


# 2026

# GREY BRUCE DRUG TOXICITY RESPONSE PLAN

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# LAND ACKNOWLEDGEMENT

We respectfully acknowledge that we live, work, and serve on the traditional territory of the Anishinaabek Nation, home to the Ojibway, Odawa, and Pottawatomi Peoples of the Three Fires Confederacy and the Saugeen Ojibway Nation, comprised of the Chippewas of Nawash Unceded First Nation and the Saugeen First Nation. These lands have been home to Indigenous Peoples for thousands of years and continue to be cared for today. We also honour the Métis peoples who share this land, whose stories, traditions, and lived experiences are part of the living spirit of this region.

We honour the enduring relationship that Indigenous Nations have with the land, waters, and communities throughout what is now known as Grey and Bruce Counties. We acknowledge the ongoing impacts of colonization, and we commit to truth, reconciliation, and meaningful action that builds respectful, reciprocal relationships with Indigenous communities. We are grateful to live and work in this territory and commit to learning from and with Indigenous Peoples, acknowledging the inequities they face and the responsibility we share to advance health equity and justice.

# A message from Grey Bruce Public Health

The Grey Bruce Drug Toxicity Response Plan reflects the collaboration between community partners, residents, and professionals across Grey-Bruce—signalling a shared commitment from all levels to respond collectively to large-scale overdose-related events that may affect our communities.

Since the Grey Bruce Opioid Response Plan was first introduced in 2019, the region has experienced continued growth and development in services for people who use substances. The unregulated drug supply has also changed, with the addition of various new and dangerous contaminants being found locally and provincially. To effectively support our communities, we must adapt to these emerging challenges. Updating and renaming the plan to the Grey Bruce Drug Toxicity Response Plan reflects this evolution.

Grey Bruce Public Health would like to extend our sincere gratitude and appreciation to everyone who has informed the development of this plan. Each organization and individual brought valuable perspectives, expertise, and experience. This strong collaboration and shared commitment to safe, equitable care have been essential in advancing efforts to reduce barriers to services for equity-deserving populations.

We also want to recognize the invaluable contributions of those with lived or living experience—thank you. Your willingness to speak openly, often in the face of stigma, helps others feel seen and understood. Your insights are vital in guiding more empathetic, dignified, and effective responses. Thank you for strengthening how we serve our communities.

This plan represents an important step, but our work continues. We remain committed to strengthening services, programs, strategies, and partnerships to respond effectively to the drug toxicity crisis and to help ensure our communities remain healthy, safe places to live, work, grow, and play.

**Dr. Ian Arra**
Medical Officer of Health & CEO
Grey Bruce Public Health

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# Introduction

The Grey Bruce Drug Toxicity Response Plan provides a framework to intervene early by providing timely and effective communication and mobilization in the event of concerning trends in opioid-related overdose rates or a substance-related emergency that has the potential to overwhelm local systems. This document lays out the Opioid Overdose Early Warning System and Incident Management System (IMS) and describes the roles and responsibilities of key partners to mitigate disruption, injury, and death in the community. The Response Plan includes an outline for effective communications for staff and the broader community and will assist in restoring the community to routine services post-emergency event.

This document was developed collaboratively by members of the Grey Bruce Community Drug and Alcohol Strategy (CDAS), representing a diverse range of organizations, sectors, approaches, and expertise. CDAS wishes to recognize community members whose lives are touched by substance use and honour the memory of those who have died. As a collective, CDAS aims to prevent and address harmful substance use with an understanding of both risk and protective factors and a balance of efforts across the four pillars of prevention, treatment, harm reduction, and justice (Grey Bruce CDAS, 2024). This comprehensive range of services and initiatives is needed in communities to support people at all points along the substance use spectrum. CDAS recognizes that it must focus on the immediate need to prevent drug-related deaths, while also working towards long-term solutions to support wellness for all (Grey Bruce CDAS, 2024). The membership and partners understand that harmful substance use and associated substance-related emergencies are best addressed through a social determinants of health lens, with anti-oppression, anti-racism, decolonial and trauma and violence-informed care approaches (Grey Bruce CDAS, 2024).

This document is limited to summarizing the short-term emergency response to a surge drug emergency and is not intended to be a comprehensive strategy to address and prevent substance-related morbidity and mortality. The CDAS membership recognizes and is actively pursuing longer-term interventions aimed at addressing stigma and improving access to housing, mental health and addiction supports, income, education, harm reduction services, and other basic needs that can protect people from harmful substance use (Grey Bruce CDAS, 2024).

# Definitions

**Overdose/poisoning/toxicity:** In this document, the following terms will be used interchangeably to attempt to benefit from all the intended meanings and minimize the unintended connotations of the terms.

- **Overdose** is commonly used to describe when a person is exposed to levels of drugs that exceed their body's tolerance (Canadian Community Epidemiology Network on Drug Use (CCENDU, 2025a); however, the term implies intentionality or carelessness on the part of the patient (Penington Institute, n.d.). Less than 3% of opioid-related deaths are intentional (i.e. suicide), leaving more than 97% accidental, a direct result of the highly toxic synthetic opioids, animal tranquillizers, and other sedatives that cause these deaths (Gomes et al., 2021).
- **Poisoning** - Using the term poisoning in place of overdose accurately reflects the state of the unregulated drug supply, but could present legal implications for the person who provided the substance to the patient (Penington Institute, n.d.).
- **Toxicity** – Using the term toxicity in place of overdose portrays the medical information about a drug emergency without laying blame on any person (Penington Institute, n.d.).

**Depressants** are a class of drugs that slow down brain activity and cause the muscles to relax (CATIE, 2022). Effects include pain management, euphoria, impaired concentration and coordination, and decreased breathing (CATIE, 2022). Examples include opioids (e.g. T3, morphine, fentanyl), alcohol, benzodiazepines, and tranquillizers (e.g. xylazine, medetomidine).

**Stimulants** are a class of drugs that raise levels of physiological or nervous activity in the body (CATIE, 2022). Examples include amphetamines (e.g. Adderall, crystal methamphetamine) and cocaine. Effects include increased energy and alertness, impulsiveness and paranoia (CATIE, 2022).

**Tolerance** refers to an individual's decreased response to a substance following repeated exposure to the substance (Health Canada, 2023). As tolerance increases, a larger amount or higher concentration of a substance is needed to elicit the intended effect (Health Canada, 2023). A person who develops physical dependence and then stops using may experience symptoms of withdrawal, which can make a person feel very unwell and impair daily functioning (Health Canada, 2023). Tolerance may build over a long period of time (months), but for some substances, returns to baseline (naivety) after short periods of abstinence (Health Canada, 2023). To mitigate risk if resuming use after a period of no use, a person should start with a very small amount.

**Fentanyl analogues** are similar to fentanyl in terms of chemical structure and effects (CCENDU, 2025b). Examples include but are not limited to flourofentanyl, methylfentanyl, and carfentanil. Most fentanyl analogues are illegally produced, and as a result, their potency and effects relative to pharmaceutical fentanyl are frequently unknown (CCENDU, 2025b). Novel, unidentified analogues continue to emerge (CCENDU, 2025b). Exposure to these substances is often accidental, as fentanyl analogues are mixed in or replace other opioids that individuals intend to use from the unregulated drug supply (CCENDU, 2025b).

**Regulated drug supply** refers to substances with standardized dosages and ingredients that are manufactured in regulated settings (UW Addictions, Drugs and Alcohol Institute (ADAI, 2022). Examples include prescription and over-the-counter medication, cannabis from authorized retail stores, and alcohol purchased under the authority of a liquor sales licence (ADAI, 2022).

**Unregulated (illegal) drug supply** refers to substances that are manufactured and/or distributed outside of regulatory systems (ADAI, 2022). Unregulated drugs do not have standardized production, packaging, or labelling, and the ingredients and potency are unknown (ADAI, 2022). The unregulated drug supply may include legal substances (e.g. diverted prescription medication) or illegal substances (e.g. crystal meth, illicitly manufactured fentanyl). In the unregulated opioid supply, other depressants are frequently found, such as xylazine, medetomidine, nonmedical benzodiazepines, and more (ADAI, 2022). This complicates overdose response and increases the risk of harm and death. Data also highlights the increasing involvement of stimulants in opioid toxicity deaths (Government of Canada, 2025). People who use stimulants may be exposed to unregulated opioids unintentionally, for example, if cross-contamination occurs during the production or mixing of the substance in an unregulated setting (ADAI, 2022). Even in small amounts, opioids can be life-threatening, especially for those who are opioid-naïve (ADAI, 2022). Additionally, qualitative research shows that people frequently use opioids and stimulants in combination to remain alert and counteract the sedation associated with the unregulated opioid supply (Ledlie et al., 2025). Using stimulants to counteract the sedating effects of unregulated opioids can lead people to overestimate their tolerance and use more opioids as a result, and this increases the likelihood of overdose (Ledlie et al., 2025). This is concerning, as naloxone, a medication which temporarily reverses opioid overdose and is widely available in communities, does not reverse the effects of stimulants or other non-opioid substances (Ledlie et al., 2025).

# Background

Significantly elevated numbers of opioid-related fatalities have been noted across Canada since the Public Health Agency of Canada began national surveillance a decade ago (Government of Canada, 2025). This tragedy is shaped by multiple factors and has had and continues to have a devastating impact on communities. In recent years, many regions have reported clusters of substance-related toxicities, and this has prompted municipalities, health system partners, and government agencies to develop plans to prepare for, respond to, and recover from these cluster events. These events threaten to overwhelm local systems and have the potential to result in disruption, injury, and death in the community.

Individuals may be exposed to substances through both prescription and non-prescription sources. All individuals using substances are at risk of toxic events.

Substances obtained through the unregulated market present a higher risk for fatal and non-fatal overdose. The unregulated opioid supply has become more unpredictable due to the presence of a combination of high-potency opioids, tranquillizers, and sedatives (CCENDU, 2025a). This poses a risk of complex overdose symptoms, including prolonged sedation and can increase the risk of long-term sequelae, such as hypoxic brain injury and related complications (CCENDU, 2025a).

**Typical and atypical opioid-related overdose presentations (not exhaustive)**

| Typical | Atypical |
|---|---|
| Breathing is slow, irregular or has stopped, with or without gurgling sounds or snoring | Chest wall and jaw rigidity |
| Blue/grey/green lips and/or fingernails | Whole body muscle stiffness/rigidity |
| Unconsciousness | Very slow heart rate |
| Unresponsiveness to shouting, shaking or painful stimuli | Involuntary muscle movement |
| Pale/dusty and clammy skin | Seizures |
| Pinpoint pupils | Prolonged sedation (sedated for an extended amount of time, after naloxone is administered and breathing has been restored) |

Adapted from Canadian Community Epidemiology Network on Drug Use (2025a)

In any overdose, medical monitoring is highly recommended (i.e. in a hospital). Prolonged sedation, even after restored respiration with naloxone, may require longer periods of observation (CCENDU, 2025a). This is especially critical because life-threatening symptoms may return after the effect of naloxone has worn off (CCENDU, 2025a).

The Harm Reduction team at Grey Bruce Public Health (GBPH) issues drug toxicity alerts to partners and community members when there is a cluster of suspected opioid-related overdoses reported or concern regarding the unregulated drug supply. Data is retrieved through the Grey Bruce Opioid Overdose Early Warning System. Data sources for this system are primarily EMS, in addition to Police, Fire, and the 211 Report a Bad Drug online form and call-in process.

# Early Warning System

The Opioid Overdose Early Warning System is in place to ensure timely monitoring and prompt communication of trends in opioid-related overdose rates. The system also identifies overdoses involving substances other than opioids, demonstrating that polysubstance use and increasing contamination of the unregulated opioid supply with tranquillizers and other sedatives are leading to substance-related harms (Ledlie et al., 2025). Through early identification, coordinated information sharing, and mitigating cluster events, this system directly supports the prevention of a mass casualty situation.

## Data Sources

GBPH monitors and reports to partners an increase over expected overdoses in a particular region or a change in the circulating substances in the community through monitoring and surveillance of:

- Paramedic Services Data: GBPH will receive a notification when Grey County and Bruce County Paramedic Services report an opioid-related event or other substance-related event of public health significance. This system is unique to Grey and Bruce and is the first of its kind in the entire province.
- Supportive Outreach Services (SOS) Drug Checking: Concerning or atypical results from the SOS mass spectrometer drug checking machine are forwarded to GBPH.

- Police Services Reports: GBPH will receive a notification when police services across Grey and Bruce Counties report an opioid-related event or other substance-related event of public health significance.
- Reports from community members via 211 Report a Bad Drug: Community members can submit information about an overdose or suspected toxic/contaminated drugs by calling or texting 211 or by using the online 211 Report a Bad Drug form.
- Reports from community members accessing local services.

GBPH issues an alert to community partners and the public when the thresholds listed below are met, indicating a significant risk of substance-related harm to the public.

## Threshold and Triggers

| Substance-Related Event | Response |
|---|---|
| **Overdose Cluster**<br>• 3 or more suspected overdoses within 48 hours, or<br>• 5 or more suspected overdoses within 5 days | **Drug Poisoning Alert**<br>• Email to distribution list including description of substance, atypical/life threatening effects, non-identifying details of geographic region, harm reduction messaging<br>• Attachments including poster format of drug alert, relevant harm reduction and naloxone posters, details of local outreaches and supports available |
| **Concerning Trend in Local Drug Supply**<br>• A situation that could result in substance-related harm to community members<br>**Loss of Life**<br>• 1 or more substance-related deaths that pose a risk to other community members | **Drug Poisoning Alert**<br>• (see above)<br>**Media Release (on a case-by-case basis)**<br>• May be released by GBPH on a case-by-case basis to reinforce reach and serious nature of the Drug Alert |
| **Significant Surge**<br>• A significant surge is determined to be markedly above normal trends in terms of number of substance-related casualties in a specific region or a situation or an impending situation that constitutes a danger of major proportions that could result in serious harm to persons, substantial damage to property, or potential to overwhelm local emergency services. | **Activate Incident Management System**<br>• Use associated decision-making guidelines to determine preliminary or full response |

GBPH also releases Quarterly and Annual Opioid Situation Reports summarizing relevant data from the above sources and providing brief comments on local trends.

The following supporting data is available with varying degrees of reporting lag time. Although this data does not contribute to real-time drug alerts or the processes outlined in this response plan, it supports the design and evaluation of substance-related initiatives and offers corroboration of information gleaned from real-time sources:

- Emergency Room (ER) Data: ER data is monitored for the following situations using the Acute Care Enhanced Surveillance System (ACES):
    1. OPI- “opioid intoxication, addiction, overdose, withdrawal” and
    2. TOX- “toxicology- not alcohol or opioids, withdrawal, substance abuse, chemical exposure”.
- Administrative Data: All Ontario hospitals are required to report cases of opioid poisoning presenting in their ERs. Data are reported to the Canadian Institute for Health Information, sent to the Ministry of Health and from there, disseminated to public health units. These data are lagged by two weeks and may change in the weeks and months following their release as ERs continue to submit and classify data. Unlike the real-time surveillance data, these data contain only verified cases of an opioid overdose.
- Substance Use and Harms Tool: Published by Public Health Ontario, this tool provides the most recent substance-related morbidity and mortality data, including ER visits, hospitalizations, and deaths (Public Health Ontario (PHO, 2025). Results can be viewed by the public health unit region, age, sex, and in some cases, drug type (PHO, 2025).
- Ontario Opioid Indicator Tool: Published by the Ontario Drug Policy Research Network (ODPRN, 2025), this tool provides public access to indicators of opioid use, opioid-related harms, and access to treatment and harm reduction in the province from 2012 onwards. For example, the number of opioid prescriptions and naloxone kits dispensed from pharmacies. Data are updated quarterly and are intended to complement the information provided by the Substance Use and Harms Tool (ODPRN, 2025).

# Activating the Incident Management System

The following section is based on the Grey Bruce Public Health (GBPH) 2025 Emergency Response Plan and the CATIE (2025) Crisis Response Guide.
The Incident Management System (IMS) is designed to give communities and organizations a common framework to communicate, co-ordinate, and collaborate during an incident response. It allows for the standardization of functions across organizations, which makes communication and cooperation among the groups easier and the process of managing an emergency more efficient. The system is flexible and scalable. It is organized into roles that make up a team structure. The team is known as the Incident Management Team (IMT).

In the event of a significant surge in substance-related harms, an assessment may be done to determine if activation of the Incident Management System is required. This assessment may be done by any partner agency or relevant group of agencies and should be based on the following:

- Does the incident put the safety of people at risk?
- Is the incident likely to interfere with normal operations for a prolonged period?
- Is the incident likely to escalate if no action is taken?
- Will the incident likely result in negative media/social media attention?

Upon determination to initiate IMS, the following should take place:

1. Roll call – Ensure necessary parties are present.
2. Establish facts – Identity full scope of incident (may use the Appendix 3: Incident Summary Form).
3. Define objectives – Determine the parameters of a successful crisis response.
4. Select response option – Consider the options available and select the most appropriate course of action.
5. Assign roles – Delegate tasks necessary to achieve the chosen response option (IMS roles are outlined below).
6. Initiate response and set check-in intervals.

Personnel for the IMS roles will be determined based on the specific emergency and the knowledge, skills, and expertise needed to respond effectively.

# Incident Management System (IMS) Roles

Each of the following roles provides a key management function for the emergency response. Only those sections required for the emergency response are activated. Sections can be activated and deactivated multiple times during an incident. The person who makes this decision regarding opening or closing sections is the Incident Manager. These roles may be fulfilled by different organizations as the emergency dictates.

**Incident Command**
The Incident Command (or Incident Manager) role oversees the incident. This role may be filled by a person or team. The Incident Command is chosen based on the specific nature and needs of the incident and the expertise of the organizations involved. Often, the first responder on scene assumes the role of Incident Command initially, but this role can be transferred if a more experienced or appropriate responder becomes involved. The Incident Command has ultimate responsibility for the development of an incident action plan, allocation of resources, and ensuring that the necessary roles are carried out. This role is provided with information, advice, and counsel from the Incident Management Team for the roles that have been activated. Other command staff may include:

- A scribe who takes notes during meetings and teleconference calls, documents key activities, events, agreements, and any matters of potential legal significance throughout an incident.
- A safety officer is responsible for creating systems related to the overall health and safety of all incident responders.

**Communications**
Communications also fall under the Incident Command role. This role is responsible for ensuring that appropriate information is provided to the public and media and that required information is provided to the Incident Management Team and staff working on the emergency. Information must be accurate, timely, and consistent across agencies. The individual in the Communications role frequently serves as the official spokesperson for the incident or may brief or assist the Incident Command when preparing for a press conference or other major information session. The communication role may be split to include:

- An emergency information officer who is responsible for developing and releasing emergency information to the public and media, with approval from the Incident Command.
- A liaison officer who serves as the primary contact for the partner organizations cooperating with or supporting the incident response.

**General Staff**
The general staff often consists of the operations, planning, logistics, and the finance section leaders. The general staff support the Incident Command in a variety of ways to coordinate, plan, and implement the response.

**Operations**
This role ensures the implementation of the specific tasks and objectives that need to be done to accomplish the goals of the response. This role manages the “front line” response.

**Planning**
The purpose of this role is to organize data, make projections and forecasts about the event, and report the information to the Incident Command to deal with future issues. The role is responsible for prioritizing staffing to deal with the emergency and all ongoing essential services. The role assists the Incident Command with the establishment of an Incident Action Plan (IAP). The information from Planning enables the Incident Command to make decisions about ramping up or contracting services. While plans are made to respond to the emergency, the person in this role also determines which day-to-day services are essential and which can either be reduced or temporarily suspended.

**Logistics**
The Logistics role provides support to the functions that have been activated so that the work can be accomplished. Logistics acquires and sets up the supports that are needed for Operations to function effectively.

**Finance**
Finance has several key responsibilities. These include ensuring that a contractual and financial process is in place for emergency procurement of supplies and tracking of resources that are expended during the response (in anticipation of recouping costs during the recovery phase of the event). The role assists Logistics with the procurement and setting up of internal and external facilities.

# Sector-Specific Roles

The following section was adapted with permission from the Community Drug Strategy for the City of Greater Sudbury's Opioid Poisonings Response Plan (2019).

Sector-specific roles represent routine roles and responsibilities that would be enhanced to support the core function of the IMS in the emergency response.

## Cross-Sector Roles

All organizations are expected to support the communication plan provided by the communication lead.

Any organizations who provide naloxone and/or harm reduction supplies should promote these items to clients who use drugs and their friends, family, and support networks, with a focus on providing harm reduction education and promoting drug testing services.

All organizations that work with people who use substances should endeavor to collect and collate information from clients, determine whether the suspected substance(s) are from a common source, and share this information with partners.

### A. Health Services

**Public Health**

- Enhance collection and analysis of substance-related morbidity and mortality data from partners, the public, and people with lived and living experience of substance use on an ongoing basis and communicate any aberrations of concern in surveillance data to the Incident Command, Ministry of Health, and Public Health Ontario.
- Share relevant data through situation reports, email and social media alerts, etc.
- Ensure availability of needle syringe and naloxone programs.
- Scale-up naloxone training and distribution to community partners and the public where needed.
- Provide enhanced support to partner agencies that provide harm reduction supplies and education to provide relevant information and training.

**Acute care (i.e. emergency departments)**

- Provide emergency healthcare to individuals experiencing a substance-related emergency and offer rapid addiction medicine therapy and/or referral to community treatment and support, as per client-identified goals.
- Prepare for surges in emergency department visits and ensure the availability of intensive care unit beds and naloxone.
- Rapidly communicate suspected drug poisoning surges to local, regional, and provincial public health authorities and relevant agencies as part of the hospital disaster plan.
- Connect with other hospitals and the Ontario Health Team (OHT) to coordinate cross-jurisdictional mutual aid as needed.

**Outreach Services**

- Provide detailed drug testing using a mass spectrometer. Coordinate rapid communication of drug test findings to front-line peers and partner organizations.
- Provide addiction medicine therapy and/or referral to community treatment and support, as per client-identified goals.
- As applicable, be present in the geographic location of the cluster and provide wrap-around support to clients and their support systems.
- Primary health, mental health and addictions services.
- Ensure availability of needle syringe and naloxone programs.
- Provide addiction medicine therapy and mental health and addictions services.
- Coordinate rapid referral pathways as able.

**First Nations health services**

- Provide on-reserve care services.
- Ensure availability of needle syringe and naloxone programs.
- Provide or ensure the provision of addiction medicine therapy and mental health and addictions services.
- Provide physical space for identified emergency measures, if required.
- Collaborate with Band Councils and Indigenous leadership tables for decision-making.

**Pharmacies**

- Scale-up naloxone training for community members.
- Provide real-time observations regarding unusual prescription trends, supply needs, etc.
- Assist with the provision of addiction medicine.

**Grey Bruce Ontario Health Team (OHT)**

- Notify health service providers about confirmed or suspected presence of high-risk drug formulations in the community through e-mail communications and encourage sign-up for alerts from Grey Bruce Public Health.
- Interpret provincial, national, and international data for relevance to the local context and communicate this information to the Incident Command.
- Report local data and contribute any analytic or interpretive insights related to this information to the Incident Command and/or to the Ministry of Health as required.

## B. Emergency First Responders

**Paramedic services**

- Provide primary and advanced paramedicine care.
- Prepare to respond to a surge in call volume and naloxone requirements.
- Connect with paramedicine partners for assistance and resources as needed.
- Enhance timely reporting of substance-related calls to GBPH, flagging trends as able.
- Participate in community education and outreach.

**Police services**

- Initiate an investigation to determine the source of high-risk drug formulations involved.
- Support paramedic services and/or perform scene management as needed.
- Transport samples of drugs to be tested to the Supportive Outreach Services team.

**Fire services**

- Support emergency first-response partners by providing emergency first aid and scene management.
- Provide Hazardous Materials (HazMat) services and support if required.

## C. Other Services

**Education**

- Each school board will notify their respective school community members about the confirmed or suspected presence of high-risk drug formulations in Grey Bruce, as appropriate.
- Provide access to grief, trauma, and crisis counselling supports for students after a toxic event, in collaboration with school-based mental health workers.

**County and municipal partners**

- Provide support for scene/incident management.
- Provide physical space for identified emergency measures, if required.
- Provide assistance with coordination of housing, shelter, and outreach resources during prolonged surges.

**Regional supervising coroner**

- Activate mass fatality plan if necessary.
- Coordinate forensic pathology, body removal services, and funerary preparations as necessary.
- Inform the Incident Command of findings and ongoing events related to suspected and/or confirmed drug poisoning mortality.

**Youth and family services**

- Provide access to grief, trauma, and crisis counselling supports for youth and families impacted by the toxic event.

# Communications

All organizations are expected to support the communication plan to ensure that appropriate information is provided to the public and media. Timely, accurate, and consistent messaging across agencies is essential (CATIE, 2025). In a situation requiring IMS response, the following are guiding principles for effective public communication. The two primary target audiences for communication are individuals who use drugs and the public, but the same communication principles apply to both groups.

**Communication Principles:**

- **Immediate initiation of communication is essential.** It is critical to ensure people who use drugs are quickly made aware of potential dangers to keep themselves and their communities safe. In addition, withholding information may result in further issues compounding the situation, loss of control over the story, or the spread of misinformation (CATIE, 2025).
- **Communicate the facts as known.** Information should be updated as available with transparency about what is known and not yet known (CATIE, 2025). Narratives should be framed in a way that does not stigmatize an area or a group of people (CATIE, 2025).

- **Use appropriate language.** Terms such as “potent”, “powerful”, “strong” should be avoided in communications with the public about the toxicity of a substance. Instead, use words that imply risk when describing substances such as “dangerous”, “toxic”, or “lethal”.
- **Acknowledge the grief and loss experienced by community members, while avoiding sensationalizing the event.**
- **Contribute to community reassurance messaging following the event.** Outline next steps, follow up and prevention plans, available services, etc.

# Plan Demobilization & Debrief

This plan will be demobilized after:

1. Surveillance data indicate that incidence of drug poisoning has returned to a ‘stable’ baseline; and/or
2. The activities can be carried out by appropriate organizations on a longer term.

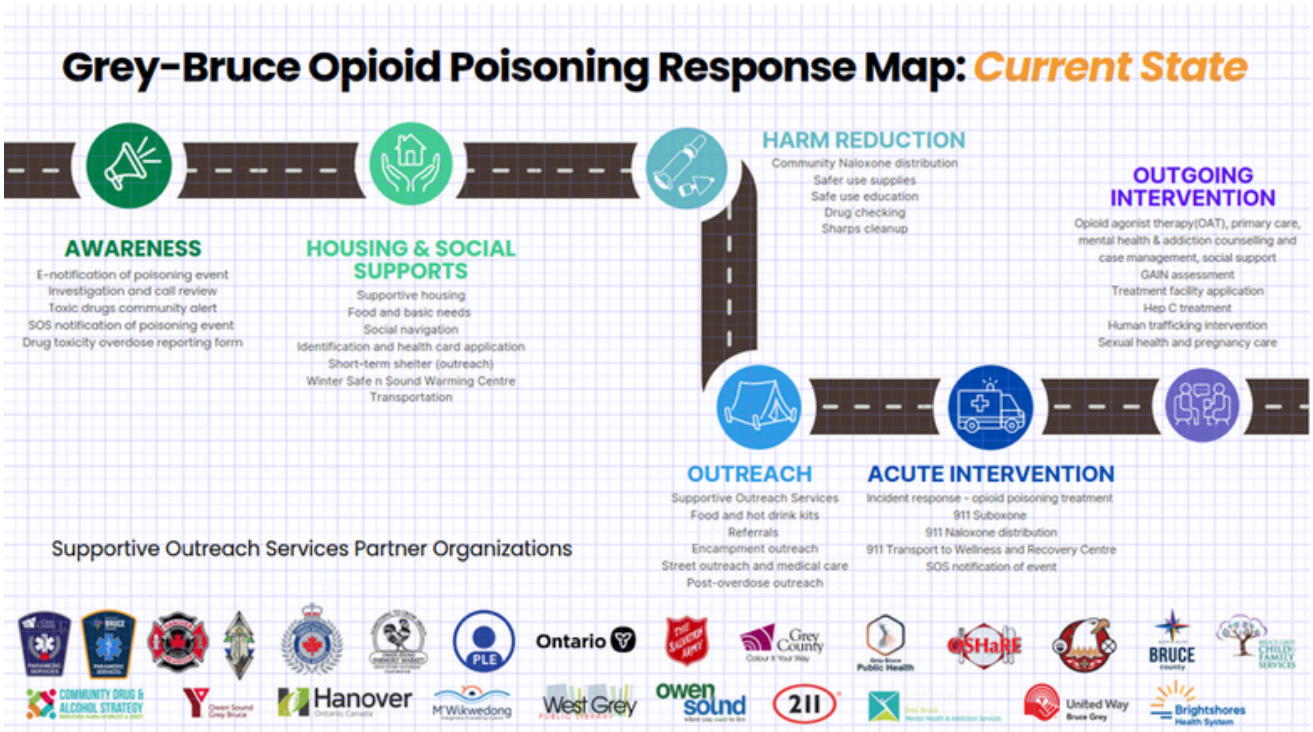
The IMS team, community partners, and the public will be notified that the plan has been demobilized.

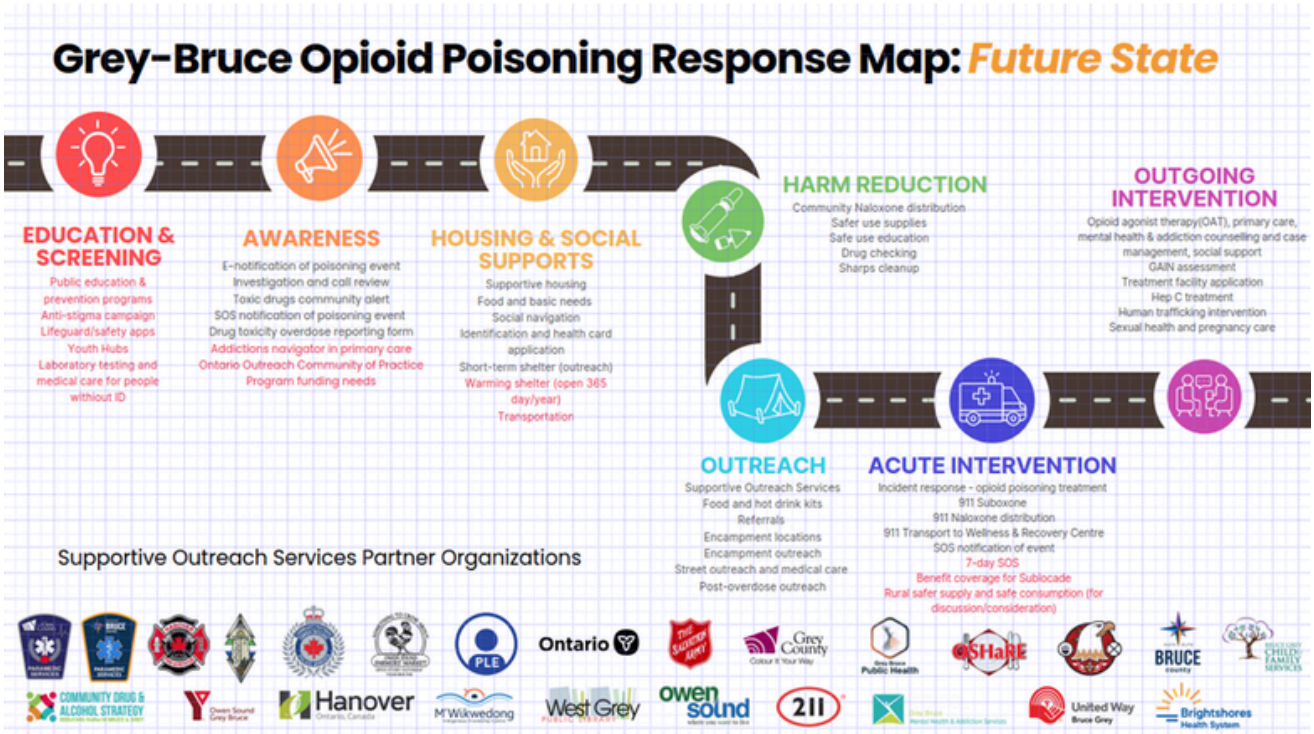
A debriefing will occur following plan demobilization. Efforts will be made to include members of equity deserving populations in the debrief process. The debriefing will review the incident, the decisions made, and actions taken and will include an evaluation component.

# Appendices

- Appendix 1 - Grey Bruce Opioid Poisoning Response Map
- Appendix 2 - Drug Alert Package (sample statement, associated resources)
- Appendix 3 - Incident Summary Form
- Appendix 4 - Communications Sample Statements
- Appendix 5 - Communications Scripts for Staff Responding to Calls
- Appendix 6 – Contact Logs

# Appendix 1 - Grey Bruce Opioid Poisoning Response Map 2024



## Appendix 2 - Drug Alert Package

The following is an email template to be used when issuing a drug alert.

Hi everyone,

Grey Bruce Public Health has been notified of [#] suspected drug poisonings, including [#] fatality, that occurred [timeframe] in [municipality]. The suspected substances were [XXXX], and [ROA] was the route of administration.

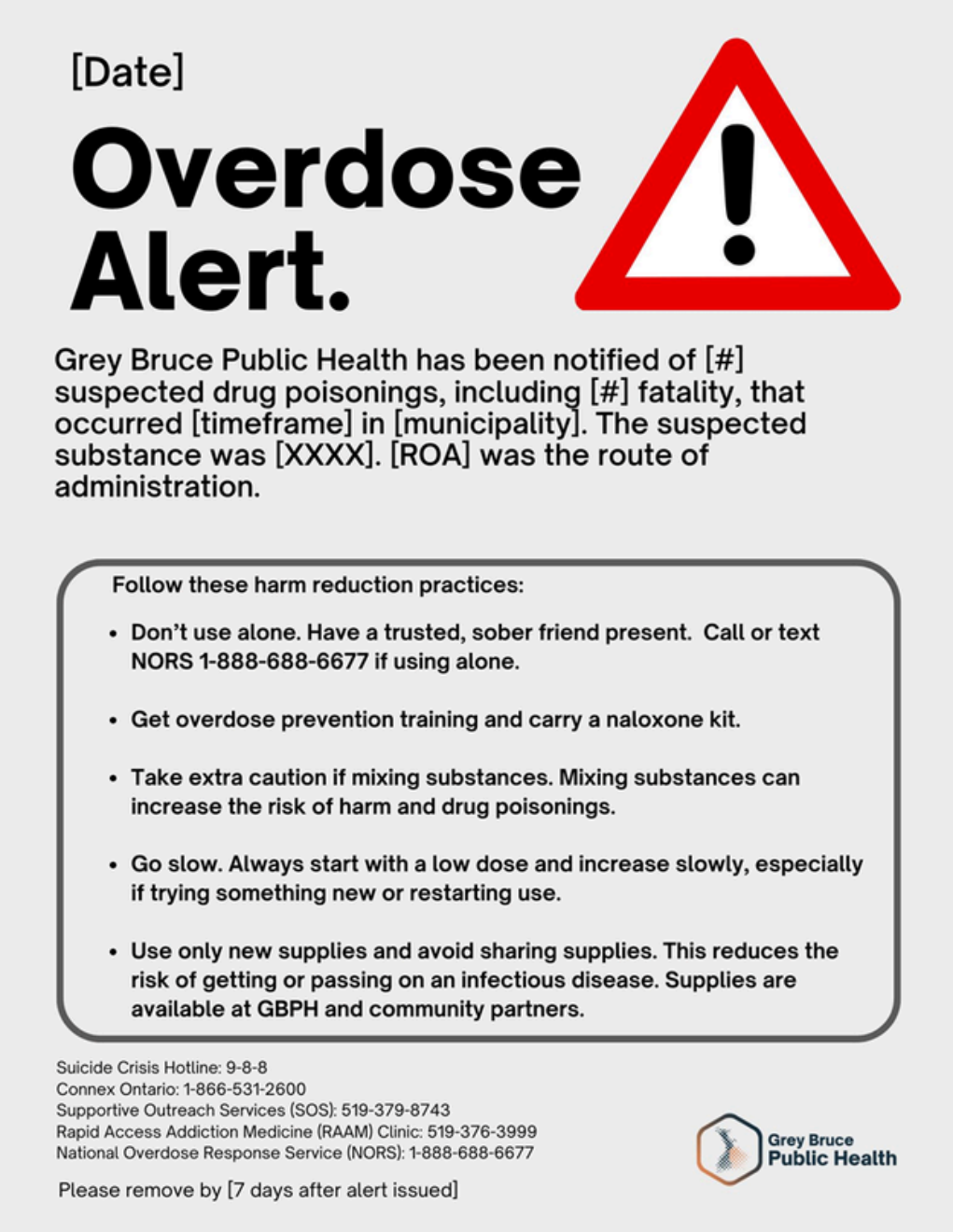
Please encourage all people who use drugs to have naloxone on hand and to always have a sober friend with them who can administer naloxone and call 911 in case of an overdose. Naloxone is available at pharmacies, participating community partners, and at Grey Bruce Public Health Mon-Fri, 8:30 am to 4 pm, no appointment needed. Please post the attached overdose alert for 7 days **(remove by [date])**.

**The next SOS fixed site event is [date] at [location] from [time]. The next Bruce County outreach is [date] at [location] from [time].**

<u>Please share the following harm reduction strategies to ensure people who use drugs do so as safely as possible:</u>

- Avoid using alone.
  - When using with someone else, avoid using at the same time
  - Call or text the National Overdose Response Service (NORS) at 1-888-688-6677 or download and use the Brave App if you must use alone
- Take extra caution if mixing substances. Mixing substances can increase the risk of harm and drug poisoning.
- Go slow. Always start with a low dose and increase slowly, especially if trying something new or restarting use.
- Use only new supplies and avoid sharing supplies. This reduces the risk of getting or passing on an infectious disease. Supplies are available at GBPH and community partners.
- Get overdose prevention training & carry a naloxone kit.
- Get your drugs tested. Call/text SOS at 519-379-8743. Drug test kits are available from GBPH and community partners.

The following is a sample drug alert poster.



[Date]

# Overdose Alert.

Grey Bruce Public Health has been notified of [#] suspected drug poisonings, including [#] fatality, that occurred [timeframe] in [municipality]. The suspected substance was [XXXX]. [ROA] was the route of administration.

**Follow these harm reduction practices:**

- **Don't use alone. Have a trusted, sober friend present. Call or text NORS 1-888-688-6677 if using alone.**
- **Get overdose prevention training and carry a naloxone kit.**
- **Take extra caution if mixing substances. Mixing substances can increase the risk of harm and drug poisonings.**
- **Go slow. Always start with a low dose and increase slowly, especially if trying something new or restarting use.**
- **Use only new supplies and avoid sharing supplies. This reduces the risk of getting or passing on an infectious disease. Supplies are available at GBPH and community partners.**

Suicide Crisis Hotline: 9-8-8
Connex Ontario: 1-866-531-2600
Supportive Outreach Services (SOS): 519-379-8743
Rapid Access Addiction Medicine (RAAM) Clinic: 519-376-3999
National Overdose Response Service (NORS): 1-888-688-6677

Please remove by [7 days after alert issued]

Grey Bruce Public Health

Additional attachments for drug alert may include, but are not limited to:

1. Outreach calendars (SOS, Bruce County Outreach)
2. GB Works (Needle Syringe Program) brochure
3. Grey Bruce OHT Mental Health & Addiction Drop-Ins poster
4. Naloxone poster
5. Polysubstance use chart
6. Tips for talking with people who use drugs

# Appendix 3 - Incident Summary

## Initial Scan by Incident Manager or Designate

| **Situation Summary:**<br>*Use this form to get an initial summary of the situation and as a guide during briefings to ensure you have key updates.* | |
|---|---|
| **Question/Consideration** | **Known Information** |
| Nature of incident (what, where, when, how)? | |
| How did you learn about the incident? | |
| Is the incident unique to your jurisdiction? | |
| Will the incident interfere with normal operations? | |
| Are there any external factors/events that might impact the incident? | |
| Are external partners expected to make statements relevant to the incident? | |
| Who else is aware of the incident (e.g. regulators, emergency responders, care holders, employees)? | |
| Has a similar situation happened to in your region before? | |
| Is there media interest? | |
| Are there conversations/reports on social media? | |
| Date/Time: | Name: |

Source: CATIE, Anti-Stigma Toolkit, Crisis Response Guide: https://www.antistigma.ca/

# Appendix 4 - Communications Sample Statement

**Sample Statement**

On (date) at (approximate time), there was a (describe mass casualty incident) at (location).

Emergency services responded promptly to the scene following reports of (brief description of the incident, e.g. number of people, symptoms).

As of [latest time], [number] individuals have been confirmed [injured/deceased], and [number] have been transported to area hospitals. The identities of the victims are being withheld pending notification of next of kin.

This is a tragic situation.

[in case of fatality] We extend our sincere condolences to the family and friends of the deceased. They are in our thoughts at this very difficult time.

[In case of injury] We wish the individuals a swift recovery, and we are committed to doing whatever we can to assist them.

The Incident Management System has been put in place to ensure a coordinated response across health, social, and enforcement sectors.

Emergency responders, including [list agencies involved], remain on the scene. We are looking into what happened and how we can prevent an incident like it in the future. More information will be provided as it becomes available.

GBPH advises that all street drugs should be deemed highly toxic and potentially fatal. People who use unregulated drugs are at significant risk of overdose due to high-potency opioids being mixed with sedatives and other tranquilizers. This combination complicates overdose response and increases the risk of harm and death.

Grey Bruce Public Health (GBPH) urges everyone who uses unregulated drugs to exercise extreme caution and always practice harm reduction strategies, which include:

- **Not using alone.** GBPH urges people to have a sober friend with them when using drugs or to contact the National Overdose Response Service (NORS) or use/download the BRAVE App if using alone. NORS can be reached by calling or texting 1-888-688-6677. A NORS operator will stay on the line with the person while the drug is used. In the event the person becomes unresponsive, NORS will call 911 to ensure help arrives.
- **Taking extra caution if mixing drugs.** Mixing drugs, including with alcohol, increases the risk of harm and overdose.
- **Going slow.** Always start with a low dose and increase slowly, especially if trying something new or restarting use.
- **Using only new supplies and avoid sharing supplies.** This reduces the risk of getting or passing on an infectious disease. Supplies are available at GBPH and community partners.
- **Getting overdose prevention training and carrying a naloxone kit.** Naloxone is available for free at most local pharmacies and at GBPH, Monday to Friday, 8:30 a.m. to 4 p.m. No appointment or prescription is needed.

GBPH encourages people who use unregulated drugs to use drug test kits in conjunction with other harm reduction strategies. Drug test kits may be available from Public Health and several community partners, including Safe ‘N Sound, Supportive Outreach Services, Canadian Mental Health Association (CMHA) Grey-Bruce, and the South East Grey Community Health Centre.

The Supportive Outreach Services mobile team offers detailed drug-checking services, providing information about what substances are present in a sample and how much. The team can be reached at 519-379-8743 from 8:30 a.m. to 6 p.m. daily.

Overdose is a medical emergency. Call 911 or go to the Emergency Department. The Good Samaritan Drug Overdose Act provides protection from simple possession charges for everyone at the scene when 911 is called for an overdose.

For additional supports and services:

- Suicide Crisis Helpline: 9-8-8
- Connex Ontario: Call 1-866-531-2600 or text 247247
- Ontario Addiction Treatment Service (OATC): 519-371-0007
- Withdrawal Management/RAAM Clinic: 519-376-5666
- G&B House: 519-371-3642 ext.1580
- CMHA Grey Bruce Mental Health and Addiction Services: 519-371-3642
- Rapid Access Addiction Medicine (RAAM) Clinic: 519-376-3999
- National Overdose Response Service (NORS): 1-888-688-6677
- If unsure – call 211

Source: CATIE, Anti-Stigma Toolkit, Crisis Response Guide: https://www.antistigma.ca/

## Appendix 5 - Communications Scripts for Staff Responding to Calls

**Employees Who Receive Media Calls**

- In the event of a crisis, you should expect media calls or requests for information. Remember to refer all media calls to [insert name of Communications Lead].
- Be calm and polite, but firm.
- Identify the caller using the following script:
  *Thank you for your call. How may I help you?*
  *Are you calling form a media outlet or other organization?*
- For media, collect the following information:
  - Name
  - Name of outlet (i.e. publication, radio station, TV station, etc.)
  - Telephone number
  - Email address
- For general public calls, use the following scripts:
  *Thank you for calling. [Insert organization name] is managing the situation. We will provide updates on our website [insert website address] and to the media as soon as we have more information to report (add relevant key messages as necessary).*
- The IMS team should use standard contact logs for all public inquiries – see Appendix 6.

Handling Media Who Arrived Unannounced

- If media arrive at your facilities, greet them politely as you would any visitor. Use the following script:
- How may I help you? Can I please have your name and the name of your media outlet? Please wait here while I call someone to assist you.
- Notify IMS lead.
- Advise media that you are not authorized to speak on behalf of your organization but would be happy to connect them with the designated spokesperson for the incident.
- Keep the person in a location near you where you can see them. Do not leave reporters, TV cameras, or photographers unattended.

Source: CATIE, Anti-Stigma Toolkit, Crisis Response Guide: https://www.antistigma.ca/

## Appendix 6 - Contact Logs

**External Contact Log**

| Name/ organization | Contact information (phone/email) | Summary of call | Initials | Date/time of contact | Follow-up required |
|---|---|---|---|---|---|
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Source: CATIE, Anti-Stigma Toolkit, Crisis Response Guide: https://www.antistigma.ca/

## Media Contact Log

| | | |
|---|---|---|
| **Name of contact** | | |
| **Name of outlet** | | |
| **Contact information (phone, email)** | | |
| **Media deadline** | | |
| **Inquiry method** | | |
| **Date/time of contact** | | |
| **Summary of discussion, questions** | | |
| **Follow-up (if required)** | | |
| **Status** | Active | Complete: |
| | Date: | Time: |
| | Name: | |

Source: CATIE, Anti-Stigma Toolkit, Crisis Response Guide: https://www.antistigma.ca/

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