government

Acknowledging:

- The fragmentation and 'siloing' of Comox Valley addiction services as identified by participants;

We recommend the development of a coordination hub – a place that carries in-depth knowledge of, and relationship with, the organizations/entities delivering medical, harm reduction, mental health and recovery- based care in the Comox Valley. This hub works to better-coordinate and dovetail services – leading to more coherent systems of care.

9 Create a PWLLE Leadership Group

Change Agent: Local Government

Acknowledging:

- The difficulties expressed by participants in accessing such fundamental services as water, power, public washrooms and a place to camp;
- The experiences participants shared of being perpetually 'moved along' and/or hassled by bylaw and/or law enforcement officers, leading to a perpetual state of displacement and the inability to stabilize their living situations;
- The links made by participants between the achievement of stabilized living scenarios and the reduction in harm;

We recommend the development of leadership teams of PWLLE, connected with municipal staff, whose wages are compensated by Local Government, and whose key task is to recommend changes to civic services, infrastructure and bylaw so as to enable the human rights for PWLLE in the enactment of changes to civic services and infrastructure.

10 Pursue ongoing improvements in housing, mental health, education

Change Agent: Local Government, Mental Health Service Providers, Island Health, Education Institutions.

Acknowledging:

- The role played by 'upstream' services in creating the conditions for, and/or helping to solve the toxic drug crisis;
- The 'housing first' sentiment expressed by numerous participants, which shows housing as a necessary first step towards stabilizing living situations, allowing PWLLE to then pursue harm reduction and recovery;
- The need expressed by participants, especially parents, for more comprehensive mental health services, including for mental health providers who hold long-term relationships with people who use drugs, and who are able to provide ongoing, knowledgeable guidance;
- The importance placed on education, especially education of young children, in the plight to equip people with the skills they require to communicate, develop resilience, and to belong within a larger social context;

We recommend that continued emphasis and engagement occur between Local Government, Mental Health Service Providers, Island Health and Education Institutions, with an aim to improve and coordinate services, and create the foundations for a reduction in harm.

11 Conduct Gaps and Opportunities Analysis

Change Agent: Island Health, Service Providers

Acknowledging:

- The needed for more research related to the service ecology at-play in the Valley, including an analysis of its strengths, weaknesses and opportunities;

We recommend the activation of a research project designed to map this ecology. Such a map may include:

- **In-depth documentation of the service provided by harm reduction and recovery agencies, soliciting data surrounding their availability, immediacy, statistical uptake, principles, etc., through in-depth interviews with program, service and organizational leaders;**
- **Identification of key gaps, successes, growth potentials, and comparison/contrast with other community service ecologies.**

12 Invest in PWLLE as Change Leaders

Change Agent: Island Health, Service Providers, Local Government, Community at large

Acknowledging:

- The importance of PWLLE in developing solutions to the crisis;
- The need for equitable, human-centred policy development created by those most impacted;

We recommend the inclusion of PWLLE in leadership roles throughout the spectrum of care addressed in this report. The success of policy changes designed to address the toxic drug poisoning crisis depends, we believe, on the development of a radically unique, grassroots approach to policy development, one that places PWLLE and their allies in leadership roles.

4.1 Summary

These recommendations sketch various pathways forward, and together create a 'potentials framework' intended to be used by community and institutional leaders to make progress in reducing harm, deaths and stigma attached to the toxic drug crisis.

5 Conclusion

In this report, we've explored key factors feeding this toxic drug poisoning crisis in the Comox Valley (and beyond) – as identified by people at the heart of this crisis – people with lived and living experience, their family members and front-line workers. We've examined the history of drug legislation in this country, including ways in which this history is tied in with colonization, race-based power dynamics and stigmatization. We've seen how these dynamics are carried forward into the present day. We've also seen how both the 'decriminalization' and 'safe supply' agendas reposition drug use as a public health issue, rather than a moral or criminal issue – and in so doing remove elements of stigma and shame. While we acknowledge and advocate this perspective, we simultaneously acknowledge the merits of an argument that shows the toxic drug crisis as existing beyond individual health and wellbeing; as indicative, also, of a society whose core philosophies, centred around individualism and consumerism, undernourish our need as humans to connect, to cultivate meaning and purpose, and to belong within a context that is larger than ourselves.

If, as many claim, the 'opposite of addiction is connection', then a response to the toxic drug crisis necessarily involves a drive to connect people in meaningful ways with one another, and with their communities. The recommendations outlined in this report identify a series of practical avenues to foster such connectivity – both through policy change that underscores the fundamental humanity and worth of PWLLE, and through community change in which we, as individuals, families, groups, publics, leaders, etc. collectively rise to a more inclusive understanding of what it means to live and exist together.

In closing, I wish to once again recognize and thank all who gave their voices, insights and stories over the course of this project, and the Walk With Me team members, with whom I've had the honour to walk alongside. In holding these stories close, and in walking with them alongside our community, we hold out hope for a future where dehumanization, stigma and racism are eradicated; where harm is diminished, community systems are nourished, and where people no longer die from preventable toxic drug poisoning deaths.

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THE CORPORATION OF THE CITY OF COURTENAY

STAFF REPORT

To: Council **File No.:** 4940-20

From: Chief Administrative Officer **Date:** October 18, 2021

Subject: Report back on Phase One of the Community Substance Use Strategy and request from Comox Valley Community Health Network for Continued Support

PURPOSE:

The purpose of this report is for Council to receive for information the Community Substance Use Strategy Phase One Report and to affirm its ongoing financial and in-kind support of the Comox Valley Community Health Network (CVCHN) in the continued development and implementation of a regional community substance use strategy.

POLICY ANALYSIS

8 (2) A municipality may provide any service that the council considers necessary or desirable, and may do this directly or through another public authority or another person or organization.

CAO RECOMMENDATIONS:

1. THAT based on the October 18, 2021 staff report "Report back on Phase One of the Community Substance Use Strategy and request from Comox Valley Community Health Network for Continued Support", Council approve OPTION 1 and receive for information the Community Substance Use Strategy Phase One Report; and,

2. THAT Council direct to staff to continue to work in partnership with the Comox Valley Community Health Network to support Phase 2 and subsequent phases of the Community Substance Use Strategy; and,

3. THAT annual operating budget funds of up to $30,000 be included in the 2022 operating budget, and $15,000 annually in the long-term financial plan to support Phase 2 and subsequent phases of the strategy; and,

4. THAT staff work with the CVCHN to update the memorandum of understanding with Phase 2 deliverables; and,

5. THAT the Chief Administrative Officer and the Director of Recreation, Culture and Community Services be authorized to execute the memorandum of understanding.

Geoff Garbutt, M.PI., MCIP, RPP
Chief Administrative Officer

BACKGROUND:

In 2002, the Community Drug Strategy Committee was founded with the support of Courtenay City Council. The mandate of the Community Drug Strategy Committee included working towards educating the community and creating awareness about the dangers of substance use, encouraging partnerships in creating solutions and the importance of making safe and healthy choices. Since then, annual funding has been allocated to support the work of this committee.

In the fall of 2019, the City recognized the need for a regional substance use strategy with a broader scope given the current state of both the provincial and local opioid crisis affecting the entire community. This lead to discussions with the Comox Valley Community Health Network (CVCHN) in recognizing the overlap in CVCHN's existing regional substance use strategy mandate with the Drug Strategy Committee's work. The City requested CVCHN to build upon the work carried out by the City's Community Drug Strategy Committee, assemble a committee of community stakeholders and take a regional approach to the development of a community substance use strategy that would reduce substance related harms in the Comox Valley.

The City entered into agreements with both the Comox Valley Regional District and the Comox Valley Community Health Network to provide clarity in each organization's respective roles in the development and support of the strategy. The City signed a memorandum of understanding (MOU) with the Comox Valley Regional District (Attachment 1) as the fiscal host of the City's funding to CVCHN and signed a MOU with CVCHN (Attachment 2) to outline CVCHN's project deliverables and reporting requirements. The term for CVCHN's MOU was originally for one year but was extended this year to accommodate delays due to a change in consultants, community stakeholder engagement, staffing and volunteer changes, and additional challenges brought on by the COVID-19 pandemic.

Further steps included:

1) CVCHN assembled the Comox Valley Community Substance Use Strategy Committee (CVCSUSC) comprised of a multi-sectoral group of people and community organization stakeholders.
2) Annual funding previously assigned to the Drug Strategy Committee was redirected to the CVCHN to hire a consultant to develop a Comox Valley Community Substance Use Strategy.
3) Consultants were engaged by the CVCSUSC to develop the strategy framework, coordinate community stakeholder sessions and summarize the findings and actions in the Phase 1 report.

DISCUSSION:

CVCSUSC has submitted the Community Substance Use Strategy: Phase One Report (Attachment 3). Phase One focused on learning and documenting the current state of substance use in the Comox Valley as well as listening to community members and stakeholders. The Phase One report provides the foundation and strategic next steps necessary to move forward with Phase Two of

the Community Substance Use Strategy which will focus on mapping the substance use system and responses in the Comox Valley, engaging with decision makers and government, and convening community engaged research dialogues to inform findings and clear next steps. Phase Three will focus on collective action for implementing the strategy based on the findings of Phase One and Two to round out a comprehensive Community Substance Use Strategy.

Staff have summarized how the Phase One report met the deliverables identified in the CVCHN MOU with the City (see Attachment 4).

City staff acknowledge the Phase One recommendations and actions are based on a snapshot in time of the work that is required to address the harms of substance use in the community. The Community Substance Use Strategy is a dynamic document and requires ongoing review, engagement, monitoring and evaluation combined with the proper resources to ensure efficacy. CVCSUSC intends to achieve these requirements in Phase Two and Three of the project.

With Phase One of the strategy complete, and with the support of Council, City staff will work with the CVCHN to update the MOU to include the implementation plans for Phase Two and Phase Three of the strategy. The updated MOU would expand on the deliverables identified in the original agreement by adding:

1) provision of a detailed implementation plan for the Phase Two and Phase Three immediate and ongoing actions;
2) prioritizing actions and identifying the resources required, both in-kind and funding;
3) provision of a project schedule outlining key milestones, key tasks, budgetary implications required to achieve each milestone and reporting requirements;
4) identification of key performance measures and development of a community scorecard for peer review and feedback on the effectiveness of the strategy.
5) Confirm regional local government support (in-kind and financial) and leverage the City's grant funding to obtain funding from other available funding sources.

FINANCIAL IMPLICATIONS:

In 2020, the City contributed $24,000 towards Phase One of the strategy. The source of funding came from the annual operating budget previously allocated to the Community Drug Strategy Committee: $15,000 from the 2020 annual operating budget and $9,000 of unspent funds carried forward from the 2019 annual operating budget.

$15,000 was approved in the 2021 operating budget towards the development of the drug strategy. These funds will not be utilized in the 2021 fiscal year and can be carried forward to the 2022 provisional operating budget. The five year financial plan included the provision of $15,000 in the 2022 operating budget, as such with the carry forward of $15,000 from the 2021 operating budget the City will be able to contribute up to $30,000 towards Phase Two of the project or

approximately 30% of CVCHN projected Phase Two project budget ($100,000). An annual operating budget amount of $15,000 has also been included for subsequent phases and ongoing work in the five year financial plan, starting in 2023.

ADMINISTRATIVE IMPLICATIONS:

Approximately 50 hours of staff time has been dedicated towards researching the background and history of the project, reviewing MOU agreements, attending community consultation meetings, reviewing the draft strategy, and meeting with the CVCHN. The Recreation, Culture and Community Services Department will continue to liaise with the CVCHN and provide in-kind staff support as part of its existing department work plan to support the work of the Community Substance Use Strategy development and implementation.

ASSET MANAGEMENT IMPLICATIONS:

There are no asset management implications at this time.

STRATEGIC PRIORITIES REFERENCE:

We focus on organizational and governance excellence

● Communicate appropriately with our community in all decisions we make

We continually invest in our key relationships

●■ Build on our good relations with K'ómoks First Nation and practice Reconciliation

● Value and recognize the importance of our volunteers

●■ Consider effective ways to engage with and partner for the health and safety of the community

▲■ Advocate and cooperate with local and senior governments on regional issues affecting our community

OFFICIAL COMMUNITY PLAN REFERENCE:

Section 2.1: The vision is for the City to become the most liveable community in the province. It can be expressed as having: an inclusive, open and caring community.

Goal 15. Supporting Social Equity: Creatively employ the City's resources and influence to foster social equity.

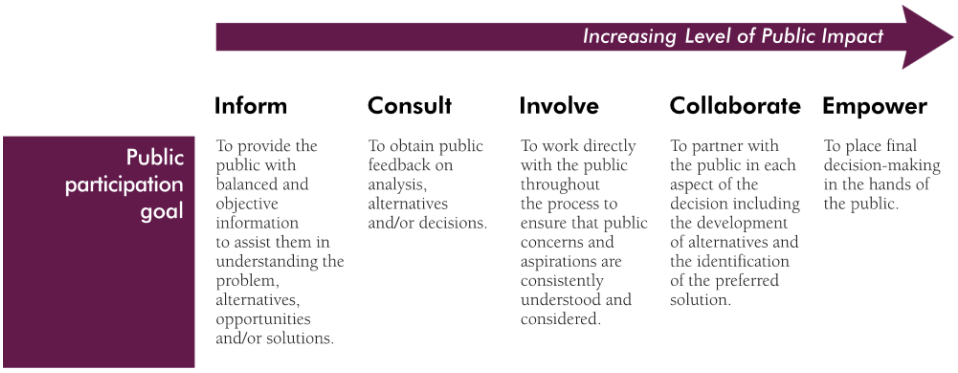
REGIONAL GROWTH STRATEGY REFERENCE:

No specific reference.

CITIZEN/PUBLIC ENGAGEMENT:

CVCHN will ensure citizen and public engagement in the development of the strategy by establishing a Comox Valley Substance Use Collaborative for Phase Two of the Community Substance Use Strategy.

Staff would inform the public based on the IAP2 Spectrum of Public Participation:



CONCLUSION:

The work of the Comox Valley Community Health Network and the development of a Community Substance Use Strategy is critical to the health and well-being of all members of the community. The strategy has identified and developed recommendations and actions to support a fair and equitable plan to reduce substance related harms in the Comox Valley.

As such, it is staff's recommendation that Council authorize staff to enter into an updated memorandum of understanding with CVCHN to continue the development of a regional community substance use strategy, continue to provide funding to support the development and implementation of the strategy, and continue to provide in-kind staff support to the CVCHN.

OPTIONS:

OPTION 1:

1. THAT based on the October 18, 2021 staff report "Report back on Phase One of the Community Substance Use Strategy and request from Comox Valley Community Health Network for Continued Support", Council approve OPTION 1 and receive for information the Community Substance Use Strategy Phase One Report; and,

2. THAT Council direct to staff to continue to work in partnership with the Comox Valley Community Health Network to support Phase 2 and subsequent phases of the Community Substance Use Strategy; and,

3. THAT annual operating budget funds of up to $30,000 be included in the 2022 operating budget, and $15,000 annually in the long-term financial plan to support Phase 2 and subsequent phases of the strategy; and,

4. THAT staff work with the CVCHN to update the memorandum of understanding with Phase 2 deliverables; and,
5. THAT the Chief Administrative Officer and the Director of Recreation, Culture and Community Services be authorized to execute the memorandum of understanding.

(Recommended)

OPTION 2: That Council refer the issue back to staff for further consideration.

OPTION 3: That Council deny CVCHN's request for continued financial and in-kind support.

Prepared by:

Susie Saunders
Director of Recreation, Culture and Community Services

Concurrence by:

Geoff Garbutt, M.PI., MCIP, RPP
Chief Administrative Officer

Attachments:

1. *CVRD MOU*
2. *CVCHN MOU*
3. *The Community Substance Use Strategy: Phase One Report*
4. *Summary of Phase 1 Deliverables*

Memorandum of Understanding
Community Substance Use Strategy

Between

City of Courtenay
830 Cliffe Avenue,
Courtenay, BC
V9N 2J7

And

Comox Valley Community Health Network
C/O Comox Valley Regional District (CVRD)
600 Comox Road,
Courtenay, BC
V9N 3P6

(Collectively the "Partners")

For the Community Drug Strategy Initiative

Date: April 1, 2020

The purpose of this Memorandum of Understanding ("MOU") is to confirm the mutual interest and desire on the part of each partnering organization to cooperatively establish and deliver a Community Substance Use Strategy through the Comox Valley Community Health Network (CVCHN).

This MOU provides an opportunity to attest to the Partner's commitment in principle to engage actively in supporting and developing a Community Substance Use Strategy.

The City of Courtenay will:

a. Provide program funding as approved by the City of Courtenay's Council in the City's annual operating budget.

The Comox Valley Regional District will:

a. Host the City funds and allocate them to the CVCHN for the sole purpose of developing a Community Substance Use Strategy as outlined in the executed MOU with CVCHN attached as Attachment A.
b. Maintain full and proper accounting financial records to support all expenditures covered by this grant.

This non-binding MOU shall be for a period of one (1) year from the date of complete execution by the Partners and may be terminated by the City by providing four (4) month's advance notice to the CVRD. This MOU may be mutually extended or amended by the agreement of both Parties in writing.

AGREED by the Parties through their authorised signatories:

For and on behalf of City of Courtenay	For and on behalf of Comox Valley Regional District
Signed	Signed
Dave Snider print name	Scott Smith print name
Director of Recreation and Cultural Services Title	General Manager of Planning and Development Title
April 29/2020 Date	April 29/2020 Date

ATTACHMENT A

CVCHN MOU

Memorandum of Understanding For a Community Substance Use Strategy

Between

City of Courtenay
830 Cliffe Avenue,
Courtenay, BC
V9N 2J7
("City")

And

Comox Valley Community Health Network
C/O Lindsay McGinn, Facilitator
("CVCHN")

For the Community Substance Use Strategy Initiative

Date: April 1, 2020

The purpose of this Memorandum of Understanding ("MOU") is to confirm the delivery of the Community Substance Use Strategy through the Comox Valley Community Health Network (CVCHN).

The Comox Valley Community Health Network will:

a. Engage community partners to develop and execute a Community Substance Use Strategy. The CVCHN will execute the objectives identified in the Community Substance Use Strategy Deliverables (Attachment 1) and subject to amendment provided both parties agree in writing.
b. Report to Council as mutually agreed upon by both parties, on how CVCHN is meeting the deliverables of this agreement including how program funding was allocated.
c. Where appropriate, acknowledge the City as a supporter of the CVCHN Community Substance Use Strategy Initiatives.

The City of Courtenay will:

b. Provide dedicated program funding to the Comox Valley Regional District as the acting financial host agency in amounts subject to Council's approval in the annual general operating budget.

This non-binding MOU shall be for a period of one (1) year from the date of complete execution by the Partners and may be terminated by the City by providing four (4) month's advance notice to the CVCHN with copy to the CVRD. This MOU may be mutually extended or amended by the agreement of both Parties in writing.

AGREED by the Parties through their authorised signatories:

For and on behalf of City of Courtenay	For and on behalf of Comox Valley Community Health Network
Signed	Signed
Dave Snider	LINDSAY M°GINN
print name	print name
Director of Rec and Culture	FACILITATOR
Title	Title
March 30, 2020	MARCH 30, 2020
Date	Date

Community Substance Use Strategy Deliverables

1. Develop a terms of reference outlining the mandate and scope of work the CVCHN will focus on in its development of a Community Substance Use Strategy.
2. Engage a qualified consultant to assist in the preparation of a community led Community Substance Use Strategy. The Community Substance Use Strategy will include the following deliverables: approach, mission and goals, expected outcomes, community stakeholder's consultation, obstacles, strategies, initiatives, and implementation plans including performance measures for monitoring and evaluating progress.
3. Project milestones for completion of action items and provide monthly project updates.

First Amendment to the Memorandum of Understanding
For a Community Substance Use Strategy

Between

City of Courtenay
830 Cliffe Avenue,
Courtenay, BC
V9N 2J7

And

Comox Valley Community Health Network (CVCHN)
C/O Lindsay McGinn, Facilitator

Herein referred to as ("the Partners")

For the Community Substance Use Strategy Initiative

This is in regards to that certain Memorandum of Understanding (MOU) between the Partners executed April 1, 2020 a copy of which is attached for reference (Schedule A). This shall serve to amend the MOU as further described herein. Unless modified by this First Amendment or otherwise in writing, all other provisions of the MOU shall remain in effect.

The following section shall be deleted:
This non-binding MOU shall be for a period of one (1) year from the date of complete execution by the Partners and may be terminated by the City by providing four (4) month's advance notice to the CVCHN with copy to the CVRD. This MOU may be mutually extended or amended by the agreement of both Parties in writing.

The following section shall be added:
This non-binding MOU shall be for a period of 15 months starting April 1, 2020 and ending June 30, 2021 and may be terminated by the City by providing four (4) month's advance notice to the CVCHN with copy to the CVRD. If at the end of the term, the MOU shall hold over with the consent of the City, the MOU shall thereafter, in the absence of written agreement to the contrary, be from month to month. This MOU may be mutually extended or amended by the agreement of both Partners in writing.

AGREED by the Partners through their authorised signatories:

For and on behalf of City of Courtenay	For and on behalf of Comox Valley Community Health Network
Signed	Signed
Susie Saunders print name	Lindsay McGinn, print name
Director of Recreation, Culture and Community Services Title	CVCHN Facilitator Title
June 29 2021 Date	Date

Schedule A

Memorandum of Understanding For a
Community Substance Use Strategy

Between

City of Courtenay
830 Cliffe Avenue,
Courtenay, BC
V9N 2J7
("City")

And

Comox Valley Community Health Network
C/O Lindsay McGinn, Facilitator
("CVCHN")

For the Community Substance Use Strategy Initiative

Date: April 1, 2020

The purpose of this Memorandum of Understanding ("MOU") is to confirm the delivery of the Community Substance Use Strategy through the Comox Valley Community Health Network (CVCHN).

The Comox Valley Community Health Network will:

a. Engage community partners to develop and execute a Community Substance Use Strategy. The CVCHN will execute the objectives identified in the Community Substance Use Strategy Deliverables (Attachment 1) and subject to amendment provided both parties agree in writing.
b. Report to Council as mutually agreed upon by both parties, on how CVCHN is meeting the deliverables of this agreement including how program funding was allocated.
c. Where appropriate, acknowledge the City as a supporter of the CVCHN Community Substance Use Strategy Initiatives.

The City of Courtenay will:

a. Provide dedicated program funding to the Comox Valley Regional District as the acting financial host agency in amounts subject to Council's approval in the annual general operating budget.

This non-binding MOU shall be for a period of one (1) year from the date of complete execution by the Partners and may be terminated by the City by providing four (4) month's advance notice to the CVCHN with copy to the CVRD. This MOU may be mutually extended or amended by the agreement of both Parties in writing.

AGREED by the Parties through their authorised signatories:

For and on behalf of City of Courtenay	For and on behalf of Comox Valley Community Health Network
Signed	Signed
Dave Snider	LINDSAY M°GINN
print name	print name
Director of Rec and Culture	FACILITATOR
Title	Title
March 30, 2020	MARCH 30, 2020
Date	Date

ATTACHMENT 1:

Community Substance Use Strategy Deliverables

1. Develop a terms of reference outlining the mandate and scope of work the CVCHN will focus on in its development of a Community Substance Use Strategy.
2. Engage a qualified consultant to assist in the preparation of a community led Community Substance Use Strategy. The Community Substance Use Strategy will include the following deliverables: approach, mission and goals, expected outcomes, community stakeholder's consultation, obstacles, strategies, initiatives, and implementation plans including performance measures for monitoring and evaluating progress.
3. Project milestones for completion of action items and provide monthly project updates.

COMMUNITY SUBSTANCE USE STRATEGY

PHASE ONE REPORT

CONNECT EDUCATE

GROW RESPOND

PREPARED BY:
COMOX VALLEY COMMUNITY SUBSTANCE USE STRATEGY COMMITTEE

FUNDED BY:

CITY OF COURTENAY

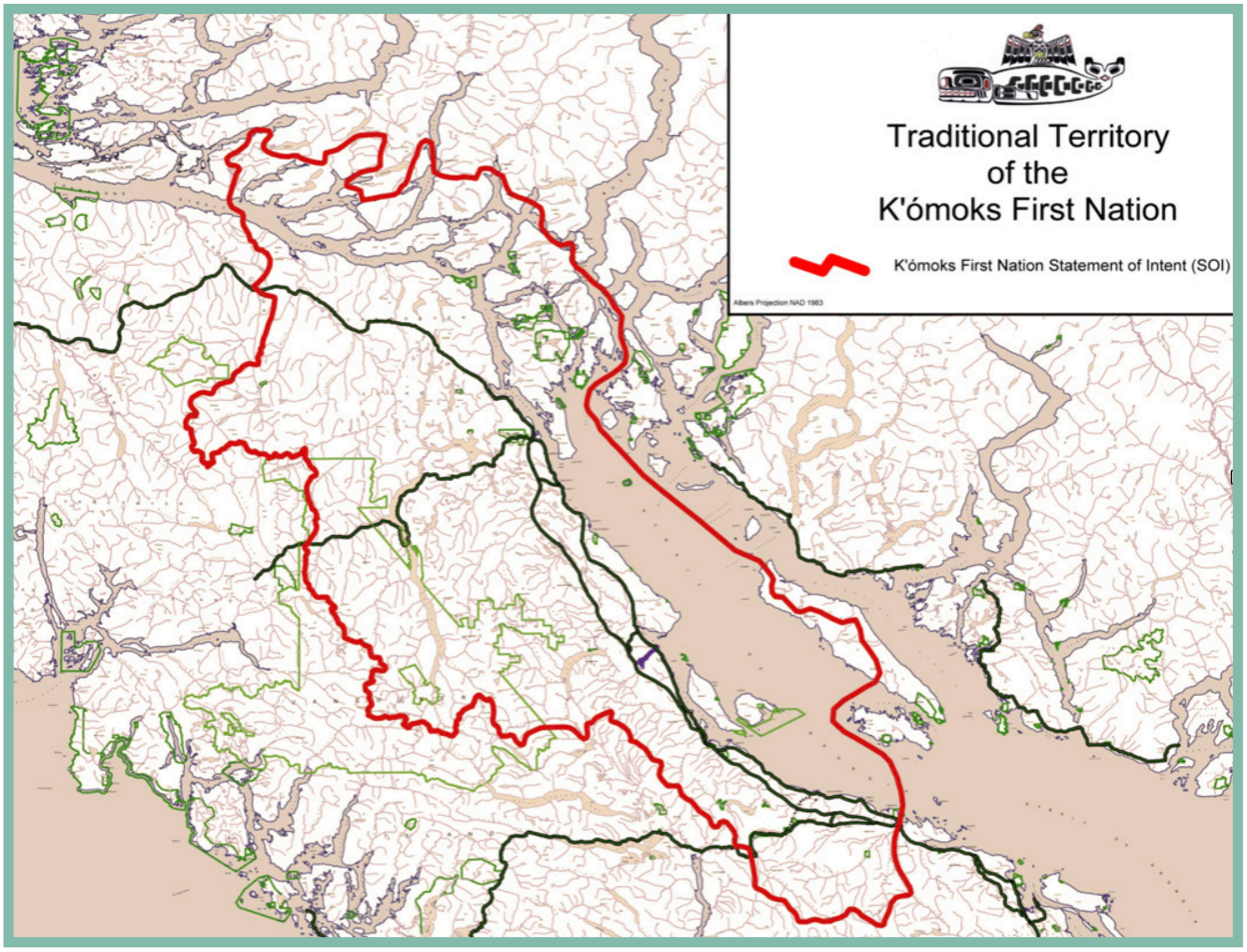
COMOX VALLEY COMMUNITY HEALTH NETWORK

LAND ACKNOWLEDGMENT

This report, and all those involved in this work want to respectfully acknowledge that we work, play and live on the Unceded traditional territory of the K'òmoks First Nation, the traditional keepers of this land.

This report encompasses all communities in what is now known as the Comox Valley in British Columbia (BC). The area in which Comox Valley local and regional governments' fall within are known traditionally as the K'ómoks First Nation territory. K'ómoks First Nation today consists of several formerly separate tribes, both culturally K'ómoks and Pentlatch. The Sathloot ('sath-loot), Sasitla ('sa-seet-la), leeksen (eys-'ick-sun) and Xa'xe ('ha-hey) are all culturally K'ómoks and have their own unique origin stories The Pentlatch had a similar culture but spoke a distinct language and also have their own unique origin story (K'ómoks First Nation, 2021).

K'ómoks translates to 'Land of Plenty'. The K'ómoks First Nations have traditional ancestral lands, air, waters and resources. To this day the K'ómoks First Nation have not ceded, surrendered, or extinguished their aboriginal rights and title to their lands and waters as acknowledged under section 25 and 35 of the Canadian Constitution Act, 1982.



(K'ómoks First Nation, 2021)

TABLE OF CONTENTS

CONTRIBUTOR ACKNOWLEDGEMENT

This report is the result of the collective effort of the organizations and individuals on the Comox Valley Community Substance Use Strategy Committee, it's working group members, peers and our consultants: Shari Dunnet, Sally Kupp, Evan Jolicoeur, and Sara Blenkhorn.

SUMMARY

This report provides a foundation and direction to move towards a comprehensive Comox Valley Substance Use Strategy, with recommendations and actions developed collaboratively with peers, service providers and decision-makers. It is a living document, and it will continue to grow as the work of the community moves forward.

A multi-sectoral group of people from across the region was brought together to form the Comox Valley Community Substance Use Strategy Committee (Committee) to develop recommendations and actions for a fair and equitable plan to reduce substance related harms in the Comox Valley, British Columbia.

DURING PHASE ONE OF STRATEGY DEVELOPMENT, THE COMMITTEE:

- participated in a dialogue facilitated by the Canadian Drug Policy Coalition to explore current drug policy landscape in BC and Canada
- developed a vision, mission, belief statements, and guiding principles for the strategy
- hired consultants to support
    - research of best practices,
    - review of current relevant data on substance use in the Comox Valley
    - collection of information on substance use services in the Comox Valley,
    - facilitation of a community engagement process
    - an environmental scan of potential funding sources and alignment with provincial and federal priorities to further work towards a complete strategy

The term substance use refers to the use of drugs or alcohol, and includes substances such as tobacco, cannabis, illicit drugs, prescription drugs, inhalants and solvents. Substance use exists on a spectrum from beneficial use to chronic dependence or substance use disorder. There are many social determinants that can contribute to substance use (eg. poverty, lack of affordable housing, history of trauma, racism, colonization, etc.) and these determinants can create additional barriers to individual and community health.

In addition to the above, there are also social inequities and gender differences in the experience of substance use and the provision of substance use services. The Comox Valley Substance Use Strategy will acknowledge the wisdom held by people who are impacted by substance use and groups that experience inequity first-hand. It will use this information to develop a strategy that addresses the inequities within our current system and underlying social determinants that impact substance use. It will also work to increase access to policy development to create a more equitable system of care within our community.

Core to this work is ensuring cultural safety, cultural humility, and trauma-informed practice are embedded within all components of strategy development and the substance use strategy itself. Both Indigenous and colonial frameworks for addressing substance use will guide strategy development; various models that are being used by the Committee are introduced in this report.

Understanding substance use within the region and creating local solutions can only happen with people at the center of this work. Through research on local-level substance use and health system data (where available), a scan of existing supports and services, and thoughtful engagement with peers (people with lived experience using substances and their friends and family), key community organizations and stakeholders in the Comox Valley, critical information was gathered and will inform Phase Two of this important strategy.

BELOW OUTLINES A BRIEF OVERVIEW OF SOME IMPORTANT KEY FINDINGS:

Quantitative Data

- More people in British Columbia died from a toxic drug supply than from COVID-19 in the first 8 months of 2020 (Mathew, 2021). In the Comox Valley, 13 died from toxic drugs in 2020. In the first 5 months of 2021, 14 people died of toxic drugs (British Columbia Coroners Service, 2021).
- In North Vancouver Island (Comox Valley north to Port Hardy), 2018, most substance use related hospitalizations for all ages and genders (attributed both wholly and partially) were due to tobacco and alcohol (CISUR, 2018).
- In the Comox Valley, the number of people diagnosed with a substance use disorder increased from 804 in 2014/15 (1.3 per 100 people) to 1120 (1.6 per 100 people) in 2018/19 (CISUR, 2018)
- North Vancouver Island (which includes the Comox Valley) had one of the highest rates of illicit drug toxicity deaths by Health Service Delivery Area (BC Coroners Service, 2021).
- Tobacco-related deaths have been steadily increasing in the Comox Valley since 2012, with the potential years of life lost from respiratory illnesses at about 3.6 years. In 2017 the deaths caused by tobacco in the Comox Valley were 136 per 100,000 people as compared to 126 per 100,000 as an average across BC (both partial and whole causes). (VIHA Local Health Area Profile, 2019).
- A longitudinal study for the Courtenay Local Health Area showed that as youth move into higher grades in secondary school, tobacco and nicotine use increase. (VIHA Local Area Profile, 2019).
- In 2017 there were 57 reported alcohol deaths in the Comox Valley compared to 48 deaths on average across BC. This is an increase from 37 deaths in 2014 in Comox Valley.

Findings from Community Engagement

- There are many existing substance use supports and services within the Comox Valley, however there is often a discrepancy between the perspective of services offered by the providers, and the experience people have in accessing and using those services.
- Stigma is a significant issue experienced by people who use substances and often impacts access to services.
- The work of peers is critical but often goes unrecognized and unfunded.
- The youth population is under-served and there is a perception that services and providers are 'out of touch' with how best to access, support and influence youth
- Housing was identified as an important first step to address substance use – stable housing aids and facilitates access to prevention, harm reduction and treatment.
- Several assets were identified and include increased collaboration between acute, medical and community supports, increased peer involvement and a commitment by services providers to meet people where they are at (including local outreach services).
- Several gaps were identified and are largely themed around: a lack of coordinated system of care that is rooted in trauma-informed practice and cultural safety, weaves Indigenous and Western approaches and includes primary care physicians; a lack of specific managed and locally available programs (managed alcohol, detox) and programs appropriate for specific populations (non-binary genders & 2SLGBTQIA+); and lack of safe supply providers and advocacy for decriminalization.
- Identified barriers to accessing substance use services included long wait times for supportive recovery (insufficient number of locally-based treatment beds) and outpatient supports.

With positive political will, more data and funding, and improved engagement and collaboration across multiple populations and sectors, the Comox Valley can make meaningful action towards a comprehensive peer-centered substance use strategy. This work began with a small amount of funding from the City of Courtenay, however more funding will be required from a variety of sources to create a comprehensive substance use strategy in Phase Two.

IMMEDIATE PROPOSED STEPS TOWARDS PHASE TWO:

- Present Phase One Report to all local government councils and introduce Phase Two engagement plan which is:
  - Support the recommendations in the Walk With Me Report.
  - Support the provincial governments intervention into the toxic drug poisoning by encouraging participation of all local stakeholders in the Comox Valley Community Action Team.
  - Partner with the Walk with Me project on a joint initiative that includes a launch event for this Phase One Report and Walk With Me's Research Report followed by a series of facilitated conversations and cultural mapping that will help inform Phase Two of the Substance Use Strategy and the Recommendations in the Walk With Me Report.

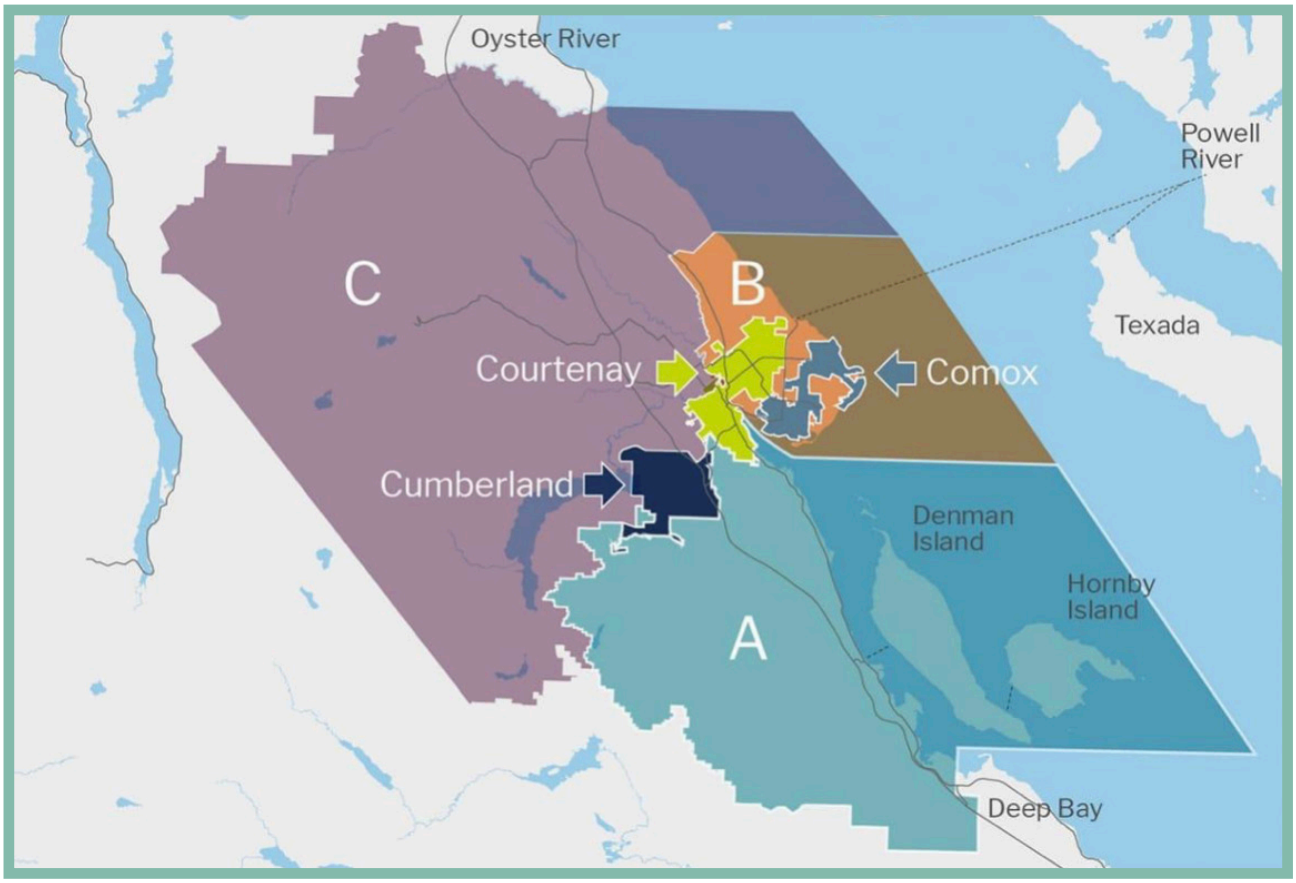
  These conversations will help to identify actions the community could take to change policies and practices locally and identify key recommendations for the final strategy.

  - Build on the Comox Valley Substance Use Committee to form a Comox Valley Substance Use Collaborative of people with lived and living experience, community agencies and teams, K'ómoks First Nation, local MPs and MLAs, local municipalities, Comox Valley Regional District , School District #71, Island Health, Division of Family Practice/Primary Care Network, Community Action Team and RCMP to coordinate the next phase and implementation of the strategy.
  - When formed the Comox Valley Substance Use Collaborative become a partner of the Comox Valley Community Health Network with the Network's other community partners.
  - Align the work of the Comox Valley Substance Use Collaborative as appropriate with the work outlined in the Regional Poverty Assessment and Reduction Plan to work with local governments and other community groups on intersecting community issues (e.g. Game Changer #1; Game Changer #2; Game Changer #3; Game Changer #4; Game Changer #8; Game Changer #10; Game Changer #14).
  - Request all local governments (municipalities, Comox Valley Regional District and School District #71) collaborate to fund the coordination and implementation of Phase Two of a Substance Use Strategy.
  - Request Comox Valley local governments (municipalities, Comox Valley Regional District and School District #71) and Island Health include the work towards a substance use strategy in their strategic planning and priorities and support the monitoring and evaluation of actions.
  - Collaborate to monitor and apply for federal and provincial funding opportunities to support the implementation of the strategy.
  - Collaborate to secure funds to enable good, in person, relationship building with First Nation, and other priority partners in the development of the strategy.
  - Collaborate to secure funding to support ongoing involvement and leadership from peers and elders/traditional knowledge keepers.

INTRODUCTION

This report provides a foundation and direction to move towards a comprehensive Comox Valley Substance Use Strategy with recommendations and actions developed collaboratively by peers, service providers and decision-makers. It is a living document, and it will continue to grow as the work of the community moves forward.

The Comox Valley region in British Columbia includes the municipalities of City of Courtenay, Town of Comox and Village of Cumberland as well as three electoral areas (A, B and C), the K'ómoks First Nation, and the Island Trust. The population of the Comox Valley has increased significantly from 2011 to 2016 to a total of 66,527, and is projected to increase to 75,000 in 2021, and 80,000 in 2035. The median age in Comox Valley in 2016 was 50.8 Census, 2016.



THE COMOX VALLEY COMMUNITY SUBSTANCE USE STRATEGY COMMITTEE

ABOUT THE COMMITTEE

In 2002, under the guidance and leadership of the City of Courtenay, various stakeholders came together to develop a drug strategy committee. The committee contributed significantly to educating people in the Comox Valley about substance use and the need to make health focused choices. In October 2019, the City of Courtenay asked the Comox Valley Community Health Network to broaden the scope and membership of the existing drug strategy committee to develop a regional substance use strategy for the Comox Valley.

A multi-sectoral group of people from across the region was brought together to form the Comox Valley Community Substance Use Strategy Committee (Committee) to develop recommendations and actions for a fair and equitable plan to reduce substance related harms in the Comox Valley. A full list of committee members can be found online here.

During Phase One of the strategy development, the Committee:

- participated in a dialogue facilitated by the Canadian Drug Policy Coalition to explore current drug policy landscape in BC and Canada
- developed a vision, mission, belief statements, and guiding principles for the strategy
- hired consultants to support them to
    - research best practices,
    - review current relevant data on substance use in the Comox Valley
    - collect information on substance use services in the Comox Valley
    - facilitate a community engagement process
    - do an environmental scan of potential funding sources and alignment with provincial and federal priorities to further work towards a complete strategy

VISION, MISSION, BELIEF STATEMENTS AND GUIDING PRINCIPLES

The Vision, Mission, Belief Statements and Guiding Principles for the Comox Valley Substance Use Strategy are seen as ever evolving and can be updated going forward as necessary. These guide all work and actions being undertaken to develop the strategy.

VISION & MISSION

Comox Valley Substance Use Strategy Vision:

The Comox Valley is a safer, healthier place that improves the lives, abilities, and health of all community members, including all diversities and generations.

Comox Valley Substance Use Strategy Mission:

Work together as a community to develop and implement a fair and equitable plan to reduce substance related harms in the Comox Valley.

Belief Statements

- We believe people have a great capacity to change and need support and information to be healthy.
- We believe people have a right to know and understand both the harms and benefits of substance use.
- We believe that substance use is part of our lives and our communities, and we are all responsible personally and collectively to minimize harm.
- We believe that most people use substances. Those who use substances come from all economic levels, genders, races, abilities, and cultures.
- We believe that people use substances in a variety of ways including therapeutic, safe and problematic. Substance use can be recurring and cyclical.
- We believe that people have a right to use substances and we do not discriminate against anyone for current or past substance use.
- We believe community members are not all equal in terms of power and privilege so do not have the same access to health and supports.
- We believe stigma and racism are deeply embedded in institutions, agencies, and cultural norms, which impact distribution of wealth, poverty, access to resources and services, and experiences of inclusion.
- We believe that we live in systems (school, families, communities, etc.) where many people face restrictions, oppression, and discrimination. These systemic pressures influence our ability to thrive.
- We believe that substance use has historically been understood as a legal (criminal) and/or moral (bad decisions) issue. This has led to stigmatization, overdose epidemics and disproportionate incarceration rates.
- We believe that substance use can be a result of the determinants of health (housing, poverty, social inclusion, education etc.). Improving determinants of health can have a positive impact on substance use and can create healthier communities.
- We believe that substance use can be both an adaptive survival tool to cope with trauma and expose people to trauma.
- We believe a history of trauma and ongoing exposure to trauma is closely linked to harmful substance use.
- We believe substance use to be a health and social issue that requires social support and public policy responses to focus on meeting people's basic human needs.
- We believe substance use must be approached from both a systems and person-centered perspective. We acknowledge that people are often harmed because of systemic constraints - examples include the criminalization of individual use, lack of safe supply, prescribing practices, etc. and not individual decisions.

Guiding Principles

Compassion and respect: We have compassion for all people with whom we interact including people affected by substances and are mindful and respectful of differing perspectives.

Inclusion: We welcome the participation of everyone in the Comox Valley and we actively seek out participation of people with lived/living experience of substances.

Diversity: We embrace diversity and listen to the unique needs of the varied people, cultures and communities in our region.

Connection, Collaboration and Sharing: We nurture relationships, connect people to each other, promote a culture of participation and collaborate across organizations and sectors. Together we are better.

Learning: We share knowledge, listen to each other, explore new ideas and generate new understanding and solutions to create a regional substance use strategy to strengthen our community.

Innovation: We strive to find new and better ways to support health and wellness in our community.

Cultural Safety & Cultural Humility: We promote emotionally, spiritually, physically, and culturally safe environments and are open to everyone's individual identity.

Accountability: We are responsible for the resources entrusted to us and strive for effective and efficient solutions and initiatives.

Equity: We recognize inequity affects health and strive to reduce social, political and financial inequities.

Anti-racism: We recognize that substance use and health are deeply affected by racism and that addressing racism directly, with strength, knowledge, resources, and education is the only way to ensure that the multiple barriers to racial equality in Canada are removed.

Anti-stigma and Plain Language: We are committed to both the use of plain language and language that does not stigmatize people who experience substances.

Consensus Decision-Making: We make decisions based on consensus. The model of consensus decision making we use can be found here.

A WORD ABOUT WORDS - INCLUSIVE LANGUAGE

The Comox Valley Substance Use Strategy Committee is committed to being inclusive. We have been given permission from the Canadian Centre on Substance Use and Addiction (CCSUA) to use Overcoming Stigma Through Language: A Primer as a guide for this work.

To use inclusive language, we must understand stigma and the negative connotation of language that comes with it. Stigma is a judgement towards another person that can dehumanize them or make them feel "less-than". Often this is reinforced by negative language when we may not understand how our own stereotypes are making a judgement about someone else without knowing their full story.

To shift our language, it is helpful to focus on person-first language - language that acknowledges someone as a person before describing their personal attributes or health conditions. (CCSUA, 2019) This means saying "person who uses substances" rather than "druggie" or "addict" which reflects a judgment. In addition to people-first language, the Respectful Language and Stigma document (BCCDC, 2017) recommends avoiding slang, using language that acknowledges substance use as a health issue as well as language that promotes the person's capacity for recovery.

A REGIONAL SUBSTANCE USE STRATEGY: THE TIME IS NOW

LEADERSHIP FOCUS

Internationally and nationally there has been a growing consensus on the importance of addressing both mental health and addiction. There is an increasing body of literature around the impacts of mental health and social and health inequities on population and individual substance use. As a result, all levels of government have begun to prioritize, support and fund issues related to substance use and mental health.

In Canada, significant work has previously been led by The Mental Health Commission of Canada, the Canadian Centre on Substance Abuse, and the Canadian Mental Health Association, in collaboration with Health Canada and the Public Health Agency of Canada. This collaboration has led to the establishment of the Canadian Mental Health Strategy (Mental Health Commission of Canada, 2012), and a Canadian Drugs and Substances Strategy (Health Canada, 2018). These two strategies provide a framework and guidance for action and funding for regional and provincial mental health and substance use interventions and policies.

Many leaders in drug policy in Canada have been successful in advocating for policy change in British Columbia and over the last few years, the province of British Columbia has dedicated significant resources towards mental health and addiction. The BC government established a stand-alone Ministry responsible for Mental Health and Addictions and developed a 10-year strategy for mental health and substance use care. Because of the unique experience of a toxic drug supply, and a more liberal culture of substance use reform, BC has led many legal, social and economic initiatives around substances. Most notably, the province has advocated for cannabis reform, safe injection sites, safe supply and an expanded scope of practice for medical professionals including prescribing rights for registered nurses. The province has been at the forefront of advocating for many progressive harm reduction, treatment, and recovery practices and policies. In 2020, the BC government supported the call to the federal government from the Canadian Association of Police Chiefs to decriminalize the possession of small amounts of controlled substances in order to address substance use and addictions.

From a regional perspective, elected officials from the City of Courtenay, Town of Comox, Village of Cumberland and the Comox Valley Regional District participate in the Committee. These elected officials actively participate in setting the direction for the strategy while providing unique political perspectives and advice and are committed to advocating for actions that will reduce the harms of substance use.

This political will, in conjunction with ongoing efforts at the provincial, national, and international level provides an opportune time for system and community wide policy, service and practice reform. The time for action is now.

THIS MOMENT IN TIME

In March 2020, the World Health Organization declared the COVID-19 global pandemic. The restrictions imposed in response to the pandemic heightened the oppression many people in our community already face. People who already face racism, discrimination, marginalization, violence, and abuse are disproportionately affected by this situation.

Many people have experienced a deterioration in their mental health since the onset of the pandemic (CMHA, 2020). In addition, we know many people are relying more heavily on coping mechanisms, including an increasing use of substances like alcohol, cannabis, and prescription medications (CMHA, 2020). At the same time as liquor stores were being deemed an essential service, there was a dramatic increase in the toxicity of street drugs and 4.7 people a day died in British Columbia in 2020.

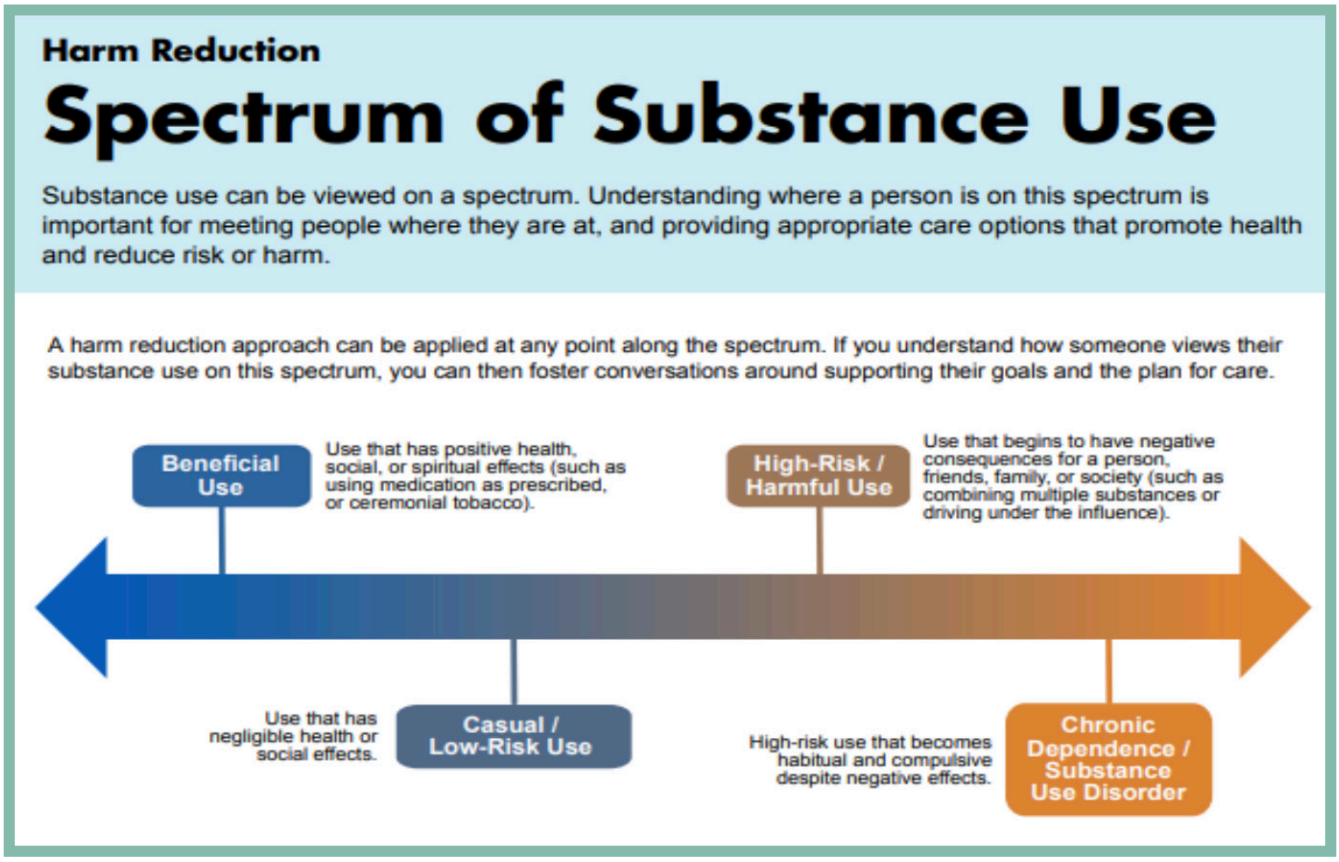
More people in British Columbia died from a toxic drug supply than from COVID-19 in the first 8 months of 2020 (Mathew, 2021). In the Comox Valley, 13 died from toxic drugs in 2020. Already, in the first 5 months of 2021, 14 people have died of toxic drugs (British Columbia Coroners Service, 2021). This is an alarming increase over last year.

The disparity in responses between the COVID-19 pandemic and the opioid crisis, by all levels of government, dramatically illustrates the stigma and discrimination that shapes policy responses to people who use illicit drugs. The common misconception that a person's substance use is a direct result of their own behaviour and decisions influences attitudes about the value and appropriateness of publicly funded solutions to the illicit drug toxicity crisis (CSCBHSN, 2016).

ABOUT SUBSTANCE USE

WHAT IS SUBSTANCE USE

The term substance use refers to the use of drugs or alcohol, and includes substances such as tobacco, cannabis, illicit drugs, prescription drugs, inhalants and solvents. Substance use exists on a spectrum from beneficial use to chronic dependence or substance use disorder.



(Alberta Health Services, 2019)

SOCIAL DETERMINANTS

There are many social determinants that can contribute to substance use and create additional barriers for individual and community health. These root causes may include but are not limited to:

- Poverty
- Lack of affordable housing
- History of trauma
- Access to services
- Stigma and discrimination
- Racism
- Colonization

In addition to the above, there are also social inequities and gender differences in the experience of substance use and the provision of substance use services. This strategy will acknowledge the wisdom held by people who are impacted by substance use and groups that experience inequity first-hand and use this information to develop a strategy that addresses the inequities within our current system. It will also work to increase access to policy development to create a more equitable system of care within our community.

Historically, substance use policies and practices have had a more profound impact on Indigenous peoples, as well as people facing poverty and/or homelessness. Our community requires a more equitable approach to policy development in relation to substance use, as well as these underlying social determinants.

Note: The Comox Valley Regional District completed a Regional Housing Needs Assessment in 2019 and will be releasing a Regional Poverty Assessment & Reduction Strategy in the fall of 2021. Both reports will inform the Comox Valley Substance Use Strategy.

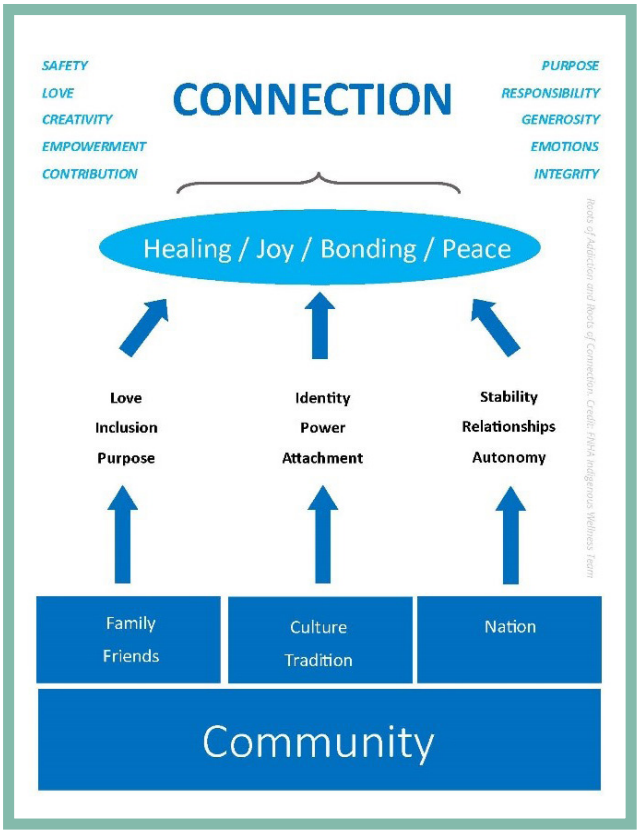
THE SCIENCE OF MENTAL HEALTH, TRAUMA & ADDICTION

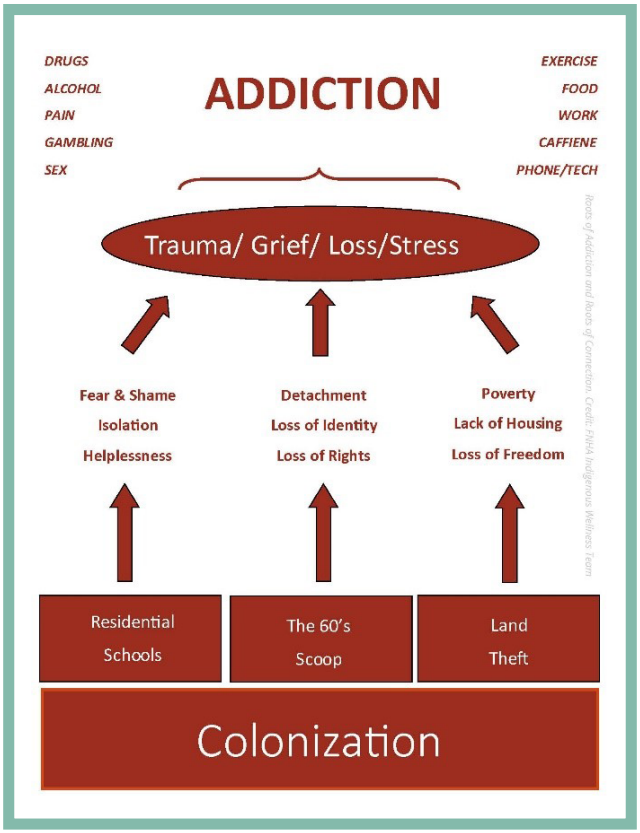
Harms from substance use and addiction are not a moral failing of the individual; instead, addiction happens within the brain. Brain changes happen before birth, at birth, and throughout a person's life.

The environment someone grows up and lives in, as well as their genetics, affects their physical and brain health. If someone is exposed to stressful events such as with violence, abuse, parents being absent (jail, addiction), or other traumatic events in their environment, then these events can change the brain chemistry and lead to addiction (NIDA, 2019). Someone may develop problematic substance use because of a history of substance use in their family, genetics, negative events that happen in their childhood (Adverse Childhood Experiences/ACES), trauma, stress, isolation, changes to the brain, or starting substance use early.

In addition, mental health and substance use issues can happen together. Concurrent mental health and substance use occurs when someone experiences a mental illness and uses substances like alcohol, nicotine or other drugs in ways that could cause harm (Canadian Mental Health Association, 2018) Rush (2008) states that "people with substance use problems are up to 3 times more likely to have a mental illness. More than 15% of people with a substance use problem have a co-occurring mental illness." When this occurs, mental illness can add to substance use harms (e.g., Increased substance use might help people cope with anxiety) or alcohol or other drugs may increase the symptoms of a mental illness.

People who experience both issues at the same time often have to go to one service for mental health treatment and another place for addiction treatment (CMHA, 2018). Sometimes services are not connected at all. While offering treatment in a concurrent way is the most successful, most people with a concurrent mood and alcohol disorder are likely to recover better if the alcohol disorder is treated first.





Above: Roots of Addiction and Roots of Connection. First Nations Health Authority (FNHA) Indigenous Wellness team. (2018, June 27). Not Just Naloxone Training: a three-day train-the-trainer workshop. FNHA)

APPROACHES TO SUBSTANCE USE

CULTURAL SAFETY, CULTURAL HUMILITY AND TRAUMA INFORMED PRACTICE

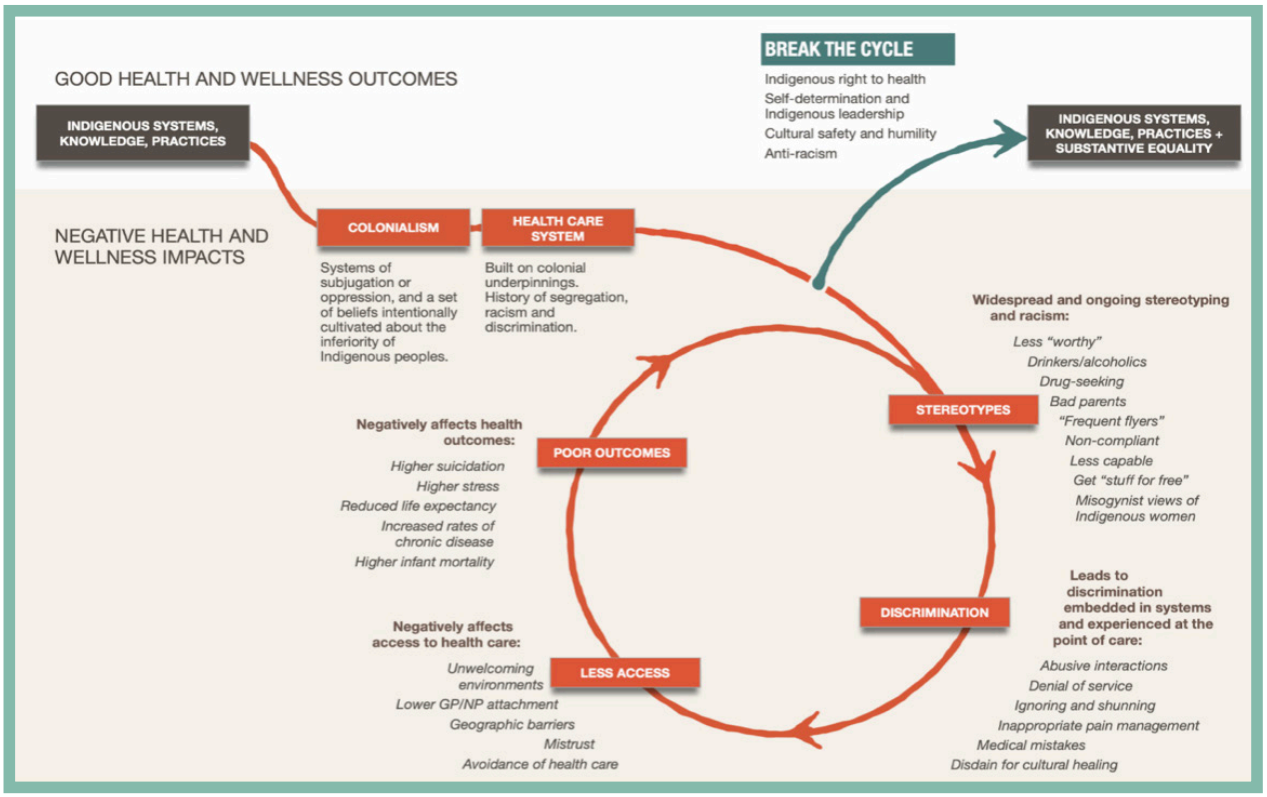
The Comox Valley is home to many diverse cultures including Indigenous, Metis and Inuit peoples as well as European settlers, Asian, South and South East Asian, Middle Eastern and many more.

Cultural safety work needs to be centered with an anti-colonial & anti-racist lens that invites a conversation and challenges power structures. Turpel-Lafond, 2020 highlighted the need to address racism in all forms within our health care system in British Columbia. In order to consider cultural safety in a strategy supporting those who use substances, we need to understand the Truth and Reconciliation Commission's Calls to Action # 18-24 (Government of Canada, 2019) related to mental health and addiction.

The First Nations Health Authority defines cultural safety as:

> **Cultural safety** is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care.
>
> **Cultural humility** is a process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience.
>
> *Source: Creating a Climate for Change*

The graphic below shows how colonialism in the healthcare system can lead to Indigenous people being stigmatized and discriminated against. These factors can lead to potential negative impacts on health and wellness outcomes for Indigenous people, however ensuring health is a human right for all, as well as Indigenous leadership and cultural safety and humility training helps to break the cycle. (In Plain Sight, Turpel-Lafond, 2020).



The Committee, peers and community members have identified a need for cultural safety in communications, meetings, and work within the community. In addition, there has been a need expressed for culturally safe spaces within health care. Learning about the culture of individuals within the substance use spectrum allows us to respect their unique care needs and connect them to cultural supports. Culture is healing and can be considered prevention, harm reduction, and treatment at different points in a person's substance use journey.

As stated in the strategy beliefs "substance use can be both a source of trauma and an adaptive survival tool to cope with trauma" (2020). Along with culturally safe care goes trauma informed practice. Trauma-informed practice means integrating an understanding of trauma into all levels of care
and avoiding re-traumatization or minimizing the individual's experiences of trauma. Practitioners ask questions on a need-to-know basis in the best interest of the individual being supported; pay attention o to the individual's spoken and unspoken responses; adapt approaches to respond to the individual's needs.

Trauma- informed practice is an overall way of working, rather than a specific set of techniques or strategies. There is no formula. Providing trauma-informed care means recognizing that some people will need more support and different types of support than others. Practitioners also adopt a strength-based approach and recognize that human beings are resilient and resourceful, and much of their healing happens outside of formal treatment services (Trauma Informed Practice Guide, 2013). Trauma-informed care and practice also recognizes each unique person's need to feel emotionally and physically safe. Best practices on supporting people with the intersection of mental health and substance use issues can be found in the guide.

FRAMEWORKS TO ADDRESS SUBSTANCE USE

In keeping with the commitment to honouring Indigenous ways of knowing and being, and creating cultural safe practices to address substance, both Indigenous as well as colonial substance use frameworks will be used to guide this work. Going forward, as actions are developed, the intent is that all perspectives are considered and honoured.

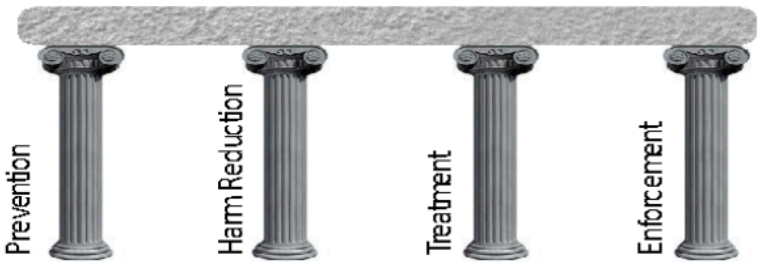
Four Fire Model

source: www.nativeyouthsexualhealth.com

The Native Youth Sexual Health Network offers a critical analysis of what reducing the harm of colonialism can look like. The Four Fire model and the examples below are the culmination of more than 10 years of community knowledge, research, and Indigenous HIV-movement wisdom. This knowledge is the result of collective learning, listening and resisting done by many youth leaders and mentors of Native Youth Sexual Health Network and includes the lived experiences of young people, Elders, other community members and Indigenous peoples living with HIV. The knowledge thus does not belong to a single individual, and it is a living praxis that shifts with community needs and voices. More information here

Indigenizing Harm Reduction

With staggering rates of HIV, HCV and IDU amongst Indigenous peoples, it is clear that current mainstream models may not be meeting Indigenous peoples where we are at. What could harm reduction look like outside of urban centers in rural, northern and remote communities?



Pillar Model

The 4 pillar model is familiar to many harm reduction workers, academics and health policy analysts. While not the only theory on how to counteract harms caused by substance use, the interpretation and implementation of these pillars can sometimes also uphold colonial ideals of health, power and oppression.

Moving Beyond 4 Pillars

Indigenous peoples have experience reducing harm in many ways, especially the violence of colonialism for the last 500 years. Mainstream harm reduction models and practices while certainly a step in the right direction, do not always fit in northern, rural, or remote communities. Indigenous peoples have many Nation-specific understandings, traditions and needs that mainstream services often ignore or interrupt.

By shifting our focus from interpretations of these pillars like policing, prisons, court mandated care and assuming 'risk' is individual instead of systemic, we offer a critical analysis of what reducing the harm of colonialism can look like. **This is not a 'one size fits all' approach** but an opportunity to reinterpret these ideas in community specific ways that recognize the diversity of Indigenous peoples.

Four Fire Model

By centering community wellbeing and the restoration of different Indigenous knowledge systems, life ways, ceremonies, culture and governance structures Indigenous peoples of many Nations and cultures can reduce the harm we experience in our lives.

Cultural Safety

"Acknowledge the power differences that exist between service provider and client/patient. Allowing and creating spaces for Indigenous peoples to feel safe to be our whole selves when receiving care"

Sovereignty

"Principles like non-interference teach us to support and meet people where they're at, ex. not forcing treatment"

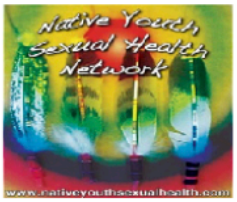
Reclamation

"Colonialism uprooted and distorted many structures and ways of life within our communities, reclaiming cultural practices can strengthen us"

Self-determination

"Allowing individuals, communities and Nations to decide specifically for ourselves what works best for us"

What would these fires looks like on the ground while understanding the importance of the central home fire?



Native Youth Sexual Health Network 2014

INDIGENOUS HARM REDUCTION PRINCIPLES AND PRACTICE

SOURCE: First Nations Health Authority

The Indigenous Wellness Program at First Nations Health Authority developed Indigenous Harm reduction principles and practices to host conversations regarding addictions and harm reduction. Indigenous harm reduction is a process of integrating cultural knowledge and values into the strategies and services associated with the work of harm reduction. Indigenous knowledge systems are strongly connected to spirituality, holism and the natural environment. Therefore, a learning model reflecting animal teachings and values was struck to support sensitive conversations around addictions and harm reduction through an Indigenous lens.

THE PRINCIPLES AND PRACTICES USE CULTURAL REPRESENTATION FROM FOUR PROMINENT ANIMALS HERE IN BC. EACH ANIMAL IS REPRESENTED BY SYMBOLISM, A HEALING PRINCIPLE, AND COMPARATIVE HARM REDUCTION STRATEGIES:

THE WOLF

- A symbol of relationships and care.
- Healing requires working together as one heart and one mind.
- This representation is associated with harm reduction principles that emphasize the importance of building relationships with people who use substances. An example of carrying out this work might look like providing outreach services.

THE EAGLE

- A symbol of knowledge and wisdom.
- Healing requires time, patience, and reflection.
- This means acknowledging that wellness is a journey instead of a destination. It aligns with the harm reduction principle that support may take many ongoing opportunities. It also means that in our professional work practice we take the time to reflect on our own emotions and allow room for patience in our engagements with people who are using substances.

THE BEAR

- A symbol of strength and protection.
- Healing is embedded in culture and tradition.
- This principle celebrates a strength-based approach in working with harm reduction. This also recognizes culture and tradition as intergenerational strengths that are methods of harm reduction on their own.

THE RAVEN

- A symbol of identity and transformation.
- Healing requires knowing who you are and accepting who you were.
- This healing principle acknowledges that the path to wellness is a journey that encompasses the exploration of identity and that mistakes will be made along the way. We do not need to carry the burdens of past, as they transform us when we learn from them.

WORKING WITH INDIGENOUS HARM REDUCTION: LEARNING COMPONENTS

FOUR PILLARS MODEL

The four pillars/streams used here include: Health Promotion and Prevention, Harm Reduction, Treatment, and Community Safety (moving away from the criminal and negative connotation associated with "enforcement").

Health Promotion and Prevention

Health Promotion practices include addressing the social determinants of health or root causes of substance use and encourage healthy behaviours, supportive environments and healthy public policies. Health promotion and prevention education should focus on people's innate resilience and strengths to empower them to be the primary drivers of their health. Doing this within a social justice and health equity lens encourages healthy public policy.

Prevention includes best practices, supports, and upstream approaches to help prevent people from starting or engaging in potentially harmful substance use. It also includes educating people to be aware of the risks associated with substance use.

Harm Reduction

"Harm reduction aims to keep people safe and minimize death, disease, and injury from high-risk behaviour. The evidence shows it works and has many benefits for people who use substances, their families and our communities (Towards the Heart, 2021)". Research shows that taking a harm reduction approach does not increase substance use. In fact, people are more likely to start treatment when a harm reduction approach is used.

Treatment

Treatment helps to reduce otherwise preventable illness, injury, and/or deaths through interventions and programs like alcohol treatment after withdrawal support and opiate agonist therapies, and counselling (City of Vancouver, 2021). Treatment may include outpatient or in patient services and includes shifting to an integrated wrap-around approach that supports people who use substances to prevent gaps in service. Treatment options are recommended to be organized to support unique needs like youth and Indigenous people who need age-appropriate and culturally safe options. A foundation of successful treatment that always needs to be considered is supportive housing (Macpherson, 2001). Housing helps people who use substances to find stability first, then choose and access services that work for them such as treatment.

Community Safety

The community safety pillar recognizes the need for peace, public order and safety. It works to reduce crime and community harms associated with substance use while protecting people and preserving and protecting life. Ensuring everyone in our community is safe, including people who use substances, allows us to shift from punishing and criminalizing to working together towards safer and more inclusive practices for all.

WHY THE COMOX VALLEY NEEDS A SUBSTANCE USE STRATEGY

WHAT WE KNOW: DATA + EXISTING SUPPORTS & SERVICES

DATA

A review of the science and data on substance used in the Comox Valley was done to find out what substances people are using, how they are affecting different subgroups and ages, and where they are using. The impact of different substances on people's health was also researched. In addition to the impact of substance use on the individual, the data highlights the impacts on family, friends and the greater community.

Note: Some data is not available at the community level, so Island-wide, provincial and federal data is also included in some cases.

Age Standardized Hospitalization Rates Attributed Wholly or Partially to Listed Substances Comox Valley Local Health Area and Vancouver Island Health Authority, 2017 & 2018 (Rate per 100,000 population)

	Comox Valley		Vancouver Island	
	2017	2018	2017	2018
Tobacco	433.3	444.4	439.5	421.4
Alcohol	373.0	397.4	451.1	480.8
Cannabis	17.1	17.4	29.7	33.4
Cocaine	NA	8.8	14.0	17.2
Depressants	31.4	28.5	31.3	31.8
Opioids	37.5	27.0	45.6	44.7
Other	17.4	30.7	24.2	32.2
Stimulants	23.9	14.5	31.7	34.3

Source: Canadian Institute of Substance Use Research; University of Victoria. http://aodtool.cisur.uvic.ca/aod/about.php

Presented here is a summary of the data. The complete data report with graphs, partnerships and data relationships started to date is here.

General Substance Use

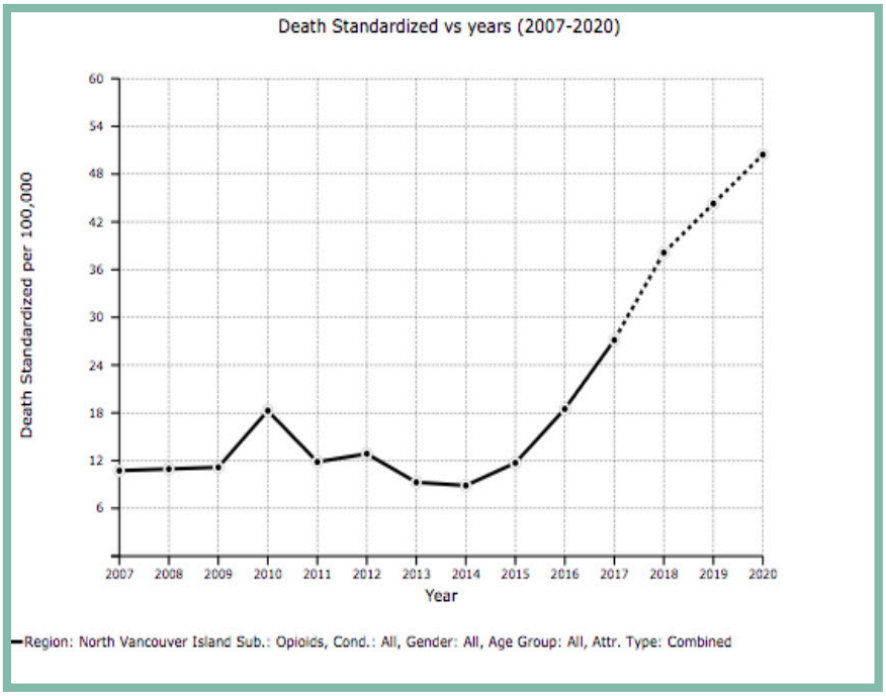
- In North Vancouver Island (Comox Valley north to Port Hardy), 2018, most substance use related hospitalizations for all ages and genders (attributed both wholly and partially) were due to tobacco and alcohol (CISUR, 2018).
- Hospitalization rates due to tobacco, alcohol and cannabis use have increased for the Comox Valley. The Comox Valley had a slightly lower increase (24.4) compared to Vancouver Island as a whole (29.7). This tells us about the medical impact, but not necessarily use rates.
- Use of depressants (i.e. benzodiazepines or barbiturates), opioids and stimulants (ie. cocaine or crystal meth) have decreased. Due to the impact of the COVID-19 pandemic, it is important to consider more recent data.
- In the Comox Valley, the number of people diagnosed with a substance use disorder increased from 804 in 2014/15 (1.3 per 100 people) to 1120 (1.6 per 100 people) in 2018/19 (CISUR, 2018).
- The highest number of deaths in North Vancouver Island, for all ages and genders in 2017 was caused by opioids (CISUR, 2018).
- As of 2017 alcohol cost the Canadian healthcare system $838 million, tobacco cost $747 million, cannabis cost $57 million, opioids cost $91 million, and other substances combined cost over an additional $165 million (Canadian Substance Use Costs and Harms (CSUCH), 2018).

Opioids

Walk With Me, is a research-based art project that has focused on the opioid crisis in the Comox Valley. They used a process called cultural mapping, where "communities impacted by the crisis were brought together to share stories and create drawings/photographs that speak to their experience." Our committee has been working along side the Walk with Me project as they work to develop their own report and recommendations which will be released in September 2021. We look forward to working together as we move into Phase Two of our work. A link to their literature review can be found in the appendix.

Island Specific Opioid Data

- In February 2021, 93% of all opioid samples tested in Island Health were positive for fentanyl, and 21.4% of drugs expected to be opioids also tested positive for benzodiazepines through the Fourier Transform Infrared (FTIR) spectrometer (BCCSU, 2021).
- North Vancouver Island (which includes the Comox Valley) had one of the highest rates of illicit drug toxicity deaths by Health Service Delivery Area (BC Coroners Service, 2021). The full report of illicit drug toxicity deaths in BC from January 1, 2011, to May 31, 2021 can be found here.
- The City of Courtenay shows a decreasing severity in illegal drug overdoses rated as 'severe' over the last six months, yet there is still a relatively high percentage (over 60%) of overdoses transported to the hospital (BCCDC, 2021). It is important to consider points of care at hospitals, both on intake and discharge, as opportunities to support people who use substances.
- In March 2021, North Vancouver Island saw more than 30 opioid related deaths per 100,000 people. (BCCDC, 2021). This rate has been about the same over the last 12 months).
- Most overdoses are happening in private homes or outside where people may be at increased risk of using alone (BC Coroners Service, 2020). Comox Valley paramedics have responded to a higher rate of overdoses in private residences at 54%, as compared to the rest of Island Health at 41% for 2020.
- In the Comox Valley, opioid related deaths have increased dramatically, especially from 2014 to 2017, as can be seen in the following graph from Canadian Institute on Substance Use (CISUR):



Stimulants

- Publicly accessible and current stimulant use data for the Comox Valley is limited. At this time, the Comox Valley Community Health Network has a data partnership with Vancouver Island Health Authority (VIHA) and anticipate having more Comox Valley-specific data soon. Stimulant use, like other drugs, can range from beneficial to harmful, to dependence or disorder. Common stimulants used that may cause harm include methamphetamines, cocaine, and crack cocaine. Another risk is that stimulants may be contaminated with toxic opioids such as fentanyl (CCSA, 2019).

- The Canadian Institute for Substance Use Research has hospitalization data related to stimulants for 2007-2018, and rates increased on the North Island up until 2017, then began to decrease (CISUR, 2018). The rate for the North Island in 2018 was at 14 hospitalizations per 100,000 people as compared to 31 per 100,000 for the whole of BC.

- Accessible death records from stimulants in the Comox Valley are only accessible up to 2017 through the Canadian Institute for Substance Use Research (CISUR) but stimulant related deaths went up from 1.81 in 2016 to 1.93 in 2017 per 100,000 people (2015).

Tobacco + Vaping

- Studies show that pulmonary illness is linked to both smoking and vaping, with indicators including: coughing, shortness of breath, and chest pain. The Canadian Institute for Substance Use Research (CISUR) states that tobacco causes the highest number of hospitalizations and deaths in BC, although the rates are dropping (2018).

- Although tobacco and vaping products are only legally allowed to be sold to those aged 19 and older, many youths under 19 are using these products with potential harms to their health.

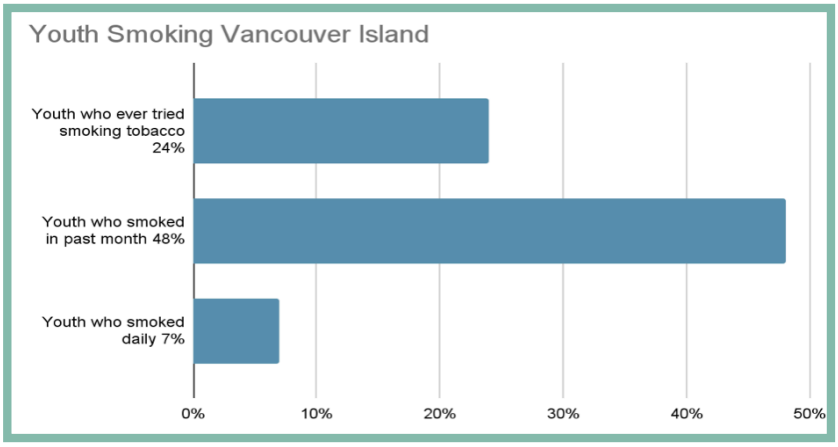
- The McCreary Centre Society report on Vaping and Tobacco Use on Vancouver Island states that from 2013 to 2018 youth smoking has been around 24%, down from 36% in 2003 (2020). This is lower than youth in Northern BC (28%), and higher than youth in Vancouver Coastal and Fraser health youth (about 15%).

- As of 2018, there were 498 hospitalizations per 100,000 people due to tobacco in the North Island (CISUR, 2020). Unfortunately, there is little research on the health impacts of vaping in Canada.

- Tobacco-related deaths have been steadily increasing in the Comox Valley since 2012, with the potential years of life lost from respiratory illnesses at about 3.6 years. In 2017 the deaths caused by tobacco in the Comox Valley were 136 per 100,000 people as compared to 126 per 100,000 as an average across BC (both partial and whole causes). (VIHA Local Health Area Profile, 2019)

- According to "Clearing the Air: A Youth-led Research Project", peer influence, supportive adults, community connection, spirituality, and meaningful activities decreased the chance that youth would smoke or vape (2019).

- A longitudinal study for the Courtenay Local Health Area showed that as youth move into higher grades in secondary school, tobacco and nicotine use increase. (VIHA Local Area Profile, 2019)

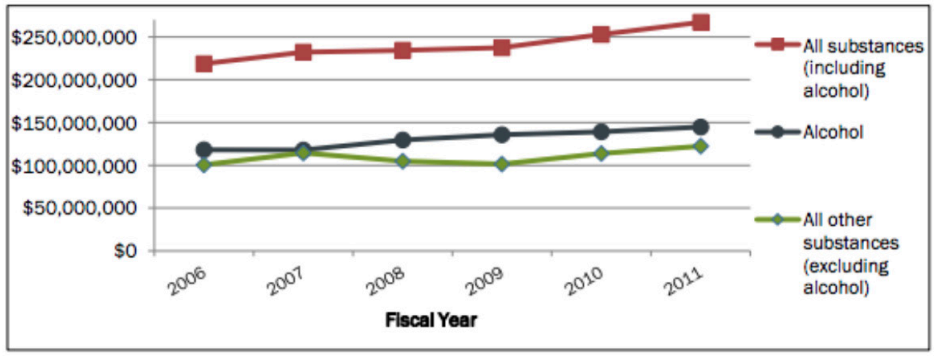


(McCreary Centre Society, 2020)

Alcohol

- First substance of choice across Canada (Health Canada, 2016)
- 78% (23.3 million) Canadians reported consuming an alcoholic beverage in 2017 (Health Canada, 2017)
- 9.16 litres Annual per capita alcohol consumption in 2019 across BC (CISUR, 2021)
- 75% of substance use deaths in Canadian hospitals are directly related to alcohol use (CIHI,2021)
- Harms related to alcohol are often understated, but in 2018, it was estimated that each year some 15,000 deaths, 90,000 hospital admissions and 240,000 years of life lost are directly attributable to alcohol use in Canada (CCSA, 2019).
- According to the Canadian Low Risk Drinking Guidelines (LRDG), on one occasion men should not drink more than 3 drinks most days or 15 standard drinks per week, whereas women should not drink more than 2 standard drinks per occasion most days or 10 standard drinks per week. In BC, amongst individuals who identify as drinkers, 24.1% chronically exceed and 19.4% actually exceed the LRDG.
- In 2019 across BC, Vancouver Island had the second highest per capita alcohol consumption rate, at 11.24 litres, which was also higher than the provincial average of 9.07 (CISUR, 2020).
- Relative to other BC communities, who's reported alcohol consumption between 2013-2019 remained stable, in Vancouver Island health region and our local Comox Valley health area, consumption has steadily increased and is projected to continue. In 2017, Comox Valley per capita alcohol consumption was 11.70 litres (CISUR, 2020.
- In Canada, the Canadian Institute of Health Information found that alcohol contributes to more than half of all hospitalizations linked to substance use. This is also thirteen times more common than opioid-related hospitalizations (CIHI, 2021). Throughout 2017-2018 there have been 361 alcohol-related hospitalizations every day per 100,000 people in BC, which is the highest across Canada (CIHI, 2021). In 2018, there were 397.40 hospitalizations in the Comox Valley which was an increase from 2017.
- In 2017 there were 57 reported alcohol deaths in the Comox Valley compared to 48 deaths on average across BC. This is an increase from 37 deaths in 2014 in Comox Valley (CISUR, 2020).
- Throughout the COVID-19 pandemic, there was an increase in alcohol consumption relative to the standard drinks per adult. After the initial lockdown in March 2020, there has been a steady increase in consumption (CISUR, 2020)
- Costs related to substance use visits to the emergency departments across Canada have been increasing. Relative to other substances alcohol related hospitalizations costs far exceed any other single substance, including the combination of all other substances (CCSA, 2019).
- Economic costs of alcohol use are up to 10 times higher compared to other substances and related to criminal justice issues, lost productivity and health care (CISUR, 2018).
- In 2014 across Canada, alcohol, contribute $14.6 billion or 38.1% of the total costs of substance use (CCSA, 2019).

Figure 10: Cost associated with hospitalizations for those with a primary diagnosis of mental and behavioral disorder due to use of alcohol versus all other substances excluding alcohol

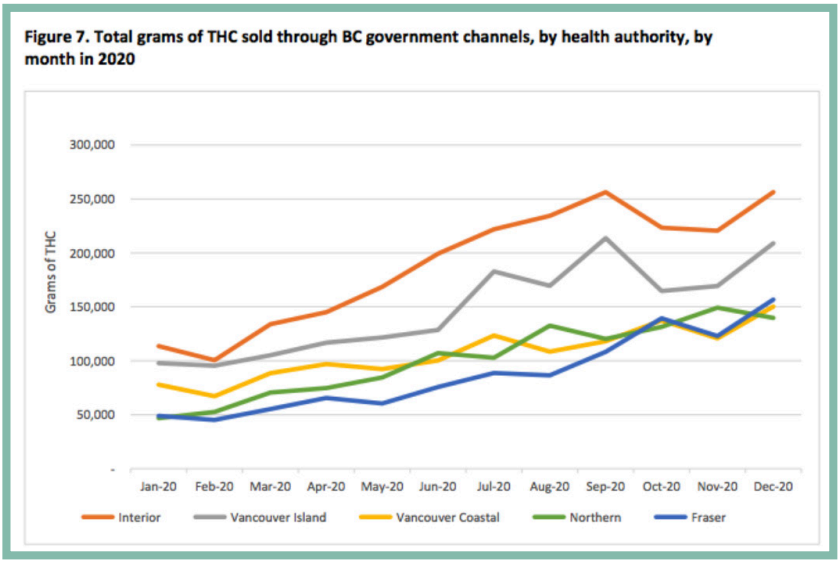


Source: CCSA, *The Impact of Substance Use Disorders on Hospital Use*, 2014

Cannabis Use

- 15% of Canadians aged 15 and older (or 4.4 million) have used cannabis in the past 12 months - 19% among age 15 to 19 years; 33% among age 20 to 24 years; and 13% among age 25 years and older (Health Canada, 2017).
- 18% of Canadian students in grades 7 to 12 (approximately 374,000) have used cannabis in the past 12 months (Government of Canada, 2019).
- 28% of British Columbians used cannabis throughout 2018 (BC Stats, 2019). Of this group 58% were men and 42% were women (BC Stats, 2019).
- Across BC health authorities, Island Health reported the highest rate of cannabis consumption, at 34% (BC Stats, 2019).
- Throughout 2020 BC there has been an increase in cannabis use and an increase in the legal sale of cannabis (Naimi, 2021).
- Vancouver Island Health Authority has the second highest total THC sold in BC sold by the government through wholesale (to licensed private retailers), government retail or government online channels (BC Stats, 2019).

Figure 7. Total grams of THC sold through BC government channels, by health authority, by month in 2020



- In BC cannabis products are becoming increasingly cheaper and more potent, and its year-over-year sales doubled between 2019 and 2020 (Naimi, 2021).
- In BC there is a 10:1 ratio of government run cannabis retail versus private run cannabis retail. Retail outlets are still on the rise, as the province went from 128 private and 11 government stores in Dec. 2019 to 270 private and 25 government in Dec. 2020 (Naimi, 2021).
- Prior to legalization (2004-2017), cannabis contributed $2.8 billion or 7.3% of the total costs of substance use in Canada (CCSA, 2019). Since the legalization of cannabis in 2018, there has been an ability to study the impacts of cannabis in more detail.
- From 2015 to 2018 the total hospitalizations due to cannabis use has been either below or at the same level of VIHA hospitalizations. In 2018, Comox Valley had 17.28 hospitalizations (BC Stats, 2019).
- Relative to other substances, cannabis has a low death rate in BC. In 2017, there were 4.9 deaths per 100,000 in Comox Valley, compared to 5.03 on Vancouver Island (BC Stats, 2019).

EXISTING SUPPORTS AND SERVICES

A survey was sent to service providers in the Comox Valley to ask about the supports and services they provided. The survey was completed by 27 programs or organizations and more in-depth conversations took place with agencies who wanted to give more information. A summary of the Report on Stakeholder Survey Results can be seen here.

Provided below is a snapshot of the supports and services in the Comox Valley. It is not an exhaustive list as services and supports change frequently. Also note that some programs and services have a waitlist. It is a beginning point and will see changes as the strategy is developed. One change that will be implemented is to identify services and supports that encompass the Four Fires and Indigenous Harm Reduction Frameworks.

***Please note:** the services listed below in alphabetical order by agency have been described by the agencies and organizations themselves. In our work with Peers and those who support them in the community we learned that there is often a discrepancy between the perspective of services offered by the providers, and the experience people have in accessing those services. As we move into Phase Two of this work, this discrepancy will be addressed through facilitated conversations between service providers and people accessing services

AIDS Vancouver Island (Comox Valley) Health and Community Services provide education, advocacy and support to clients and education and prevention information to schools, the broader community and target populations that include educational materials promoting improved health, safer drug use, safer sex and more; Naloxone distribution and training; harm reduction supplies, support and education: education for safer drug use: referrals and links to other services; referral to and assistance navigating social and health care systems.

Alano Club of Courtenay is a drug and alcohol-free zone that offers social interaction, cafe and 12 step (Alcoholics Anonymous) meetings on a regular basis. Membership is required to attend.

BC Emergency Health Services address the acute phase (overdose, poisoning, accidental ingestion) of any type of substance use situation or crisis. Paramedics often have to administer naloxone in suspected narcotic overdoses. Paramedics also promote harm reduction and are able to hand out "Take Home Naloxone" (THN) Kits. Rural and remote community paramedics, such as on Denman and Hornby also have a role in education and outreach services - they do everything from client visits to community outreach programs.

Cocaine Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from their addiction. The only requirement for membership is a desire to stop using cocaine and all other mind-altering substances. There is a meeting in the Comox Valley on Friday evenings.

Community Justice Center (CJC) supports restorative justice between those who have participated in a criminal activity or created hurt towards another person, and those who have been hurt or have had a crime committed against them. The CJC operates from a relationship building and a person-centered approach where participants who offend can take responsibility for their actions to help heal the hurt they caused. The CJC does this through education, creating safe spaces for healing communication and restorative actions. This preventative approach supports those with mental health and/or substance use issues at an early point of engaging in criminal activity. People who go through the process also make healing connections and informal connections to other social service and/or health providers and are instead given an opportunity to learn and grow rather than "fall through the cracks" in our systems.

EXISTING SUPPORTS AND SERVICES

Comox Bay Care Society the Care-A-Van provides low-barrier, ethical and compassionate heath and social development services through a Mobile Health Care Unit. The Care-A-Van has a regular route throughout the community which can change in response to the needs of the people using our Services. Changes in schedule are publicized in advance. People using out services can immediately speak to and interact with nurses, physicians, mental health workers, harm reductionists, and peers, and affiliated professionals on site regarding their health needs. They can receive services such as health assessments/services, wound care, foot care, health assessments & monitoring, mental health services, harm reduction education, supplies and services, overdose prevention strategies, initial vision screening, free hygiene/ water supplies, sundries, food & clothing. Coordinated support services and referral services are provided for dental/denture service, audiology screening, vision screening, short term case management mental health supports, overdose prevention, referral to detox treatment, mental health service, outreach programs and support with health promotional strategies, provision of onsite phone services to arrange appointments and facilitate transportation.

Comox Valley Addictions Clinic (CVAC) offers Opiate Agonist Therapy (OAT) such as Methadone, Suboxone, and Kadian as well as medications to reduce the cravings of alcohol. There is a peer who works at the clinic and people report feeling welcome and safe.

Comox Valley Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other so that they may solve their common problem and help others to recover from alcoholism. The only requirement for membership is a desire to stop drinking. There are several meetings every week at various locations in the Comox Valley. One of the weekly meetings is a Rainbow LGBTQ2 group.

Comox Valley Community Action Team works in the community to strengthen the multi-sectoral response to the overdose/drug poisoning crisis and has successfully brought on 10 peer advisors including three Indigenous peer advisors. Three peer-led projects, initiated in 2020, include Comox Valley Street Outreach, Drug Testing Project and Brave App Pilot Project. More peer projects are being initiated in 2021.

Comox Valley Primary Care Network provides primary care, substance use and mental health referrals and support, access to Opioid Antagonist Therapy, Counselling, Life Skills.

Comox Valley Recovery Centre offers 10 supportive recovery beds for men for 30, 60, or 90 days, two social withdrawal/ stabilization beds (non-medical) for up to a max of 14 days at discretion of Mental Health and Substance Use withdrawal management nurse. The program is group based with individual counselling sessions.

Comox Valley Transition Society

Lilli House Transition House is for women fleeing violence.

Amethyst House offers 9 supportive recovery beds for women for 30, 60, or 90 days and 1 or 2 withdrawal or stabilization beds (non-medical) for a maximum of 14 days at discretion of withdrawal management nurse. Trained staff are on-site 24 hours a day, 7 days a week, and facilitate a structured program that takes a holistic approach to recovery focusing on the physical, mental, social, cultural, and spiritual realms of each woman's life.

Other Housing 23 units of provincially subsidized housing: 40 units of temporary supportive housing for unhoused people at a local motel.

Housing supports (access to resources, develop skills, practical supports) and rental supplements for women, children and families.

Connect Warming Centre offers refuge for unhoused people, temporary storage of belongings, access to washrooms, on-site outreach workers who offer access to housing, assistance filling out forms, assistance with ID replacement, vulnerability assessments, referrals to social services, access to living supports, literacy and education, volunteer opportunities, scheduled workshops, training, and activities, and visits from social service providers.

First Nations Health Authority: Virtual Substance Use and Psychiatry Service: The First Nations Virtual Substance Use and Psychiatry Service provides individuals with access to specialists in addictions medicine and psychiatry as well as mental health and wellness care coordinators. This is a referral-based service and is available at no cost to all First Nations people and their family members living in BC, including family members who are not Indigenous.
Specialists and care coordinators are dedicated to the principles and practices of cultural safety and humility, and to delivering trauma-informed care.

The Hornby and Denman Community Health Care Society provides free, confidential, community-based mental health services for Hornby and Denman adults, children, youth and families including counselling, referrals, bridging to community resources, harm reduction information and supplies, and parent support groups. We support people who are facing many different types of challenges including depression, anxiety, grief, substance use, school-related, relationship, child behaviour and parenting.

Indigenous Women's Sharing Society: Unbroken Chain, Indigenous Harm Reduction Program, provides support to individuals impacted by the overdose crisis, including people with lived and living experiences, family and friends, and youth. Unbroken Chain programming is Indigenous peer-led, managed. They provide Naloxone training, harm reduction workshops, peer support and peer counseling, positive wellness support groups, sharing & healing circles, various workshops, peer training, connections & support from Elders, healing circles, beading circles, community gatherings and community outreach, advocacy and education.

Island Health

Overdose Prevention Site provides a fixed location at a designated site for people to IV use called "episodic OPS" at a Mental Health and Substance Use site. Staff provide a confidential, safe space for people to access harm reduction, naloxone kits, fentanyl testing, drug alerts and to IV use substances on-site. Located at 941-c England Ave (blue door on the left).

Harm Reduction Services (through Public Health) All Mental Health and Substance Use (MHSU) sites provide Take Home Naloxone training. Harm Reduction initiatives at VIHA include HR supply distribution, Needle disposal boxes, Drug Alerts, HIV testing services, HIV/HCV/BBI's care treatment and support.

Harm Reduction Education that is evidence informed, compassionate and non-stigmatizing, acknowledges the context of colonization and systemic oppressions, and identifies substance use dependency as a health condition. School based substance use education includes peer to peer education programs, broad population-based media campaigns and public forums.

Outpatient recovery services provide Substance Use assessment, treatment planning, referrals, individualized counselling and group services. Services are offered both 1 to 1 and also in group settings. People may be self, or health care provider referred.

Early Recovery Program A 5-week psychoeducational based drop-in group program where each session provides a mindfulness component, daily plan and a specific session topic. These sessions are currently limited to 5 participants (under current COVID19 restrictions) and run Wed/Thur/Fri in-person currently 9:30am to 10:45am.

Intensive Case Management Team is an interdisciplinary, outreach team that practices from a harm reduction, strength-based philosophy with individuals who are actively using substances. They provide support for people 19 years of age or older who have persistent and severe substance use disorder with or without mental health concerns; are experiencing moderate to severe impacts in their daily functioning due to a high level of substance use and may have regular involvement with emergency services including the legal system. People can self-refer or be referred by a health care provider and/or community partner.

Withdrawal Management Nurse: 4 days/week for intake, assessment and access to non -medical withdrawal services at CV Recovery Centre and Amethyst House. Services are for all substances (opioids, stimulants, alcohol, pharmaceuticals, etc). Also supports people to access medical detox at Clearview Community Medical Detox in Nanaimo and connects them to supports when they return to the Comox Valley. This program also works to align withdrawal management services with support recovery/program beds to decrease transition points between services.

Comox Valley Nursing Centre Health Connections Clinic provides primary care along with addictions medicine and opioid agonist therapy (OAT) through a unique team-based approach that works best for those challenged with finding a Primary Care Practitioner and who have medical and non-medical needs. OAT gives people who use substances another option for treatment and can help treat opioid addiction to drugs that may include fentanyl, heroin, Percocet, or oxycodone (VIHA, 2021). Therapy involves taking medications that prevent withdrawal and reduce cravings. Medications include Methadone and Buprenorphine (Suboxone).

John Howard Society of North Island (Comox Valley) offers prevention education and support to youth in schools and community; youth (12-19) outreach support for such things as anxiety, stress, life skills, substance use, sexual exploitation, access to community resources, advocacy as necessary; youth alcohol and drug counselling; substance use counselling; second stage supported recovery for youth, and adult supportive housing (46 units) for people experiencing chronic homelessness.

The Junction includes 46 units of adult supportive housing for people experiencing chronic homelessness.

The Station includes 5 units of youth transitional housing and will open 5 supportive recovery beds for youth in mid-2021. Supports includes recreation and community access, group sessions, life skills, counselling, and harm reduction, as well as access to cultural activities and supports. Youth will also be linked to Island Health funded-substance use counselling.

Kwakiutl District Council Health (KDC): Mental Health and Addictions Programs offer programming that is culturally sensitive and steeped in the traditions of Kwakwaka'wakw people. They offer ceremony and tradition as a part of every program. Programs that address mental wellness and substance include Suicide or ideation; substance use; trauma; grief & loss; mental wellness; stress, anxiety, depression, and parenting/attachment.

Narcotics Anonymous is a fellowship of recovering addicts who meet regularly to help each other stay clean. This is a program of complete abstinence from all drugs and has only one requirement for membership, desire to quit using. Provides a 24 hour helpline and several options for meetings in the Comox Valley.

Royal Canadian Mounted Police (RCMP) The Comox Valley RCMP is responsible for responding to crime in our community, including the investigation of offences under the Controlled Drugs and Substances Act. Additionally, RCMP Victim Services is based within the Comox Valley RCMP Detachment. RCMP Victim Services provides emotional support, information, court support, and referrals to community agencies for victims of crime and trauma. The RCMP offers online prevention resources for any member of the public as well as resources specific for educators and youth in our community.

School District 71 (SD71) supports a proactive and comprehensive approach to substance use which emphasizes preventative curriculum, early intervention, counseling and disciplinary actions" (2019). They also support an environment free from tobacco, vapour and cannabis on all school property and have education programs for the prevention and cessation of smoking.

Stepping Stones Recovery House for Women provides a safe and supportive environment for a maximum of six resident women who have committed to participate in a three-month, (up to six months), program. During the 3 months residents will receive Group Therapy, Life Coaching, participate in 12 Step Study Group, in-house 12 Step Meetings, Fitness, Community 12 Step Meetings and more. It is a private pay and faith based but not faith restrictive program. Stepping Stones also has a Second Stage Transitional Housing facility with 8 beds for women who have completed 3 months of a treatment program somewhere. These residents will also receive Group Therapy, Life Coaching, be part of 12 Step in-house meetings, also do Community Volunteer work, schooling, or a part-time job.

Wachiay Friendship Centre: Homeless & Housing Programs: The Homelessness Prevention Program (HPP) provides temporary housing subsidies for Indigenous People, women fleeing domestic violence, youth (including those leaving care) and individuals leaving corrections or health systems and **Homelessness Outreach Program (HOP)** connects homeless or at risk of homelessness people to housing, income assistance and community-based services.

WHAT WE HEARD: COMMUNITY ENGAGEMENT

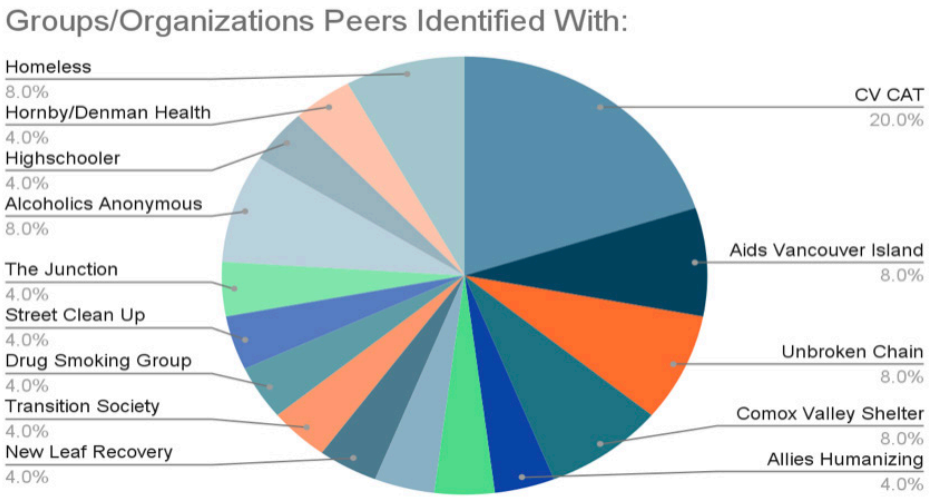
Understanding substance use and creating solutions can only happen with people at the center of this work. Phase One of Comox Valley Substance Use Strategy development included several engagement opportunities with peers, key community organizations and stakeholders in the Comox Valley.

PEER ENGAGEMENT: GROUP CONVERSATION, SURVEY + INDIVIDUAL CONVERSATIONS

People with lived and living experience of substance use (peers) provided their valuable input in the development of this report in multiple ways. These included an in-person group conversation, individual conversations and a Peer Survey. Best Practices for Peer Engagement were used and peers were paid a stipend for their time according to the BCCDC Peer Payment Standards (2018) and Peer Engagement Principles and Best Practices (2017).

Peer Group Conversation

The Peer Group conversation was held for two hours outdoors at Simms Park with COVID-19 safety precautions in place, and included 21 people. A diverse group of community members from Courtenay, Cumberland and Comox aged 18-72 years old joined the conversation. There was representation from all types of use including drugs, alcohol, pharmaceuticals, cannabis, tobacco, and other substances. Substance use ranged from past, recent and recreational use and included people who had used for as long as 37 years.



PEER ENGAGEMENT

Peers were informed that their input would contribute to the development of a community substance use strategy and that their responses would be confidential. Consent was received from all participants. Peer and facilitator supports were offered with multiple options for debrief if desired. The Peer Survey Questions were used as the basis for the conversation.

Peer Survey and Individual Conversations

Six people responded to the Peer Survey from the communities of Hornby, Denman, Courtenay, and Cumberland. In addition, six individuals provided input by phone. Because of the low number of respondents, these results have been combined with the Peer Group Conversation information.

KEY THEMES

Stigma

Stigma was one of the key themes that emerged through conversations with peers, with education and videos being named as one of the most powerful ways to reduce it.

"I mean, the biggest problem for addiction is stigma. And, uh, because it drives people into being labeled, and NOBODY wants to be labeled a drug addict."

Insufficient Local Detox and Recovery Beds

Peers identified that substance use is not only about the person using but includes biopsychosocial factors such as the lack of local detox and recovery spots, lengthy wait lists, and an inability to access needed supports when the person is ready. Eight peers reported having attended detox services, and of those, five people had to wait a month or less, one wait was 2-6 months, and one wait was between 6 months to a year. In addition, two people had experience receiving safe supply. Peers also shared that excitement about having another treatment option through a new Comox Valley Addictions Clinic started by a local physician who has employed a peer.

"There's not enough detox and recovery beds for the people who want to get in"

Unrecognized Work of Peers

We also heard that almost everyone who attended worked or volunteered in areas of harm reduction, prevention, treatment, and helping make communities safer. Most peers reported doing this work between 3-7 days a week, and at least half of them did this work unpaid. This highlights the often unseen, important work happening in the community, but also the unstable nature of this work. Greer et al. state that beneficial harm reduction work can be diminished "if inequities in peer work are perpetuated, unrecognized and unaddressed" (2020).

"I want to bring it back to my friends. There's a bunch of missing spots here. I've lost six friends in the last month and they don't do heroin, but somehow they got it into the drugs that are deadly. I've recovered 24 years, and I brought three people back from death in the last eight months to help. I do what I can to help people"

Perceived Strengths of Substance Use Supports

Peers discussed that some of the best education to and from peers came from the sharing of personal stories. There were also multiple mentions of the importance of building self esteem throughout discussions with peers. They saw success in the community in the needle exchange program, video education on anti-stigma, mindfulness practices like yoga, therapy, Naltrexone, 12 Step programs like AA and NA, some housing supports, recovery groups and the SMART recovery model. There was also multiple mentions of the support and community built through the community organization AIDS Vancouver Island (AVI).

Perceived Weaknesses of Substance Use Supports

Longer wait times to access substance use services was one of the key concerns for peers, especially around access to medical detox and treatment supports. Again, stigma came up as a concern throughout the discussion in relation to accessing healthcare such as at the emergency department, and stigma towards people who relapse.

Peers talked about low-income housing having too many rules, not enough shelter beds, and the need for more low-barrier housing. There were concerns about limited places to safely smoke substances in a supervised way and the toxic contamination of the drug supply. As well, there was a theme of mistrust in some institutions and structures due to a perceived lack of meaningful involvement and unclear communication.

"With the housing that's available for folks, there is all kinds of red tape. You've got to fit into a slot. You don't fit into that slot and you're not considered, you know, and it's a hurry up and wait game constantly for people"

Peers were very grateful to be involved in the conversation about substance use for the Comox Valley and requested more opportunities like this to continue the conversation. One peer stated that being involved in the conversation made them feel heard and seen, and that in itself helps with breaking down stigma and discrimination. See the full report from the peer conversations, survey and consultations for more details.

Restrictions due to the pandemic limited the way in which we were able to meet and consult stakeholders. Best practice would be to bring peers, their families and friends as supporters, service providers and other key stakeholders together in person to meet and discuss recommended actions for the community.

COMMUNITY MEETINGS

Community input sessions took place by Zoom (due to COVID-19 restrictions) over two consecutive days for 3 hours each day. There were peers, staff, managers, coordinators, educators, service providers, elected officials, and others. The agenda for the sessions is here and the complete report for the two sessions is here. Participants reported that having the option of in person and online engagement was important.

In addition to the input sessions, seven one on one key informant consultations either by phone or Zoom were conducted. These included consultations with Population Health Assessment and Epidemiology (VIHA), Mental Health and Substance Use (VIHA), Overdose Prevention Site (VIHA), Community Action Team (CAT) Comox Valley, Pride Society of Comox Valley, and Comox Valley Community Justice Center.

IDEAS AND SUGGESTIONS FROM THE COMMUNITY MEETINGS

The following information was collected at the Community Meetings held in May 2021. It is presented the way the sessions were structured using the 4 Pillars model. Moving forward we will include the Four Fires and FNHA Harm Reduction models when presenting and collecting information.

These ideas are not exhaustive of all potential recommendations, strategies or priorities to be implemented in Comox Valley. The solutions to address substance use are multiple and often interconnected.

Health Promotion + Prevention

The theme of prevention came up throughout all community consultation especially in relation to youth and education topics such as stigma. Some of the more commonly discussed ideas from the engagement sessions include:

- Professional development and training programs for clinical staff, professionals and staff who support people who use substances.
- Evidence-based education for parents on topics such as trauma, resiliency, emotional connection to youth, and how to support youth to prevent or delay substance use.
- Peer empowerment: fair and equitable pay for peer work, more peers in health service delivery.
- Decolonization, work in circles, cultural awareness training.
- Indigenous healing training.
- Implement a community development approach to build capacity and enhance relationships.
- Assess for intentional or unintentional marketing and advertising by community groups and businesses that encourage substance use.
- Decrease stigma of those living with addiction and reduce harms from substance use through community education on substance use as a health issue, brain development, and addiction science.
- Health Human Resource cultural training - speak to classism and othering of folks who have different lifestyles then the practitioners/providers who serve them.
- Promote health of the community through a social marketing campaign.
- Raise awareness around impacts of stigma on community members through a social marketing campaign.

Harm Reduction

priority area of work identified by peers and service providers. We heard many recommendations around enhancing existing services and programs, in addition to developing and implementing new initiatives and interventions. Some key suggestions and ideas include:

- Decriminalization: Decriminalization is a policy strategy in which non-criminal penalties, such as fines, are available for designated activities, such as possession of small quantities of a controlled substance. It has been proposed as a way to reduce the harms associated with the opioid crisis.
- Fund, develop and implement a peer-centered and youth specific overdose prevention site (OPS).
- Fund, develop, and implement a mobile OPS.
- Increase total number of community members trained in naloxone administration.
- Increase availability and access to barrier free Take-Home-Naloxone kits.
- Ensure service providers are accessible by addressing how language, power, classism, culture impacts service provision.
- Establish a barrier free and accessible local drug testing site using specifically spectrometers.
- Enhance overdose prevention services to include safer inhalation space.
- All health and social service staff who provide direct care to community members (eg. patient, client) receive harm reduction training and have access to supplies.
- Initiate harm reductions services within all acute care (eg. hospital).
- Continue promotion of Lifeguard app.
- Fund and deliver larger open door drop-in center.
- Fund and provide outreach services that offer harm reduction in the evenings and on weekends.
- Fund, develop, and implement a barrier free Managed Alcohol Program (MAP) for folks who use alcohol.

Treatment

Some treatment services exist in the Comox Valley however many consulted reported the need for more locally-based treatment options. These treatment options need to be available to diverse community members and available to people who need them within a timely manner. Of specific concern was more medical detox spots for all substances and that cultural safety, trauma informed practice and anti-stigma training should apply for all treatment options. Other key ideas and suggestions include:

- Increased availability of safer supply as treatment including rapid taper, safe supply prescribers, teaching on medication side effects (like Methadone).
- Culturally safe and supportive Indigenous local treatment center.
- More local detox and treatment beds available rapidly accessible to all, and financial supports for programs/services that cost money.
- Improved access to psychiatry and addictions medicine specialists.
- Increase supports within the community for those wishing to access treatment options, and the friends and family who support them.
- Create more capacity within treatment programs (such as detox spaces with medical support).
- Housing based treatment options should be local, affordable, and easily accessible for all.
- Need for safe childcare or family supports when a parent/s enters a treatment or support bed and ways for parents and children to have some planned contact.
- Need for a different funding structure that is less complicated, easier to understand and access and does not cover the full cost of treatment.
- Identify a system that allows for costs to be fully covered so people can still cover their cost of living and maintain housing while in treatment.
- Program length should be done based on an individualized clinical treatment plan.
- A better understanding of the continuum of substance use services and in particular the local Substance Use Outpatient Clinic service which helps those seeking service to determine what type of support they are looking for.

- A holistic approach to treatment that includes supports or mentorships to help to create a sense of belonging for everyone in our community.
- Sessional physician funding to treatment programs to act as interface with the medical system.
- Encourage a belief in support within and around the local continuum of substance use services as those who are seeking help need some part of or all of it and depending on their needs.
- Understand local linkages between Mental Health and the Substance Use Continuum of services as many people have concurrent concerns. Adopting the "Every Door is the Right Door" philosophy.

Community Safety

- Establish a community committee to develop a Community Safety Strategy.
- Establish a needle recovery program and more harm reduction supply pickup options.
- Enhance and expand existing community restorative justice programs that support people & divert them from being criminalized.
- Explore the option of funding and implementing a CAHOOTS style model of care to addressing mental health and substance use crises.
- Seek support by all levels of government to increase collaboration between RCMP and social services.
- Decolonize and de-centering power in all systems and practices.
- Stop police from responding to mental health calls and OD responses and more staffing for Intensive Case Management teams.

Housing

Community discussions identified housing as an important first step to address substance use. Stable housing aids and facilitates access to prevention, harm reduction and treatment. Key ideas and suggestions in this area include:

- Increase homelessness services, low income & low barrier housing options.
- Tiny home communities built to support specific needs including for people who use substance, people in recovery, youth, LGBTQ2S, and female and trans identified.
- Supported green spaces for community to gather and for people to camp as needed (for people experiencing homelessness).
- Political advocacy at the local level to support the Federal Housing Strategy.
- Continue to support the work of the Comox Valley Coalition to End Homelessness Action Coalition.
- Advocate for housing options (e.g. shelters beds) that supports and welcome those who use alcohol (i.e. MAP).

Youth

Throughout the consultations we engaged with youth and people who work with youth. It was clear that this population is under-served and there was a shared perception that services and providers were 'out of touch' with how best to access, support and influence youth. It was highlighted that youth often go to their peers to learn about substance use and substances more broadly. There was consensus that the traditional models of education were not reaching youth either by outdated language and methods or inaccessible services. Some of the more commonly discussed suggestions and ideas were:

- More effective, researched, and peer led education programs for youth.
- Change substance use education in school system from science to an educated peer-based model (with more real-life examples and formalizing the informal process already happening).
- Create strengths-based substance use education programs for youth in schools, as well as supports for any youth with addiction.
- Provide training & education to school district staff on harm reduction.
- Fund and implement harm reduction services within schools.
- Integrated education on harm reduction (drugs, alcohol, smoking) life skills, safer sex, youth mental health.
- More support for youth experiencing bullying.
- Support a Comox Valley Strategy for Youth Health and Well Being.
- Continue Pathways to Hope (SD71).
- Elect a school-based youth council to talk about substance use.

Collaboration + Political Action

This section includes a strong focus on rethinking and reorganizing the way in which planning, coordinating and delivery programs and services are currently done. It was clear more needed to be done to include peers at all levels of this work. Many ideas and suggestions are political in nature and will require significant political will and leadership. In addition, federal and provincial policy requirements were considered and have been included here.

- Collaboration across sectors (government, not for profit, business, community and peers) to advocate, lobby and support decriminalization.
- Fund, develop, and facilitate a regional process for regular communication and networking between peers, community members, and service providers. This would include sharing of ideas, knowledge dissemination, resource sharing, and mapping of groups working in substance use and "how they all relate".
- Centering peers and ensuring mandatory involvement at all levels of services and programming.
- Fair compensation and pay for peers involved in work.
- Collaboration across all levels of government.
- Actively engage with priority populations including members and organizations from the following communities: BIPOC, LGBTQ2S, people with disabilities and others.
- Update the Comox Valley Drug & Alcohol Services Directory.
- Develop a user-friendly resource to help people navigate local substance use services.
- Foster partnerships with the K'ómoks First Nation, honouring their strengths, wisdom, and insights on closing the gaps in care for those with substance use.
- Acknowledgement and community information sharing on success of existing programs that support people who use substances within the community (i.e., Unbroken Chain Indigenous Harm Reduction, Walk With Me, Warming Shelter, AVI, healing spaces such as Traditional Plants and Medicines gardens).

ASSETS, GAPS AND BARRIERS IN THE COMOX VALLEY

Outlined below are several assets, gaps and barriers to substance use supports and services in the Comox Valley that peers and service providers identified.

Assets

Increased collaboration between acute care, medical services and community supports – some examples are: the primary care network, the wellness collaborative, the community action team, Walk with Me, etc.

Commitment by many service providers towards meeting people where they are – this can include substance use counselors, parent groups or medical staff.

Increased Peer involvement – many service providers commented on the role of peers in the development of programs and supports as an asset.

Local Outreach Services – local outreach workers were identified as an asset in the community, providing support, accesses to services and saving lives. However, a recent conversation held with these frontline workers in the Comox Valley identified a strong needs for more structured supports for frontline workers in the face of serious burnout from dealing with two concurrent health crisis'. This issue was recently highlighted in this Globe and Mail article (2021) "Toxic drug crisis, pandemic have left front-line workers struggling to cope."

Building a sense of belonging – find ways to hold onto the sense of community, to meet this human need to be together, and to work together. Keep working together as "we" – not as "us and them."

Gaps

Lack of a System of Mental Health and Substance Care across all sectors where all providers are respected and treated as equal partners working towards a common goal. This includes improved communication between all sectors as too many clients have to tell their stories over and over again.

Lack of Weaving Together Indigenous and Western Approaches to Care – invite Indigenous elders to be involved in front line programming and healing and employ Indigenous healers as part of mental health and substance use teams.

Lack of trauma informed care and cultural safety policies and practices across all services - including anti-racism, anti-oppression policies in place to hold people accountable. Work with Indigenous leaders and service providers, frontline workers and peers to redesign the healthcare system to better serve those who have been systemically excluded.

Lack of services for people who identify as Non-Binary Genders and 2SLGBTQIA+ - there are currently no spots within shelters, the withdrawal systems, or housing specifically designated to those who do not identify as male and female even though the 2SLGBTQIA+ population are at a higher risk for substance use compared to the heteronormative population. Some organizations speak of being open to those who are non-binary, however those individuals are often designated a spot that is not necessarily safe or welcoming to them. It has been reported that the 2SLGBTQI+ sector experience discrimination not only from other clients, but from service providers as well.

Lack of Housing – there is a huge affordable housing gap and Comox Valley needs all types of housing from supportive, transitional to affordable rentals for all types of people including Indigenous, seniors and family. There is also a need for more second-stage/transitional housing for people leaving supportive recovery. See CVRD Housing Needs Assessment.

Lack of Medical Withdrawal Management (detox) - there is no Medical Withdrawal Management in the Comox Valley. The closest medical detox is Clearview Community Medical Detox in Nanaimo and the emergency department at the North Island Hospital Comox Valley does not do medical detox, although some Primary Care Physicians with admitting privileges do medical detox if needed.

Lack of Managed Outpatient Alcohol Program – there is no program in the Comox Valley and could prevent people needing more intensive programs.

Lack of Services in Rural Communities - young adult mental health and substance use (MH/SU) services for Hornby & Denman Islands are extremely limited in scope. A community social worker to address both serious MH/SU challenges for a significant portion of our population would be helpful. The Care-a-Van is the only mental health and addiction services in the Village of Cumberland. The Village also lost its only doctors office in July of 2021.

Lack of Primary Care Physicians - substance use disorder and addictions medicine seen as a speciality instead of part of the continuum of normal primary care needs.

Lack of Option for Inhalation Use at Overdose Prevention Site – more and more people are inhaling substances and there is no ability to do this at the CV OPS even though it is available at other sites on the island. The CV OPS is also underutilized compared to other sites on the island which is a concern.

Lack of Safe Supply Providers and Advocacy for Decriminalization – need to see substance use as a health issue not a legal issue.

Lack of service that partners RCMP and Mental Health and Substance Use Practitioners – this is done informally when possible but there needs to be a wrap around process (e.g., CAHOOTS model) to ensure people's needs are addressed. The RCMP have expressed interest in exploring this.

Barriers

Wait Times for Supportive Recovery – people need treatment immediately when they are ready for it and for some services in the Comox Valley there are waits between 2 and 3 months. This often creates a gap between detox and a supportive recovery bed. In addition, a lack of housing contributes to making this gap even more difficult as once they are back on the street the potential for using again is greater.

Wait Times for Outpatient Mental Health and Substance Use Services (including Child and Youth Mental Health Services) – similar to above people report having to wait a long time for individual counselling and outpatient services when they are ready for help and if they get it in a timely manner, it might prevent the need for more intensive services.

A PATH FORWARD: KEY NEXT STEPS

With positive political will, more data and funding, and improved engagement and collaboration across multiple populations and sectors, the Comox Valley can make meaningful action towards a comprehensive peer-centered substance use strategy. Three core areas of focus for Phase Two of this strategy are identified below, along with proposed immediate and ongoing actions.

PHASE TWO CORE AREAS OF FOCUS

Funding & Staffing

This work began with a small amount of funding from the City of Courtenay, however more funding will be required from a variety of sources to create a comprehensive substance use strategy in Phase Two.

Community & Stakeholder Engagement

Phase Two of the development of a strategy requires inclusion of people with lived/living experience of substance use, Elders/ Knowledge Keepers, all levels of government, service providers, businesses and community members. This work will require coordination, planning and, commitment to working together that builds on the relationships and work established to date. Engagement in potentially challenging conversations on what is working, what and where gaps are and what requires change will be necessary to address issues, explore solutions and create recommendations for action.

Data

Throughout Phase One key gaps to be able to access, collate, analyze and report on relevant local or regional data were identified. A key to successful and appropriate planning, coordination, funding and delivery of programs and services is up-to-date data. Therefore, the need to enhance data collection and analysis will be important in Phase Two and ongoing as the strategy is implemented and updated.

PHASE TWO ACTIONS

Immediately/As Soon As Possible

Present Phase One Report to all local government councils and introduce Phase Two engagement plan which is to:

- Support the recommendations in the Walk With Me Report.
- Support the provincial governments intervention into the toxic drug poisoning by encouraging participation of all local stakeholders in the Comox Valley Community Action Team.
- Partner with the Walk with Me project on a joint initiative that includes a launch event for this Phase One Report and Walk With Me's Research Report followed by a series of facilitated conversations and cultural mapping that will help inform Phase Two of the Substance Use Strategy and the Recommendations in the Walk With Me Report.

These conversations will help to identify actions the community could take to change policies and practices locally and identify key recommendations for the final strategy.

- Build on the Comox Valley Substance Use Committee to form a Comox Valley Substance Use Collaborative of local municipalities, Comox Valley Regional District, School District #71, Island Health, Division of Family Practice/ Primary Care Network, Community Action Team and RCMP to coordinate the next phase and implementation of the strategy.
- When formed the Comox Valley Substance Use Collaborative become a partner of the Comox Valley Community Health Network with the Network's other community partners.

- Align the work of the Comox Valley Substance Use Collaborative as appropriate with the work outlined in the Regional Poverty Assessment and Reduction Plan to work with local governments and other community groups on intersecting community issues (e.g. Game Changer #1; Game Changer #2; Game Changer #3; Game Changer #4; Game Changer #8; Game Changer #10; Game Changer #14).
- Request all local governments (municipalities, Comox Valley Regional District and School District #71) collaborate to fund the coordination and implementation of Phase Two of a Substance Use Strategy.
- Request Comox Valley local governments (municipalities, Comox Valley Regional District and School District #71) and Island Health include the work towards a substance use strategy in their strategic planning and priorities and support the monitoring and evaluation of actions.
- Collaborate to monitor and apply for federal and provincial funding opportunities to support the implementation of the strategy.
- Collaborate to secure funds to enable good, in person, relationship building with First Nation, and other priority partners in the development of the strategy.
- Collaborate to secure funding to support ongoing involvement and leadership from peers and elders/traditional knowledge keepers.

Ongoing

- Act on lived experience of people who use substances, their families and the people who support them in the design and implementation of policies, services, changes to existing services, and as qualitative evidence that supports action in our community response to substance use.
- Engage more intensively with members and organizations from key priority groups such as youth, Indigenous, spiritual and religious, community organizations (e.g., Rotary, Indigenous, and 2SLGBTQIA).
- Leverage existing political will in the community to advocate for organizational commitment (e.g., coordination, funding and staffing) from service providers (e.g., VIHA, AVI, John Howard Society etc.) and stakeholders (e.g., RCMP, SD71) for ongoing implementation of the strategy actions.
- Advocate for peer delivered services and paid positions within all organization for people with lived/living experience.
- Secure commitment of key partners & regional stakeholders to apply for provincial and national funding when available.
- Seek endorsement letters from key partners.
- Establish ongoing Data Sharing Agreements between the Comox Valley Substance Use Collaborative and local data collectors.
- Establish ongoing Data Sharing Agreement between the Collaborative and service providers to share program and service evaluation data (e.g., number of individuals who access service, number of naloxone kits distributed, demographic data).
- Advocate for ongoing provincial and regional collection of data on social determinants about substance use (e.g., why people use substances, social determinants and how they contributed to death or drug poisoning, etc.).
- Increase collection and reporting of data around access to services & service impact and data on the benefits of substance use.
- Innovate ways to collaborate across government, academia and community agencies on collection of data.
- Strengthen reporting, charting and resources provided on discharge diagnosis for the emergency departments.

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Attachment 4: Summary of Phase One Deliverables

Community Substance Use Strategy – Phase One MOU Deliverables Summary

MOU Deliverables	How the report met the deliverables
Approach	• Informed through research and based on the 4 Pillars Approach informed by current BC and Canadian current drug policy. • Clear vision, mission, belief statements, and guiding principles for the strategy • Based on the local situation in the Comox Valley • Based on qualitative and quantitative data collection and analysis • Includes community consultation
Vision, Mission and Goals	• Collaborate towards a safe and healthy community that improves the lives, abilities, and health of all community members through a fair and equitable plan to reduce substance related harms in the Comox Valley.
Expected Outcomes	• Adequate funding and staff resources to support the strategy • Support, collaboration and participation from all levels of local government • Continued community and stakeholder engagement with an equity, inclusion and diversity lens. • Enhanced data collection and analysis on regional/local data
Community Stakeholder Consultation	• Group workshops, surveys and direct peer input • Formation of the Comox Valley Substance Use Collaborative to actively engage in the next phase of the strategy implementation. • Involves people with living and lived experience with substance use • Includes not-for- profit organizations in mental health and substance use fields • Inclusion of elected officials representation at the federal, provincial and municipal level • Inclusion of the local school district and law enforcement
Obstacles	• Social stigma and racism • Insufficient resources for detox and recovery • Unrecognized work of peers supporting harm reduction • Barriers to access to local support services or significant wait times to access available support services • Lack of affordable housing • Lack of inclusion to access to services

	• Lack of culturally informed approaches
Strategies	• Four Pillars Model • Four Fire Model • Focus on Social Determinants of Health • Equity, inclusion and diversity lens • Culturally sensitive, utilizing both indigenous and colonial framework
Initiatives	• Continue enhanced data collection and analysis • Focus on developing initiatives to support health promotion and prevention, harm reduction, treatment, community safety, housing, youth specific, collaboration across sectors (government, not for profit, business, community and peers) • Continue opportunity to share personal impact stories • Cultural safety, cultural humility and trauma informed practice • Alignment with other local government documents supporting community issues
Implementation Plans	• Identification of recommended Phase Two Actions in the form of immediate and ongoing actions • Strategy for securing core funding • Strategy for staff and local government involvement
Performance Measures	• To be identified in Phase Two

THE CORPORATION OF THE CITY OF COURTENAY

STAFF REPORT

To: Council **File No.:** 2380-20

From: Chief Administrative Officer **Date:** Oct. 18th, 2021

Subject: 685 Cliffe Avenue – Form of Agreement and Shelter Services

PURPOSE:

The purpose of this report is to seek Council approval to transition the current temporary Licence of Occupation Agreement between the City of Courtenay and the Comox Valley Transition Society (CVTS) for the property located at 685 Cliffe Avenue (Connect Centre) to a one year lease agreement and to permit the operation of an overnight shelter under the terms and conditions of the lease.

CAO RECOMMENDATIONS:

1. THAT based on the October 8th, 2021 staff report "685 Cliffe – Form of Agreement and Shelter Services," Council approve OPTION 1 and delegate authority to staff to transition the current Licence of Occupation Agreement between the Comox Valley Transition Society and the City of Courtenay for the property having a legal description of PID:006-102-930, Lot 3, Section 61 Comox District plan VIP3817 to a one year lease agreement with four one year renewal options to permit the consistent operation of the Connect Day centre and an overnight shelter for individuals experiencing homelessness; and,

2. THAT Council exercise their authority under the BC Building Code Section 1.1.1.1(2)(f)(iv) and exempt the Extreme Weather Response shelter located at 685 Cliffe Avenue from the building code having deemed it to be a temporary emergency facility due to extreme weather conditions; and,

3. THAT the Mayor and an Officer of the City be authorized to execute all documentation relating to the Lease Agreement.

Geoff Garbutt, M.PI., MCIP, RPP
Chief Administrative Officer

BACKGROUND:

The Comox Valley Coalition to End Homelessness (CVCEH) through the Comox Valley Transition Society (CVTS), and with funding from BC Housing operated an Extreme Weather Response shelter (EWR) at 685 Cliffe Avenue from December 11th, 2020 to March 31st, 2021. Anticipating the termination of the EWR, the Comox Valley Coalition to End Homelessness requested Council consider permitting the continuation of an overnight shelter due to the ongoing covid-19 pandemic. At the March 29th 2021 Council meeting, Council adopted the following resolution:

THAT Council authorize staff to work with external legal counsel to amend the current Licence to Occupy Agreement between the Comox Valley Transition Society (CVTS) and the City for the property having a legal description of PID: 006-102-930, Lot 3, Section 61 Comox District plan VIP3817 to temporarily permit the operation of an Emergency Shelter at 685 Cliffe Avenue with the following conditions:

a) *Permit the operation of an emergency shelter during which time a Provincial State of Emergency has been declared due to the COVID-19 pandemic, from April 1st, 2021 to April 30th, 2021.*
b) *Include all applicable shelter operation terms and conditions originally contained within the February 22nd, 2021 Licence of Occupation Amendment #3, and other amendments deemed necessary by staff or under the advice of legal counsel to facilitate the temporary operation of an emergency shelter; and,*

THAT the Mayor and Corporate Officer be authorized to execute all documentation relating to the amended terms of the Licence to Occupy Agreement.

Upon the pending expiration of the original approval, at the April 26, 2021 Council meeting, Council adopted the following resolution:

THAT based on the April 26, 2021 staff report "Emergency Pandemic Shelter – 685 Cliffe Avenue," Council approve OPTION 1 and auhtorize staff to work with external legal counsel to amend the current Licence to Occupy Agreement between the Comox Valley Transition Society and the City for the property having a legal description of PID:006-102-930, Lot 3, Section 61 Comox District plan VIP3817 to temporarily permit the operation of an Emergency Pandemic Shelter at 685 Cliffe Avenue including the following conditions:

a) *permit the operation of an Emergency Pandemic Shelter from May 1st 2021 to October 5, 2021 or until such time as the Provincial State of Emergency is rescinded – whichever comes/occurs first,*
b) *include all applicable shelter operation terms and conditions originally contained within the February 22nd, 2021 Licence of Occupation Amendment #3 and the March 31st, 2021 Licence of Occupation Amendment #4, and other amendments deemed necessary by staff or under*

the advice of legal counsel to facilitate the temporary operation of an emergency pandemic shelter and transfer liability to the license holder; and,

c) *sleeping accommodation be strictly limited to ten (10) or less.*

THAT Council exercise their authority under BC Building Code Section 1.1.1.1(f)(4) and exempt the Emergency Pandemic Shelter located at 685 Cliffe Avenue from the BC Building Code having deemed it to be a temporary emergency facility during the Provincial State of Emergency due to the COVID-19 pandemic.

THAT the Mayor and an Officer of the City be authorized to execute all documentation relating to the amended terms of the Licence to Occupy Agreement.

The overnight emergency pandemic shelter closed on June 30th, 2021 due to the cessation of funding from BC Housing and the rescindment of the Provincial State of Emergency on July 1st, 2021.

DISCUSSION:

Extreme Weather Response Shelter

To permit the provision of an Extreme Weather Response shelter (EWR) at the 685 Cliffe Avenue location a policy decision of Council to exempt the building from the building code is required as the building does not currently comply with the building code and City Bylaws related to the proposed shelter use. Council can exempt the building during the activation of a EWR shelter of all code requirements by exercising the emergency facilities exemption, however with increased exemptions there is an increase risk to the health and safety of the employees and clients. The City of Courtenay Fire Chief, to diminish risk to health and safety has consistently sought a capacity limit of no more than ten (10) for sleeping accommodations as increased capacity beyond ten would require exempting additional fire building code requirements.

EWR shelters are funded by BC Housing annually; this year funding is available for the period October 1, 2021 to March 31, 2022. The Extreme Weather Response (EWR) program is a provincially funded initiative that supports community-based services to provide additional temporary emergency shelter spaces during periods of extreme winter weather which threaten the health and safety of individuals experiencing homelessness.

Regular Provision of Shelter Services

Shelter services at the Connect Centre have previously been provided as a response to an emergency situation including extreme weather and the Covid-19 pandemic. The Comox Valley Transition Society has requested Council to approve entering into a lease that would allow for overnight shelter operations at the current Connect Centre site as a consistent community service. Provision of overnight shelter services has been impacted by inconsistent funding from the Province, however the Comox Valley Regional District, in partnership with the City of Courtenay,

the Coalition to End Homelessness, and the Comox Valley Transition Society were recently successful in receiving $1,093,000 in grant funding through the UBCM Strengthening Communities' Services Program of which a significant portion is to be dedicated to expanding shelter and outreach services in the Comox Valley. With access to the grant funding the Comox Valley Transition Society is seeking a change in their Agreement with the City to permit general overnight shelter services for a one year term with options to renew. Additionally, the City and Transition Society continue to engage in conversations with BC Housing to secure BC Housing funding towards an overnight shelter at this location or other viable locations within Courtenay in the future.

As the EWR shelter is activated under emergency conditions, Council can exempt the building from building code and City Bylaw requirements, however the operation of a shelter that is not necessitated by an emergency situation would require full compliance with applicable building codes as deemed necessary by the City's Building Inspector. At such time as the building is compliant with the building code and City Bylaws to the standard acceptable to the City's Building Inspector, the Transition Society would be permitted to operate an overnight shelter under the terms of the lease and without the current capacity limits as set by Council. Staff are working with the Transition Society to support them in assessing the building code requirements necessary to permit general overnight shelter at this location.

Transition from a Licence of Occupation to a Lease Agreement

The current Licence of Occupation Agreement (LOA) permits the operation of the Connect Warming Centre (expiration- November 30th, 2021) and subsequent amendments to the Agreement have permitted the operation of EWR and Emergency Pandemic shelters – all shelter amendments have expired. The LOA outlines general use terms and includes Council's authority to terminate the agreement at any time with notice. Unlike a LOA a lease would provide the Comox Valley Transition Society with exclusive use of 685 Cliffe Avenue for a defined period and purpose, and the option to terminate would be based on standard default lease terms including but not limited to default in payment or non-compliance with covenants, agreements or obligations under the lease. Standard lease terms would address building code and City Bylaw compliance requirements, perimeter cleaning, sidewalk maintenance, nuisance, fire safety, insurance, "as is" condition, and assignment and subleases.

Term

1 year with up to four one (1) year renewal terms - consent of council required for each renewal.

FINANCIAL IMPLICATIONS:

Prior to the operation of the Connect Warming Centre, the city incurred approximately $9,000 per year in annual operating costs associated with this address. Since the addition of the Connect Warming Centre, the annual operating costs have increased to approximately $21,000 annually due to increased utilities, maintenance, and other operating costs. The LOA between the City and the Transition Society did not require the Transition Society to reimburse the City for these incremental

costs, partly in light of the tenuous funding situation for overnight shelter operations and the increased expenses incurred due to fire safety requirements.

With a more stable source of funding available through the UBCM Strengthening Communities' Services Program and the transition from a LOA to a Lease, the Transition Society is now in a position to reimburse the City for the incremental costs associated with their use of the building, approximately $12,000 per year which will be paid monthly at a rental rate of $1,000 per month. As described in Schedule A of the lease the tenant will be responsible for the following costs including but not limited to: garbage and snow removal, window cleaning, janitorial, liability insurance, operational expenses including internet and telephone and interior building repairs and maintenance. The City will be responsible for the following including, but not limited to: utility costs, preventative maintenance, building insurance, security, capital repairs, and exterior repairs and maintenance.

This will reduce the City's financial subsidy for the use of the space however still reflects a subsidy of approximately $2000 per month ($24,000 per annum) based on the difference between the costs paid by the Transition Society and the market rent that would otherwise be achieved for this location. This subsidy by the City is a reflection of the valuable service the Transition Society provides to the community and especially those members of our community who are experiencing homelessness, poverty, and marginalization.

ADMINISTRATIVE IMPLICATIONS:

Approximately 190 hours of staff time have been dedicated to drafting the Licence of Occupation Agreement and related amendments, consulting external counsel, stakeholder discussions, consultation with other City departments, and fire inspections and training.

ASSET MANAGEMENT IMPLICATIONS:

The property located at 685 Cliffe and the adjacent parking lots were recently identified as a potential affordable housing development location. Although the City was not successful in its original application for funding Council may wish to maintain some control of these lots (through the lease agreement renewal terms) to maintain the properties as an option for future supportive and/or affordable housing and or other Council priorities. Considering the existing condition of the building, lease of the space may result in reassessing the asset management renewal strategies for this location.

STRATEGIC PRIORITIES REFERENCE:

We focus on organizational and governance excellence

- Responsibly provide services at levels which the people we serve are willing to pay
- Value community safety and support our protective services

We proactively plan & invest in our natural and built environment

- Support social, economic & environmental sustainability solutions

We continually invest in our key relationships

- ● Value and recognize the importance of our volunteers.
- ●■ Consider effective ways to engage with and partner for the health and safety of the community
- ▲■ Advocate and cooperate with local and senior governments on regional issues affecting our community

● **AREA OF CONTROL:** The policy, works and programming matters that fall within Council's jurisdictional authority to act

▲ **AREA OF INFLUENCE:** Matters that fall within shared or agreed jurisdiction between Council and another government or party

■ AREA OF CONCERN: Matters of interest that are outside Council's jurisdictional authority to act

OFFICIAL COMMUNITY PLAN REFERENCE:

Not referenced.

REGIONAL GROWTH STRATEGY REFERENCE:

No specific reference.

CITIZEN/PUBLIC ENGAGEMENT:

As time is of the essence, there has not been an opportunity to engage stakeholders on the options presented in this report. Council would base their decision on the perceived need, urgency and community impact.

Although the City has not facilitated stakeholder engagement, the CVCEH and CVTS have reported that stakeholder engagement activities are underway with local businesses and the Downtown Courtenay Business Improvement Area members.

Should Council decide to enter into a lease with the Transition Society for the continued operation of the Connect Day Centre and overnight shelter, as permitted within the terms of the lease, staff will request that the Transition Society initiate further stakeholder engagement to support their successful operation over the coming year including the establishment of a Community Advisory Committee.

OPTIONS:

OPTION 1: 1. THAT based on the October 8th, 2021 staff report "685 Cliffe – Form of Agreement and Shelter Services," Council approve OPTION 1 and delegate authority to staff to transition the current Licence of Occupation Agreement between the Comox Valley Transition Society and the City of Courtenay for the property having a legal description of PID:006-102-930, Lot 3, Section 61 Comox

District plan VIP3817 to a one year lease agreement with four one year renewal options to permit the consistent operation of the Connect Day centre and an overnight shelter for individuals experiencing homelessness; and,

2. THAT Council exercise their authority under the BC Building Code Section 1.1.1.1(2)(f)(iv) and exempt the Extreme Weather Response shelter located at 685 Cliffe Avenue from the building code having deemed it to be a temporary emergency facility due to extreme weather conditions; and,

3. THAT the Mayor and an Officer of the City be authorized to execute all documentation relating to the Lease Agreement.

(Recommended)

OPTION 2: Council provide alternative direction to staff.

OPTION 3: No further action.

Prepared by,

Kate O'Connell, BA, MPP, CLGA, PCAMP
Director of Corporate Support Services

Susie Saunders
Director of Recreation, Culture and Community Services

Concurrence by,

Geoff Garbutt, M.PI., MCIP, RPP
Chief Administrative Officer

THE CORPORATION OF THE CITY OF COURTENAY

STAFF REPORT

To: Council **File No.:** 3360-20-2012

From: Chief Administrative Officer **Date:** October 18, 2021

Subject: Zoning Amendment Bylaw No. 3021 to Allow for a Secondary Suite at 2099 Hawk Drive

PURPOSE:

The purpose of this report is for Council to consider an application to rezone the property located at 2099 Hawk Drive from Residential One to Residential One S Zone (R-1S) to permit the addition of a secondary suite to an existing house.

CAO RECOMMENDATIONS:

THAT based on the October 18th, 2021, staff report "Zoning Amendment Bylaw No. 3021 to Allow for a Secondary Suite at 2099 Hawk Drive" Council approve OPTION 1 and proceed to First and Second Readings of Zoning Amendment Bylaw No. 3021, 2021; and,

THAT Council considers Zoning Amendment Bylaw No. 3021, 2021 consistent with the City's Official Community Plan; and

THAT Council waives the requirement to hold a public hearing with respect to Zoning Amendment Bylaw No. 3021, 2021 pursuant to Section 467 (2) of the *Local Government Act* and directs staff to give notice of the waiver of the public hearing pursuant to Section 467 of the *Local Government Act* in advance of considerations of 3rd Reading of the bylaw.

Respectfully submitted,

Geoff Garbutt M.Pl., MCIP, RPP
Chief Administrative Officer

BACKGROUND:

The subject property is an approximately 654m^2 residential lot located at 2099 Hawk Drive in East Courtenay ***(Figure 1).*** The property is currently zoned Residential One (R-1) and there is an existing 201m^2 (2,163ft^2) two-storey single family dwelling on the parcel. The house contains an illegal suite which has current tenants. Staff were made aware about the illegal suite as a result of a complaint. The applicant elected to apply for a rezoning rather than decommission the suite. Should the rezoning be approved, the applicant will need to apply for a Building Permit to ensure that the suite is compliant with BC Building Code. The building department will ensure proper fire separation, access and sound transmission details at time of Building Permit. Generally, a suite does not result in any significant structural changes to a building.

The secondary suite is on the first floor of the existing home. The proposed suite is 53 m^2 (570 ft^2) in size and includes a bedroom, bathroom, a kitchen and living room (***Attachment No. 1***). The applicant has provided a letter of rationale and a statement on the affordable housing policy, which can be found in

Attachment No. 4. There is a one-car garage and also space for two vehicles in the driveway, as well as a gravel pad beside the driveway (for a total of four parking spaces). Plans and elevations are shown in ***Attachment No. 1***.

Figure 1. Context map with the Subject Property outlined in yellow.

DISCUSSION:

The subject property is located within less than two kilometres of the Crown Isle Shopping Complex, Valley View Elementary, and Mark R. Isfeld Secondary School and the Aspen Grove and Highland Village Shopping Centres in Comox. These destinations are accessible by cycling, walking, or transit (with two bus routes that travel along Lerwick Road).

OCP Review

The proposed application represents infill development within an established neighbourhood designated Urban Residential in the Official Community Plan (OCP).

The OCP and the Affordable Housing Policy support infill development within existing Urban Residential areas provided it is in keeping with the character and scale of the surrounding neighbourhood. Infill housing provides more rental housing stock and diversity of housing types, and promotes more efficient use of land that is already serviced.

Zoning Review

This application meets zoning requirements, including building height, lot coverage, building setbacks and parking for both R-1 and R-1S zones. It also specifically meets all R-1S zoning requirements for secondary suites, summarized in the table below.

Requirements	Proposal
Total not more than 90.0 m^2	Approximately 53m² (1 bedroom, 1 bathroom, living room, kitchen)
Floor Area Less than 40% of the total habitable floor space of the building	~25%
Located within a building of residential occupancy containing only one other dwelling unit	Yes
Located within a building which is a single real estate entity	Yes
Three Parking Spaces *(2 spaces for the principal dwelling unit and 1 additional space for the secondary suite)*	4 parking spaces: 1 garage space, and 3 parking spaces in the driveway (***Attachment No. 1***)

FINANCIAL IMPLICATIONS:

Application fees in the amount of $500 have been collected in order to process the rezoning amendment application. Should the proposed Zoning Amendment Bylaw be adopted, Building Permit application fees will apply.

Properties with a secondary residence are charged a second utility fee (sewer, water, garbage) for the additional dwelling unit. Should the rezoning application be approved, the additional utility fees will be charged to the property at the time of occupancy permit. Secondary residences are exempt from paying Development Cost Charges to the City and Regional District.

ADMINISTRATIVE IMPLICATIONS:

Processing Zoning Bylaw amendments is a statutory component of the corporate work plan. Staff has spent approximately 30 hours processing this application to date. Should the proposed zoning amendment proceed to public hearing, an additional two hours of staff time will be required to prepare notification for public hearing and to process the bylaw. Additional staff time will be required to process the subsequent building permit application including plan checking and building inspections.

ASSET MANAGEMENT IMPLICATIONS:

The proposed development utilizes existing infrastructure and is connected to City water, sewer and storm mains. There are no direct asset management implications associated with this application.

2019 - 2022 STRATEGIC PRIORITIES REFERENCE:

- Communicate appropriately with our community in all decisions we make
- Encourage and suport housing diveristy

OFFICIAL COMMUNITY PLAN REFERENCE:

The proposed zoning amendment is consistent with the Urban Residential land use designation of the Official Community Plan. It represents infill residential development near existing amenities and services, providing a range of housing choice, while fulfilling OCP Section 4.4.3 4 a) – limited infill will be considered only in keeping with the character and scale of an existing neighbourhood and 4.4.3.4 d) – secondary suites will be considered as part of a principle single family residential building subject to zoning approval.

REGIONAL GROWTH STRATEGY REFERENCE:

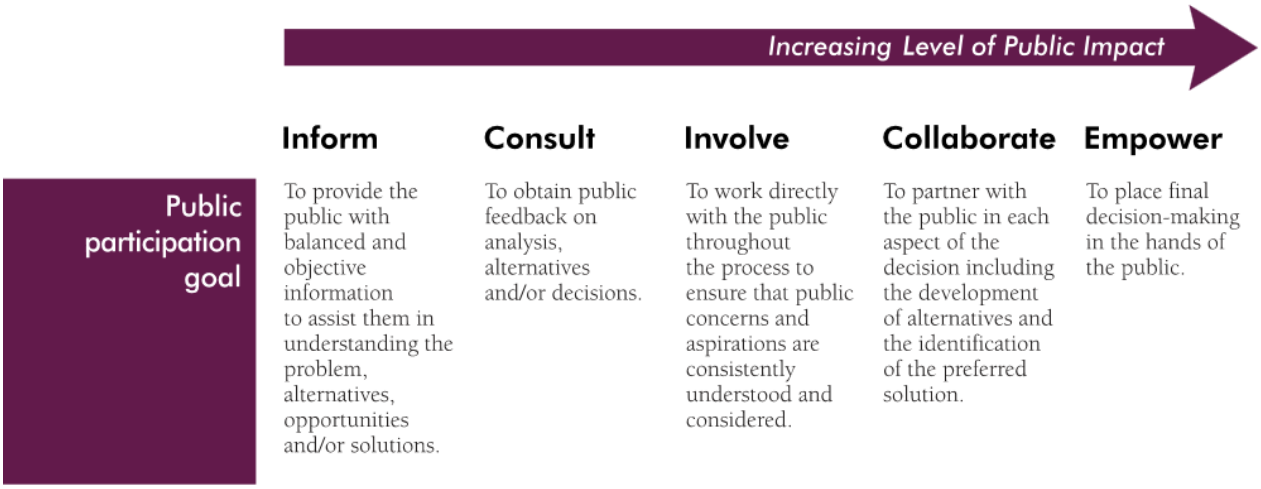
The development proposal is consistent with the RGS Housing Goal to "ensure a diversity of affordable housing options to meet evolving regional demographics and needs" including:

Objective 1-A: Locate housing close to existing services; and

Objective 1-C: Develop and maintain a diverse, flexible housing stock.

CITIZEN/PUBLIC ENGAGEMENT:

Staff will "**Consult**" the public based on the IAP2 Spectrum of Public Participation:



Prior to this application proceeding to Council, the applicant distributed an alternative public information package to property owners and occupiers within 100m of the property, over a two week period and collected and summarized feedback as per the new Alternative Public Information Meeting process. The information provided to neighbours and the summary of the process can be found in ***Attachment No. 2***. The City received one comment from the public, opposing the suite. The reasons for the opposition are parking and traffic concerns. The applicant received no comments as a result of the PIM mail out.

The feedback and PIM summary can be found in ***Attachment No. 3.***

OPTIONS:

OPTION 1: (Recommended)

THAT based on the October 18, 2021 staff report "Zoning Amendment Bylaw No. 3021 to Allow for a Secondary Suite at 2099 Hawk Drive" Council approve OPTION 1 and proceed to First and Second Readings of Zoning Amendment Bylaw No. 3021, 2021; and,

THAT Council considers Zoning Amendment Bylaw No. 3021, 2021 consistent with the City's Official Community Plan; and

THAT Council waives the requirement to hold a public hearing with respect to Zoning Amendment Bylaw No. 3021, 2021 pursuant to Section 467 (2) of the *Local Government Act* and directs staff to give notice of the waiver of the public hearing pursuant to Section 467 of the *Local Government Act* in advance of considerations of 3rd Reading of the bylaw.

OPTION 2:
THAT Council approve OPTION 2 and proceed to First and Second Readings of Zoning Bylaw No. 3021, 2021; and

THAT Council direct staff to schedule and advertise a statutory Public Hearing with respect to the above referenced bylaw.

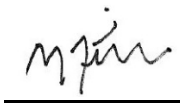
OPTION 3: Defer consideration of Bylaw No. 3021 with a request for more information.

OPTION 4: Defeat Bylaw No. 3021.

Prepared by:

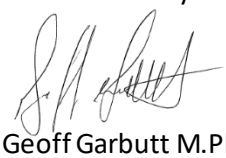
Cassandra Marsh
Planner I

Reviewed by:



Matthew Fitzgerald, RPP, MCIP
Manager of Development Planning

Concurrence by:

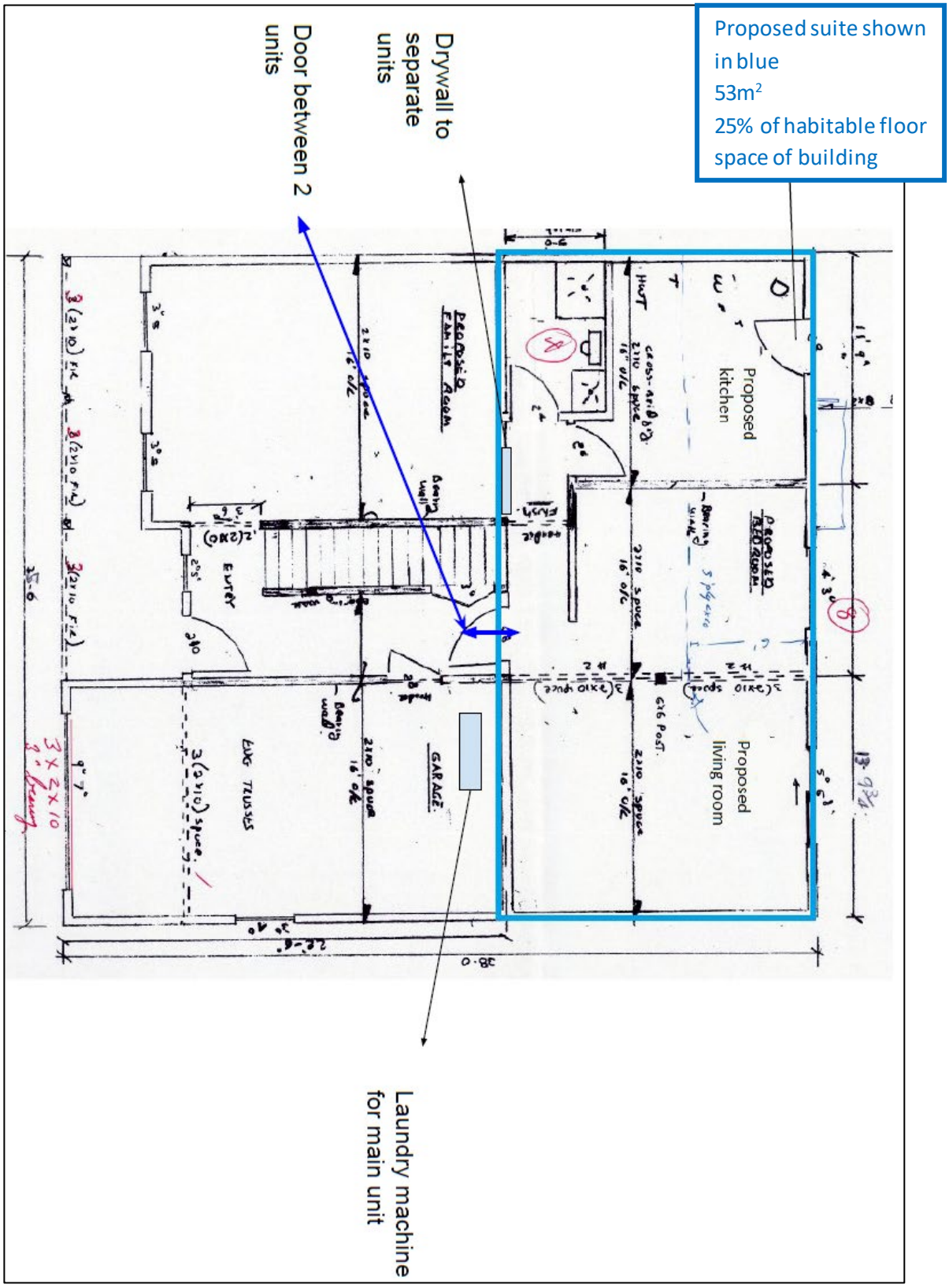


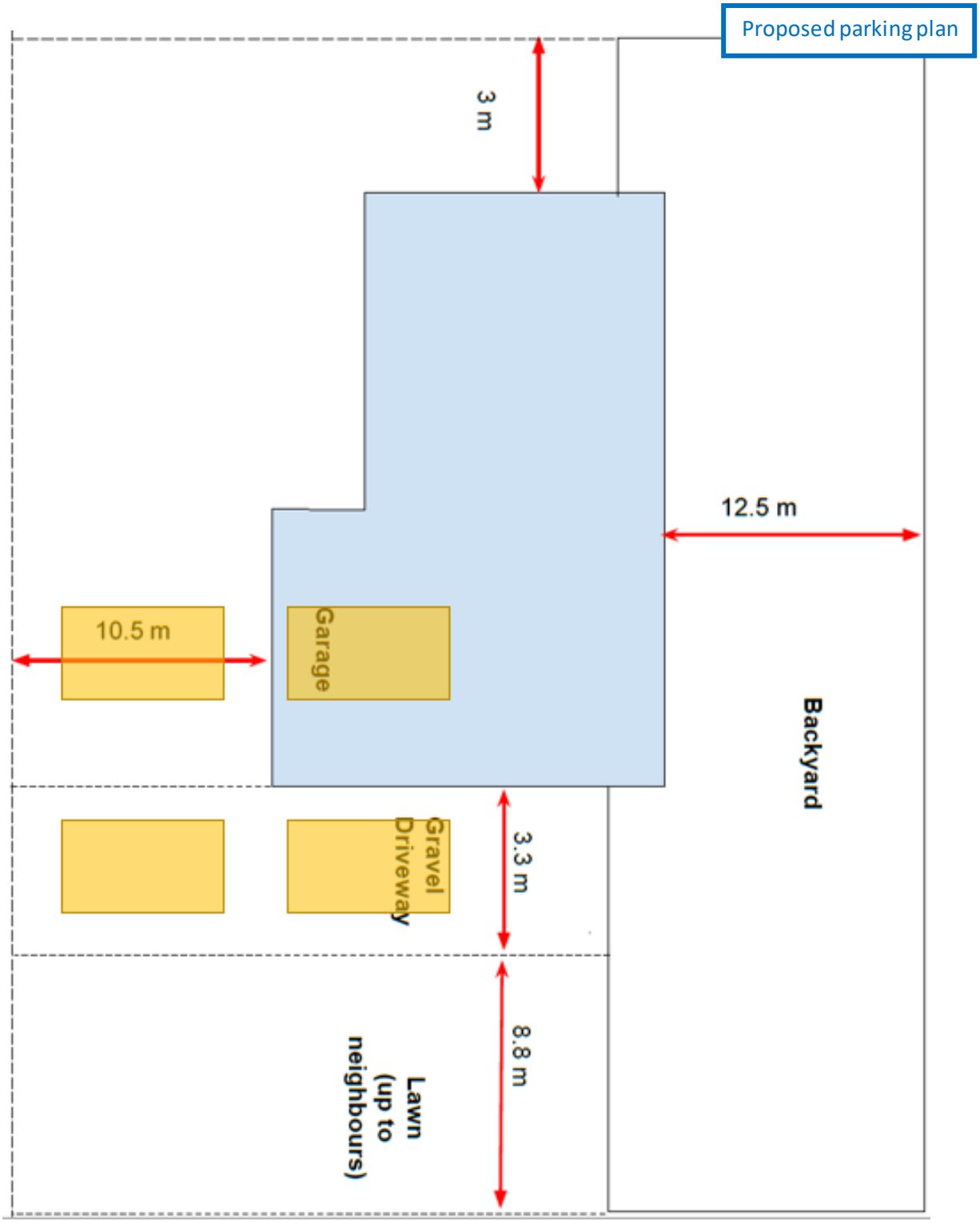
Geoff Garbutt M.Pl., MCIP, RPP
Chief Administrative Officer

Attachments:

1. *Attachment No. 1: Plans and Elevations*
2. *Attachment No. 2: Alternative Public Information Meeting Mail Out and Summary*
3. *Attachment No. 3: Public Comments*
4. *Attachment No. 4: Applicant's Rationale and Statement on Affordable Housing Policy*

Attachment No. 1: Plans and Parking




Proposed parking plan
3 m
12.5 m
10.5 m
Garage
Backyard
Gravel Driveway
3.3 m
8.8 m
Lawn (up to neighbours)

Attachment No. 2: Public Information Mail out Summary

August 25, 2021
City of Courtenay
Planning Department
Attn: Cassandra Marsh

Re: Rezoning file RZ000051

The attached letter was mailed to residents within 100 m of our property on Thursday, July 15th. Below is our Public Information Mailout (PIM) Summary for our property on 2099 Hawk Drive:

- Comments received via mail: 0
- Comments received via email: 0
- Comments received via telephone: 0

Regards,

Pedram Mahinpour & Mania Soltanzadeh

250 808 8934

Pederam Mahinpour
460 Dufferin Street, Fredericton, NB
E3B 3A7

Dear Neighbor(s),

We are writing to inform you that we have filed formal application for re-zoning our property from R1 to R1-S for purpose of being able to create a secondary suite in our house.

The address of the zoning change is 2099 Hawk Drive, Courtenay BC. There will be no changes to the footprint of the house.

This is our first house, we love it, we love the neighborhood, and we are planning to live in it for many years to come.

For your review and comment, our plans and zoning application may be viewed on the City of the Courtenay website: www.courtenay.ca/devapptracker.

The planning office would like to collect all the comments as a package. Please send us your feedbacks by mail (to the address above), email: pedram.mahinpour@gmail.com or call me at 250 808 8934. You can also cc your comments to the planning office (contact information provided below). If you send, your comments to the city please reference folder RZ000051 and our address 2099 Hawk Drive, Courtenay BC, V9N 9B1. Comments to the city may be sent per their instructions below:

Comments can be submitted to the City of the Courtenay by the one of the following methods:

- **Drop your comment sheet off in the drop box located at the front entrance of the City of the Courtenay or mail: City of the Courtenay, Planning Services Department, 830 Cliffe Avenue, Courtenay BC V9N 2J7**
- **Email your comments to planning@courtenay.ca**
- **Fax your comments to 250-334-4241**

Please send your comments by August 15, 2021.

Thanks and regards,

Pedram Mahinpour

Attachment No. 3: Public Comments

Tue 8/17/2021 1:54 PM

[redacted]

Rezoning of 2099 Hawk Dr.

To PlanningAlias

Sir or Madame

As area residents, my wife and I are opposed to this request. We drive past the address in question every day as well as walks in the evening, and with parking congestion as it is currently, this will only worsen it. Vehicles are parked on both sides of the road from Whisky Jack way around the corner onto Swallow Cres and the road is too narrow to safely accommodate this. Some of the vehicles even park with two wheels on the sidewalk in order to allow more room for single lane travel. Some of the vehicles parked on the road are from residents of the Condos on Hawk because their complex lacks sufficient parking. With a few of the residents in the area having small children, this is an accident waiting to happen. Something needs to be done with the parking as it currently is, including the corner by Hawk Glen Park.

[redacted]k
2168 Swallow Cres
[redacted]

Attachment No. 4: Applicant's Rationale

Project Summary:

Propose of this project is to change zoning from R-1 to R-1S of the property located at:

2099 Hawk Dr.,
Courtenay, BC
V9M 9B1

This provides the opportunity to add a rental unit within this single family property.

Lot size is 650 m^2 and total habitable floor space of the building is 201 m^2. Proposed rental unit will be 50 m^2 within the existing house, which is about 25% of the total area of the house. This unit includes 1 bedroom, 1 living room, a kitchen and a full bathroom (please see figure below). This unit also has its own parking space. Main unit has a garage and a drive way for at least one car.

This rental suite can accommodate up to 2 person and it is in walking distance to amenities such as major grocery stores, school, NIC and aqua center. This proposal satisfies all the by-law requirements as summarized in the table below:

Requirements	Proposal
Total area not more than 90 m^2	50 m^2 (include 1 bedroom, a living room and bathroom)
Floor area less than 40% of the total habitable floor space of the building	25%
Located within a building of residential occupancy containing only one other dwelling unit	Yes
Located within a building which is a single real state entity	Yes
3 parking spaces (2 spaces for the principle dwelling unit and 1 additional space for the secondary suite	3 parking spaces (1 garage + 2 driveway)

Mania Soltanzadeh & Pedram Mahinpour
[redacted]

June 13, 2020

Statement on Conformance to Affordable Housing Policy:

In accordance to Affordable Housing Policy, the reconstruction of the ground level of the property addressed above will add a secondary suite to the property that provide less expensive rental for our community.

This one bedroom suite can accommodate up to 2 person with a private parking space. Property is in walking distance to amenities such as major grocery stores, walking trail and parks as well as North Island College and aquatic center.

Monthly rental fee would be $900-$1000 a month with the intention to keep it inexpensive to increase the affordability.

Contact:

Email: [redacted]

Cell: [redacted]

THE CORPORATION OF THE CITY OF COURTENAY

STAFF REPORT

To: Council **File No.:** 3090-20-2103

From: Chief Administrative Officer **Date:** October 18, 2021

Subject: Development Variance Permit No. 2103 for 3202, 3212, 3216, 3220, 3224, 3228, 3232, 3248, 3258 and 3304 Klanawa Crescent

PURPOSE:

The purpose of this report is for Council to consider the issuance of a Development Variance Permit to reduce the minimum rear yard setback for the planned houses to be constructed on ten different lots.

CAO RECOMMENDATIONS:

THAT based on the October 18, 2021 staff report, "Development Variance Permit No. 2103 – 3202, 3212, 3216, 3220, 3224, 3228, 3232, 3248, 3258 and 3304 Klanawa Crescent", Council approve OPTION 1 and issue Development Variance Permit No. 2103.

Respectfully submitted,

Geoff Garbutt, M.Pl., RPP, MCIP
Chief Administrative Officer

BACKGROUND:

The subject properties are located within the Northridge Estates subdivision located northeast of the intersection of Mission Road and Klanawa Crescent. Surrounding the properties are established residential subdivisions along Cascara Crescent, Salal Place, Mission Road and Crown Isle Boulevard that are zoned for single family residential use. Forested lands in the Agricultural Land Reserve (ALR) exists to the north of the subdivision and to southwest there is a mix of light industrial and institutional uses.

Figure 1: Subject Properties (outlined in red) (Lots 12, 14, 15, 16, 17, 18, 19, 23, 24, 26)

DISCUSSION:

The proposal is located within the Residential One S Zone (R-1S). This zone allows a minimum lot size of 650m² or 725m² for corner lots. A majority of the subject lots are near the minimum area with exact lot sizes shown in Table 1 below.

The applicant notes a relaxation of the rear yard setback is being sought in order to provide uniform setback distances from rear property lines, increase the amount of buildable area on the lots and to promote flexibility in the design for single family residences.

Table No. 1 below summarizes the requested variances which are measured to the building face.

Rear Yard Setback Single Residential Lot	**Required**	**Proposed Variance (measured to building face)**	**Current Lot Size (Subdivision Plan EPP102825)**
Lot 12	12.0m	10m	978.4m²
Lot 14	12m	10m	654.8m²
Lot 15	12m	10m	650.6m²
Lot 16	12m	10m	651.4m²
Lot 17	12m	10m	651.0m²
Lot 18	12m	10m	650.3m²

Lot 19	12m	10m	665.6m²
Lot 23	12	10m	702.1m²
Lot 24	12m	10m	691.9m²
Lot 26	12m	10m	672.8m²

Table No.1: Proposed Variances

Adjacent Agricultural Lands

In 2017 the subject lands were rezoned from Residential One B (R-1B) to Residential One S (R-1S) and Public Assembly Two (PA-2) to permit single family dwellings with secondary suites and City Parkland.

During the rezoning process the Planning Division referred the application to the Ministry of Agriculture (MoA) and consulted in detail about the required buffering between the future residential lots and the adjacent farmland to the north. MoA's recommended buffer is outlined in MoA's Guide to Edge Planning and calls for a 15m wide vegetated buffer with an additional 15m building setback (30m total buffer from the ALR land to the building)

As seen in Table No. 2 below the City approved a buffer ranging from approximately 24.3m to 27m which is inclusive of the 15m City Trail (parkland) running along the northern property boundary and the rear yard building setback (in the R-1S zone) of 12m.

	Ministry of Agriculture Recommendation	Development Proposal
Buffer Width	15 m	12.3 – 15 m (represented by 15m City Trail (parkland) running along the northern property boundary)
Building Setback	15 m	12 m (current rear yard building setback)
Total Distance from Back of House to Agricultural Land	30 m	24.3 m – 27 m (represented by 15m City Trail (parkland) running along the northern property boundary combined with rear yard building setback distance of 12m)

Table No. 2. Agricultural Buffering approved during 2017 rezoning

Additionally, the City, based on MoA's recommendation, is requiring that lot owners install fencing on the subject lots (*as seen in Figure No. 2*) and for the developer to install ALR signage along the northern property boundary adjacent to the farmland. These requirements have been secured through a covenant registered on the land.

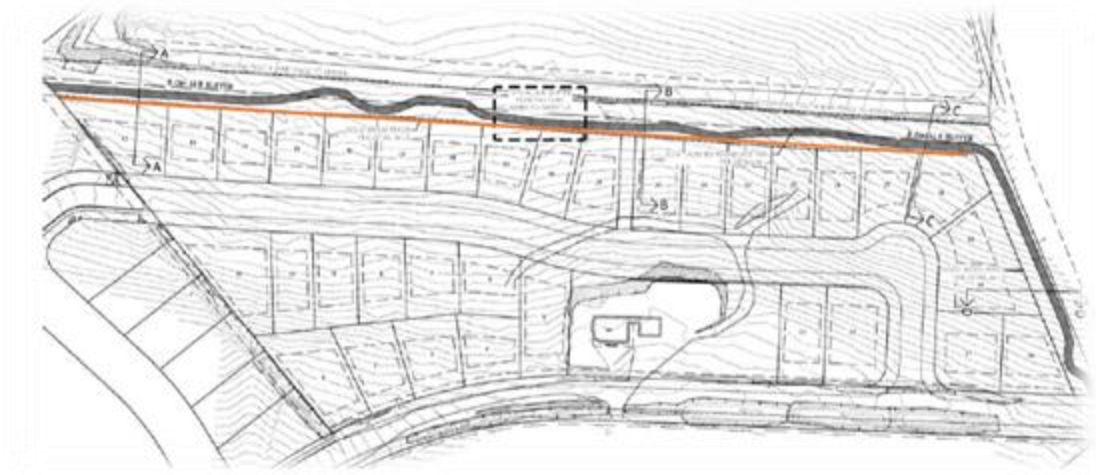


Figure 2: Schedule B, Covenant #CA6418526 (area where fencing is required is highlighted in orange)

Staff note that variances on the lots, if approved, still provide a buffer of 24m (inclusive of the 15m vegetated trail and the applicant's proposed 9m rear yard building setbacks). Staff feel that the width of the buffer is adequate and remains consistent with the intent of buffering established in 2017.

Staff have no concerns with the request to vary the rear yard setbacks on these lots as they will have minimal impact on the character of the streetscape; will promote design flexibility for the single family residences constructed on the lots creating a more diverse neighborhood. Additionally the proposal respects the previously established tree retention areas and maintain an appropriate buffer from the ALR lands. **Staff assess the requested variances as supportable.**

FINANCIAL IMPLICATIONS:
There are no direct financial implications related to the processing of this Development Variance Permit as the fees are designed to offset administrative costs. The application fee for the DVP was $1,000.

ADMINISTRATIVE IMPLICATIONS:
Processing development variance permits is a statutory component of the work plan. Staff has spent approximately 18 hours processing this application to date. Should the proposed development variance permit be approved, an additional two hours of staff time will be required to register the permit and close the file. Additional staff time will be required to process subsequent subdivision and building permit applications including inspections.

ASSET MANAGEMENT IMPLICATIONS:
There are no immediate asset management implications related to the proposed application.

2019 - 2022 STRATEGIC PRIORITIES REFERENCE:

● Communicate appropriately with our community in all decisions we make

●▲ Encourage and support housing diversity

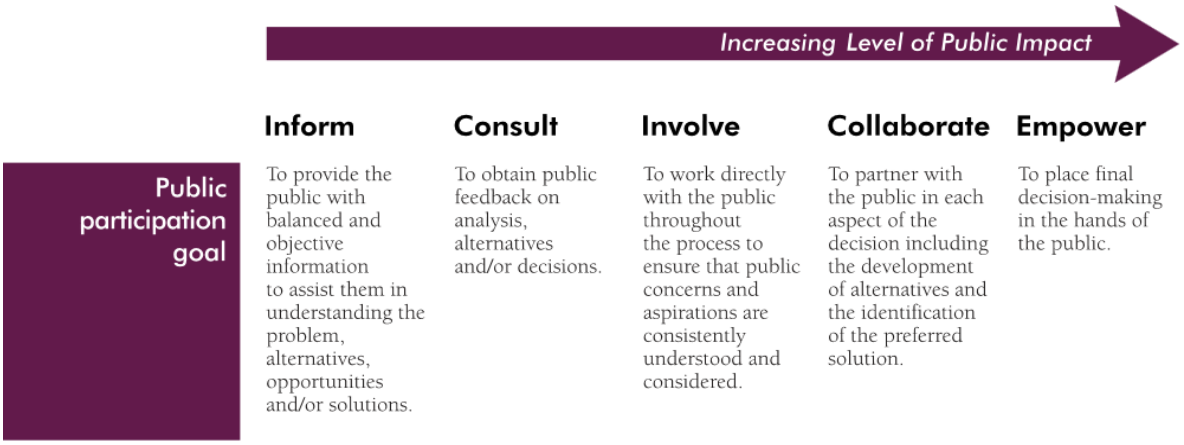
The November 2019 Strategic Priorities Check-in also identified the following references under the "Next Council Priorities" subsection:

- Housing Need Assessment

OFFICIAL COMMUNITY PLAN REFERENCE:
The subject property is designated as "Urban Residential" in the OCP and consistent with the policy direction provided.

REGIONAL GROWTH STRATEGY REFERENCE:
The proposed development is located within the core settlement area outlined in the Comox Valley Regional Growth Strategy. The Regional Growth Strategy states that at least 90 percent of growth in the Comox Valley should be directed to Core Settlement Areas.

CITIZEN/PUBLIC ENGAGEMENT:
As per Council's direction, under the IAP2 Spectrum of Public Participation the level of public input that has been undertaken is "Consult".



The applicant mailed out a public information meeting package on September 1, 2021 to adjacent property owners and occupiers and one public comment was received. The information contained in the public information package including one public comment from the adjacent neighbour to the north, Beaver Meadow Farms, is referenced in ***Attachment No. 5.***

In accordance with *the Local Government Act*, the City has notified property owners and occupants within 30 metres of the subject property of the requested variances and provided the opportunity to submit written feedback. To date, staff has received no responses.

OPTIONS:

OPTION 1: (Recommended)

THAT based on the October 18, 2021 staff report, "Development Variance Permit No. 2103 – 3202, 3212, 3216, 3220, 3224, 3228, 3232, 3248, 3258 and 3304 Klanawa Crescent", Council approve OPTION 1 and issue Development Variance Permit No. 2103.

OPTION 2: Defer consideration of Development Variance Permit No. 2103 pending receipt of further information.

OPTION 3: Not approve Development Variance Permit No. 2103.

Prepared by:

Dana Beatson, RPP, MCIP
Planner II- Development Planning

Reviewed by:

Matthew Fitzgerald, RPP, MCIP
Manager of Development Planning

Concurrence by:

Geoff Garbutt, M.Pl., RPP, MCIP
Chief Administrative Officer

Attachments:

Attachment No. 1: Draft Development Variance Permit No. 2103
Attachment No. 2: CA8847889; Geotechnical Covenant; Design Specifications
Attachment No. 3: #CA6418526 Tree Retention Areas Covenant on Lots 12, 14, 15, 16, 17, 18, 19
Attachment No. 4: Geotechnical Engineer's Letters of support
Attachment No. 5: Public Information Package and Public Comments
Attachment No. 6: Sustainability Evaluation Checklist

Attachment 1: Draft Development Variance Permit No. 2103

THE CORPORATION OF THE CITY OF COURTENAY

Permit No. 3090-20-2103

DEVELOPMENT VARIANCE PERMIT

To issue a Development Variance Permit

To: Name: 0953484 B.C. LTD., INC.NO. BC0953484

Address: 101 - 1930 Island Diesel Way
Nanaimo, BC
V9S 5W8

Properties to which permit refers:

Legal (s): Lot 12 District Lot 236 Comox District Plan EPP102825
Lot 14 District Lot 236 Comox District Plan EPP102825
Lot 15 District Lot 236 Comox District Plan EPP102825
Lot 16 District Lot 236 Comox District Plan EPP102825
Lot 17 District Lot 236 Comox District Plan EPP102825
Lot 18 District Lot 236 Comox District Plan EPP102825
Lot 19 District Lot 236 Comox District Plan EPP102825
Lot 23 District Lot 236 Comox District Plan EPP102825
Lot 24 District Lot 236 Comox District Plan EPP102825
Lot 26 District Lot 236 Comox District Plan EPP102825

Civic (s): 3202 Klanawa Crescent
3212 Klanawa Crescent
3216 Klanawa Crescent
3220 Klanawa Crescent
3224 Klanawa Crescent
3228 Klanawa Crescent
3232 Klanawa Crescent
3248 Klanawa Crescent
3258 Klanawa Crescent
3304 Klanawa Crescent

Conditions of Permit:

Permit issued to for the properties legally described as Lots 12, 14, 15, 16, 17, 18, 19, 23, 24, 26, District Lot 236 Comox District Plan EPP102825 with the following variances to the *City of Courtenay Zoning Bylaw No. 2500, 2007:*

8.1.61 Setbacks
(2) Reduce the minimum rear yard setback from 12m to 10m.

Development Variance Permit No. 2103 is subject to the following conditions:

- That prior to issuance of a building permit, that Geotechnical Covenant CA8847889 be modified to reflect the Project Engineer's revised minimum offset requirements between the building foundation and rock pit on the subject lots.

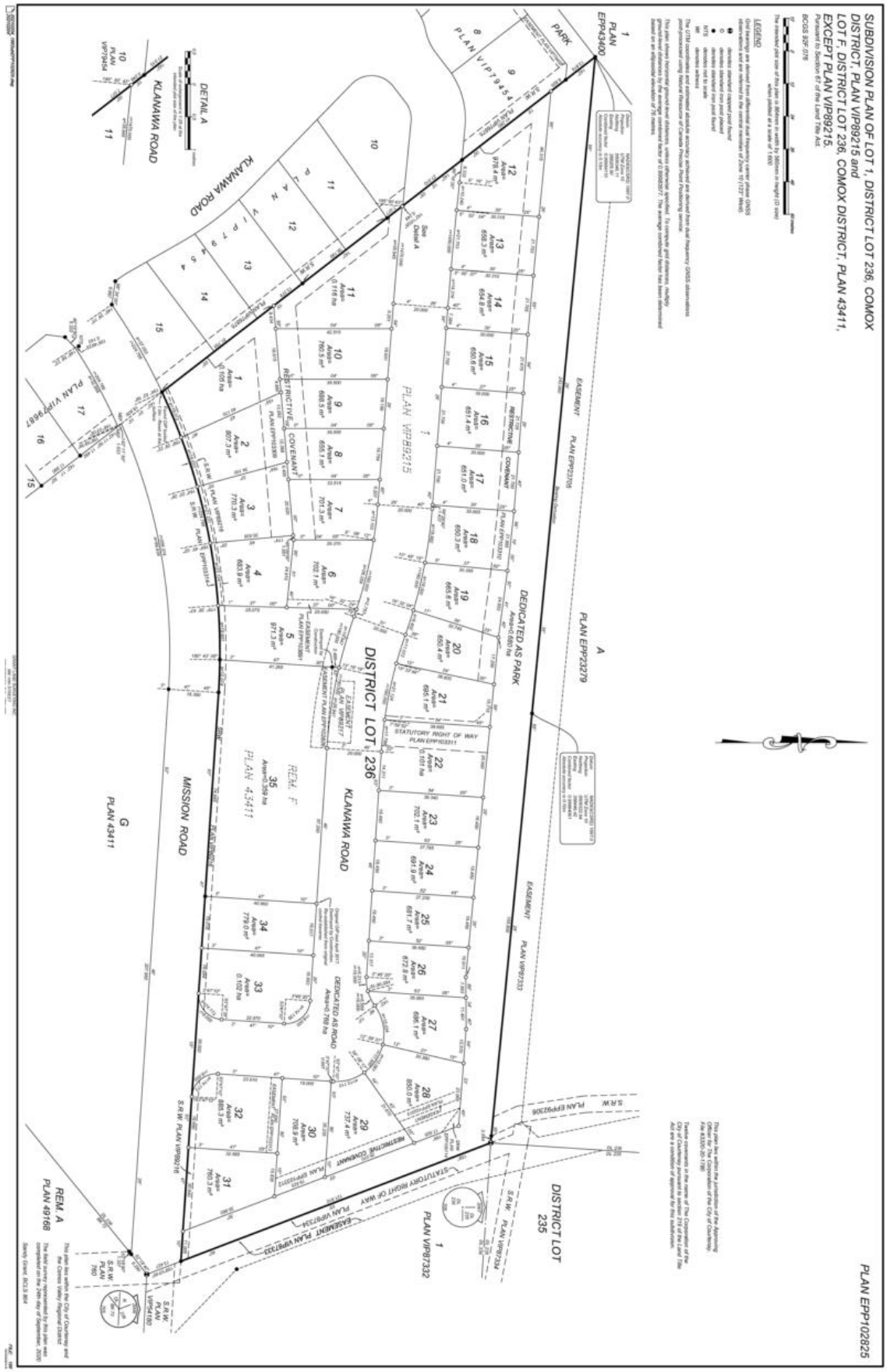
Time Schedule of Development and Lapse of Permit

That if the permit holder has not substantially commenced the construction authorized by this permit within (12) months after the date it was issued, the permit lapses.

Date

Corporate Officer

Schedule No. 1: Approved Subdivision Plan (Northridge Estates)



Attachment No. 2: Geotechnical Covenant (#CA8847889)

Status: Registered | Doc #: CA8847889 | RCVD: 2021-03-17 RQST: 2021-04-27 15.15.41

FORM_C_V27 (Charge)

VICTORIA LAND TITLE OFFICE
Mar-17-2021 09:23:45.008

DECLARATION(S) ATTACHED
CA8847889 CA8847891

LAND TITLE ACT
FORM C (Section 233) CHARGE
GENERAL INSTRUMENT - PART 1 Province of British Columbia

PAGE 1 OF 36 PAGES

Your electronic signature is a representation that you are a designate authorized to certify this document under section 168.4 of the *Land Title Act*, RSBC 1996 c.250, that you certify this document under section 168.41(4) of the act, and that an execution copy, or a true copy of that execution copy, is in your possession.

Brian James Senini IAT7J9 — Digitally signed by Brian James Senini IAT7J9 Date: 2021.03.11 11:03:45 -08'00'

1. APPLICATION: (Name, address, phone number of applicant, applicant's solicitor or agent)

Michele Buick, Legal Assistant
HEATH LAW LLP, Barristers & Solicitors
200 - 1808 Bowen Road
Nanaimo BC V9S 5W4

City File No. SD1708; HL File No. 54806-1;
Tel: (250) 824-2080
Type: (Scafe) Rock Pit Covenant Lots 5-20, 23-26, 33, 34

Document Fees: $224.61 Deduct LTSA Fees? Yes ☑

2. PARCEL IDENTIFIER AND LEGAL DESCRIPTION OF LAND:
[PID] [LEGAL DESCRIPTION]

SEE SCHEDULE

STC? YES ☐

3. NATURE OF INTEREST | CHARGE NO. | ADDITIONAL INFORMATION

SEE SCHEDULE

4. TERMS: Part 2 of this instrument consists of (select one only)
(a) ☐ Filed Standard Charge Terms D.F. No. (b) ☑ Express Charge Terms Annexed as Part 2
A selection of (a) includes any additional or modified terms referred to in Item 7 or in a schedule annexed to this instrument.

5. TRANSFEROR(S):

SEE SCHEDULE

6. TRANSFEREE(S): (including postal address(es) and postal code(s))

THE CORPORATION OF THE CITY OF COURTENAY

830 CLIFFE AVENUE
COURTENAY BRITISH COLUMBIA
V9N 2J7 CANADA

7. ADDITIONAL OR MODIFIED TERMS:

8. EXECUTION(S): This instrument creates, assigns, modifies, enlarges, discharges or governs the priority of the interest(s) described in Item 3 and the Transferor(s) and every other signatory agree to be bound by this instrument, and acknowledge(s) receipt of a true copy of the filed standard charge terms, if any.

Officer Signature(s)	Execution Date Y	M	D	Transferor(s) Signature(s)
BRIAN J. SENINI Barrister & Solicitor 200 - 1808 BOWEN ROAD Nanaimo, BC V9S 5W4	21	02	05	0953484 B.C. LTD. by its authorized signatory: Name: JOSH FAYERMAN

OFFICER CERTIFICATION:
Your signature constitutes a representation that you are a solicitor, notary public or other person authorized by the *Evidence Act*, R.S.B.C. 1996, c.124, to take affidavits for use in British Columbia and certifies the matters set out in Part 5 of the *Land Title Act* as they pertain to the execution of this instrument.

Page 1 of 41

Status: Registered Doc #: CA8847889 RCVD: 2021-03-17 RQST: 2021-04-27 15.15.41

FORM_D1_V27

LAND TITLE ACT
FORM D

EXECUTIONS CONTINUED PAGE 2 of 36 PAGES

Officer Signature(s)	Execution Date Y	M	D	Transferor / Borrower / Party Signature(s)
JENNIFER G. HUBBARD Barrister & Solicitor #2 - 707 Primrose Street Qualicum Beach, BC V9K 2K1	21	02	09	WINDSOR BUILDING SUPPLIES LTD. by its authorized signatory: Name: RANDLE JONES
MARINKO JELOVIC Barrister & Solicitor 600 - 105 21st Street East Saskatoon, SK S7K 0B3	21	02	08	JJD WALKER HOLDINGS LTD. by its authorized signatory: Name: DAVE WALKER
BRIAN J. SENINI Barrister & Solicitor 200 - 1808 BOWEN ROAD Nanaimo, BC V9S 5W4	21	02	05	MILESTONE EQUIPMENT CONTRACTING INC. by its authorized signatory: Name: JOSH FAYERMAN

OFFICER CERTIFICATION:
Your signature constitutes a representation that you are a solicitor, notary public or other person authorized by the *Evidence Act*, R.S.B.C. 1996, c.124, to take affidavits for use in British Columbia and certifies the matters set out in Part 5 of the *Land Title Act* as they pertain to the execution of this instrument.

Page 2 of 41

Status: Registered Doc #: CA8847889 RCVD: 2021-03-17 RQST: 2021-04-27 15.15.41

FORM_D1_V27

LAND TITLE ACT
FORM D

EXECUTIONS CONTINUED PAGE 3 of 36 PAGES

Officer Signature(s)	Execution Date Y	M	D	Transferor / Borrower / Party Signature(s)
BRIAN J. SENINI Barrister & Solicitor 200 - 1808 BOWEN ROAD Nanaimo, BC V9S 5W4	21	02	11	MARK NEUMEYER
REMO PAOLO DE SORDI Notary Public 2300 - 201 Portage Avenue Winnipeg, MB R3B 3L3	21	02	10	5277095 MANITOBA LTD. by its authorized signatory: Name: TOM WILTON
REMO PAOLO DE SORDI Notary Public 2300 - 201 Portage Avenue Winnipeg, MB R3B 3L3	21	02	10	5277109 MANITOBA LTD. by its authorized signatory: Name: AL ALEXANDRUK

OFFICER CERTIFICATION:
Your signature constitutes a representation that you are a solicitor, notary public or other person authorized by the *Evidence Act*, R.S.B.C. 1996, c.124, to take affidavits for use in British Columbia and certifies the matters set out in Part 5 of the *Land Title Act* as they pertain to the execution of this instrument.

Page 3 of 41

FORM D

EXECUTIONS CONTINUED PAGE 4 of 36 PAGES

Officer Signature(s)	Execution Date Y	M	D	Transferor / Borrower / Party Signature(s)
Rayanne Matthews Commissioner for Taking Affidavits in British Columbia 830 CLIFFE AVENUE COURTENAY, BC V9N 2J7 (as to both signatures)	21	03	03	THE CORPORATION OF THE CITY OF COURTENAY by its authorized signatory(ies): Name: Bob Wells, Mayor Wendy Sorichta, Corporate Officer
	21	03	09	This is an instrument required by the Approving Officer for Subdivision Plan EPP102825 creating the condition or covenant entered into under s.219 of the Land Title Act. Richard Feucht, Approving Officer

OFFICER CERTIFICATION:
Your signature constitutes a representation that you are a solicitor, notary public or other person authorized by the *Evidence Act*, R.S.B.C. 1996, c.124, to take affidavits for use in British Columbia and certifies the matters set out in Part 5 of the *Land Title Act* as they pertain to the execution of this instrument.

Page 4 of 41

Status: Registered Doc #: CA8847889 RCVD: 2021-03-17 RQST: 2021-04-27 15.15.41

FORM_E_V27

LAND TITLE ACT
FORM E

SCHEDULE PAGE 5 OF 36 PAGES

2. PARCEL IDENTIFIER AND LEGAL DESCRIPTION OF LAND Related Plan Number: **EPP102825**

STC for each PID listed below? YES ☐

[PID]	[LEGAL DESCRIPTION – must fit in a single text line]
NO PID NMBR	LOT 5 DISTRICT LOT 236 COMOX DISTRICT PLAN EPP102825
NO PID NMBR	LOT 6 DISTRICT LOT 236 COMOX DISTRICT PLAN EPP102825
NO PID NMBR	LOT 7 DISTRICT LOT 236 COMOX DISTRICT PLAN EPP102825
NO PID NMBR	LOT 8 DISTRICT LOT 236 COMOX DISTRICT PLAN EPP102825
NO PID NMBR	LOT 9 DISTRICT LOT 236 COMOX DISTRICT PLAN EPP102825
NO PID NMBR	LOT 10 DISTRICT LOT 236 COMOX DISTRICT PLAN EPP102825
NO PID NMBR	LOT 11 DISTRICT LOT 236 COMOX DISTRICT PLAN EPP102825
NO PID NMBR	LOT 12 DISTRICT LOT 236 COMOX DISTRICT PLAN EPP102825
NO PID NMBR	LOT 13 DISTRICT LOT 236 COMOX DISTRICT PLAN EPP102825
NO PID NMBR	LOT 14 DISTRICT LOT 236 COMOX DISTRICT PLAN EPP102825
NO PID NMBR	LOT 15 DISTRICT LOT 236 COMOX DISTRICT PLAN EPP102825
NO PID NMBR	LOT 16 DISTRICT LOT 236 COMOX DISTRICT PLAN EPP102825
NO PID NMBR	LOT 17 DISTRICT LOT 236 COMOX DISTRICT PLAN EPP102825
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NO PID NMBR	LOT 23 DISTRICT LOT 236 COMOX DISTRICT PLAN EPP102825
NO PID NMBR	LOT 24 DISTRICT LOT 236 COMOX DISTRICT PLAN EPP102825
NO PID NMBR	LOT 25 DISTRICT LOT 236 COMOX DISTRICT PLAN EPP102825
NO PID NMBR	LOT 26 DISTRICT LOT 236 COMOX DISTRICT PLAN EPP102825
NO PID NMBR	LOT 33 DISTRICT LOT 236 COMOX DISTRICT PLAN EPP102825
NO PID NMBR	LOT 34 DISTRICT LOT 236 COMOX DISTRICT PLAN EPP102825

Page 5 of 41

Status: Registered Doc #: CA8847859 RCVD: 2021-03-17 RQST: 2021-04-27 15.15.41

FORM_E_V27

LAND TITLE ACT
FORM E

SCHEDULE PAGE 6 OF 36 PAGES

NATURE OF INTEREST	CHARGE NO.	ADDITIONAL INFORMATION
Covenant		S.219
Priority Agreement		Granting the Covenant granted herein priority over Mortgage CA2848094
Priority Agreement		Granting the Covenant granted herein priority over Mortgage CA3462539

Status: Registered Doc #: CA8847889 RCVD: 2021-03-17 RQST: 2021-04-27 15.15.41

FORM_E_V27

LAND TITLE ACT
FORM E

SCHEDULE PAGE 7 OF 36 PAGES

ENTER THE REQUIRED INFORMATION IN THE SAME ORDER AS THE INFORMATION MUST APPEAR ON THE FREEHOLD TRANSFER FORM, MORTGAGE FORM, OR GENERAL INSTRUMENT FORM.

5. TRANSFEROR(S):

0953484 B.C. LTD., Inc. No. BC0953484 (as to Covenant)

WINDSOR BUILDING SUPPLIES LTD., Inc. No. BC0951465 (as to Priority)

JJD WALKER HOLDINGS LTD., Inc. No. _____ (as to Priority)

MILESTONE EQUIPMENT CONTRACTING INC., Inc. No. BC0727045 (as to Priority)

MARK NEUMEYER (as to Priority)

5277095 MANITOBA LTD., Inc. No. _____ (as to Priority)

5277109 MANITOBA LTD., Inc. No. _____ (as to Priority)

Status: Registered Doc #: CA8847889 RCVD: 2021-03-17 RQST: 2021-04-27 15.15.41

TERMS OF INSTRUMENT - PART 2

SECTION 219 COVENANT

THIS AGREEMENT made the 22nd day of January, 2021.

BETWEEN:

0953484 B.C. LTD.
1553 Seaview Road
Black Creek, BC V9J 1J6

(hereinafter called the "Grantor")

AND:

THE CORPORATION OF THE CITY OF COURTENAY, a Municipal Corporation under the *Local Government Act*
830 Cliffe Avenue
Courtenay, BC V9N 2J7

(hereinafter called the "City")

WHEREAS:

A. The Grantor is the registered owner of ALL AND SINGULAR those parcels of land in the City of Courtenay in the Province of British Columbia legally described in Item 2 of Part 1 of the *Land Title Act* Form C to which this Agreement is attached and which forms part of this Agreement (the "Lands");

B. Section 219 of the *Land Title Act* of British Columbia permits the registration of a covenant of a negative or positive nature in favour of a municipality, in respect of the use of land, the building on land, the subdivision of land and the preservation of land or specified amenity on the land; and

C. As a condition of the Approving Officer for the City granting final subdivision approval to create the Lands, the Grantor has agreed to the registration of a covenant under Section 219 of the *Land Title Act* of British Columbia against title to the Lands on the terms and conditions set out herein.

THIS AGREEMENT is evidence that in consideration of payment of $1.00 by the City to the Grantor and other and valuable consideration, the receipt of which is acknowledged by the Grantor, the Grantor covenants and agrees with the City in accordance with Section 219 of the *Land Title Act* as follows:

1. The Grantor covenants and agrees with the City that no building or structure, including foundation, shall be constructed or occupied on the Lands unless and until the Grantor constructs, installs and maintains in good working order on the Lands a rock pit in accordance with all of the recommendations, including section 4.10, in the report prepared by Joe Brunelle, P. Eng. of Lewkowich Engineering Associates Ltd., dated January 20, 2021, for project "Northridge Estates 34-Lot Residential Subdivision 3300 Mission Road, Courtenay, BC" (the "Report"), a reduced copy of which is attached hereto as Schedule "A" and a full copy of which is kept by the City of Courtenay.

2. The Building Inspector for the City or a person authorized by him or her is authorized to enter the Lands at any time to ascertain whether the terms of this Agreement have been complied with.

3. This Agreement shall restrict use of the Lands in the manner provided herein despite any right or permission to the contrary contained in any bylaw or permit of the City.

4. The Grantor releases the City and shall indemnify and save harmless the City and its councillors, officers, employees and agents from any claim of any nature by the Grantor or any other person that may be made against the City or its councillors, officers, employees or agents arising out of or in any way related to the granting or existence of this Agreement or any breach of this Agreement.

5. The Grantor shall comply with all requirements of this Agreement at its own cost and expense.

6. The Grantor shall, at the Grantor's expense, do or cause to be done all acts reasonably necessary to register this Agreement against title to the Lands with priority over all financial charges, liens and encumbrances registered or pending registration at the time of application for registration of this Agreement against title to the Lands.

7. The parties agree that this Agreement creates only contractual obligations and obligations arising out of the nature of this document as a covenant under seal. The parties agree that no tort obligations or liabilities of any kind exist between the parties in connection with the performance of, or any default under or in respect of, this Agreement. The intent of this section is to exclude tort liability of any kind and to limit the parties to their rights and remedies under the law of contract and the law pertaining to covenants under seal.

8. Every obligation and covenant of the Grantor in this Agreement constitutes both a contractual obligation and a covenant granted under section 219 of the *Land Title Act* in respect of the Lands and this Agreement burdens the Lands and runs with them and binds the successors in title to the Lands until discharged by an instrument in writing duly executed by the City and filed at the Victoria Land Title Office. This Agreement burdens and charges all of the Lands and any parcel into which the Lands are subdivided by any means and any parcel into which the Lands are consolidated (including by removal of

Status: Registered Doc #: CA8847889 RCVD: 2021-03-17 RQST: 2021-04-27 15.15.41

interior parcel boundaries) and shall be extended, at the Grantor's cost, to burden and charge any land consolidated with the Lands.

9. The rights given to the City by this Agreement are permissive only and nothing in this Agreement imposes any legal duty of any kind on the City to anyone, or obliges the City to enforce this Agreement, to perform any act or to incur any expense in respect of this Agreement, except that nothing in this section shall affect the contractual rights and obligations of the parties hereto under this Agreement.

10. An alleged waiver of any breach of this Agreement is effective only if it is an express waiver in writing of the breach in respect of which the waiver is asserted. A waiver of a breach of this Agreement does not operate as a waiver of any other breach of this Agreement.

11. If any part of this Agreement is held to be invalid, illegal or unenforceable by a court having the jurisdiction to do so, that part is to be considered to have been severed from the rest of this Agreement and the rest of this Agreement remains in force unaffected by that holding or by the severance of that part.

12. This Agreement shall enure to the benefit of and be binding upon the parties hereto and their respective successors and assigns.

13. Nothing in this Agreement shall affect or restrict the City in the exercise of any of its statutory powers, nor does the granting or registration of this Agreement commit the City to the adoption of any bylaw or resolution.

14. The parties hereto shall execute and do all such further deeds, acts, things and assurances that may be reasonably required to carry out the intent of this Agreement.

IN WITNESS WHEREOF the parties have executed this Agreement on Forms C and D to which this Agreement is attached and which form part of this Agreement.

Status: Registered Doc #: CA8847889 RCVD: 2021-03-17 RQST: 2021-04-27 15.15.41

PRIORITY AGREEMENT

WHEREAS **WINDSOR BUILDING SUPPLIES LTD.** (Inc. No. BC0951465) (the "Chargeholder") is the holder of the Mortgage (the "Charge") encumbering the lands (the "Lands") described in item 2 of the *Land Title Act* Form C attached hereto, which was registered in the Victoria Land Title Office under number **CA2848094**.

The Chargeholder, in consideration of the premises and the sum of One Dollar ($1.00) now paid to the Chargeholder by the Transferee, hereby approves of, joins in and consents to the granting of the within Agreement and covenants and agrees that the same shall be binding upon its interest in or charge upon the Lands and shall be an encumbrance upon the Lands prior to the Charge in the same manner and to the same effect as if it had been dated and registered prior to the Charge.

IN WITNESS WHEREOF the Chargeholder has executed this Agreement on Form D to which this Agreement is attached and which forms part of this Agreement.

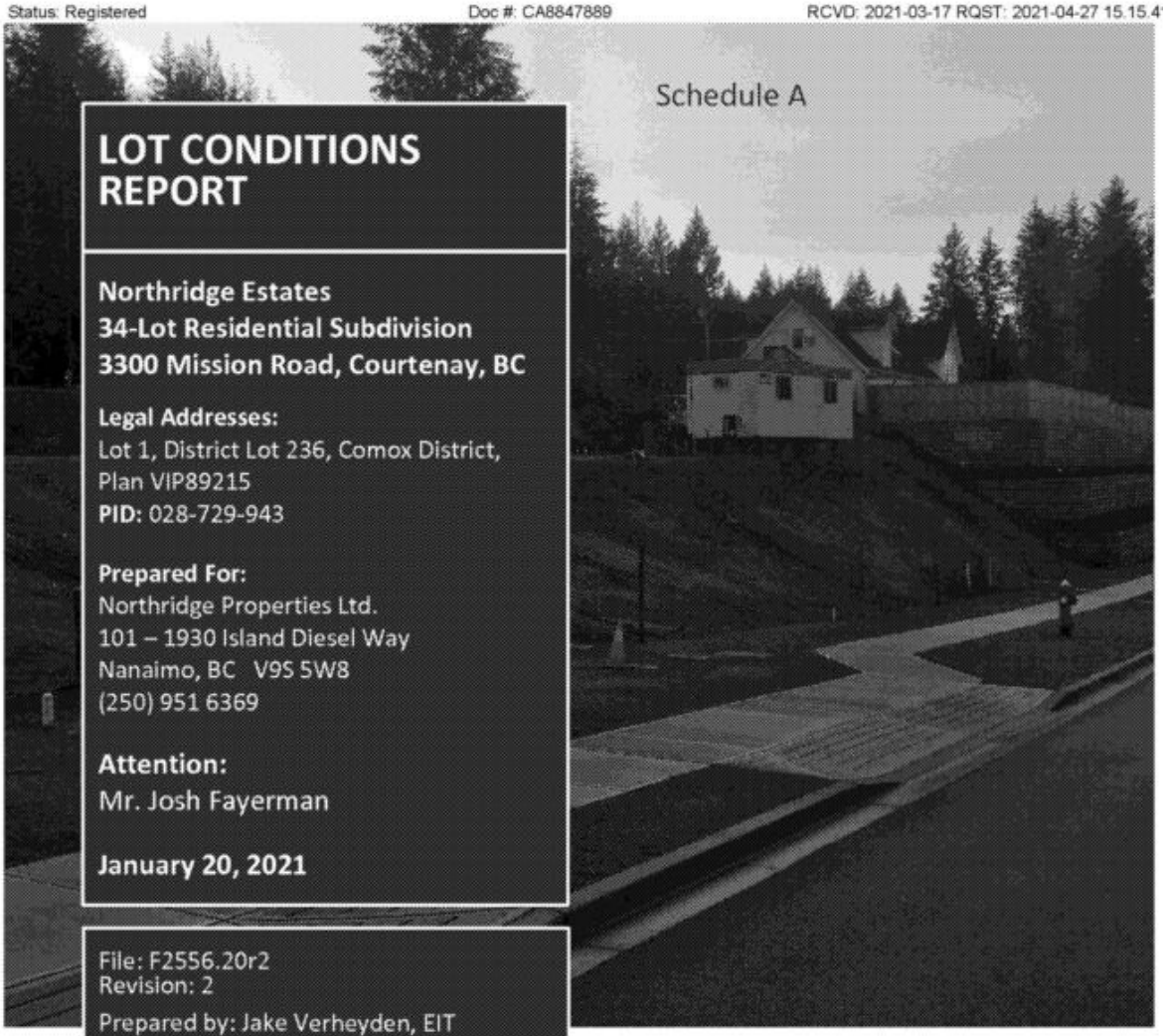
Status: Registered Doc #: CA8847889 RCVD: 2021-03-17 RQST: 2021-04-27 15.15.41

PRIORITY AGREEMENT

WHEREAS **JJD WALKER HOLDINGS LTD., MILESTONE EQUIPMENT CONTRACTING INC., MARK NEUMEYER, 5277095 MANITOBA LTD.,** and **5277109 MANITOBA LTD.** (collectively, the "Chargeholder") is the holder of a Mortgage (called the "Charge") encumbering the lands (the "Lands") described in item 2 of the Land Title Act Form C attached hereto, which was registered in the Victoria Land Title Office under number **CA3462539**.

The Chargeholder, in consideration of the premises and the sum of One Dollar ($1.00) now paid to each of the persons comprising the Chargeholder by the Transferee, hereby approves of, joins in and consents to the granting of the within Agreement and covenants and agrees that the same shall be binding upon its interest in or charge upon the Lands and shall be an encumbrance upon the Lands prior to the Charge in the same manner and to the same effect as if it had been dated and registered prior to the Charge.

IN WITNESS WHEREOF, each of the persons comprising the Chargeholder has executed and delivered this Consent and Priority Agreement by executing the Land Title Act Form D above which is attached hereto and forms part of this Agreement.



LOT CONDITIONS REPORT

Northridge Estates
34-Lot Residential Subdivision
3300 Mission Road, Courtenay, BC

Legal Addresses:
Lot 1, District Lot 236, Comox District,
Plan VIP89215
PID: 028-729-943

Prepared For:
Northridge Properties Ltd.
101 – 1930 Island Diesel Way
Nanaimo, BC V9S 5W8
(250) 951 6369

Attention:
Mr. Josh Fayerman

January 20, 2021

File: F2556.20r2
Revision: 2

Prepared by: Jake Verheyden, EIT
Joe Brunelle, P.Eng.

Reviewed by: Chris Hudec, M.A.Sc., P.Eng.

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LEA Lewkowich Engineering Associates Ltd.

OQM CERTIFIED

Page 13 of 41

Status: Registered Doc #: CA8847889 RCVD: 2021-03-17 RQST: 2021-04-27 15.15.41

PROJECT: Northridge Estates Subdivision, Courtenay, BC
FILE: F2556.20r2
DATE: January 20, 2021

DISCLAIMER

1. Lewkowich Engineering Associates Ltd. acknowledges that this report, from this point forward referred to as "the Report," may be used by the City of Courtenay (CoC) as a precondition to the issuance of a development and/or building permit and that this Report and any conditions contained in the Report may be included in a restrictive covenant registered to the title of the subject property at the discretion of the CoC.
2. This Report has been prepared in accordance with standard geotechnical engineering practice solely for and at the expense of Northridge Properties Ltd. We have not acted for or as an agent of the CoC in the preparation of this Report.
3. The conclusions and recommendations submitted in this Report are based upon information from construction monitoring to date during the subdivision construction process, a visual site-assessment of the property during the preparation of this Report, anticipated and encountered subsurface soil conditions, current construction techniques, and generally accepted engineering practices. No other warrantee, expressed or implied, is made. If unanticipated conditions become known during future residential construction or other information pertinent to the structure(s) becomes available, the recommendations may be altered or modified in writing by the undersigned.
4. The conclusions and recommendations in this Report are valid for a maximum of two (2) years from the date of issue. The 2-year term may be reduced as a result of updated bylaws, policies, or requirements by the authority having jurisdiction, or by updates to the British Columbia Building Code. Updates to professional practice guidelines may also impact the 2-year term. If no application of the findings in this Report have been made to the subject development, the conclusions issued in this Report become void and re-assessment of the property will be required.
5. This Report has been prepared by Jacob Verheyden, EIT and Joe Brunelle, P.Eng., and reviewed by Chris Hudec, M.A.Sc., P.Eng. Verheyden, Brunelle, and Hudec are all adequately experienced and members in good standing with the Engineers and Geoscientists of British Columbia.

EXECUTIVE SUMMARY

1. The following is a brief synopsis of the property, assessment methods, and findings presented in the Report. The reader must read the Report in its entirety; the reader shall not rely solely on the information provided in this summary.
2. The subject property, 3300 Mission Road, Courtenay, BC, from this point forward referred to as "the Property," is located on the east coast of Vancouver Island within the jurisdictional boundaries of the CoC. At the time of this Report, subdivision construction is complete; future construction within the new lots is expected to consist of single-family residential structures to a maximum of three stories in height.
3. In addition to construction monitoring services to date during subdivision development, a site-specific review was conducted to assess the subdivision works and final lot grading to identify potential geotechnical hazards for the Property and future residential development of the new lots. Our assessment determined that there were no geotechnical hazards that may impact the proposed development.
4. The findings confirm the development and future residential lots are considered safe as proposed.

List of Abbreviations and Acronyms Used in the Report

Abbreviation	Title
ASTM	American Society for Testing and Materials
BCBC	British Columbia Building Code
CCE	Cascara Consulting Engineers Ltd.
CoC	City of Courtenay
CVRD	Comox Valley Regional District
H	Horizontal
LEA	Lewkowich Engineering Associates Ltd.
SLS	Service Limit State
ULS	Ultimate Limit State
V	Vertical

Status: Registered Doc #: CA8847889 RCVD: 2021-03-17 RQST: 2021-04-27 15.15.41

PROJECT: Northridge Estates Subdivision, Courtenay, BC
FILE: F2556.20r2
DATE: January 20, 2021

LEA

TABLE OF CONTENTS

Status: Registered Doc #: CA8847889 RCVD: 2021-03-17 RQST: 2021-04-27 15.15.41

PROJECT: Northridge Estates Subdivision, Courtenay, BC
FILE: F2556.20r2
DATE: January 20, 2021

1.0 INTRODUCTION

1.1 General

As requested, LEA has evaluated geotechnical site conditions of Lots 1 through 34 at the above referenced subdivision development. This Report provides a summary of our findings, conclusions, and recommendations.

1.2 Background

a. LEA has assumed that the proposed structures would be single-family type structures, with wood framed superstructures one (1) to three (3) stories in height supported by conventional cast-in-place strip and pad concrete foundations.

b. As part of the development process LEA prepared a geotechnical report[a] in support of the proposed residential subdivision development. The subdivision layout is shown in the attached final lot grade plan prepared by CCE.

1.3 Assessment Methodology

a. The assessment methodology for this portion of the development included reviewing previous geotechnical reports and drawings completed by our office, as well as a detailed review of the civil and survey drawings, and construction monitoring to date during site development.

b. A site reconnaissance of the completed subdivision was carried out during the preparation of this Report.

2.0 SITE CONDITIONS

2.1 Physical Setting

a. The Property is located in the northeastern region within jurisdictional limits of the CoC. It is identified with the following civic and legal address:

   i. 3300 Mission Road, Courtenay; Lot 1, District Lot 236, Comox District, Plan VIP89215; PID: 028-729-943.

b. The Property is currently zoned for residential construction, designated R-1S Single Dwelling Residential – allows secondary suite, accessory buildings and structures. Based on our review of the CoC zoning[b] during the preparation of this Report, we note the zoning for the Property is consistent with the subdivision layout of the development. We expect the CoC zoning map has been updated in accordance with the new subdivision. The zoning, current to the date of this Report, is shown below in Figure 2.1.1.

PROJECT: Northridge Estates Subdivision, Courtenay, BC
FILE: F2556.20r2
DATE: January 20, 2021

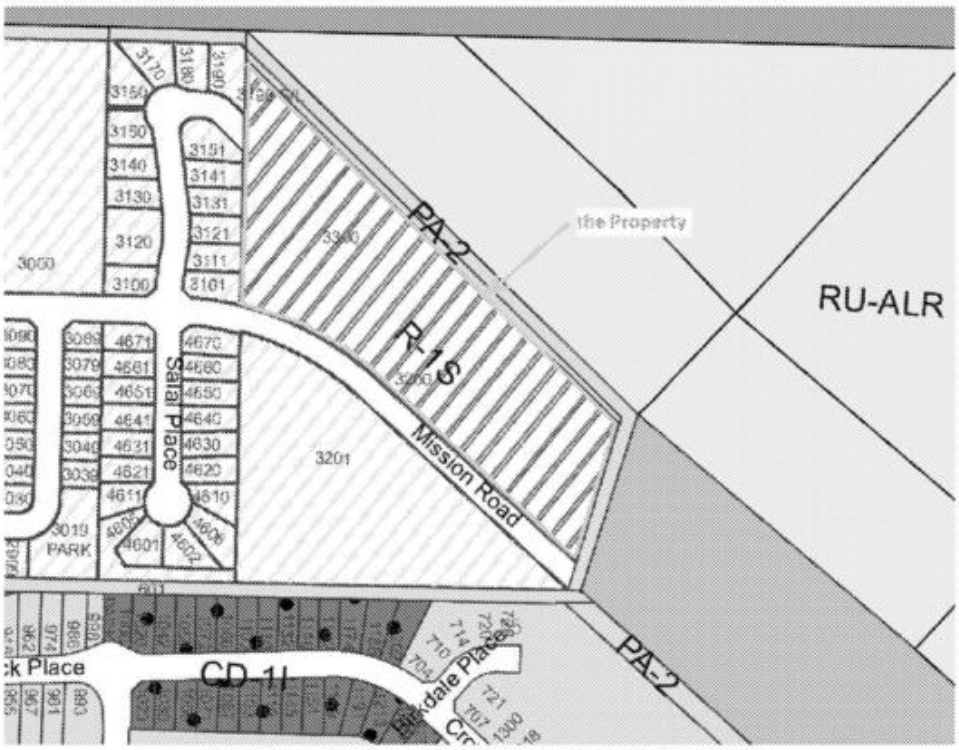


Figure 2.1.1 – The Property on CoC Zoning Map, Residential R-1S

c. The Property is located on the north side of Mission Road which was extended east as part of the subdivision development. The existing Klanawa Crescent is to the west of the development and has been extended to meet Mission Road in the southeast portion of the Property. See Figure 2.1.2 which shows the Property location with 2018 air photo.

Figure 2.1.2 – Property Location (from online CVRD iMap[c])

d. A plan layout of the subdivision with the 34 residential lots and the Klanawa Crescent extension is shown in Figure 2.1.3.

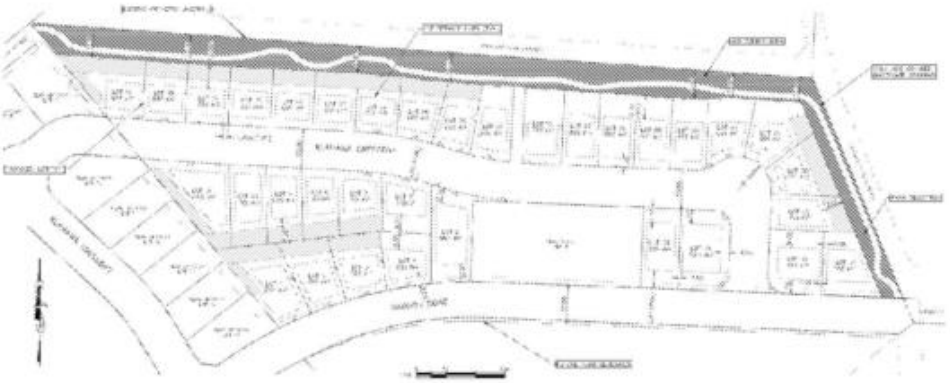


Figure 2.1.3 – Site Plan, Layout of Subdivision

2.2 Terrain and Features

a. The terrain of the Property slopes down, from south to north with approximately 20m of vertical relief across the lands.

b. There is one defined slope located on the Property. A fill embankment at the northeast portion of the Property corresponds to lots 25 to 32 where structural fill has been placed. Lots 26, 27, 28, 29, 30 have an approximate vertical relief of 9m, 11.5m, 13.5m, 11.5m, 7m from front to back of their lots respectively.

Final site grading by CCE is attached.

c. Tree retention areas are located throughout the Property where mature coniferous trees remain. A gravel walking/hiking path has been created along the north and east sides of the subdivision to establish a vegetated buffer to the agricultural lands.

2.3 Regional Geology and Aquifers

a. Surficial geology for the area is predominantly shallow, well consolidated, sandy alluvial deposition from a post glacial outwash. These materials are underlain with dense silty sands (glacial till) that are in turn are underlain with dense, horizontally stratified sands.[d,e]

b. Review of groundwater wells and aquifers in the BC Water Resources Atlas[f] indicates that Aquifer 408 and Aquifer 411 have been mapped to the area. Aquifer 408 is a sand and gravel layer associated with the Quadra Sediments. It is often found confined between the upper Vashon Drift and the lower Dashwood Drift - glacial tills. Aquifer 411 is attributed to the fractured sedimentary bedrock. Also noted in the logs, none of the wells in the vicinity of the Property were drilled deep enough to encounter bedrock.

c. Bedrock geology for the area is classified as Upper Cretaceous Nanaimo Group Undivided Sedimentary Rocks.[g] The strata of the Nanaimo Group formation in the Comox/Georgia basin consists of alternating succession of shales, sandstones, conglomerates, and some coal.[h,i] Depth to bedrock at the Property is undetermined.

2.4 Soil Conditions

a. LEA completed a test pitting and borehole program at the feasibility stage development and comprehensive details of the subsurface soil conditions encountered was captured in a report.[a]

b. Naturally deposited soil conditions within the Property encountered during our initial report[a] preparation, were consistent with the soils observed over the course of our involvement during subdivision construction. The encountered conditions were consistent with the geology mapping for the area.

c. No appreciable fill soils or other deleterious materials were encountered during our initial assessment, nor during the course of subdivision construction.

2.5 Groundwater Conditions

a. Given the encountered conditions, two (2) boreholes were completed to further investigate ground conditions. It was noted on April 17, 2017 during drilling operations that only one of the two holes was drilled deep enough to encounter water seepage, specifically at 15.2m below existing ground elevation in borehole BH17-02. This groundwater was found in a deposit of dense horizontally stratified sand that extended to at least 21m below grade.

b. Groundwater levels can be expected to fluctuate seasonally with cycles of precipitation. Groundwater

conditions at other times and locations can differ from those observed during the course of subdivision construction.

c. If groundwater flows or conditions are different than those encountered during our involvement to date with the Property, additional measures may be required during future construction. Contact the Geotechnical Engineer for review if unanticipated conditions are encountered at any point during construction.

d. Depths are referenced to the existing ground surface at the time of our field investigation. Soil classification terminology is based on the Modified Unified Classification System. The relative proportions of the major and minor soil constituents are indicated by the use of appropriate group names as provided in ASTM D2487 and D2488. Other descriptive terms generally follow conventions of the Canadian Foundation Engineering Manual.

3.0 LOT CONDITIONS

3.1 Lots 1 to 11

a. These lots underwent some manipulation during the course of construction. The buildable areas of each lot were cleared, grubbed, and stripped of loose organic-rich overburden soils.

b. A tree retention area is found at the rear of lots 1 to 3 and lots 7 to 11. This tree retention area will provide soil stability to a moderate north-facing slope.

c. To level the buildable areas, some of the poorly graded native sands were removed in this area and used at the interior/lower core of the engineered fill embankment below the northeast bulb of Klanawa Crescent. Additionally, glacial till soils encountered on lots 8 to 11 were removed and used at the outer/lower part of the engineered fill embankment of lots 26 to 30.

d. Lots 1 to 5 have been graded with up to 2 m thick of non-structural fills.

e. Suitable bearing soils can be expected within shallow depths (a meter or less) for lots 6 to 11.

f. Any loose/disturbed fill soils, or otherwise deleterious materials, shall be removed during the course of construction for each of the future residential structures. LEA recommends contacting the developer/owner, Josh Fayerman of Northridge Properties, if the exact location, extent and thickness of deleterious materials and fills is required to be known prior to purchase.

g. We recommend that subgrade soils and footing conditions are reviewed in the field to confirm suitability at the time of construction.

3.2 Lots 12 to 21, Lot 23, and Lot 24

a. These lots underwent some manipulation during the course of construction. The buildable areas of each

lot were cleared, grubbed, and stripped of loose organic-rich overburden soils.

b. A tree retention area is found at the rear of lots 12 to 20. This tree retention area will provide stability to the moderate north-facing slope.

c. The rear buildable portions of the lots were graded level with native sand and gravel. Klanawa Crescent road structure and gas servicing has built up the front of the lots higher than the rear. The lots slope down to the north with a vertical relief of 3m (lot 12 in the west) increasing to 6m (lot 24 in the east), measured from front to rear lot boundaries.

d. Lots 12 to 20 had been excavated down to undisturbed native, suitable bearing soils to facilitate Klanawa Crescent construction. The structural prism providing subjacent road support extends into the buildable area on the lots. Above the undisturbed native soils and structural road prism the lots have been graded with up to 3 m thick of non-structural fill.

e. The elevation of the Klanawa Crescent road structure will require appropriate site grading with fills on lots 12 to 20. These fills would need to be structural under buildings and driveways.

f. We recommend that subgrade soils and footing conditions are reviewed in the field to confirm suitability at the time of construction. LEA recommends contacting the developer/owner, Josh Fayerman of Northridge Properties, if the exact location, extent and thickness of deleterious materials and fills is required to be known prior to purchase.

3.3 Lot 22 – Special Consideration

a. Lot 22 contains a StormTech® infiltration gallery in the north side of the lot. The base of any footings shall be offset from the base of the StormTech® chambers by a 1V:1H plane, at a minimum.

b. Review of LEA memo F2556.18r1[i] and most up-to-date civil drawings should be done prior to design and construction of a single-family residence on lot 22.

c. We recommend that subgrade soils and footing conditions are reviewed in the field to confirm suitability at the time of construction. LEA recommends contacting the developer/owner, Josh Fayerman of Northridge Properties, if the exact location, extent and thickness of deleterious materials and fills is required to be known prior to purchase.

3.4 Lots 25 to 32 – Structural Lot Fills

a. Proposed Lots 25 through 32 contain engineered fills consisting of reworked native sands at the interior of the Klanawa Crescent embankment, reworked native sandy silt and gravel (glacial till) at the outer extents, and compacted imported sand and gravel pit run in the upper extents. This engineered fill placement methodology that was followed during construction was prescribed in LEA memo F2556.07[k].

b. The stripped subgrade conditions within each of the referenced lots, as well as the placement and

compaction of engineered fill materials were observed and inspected in the field by LEA during the course of construction. Structural fill thicknesses vary across each lot with a maximum of 8.5m on lots 28 and 29.

c. The structural fills were placed and graded to facilitate the construction of the Klanawa Crescent road structure.

d. The current embankment geometry slopes at 36° from horizontal. LEA understands these lots will require significant amount of additional structural fill below footings to adequately site the residences within the buildable area while considering lot grading. Grading should be done to facilitate long-term surface grades of 27° (2H:1V) or less. We anticipate grading on these lots would facilitate a level entry/basement walkout style of homes.

e. Additionally, we understand that a two-tier retaining wall is to be built at the base of Lots 28 to 31 to facilitate the necessary site geometry, see CCE drawing C19[l] for more information. Since the planned retaining wall installation extends across Lots 28 to 31 it would need to be completed prior to building on any of Lots 28 to 32.

f. A tree retention area is found at the rear of lots 28 to 30, at the base of the engineered fill embankment.

g. We recommend that subgrade soils, placement of structural fills, and footing conditions are reviewed in the field to confirm suitability at the time of construction.

h. LEA recommends contacting the developer/owner, Josh Fayerman of Northridge Properties, if the exact location and thickness of structural fills, deleterious materials or fill material is required to be known prior to purchase.

3.5 Lots 33 and 34

a. These lots underwent some manipulation during the course of construction. The buildable areas of each lot were cleared, grubbed, and stripped of loose organic-rich overburden soils.

b. In general, the terrain on these lots did not change significantly during the course of construction and suitable bearing soils can be expected within shallow depths (a meter or less).

c. We recommend that subgrade soils and footing conditions are reviewed in the field to confirm suitability at the time of construction.

3.6 General Site Grading, Post-Construction

a. The lots are currently developed with related civil works and services including storm and sanitary sewer, water mains, gas, and streetlighting. As part of this Report, we have reviewed and given consideration to construction monitoring to date by our office, as well as a review of the civil engineering plans[l] and lot grades plan prepared by CCE.

b. In general, the Property was cleared, grubbed, and stripped down to a suitable bearing grade across all

Status: Registered Doc #: CA8847889 RCVD: 2021-03-17 RQST: 2021-04-27 15.15.41

lots. Depth to bearing grades is expected to be up to 3 meters from the post-construction final grades. We anticipate significant amounts of structural fill will be required on lots 26 to 30 to achieve suitable footing grades for single-family residences. Structural fill may be needed on other lots on a case-by-case basis for house foundations.

c. LEA anticipates most lots will use fills to shape the ground surface of their lot after homes have been built.

3.7 Individual Lot Drainage

a. Each of the future lots has been designed with individual stormwater management measures in the form of an infiltration pit or shallow swales that overflow to lawn basins and vegetated areas.

b. Lots 1 to 4 were considered impermeable due to the presence of impermeable tills at shallow depth. The storm drainage for these lots hooks directly to the storm service at Mission Road which outfalls to the storm ditching at the east boundary of the subdivision.

c. As part of subdivision construction lots 5 to 11, 33, and 34 have Type 2 rock pits installed on the north edge of these lots and generally conform to LEA memo F2556.08r1[m] with overflows to the CoC Klanawa Crescent storm line. LEA observed the installed rock pits to be sited within native sand or sand with silt deposits. Rock pits were observed to have a minimum plan area of 4m^2. See attached LEA record drawing for additional details.

d. Soil conditions at lots 12 to 20 and lots 23 to 26 are conducive to infiltration and Type 1 rock pit trenching is recommended at the rear (north) lot boundaries, as prescribed in LEA assessment F2556.01r1[a]. Type 1 rock pits are expected to be built at the same time as the corresponding single-family residence. See attached LEA issued for construction drawing for additional details.

e. Due to infrastructure constraints, stormwater from lots 21 and 22 feed directly CoC storm line which leads to the StormTech® infiltration gallery sited on lot 22.

f. Lots 27 to 32 were considered impermeable due to the presence of impermeable tills at the base and in the lower portion of the engineered fill embankment. The storm drainage for lots 27 to 29 connects to the storm service at the north side of the lots. Lots 30 to 32 connect directly to the storm service at Klanawa Crescent which outlets to the StormTech® infiltration gallery installed on lot 22.

4.0 DISCUSSIONS AND RECOMMENDATIONS – FUTURE CONSTRUCTION

4.1 General Excavation – Future Building Sites

a. Prior to construction, all unsuitable materials should be removed to provide a suitable base of support. Unsuitable materials include any non-mineral material such as vegetation, topsoil, peat, fill or other materials containing organic matter, as well as any soft, loose, or disturbed soils.

b. Prior to placement of concrete footings, any bearing soils that have been softened, loosened, or otherwise disturbed during the course of construction should be removed, or else compacted following our recommendations for structural fill. Compaction will only be feasible if the soil has suitable moisture content and if there is access to heavy compaction equipment. If no structural fill is placed, a smooth-bladed clean up bucket should be used to finish the excavation.

c. The Geotechnical Engineer is to confirm the removal of unsuitable materials and approve the exposed competent inorganic subgrade.

d. Groundwater entering into any excavations should be controlled with a perimeter ditch located just outside of the building areas, conveying water away from the excavation.

e. Trench and bulk excavation work should conform to Occupational Health and Safety guidelines. In general, excavations into fills, silt, clay or sands at depths greater than 1.2m may be subject to sloughing or caving that would be considered hazardous. Excavations deeper than 1.2m should be reviewed in the field by the Geotechnical Engineer. For preliminary design purposes, we expect the near surface soils may be stable at a 3H:4V slope configuration, assuming no seepage. Dewatering should be implemented as needed.

4.2 Foundation Design and Construction

a. Prior to construction, future building areas and areas of subjacent support must be stripped to remove all unsuitable materials to provide an appropriately prepared subgrade for the footing support. We expect the suitable subgrade conditions to consist of either undisturbed inorganic sands, glacial till, or engineered fill materials placed during the subdivision phase of construction.

b. Foundation loads should be supported on natural undisturbed material approved for use as a bearing stratum by our office or structural fill and may be designed using the following values. These values assume a minimum 0.5m depth of confinement or cover.

   i. For foundations constructed on non cohesive soils classified as dense or very dense sand or gravel an SLS bearing pressure of 100 kPa, and a ULS bearing pressure of 135 kPa may be used for design purposes.

   ii. For foundations constructed on undisturbed glacial till or a minimum thickness 0.6m engineered fill as outlined in Section 4.3 of this Report an SLS bearing pressure of 150 kPa, and a ULS bearing pressure of 200 kPa may be used for design purposes.

c. Exterior footings should be provided with a minimum 0.5m depth of ground cover for frost protection purposes.

d. The Geotechnical Engineer should evaluate the bearing soils at the time of construction to confirm that footings are based on appropriate and properly prepared founding material.

Status: Registered Doc #: CA8847889 RCVD: 2021-03-17 RQST: 2021-04-27 15.15.41

4.3 Structural Fill

a. Where fill is required to raise areas that will support buildings, slabs, or pavements, structural fill should be used. The Geotechnical Engineer should first approve the exposed subgrade in fill areas, to confirm the removal of all unsuitable materials.

b. Structural fill should be inorganic sand and gravel. If structural fill placement is to be carried out in the wet season, material with a fines content limited to 5% passing the 75µm sieve should be used, as such a material will not be overly sensitive to moisture, allowing compaction during rainy periods of weather.

c. Structural fill should be compacted to a minimum of 95% of Modified Proctor maximum dry density (ASTM D1557) in foundation and floor slab areas, as well as in paved roadway and parking areas.

d. Structural fills under foundations, roadways, and pavements should include the zone defined by a plane extending down and outward a minimum 0.5m from the outer edge of the foundation at an angle of 45° from horizontal to ensure adequate subjacent support. This support zone is shown below in Figure 4.3.

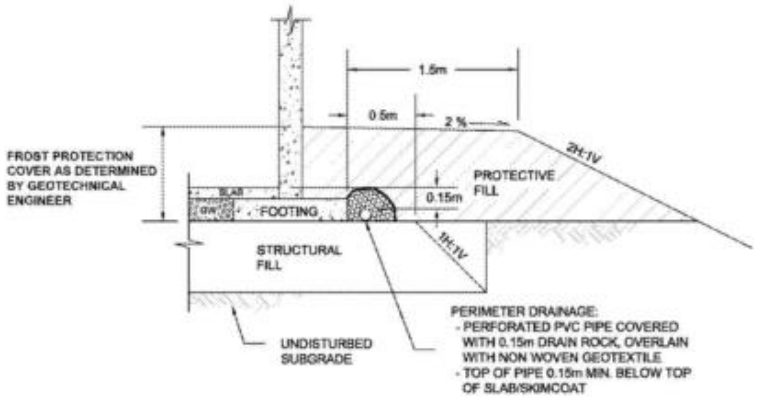


Figure 4.3 – Typical Section, Structural Fill

e. Compaction of fill should include moisture conditioning as needed to bring the soils to the optimum moisture content and compacted using vibratory compaction equipment in lift thicknesses appropriate for the size and type of compaction equipment used.

f. A general guideline for maximum lift thickness is no more than 100mm for light hand equipment such as a "jumping-jack," 200mm for a small roller and 300mm for a large roller or heavy (>500 kg) vibratory plate compactor or a backhoe mounted hoe-pac or a large excavator mounted hoe-pac, as measured loose.

g. It should be emphasized that the long-term performance of buildings, slabs, and pavements is highly dependent on the correct placement and compaction of underlying structural fills. Consequently, we recommend that structural fills be observed and approved by the Geotechnical Engineer. This would

Status: Registered Doc #: CA8847889 RCVD: 2021-03-17 RQST: 2021-04-27 15.15.41

include approval of the proposed fill materials and performing a suitable program of compaction testing during construction.

4.4 Re-use of Excavated Materials as Structural Fill

a. Following laboratory testing, the native site soils have been approved by LEA for various applications across the site during subdivision construction.

b. There is potential for the native site soils to be used as structural fill under foundations of the future single-family residences. A geotechnical engineer should be consulted to approve re-use of native on-site soils prior to use as structural fill; this approval may require additional laboratory testing and would be at the discretion of the Geotechnical Engineer.

4.5 Future Site Grading

a. The following guidelines shall be considered for individual lot grading during future single-family residence and lot build out construction:

b. Fill shall be placed at the optimum moisture for compaction. Moisture conditioning (adjustment to the moisture content for compaction) should preferably be done prior to placement. This conditioning should include breaking down any cohesive "lumps" to facilitate thorough mixing with water, or drying, as applicable.

c. Reference Section 4.3 of this Report for specific recommendation for material type, placement, and compaction.

d. Permanent excavation slopes shall not exceed 2H:1V except as approved by a Professional Engineer or Professional Geoscientist. Similarly, fill compacted to a minimum of 95% of the Modified Proctor dry density (ASTM D1557) shall not exceed 2H:1V. Final slopes shall be trimmed of all loose or disturbed soils.

e. Grading should be done in a way which prevents pooling of water adjacent buildings.

f. Details for slope protection should be reviewed by a Professional Engineer or Professional Geoscientist prior to and during installation to ensure slopes are adequately protected.

4.6 Slope Considerations

a. As discussed in this Report, there is an engineered fill slope at proposed lots 26 to 30.

b. We have completed physical and desktop reviews of these slopes as they relate to the recent subdivision works, as well as the future residential development of the newly created lots. We have reviewed the geometry of the referenced slopes in conjunction with our knowledge of subsurface conditions in proximity to the Property.

c. Based on our review and that future site grading recommendations are followed, the 2H:1V planned grading of the lots along with the controlled placement of structural lot fills will provide for stable slope

conditions for the future single-family residences.

4.7 Erosion Control

a. The site is rated as being moderately resistant to erosion due to the controlled placement of fills observed at this site. However, the potential for a problematic level of erosion (typically from disturbed on-site soils) should not be ignored.

b. Individual lot owners should maintain sloping areas in a vegetated condition as a control against erosion. The vegetated mat may consist of grass or other types of ground cover that provide a dense root system. If the ground cover is disturbed late in the fall season, or during the typically wet winter season, lack of germination may result in inadequate protection from surface erosion. In this event, sloping areas should be protected with erosion control measures determined to be adequate by experienced registered professionals.

4.8 Seismic Considerations

a. No compressible or liquefiable soils were encountered during the subdivision construction monitoring phase.

b. Based on the BCBC 2018, Division B, Part 4, Table 4.1.8.4.A, *Site Classification for Seismic Site Response*, the soils and strata encountered on the Property to date would be "Site Class C" (Very dense soil and soft rock).

4.9 Foundation Drainage

Conventional requirements of the BCBC 2018 pertaining to building drainage are considered suitable at this site.

4.10 Stormwater Management

a. Stormwater infrastructure has been installed on each lot as described in Section 3.7.

b. Maintenance requirements for all rock pit installations include regular (annual) system cleanout. This would include emptying sediments catch basins and clearing the PVC pipes from house to connection with CoC storm service.

c. We have reviewed the rock pit locations as shown on the CCE drawings[1], and confirm the locations of the rock pits are suitably located and should not constitute a hazard for the Property or future lots associated with the subdivision.

4.11 Surface Drainage Considerations

a. We understand that final lot grades have been designed by CCE to promote surface drainage patterns similar to pre-development patterns within the lots as much as possible. We understand the final grading

has been designed to mitigate direct or concentrated surface flows within the lots.

b. It is recommended that the owner of the land or any lot into which the land is subdivided ensure that development is carried out in a way that prevents storm water or other surface drainage from draining onto neighboring lands

c. It is recommended that as a condition of development of the land that the owner of the land or any owner of any lot into which the land is subdivided ensure that works are installed to deal with stormwater or other surface drainage at the time of development and that any lots into which the land is subdivided be developed so as to ensure that there is no runoff or other surface water emanating from any lot. Failure to do so may result in damages that could include soil movement from their properties into the storm drainage system, considering environmental sensitivity and natural habitat downstream of the storm sewer outlet.

d. Mitigation for storm water runoff onto adjacent lots and areas below the development area can be readily achieved by installing drainage facilities within each of the lots, and direction of clean (non-turbid) surface runoff into the storm sewer system. Aspects of the drainage system to achieve this mitigation shall include the following:

   i. Shape the lots to provide a uniform surface drainage.

   ii. Provide a catchment system that directs clean (non-turbid) concentrated surface water into the municipal storm drainage system. Area drains should be connected to the storm sewer system.

   iii. Provide erosion control measures to mitigate soil migration into the storm sewer system during and after construction.

4.12 Aquifer Discussion

a. The aquifer associated with the Quadra Sediments underlies the proposed subdivision development. An aquifer is also attributed to the fractured sedimentary bedrock at an unknown depth.

b. Based on our review of the site, construction works are expected to be limited in depth (approximately 0.5m depth below existing ground), therefore will not have a significant impact on any shallow aquifer.

5.0 CONCLUSIONS

5.1 Local Government Conformance Statement

a. From a geotechnical point of view, and provided the recommendations in this Report are followed, the land is considered safe for the use intended, defined for the purposes of this Report as a 34-lot residential subdivision. This conclusion considers the probability of a geotechnical failure resulting in property damage of less than:

i. 2% in 50 years for geotechnical hazards due to seismic events, including slope stability; and

ii. 10% in 50 years for all other geotechnical hazards.

5.2 Geotechnical and Quality Assurance Statement

The BCBC 2018 requires that a geotechnical engineer be retained to provide Geotechnical Assurance services for the construction of buildings that fall outside Part 9 of the BCBC. Geotechnical Assurance services include review of the geotechnical components of the plans and supporting documents, and responsibility for field reviews of these components during construction.

5.3 Acknowledgements

a. We acknowledge that this Report has been prepared solely for, and at the expense of Northridge Properties Ltd.

b. Lewkowich Engineering Associates Ltd. acknowledges that this Report may be requested by the building inspector (or equivalent) of the City of Courtenay as a precondition to the issuance of a building or development permit. It is acknowledged that the Approving Officers and Building Officials may rely on this Report when making a decision on application for development of the land.

c. We have not acted for or as an agent of the City of Courtenay in the preparation of this Report. We acknowledge the City of Courtenay and the Approving Officer(s) are authorized users of this Report. We acknowledge that this Report may be registered to the title of the Property as a restrictive covenant.

5.4 Limitations

a. The conclusions and recommendations submitted in this Report are based upon the data from our prior assessments, the subdivision phase of construction, and a site visit during the preparation of this Report. The recommendations given are based on the subsurface soil conditions encountered, current construction techniques, and generally accepted engineering practices. No other warrantee, expressed or implied, is made.

b. If unanticipated conditions become known during construction or other information pertinent to the development become available, the recommendations may be altered or modified in writing by the undersigned.

Status: Registered Doc #: CA8847889 RCVD: 2021-03-17 RQST: 2021-04-27 15.15.41

6.0 CLOSURE

Lewkowich Engineering Associates Ltd. appreciates the opportunity to be of service on this project. If you have any comments, or additional requirements at this time, please contact us at your convenience.

Respectfully Submitted,
Lewkowich Engineering Associates Ltd.

Jacob Verheyden, EIT
Technician

Joe Brunelle, P.Eng.
Geotechnical Engineer

Reviewed By,

January 20, 2021

Chris Hudec, M.A.Sc., P.Eng.
Senior Project Engineer

Status: Registered Doc #: CA8847889 RCVD: 2021-03-17 RQST: 2021-04-27 15.15.41

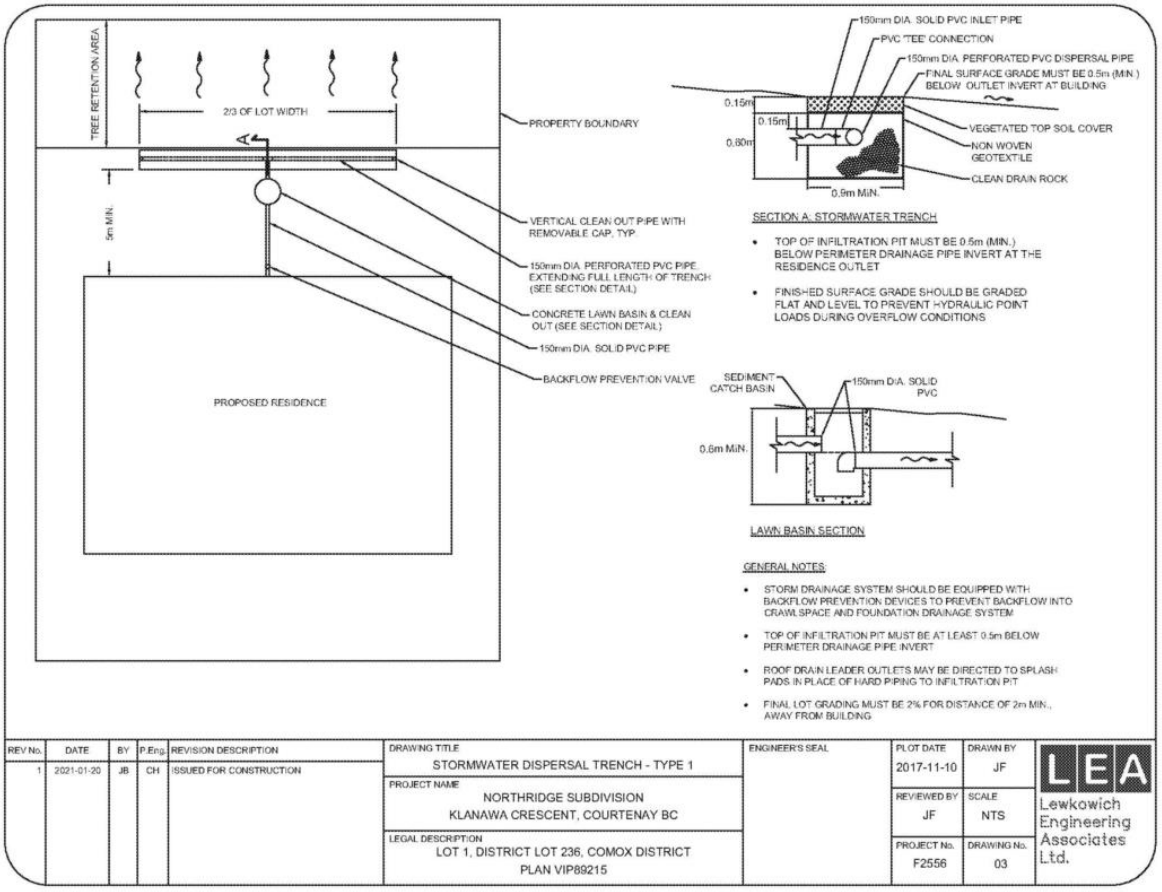
7.0 ATTACHMENTS

1. LEA, drawing titled *Stormwater Dispersal Trench – Type 1 – Northridge Subdivision*, drawing number F2556-03r1, revision 1, dated January 20, 2021.
2. LEA, drawing titled *Standard Rock Pit Detail – Type 2 – Northridge Subdivision*, drawing number F2556-10r2, revision 2, dated January 20, 2021.
3. CCE, drawing titled *Northridge Subdivision – Lot 1, DL 236, Comox District, Plan VIP89215 – Courtenay, BC – Lot Grading Plan*, drawing number C18, revision 8, dated October 19, 2020.

8.0 REFERENCES

a. Lewkowich Engineering Associates Ltd., report titled *Geotechnical Assessment – Northridge Development – 3300 Mission Road, Courtenay, BC*, file number F2556.01r1, dated December 6, 2017.
b. City of Courtenay, bylaw titled *Zoning Bylaw No. 2500, 2007*.
c. Comox Valley Regional District, online iMap, version 3.1, 49.719N 124.963W, < http://imap2.comoxvalleyrd.ca/imapviewer/>, accessed December 11, 2020.
d. Jungen J, prepared for British Columbia Ministry of Environment, map titled *Soils of South Vancouver Island, British Columbia, Soil Survey Report No. 44, Sheet 5*, date of mapping 1975-1978.
e. Guthrie RH and Penner CR, prepared for British Columbia Ministry of Environment, map titled *Vancouver Island Surficial Geology*, dated 2005.
f. British Columbia Ministry of Environment and Climate Change Strategy, online BC Water Resources Atlas, 49.719N 124.964W, <https://maps.gov.bc.ca/ess/hm/wrbc/>, accessed December 15, 2020.
g. British Columbia Geological Survey, Bedrock Geology, 49.719N 124.964W, online MapPlace 2 Viewer, <https://www2.gov.bc.ca/gov/content/industry/mineral-exploration-mining/british-columbia-geological-survey/mapplace>, accessed December 15, 2020.
h. Usher JL, Geological Survey of Canada – Department of Mines and Technical Surveys, Bulletin 21, titled *Ammonite Faunas of the Upper Cretaceous Rocks of Vancouver Island, British Columbia*, dated 1952.
i. Fyles JG, Geological Survey of Canada – Department of Mines and Technical Surveys, Memoir 318, titled *Surficial Geology of Horne Lake and Parksville Map-Areas, Vancouver Island, British Columbia*, dated 1963.
j. Lewkowich Engineering Associates Ltd., geotechnical memo titled *Northridge Subdivision, Courtenay, BC – Lot 22 Buildable Area*, file number F2556.18r1, dated November 26, 2020.
k. Lewkowich Engineering Associates Ltd., geotechnical memo titled *Northridge Subdivision, Klanawa Cr., Courtenay, BC – Bearing Grade Review – Lots 26 to 32*, file number F2556.07, dated May 25, 2018.
l. Cascara Consulting Engineers Ltd., drawing set titled *Northridge Subdivision – Lot 1, DL 236, Comox District, Plan VIP89215 – Courtenay, BC*, revision 8, includes 27 sheets, dated October 19, 2020.
m. Lewkowich Engineering Associates Ltd., geotechnical memo titled *Northridge Subdivision – 3300 Mission Road, Courtenay, BC – Response to City of Courtenay Review (April 28, 2018)*, file number F2556.08r1, dated February 3, 2020.

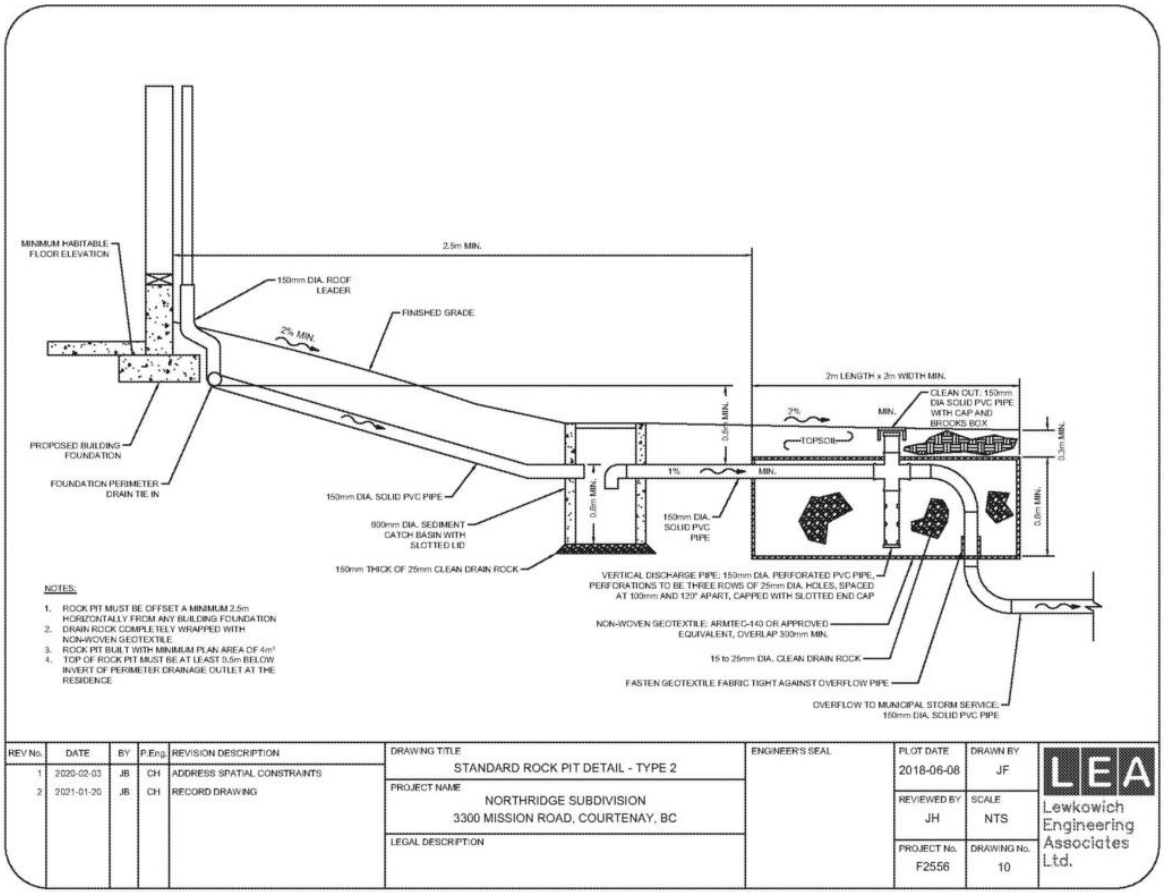
Status: Registered Doc #: CA8847889 RCVD: 2021-03-17 RQST: 2021-04-27 15.15.41



REV No.	DATE	BY	P.Eng.	REVISION DESCRIPTION
1	2021-01-20	JB	CH	ISSUED FOR CONSTRUCTION

DRAWING TITLE: STORMWATER DISPERSAL TRENCH - TYPE 1
PROJECT NAME: NORTHRIDGE SUBDIVISION, KLANAWA CRESCENT, COURTENAY BC
LEGAL DESCRIPTION: LOT 1, DISTRICT LOT 236, COMOX DISTRICT, PLAN VIP89215
ENGINEER'S SEAL
PLOT DATE: 2017-11-10 | DRAWN BY: JF
REVIEWED BY: JF | SCALE: NTS
PROJECT No.: F2556 | DRAWING No.: 03
Lewkowich Engineering Associates Ltd.

Page 34 of 41



REV No.	DATE	BY	P.Eng.	REVISION DESCRIPTION
1	2020-02-03	JB	CH	ADDRESS SPATIAL CONSTRAINTS
2	2021-01-20	JB	CH	RECORD DRAWING

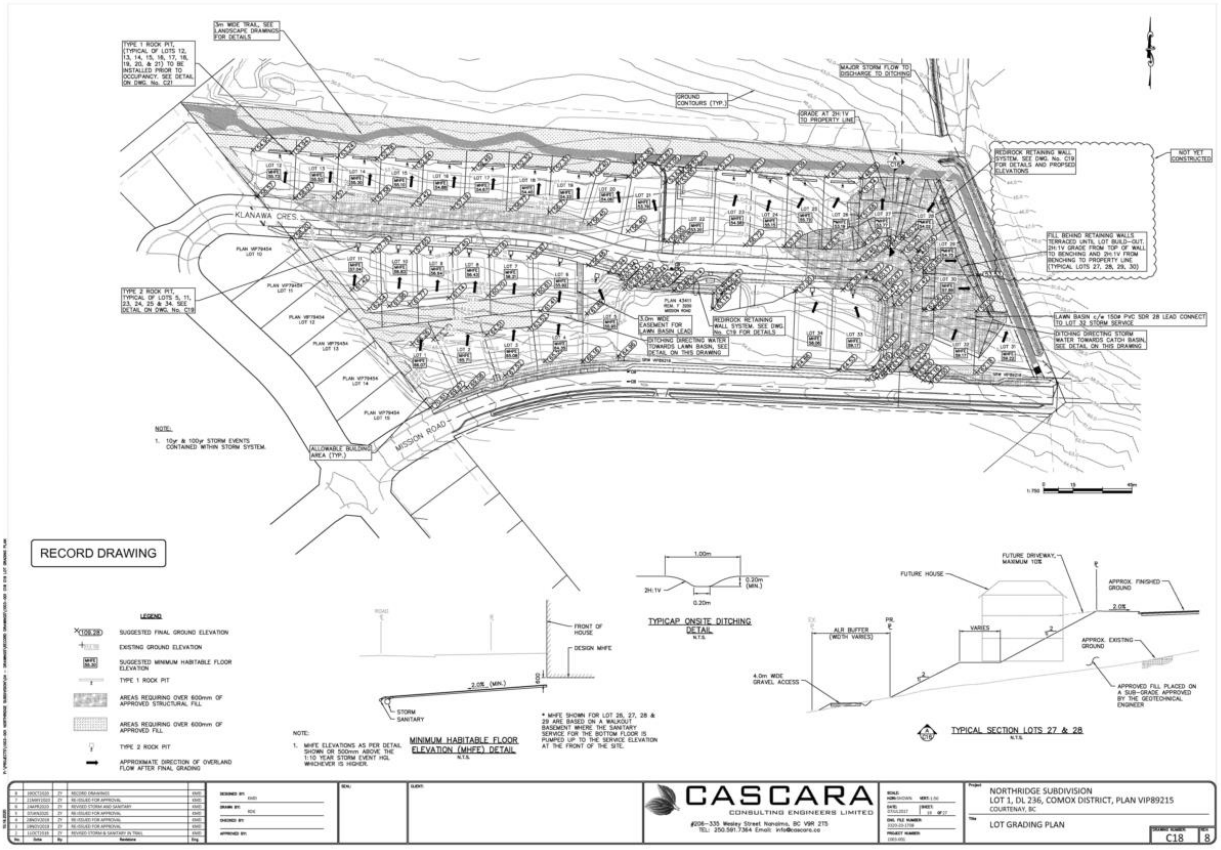
DRAWING TITLE: STANDARD ROCK PIT DETAIL - TYPE 2
PROJECT NAME: NORTHRIDGE SUBDIVISION
3300 MISSION ROAD, COURTENAY, BC
LEGAL DESCRIPTION
ENGINEER'S SEAL

PLOT DATE	DRAWN BY
2018-06-08	JF
REVIEWED BY	SCALE
JH	NTS
PROJECT No.	DRAWING No.
F2556	10

LEA Lewkowich Engineering Associates Ltd.

Page 35 of 41

Status: Registered Doc #: CA8847889 RCVD: 2021-03-17 RQST: 2021-04-27 15.15.41



Status: Registered Doc #: CA8847889 RCVD: 2021-03-17 RQST: 2021-04-27 15.15.41

FORM_DECGEN_V20

LAND TITLE ACT
FORM DECLARATION

Related Document Number: CA8847889

PAGE 1 OF 4 PAGES

Your electronic signature is a representation that you are a designate authorized to certify this application under section 168.4 of the *Land Title Act*, RSBC 1996, c.250, that you certify this application under section 168.43(3) of the act, and that the supporting document or a true copy of the supporting document, if a true copy is allowed under an e-filing direction, is in your possession.

Brian James Senini IAT7J9

Digitally signed by Brian James Senini IAT7J9
Date: 2021.03.17 11:51:53 -07'00'

I, BRIAN J. SENINI, Barrister and Solicitor, of #200 - 1808 Bowen Road, Nanaimo, BC V9S 5W4, DECLARE THAT:

1. In connection CA8847889, please find attached copies of the Certificates of Status for each of JJD Walker Holdings Ltd., 5277095 Manitoba Ltd. and 5277109 Manitoba Ltd. in support of this Application.

BRIAN J. SENINI

(Client File Ref. 54806-1)

NOTE:
A Declaration cannot be used to submit a request to the Registrar for the withdrawal of a document.

Fee Collected for Document: $0.00

Page 37 of 41

Certificate of Status

I certify that:

J.J.D. WALKER HOLDINGS LTD.

101025605

was Incorporated as a Saskatchewan Corporation
under *The Business Corporations Act*
on October 01, 2001
and was Active as of February 01, 2021

Saskatchewan
Director of Corporations

Director of Corporations
February 01, 2021

Information Services Corporation

Page 38 of 41

Status: Registered Doc #: CA8847889 RCVD: 2021-03-17 RQST: 2021-04-27 15.15.41

COMPANIES OFFICE
OFFICE DES COMPAGNIES

Manitoba

1010-405 Broadway, Winnipeg, Manitoba R3C 3L6 405, Broadway, bureau 1010, Winnipeg (Manitoba) R3C 3L6

Certificate of Status / Certificat de Status

This is to certify that Nous certifions par les présentes que

5277095 MANITOBA LTD.

Business Number Numéro d'entreprise

860852326MC0001

Incorporated / Amalgamated Constituée / Fusion

1 APRIL/AVRIL 2006

current jurisdiction autorité législative courante

MANITOBA

is registered under The Corporations Act. According to the information contained on our records, as of this date, the body corporate is still in existence.

est enregistrée sous le régime de la Loi sur les corporations. D'après les renseignements que nous avons, cette personne morale existe toujours aujourd'hui.

Dated Fait le

2 FEBRUARY/FÉVRIER 2021

Issued Electronically
Délivré par voie électronique

Deputy Director/directeur adjoint
Corporations Act/
Loi sur les corporations

Service Request Number / Numéro de la demande de service - 108228258

Page 39 of 41

Status: Registered Doc #: CA8847889 RCVD: 2021-03-17 RQST: 2021-04-27 15.15.41

COMPANIES OFFICE / OFFICE DES COMPAGNIES

Manitoba

1010-405 Broadway, Winnipeg, Manitoba R3C 3L6 405, Broadway, bureau 1010, Winnipeg (Manitoba) R3C 3L6

Certificate of Status / Certificat de Status

This is to certify that / Nous certifions par les présentes que

5277109 MANITOBA LTD.

Business Number / Numéro d'entreprise

860854124MC0001

Incorporated / Amalgamated / Constituée / Fusion

1 APRIL/AVRIL 2006

current jurisdiction / autorité législative courante

MANITOBA

is registered under The Corporations Act. According to the information contained on our records, as of this date, the body corporate is still in existence.

est enregistrée sous le régime de la Loi sur les corporations. D'après les renseignements que nous avons, cette personne morale existe toujours aujourd'hui.

Dated / Fait le

2 FEBRUARY/FÉVRIER 2021

Issued Electronically
Délivré par voie électronique

Deputy Director/directeur adjoint
Corporations Act/
Loi sur les corporations

Service Request Number / Numéro de la demande de service - 108228124

Page 40 of 41

Status: Registered Doc #: CA8847889 RCVD: 2021-03-17 RQST: 2021-04-27 15.15.41

FORM_DECGEN_V20

LAND TITLE ACT
FORM DECLARATION

Related Document Number: CA8847889

PAGE 1 OF 1 PAGES

Your electronic signature is a representation that you are a designate authorized to certify this application under section 168.4 of the *Land Title Act*, RSBC 1996, c.250, that you certify this application under section 168.43(3) of the act, and that the supporting document or a true copy of the supporting document, if a true copy is allowed under an e-filing direction, is in your possession.

Brian James Senini IAT7J9

Digitally signed by Brian James Senini IAT7J9
Date: 2021.03.31 15:17:24 -07'00'

I, BRIAN J. SENINI, Barrister and Solicitor, of #200 - 1808 Bowen Road, Nanaimo, BC V9S 5W4, DECLARE THAT:

Please amend Item 5 Transferor, Windsor Building Supplies Ltd. in Charges CA8847880, CA8847883, CA8847886, CA8847889, CA8847892, CA8847895, CA8847904, CA8847908, CA8847912, CA8847916 and CA8847947, together with the associated Consent and Priority Agreements to read as follows:

Windsor Building Supplies Ltd. (Inc. No. BC1224868)

BRIAN J. SENINI

(Client File Ref. 54806-1)

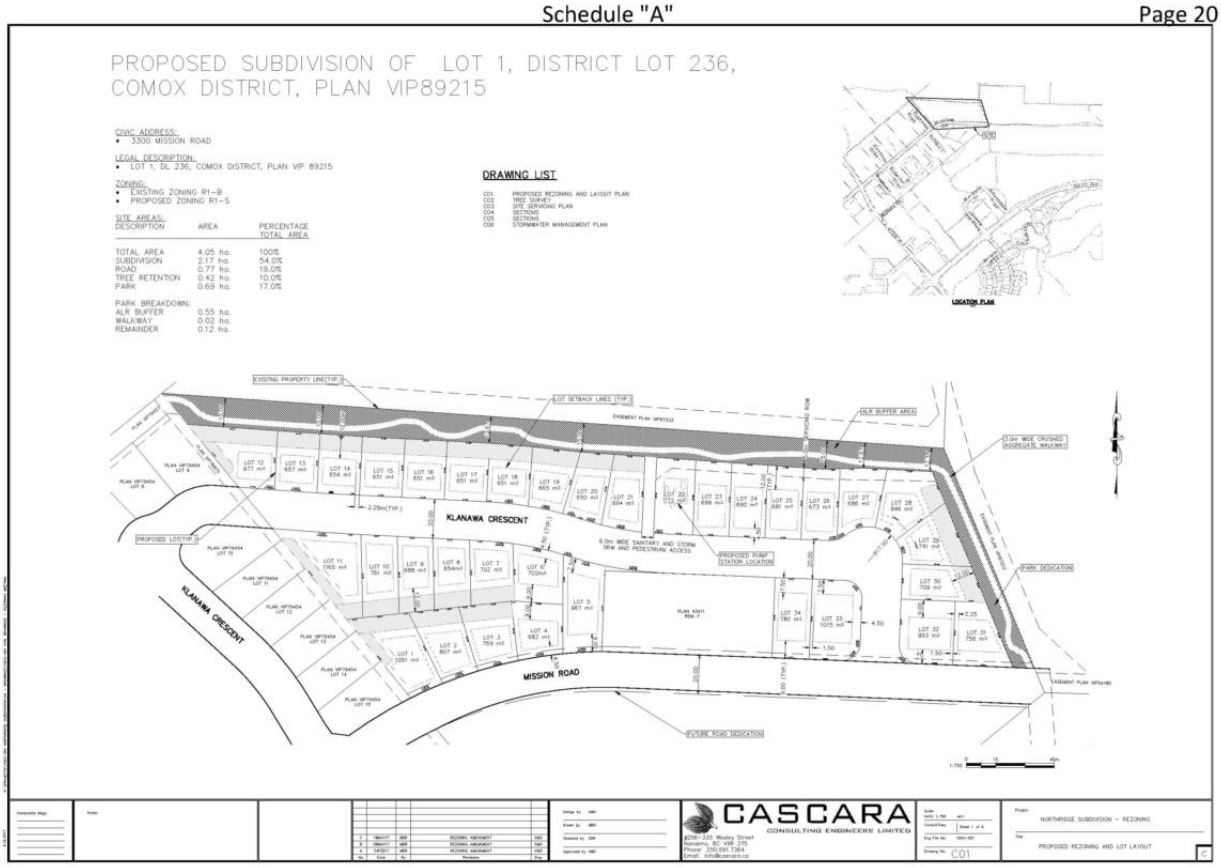
NOTE:
A Declaration cannot be used to submit a request to the Registrar for the withdrawal of a document.

Fee Collected for Document: $0.00

Page 41 of 41

Attachment No. 3: Tree Retention Covenant Areas on Lots 12, 14, 15, 16, 17, 18, 19

Schedule "A"
Page 20



Attachment No. 4: Geotechnical Engineer's Letters of support (Lots 12, 14, 15, 16, 17, 18, 19)

LEA **Lewkowich Engineering Associates Ltd.**
geotechnical • environmental, health & safety • materials testing

GEOTECHNICAL MEMO

Ballard Fine Homes Ltd. **File: F9564.02**
1 – 546 Island Highway, Parksville, BC V9P 1H2 **August 23, 2021**

Attention: Darren Gaudreault

PROJECT: NEW SINGLE-FAMILY RESIDENCE
ADDRESS: 3202 KLANAWA CRESCENT (LOT 12), COURTENAY, BC; PID: 031-341-748
SUBJECT: ROCK PIT BUILDING FOUNDATION MINIMUM OFFSET

1. As requested, Lewkowich Engineering Associates Ltd. (LEA) reviewed drainage conditions for a new single-family residence.

2. Previously, LEA provided the rear lot stormwater dispersal trench (rock pit) design for applicable residential lots of the Northridge Estates subdivision in report F2556.20r2. A typical minimum horizontal offset from building foundations of 5m was prescribed on IFC drawing F2556-03r1. Subsequently, a 12m rear lot boundary setback was established for the newly created residential lots (6m tree retention buffer + 1m wide dispersal trench + 5m minimum offset to building foundations).

3. Due to spatial constraints for the buildable areas on Lots 12 to 20, the builder has asked LEA if the minimum offset of 5m can be reduced.

4. LEA has considered:

   i. Site soils are considered to be well drained and the groundwater table is at significant depth.

   ii. The topography of the lot grades away from the building. North is downhill.

   iii. The stormwater dispersal trench would be located beside (as close as possible to) the tree buffer.

   iv. The trench would be at a suitable elevation below the perimeter drains as prescribed in LEA IFC drawing F2556-03r1.

   v. The catch basin will have a grate cover which will act as an overflow release. During infrequent high volume storm events when soils become saturated, stormwater would exit the system and travel overland downhill into the tree buffer where there is additional infiltration capacity.

   vi. Other than the minimum offset from building foundations, all other design requirements prescribed on LEA IFC drawing F2556-03r1 remain the same.

5. In consideration of the factors listed in Item 4 above, it is LEA's opinion that the minimum offset from building foundation may be reduced to 3m (a reduction of 2m) and that the 3m offset will provide safe and suitable conditions for the single-family residence.

2351 B Rosewall Crescent, Courtenay, BC, Canada V9N 8R9 • Tel: 250.334.0384 • Fax: 250.334.9601 1
www.lewkowich.com

PROJECT: Rock Pit, 3202 Klanawa Crescent, Courtenay, BC
FILE: F9564.02
DATE: August 23, 2021

6. LEA would expect the rear lot boundary setback may be relaxed to 10m (6m tree retention buffer + 1m wide dispersal trench + 3m minimum offset to building foundations).
7. Lewkowich Engineering Associates Ltd. appreciates the opportunity to be of service on this project. If you have any comments, or if we can be of further assistance, please contact us at your convenience.

Respectfully Yours,
Lewkowich Engineering Associates Ltd.

Joe Brunelle, P.Eng.
Geotechnical Engineer

Lewkowich Engineering Associates Ltd.
geotechnical • environmental, health & safety • materials testing

GEOTECHNICAL MEMO

Ballard Fine Homes Ltd. **File: F9562.02**
1 – 546 Island Highway, Parksville, BC V9P 1H2 **August 23, 2021**

Attention: Darren Gaudreault

PROJECT: NEW SINGLE-FAMILY RESIDENCE
ADDRESS: 3212 KLANAWA CRESCENT (LOT 14), COURTENAY, BC; PID: 031-341-764
SUBJECT: ROCK PIT BUILDING FOUNDATION MINIMUM OFFSET

1. As requested, Lewkowich Engineering Associates Ltd. (LEA) reviewed drainage conditions for a new single-family residence.

2. Previously, LEA provided the rear lot stormwater dispersal trench (rock pit) design for applicable residential lots of the Northridge Estates subdivision in report F2556.20r2. A typical minimum horizontal offset from building foundations of 5m was prescribed on IFC drawing F2556-03r1. Subsequently, a 12m rear lot boundary setback was established for the newly created residential lots (6m tree retention buffer + 1m wide dispersal trench + 5m minimum offset to building foundations).

3. Due to spatial constraints for the buildable areas on Lots 12 to 20, the builder has asked LEA if the minimum offset of 5m can be reduced.

4. LEA has considered:

   i. Site soils are considered to be well drained and the groundwater table is at significant depth.

   ii. The topography of the lot grades away from the building. North is downhill.

   iii. The stormwater dispersal trench would be located beside (as close as possible to) the tree buffer.

   iv. The trench would be at a suitable elevation below the perimeter drains as prescribed in LEA IFC drawing F2556-03r1.

   v. The catch basin will have a grate cover which will act as an overflow release. During infrequent high volume storm events when soils become saturated, stormwater would exit the system and travel overland downhill into the tree buffer where there is additional infiltration capacity.

   vi. Other than the minimum offset from building foundations, all other design requirements prescribed on LEA IFC drawing F2556-03r1 remain the same.

5. In consideration of the factors listed in Item 4 above, it is LEA's opinion that the minimum offset from building foundation may be reduced to 3m (a reduction of 2m) and that the 3m offset will provide safe and suitable conditions for the single-family residence.

2351 B Rosewall Crescent, Courtenay, BC, Canada V9N 8R9 • Tel: 250.334.0384 • Fax: 250.334.9601 1
www.lewkowich.com

PROJECT: Rock Pit, 3212 Klanawa Crescent, Courtenay, BC
FILE: F9562.02
DATE: August 23, 2021

6. LEA would expect the rear lot boundary setback may be relaxed to 10m (6m tree retention buffer + 1m wide dispersal trench + 3m minimum offset to building foundations).
7. Lewkowich Engineering Associates Ltd. appreciates the opportunity to be of service on this project. If you have any comments, or if we can be of further assistance, please contact us at your convenience.

Respectfully Yours,
Lewkowich Engineering Associates Ltd.

Joe Brunelle, P.Eng.
Geotechnical Engineer

Lewkowich Engineering Associates Ltd.

geotechnical • environmental, health & safety • materials testing

GEOTECHNICAL MEMO

Ballard Fine Homes Ltd. **File: F9813.01**
1 – 546 Island Highway, Parksville, BC V9P 1H2 **August 24, 2021**

Attention: Darren Gaudreault

PROJECT: NEW SINGLE-FAMILY RESIDENCES
ADDRESSES: 3216 KLANAWA CRESCENT (LOT 15), COURTENAY, BC; PID: 031-341-772
3220 KLANAWA CRESCENT (LOT 16), COURTENAY, BC; PID: 031-341-781
3224 KLANAWA CRESCENT (LOT 17), COURTENAY, BC; PID: 031-341-799
3228 KLANAWA CRESCENT (LOT 18), COURTENAY, BC; PID: 031-341-802
3232 KLANAWA CRESCENT (LOT 19), COURTENAY, BC; PID: 031-341-811
SUBJECT: ROCK PIT BUILDING FOUNDATION MINIMUM OFFSET

1. As requested, Lewkowich Engineering Associates Ltd. (LEA) reviewed drainage conditions for new single-family residences.

2. Previously, LEA provided the rear lot stormwater dispersal trench (rock pit) design for applicable residential lots of the Northridge Estates subdivision in report F2556.20r2. A typical minimum horizontal offset from building foundations of 5m was prescribed on IFC drawing F2556-03r1. Subsequently, a 12m rear lot boundary setback was established for the newly created residential lots (6m tree retention buffer + 1m wide dispersal trench + 5m minimum offset to building foundations).

3. Due to spatial constraints for the buildable areas on Lots 12 to 20, the builder has asked LEA if the minimum offset of 5m can be reduced.

4. LEA has considered:

   i. Site soils are considered to be well drained and the groundwater table is at significant depth.

   ii. The topography of the lot grades away from the building. North is downhill.

   iii. The stormwater dispersal trench would be located beside (as close as possible to) the tree buffer.

   iv. The trench would be at a suitable elevation below the perimeter drains as prescribed in LEA IFC drawing F2556-03r1.

   v. The catch basin will have a grate cover which will act as an overflow release. During infrequent high volume storm events when soils become saturated, stormwater would exit the system and travel overland downhill into the tree buffer where there is additional infiltration capacity.

   vi. Other than the minimum offset from building foundations, all other design requirements prescribed on LEA IFC drawing F2556-03r1 remain the same.

5. In consideration of the factors listed in Item 4 above, it is LEA's opinion that the minimum offset from

2351 B Rosewall Crescent, Courtenay, BC, Canada V9N 8R9 • Tel: 250.334.0384 • Fax: 250.334.9601 1
www.lewkowich.com

PROJECT: Rock Pit, Klanawa Crescent (Lots 15 to 19), Courtenay, BC
FILE: F9813.01
DATE: August 24, 2021

building foundation may be reduced to 3m (a reduction of 2m) and that the 3m offset will provide safe and suitable conditions for the single-family residences.

6. LEA would expect the rear lot boundary setback may be relaxed to 10m (6m tree retention buffer + 1m wide dispersal trench + 3m minimum offset to building foundations).

7. Lewkowich Engineering Associates Ltd. appreciates the opportunity to be of service on this project. If you have any comments, or if we can be of further assistance, please contact us at your convenience.

Respectfully Yours,
Lewkowich Engineering Associates Ltd.

Joe Brunelle, P.Eng.
Geotechnical Engineer

Attachment No. 5: Public Information Package and Public Comment

PUBLIC INFORMATION MAIL OUT

PROPOSED DEVELOPMENT VARIANCE APPLICATION BYLAW NO. 2790, 2014

LOT 12/14/15/16/17/18/19/23/24/26 KLANAWA CRESCENT, COURTENAY

An application has been made to reduce the rear yard setbacks to 10 meters.

Application date: July 7, 2021

To get more information and view relevant documents on the City of Courtenay website: www.courtenay.ca/devapptracker (search by file number or address)

Or visit: City of Courtenay, Planning Department, 830 Cliffe Avenue, Courtenay, BC, V9N2J7
Tel: 250.703.4839 Fax: 250.334.4241 Email: planning@courtenay.ca

Page over.....

PUBLIC INFORMATION MAIL OUT

PROPOSED DEVELOPMENT VARIANCE APPLICATION BYLAW NO. 2790, 2014

Applicant Information: Ballard Fine Homes Ltd., #1-546 Island Hwy W, Parksville, BC, V9P1H2

Phone 250.586.9077 / Email darrengaudreault@shaw.ca

Information requests and comments may also be submitted to applicant.

Please contact the applicant with any questions or concerns, Monday to Friday, 9-5 daily.

Please return your comments by September 7, 2021.

Comments can also be submitted to the City of Courtenay by one of the following methods:

Drop your comment sheet off in the drop box located at front entrance of the City of Courtenay or mail: City of Courtenay, Planning Services Department, 830 Cliffe Avenue, Courtenay, BC, V9N 2J7

Email your comments to planning@courtenay.ca

Fax your comments to 250.334.4241

09/02/2021 06:25PM 2503394057 BEAVER MEADOW FARMS PAGE 01/01

Sept 3/21

To City of Courtenay
Planning Services Dept
830 Cliffe Ave
Courtenay B.C. V9N 2J7

Fax 250 334 4241

RECEIVED
SEP 03 2021
CITY OF COURTENAY

RE: Public Information about Dev't.

In response to the proposed developement variance application bylaw no. 2790, 2014 for lots 12/14/15/16/17/18/19/23/24/26/ Klanawa CRESCENT.

We are opposed to the granting of this variance reducing the rear yard set back. As the adjacent property owner we will find this variance if granted to further impact our farming activities that will be carried out in the future. It is very important that the distances proposed in the original subdivision bylaw are maintained such that our agricultural uses, sounds, smells, and sighting are maintained and protected by maximum yard & building set backs. Under no manner are we agreeable to this variance being granted at the expense of future agricultural use of our property. We are aware that the applicant Ballard Fine Homes Ltd was aware of the [redacted] developement set backs that were guaranteed and made public before their purchase of the lots. They can be expected to change their plans to adopt to the accepted by law.

Sincerely

[redacted]

Attachment No. 6: Sustainability Evaluation Checklist

CITY OF COURTENAY
Development Services
830 Cliffe Avenue
Courtenay, BC, V9N 2J7
Tel: 250-703-4839 Fax: 250-334-4241
Email: planning@courtenay.ca

SUSTAINABILITY EVALUATION

COMPLIANCE CHECKLIST

The following checklist provides a quick reference list of required sustainability criteria that, where applicable, shall be satisfied for all development applications including Official Community Plan (OCP) and Zoning Bylaw amendments, Development Permits, Development Variance Permits, Tree Cutting and Soil Removal Permits, Agricultural Land Reserve and Subdivision applications. These criteria are established to ensure that the goals and objectives of the OCP are satisfied. **Please briefly state in the "Description" column how the application achieves the stated criterion.** Where an element of the development proposal does not comply with a sustainability criterion, a justification stating the divergence and the reason shall be made. A separate sheet may be used to provide comment. **Incomplete forms will result in application delays.**

The Sustainability Evaluation Checklist Policy states: *Proposed developments will be considered where a development:*

a. *provides substantial benefits to the City;*
b. *will not negatively impact on the City's infrastructure, neighborhood or environment;*
c. *new development that supports destination uses such as the downtown, Riverway Corridor or a Comprehensive Planned Community;*
d. *Meets applicable criteria set out in the OCP.*

The complete Sustainability Evaluation Checklist policy is contained within the City of Courtenay Official Community Plan No. 2387, 2005.

Project Address: Lot 12/14/15/16/17/18/19/23/24/26 Klanawa Crescent	**Date:** July 9, 2021
Applicant: Ballard Fine Homes Ltd.	**Signature:** D J

APPLICATION REQUIREMENTS To be filled out by applicant

Land Use. *The application:*	**Description of how the criteria are met**
a) Provides a mix of housing types and sizes;	Custom designed SFD's
b) Balances the scale and massing of buildings in relation to adjoining properties;	Similar form and character
c) Complements neighboring uses and site topography;	Similar quality finished SFD's
d) Provides or supports mixed used developments or neighborhoods;	Adhere to R1S zoning
e) Promotes walking to daily activities and recreational opportunities;	Backing onto parkland and green space
f) Supports a range of incomes;	Various price point and house sizes
g) Is a positive impact on views and scenery;	Custom designed homes and landscaping
h) Preserves and provides greenspace, trails and landscaping;	Protected green space areas

Building Design. *The application:*	**Description of how the criteria are met**
a) Exhibits high standard of design, landscaping and environmental sensitivity;	Professionally designed landscaping
b) Maintains a high standard of quality and appearance;	Custom designed SFD's
c) Includes articulation of building faces and roof lines with features such as balconies, entrances, bay windows, dormers and vertical and horizontal setbacks with enhanced colors;	Custom designed features in every home
d) Avoids creating a strip development appearance;	Custom designed SFD's all unique
e) Satisfies Leadership in Energy and **Environmental Design (LEED) certification (or** accepted green building best practices);	Step Code 3 compliant
f) Uses environmentally sensitive materials which are energy sensitive or have accepted low pollution standards;	Step Code 3 compliant
g) Builds and improves pedestrian amenities;	Walking trails and park land
h) Provides underground parking;	SFD's with enclosed garages
i) Applies CPTED (Crime Prevention Through Environmental Design) principles;	SFD's with security
Transportation. *The application:*	**Description of how the criteria are met**
a) Integrates into public transit and closeness to major destinations;	Walking distance to bus routes
b) Provides multi-functional street(s);	Park land and green space provided
c) Prioritizes pedestrian and cycling opportunities on the public street system and through the site location that can provide an alternative to public road;	Park land and walking trails
d) Provides or contributes towards trail system, sidewalks, transit facilities, recreation area or environmentally sensitive area;	Walking trails
Infrastructure. *The application:*	**Description of how the criteria are met**
a) Includes stormwater techniques that are designed to reduce run-off, improve groundwater exchange and increase on-site retention;	On site engineered storm water management
b) Utilizes renewable energy sources (i.e. solar, geothermal) within servable area to City standards;	High efficiency gas heating and water systems

Character & Identity. *The application:*	**Description of how the criteria are met**
a) Provides a positive image along waterfront areas and fronting road;	Custom designed SFD's
b) Is designed with quality and variety of features within the project (i.e. street furniture, street lights, signs, curb treatments);	Full curb and gutters and street lighting
c) Provides public and private amenity space;	Park land and green space
d) Preserves heritage fixtures;	Building scheme in place
e) Orients to views, open space and street;	Building envelopes in place
Environmental Protection & Enhancement. *The application:*	**Description of how the criteria are met**
a) Protects riparian areas and other designated environmentally sensitive areas;	Protected green space
b) Provides for native species, habitat restoration/improvement;	Protected trees
c) Includes tree lined streetscapes.	Boulevard trees

Dear Comox Valley Mayors and Councillors

Our organization, the Comox Valley Council of Canadians has signed onto a letter *[sample attached]* calling on the BC government to confront the climate emergency with bold action in order to mitigate the type of heat waves, drought conditions and forest fires we have recently experienced in BC. We feel that the provincial government's Clean BC climate action plan is not strong enough to limit warming to 1.5 degrees C and will not keep British Columbians safe from the impacts of climate change.

This letter has been signed by over 90 environmental and climate groups around the province. We have been asked to enlarge that circle to include others who are concerned about the impacts of the climate crisis on citizens within their mandate. Decisions made by municipal governments have a direct impact on the communities within their jurisdiction. If a majority of municipal governments across BC signed onto such a letter it would be a significant call to action for our provincial government.

The organizers of this campaign are going to present this letter to Premier Horgan and his MLAs by Sept. 26. However we want to continue to expand this call for climate action beyond those who have signed on already to include a wider ranch of citizens.

We ask that you read this letter and consider signing onto this call for climate action by the provincial government.

https://docs.google.com/document/d/1MDePqitvVsAMSjvBD_xN27EZUuq925Q3pBa11AlWOUc/edit

We look forward to hearing from you on this issue.

Respectfully,
Barbara Berger
on behalf of the CofC
Comox Valley Chapter

September 9, 2021

Dear Premier Horgan and the Government of BC,

Re: Confront the Climate Emergency

We write on behalf of diverse environmental, Indigenous, labour, health, business, local government, academic, youth, and faith communities who collectively represent XX British Columbians.

We call on the BC government to recognize the urgency and alarm that people all over the province are feeling as the climate crisis directly impacts our communities and our health: deadly heat waves, wildfires, drought, floods, crop failure, fisheries collapse, and costly evacuations and infrastructure damage. These climate-related impacts are unprecedented and intensifying. Indigenous peoples stand to be disproportionately impacted by climate events despite successfully taking care of the land since time immemorial.

The latest report from the Intergovernmental Panel on Climate Change is a 'code red' for humanity. The International Energy Agency has called on world governments to immediately stop investments in and approvals of new oil and gas projects. The provincial government's *CleanBC* climate action plan is insufficient to limit warming to 1.5°C and will not keep British Columbians safe from the worst impacts of climate change.

We therefore urge the BC government to develop and implement a transformative climate emergency plan that recognizes the interconnected climate, ecological, and social crises; embeds equity, anti-racism, and social justice at its core; and upholds Indigenous Title and Rights, and Treaty Rights.

To implement the rapid systemic change that is required, we call on the provincial government to demonstrate the leadership necessary to confront the climate emergency, and immediately undertake the following 10 actions:

1. **Set binding climate pollution targets based on science and justice**
   Reduce BC's greenhouse gas emissions by ~7.5% per year below 2007 levels. Set binding reduction targets of 15% by 2023; 30% by 2025; 60% by 2030, and 100% by 2040 (below 2007 levels). Review and update targets regularly as climate science evolves.

2. **Invest in a thriving, regenerative, zero emissions economy**
   Invest 2% of BC's GDP ($6 billion dollars per year) to advance the zero emissions economy and create tens of thousands of good jobs. Spend what it takes to immediately reduce greenhouse gas emissions and create new economic institutions to get the job done. Ensure that the economic component of Aboriginal Title is recognized through the sharing of benefits and revenues that result.

3. **Rapidly wind down all fossil fuel production and use**
   Immediately stop all new fossil fuel infrastructure including fracking, oil and gas pipelines, liquefied natural gas (LNG), and fossil fuel-derived hydrogen. Rapidly phase out and decommission all existing fossil fuel production and exports.

4. **End fossil fuel subsidies and make polluters pay**
   End all fossil fuel subsidies and financial incentives by 2022. Ensure that those industries that profit from fossil fuel pollution pay their fair share of the resulting climate damage.

5. **Leave no one behind**
   Ensure a just transition for fossil fuel workers, resource-dependent communities, and Indigenous and remote communities impacted by fossil fuel production. It will be critical to collaborate in true partnership with Indigenous peoples in climate action. Prepare our communities for the impacts of the climate crisis to minimize human suffering and infrastructure damage. Support those most vulnerable to climate change impacts.

6. **Protect and restore nature**
   Protect 30% of terrestrial and marine ecosystems by 2030; support and invest in Indigenous-led conservation initiatives; restore natural ecosystems to enhance ecosystem functions and services, preserve biodiversity, increase carbon sequestration, and improve human and ecosystem resilience to climate impacts. Impose an immediate moratorium on the industrial logging of all old growth forests which are critical carbon sinks.

7. **Invest in local, organic, regenerative agriculture and food systems**
   Incentivize carbon storage in soil, restore biodiversity, and ensure food sovereignty and food security across the province. Increase consumption of plant-based foods, and reduce food waste. Support Indigenous communities that wish to maintain traditional food systems and enhance their food security.

8. **Accelerate the transition to zero emission transportation**
   Invest in affordable, accessible, and convenient public transit within and between all communities. Reallocate infrastructure funds from highway expansion to transit and active transportation (cycling, rolling, and walking). Mandate zero emissions for all new light vehicles by 2027, and all medium and heavy duty vehicles by 2030.

9. **Accelerate the transition to zero emission buildings**
   Ban new natural gas connections to all new and existing buildings by the end of 2022. Create a Crown Corporation to mobilize the workforce to retrofit all existing buildings and eliminate fossil fuel heating by 2035, and to build new affordable zero emissions buildings.

10. **Track and report progress on these actions every year**
    Embed all of these actions in legislation to ensure accountability, transparency, and inclusion. Establish rolling 5-year carbon budgets that decline over time towards zero emissions by 2040 or sooner.

Tackling the climate crisis offers an unprecedented opportunity to generate new, vibrant economic and social wealth as we transform where our energy comes from and how it is used. It offers an opportunity to achieve energy security, ensure food security, develop more sustainable local economies and jobs, transform our buildings, redesign transportation, reduce pollution, improve human health and wellbeing, and enhance our quality of life. The transition from fossil fuels to a zero emissions economy has clear benefits for people and natural ecosystems, and is an opportunity to create a more prosperous, just, and equitable society.

Every person, every business, every industry, and every government has a role to play as we coordinate individual and collective actions to create a thriving, resilient, and regenerative society that respects its interdependence with healthy ecosystems and a safe climate.

British Columbia is positioned to become a visionary world leader and demonstrate that innovative and rapid change is possible as we transition to a zero emissions economy.

We urge you to seize these opportunities, and demonstrate to British Columbians that our government is indeed a true climate leader by implementing the 10 climate emergency actions set out in this letter.

We must act now.

Sincerely,

[organizations]

Royal Canadian Mounted Police

Gendarmerie royale du Canada

Mayor Bob Wells
830 Cliffe Avenue
Courtenay B.C. V9N 2J7

OIC RCMP
Comox Valley Detachment
800 Ryan Road
Courtenay, B.C. V9N 7T1

Dear Mayor Wells

Re: City of Courtenay Quarterly Report

July 1, 2021 to September 30, 2021

The Comox Valley Royal Canadian Mounted Police (RCMP) will be providing quarterly updates on policing in the community. This will include Calls for Service (CFS), crime types and traffic statistics. Quarterly reporting reports will coincide with the Comox Valley RCMP Annual Performance reporting time lines in conjunction with Community priorities.

First Quarter: April 1st to June 30th
Second Quarter: July 1st to September 30th
Third Quarter: October 1st to December 31st
Fourth Quarter: January 1st to March 31st

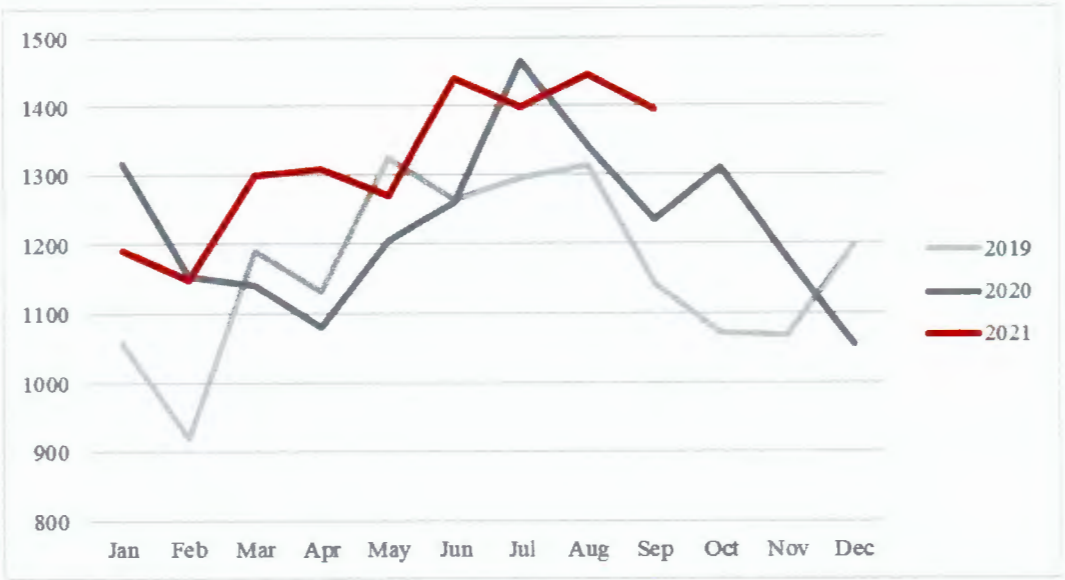
2021-2022 2ND QUARTER COMMUNITY REPORT - COURTENAY

CALLS FOR SERVICE

Relative to last quarter, there was a 5.5% increase of Calls for Service in Courtenay.

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	1057	919	1190	1132	1324	1264	1296	1313	1143	1071	1068	1198
2020	1318	1155	1142	1080	1205	1260	1466	1341	1235	1310	1180	1055
2021	1190	1148	1299	1308	1269	1440	1398	1445	1394			

Canada



TRAFFIC

Relative to last quarter, there was a 3% increase of traffic files in Courtenay.

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	89	70	91	121	122	105	131	104	97	107	85	88
2020	81	98	78	79	104	116	121	94	131	142	104	102
2021	77	85	104	126	115	127	144	110	126			

BREAK AND ENTERS

Relative to last quarter, there was 1 more break and enter file in Courtenay.

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	13	14	18	19	16	20	24	18	20	20	20	33
2020	41	26	20	15	12	5	22	20	8	13	12	20
2021	16	18	16	11	21	11	20	13	11			

THEFT FROM VEHICLE

Relative to last quarter, there was a 32% decrease in theft from vehicle files in Courtenay.

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	41	29	15	33	40	34	32	23	42	15	11	24
2020	61	28	32	31	20	26	51	40	26	33	21	31
2021	34	33	31	47	35	44	22	28	29			

ASSAULT

Relative to last quarter, there were 26% more assault files in Courtenay.

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	30	28	31	23	18	22	29	29	20	21	28	23
2020	24	25	27	20	30	26	35	44	40	44	28	22
2021	37	38	32	26	22	51	39	38	48			

SEX OFFENCES

Relative to last quarter, there were 5 more sex offence files in Courtenay.

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	8	5	16	9	3	4	5	7	4	5	5	10
2020	4	10	7	6	13	5	11	8	9	8	7	5
2021	7	7	15	7	6	12	7	7	16			

DOMESTIC (PARTNER/SPOUSAL) VIOLENCE

Relative to last quarter, there were 14 fewer domestic violence files in Courtenay.

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	19	16	25	13	17	10	28	20	14	18	18	25
2020	19	30	26	13	21	31	21	49	21	41	18	17
2021	34	23	27	35	19	25	22	17	26			

Yours truly,

Insp. M.J. Kurvers
OIC Comox Valley Detachment

THE CORPORATION OF THE CITY OF COURTENAY

BRIEFING NOTE TO COUNCIL

To: Council **File No.:** 5335-20

From: Chief Administrative Officer **Date:** October 18, 2021

Subject: 5th Street Bridge Rehabilitation Project Update

PURPOSE:

The purpose of this briefing note is to update Council on the current status of the 5th Street Bridge Rehabilitation Project including updates to schedule, project scope/budget and communications plan.

BACKGROUND:

The 5th Street Bridge plays an important role in the entire Comox Valley transportation network serving 20,000 vehicles, 650 pedestrians and 500 cyclists each day. Completed in 1960, the 72-metre steel truss bridge has two vehicle lanes and 1.5 metre sidewalks on both sides of the bridge.

The rehabilitation project started in April 2021 and has been an active construction area since that time. The bridge has remained open to all modes of traffic during construction; however, traffic patterns have been altered to safely complete the work. Public and stakeholder communications are on-going to both mitigate impacts, communicate overall progress and schedule delays.

UPDATE:

Project Status

The first two containment areas were recently completed, providing a view of the fresh classic green paint coating. The overall response to the colour has been very positive and many have noted the preference survey that was completed last spring, highlighting the City's responsiveness to the community's preference for classic green.

The final containment (Containment #3) has been installed in the centre of the bridge and coating removal is almost complete. High noise levels are present during coating removal and recoating; however, to date few comments or complaints have been received about the noise level.

The bridge deck repairs are expected to begin in mid-October. New equipment will begin mobilizing to the site in anticipation of the bridge deck repairs in the coming weeks. The equipment and materials used to recoat the bridge will begin to demobilize from site.

The temporary pedestrian walkway on the bridge deck will also be removed allowing pedestrians to return to the existing sidewalks. To start, only the south sidewalk will be open as the contractor removes the scaffolding above the deck. Discussions are continuing with the contractor about reopening the north sidewalk. The grassy area at the northwest corner of the bridge will be an active construction site as

electrical earth work and tie-ins will be completed in this area. This may prevent the north sidewalk from opening safely to pedestrians.

A new digital sign board was placed near the park approaching downtown to help further convey the height restrictions on the bridge. New signage was also added to the temporary traffic signals at each end of the bridge. As a result of the new digital sign board and increased communications, we have seen a marked decrease in over-height vehicles attempting to use the 5th Street Bridge and no additional close calls have been reported.

Late last month, bike boxes were painted at each temporary traffic signal. The new bike boxes provide a more visible area for cyclists to safely queue while waiting to travel across the bridge.

Schedule Update

The contractor's schedule has continued to slip over the last month with the planned completion date (removal of single lane alternating traffic) now being January 3rd. It is acknowledged that this is a significant schedule change, and will have an impact on the community, especially during the upcoming holiday season. All actions reasonably possible will be made to minimize impacts, and support the community and stakeholders through messaging and liaison activities with stakeholders.

The reasons for this second schedule extension are that Containment #2 (East end) took longer to complete than previously anticipated by the contractor. The revised estimates to complete Containment #3 (centre) are also higher than originally anticipated by the contractor, adding additional time to the schedule. This represents a six week extension to the schedule.

Previously, the schedule was extended from October 15th to November 19th. This was due to additional time needed to resolve scaffolding issues, and delays caused by malfunction of key equipment. This resulted in a five week extension to the schedule.

The project team continue to work with the contractor to investigate all options to minimize schedule impacts, including night work and work phase overlap. The contractor and their sub-contractors are reporting issues with securing the additional labour required to support double shifts and/or night work, which might have helped to mitigate these schedule impacts. This limits the ability to work more than 12 hours a day, which was the originally planned level of effort. Over the last month, the coating crew has been rotating days off to avoid full shutdowns and to ensure work continues 12 hours a day and 7 days a week.

Labour shortages are an ongoing issue across all industries including the construction industry. The work being undertaken on the bridge is specialized which makes it even more difficult to secure additional labour in order to add additional crews to work additional shifts.

To make up for lost time in the schedule, a full closure of the bridge to vehicle traffic was considered for the next phase of work (deck rehabilitation). The contractor has estimated that approximately 21 days could be saved if the bridge were closed to vehicle traffic for the remainder of the work. Although technically feasible, the disruption to the general public as well as to transit, emergency services, and downtown businesses was deemed too large. There are also concerns that the rest of the road network

(17th St Bridge, Condensory Bridge, etc.) may not able to support the increase in traffic resulting from a full closure, leading to further traffic delays.

Lastly, there continues to be schedule risk in the project with winter weather approaching. Concrete placement and curing can be affected by colder temperatures and rain/snow. The contractor is experienced in working in all conditions during winter, but this still presents a potential risk.

The updated schedule can be found below:

5th St Bridge - Project Schedule								
Phase	**Sep Wk 3-4**	**Oct Wk 1-2**	**Oct Wk 3-4**	**Nov Wk 1-2**	**Nov Wk 3-4**	**Dec Wk 1-2**	**Dec Wk 3-4**	**Jan Wk 1-2**
Scaffold/Containment								
Blasting/Coating								
Deck Repairs								
Cathodic Protection								
Demobilize / Site Cleanup								

Single lane alternating traffic will continue until January 3rd, at which point traffic control measures will be removed, and traffic movements will be returned to pre-project condition. Ensuring the return to two-way traffic as soon as possible is a top priority for both the contractor and the project team. All options are being investigated to meet this priority.

Project Budget and Scope Update

Structural investigations have revealed additional corrosion on the beam ends as well as gusset plates. Many of these repairs are considered urgent and should be completed during this project. These repairs can be done concurrently with the regularly scheduled work as these repairs will occur under the bridge deck. Staff are working with our consultants and contractors to determine pricing and schedule for these repairs. It is anticipated that these costs can be covered by available contingency.

Included in the contract for this work was a provision for compensation owed to the City if the project runs over-schedule due to the actions of the contractor.

At this time, the project is still projected to be delivered within the approved budget.

Communications Update

Highest priority was communicating the change in completion date to project stakeholders, and the public. This was done on October 7th. We are still working to engage with project stakeholders directly via e-mail and meetings.

In parallel, communication channels such as Facebook, Instagram, and Twitter have been used to broadcast the news of the change in project completion date. In addition, a new project e-newsletter, and media release have been drafted and issued.

Although, the schedule slippage is unfortunate, the completion of the coating system and the removal of the containment system, scheduled for mid-October, will mark a visible milestone in the project's progress.

Prepared by:

Adam Pitcher, AScT, PMP
Engineering Technologist

Reviewed by:

Chris Davidson, P.Eng, PMP
Director of Engineering Services

Concurrence:

Geoff Garbutt, MCIP RPP
Chief Administrative Officer

THE CORPORATION OF THE CITY OF COURTENAY

BYLAW NO. 3021

A bylaw to amend Zoning Bylaw No. 2500, 2007

The Council of the Corporation of the City of Courtenay in open meeting assembled enacts as follows:

1. This bylaw may be cited for all purposes as **"Zoning Amendment Bylaw No. 3021, 2021"**.

2. That "Zoning Bylaw No. 2500, 2007" be hereby amended as follows:

   (a) by rezoning Lot 11, District Lot 158, Comox District Plan VIP73886 (2099 Hawk Drive), as shown in bold outline on **Attachment A** which is attached hereto and forms part of this bylaw, from Residential One Zone (R-1) to Residential One S Zone (R-1S); and

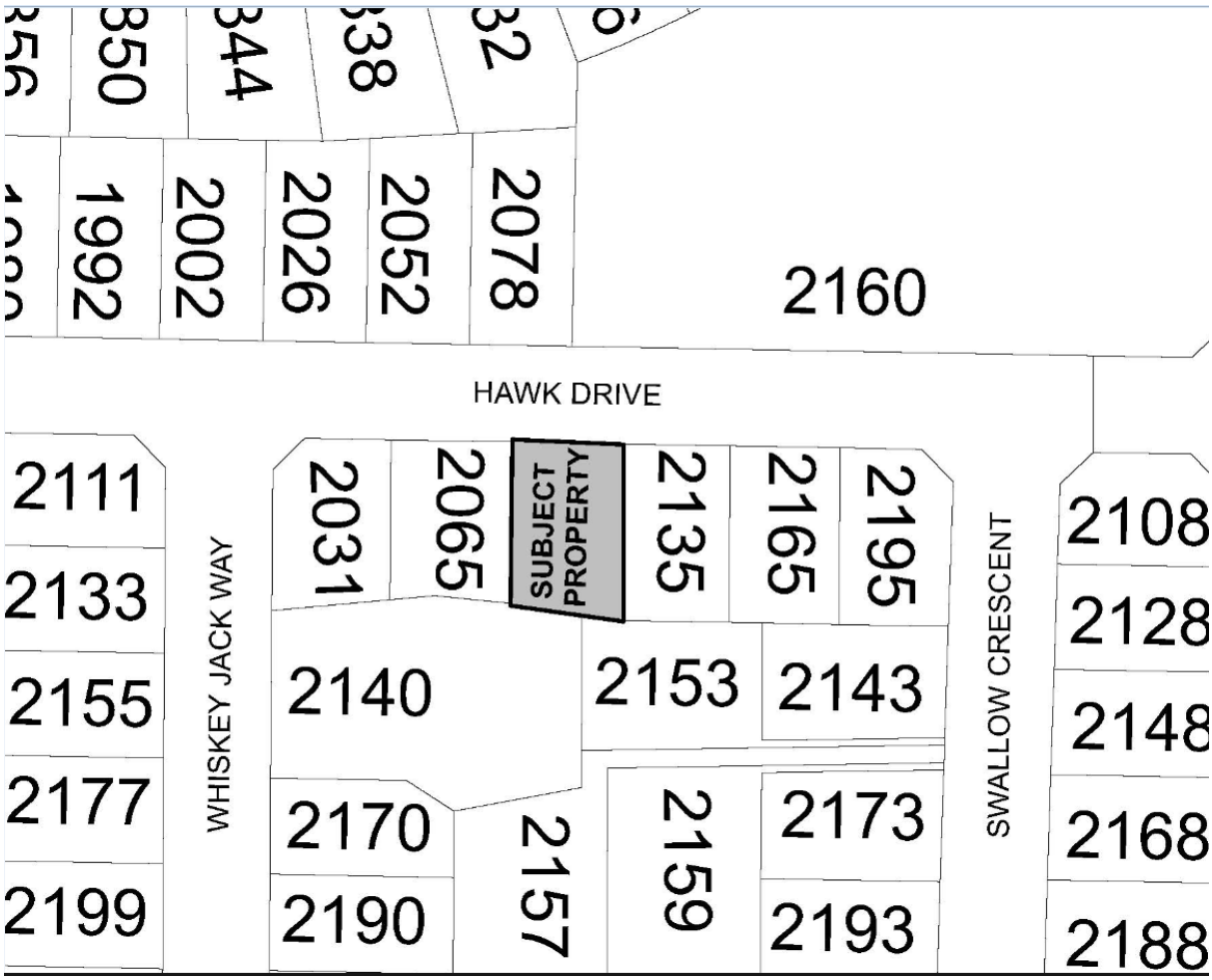
   (b) That Schedule No. 8, Zoning Map be amended accordingly.

3. This bylaw shall come into effect upon final adoption hereof.

Read a first time this	day of	, 2021
Read a second time this	day of	, 2021
Considered at a Public Hearing this	day of	, 2021
Read a third time this	day of	, 2021
Finally passed and adopted this	day of	, 2021

Mayor

Corporate Officer



THE CITY OF COURTENAY
ATTACHMENT "A"
Part of Bylaw No. 3021, 2021
Amendment to the
Zoning Bylaw No. 2500, 2007

CITY OF COURTENAY

BYLAW REFERENCE FORM

BYLAW TITLE

1) Tax Exemption 2022 Bylaw No. 3047, 2021
2) Tax Exemption Churches 2022 Bylaw No. 3048, 2021
3) Tax Exemption 2022-2031 Bylaw No. 3049, 2021

REASON FOR BYLAW

To consider three readings of the above permissive tax exemption bylaws for the 2022 taxation year.

STATUTORY AUTHORITY FOR BYLAW

Section 224 of the *Community Charter*

OTHER APPROVALS REQUIRED

STAFF COMMENTS AND/OR REPORTS

Bylaws are prepared in accordance with the September 7, 2021 Council approved list of recipients and prescribed exemption levels.

Final adoption required by October 29, 2021 to take effect for the 2022 taxation year.

OTHER PROCEDURES REQUIRED

Statutory Advertising required will be completed for two weeks prior to the expected final adoption of the bylaws on October 18, 2021.

September 27, 2021

A. Berard
Staff Member

THE CORPORATION OF THE CITY OF COURTENAY

BYLAW NO. 3047

A bylaw to exempt certain lands and improvements from taxation for the year 2022

WHEREAS the Council of the Corporation of the City of Courtenay deems that land and improvements described herein meet the qualifications of Section 224 of the *Community Charter*;

NOW THEREFORE the Council of the Corporation of the City of Courtenay in open meeting assembled, enacts as follows:

1. This bylaw may be cited for all purposes as **"Tax Exemption 2022 Bylaw No. 3047, 2021"**.

2. The following properties are hereby exempt from taxation for land and improvements to the extent indicated for the year 2022:

FOLIO	LEGAL DESCRIPTION	CIVIC ADDRESS	REGISTERED OWNER/LESSEE	PERCENTAGE EXEMPTION
49.000	LOT 41, SECTION 61, CD, PLAN 311	280 – 4TH STREET	EUREKA SUPPORT SOCIETY	100%
122.000 1650.000	LOT 1, PLAN 40587 PARCEL A, DD59610N OF LOT B, SECTION 16, PL 5618	367 CLIFFE AVENUE 101 ISLAND HIGHWAY	ROYAL CANADIAN LEGION	100%
169.000	PARCEL B (BEING A CONSOLIDATION OF LOTS 14, 17, 18, 21, 22 SEE CA6169477) SECTION 61, CD, PLAN VIP1517	237 – 3RD STREET	COMOX VALLEY CHILD DEVELOPMENT ASSOCIATION	100%
170.002	LOT A, SECTION 61, PLAN 54105 PID 017-752-141	280 2ND STREET	COMOX VALLEY TRANSITION SOCIETY (LEASED FROM FOUR PAWS INVESTMENTS LTD.)	100%
348.000	LOT 15, SECTION 61, CD, PLAN 4906	543 – 6TH STREET	ALANO CLUB OF COURTENAY	100%

FOLIO	LEGAL DESCRIPTION	CIVIC ADDRESS	REGISTERED OWNER/LESSEE	PERCENTAGE EXEMPTION
400.000	LOT A, SECTION 61, CD, PLAN 18979	A1-310 8TH STREET	CITY OF COURTENAY (LEASED FROM WEST ISLAND CAPITAL CORP)	100% OF THE ASSESSMENT ALLOCATED TO THE SPACE LEASED BY THE LEASEE
513.000	LOT A, DL 127, CD, PLAN 7719	755 HARMSTON AVENUE	OLD CHURCH THEATRE SOCIETY	100%
580.000	LOT A, SECTION 127, DL 15, PLAN VIP 63529 PID 023-459-832	877 5TH STREET	BOYS AND GIRLS CLUB OF CENTRAL VANCOUVER ISLAND (LEASED FROM GOLDFINCH SMALL HOME DESIGN LTD)	100% OF THE ASSESSMENT ALLOCATED TO THE SPACE LEASED BY THE LEASEE
750.020	LOT 1, DL 127, CD, PLAN VIP62285	641 MENZIES AVENUE	COMOX VALLEY RECOVERY CENTRE SOCIETY (LEASED FROM CITY OF COURTENAY)	100%
1037.000	LOTS 1 AND 2, SECTION 41, CD, PLAN 3930	1415 CLIFFE AVENUE	COMOX VALLEY FAMILY SERVICES ASSOCIATION	100%
1200.000	LOT 1, SECTION 68, DL 15, PLAN 15512, PID 004-154-665	2040 CLIFFE AVENUE	COMOX VALLEY CANOE RACING CLUB (LEASED FROM CITY OF COURTENAY)	100% OF THE ASSESSMENT ALLOCATED TO THE SPACE LEASED BY THE LEASEE
1494.000 1494.010 1494.050	LOT 1 AND 2, SECTION 6 AND 8, CD, PLAN 2849, EXCEPT PLAN 35008 LOT A, SECTION 6 AND 8, CD, PLAN 35008	2470 BACK ROAD 2450 BACK ROAD	GLACIER VIEW LODGE SOCIETY	100%
1577.018	LOT 4, SECTION 16, PLAN VIS2269, PID 017-693-071	#4 - 204 ISLAND HWY N	COMOX VALLEY PREGNANCY CARE CENTRE	100%
2200.044	LOT 3, DL 138, CD, PLAN 20288	2564 CUMBERLAND ROAD	COURTENAY & DISTRICT HISTORICAL SOCIETY IN TRUST	100%

FOLIO	LEGAL DESCRIPTION	CIVIC ADDRESS	REGISTERED OWNER/LESSEE	PERCENTAGE EXEMPTION
3200.072	LOT A, SECTION 18, CD, PLAN 12735	4835 HEADQUARTERS RD	COMOX VALLEY CURLING CLUB	100%
757.000 757.001 758.000	LOT A, BLOCK 2, PLAN 1951 LOT A, BLOCK 2, PLAN 1951 EXCEPT PLAN 4288 & 4941 LOT A&B, PLAN 16907	1061 – 8TH STREET 1051 – 8TH STREET 635 PIDCOCK AVE	COMOX VALLEY KIWANIS VILLAGE SOCIETY	75%
1286.045	LOT 8, BLOCK 3, PLAN 16252	534 – 19TH STREET	L'ARCHE COMOX VALLEY	75%
88.000	LOT 85, PLAN VIP 311 SECTION 61, LD 15 EXCEPT PLAN 66BL PID 000-337-366	355 6TH STREET	AVI HEALTH AND COMMUNITY SERVICES (LEASED FROM ERNST VON SCHILLING)	40% OF THE ASSESSMENT ALLOCATED TO THE SPACE LEASED BY THE LEASEE
34.000	LOT 2, SECTION 61, CD, PLAN 20159 PID 003-698-254	231 6TH STREET	COURTENAY ELKS' LODGE #60 OF THE BENEVOLENT AND PROTECTIVE ORDER OF THE ELKS' OF CANADA	40%
131.002	LOT A, SECTION 61, PLAN EPP61970, PID 029-906-431	356 3RD STREET	COMOX VALLEY TRANSITION SOCIETY	40%
166.000	LOT 8 PLAN 2834 PID 003-451-941	267 3RD STREET	COMOX VALLEY CHILD DEVELOPMENT ASSOCIATION	40%
409.000	LOT A, SECTION 61, PLAN 1674, PID 001-159-526	625 ENGLAND AVENUE	COMOX VALLEY TRANSITION SOCIETY (LEASED FROM SECRET VENTURE HOLDINGS LTD)	40%
432.000	LOT 14, SECTION 61, LD 15, PLAN VIP3939 PID 004-154-894	A & C 450 – 8TH STREET	1124430 BC LTD (LEASED TO COMMUNITY JUSTICE CENTRE OF THE COMOX VALLEY)	40% OF THE ASSESSMENT ALLOCATED TO THE SPACE LEASED BY THE LEASEE

FOLIO	LEGAL DESCRIPTION	CIVIC ADDRESS	REGISTERED OWNER/LESSEE	PERCENTAGE EXEMPTION
459.000	LOT B, PLAN 20211 PID 003-519-376	956 GRIEVE AVENUE	UPPER ISLAND WOMEN OF NATIVE ANCESTRY	40%
461.050	LOT A, SECTION 61, DL15, PLAN 31213 PID 001-170-074	575 10TH STREET	JOHN HOWARD SOCIETY OF NORTH ISLAND	40%
750.100	LOT 1, PLAN VIP 62247 PID 023-241-667	994 – 8TH ST		
1113.000	LOT 19, SECTION 41, DL 15, PLAN 9230, PID 005-583-314	1465 GRIEVE AVENUE	L'ARCHE COMOX VALLEY	40%
1171.005	LOT C, PLAN 13660, SECTION 41, LD 15 PID 004-619-048	1625 MCPHEE AVENUE	WACHIAY FRIENDSHIP CENTRE SOCIETY	40% OF THE ASSESSMENT – *EXCLUDING* 26% OF FACILITY USED FOR REVENUE GENERATING BUSINESS (WACHIAY STUDIO AND MULTIMEDIA AND DAYCARE)
1171.006	LOT 5, PLAN 13075, SECTION 41, LD 15 EXCEPT PLAN VIP68431 PID 004-711-823	1679 MCPHEE AVENUE		
1175.034	STRATA LOT 13, PLAN VIS2667, SECTION 41, LD 15 PID 018-180-876	#13, 1520 PIERCY ROAD	DAWN TO DAWN ACTION ON HOMELESSNESS SOCIETY	40%
1224.080	STRATA LOT 26, PLAN VIS2232, SECTION 68, LD 15 PID 017-586-801	#17, 375 - 21ST STREET		
1288.004	STRATA LOT 30, PLAN VIS932, DL 104, LD 15 PID 000-806-161	#102, 1015 CUMBERLAND ROAD		
1288.060	STRATA LOT 30, PLAN VIS932, DL 104, LD 15 PID 000-806-471	#311, 1015 CUMBERLAND ROAD		
1700.332	STRATA LOT 2, SECTION 67, LD 15, PLAN VIS3934 PID 023-378-158	#10-12, 2683 MORAY AVENUE	THE CANADIAN RED CROSS SOCIETY (LEASED FROM 670431 BC LTD)	40% OF THE ASSESSMENT ALLOCATED TO THE SPACE LEASED BY THE LEASEE

FOLIO	LEGAL DESCRIPTION	CIVIC ADDRESS	REGISTERED OWNER/LESSEE	PERCENTAGE EXEMPTION
1960.004	LOT B, SECTION 67, CD, PLAN 33851 PID 000-262-170	#8, 468 - 29TH STREET	THE GOVERNING COUNCIL OF THE SALVATION ARMY IN CANADA (LEASED FROM LENCO/NORCO AND FERNCO DEVELOPMENT LTD)	40% OF THE ASSESSMENT ALLOCATED TO THE SPACE LEASED BY THE LEASEE
1960.006	LOT C, SECTION 67, CD, PLAN 33851 PID 000-217-158	2966 KILPATRICK AVE	AARON HOUSE MINISTRIES (LEASED FROM LENCO/NORCO AND FERNCO DEVELOPMENT LTD)	40% OF THE ASSESSMENT ALLOCATED TO THE SPACE LEASED BY THE LEASEE
2016.006	LOT 6, PLAN 27200 PID 002-344-408	1535 BURGESS ROAD	STEPPING STONES RECOVERY HOUSE FOR WOMEN (LEASE)	40%
2024.009	LOT 2 PLAN VIP53672 PID 017-650-097	1755 13TH STREET	HABITAT FOR HUMANITY VANCOUVER ISLAND NORTH SOCIETY	40% OF THE ASSESSMENT ALLOCATED TO THE SPACE USED FOR ADMINISTRATION OFFICES
3200.032	LOT A, SECTION 18, CD, PLAN VIP 75369 PID 025-673-017	4729 HEADQUARTERS RD	YOUTH FOR CHRIST COMOX VALLEY	40% OF THE ASSESSMENT – *EXCLUDING* CARETAKER RESIDENTIAL SPACE

Read a first time this 27th day of September, 2021

Read a second time this 27th day of September, 2021

Read a third time this 27th day of September, 2021

Finally passed and adopted this day of October, 2021

Mayor

Deputy Corporate Officer

CITY OF COURTENAY

BYLAW REFERENCE FORM

BYLAW TITLE

1) Tax Exemption 2022 Bylaw No. 3047, 2021
2) Tax Exemption Churches 2022 Bylaw No. 3048, 2021
3) Tax Exemption 2022-2031 Bylaw No. 3049, 2021

REASON FOR BYLAW

To consider three readings of the above permissive tax exemption bylaws for the 2022 taxation year.

STATUTORY AUTHORITY FOR BYLAW

Section 224 of the *Community Charter*

OTHER APPROVALS REQUIRED

STAFF COMMENTS AND/OR REPORTS

Bylaws are prepared in accordance with the September 7, 2021 Council approved list of recipients and prescribed exemption levels.

Final adoption required by October 29, 2021 to take effect for the 2022 taxation year.

OTHER PROCEDURES REQUIRED

Statutory Advertising required will be completed for two weeks prior to the expected final adoption of the bylaws on October 18, 2021.

September 27, 2021

A. Berard
Staff Member

THE CORPORATION OF THE CITY OF COURTENAY

BYLAW NO. 3048
A bylaw to exempt certain lands and improvements, set apart for public worship, from taxation for the year 2022

WHEREAS the Council of the Corporation of the City of Courtenay deems that land and improvements described herein meet the qualifications of Section 220 of the *Community Charter*;

NOW THEREFORE the Council of the Corporation of the City of Courtenay in open meeting assembled enacts as follows:

1. This bylaw may be cited for all purposes as **"Tax Exemption Churches 2022 Bylaw No. 3048, 2021"**.

2. Pursuant to Section 224(2)(a)(f)(g) of the *Community Charter*, the following properties on which a church hall or facility is situated, the land on which such a hall stands, the remaining area of land surrounding the building set apart for public worship, and the remaining area of land surrounding the exempted building, exempted hall, or both, are hereby exempted from taxation for land and improvements to the extent indicated for the year 2022 *except for that portion of the property used for residential or commercial purposes:*

	FOLIO	LEGAL DESCRIPTION	CIVIC ADDRESS	REGISTERED OWNER	PERCENTAGE EXEMPTION
1.	143.000	LOT AM 11, SECTION 61, CD, PLAN 33854N	467 – 4TH STREET	GRACE BAPTIST CHURCH OF THE COMOX VALLEY	100%
2.	313.100	LOT 1, SECTION 62, CD, PLAN VIP 74608	579 – 5TH STREET	ANGLICAN SYNOD DIOCESE OF B.C.	100%
3.	341.000	AMENDED LOT 1, PLAN 55886N, SECTION 61 CD, PLAN 4906	566 – 5TH STREET	ELIM GOSPEL CHAPEL TRUSTEES	100%
4.	342.000	LOTS 3 & 4, BLOCK 6, CD, PLAN 472B	576 – 5TH STREET	ELIM GOSPEL CHAPEL TRUSTEES	100%
5.	346.000	LOTS 10,11,12, AND 13, SECTION 61, CD, PLAN 4906	505 – 6TH STREET	ST. GEORGES CHURCH	100%
6.	568.000	LOT A (DD EL132291), DL 127, PLAN 1464 EXCEPT PLAN VIP67475	765 MCPHEE AVENUE	CENTRAL EVANGELICAL FREE CHURCH	100%
7.	618.220	LOT 1, DL 118, CD, PLAN VIP 73074	2201 ROBERT LANG DRIVE	RIVER HEIGHTS CHURCH SOCIETY	100%

	FOLIO	LEGAL DESCRIPTION	CIVIC ADDRESS	REGISTERED OWNER	PERCENTAGE EXEMPTION
8.	1074.050	LOT A, PLAN 54316P, SECTION 41, CD, PLAN 7449	1580 FITZGERALD AVENUE 1590 FITZGERALD AVENUE	GOVERNING COUNCIL SALVATION ARMY CANADA WEST	100%
9.	1166.000	LOT A, PLAN 121193EF, SECTION 41, CD, FORMERLY LOTS 32 & 33, CD, PLAN 10725	771 – 17TH STREET	TRUSTEES LUTHERAN CHURCH	100%
10.	1211.004	LOT 4, SECTION 68, CD, PLAN 14176	1814 FITZGERALD AVE	VALLEY UNITED PENTACOSTAL CHURCH OF BC	100%
11.	1524.102	LOT B, SECTION 15, CD, PLAN 54793 EXCEPT PLANS 14713, 36414, 51121	1599 TUNNER DRIVE	BISHOP OF VICTORIA, CHRIST THE KING CATHOLIC CHURCH	100%
12.	1594.000	LOT 16, SECTION 16, CD, PLAN 7037 EXCEPT PLAN 44368	1581 DINGWALL RD	TRUSTEES OF THE KINGDOM HALL OF JEHOVAH WITNESS	100%
13.	1691.030	LOT 1, SECTION 17, CD, PLAN VIP 79479	4660 HEADQUARTERS ROAD	SEVENTH DAY ADVENTIST CHURCH	100%
14.	1691.044	LOT 2, SECTION 17, CD, PLAN VIP 61425	4634 ISLAND HWY	ANGLICAN SYNOD DIOCESE OF BC	100%
15.	1691.046	LOT 3, SECTION 17, CD, PLAN VIP 61425	1514 DINGWALL ROAD	ANGLICAN SYNOD DIOCESE OF BC	100%
16.	2005.000	LOT 12, DL 96 & 230, CD, PLAN 1406	1901 – 20TH STREET	LDS CHURCH	100% EXCEPT THE PART ASSESSED FOR SCHOOL USE
17.	2017.034	LOT 1, DL 96, CD, PLAN VIP 59504	1640 BURGESS RD	FOURSQUARE GOSPEL CHURCH OF CANADA	100%
18.	2200.088	LOT A, PLAN 27596	2963 LAKE TRAIL ROAD	COURTENAY BAPTIST CHURCH	100%

Read a first time this 27th day of September, 2021

Read a second time this 27th day of September, 2021

Read a third time this 27th day of September, 2021

Finally passed and adopted this day of October, 2021

Mayor

Deputy Corporate Officer

CITY OF COURTENAY

BYLAW REFERENCE FORM

BYLAW TITLE

1) Tax Exemption 2022 Bylaw No. 3047, 2021
2) Tax Exemption Churches 2022 Bylaw No. 3048, 2021
3) Tax Exemption 2022-2031 Bylaw No. 3049, 2021

REASON FOR BYLAW

To consider three readings of the above permissive tax exemption bylaws for the 2022 taxation year.

STATUTORY AUTHORITY FOR BYLAW

Section 224 of the *Community Charter*

OTHER APPROVALS REQUIRED

STAFF COMMENTS AND/OR REPORTS

Bylaws are prepared in accordance with the September 7, 2021 Council approved list of recipients and prescribed exemption levels.

Final adoption required by October 29, 2021 to take effect for the 2022 taxation year.

OTHER PROCEDURES REQUIRED

Statutory Advertising required will be completed for two weeks prior to the expected final adoption of the bylaws on October 18, 2021.

September 27, 2021

A. Berard
Staff Member

THE CORPORATION OF THE CITY OF COURTENAY

BYLAW NO. 3049
A bylaw to exempt certain lands and improvements from taxation for the years 2022 - 2031

WHEREAS the Council of the Corporation of the City of Courtenay deems that land and improvements described herein meet the qualifications of Section 224 of the *Community Charter*;

NOW THEREFORE the Council of the Corporation of the City of Courtenay in open meeting assembled, enacts as follows:

1. This bylaw may be cited for all purposes as **"2022-2031 Tax Exemption Bylaw No. 3049, 2021"**.

2. The following properties are hereby exempt from taxation for land and improvements to the extent indicated for the years 2022 to 2031:

FOLIO	LEGAL DESCRIPTION	CIVIC ADDRESS	REGISTERED OWNER/LESSEE	PERCENTAGE EXEMPTION
467.000	PID 011-147-431	RAILWAY CORRIDOR	ISLAND CORRIDOR FOUNDATION	100%
467.100	PID 011-147-504	RAILWAY CORRIDOR	ISLAND CORRIDOR FOUNDATION	100%
613.100	PID 007-602-430	RAILWAY CORRIDOR	ISLAND CORRIDOR FOUNDATION	100%
1012.205	PID 024-488-208	RAILWAY CORRIDOR	ISLAND CORRIDOR FOUNDATION	100%
2154.000	PID 009-520-317 PID 024-478-539 PID 024-483-966 PID 011-147-555	RAILWAY CORRIDOR	ISLAND CORRIDOR FOUNDATION	100%
2154.001	PID 009-529-535	RAILWAY CORRIDOR	ISLAND CORRIDOR FOUNDATION	100%
2154.003	PID 011-078-189	RAILWAY CORRIDOR	ISLAND CORRIDOR FOUNDATION	100%
2154.013	LAND DIST 15	RAILWAY CORRIDOR	ISLAND CORRIDOR FOUNDATION	100%
1493.003	PID 028-006-089	1901 COMOX ROAD	PROJECT WATERSHED SOCIETY	100%
1493.005	PID 028-006-097	1901 COMOX ROAD	PROJECT WATERSHED SOCIETY	100%
1493.007	PID 028-006-101	1901 COMOX ROAD	PROJECT WATERSHED SOCIETY	100%

FOLIO	LEGAL DESCRIPTION	CIVIC ADDRESS	REGISTERED OWNER/LESSEE	PERCENTAGE EXEMPTION
1493.009	PID 028-006-119	1901 COMOX ROAD	PROJECT WATERSHED SOCIETY	100%
1566.000	LOT 1, PLAN 27169 SECTION 16, LD 15 PID 002-568-098	810 BRAIDWOOD ROAD	M'AKOLA HOUSING SOCIETY	100%
1960.300	LOT A, PLAN 15464 PID 004-144-279	SANDPIPER DRIVE	THE NATURE TRUST OF BRITISH COLUMBIA	100%
2023.014	LOT 1, SECTION 79, CD PLAN 8249, EXCEPT PLAN 8464, & EXC PCL A DD 666650 & EXC PID 005-497-264	656 ARDEN ROAD	THE NATURE TRUST OF BRITISH COLUMBIA	100%

3. The "2012-2021 Tax Exemption Bylaw No. 2802, 2014" is hereby repealed in its entirety.

Read a first time this 27th day of September, 2021

Read a second time this 27th day of September, 2021

Read a third time this 27th day of September, 2021

Finally passed and adopted this day of October, 2021

Mayor

Deputy Corporate Officer