

# **'We are the first responders': overdose response experiences and perspectives among peers in British Columbia**

Zahra Mamdani, Jackson P. Loyal, Jessica Xavier, Bernie Pauly, Emma Ackermann, Skye Barbic, Jane A. Buxton, & Alissa Greer  
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## 'We are the first responders': overdose response experiences and perspectives among peers in British Columbia

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### ABSTRACT

**Aims:** Peers, i.e. people with lived/living experience of substance use, are at the forefront of harm reduction initiatives in British Columbia, yet they often lack recognition for their contributions. This study aims to understand the role of peers in overdose response settings and their experiences interacting with emergency service providers (ESPs) within the context of the *Good Samaritan Drug Overdose Act (GSDOA)*.

**Methods:** Telephone interviews were conducted with 42 people aged 16 years and older, who were likely to witness and respond to overdoses. Participants were asked about their experiences witnessing or responding to overdoses, and interactions with ESPs. Interview transcripts were analyzed thematically.

**Findings:** Peers were often the first to respond to overdoses due to their positioning and saw themselves as having unique expertise in responding to overdoses and connecting with other people who use substances. However, peers perceived several barriers that impacted their ability to respond, including stigmatizing attitudes toward ESPs, lack of recognition, and lack of adequate resources.

**Conclusions:** While policies, such as the *GSDOA* are in place to promote calling 9-1-1, peers feel confident and competent in responding to overdoses and often consider calling 9-1-1 a waste of resources. There is a need to better recognize and support peers as first responders in overdose contexts.

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## Background

Illicit drug overdose is the leading cause of unintentional death in British Columbia (BC), Canada (BC Coroners Service, 2021). In 2016, the BC government declared a public health emergency due to the unprecedented increase in illicit drug toxicity deaths (BC Gov News, 2016). The onset of the second public health emergency in BC in March 2020 related to COVID-19 has compounded the effects of the drug toxicity crisis; in 2021, 2224 suspected illicit drug toxicity deaths were reported, surpassing every annual death toll on record (BC Coroners Service, 2021).

In response to the increasing drug toxicity deaths over the years, programs, such as the Take Home Naloxone program and overdose prevention services were established to address overdose risks (BC Centre for Disease Control & Provincial Health Officer, 2019). The Take Home Naloxone program aims to train individuals at risk of witnessing or experiencing an opioid overdose to recognize an opioid overdose and respond by administering the opioid antagonist, naloxone (Moustaqim-Barrette, Dhillon, et al., 2021). Overdose prevention services provide spaces for people to use previously-obtained illegal substances with sterile equipment, in settings where they can be observed

and others can quickly intervene in the event of an overdose (Wallace et al., 2019). Between April 2016 and December 2017, an estimated 3,030 death events were averted as a result of these interventions (Irvine et al., 2019). An important component that is promoted during naloxone training is calling 9-1-1. Yet, in BC, between 2015 and 2017, 9-1-1 calls occurred in only 55.7% of overdose events (Karamouzian et al., 2019). In 2017, the Good Samaritan Drug Overdose Act (GSDOA) was enacted by the Canadian government to promote calling 9-1-1 by legally protecting the caller, the person experiencing an overdose, along with any bystanders at the scene of an overdose against charges for possession of drugs for personal use as well as breaches of conditions related to personal drug possession (Government of Canada, 2019). Similar legislation, i.e. drug-related Good Samaritan Laws providing legal protections for personal drug possession, has been implemented in many states in the United States of America, with some variation across jurisdictions (Prescription Drug Abuse Policy System, 2021). While the evidence is mixed around the effectiveness of Canada's GSDOA in encouraging people to call 9-1-1 (Jakubowski et al., 2018; Moallem et al., 2021; Watson et al., 2018) and reducing concerns about police presence (Butler-

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McPhee et al., 2020; Koester et al., 2017; Latimore & Bergstein, 2017; Tesfaye Rogoza et al., 2020; Wagner et al., 2019), it is important to note that the reasons behind peoples' decision not to call 9-1-1 in the event of an overdose are multi-faceted. Decriminalization, at and outside of overdose events, may reduce concerns around being charged for personal possession and stigma toward substance use. However, these policies are not designed to address larger systemic issues around defining roles in the crisis and appropriate resource allocation. In addition, decriminalization does not address the root cause of the crisis—the contaminated, toxic supply.

People with lived/living experience of substance use, commonly referred to as peers<sup>1</sup> (also sometimes called experiential workers, and lived experience experts) are at the forefront of harm reduction policies, advocacy, program development, and implementation (Bardwell, Kerr, et al., 2018; Gillespie et al., 2018; Greer, 2019; Kennedy et al., 2019; Wagner et al., 2014) and are important actors in overdose response initiatives in BC (Law, 2018; Smart, 2018). In this context, peers are those with past or present drug use experience who use that lived/living experience to inform their professional work (Greer et al., 2016). Peers work in a variety of settings in BC, including shelter and housing agencies and overdose prevention services (Greer et al., 2016). Drawing on their lived experiences and expertise, peers are involved in responding to overdoses, distributing harm reduction supplies, providing outreach, witnessing substance use, conducting peer-to-peer debriefing, and providing referrals to external services (i.e. systems navigation) (Greer et al., 2021).

Research has indicated that peers are both practically and socially competent in responding to overdoses using naloxone (Neale et al., 2019). In fact, some studies show that the lived/living experience of peers who administer naloxone during overdose events is as crucial to the success of overdose prevention as the pharmacological potency of naloxone (Faulkner-Gurstein, 2017). Peer involvement in harm reduction services engenders a sense of safety, and feelings of trust and support such that people who use substances prefer services attended to by peers (Bardwell, Kerr, et al., 2018). Simultaneously, peers derive a sense of purpose from their involvement, and feel empowered and connected to their community (Marshall et al., 2017). When responding to an overdose using naloxone, peers benefit from strengthened relationships and a sense of community and feel proud and heroic for saving lives (McAuley et al., 2018; Pauly et al., 2021; Wagner et al., 2014). Peers are well positioned to intervene in the event of an emergency, and in the context of increasingly available naloxone, responsibility for addressing overdose harms has often shifted to them (Farrugia et al., 2019; McAuley et al., 2018; Olding, Boyd, et al., 2021). Peers often act as a bridge between other people who use substances and harm reduction programs and services, promoting accessibility and acceptability of services (Greer et al., 2016; Pauly et al., 2021). Programs and services led by peers can be more responsive to the needs of the community and more accessible because of the trust and connection that peers share with other people who use substances (Bardwell, Anderson, et al., 2018; Greer, 2019; Harris & Larsen, 2007; Kennedy et al., 2019; Pauly et al., 2020; Wallace et al., 2018). Studies show that this connection leads to a more

comfortable and welcoming space for community members in health and harm reduction settings (Bardwell, Kerr, et al., 2018; Greer et al., 2016; Kennedy et al., 2019).

While the benefits of engaging peers in programs and services supporting people who use substances are well known, peers simultaneously experience fatigue, emotional burnout, and trauma from responding to overdoses (Kolla & Strike, 2019; Wagner et al., 2014). These feelings are further exacerbated by a lack of formal and consistent employment opportunities for peers (Greer et al., 2020). As such, peers often provide care and services within their community voluntarily without pay (Bardwell, Anderson, et al., 2018; Greer et al., 2020). Moreover, despite the critical role they play in the community, peers often lack recognition and respect for their contributions to harm reduction initiatives (Mamdani, McKenzie, Pauly, et al., 2021). In 2017, the BC Emergency Health Services publicly thanked '[the] dispatchers and paramedics for the energy, time and patience they give each day' in reversing overdoses (BC Emergency Health Services, 2017). In 2021, BC's Premier released a public statement recognizing the work of healthcare workers, first responders, and others who maintained essential services throughout the COVID-19 pandemic (BC Gov News, 2021). In both instances, peers were not acknowledged for their involvement in harm reduction services despite the significant increase in peer workers' workloads since the onset of COVID-19 due to the rise in the number of overdoses and reduced hours of operation of many essential harm reduction services (Mamdani, Fan, et al., 2021; Mamdani, Pauly, et al., 2021).

Peers have played and continue to play critical roles in addressing the drug toxicity crisis alongside first responders, defined as people with specialized training who are among the first to be at the scene and respond to an emergency (Canadian Institute for Public Safety Research and Treatment, 2020). Within the context of expanding the responsibilities of peers to address overdose harms, it is important to understand the perceptions and experiences of peers who respond to overdoses to inform drug initiatives and policies, service planning, and supply distribution (e.g. naloxone) (Neale & Strang, 2015). However, there is limited research investigating how enactment of the GSDOA in 2017, which encourages calling 9-1-1, has impacted PWLLE's approaches to responding to overdose. Additionally, there is a need to understand how the GSDOA, alongside several other factors, such as readily available naloxone, drastically increasing overdose-related deaths, discussions around broader decriminalization, and COVID-19, have impacted peers' interactions with emergency service providers (ESPs), such as paramedics, fire services, and police. Thus, the aim of this study is to better understand peers' involvement in overdose response settings following the implementation of the GSDOA, including their experiences interacting with ESPs.

## Methods

This study draws on qualitative data from a larger multi-methods evaluation assessing knowledge of and attitudes toward the GSDOA. Participants included people over the

age of 16 years who were likely to witness and respond to an overdose.

The project used a community-based research design, guided by the principles of collaboration, inclusivity, and social change (Collins et al., 2018). Six peers referred to as peer research assistants were hired to inform and help with all aspects of the project, including recruitment and obtaining consent from eligible and interested participants. The peer research assistants were paid \$25 CAD per hour, as per best practice guidelines for paying peers in BC (BC Centre for Disease Control, 2018). Two community-based youth organizations also advertised information about the study to recruit youth aged 16–24 years. Previous research has indicated that peer engagement promotes capacity building, social inclusion, and empowerment among a population that is historically stigmatized and marginalized (Greer et al., 2016). Furthermore, the engagement of peers in data validation improves the quality of data and the interpretations (Greer et al., 2016; Mamdani, Fan, et al.).

Interviews were conducted between October 2020 and April 2021 by the research coordinator (JX) over the telephone due to COVID-19 distancing guidelines. Before each interview, informed consent was obtained verbally.

Interviews were guided by a semi-structured question guide developed by some of the qualitative research team members (JX, JB, AG), with insights from the peer research assistants. The guide was regularly reviewed and evolved as concepts and topics arose during data collection, thus promoting the relevance of questions and the quality of data (Patton, 2002). During the interviews, participants were asked questions regarding their awareness of and perspectives on the GSDOA. Participants were also asked to recount their experiences witnessing or responding to an overdose, including if 9-1-1 was called any concerns they had calling 9-1-1, what happened when ESPs (i.e. police, paramedics, and fire services) arrived, and their interactions with these providers. A copy of the interview guide has been provided in the [Appendix A](#).

Each interview lasted ~1 h and was audio-recorded. Participants received a \$20 CAD honorarium. Audio recordings were transcribed verbatim by an external transcriber and the transcripts were de-identified to promote confidentiality and anonymity. Transcripts were then uploaded into NVivo (QSR International, Version 12) for organization and coding.

For the purpose of this study, we focused our analysis on the experiences of peers at the scene of an overdose as well as their interactions with ESPs. Specifically, we were interested in the competencies peers were describing, the challenges they faced, and the relationships they described having with ESPs. We utilized thematic analysis to identify, organize, and report key findings with the applied focus of our study (Braun & Clarke, 2006). The thematic analysis type follows Braun and Clarke's codebook approach which is typically used in applied research (Braun & Clarke, 2019a). Our analysis combined deductive and inductive approaches (Braun & Clarke, 2019b); deductive in that we explored the data with specific research questions and theoretical constructs based on the purpose of this current study, and inductive in that we were open to new ideas and concepts

relating to the study aim. Eight qualitative team members developed a preliminary coding framework based on an initial read of a subset of transcripts (JX, JB, AG, BP, SB, EA, JL, and ZM). The framework was applied by four research team members (JX, EA, JL, and ZM) to code the transcripts in NVivo. Each coder was assigned transcripts to code independently. Every fourth transcript was coded jointly to compare and ensure consistency. We revised the coding framework iteratively throughout this process, based on the findings. After initial coding to organize high-level ideas, we moved to deeper levels of interpretation, whereby the first and second authors (ZM and JL) organized the data into themes and hierarchies for more granular ideas and concepts relating to the aim of the current study. During this process, we looked at the coded data and asked ourselves some of the following questions: 'How does this participant interpret their experience at the scene of an overdose?' 'What roles do participants describe playing versus the other bystanders and/or ESPs,' and 'What assumptions do participants seem to be making?' Attention was also given to participants' choice of words and expressed tone, for example, long pauses, hesitation, etc., which provided insights into the meaning behind the quotes. We considered alternative explanations for quotes, consistent with thematic analysis methodologies outlined by Braun and Clarke (2006). We were mindful of the potential bias in our interpretation given the overlap and recurring themes between this study and the Peer2Peer project in that several authors are involved. As such, once the topic domains and themes were developed, the rest of the qualitative team was involved for discussion and further interpretation. The findings were also shared with peers from the Peer2Peer project for validation and to situate the themes within the context of their lived experiences.

## Findings

The findings of this study are based on interviews with 42 participants from across BC. Of these, fourteen were under the age of 25. Participants' characteristics are presented in [Table 1](#). The majority of the participants (both adults and youth) identified as cis women (54 and 43%, respectively). The majority of adults reported being non-Indigenous (61%), while the majority of youth reported being Indigenous (57%). Adult participants were fairly spread out across the province, with the highest number of participants from the Vancouver Coastal region (32%). Roughly half of the youth participants resided in the Vancouver Coastal region, and the other half resided on Vancouver Island. Approximately three-quarters of adults and half of the youth reported currently using substances. To promote the confidentiality and anonymity of participants, identifying information, such as the specific age is not shared alongside individual quotes in the article. We do indicate whether the participant was an adult or youth, their self-identified gender, and their health region to demonstrate the diversity of our participants.

Following analysis, four topic domains and themes emerged in relation to the involvement of peers in responding to overdoses ([Table 2](#)). The four main domains presented

below are: (1) Peers' positioning within the community; (2) Expertise of peers in overdose response; (3) Challenges faced by peers in responding to overdoses; and (4) Secondary trauma among peers.

### Peers' positioning within the community

Participants' narratives highlighted that peers were often positioned close to the scene of an overdose and were the first to respond to overdoses. Participants were typically the first to conduct assessments, provide rescue breaths, administer naloxone, and monitor the person who had experienced an overdose for potential overdose re-occurrence. Many participants identified the first responders as peers rather than ESPs, such as paramedics. As described earlier, a first responder is defined as a person with specialized training

**Table 1.** Demographic characteristics of adult and youth participants in the study.

	Adults aged 25 years and older (N = 28) n (%)	Youth aged 24 years and younger (N = 14) n (%)
Gender		
Cis woman	15 (54%)	6 (43%)
Cis man	10 (36%)	4 (29%)
Trans and gender expansive	0 (0%)	3 (21%)
Not reported	3 (11%)	1 (7%)
Age		
16–18	–	3 (21%)
19–24	–	10 (71%)
25–35	9 (32%)	–
36–45	8 (29%)	–
46–55	5 (18%)	–
56+	3 (11%)	–
Not reported	3 (11%)	1 (7%)
Indigenous self-identification		
Indigenous	8 (29%)	8 (57%)
Non-Indigenous	17 (61%)	5 (36%)
Unknown	3 (11%)	1 (7%)
Health region		
Vancouver coastal	9 (32%)	8 (57%)
Interior	6 (21%)	0 (0%)
Island	5 (18%)	5 (36%)
Fraser	4 (14%)	1 (7%)
Northern	4 (14%)	0 (0%)
Not reported	0 (0%)	0 (0%)
Urbanicity		
Metropolitan	9 (32%)	8 (57%)
Urban	19 (68%)	4 (29%)
Rural hub	0 (0%)	1 (7%)
Not reported	0 (0%)	1 (7%)
Currently use substances		
Opioids only	3 (11%)	2 (14%)
Stimulants only	8 (29%)	2 (14%)
Opioids and stimulants	10 (36%)	3 (21%)
Do not use substances currently	4 (14%)	6 (43%)
Not reported	3 (11%)	1 (7%)

**Table 2.** Domains and themes from the qualitative interviews.

Domain	Themes
1. Peers' positioning within the community	
2. Expertise of peers in overdose response	a. Formal training and experience in responding to overdoses b. Expertise related to shared lived/living experience d. Peers' perception of the differences between peers and ESPs
3. Challenges faced by peers responding to overdoses	a. Lack of adequate resources b. Perceived delegitimization of peers' expertise and interactions between ESPs and peers
4. Secondary trauma among peers	

who is among the first to be at the scene and respond to an emergency (Canadian Institute for Public Safety Research and Treatment, 2020). As one participant noted:

*'We [peers] saved them [the people who overdose]. We are the first responders. That's logic. [...] If we're not there, who's going to take care of them and then overdoses are going to go through the friggin' roof. We are the first responders. We're here to help people.'* (Adult, female, Vancouver Coastal region)

Peers' positioning in the community was the main way that they could provide timely or a 'first' response to overdose. For example, one youth participant described their ability to quickly respond to their partner's overdose at home: *'Luckily, I had Narcan. It happened at our house, in our room, so I was able to [respond] and I had a phone luckily'* (Youth, male, Fraser region). Another participant mentioned how he was revived by his close friends who were with him at the time of the overdose: *'I've overdosed three times, and fortunately my friends knew what to do so I never did have to go to the hospital.'* (Adult, female, Fraser region). In both these instances, peers were able to intervene quickly because of their proximity to the scene of the overdose as well as their access to a phone and naloxone.

In contrast to the timely response, peers could provide, participants described that paramedics and other ESPs were often delayed and/or unable to respond to overdoses in a timely manner:

*'If you left it up to [the ESP], you're going to be dead. 'Cause they can't get here quick enough. [...] It doesn't matter if it's police, fire department or the ambulance. [...] If somebody OD'ed out here, right, and there was no Narcan, we didn't have Narcan and stuff, that person is dead.'* (Adult, gender identity unknown, Interior region)

In this quote, the participant highlights how overdoses require an immediate response and how ESPs are often unable to provide this because of the time it takes to drive to the overdose location.

Given the delayed arrival of ESPs at the scene of an overdose, as well as peers' proximity and ability to respond quickly, some participants described how calling 9-1-1 felt unnecessary or impractical:

*'A lot of people that live here, tent city, are actually the ones that are [...] the helpers, they're good people. [...] They're smart people and they have first aid and shit. [...] The ambulance to show up and get escorted by the police and for them to just get there after we've done everything. [...] I don't want to waste the ambulance's time. I don't really see much situations where 9-1-1's necessary.'* (Youth, non-binary, Vancouver Coastal region)

This quote demonstrates participants perception of calling 9-1-1 as unnecessary and a 'waste' of time. In participants' experience, most of the life-saving work was completed

before ESPs arrived—largely due to their positioning in the community and proximity to people who use substances.

### **Expertise of peers in overdose response**

#### **Formal training and experience responding to overdoses**

According to participants' descriptions, peers were not only physically well-positioned to respond to overdoses, but also possessed expertise and training in doing so. Several participants reported being formally trained (e.g. first aid certification), as well as having received other comprehensive training in responding to overdoses. In the words of participants: *'I was trained [...] in all the steps that need to be taken to get someone to come back'* (Adult, female, Island region); *'I do have my first aid and stuff like that. So, I'm very educated about all that kind of stuff and make sure that they're all right and make sure that they're not going to re-overdose again.'* (Adult, female, Northern region). In these narratives, participants indicated that they had sufficient training, and as such, felt competent in overdose reversal and monitoring for the occurrence or re-occurrence of overdose.

The formal training of participants was often complemented by the participants' breadth and depth of experience responding to overdoses. One participant mentioned: *'There's a whole bunch of us that dealt with a lot of this. [...] It's almost like a natural thing now'* (Adult, male, Vancouver Coastal region). This quote highlights that the frequency of peers responding to overdoses made it second nature to them. Further, that *'a whole bunch'* of peers responded to numerous overdoses demonstrates that this experience was not perceived as unique, but rather, the norm—likely indicating that peers were filling a ubiquitous need for timely overdose response in their communities.

Given the amount of training and experience peers reported having in responding to overdoses, it was unsurprising that participants demonstrated a range of competencies. Many participants outlined the steps they took in responding to overdoses, which aligned with best practice guidelines (BC Centre for Disease Control, 2020), including how to identify an overdose, how to provide rescue breaths and the appropriate naloxone dosage.

Some participants shared how their experiences responding to overdoses led them to feel confident to independently handle an overdose:

*'I'm confident in my abilities [...] to fucking bring them back without having to call paramedics first. Because I know what follows. And I'll try to do so beforehand, before calling, 'cause I am confident in my abilities that I can (a) perform under pressure, (b) resuscitate people [...]. And I'm more than willing to do so again.'* (Adult, male, Interior region)

Such confidence in the abilities of peers to provide timely and appropriate care to individuals overdosing reiterates the earlier point that calling 9-1-1 may not always be deemed necessary.

#### **Expertise related to shared lived/living experience**

In addition to formal training and experience, some participants described that they learned to respond to overdoses

from their time and experience in the community with people who use substances. Some participants shared techniques they had developed over time in responding to overdoses. While not necessarily aligned with best practice guidelines, peers used these approaches when resources were limited. As one participant explained:

*'In terms of, the modes that I've used as well when people are overdosing: There's a lot of different things you can do, like, simple words can bring someone out of an overdose. Crazy. I know it sounds crazy, but it's true. Like just saying certain things to somebody or [...] touching them a certain way if you know someone's really ticklish. [...] And if you can do that, sometimes you can knock somebody out of something like that.'* (Adult, female, Island region)

Indeed, as this quote indicates, peers drew upon their past experiences to respond to overdoses.

The shared lived/living experience of participants and others in the community also facilitated trust and relationship-building with the people who they responded to. As some participants described, their shared history was particularly important for gaining trust from peers:

*'If you don't have the lived experience, sometimes it just doesn't hit the mark, right. [...] As most of us know who work in this field, trauma is the root cause of people who have poor relationships with substances. [...] And I knew every single person's story. 'Cause that was something I wanted to know about them. [...] That creates the transparency between you to create an authentic relationship.'* (Adult, female, Northern region)

As highlighted in this narrative, understanding the role of trauma and personal history in the lives of some peers was considered fundamental to building trust and relationships with peers. In some cases, pre-existing relationships with peers gave participants insider knowledge of the substances typically used by each person, which helped expedite overdose response procedures. One participant described their experience responding to the overdose of someone they knew: *'She tends to do [...] heroin when she's drinking [or] fentanyl when she's drinking. And the two don't mix, so she ends up OD'ing'* (Adult, gender identity unknown, Interior region). Having personal relationships and insider knowledge enabled peers to respond promptly and appropriately to an overdose.

#### **Peers' perceptions of differences between peers and ESPs**

Many participants described the fundamental differences between peers and ESPs in responding to overdoses; participants felt that peers were more committed to saving lives, were more empathetic toward the people they responded to, and were often more confident and competent in responding. These perceived differences may be shaped by the history of stigmatization faced by peers.

Given the strong ties that peers had with members of their community, rooted in their shared lived/living experience, many participants described how they often went above and beyond to save the lives of other peers. As one participant described:

*'Lots of people don't want to give breaths. [...] I find a lot of service providers don't give breaths. [...] [if the mask] broke off and*

*I would huck them and I would just give them mouth to mouth. [...] The worst I might get is, you know, COVID maybe now. Or a cold sore or they might vomit on me or T.B. or something. But I'll survive that. I'd rather save someone's life by giving them breaths than not.'* (Adult, female, Fraser region).

This narrative shows the strong commitment of peers to saving the lives of members of their community. This was especially evident in the context of the COVID-19 pandemic, whereby peers prioritized saving lives despite the risks that responding may pose. On the other hand, participants felt that ESPs were perceived to place a higher importance on following their personal safety and protocols (e.g. donning of personal protective equipment) than on saving the lives of people experiencing an overdose. This shows how in a stigmatizing context, actions that might often go unnoticed and be considered unremarkable (e.g. personal protective equipment) can emerge as highly meaningful symbols that certain concerns and even lives are more important than others.

Related to the notion of genuine care and commitment toward members of their community, participants mentioned being friends and family of the people overdosing. As such, they were emotionally invested and impacted by their roles in the community as first responders. Many participants felt that this closeness to the community was an important difference between peers and ESPs: *'It's just a job to them [police and paramedics]. [...] You gotta have compassion for a person.'* (Adult, gender identify unknown, Interior region). According to the participants, police, and paramedics were more mechanical in responding to an overdose, and lacked a compassionate and/or an empathetic response.

In some cases, participants suggested that peers may be more competent and confident responding to overdoses than ESPs:

*'A fellow [peer] is more trained on how to bring somebody back [...] than our first responders are. [...] This lady [paramedic] nailed the guy with 10 cc's of, like, Narcan and it's only supposed to be 1 cc. [...] there was so much Narcan it literally brought him back from the dead. [...] And she didn't know any different [...] This is an ambulance attendant – she didn't know any difference.'* (Adult, gender identity unknown, Interior region)

As illustrated in this quote, participants felt that they were better equipped and more experienced to make assessments, such as the amount of naloxone required, and were more comfortable administering it than some ESPs. Furthermore, participants demonstrated their adeptness at assessing and deciding what interventions were necessary for reversing an overdose. One participant described how they refused to start CPR despite being instructed to do so by a dispatcher:

*'The person on the phone [9-1-1 dispatch] told [peers] to start CPR which she refused because the heart was beating. And she knew that that wasn't a good idea so [...] she said no to [doing CPR]. But to give breaths, yes.'* (Adult, male, Fraser region)

In this instance, peers felt they were more knowledgeable than ESPs and dispatchers about the correct response in a particular context.

Some participants suggested that peers were the preferred responders during an overdose, compared to ESPs, such as paramedics and police. One participant mentioned: *'Quite often our clients don't want to deal with the ambulance or the cops'* (Adult, male, Vancouver Coastal region). Hesitancy to deal with ESPs and preference for peers may be due to the trust and relationships between peers as well as the perception of peers as being experienced and capable of appropriately responding to an overdose.

## **Challenges faced by peers responding to overdoses**

### **Lack of adequate resources**

Peers encountered several barriers that impacted their ability to respond to an overdose. While our findings demonstrate peers' expertise and the value of lived/living experience for an appropriate and accepted overdose response, many participants shared that peers often had limited resources. As one participant remarked: *'But if someone, like you said, is totally purple, and I walk in and I'm, like, okay, no, no, no, this is not okay. We need oxygen and we need to call 9-1-1 stat. [...] 'Cause that obviously right there is brain trauma when there's lack of oxygen already'* (Adult, female, Island region). Similarly, participants recalled times when they did not have an adequate supply of naloxone: *'If I have to Narcan them more than three times, and I've used the nose Narcan before and then I've still had to use the injection Narcan, then I call 9-1-1'* (Adult, female, Northern region). Limited access to supplies jeopardizes the health and well-being of those who have overdosed, potentially leading to complications, such as anoxic brain injury, or worse.

Complex overdose presentations appear to be more and more common due to the increasingly toxic drug supply, and as such multiple doses of naloxone are often needed and/or administered. As one participant remarked: *'I don't think that's [people responding to a single dose of naloxone] very common, no. And lately it's been taking more and more, like, four shots and—yeah, I don't see anyone coming back that quickly anymore'* (Adult, female, Northern region). Inadequate resourcing as well as severe and complex overdose presentations (e.g. non-responsive despite reversal attempts) limited peers' abilities to respond to an overdose, and in many instances prompted peers to call emergency health services.

### **Perceived delegitimization of peers' expertise and interactions between ESPs and peers**

Peers were considered well-positioned to respond to overdoses given their proximity to the scenes of overdoses, their expertise, and their ability to establish trusting connections with other peers. Despite this, many participants suggested that peers' capabilities were not recognized as legitimate and/or comparable to ESPs. Participants recalled instances where ESPs seemed to question peers' expertise and abilities, delegitimizing their role as first responders. As one participant noted: *'We've had many cases where they [the police] come out and we've been working on a client and they try and*

get us to leave the person alone or something, you know, wait till the professionals get here type of thing' (Adult, male, Vancouver Coastal region). Positioning paramedics as the sole professionals capable of appropriately responding to an overdose, participants felt that ESPs devalued and delegitimized peers' capabilities—creating a hierarchy that placed peers below paramedics.

Many participants also described how other service providers, such as shelter staff, were seen to discredit peers' expertise:

*'There was an overdose at the end of August, beginning of September, with my friend in front of a shelter. And one of the staff, I was the first responder, I was the one that alerted the staff. I was the one that grabbed the kit and I shot him with the first shot. When the second staff member came out, he literally got into my personal bubble and shoved me out of the way: you are no longer needed.'* (Adult, male, Interior region)

Along with prioritizing a response from paramedics or other ESPs, participants recalled instances in which peers were criticized for their procedures in responding to an overdose. For example, one participant mentioned that paramedics disparaged them for administering a certain dose of naloxone to a friend who had overdosed: *'They were giving us shit for giving her so many injections. That's the only thing they did. They didn't say anything positive... And they were awful to us. They were scolding us'* (Adult, female, Fraser region). In these two instances, peers were the first to respond to the overdose which likely contributed to the survival of both individuals who had overdosed. However, despite peers responding promptly, participants described instances where other service providers discredited the expertise and skills of peers, rather than acknowledging their efforts and contributions. Such experiences left peers feeling devalued and taken for granted.

Throughout their narratives, our participants recognized and attested to their own and other peers' abilities to effectively respond to an overdose. Many participants often described receiving formal training (e.g. first aid, naloxone administration) as if to validate their skills. As one participant put it: *'I have enough training to be a paramedic'* (Adult, male, Interior region). This excerpt emerged from a broader conversation about the delegitimization of peers' expertise and revealed sensitivities and issues around legitimizing skills acquired through lived experience compared to the formal training and education of ESPs.

Some participants felt the devaluing of peers' expertise was driven by a competitive attitude from ESPs: *'I have this feeling like the paramedics didn't like the fact that we were responding to overdoses. Like we had naloxone. It was almost like a competitive feeling, right'* (Adult, female, Fraser region). Indeed, this competitive atmosphere between ESPs and peers responding to overdose was iterated by one participant's account; they described the City of Vancouver's reaction to a protest planned in support of peer workers, explaining that peers were planning on making buttons that read, *'We are the first responders,'* but in response, the City asked, *'Don't you think we are going to step on the toes of the ambulance people?'* (Adult, female, Vancouver Coastal region). Positioning ESPs and peers against one another may

conceivably contribute to antagonism, rather than collaboration, between the two groups.

A consistent narrative among participants was the desire to be treated *'like a human being'* (Adult, female, Vancouver Coastal region). As one participant described: *'First and foremost we're all fucking humans. [...] Whether you're against drugs, whether you're whatever. You don't know what that person's story is. You don't know why that person is doing drugs. [...] They [Paramedics] just look down on you because, you know, you do drugs. [...] They don't really give a shit. You're just another junkie to them. Most of them. Not all of them, but the greater majority'* (Adult, gender identity unknown, Interior region). This quote highlights an important point: perceived stigma underlays and influences ESPs' actions toward peers in overdose response roles.

Other participants perceived ESPs to be hesitant or reluctant to respond rapidly to an overdose, which appeared amplified by the advent of COVID-19. As one participant described:

*'A lot of people [ESPs] are apprehensive. They are a little scared to deal with it because obviously [...] it's just like the unknown. 'Cause there is stigma and judgement towards people that are [...] out here on the street or using drugs because [...] I think they have their own preconceived judgement towards or their idea of what [...] drug addicts are. As far as they know, they're dirty or they have their own [...] judgements.'* (Adult, male, Vancouver Coastal region)

These narratives reveal how the apparent reluctance of ESPs to respond to overdoses was seen to be rooted in stigma, which could negatively impact emergency response. Furthermore, these narratives demonstrate how concerns around COVID-19 transmission were seen to be intertwined and informed by stigma against people who use substances, as well as people who are experiencing homelessness, as more likely to have transmissible diseases. While stories about similar, seemingly negative interactions between ESPs and peers were not ubiquitous, they were nevertheless common.

Not all relationships between peers and ESPs, as described by the participants, were negative. Several participants recalled instances in which ESPs appeared to appreciate the efforts of peers responding to an overdose. As one participant described: *'the paramedics showed up [to the overdose] and they were so thankful I actually showed up and everything like that'* (Adult, female, Northern region).

The relationship between peers and ESPs appeared to be influenced by the overdose context, including the temporal and/or physical context. As one participant noted:

*'A lot of paramedics are like that [look down upon peers] for the first couple years too. But now they realize that we've been on more overdoses than they have so—and they tend to respect us a little more and can actually take advice from us'* (Adult, male, Vancouver Coastal region).

Another participant described how *'[when] I am at work, they [the paramedics] are great'* (Adult, male, Island region). This may be because paramedics and other service providers associate a certain level of professionalism with being *'at work.'* On the other hand, interactions with peers in

perceived out-of-work contexts were not always positive. As described by one participant:

*'I find the paramedics are nervous in a lot of situations. Like, if they go to a place, like a low-income house, there's a lot of overdoses, or a lot of crime and drug activity. I find they're really nervous and that sometimes they'll actually wait for the cops even to come inside to help somebody. So, it's the stigma thing that's really getting in the way of saving people's lives. So, then they'll come and they're really nervous, and they'll almost kick you out of the way. Like, physically kick you out of the way because they sort of just assume that you're using with [the person]. So... they can get pretty rough and pretty aggressive.'* (Adult, male, Island region)

These examples highlight how the relationships and interactions between peers and ESPs, as well as the recognition of peers' skills and expertise, were provisional and influenced by multiple factors, such as perceived stigmatizing attitudes toward substance use and people who use substances, the tenure of ESPs, and where an overdose took place.

### Secondary trauma among peers

An important theme underlying the experiences of peers was the trauma of responding to overdoses and grieving losing loved ones. These feelings seemed to be exacerbated since the onset of COVID-19. Participants described overdose situations as *'very scary,'* and *'horrific,'* especially as they were often responding to the overdose of a family member, partner, or friend. As one participant remarked: *'I knew the person very closely and it's different and it's difficult to have to administer naloxone to someone you care about as opposed to someone that you don't know. It just triggering'* (Adult, female, Interior region). This was further emphasized by another participant: *'I was so, like, distraught. And I was, like, crying and hyperventilating and I was, like, I was giving him chest compressions. And I was, like, they're, like, okay, okay, you can get off him. And I just like fell off him and I just broke, like, just completely broke, right. It was hard. It was really hard...'* (Adult, female, Island region). While peers' relationship and familiarity with someone experiencing an overdose may be beneficial in terms of knowledge of the person's drug use and providing re-assurance, responding to overdoses—especially to friends and family members—was highly stressful and traumatic.

Repeated exposure to traumatizing experiences was associated with feelings of burnout among peers. As one participant described: *'We have to take care of the people who manage sites 'cause if we don't, like, I told you when I got burnt out and wanted to quit. I still want to quit, but the thing is I can't'* (Adult, female, Vancouver Coastal region). This quote highlights how peers may feel obligated to continue providing care despite the burnout and compassion fatigue they were experiencing, and draws attention to the need for more resources and support for peers.

These feelings of obligation that some participants expressed may have been driven, in part, by the barriers to timely care from ESPs, ESPs' perceived reluctance to provide care due to pre-conceived notions about peers, as well as concerns around stigmatizing and discriminatory treatment toward peers at the scene of an overdose. As mentioned

earlier, many participants noted prolonged waiting times for emergency services to arrive at the scene, particularly during the COVID-19 pandemic. One participant shared:

*'Because of COVID and everything that's been going on, it's been a lot harder and it does seem like it takes a little longer, 'cause, I don't know how many times I've had to do [...] chest compressions and all this other stuff [and] doing it for longer periods of time than I should. Because they [ESPs] take their time 'cause they have to get ready and then they're obviously taking their precautions, right. [...] It can be difficult ... mostly I get frustrated dealing with it because I'm in distress myself. And I have to make sure that the person's okay and it kind of seems like it takes forever.'* (Adult, male, Vancouver Coastal region)

This quote highlights that lengthy wait times for emergency services, as well as the increased preparation time required due to COVID-19 and the need for personal protective equipment, resulted in increased distress for peers responding to an overdose. The prioritization of COVID-19 protocols over a timely overdose response was seen by many participants as an indicator that ESPs were indifferent to peers overdosing. However, other participants recognized ESPs need to protect themselves—and by extension, others—from contracting COVID-19. Regardless, delayed responses from ESPs increased the onus placed on peers responding to overdoses. Participants shared that this pressure on peers to counterbalance ESP delays exacerbated the physical, mental, and emotional tolls of responding to overdoses.

Additionally, COVID-19 and emergency service delays forced peers to navigate ethical and moral issues surrounding withholding or delivering certain types of care:

*'Well, I mean, I know how to administer naloxone. I know how to give breaths. But, like, I think that is a real question is, like, you have to get up close and personal with somebody when you're giving them Narcan when somebody goes down. And, like, how do you do that during COVID, not knowing if somebody's like, you know, has an immune issue and maybe you're carrying COVID, you have no idea. Are you doing more harm than good reviving somebody who has an autoimmune disease? Who knows? And so, I see that a lot.'* (Youth, intersex, Vancouver Coastal region)

Indeed, the onset of COVID-19 has subjected peers to a moral dilemma—to either prioritize the risks of potentially contracting/spreading COVID-19, or the risks posed by an overdose (e.g. brain trauma, death). Despite this dilemma, the trauma experienced by peers, the increased workload due to COVID-19, and minimal recognition and support, peers continue to be pivotal players in the frontlines of the drug toxicity crisis, demonstrating their dedication and commitment to their communities.

## Discussion

Our study highlights how peers saw themselves as first responders in the drug toxicity crisis and provide insights into peers' unique expertise, and the challenges they faced when responding to an overdose. While the GSDOA was enacted to encourage people witnessing/experiencing an overdose to call ESPs, our findings indicate that people who use substances often did not want to interact with ESPs and preferred a

peer-led response. Peers perceived themselves to be highly capable, well-positioned in the community, and equipped with the necessary and unique expertise that enabled them to respond to an overdose. Peers felt that in some instances, they were even better able to respond to overdoses, compared to ESPs, due to insider knowledge they often had about a person's substance use. In part, this insider knowledge was influenced by peers' shared experiences, which empowered them to establish trust and form connections with other peers. However, peers simultaneously felt they lacked recognition as first responders and their skills were delegitimized relative to ESPs. Further, many peers reported having strained interactions with ESPs due to perceived stigmatizing and discriminatory attitudes of ESPs toward people who use substances. Overall, these findings provide insights into the pivotal role peers saw for themselves in responding to the drug toxicity crisis. Our findings emphasize the need for systemic recognition of peers as legitimate first responders, alongside appropriate resourcing, and support, and have important implications in terms of sustainability, effectiveness, and equity for peers who are informally or formally working in overdose response settings.

The main finding from this study was the perception that peers are highly competent, confident, and well-positioned to respond to overdoses. The confidence peers had was based on several factors: their experience in responding to overdoses, their compassionate and trauma-informed approach, and the timely response they provided given that they were often physically and/or socially proximal to overdoses. Research consistently shows that peers are willing and able to take action in the event of witnessing opioid overdoses (Bardwell, Anderson, et al., 2018; Faulkner-Gurstein, 2017; Kennedy et al., 2019; McAuley et al., 2018; Wagner et al., 2019; Wallace et al., 2019), and that bystander-administered naloxone is safe and effective for opioid overdose reversal (Moustaqim-Barrette, Papamihali, et al., 2021). Naloxone distribution data indicate that over 90% of kits reported used each year between 2017 and 2020, were by individuals likely to experience an overdose (i.e. people who use substances), which suggests that peers are most often the ones responding to overdose events (Geiger et al., 2021; George et al., 2021). Moreover, bystander responses performed by peers continue to be highly valued and preferred as responders by people who use substances in BC (Pauly et al., 2021). Our findings are also consistent with those of naloxone studies outside of BC which indicate that the administration of naloxone by peers is as crucial to the success of overdose response as the effectiveness of naloxone itself due to the utilization of the expertise, experience, and social connections of peers as people with lived/living experience (Faulkner-Gurstein, 2017).

Among participants in our study, there was an appeal to better recognize, value, and legitimize peers' expertise and roles in addressing the drug toxicity crisis. Current research demonstrates that much of the work performed by peers is unrecognized, unpaid, and remains informal (Bardwell, Anderson, et al., 2018; Greer, 2019; Greer et al., 2021; Mamdani, McKenzie, Pauly, et al., 2021); indeed, peer workers are often paid much less than other front-line workers doing

similar work (Greer et al., 2020; Mamdani, McKenzie, Pauly, et al., 2021; Olding, Barker, et al., 2021). Lack of recognition and respect is one of the key stressors faced by peers and stems from stigma against people who use substances (Mamdani, McKenzie, Pauly, et al., 2021). Consistent with our findings, several studies have found that individuals without lived/living experience of substance use often have negative attitudes toward peers and other people who use substances (Bryant et al., 2008; Goodhew et al., 2019; Patterson et al., 2009). It may be that the emotional toll experienced by ESPs responding to overdoses engenders feelings of helplessness, burnout, and frustration (Pike et al., 2019), resulting in lessened empathy among ESPs for people who use substances (Williams et al., 2017). As ESPs respond more frequently to overdoses, they may adopt increasingly negative views of naloxone and drug use (Murphy & Russell, 2020), though this is at odds with our finding that ESPs who attended more overdoses were seen to respect peers more. Regardless of the source, when viewed through a politics of care lens, which emphasizes social relations and how responding to an overdose produces meaning beyond reversing an overdose (Farrugia et al., 2019, 2020), perceived stigma and discrimination against peers and their contributions to overdose response undermine peers' efforts to become 'legitimate,' thereby perpetuating social marginalization (Farrugia et al., 2020). As some participants remarked, this appeared to be driven by competition, potentially reflecting a symbolic threat to the traditional medical authority which take-home naloxone and peer-response to overdose presents (Faulkner-Gurstein, 2017). It is possible that such past negative experiences shape peers' day-to-day experiences and may cloud their current and future interactions and experiences with ESPs. This would explain why a seemingly unremarkable action, such as wearing personal protective equipment can be considered by peers as a lack of care for people who use substances. Alternatively, what was perceived as competition by peers may have been viewed as a collaboration by ESPs. In previous studies, paramedics have described assuming a leadership role when arriving at the scene of an overdose where peers are responding to an overdose, coaching and double-checking peers' response techniques (Williams-Yuen et al., 2020).

Given that the health system continues to leverage peers as a key part of the drug toxicity crisis response across Canada (Buchman et al., 2018), formal recognition and sufficient support for peers are vital. This key message has been articulated by several other studies in recent years (Bardwell, Kerr, et al., 2018; Greer et al., 2021; Kennedy et al., 2019; Mamdani, McKenzie, Cameron, et al., 2021; Mamdani, McKenzie, Pauly, et al., 2021; Olding, Boyd, et al., 2021; Pauly et al., 2021). Many peers lack basic resources at work, such as photo IDs and business cards, which can be important symbols of professionalism (Mamdani, McKenzie, Cameron, et al., 2021). Improved recognition of peers through symbols of professionalism, and campaigns that foster awareness of the work performed by peers may be important for creating better working conditions, pay, and access to training and resources for peers (Greer et al., 2021; Mamdani, McKenzie, Cameron, et al., 2021; Mamdani, McKenzie, Pauly, et al., 2021). Our findings indicate that since

the onset of COVID-19, which seems to have resulted in longer wait times for emergency services, peers have felt added pressure to respond to overdoses. This strain may be further compounded by a range of other pre-existing stressors faced by peers, such as trauma, financial insecurity, and housing insecurity (Bardwell, Kerr, et al., 2018; Mamdani, McKenzie, Pauly, et al., 2021). Thus, support for peers is vital and may mitigate burnout, compassion fatigue, and inequities that persist and impact peers' ability to provide life-saving interventions (Ackermann et al., 2021; Kennedy et al., 2019; Kolla & Strike, 2019; Mamdani, McKenzie, Pauly, et al., 2021; Olding, Boyd, et al., 2021; Perri et al., 2021). Some studies have also suggested the need for interventions that address the poverty and social isolation of people who use substances (McLean, 2016). All these potential solutions aimed at responding to and reversing overdoses, may still, at best, be considered band-aid solutions within a context where drug use is considered criminal and where stigma against substance use persists. There is, therefore, an urgent need to implement policies and initiatives that prevent overdoses in the first place (e.g. safe supply) and reduce stigma against substance use by de-associating people who use substances from crime and notions of 'good' and 'bad,' through broader decriminalization.

Although participants in our study shared that it was not always necessary to call 9-1-1, there are times when paramedics' comprehensive training and tools in emergency medical response, beyond overdose reversal, may be needed. For instance, paramedics have access to an ample and adequate supply of naloxone, oxygen, and other medications or response skills (e.g. the ability to respond to cardiac arrest). Due to the intersecting structural vulnerabilities and inequities that many peers face, the necessary tools to respond to an overdose, such as naloxone, may not always be readily available, particularly to those with unstable housing (Ataia et al., 2021; Wagner et al., 2019). Limited access to resources, alongside an increasingly toxic drug supply, has led to severe and complex overdose presentations (e.g. non-responsive despite reversal attempts) (Palis et al., 2022), underscoring the ongoing role of 9-1-1 and ESPs amid the drug toxicity crisis. Indeed, calling 9-1-1 remains an important step in overdose response protocols (Kolla & Strike, 2019). However, more research is needed that identifies the medical and contextual factors that might prompt a necessary response from paramedics. Between 2015 to 2017, 9-1-1 calls occurred in only 55.7% of overdose events in BC (Karamouzian et al., 2019; Tobin et al., 2005). The primary reason cited for not calling 9-1-1 was feeling that the PWLLE 'had it under control' (Karamouzian et al., 2019), which is consistent with our findings. Other reasons PWLLE may not call 9-1-1 include concerns about unintended outcomes, such as eviction (Kolla & Strike, 2019). Thus, there is need for a more nuanced overdose response protocol that does not generalize and recommend that 9-1-1 be called for every overdose event, but rather provides criteria that responders can use to determine whether calling 9-1-1 is necessary. Policies, such as the GSDOA also need to provide further protections from potential unintended consequences, which undermine efforts to promote calling 9-1-1.

There are some study limitations to note. Due to convenience sampling, the depth and range of participants' views regarding overdose response among peers may be limited. This limitation was mitigated by ensuring that the sample represented diverse demographics. This analysis is a component of a larger multi-methods evaluation assessing knowledge of and attitudes toward the GSDOA, which focused on the experiences and perspectives of peers. Given the wide scope of the project, we had limited opportunities to ask critical questions about interactions of peers with ESPs. Furthermore, we did not include ESPs in our sample. Further research on interactions between peers and ESPs is warranted with the incorporation of ESPs' perspectives. Another limitation to note that was the raw data in our study was coded by academic researchers, and thus some important aspects of the reality of peers' lives may have been missed by not including peer research assistants in the coding process. However, the findings of the qualitative analysis were shared with peers for validation purposes as well as for further interpretation.

## Conclusion

The drug toxicity crisis in BC is intensifying with 2021 having the highest number of overdose deaths on record. Peers are uniquely positioned in the community to provide a prompt, compassionate response to overdoses, yet their role as first responders often goes unrecognized. Due to their shared lived/living experience with members of their community, and contrasting perceived stigmatizing and discriminatory treatment peers often face from ESPs, peers are often the preferred responders in overdose contexts. Despite their pivotal role in overdose response, peers lack resources, such as an adequate supply of oxygen which can limit their ability to respond. In addition, peers lack recognition and legitimization as first responders. These findings highlight the importance of peers in ongoing overdose response efforts and the responsibility that has been placed on peers to take care of their community. While policies, such as the GSDOA are in place to promote calling 9-1-1, there is a need to recognize why peers often respond themselves and may not call 9-1-1, beyond concerns around police and arrests, and respond accordingly with resource allocation and relevant policies. There is a critical need to better recognize and legitimize peers as first responders in the context of overdoses to ensure sustainability, effectiveness, and equity for peers at the frontlines of the drug toxicity crisis. This warrants further research to better understand how peers can be better supported to respond to an overdose and following an overdose (e.g. to address vicarious trauma), and simultaneously to understand the impacts of chronic stress for peers regularly responding to overdoses.

## Note

1. In recent studies in British Columbia (31, 40), several individuals with lived/ living experience indicated that they find the term 'peer' derogatory and suggested the use of the term 'experiential worker' or 'people with lived/ living experience (PWLLE)' instead. However,

given that the term 'peer' is still widely recognized internationally and used in literature, we have used this term as well.

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## Ethical approval

The study received Behavioral Research Ethics approval from the University of British Columbia Research Ethics Board (REB #: H19-01842). All interview participants provided fully informed verbal consent for participation.

## Health and safety

All mandatory health and safety procedures have been complied with in the course of conducting this study.

## Author contributions

JB is the principal investigator for this study. JX was involved in data collection. ZM, JL, EA, and JX conducted the initial coding. ZM and JL did the thematic analysis and interpretation for this manuscript. ZM, JL, and AG wrote the initial draft of the manuscript. ZM, JL, JX, BP, EA, SB, JB, and AG reviewed and edited the manuscript. All authors read and approved the final version.

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## Data availability statement

The authors confirm that the data supporting the findings of this study are available within the article.

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## Appendix A: Interview Guide

### GSDOA: person with lived experience interview guide

*The purpose of our interview today is to gain an understanding of what your experiences have been with the law and police in the event of an overdose, and your knowledge about the Good Samaritan Drug Overdose Act. If you don't know what that Act is, that is O.K. We will go over this in more detail later on in the interview.*

### Overdose situations and calling 9-1-1

*We are interested in chatting with people about their experiences in overdose situations—either when they have overdosed themselves or witnessed one (i.e. when the body has too much drug for example an opioid like heroin or fentanyl)*

1. I was wondering if we could start by telling how often you (1) experienced (2) witnessed an overdose and how often out of these times was 9-1-1 called (often, sometimes, rarely), and then we'll get into the details of those.

*Thanks. Let's start out by talking about one in particular that stands out for you where 9-1-1 was called AND where 9-1-1 was not called (ask about both) AND where police attended (if it does not come up in first two events)—doesn't need to be positive or negative or the most recent.*

2. Can you start by telling me a bit about what happened during that situation? (Prompts: what was the setting or where were you, who was there, what were you and others doing, what time of day, do you know what the drug involved what did you observe)
  - a. Was 9-1-1 called? Can you tell me a bit about how you or the people there made the decision to call/not call 9-1-1?
    - i. Did other people around you influence whether or not to call? Can you describe this?
    - ii. Were there any concerns that influenced you to call or not call 9-1-1? If yes, what were those concerns (e.g. legal or otherwise)? If no, why do you think legal concerns did not influence your decision?
  - b. Was naloxone available and given at that time? Did the decision to use or not use naloxone influence your decision to call/not call 9-1-1? How or so?
  - c. What concerns, if any, did you have about

- i. Police coming
  - ii. Emergency services like fire and ambulance coming? How did this differ from police?
  - iii. Were there any concerns about going to the hospital?
  - iv. Did any past experiences with police, fire and ambulance services, and/or hospital settings contribute to your concerns about emergency health services coming or going to hospital?
3. If you called 911 and the police came, what happened?
    - a. How were you treated when the police arrived? How were other people treated?
    - b. What did the police do (e.g. help with responding to the overdose, check IDs, de-escalate people...)? Is this what you had expected?
    - c. Did you or others directly interact with the police? If so, how did it go?
    - d. Thinking about the way the police behaved, what went well in that situation (what was good)? What didn't go well (what was bad)? What do you think they could have done differently?
  4. Thinking about this situation, do you wish anything had been done differently by emergency responders (e.g. paramedics, police, fire services, harm reduction workers...)? (If so what?)
  5. Is there anything else about the event that sticks out for you?
 

**Prompts:** If you've witnessed more than one, is the situation you described typical? If not, how did the situation differ from others you have been involved in (e.g. setting, 9-1-1 response, your response...)

    - a. How long ago did this happen? If you witnessed an overdose, say in a week from now, do you think it would go differently? What has changed since the overdose you shared about? Are there different regulations/supports that exist now?
    - b. Have you learned something that you did not know at the time of that overdose?
  6. How would you describe your experiences, in general, with calling 9-1-1? (e.g. negative or positive)
  7. Thinking about overdose situations in general, did yours or someone else's race have an impact on: willingness to call 911 and/or your interactions with police or other emergency responders?
  8. In your opinion or in your experience, does COVID-19 impact what you and other people might do in the event of an overdose?
    - a. **Prompt:** Do you have any concerns about police or the ambulance coming that you may not have had before this pandemic?
    - b. Is PWLE or peers ability to help respond to overdoses impacted by COVID (e.g. access to supplies, ability to enter spaces, emergency health care professional instructions)

### Knowledge of the law

We are also interested in knowing about people's views of the 9-1-1 Good Samaritan Drug Overdose Act. Are you aware of it? **If yes, proceed.** If no, give description of the Act.

1. If yes: can you tell me a bit about what you know about the GSDOA?
  - a. Can you describe what you think the Act means?
  - b. How did you hear about the Act? Have you seen posters or other materials about the GSDOA? Were they useful/informative?
  - c. How did you feel about it when you first found out about it?
  - d. How has your opinion changed since then (if at all)?
  - e. Has the act influenced your decision to call 9-1-1 in an overdose situation at all? How so?

**If no:** What are some of the reasons you don't think you've heard about the Act?

  - f. If you had known about the Act in the past, do you think it would have influenced your decision to call 9-1-1 in the past? How so?

**Now I'd like to tell you about the Good Samaritan Drug Overdose Act, which was made law in May 2017. It protects the person who overdoses, the person who calls 9-1-1, and anyone else at the scene of an overdose from being arrested for 'simple' possession that means having illegal drugs for their own personal use. It does not protect anyone at an overdose from being arrested for outstanding warrants, trafficking or production, or any other serious offense.**

2. Do you have any questions about the GSDOA? Is there anything that is unclear about the way it is written out?
3. What do you think some of the barriers to people calling 9-1-1 are even though the Act exists?
4. How effective or successful do you think the Act is in preventing people from being charged with drug possession during an overdose event? Do you have an example or experience that you could share about how act is actually working?
5. How effective or successful do you think the Act is overall in making people feel more comfortable about calling 9-1-1?
6. Knowing about the GSDOA, are you still concerned with police showing up at the scene of an overdose? What sorts of things, outside of simple possession, may people who use drugs be worried about?
7. Is there anything about the Act that you'd change in order to make it better?
8. What groups of people do you think do not know about the Act? Why do you think they don't know about it?
  - a. What are some of the reasons you think they aren't aware of it?
  - b. How important is getting information to people about the ACT?
  - c. What are some reasons why you think it would be important or not important to get this information about the law to them?
  - d. What are some of the best ways to get information about the Act to them?
9. How do you think your knowledge of the GSDOA might change or not change your behavior in an overdose situation in the future?
10. Is there any other changes that you think would make a difference in overdose situations?

### Finally, I'd like to ask about drug alerts.

11. Alerts tell people when street drugs are toxic. For example, when fentanyl is found in a stimulant or when drugs are causing unusual overdose responses. Are you aware of drug alerts in your community?
  - a. Can you tell me about an occasion you heard or saw information about an alert?
    - b. Where did you hear/see the alert, what did it mean to you? Do you think you/your friends change how they use drugs if they know the drugs are more toxic?
12. How do think we can better reach out with information about toxic drugs?
  - a. If using posters—where should they be put?
  - b. What type of social media? Texts
  - c. Any other suggestions re platforms
  - d. Anything that should be avoided?
13. What should the messaging look/sound like
  - a. Prompts: Is there language, messaging, platforms that would be important for PWLLE? Is there language, messaging, platforms that should be avoided? Or make people seek out toxic drugs

Any other things we haven't talked about that you'd like to say before we end?

Thanks!