Pockets of Safety: Implementing an Overdose Prevention Site into an Emergency Shelter During a Public Health Emergency

by

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We acknowledge and respect the lək̓ʷəŋən peoples on whose traditional territory the university stands and the Songhees, Esquimalt and W̱SÁNEĆ peoples whose historical relationships with the land continue to this day.

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Abstract

Background: In April 2016, after several months of increased numbers of unintentional drug toxicity deaths, British Columbia's Provincial Health Offer declared a public health emergency in response to this prolonged spike. In December 2016, the BC Minister of Health released Ministerial Order 488, supporting the implementation and expansion of overdose prevention services. In response to the toxic drug policy crisis in BC, one such overdose prevention site (OPS) was implemented within an emergency shelter, in Victoria, BC, in December 2016. This research sought to understand the role of OPS in responses to substance use and harms for people who use drugs and alcohol from the perspective of people accessing the shelter. Interviews were conducted in the spring of 2018, approximately 1.5 years after the OPS was opened.

The primary research questions for this study were: How has the implementation of an OPS contributed to responses to substance use and the uptake of harm reduction policy, philosophy, and practice within the shelter, from the perspective of people accessing the shelter? What were the impacts of implementing an overdose prevention site for people accessing the shelter?

To answer these broader questions, my specific research questions were:

1. Has the implementation of an OPS influenced responses to substance use in a shelter setting?
2. Has the implementation of an OPS reduced the harms experienced by people accessing the shelter?
3. How have the policies and practices within the shelter and organization impacted the implementation of the OPS?
4. Has the implementation of an OPS influenced the broader uptake and implementation of harm reduction policy, philosophy, and practice within the shelter setting?

Methods: This qualitative study utilized an Interpretive Description methodology and is aligned with a social constructivist paradigm. The applied, practice-based orientation of Interpretive Description balances hermeneutic interpretive tradition with descriptive approaches. Participants were recruited by a third party using purposive sampling. Twenty-one participants were interviewed, and all participants had lived experience of substance use (legal or illegal substances) and were accessing services at the emergency shelter at the time of data collection. Accessing the OPS was not a criterion for participation; as such, experience accessing the OPS varied across participants providing deep insights into the implementation and impacts of the OPS in a shelter setting. Qualitative interviews were audio recorded and transcribed verbatim. Data were organized using NVivo software and analyzed using Interpretive Description. Rhodes' Risk Environment Framework was used to guide the interpretation of findings.

Findings: The OPS provided important micro-level pockets of safety for PWUD within the broader organizational context of the shelter as part of the meso-level risk environment. There were many positive impacts of OPS implementation including saving lives, providing novel inhalation services, preventing harms and complications, reducing criminalization, reducing stigma, improving relationships with staff, improving quality of care, and facilitating connections to care. Primary implementation issues include hours of operation, physical space, and privacy. Informal policy and substance use rules, a constantly changing policy environment, inconsistency in the application of rules, consequences of inconsistent application of rules, and a

desire for consistency in the application of rules were all aspects of the broader policy context of the shelter that impacted the implementation of the OPS. Several aspects of the broader shelter influenced and were influenced by the implementation of an OPS. These included an organizational culture in transition, staffing within a transitional culture, the criminalization of substance use, and stigma. Lastly, the meso-level economic context of the shelter identified opportunities to further support implementation, including a need for increased resources, and the intersections of economics and safety.

Conclusions: The OPS had positive impacts for those accessing it; however, these impacts were largely limited to the OPS itself. While the OPS shifted the micro risk environment for individuals accessing the OPS, the meso environment remained a risk environment in several ways. The novel inhalation service provided important spaces for safety; however, some lingering risks remained. Peer witnessing and eOPS are important adjuncts to OPS services for people who are unable or unwilling to access traditional OPS. Implementing OPS into an organization that serves diverse populations with different substance use goals and needs presents unique challenges. Organizational and funder policies, aligned with principles of harm reduction, are important for the robust implementation of OPS services and the uptake of harm reduction policy, philosophy, and practice. Peers were critical to the success of the OPS, but the inclusion of peers must go beyond service delivery to also include service planning and design. Adequate resourcing is important for the successful implementation of services, and without adequate resources, risk environments can remain. Robust implementation planning is an essential component of successful service implementation and organizational culture change.

Keywords: Overdose prevention site, harm reduction implementation, overdose prevention, housing, emergency shelters, homelessness, harm reduction, harm reduction policy

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Acknowledgements

I have had the privilege of living, studying, working, and growing on Lekwungen and W̱SÁNEĆ territories for the last 37 years. I acknowledge the systems of oppression that Canada has been built upon and that continue within our systems and structures today. I acknowledge my position as a white settler and the many ways I benefit from these systems of oppression. I am working towards a better understanding of how I can support reconciliation, decolonisation, and Indigenous sovereignty on what is colonially known as Vancouver Island.

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I would like to thank my husband, Sherif for his unending love and support, for his encouragement and dedication to ensuring I complete my studies. Finally, I would like to thank my parents, my siblings, family and friends for their love and support over the years, for understanding my absence while completing my thesis and for encouraging me throughout the process.

Dedication

To my husband, Sherif, your unconditional love and support every day has been essential to my being and my success. Completing this thesis would not have been possible without you. You are my greatest ally and my greatest support.

To my friend Rebecca, your life may have been cut short, but you left an indelible impact on this world and on my life. You have inspired my career and pursuit of social justice.

At the time of writing this thesis, over 13,000 individuals have lost their life to the drug policy crisis in BC alone. These are over 13,000 preventable deaths. Over 13,000 members of our communities lost, and over 13,000 families that will never be the same.

To all the individuals who have lost their lives to the unregulated drug policy crisis, we grieve your deaths, and my deepest sympathy and support goes out to the loved ones who mourn you every day.

To the participants of this research study, including those who have since lost their lives during this public health emergency, may your voices and experiences live forever in this thesis. I cannot begin to thank you enough for gifting me the opportunity to get to know you, and bear witness to your lived experience.

Chapter 1: Introduction

Section 1.0- Introduction

British Columbia is currently experiencing a devastating number of people dying due to an unregulated and contaminated drug supply, which has continued at crisis levels since 2015. In response to this crisis, the Provincial Health Officer (PHO) declared a public health emergency in April of 2016 (Government of British Columbia, 2016b). At the time, the PHO warned that without additional steps to address this increase in overdoses, BC could face 600-800 deaths from overdose in 2016. Tragically, by the end of 2016, the number of overdose deaths would surpass these estimates, with 995 reported deaths from unintentional drug overdose. The number of overdose deaths for 2017 and 2018 increased further still, reaching approximately 1500 deaths per year (BC Coroners Service, 2023b). The intersection of the ongoing drug policy crisis and the COVID-19 global pandemic further exacerbated the number of overdose deaths, with the number of deaths nearing 2,000 in 2020, and exceeding 2,300 in both 2021, and 2022. The current Coroners Report for 2023 indicates that unfortunately 2023 is likely to see record high numbers of deaths as well (BC Coroners Service, 2023b).

As of August 2023, over 13,000 people in BC have lost their life from unintentional drug toxicity since 2016 (BC Coroners Service, 2023b). Illicit drug toxicity is now the leading cause of unnatural death in BC and accounts for more deaths than suicides, homicides, fire-related deaths, drowning and motor vehicle accidents combined (BC Coroners Service, 2023b). Overdose deaths due to drug policy and an unregulated drug supply affect all segments of society, but harms of unintentional overdose are increased for people experiencing homelessness, people experiencing poverty, and Indigenous peoples (BC Coroners Service, 2022, 2023b; First Nations Health Authority, 2023).

The term “overdose” implies that an individual knows what they’re taking, and the potency of what they’re taking, and so “unregulated drug policy emergency” is a more accurate term to describe the public health emergency, which is the result of drug policy decisions. However, colloquially, this public health emergency is often referred to as the “overdose crisis” or “overdose emergency” and so “overdose”, “toxic drug policy death”, “overdose emergency” and “drug policy emergency” will be used interchangeably throughout this thesis. Additionally, the BC Coroners Service uses “unintentional drug toxicity death” and so when referencing BC Coroners data, I reflect the language used in their reports.

The use of the word “toxic” refers to the unregulated and contaminated state of the illegal drug supply currently in BC and does not imply that all substance use is toxic or that substance use is inherently toxic. Indeed, by adding the word “toxic” I’m acknowledging the unregulated and contaminated nature of the drug supply as the cause of morbidity and mortality, rather than substance use in and of itself. The highly stigmatized nature of some forms of substance use requires an intentional and nuanced choice in language. While I have done my level best to use language that does not perpetuate stigmatizing narratives, I recognize that the language and terminology will continue to be debated and evolve.

While overdose prevention sites were introduced in 2016, BC has a long history of providing supervised consumption services (SCS), with a robust evidence base demonstrating many clear benefits in reducing the harms of substance use, including overdose and death (Kennedy et al., 2017; Kerr et al., 2017; Levengood et al., 2021; McCann & Temenos, 2015; Potier et al., 2014; Wallace et al., 2019). In addition to preventing overdose and providing life-saving overdose response, SCS have been shown to prevent the transmission of blood-borne infections, connect people to other health and social services (including housing, employment

assistance, primary care, substance use treatment), support social determinants of health, reduce strain on emergency medical services, and reduce downstream health system costs (Bourque et al., 2019; Gehring, Speed, Launier, et al., 2022; Ivsins et al., 2023; Kennedy et al., 2017; Kerman et al., 2020; Magwood et al., 2020; McCann & Temenos, 2015; Pijl et al., 2023; Pijl et al., 2021; Rubin & Suran, 2022). Additionally, SCS have been shown to support important social connections between staff and peers, reduce public drug use and support the safe disposal of used or discarded safer use supplies. While much of the early literature on supervised consumption sites focused on injection drug use, more recent literature has demonstrated the important benefits of expanding SCS to include inhalation services (Bourque et al., 2019; Pijl et al., 2023). In addition to the body of evidence supporting SCS, there is a substantive body of literature that supports other forms of witnessed consumption, including overdose prevention sites (OPS), as important strategies in addressing a select range of harms and challenges related to substance use (Kerr et al., 2017; Levengood et al., 2021; Mercer et al., 2021; Potier et al., 2014). The evidence on OPS suggests OPS provide many of the same benefits of SCS with the additional benefits of reduced bureaucratic obstacles, and a capacity for nimble implementation and response (Wallace et al., 2019).

To establish supervised consumption sites, federal legislation has required that service providers obtain a federal exemption to the Controlled Drugs and Substances Act. The application process for a federal exemption has been extremely resource intensive and the opportunity for flexibility in service design, often limited. In response to the drug policy emergency and the need to scale up overdose response efforts, the Government of British Columbia released a Ministerial Order, in 2016, sanctioning the implementation of overdose

preventions sites wherever needed, and without a federal exemption (Government of British Columbia, 2016a).

In 2021, after record-high numbers of overdose deaths, Health Canada developed Urgent Public Health Need Sites (UPHNS), on a temporary basis, to support expansion of overdose prevention services. Urgent Public Health Need Sites are in essence, overdose prevention sites, simply by another name, and supported by the federal government. To support expansion of these sites, Health Canada offered a Section 56(1) class exemption to the Controlled Drugs and Substances Act to each province and/or territorial government. This exemption differs from the previous process for SCS in that it's a general exemption given to the provincial government, rather than a specific exemption given to individual sites. Although BC had already enabled the provision of OPS in 2016, the UPHNS provided an important opportunity for additional legal protections, and the federal class exemption during COVID-19 helped to further expand these services.

As of 2022, there were 4 supervised consumption sites (with federal exemptions) and approximately 36 fixed-site overdose prevention sites in the Province of BC (Health Canada, 2022a). Unfortunately, at the time of writing, 2023 statistics on SCS were not available from the Health Canada website. The fixed-site OPS in BC are provided in a variety of settings, which can include stand alone OPS services as well as OPS embedded within housing programs, emergency shelters, and peer-based programs. Embedding OPS and harm reduction interventions within other services can present unique challenges. However, there is little research on the implementation and impacts of OPS within other organizational settings, and so this is an important and much needed area for further research.

Section 1.1- Purpose of the Study

The purpose of this study is to understand the impacts of overdose prevention services within a homeless shelter and how the implementation of an OPS contributes to responses to substance use and the uptake of harm reduction policy, philosophy, and practice within a shelter setting.

Section 1.2- Research Questions

How has the implementation of an overdose prevention site (OPS) contributed to responses to substance use and the uptake of harm reduction policy, philosophy, and practice in an emergency shelter, from the perspective of people accessing the shelter? What were the impacts of implementing an overdose prevention site for people accessing the shelter?

To answer my overarching questions above, I asked the following sub-questions:

1. Has the implementation of an OPS influenced responses to substance use in a shelter setting?
2. Has the implementation of an OPS reduced harms experienced by people accessing the shelter?
3. How have the policies and practices within the shelter and organization impacted the implementation of the OPS?
4. Has the implementation of an OPS influenced broader uptake and implementation of harm reduction policy, philosophy, and practice within the shelter setting?

To answer these questions, I designed a qualitative study using an Interpretive Description methodology (Thorne, 2008, 2016; Thorne et al., 1997), and interviewed people who accessed shelter services and identified as using substances (any type of substance use, including

alcohol and cannabis, or previous substance use if currently abstaining). While some participants used the OPS, experience accessing the OPS or other harm reductions services was not a criterion for eligibility and so experiences with the OPS and harm reduction services intentionally varied across participants. Eligibility simply required participants to be accessing shelter services at the time of interviews and identify as using any substance (legal or illegal). This variation in experience across participants was intentional to elicit deeper insights into the implementation of the OPS within a broader organizational and service setting.

Section 1.3- Self-Location

As this research is philosophically aligned with a social constructivist paradigm wherein knowledge is co-created through interaction between researcher and participant, it is important to locate myself within this research, as my experiences and reality implicitly and/or explicitly influence the design and interpretation of this research.

I come to this research as a cis-gendered, heterosexual, white female of European ancestry. I acknowledge that I am an ancestor of uninvited settlers, on these traditional, Indigenous lands. Currently, I am an uninvited resident on the traditional lands of the Songhees and xʷsepsəm (Esquimalt) First Nations.

I also come to this research with lived experience of personal loss due to drug overdose. This loss has had a formative impact on my academic pursuits within the field. During the summer of 2004, one of my best friends died from a drug overdose. Fear of criminalization of substance use resulted in my friend dying alone, and without help. Though I didn't have the language for it at the time, I sensed there was something larger at play and the common discourses that blame people who use drugs seemed problematic to me. This was the most powerful experience of structurally produced harm that I had experienced at that point in my life,

although I didn't yet fully understand the forces at play. Furthermore, the stigma around substance use really became apparent to me when her parents refused to hold a service for her, and the people that had once called her a friend stopped speaking of her, as though to distance themselves from ever having known somebody that could die from a drug overdose. It was as though the overdose not only ended her life, but also erased the 17 years of life she had lived. These early experiences strongly influenced my path of academic learning and after many years of post-secondary education, I now have the language and understanding of some of the phenomena at play.

I come to this research with a background in psychology and substance use research, using both qualitative and quantitative methodologies. Though my background in psychology has provided me with strong and rigorous research skills, my practice-based work within the field of mental health illuminated many social and structural inequities and production of illness. These experiences challenged my previously held, often individualized, understanding of health and wellness, which I had developed within psychology. These combined experiences were the impetus for my pursuing the Social Dimensions of Health MA program and interdisciplinary research and have contributed to my current focus on the social and structural production of health and illness. Through the 4 years of substance use research experience, I gained while at the Canadian Institute for Substance Use Research, I developed an appreciation for the importance of practice-relevant research within such applied topics. This inclination towards applied, practice-relevant research aligns well with an Interpretive Description methodology and the focus of this research.

This thesis is comprised of 9 chapters. In Chapter 1, I introduce the research study, my positionality within the research and outline the research questions and rationale for the study. In

Chapter 2, I synthesize the relevant literature informing this research. In Chapter 3, I outline the key components of the theoretical framework used for the interpretation of findings in this research. In Chapter 4, I discuss the methodology guiding this research, as well as the methods used to conduct the research. In Chapter 5, I outline the key participant demographic information, describing the study participants and providing a summary of participant history of substance use for additional context. In Chapters 6 and 7, I present the research findings from this study. Chapter 6 outlines the impacts of OPS implementation, as well as implementation issues and recommendations specific to the OPS. Chapter 7 presents findings related to the broader context of the shelter, including the shelter policy context, the organizational culture of the shelter, and the meso-level economic context within which implementation occurred. In Chapter 8, I provide a summary of the key findings, and interpretation and discussion of the findings in relation to the literature and research questions. Finally, in Chapter 9, I identify strengths and limitations of the research, recommendations for programmes considering implementing OPS, recommendations for policy, and recommendations for future research. Lastly, I provide my concluding thoughts.

Chapter 2: Review of the Literature

Section 2.0- Introduction

In this chapter, I provide a synthesis of the literature in which this research is situated. In section 2.1, I discuss the intersections of substance use and homelessness. In section 2.2, I outline the harms associated with substance use, including the structural production of harm, overdose and the drug policy emergency, and stigma. In section 2.3, I describe harm reduction as an approach, and I outline the history and evolution of harm reduction. In section 2.4, I provide information specific to SCS and OPS, including the evidence base for SCS and OPS, the policy context for SCS and OPS in BC, and the history and origins of SCS and OPS in BC. In section 2.5, I outline the BC housing and harm reduction policy context, and finally in section 2.6, I summarize the literature related to the implementation of harm reduction in responses to homelessness.

Section 2.1- Substance Use and Homelessness

Substance use by both housed and unhoused populations occurs along a continuum of use and can include both legal and illegal substances (Health Canada, 2022b). Legal drugs are those not currently criminalized in Canada and include tobacco, alcohol, caffeine, and cannabis. Illegal or illicit drugs are those substances criminalized in Canada (e.g., heroin, cocaine, crystal meth, crack, LSD) and criminalized under the Controlled Drugs and Substances Act (Government of Canada, 2023). Illicit use can also include the use of prescription drugs used in a way other than medically intended (e.g., use of prescription opioids without a prescription or not as prescribed). Illicit use can also include the use of substances not meant for consumption, to induce intoxication (e.g., non-beverage alcohol, such as hand sanitizer or rubbing alcohol).

Prevalence rates of substance use amongst the general population in Canada vary by type of substance, but the majority of Canadians use a substance of some type (Government of Canada, 2021c, 2021d). For example, the 2019 Canadian Alcohol and Drug Survey (CADS) reported that approximately 76% of Canadian adults consumed alcohol in the past year (Government of Canada, 2021b), and approximately 21% of Canadians (23% of males and 19% of females) reported using cannabis in the past year. Cannabis is the most frequently consumed drug in Canada, after alcohol. Approximately 10% of Canadians reported using tobacco in the past year (Government of Canada, 2022), and approximately 3% of Canadians included in the CADS study reported use of illegal drugs (cocaine/crack, speed/methamphetamine, ecstasy, hallucinogens, heroin, salvia) in the past year. Use of illegal drugs has remained relatively stable since 2015 among a small percentage of Canadians. Approximately 20% of Canadians will meet diagnostic criteria for a substance use disorder in their lifetime (Government of Canada, 2021b).

Prevalence rates of substance use amongst unhoused populations can be difficult to quantify (Fazel et al., 2014) due to methodological and definitional differences across regions, and unhoused populations are not always included in typical data collection approaches (Davis et al., 2023; Fazel et al., 2014; Government of Canada, 2021c). Additionally, studies vary in how they quantify substance use, and whether they record any substance use, or only substance use that would be considered ‘problematic’ such as meeting diagnostic criteria for a substance use disorder (SUD) (Johnson & Chamberlain, 2008). Within both housed and unhoused populations, substance use occurs along a spectrum, and only a proportion of total substance use would be considered ‘problematic’ or meet diagnostic criteria for a substance use disorder (Canadian Centre on Substance Use and Addiction, 2022; Health Canada, 2022b).

Despite methodological challenges, the evidence suggests that prevalence rates of substance use, including the use of illegal substances, in unhoused populations are high, and rates are typically higher among males (Fazel et al., 2014; Torchalla et al., 2014). Estimates suggest that for unhoused populations, prevalence rates for alcohol dependence range from 8-58% and prevalence rates for drug dependence range from 5-54% (Fazel et al., 2014). Prevalence rates for substance use are typically reported for substance use disorders or dependence, rather than any use. As such, I have only included prevalence rates related to dependence or AUD/SUD, rather than prevalence rates for any substance use as these are not widely available.

The relationship between experiences of homelessness and substance use is complex (Fazel et al., 2014; McVicar et al., 2015; Nilsson et al., 2023) and some evidence suggests that rates of substance use and SUD increase with time spent homeless (Davis et al., 2023; Government of Canada, 2021a). It is difficult to assess a causal relationship or temporal order of events between substance use and homelessness (Johnson & Chamberlain, 2008; McVicar et al., 2015); however, substance use and homelessness are often viewed as bi-directional. People who use substances are more likely to become homeless and people who experience homelessness are more likely to use substances. Research suggests that while some substance use does precede homelessness and is a cited cause of homelessness in a minority of cases, substance use is more often an adaptation to homelessness (Johnson & Chamberlain, 2008). Substance use can often be an adaptive response to traumatic experiences and experiences of substance use can increase or become exacerbated through experiences of homelessness, often to cope with the hardships of living on the street or being unhoused (Davis et al., 2023; Johnson & Chamberlain, 2008; Torchalla et al., 2014).

The most recent Point in Time Count data for Victoria BC (Davis et al., 2023) indicate that rent unaffordability and a lack of available rental housing are primary reasons for loss of housing (Davis et al., 2023). Other research suggests that where substance use is cited as a cause of homelessness, it's often a secondary or tertiary cause, rather than a primary cause (McVicar et al., 2015). Additionally, reporting on "reasons for homelessness" can be challenging due to methodological issues or differences in methodology and operational definitions across studies. For example, some surveys inquire only about most recent experience of homelessness, (Government of Canada, 2021a) whereas others look at first experience of homelessness. Reasons for initial loss of housing could be categorically different than reasons for most recent experience of homelessness due to the intervening experiences and potential traumas since the initial loss of housing. Homelessness can be episodic or chronic (Fazel et al., 2014), and even for people who experience chronic homelessness, they can have temporary periods of being housed, before losing their housing once again. In this sense, it is difficult to assess cause of homelessness if measuring most recent homelessness as it doesn't capture the root cause of loss of housing initially (Fazel et al., 2014; McVicar et al., 2015).

Despite some differences across studies, the data do demonstrate a complex interplay between structural and individual factors that impact both loss of housing and barriers to accessing housing, and structural factors that can create and perpetuate homelessness (Fazel et al., 2014; Moss et al., 2020). Some populations are disproportionately impacted by homelessness due to structural factors (Fazel et al., 2014). For example, in Victoria, Indigenous peoples make up approximately 5% of the total population, but 32.9% of respondents in the most recent Point in Time Homelessness Count identified as Indigenous (Davis et al., 2023). This increased

likelihood of experiencing homelessness results from systemic barriers and consequences of historic and ongoing colonisation (Davis et al., 2023).

Substance use is often associated with a high rate of stigma and discrimination, especially when combined with poverty and homelessness. Indeed, the stigma surrounding illegal drug use can act as a barrier to services and can result in longer periods of homelessness. Research exploring the relationship between homelessness and substance use suggests that a lack of housing and substance use resources increase transitions into homelessness while simultaneously acting as barriers to transitioning out of homelessness (Austin et al., 2021; Cheng et al., 2013; Davis et al., 2019; Dickson-Gomez et al., 2007; Krüsi et al., 2010; Moxley et al., 2020). Additionally, due to a shortage of housing, combined with stigma towards poverty, homelessness and substance use, people who use substances face multiple barriers to obtaining housing and exiting homelessness (Fazel et al., 2014; Pauly, Wallace, & Barber, 2018; Sample & Ferguson, 2020; Shinn & Gillespie, 1994).

Section 2.2- Substance Use Harms

Harms of substance use can be categorized as acute or chronic and can include health, social and legal impacts for the individual (Canadian Substance Use Costs and Harms Scientific Working Group, 2020; Firestone et al., 2015; Rhodes, 2009). The harms can occur because of the substance itself, the policies that regulate a substance or the laws that criminalize the substance (Canadian Substance Use Costs and Harms Scientific Working Group, 2020; Rhodes, 2002, 2009; Rhodes et al., 2005). Acute harms result from the immediate effects of alcohol and other drugs on the body (e.g., injuries, toxicity and abscesses), whereas chronic harms are the long-term effects of substance use on the body (e.g., liver disease, HIV, HCV, respiratory problems) (Ahern et al., 2007; Fazel et al., 2014; Rehm et al., 2009; World Health Organization, 2018).

Physical harms related to substance use can result from acute or chronic use, as well as drug policy decisions and criminalization (e.g. the ongoing drug policy crisis) and can result in injury or death for individuals (Acuff et al., 2021; Loxley et al., 2004; Parkes et al., 2022; van Amsterdam et al., 2013). Social harms are the negative effects of alcohol and other drug use on the social conditions necessary for health and well-being (e.g., loss of housing, breakdown in relationships, marginalization, and stigma, etc.) (Fazel et al., 2014; Goodyear et al., 2021; Hyshka, Anderson, & Wild, 2017; Rehm et al., 2009; Sherk et al., 2020; Wogen & Restrepo, 2020; World Health Organization, 2018). These harms are largely influenced by social factors such as poverty, access to primary care, stigma, and unmet social determinants of health which often create barriers to health for people who use drugs (Fazel et al., 2014; Piat et al., 2015). Legal harms of substance use, such as criminalization, are often the result of policies and stigma that result from the prohibition of drugs (Gehring, Speed, Wild, et al., 2022; Johnstad, 2023; Kammersgaard, 2019; Moniruzzaman et al., 2022; Pamplin et al., 2023). These harms will be further discussed below as part of the structural production of harms.

Structural Production of Harms

While harms of substance use can be experienced by anybody, there are many structural factors that can result in certain populations experiencing more harms than others (Alexander et al., 2022; Fazel et al., 2014; McNaughton, 2008; Rhoades et al., 2011). The inequitable distribution of illness and poor health is structurally produced through systems of oppression and marginalization related to intersections of poverty, sexism, racism, colonisation, and criminalization. These systems of oppression create inequities in health, which in turn creates inequitable burden of illness and harms (Barrow et al., 1999; Farahmand et al., 2020; Farmer, 1996, 2010). Additionally, these systems of oppression cause trauma for people impacted by

them, and substance use is often a response to that systemically produced trauma (Alexander et al., 2022; Fazel et al., 2014; Rhoades et al., 2011; Torchalla et al., 2014). These intersecting systems of oppression cause harms for people, and substance use itself can be one of those harms (Alexander et al., 2022; Gehring, Speed, Wild, et al., 2022; McNaughton, 2008; Rhoades et al., 2011). HIV, HCV and overdose deaths are higher among people living in poverty and are disproportionately high among Indigenous peoples due to colonisation and ongoing systems that reinforce colonial interests while devaluing Indigenous populations and experiences (BC Coroners Service, 2022; Firestone et al., 2015; First Nations Health Authority, 2023; Galea et al., 2003; McNaughton, 2008). Furthermore, there's an Increased risk of STI's, HIV and HCV for women (Fazel et al., 2014; Spittal et al., 2006), and there's an increased risk of HIV for people in prisons and for those who don't have access to stable housing (Fazel et al., 2014). Lastly, there are increased mortality rates associated with the intersection of substance use and homelessness due to these intersecting systems of oppression that create harms, including overdose death (BC Coroners Service, 2022; Cheung & Hwang, 2004; Fazel et al., 2014; Spittal et al., 2006).

Under the Controlled Drugs and Substances Act, Canada has a policy of prohibition and zero tolerance in relation to certain kinds of substance use (e.g., heroin, cocaine, crack, crystal methamphetamine, LDS, etc.). Within the current paradigm of drug prohibition and criminalization, harms related to substance use are often structurally produced and compounded by drug laws, policies and practices (Rhodes et al., 2005). Drug criminalization creates harms of substance use external to the substance itself (e.g., incarceration, loss of parental custody etc.) and often compounds existing or creates further harms related to the substance use. For example, risk of overdose due to an illegal and unregulated market, increased risk of blood borne disease transmission due to policies around needle exchange programs and funding, and increased risk of

overdose due to prohibitory policies and the need to use in secret, etc. (Gehring, Speed, Wild, et al., 2022; Moniruzzaman et al., 2022; Pamplin et al., 2023). Many of these structurally produced harms are further compounded when intersected with experiences of poverty and/or homelessness (Bardwell, Ivsins, et al., 2021; Cano et al., 2022; Van Draanen et al., 2020).

Overdose and the Drug Policy Emergency

In 2012, the BC Coroners Service began detecting illicit fentanyl in drug-related mortality investigations, although at the time, the numbers were quite low with illicit fentanyl being detected in only 4% of unintentional overdose deaths (BC Coroners Service, 2023a). In late 2015, the number of fentanyl-related deaths, began to steadily increase, reaching 29% (BC Coroners Service, 2023a). By April 2016, these numbers continued to increase even further, reaching 67% (BC Coroners Service, 2023a). In response to rising rates of overdose deaths, the Public Health Officer declared a Public Health Emergency in BC (Government of British Columbia, 2016b). The purpose of declaring the Public Health Emergency was to enable public health powers and interventions to collect robust, real-time data to identify where the greatest risks were present or arising in order and proactively warn people who use drugs (Government of British Columbia, 2016b).

Unintentional overdose deaths are a significant harm of criminalized substance use. As identified above, there are many intersecting social, economic and policy contexts that increase substance use harms for people experiencing homelessness (BC Coroners Service, 2022; Park et al., 2020; Rhodes, 2002, 2009; Rhodes et al., 2005). The harms of unintentional overdose and drug poisonings due to an unregulated and contaminated illicit drug supply are both produced and distributed through structural factors. Social injustice for specific populations, including Indigenous peoples, and people experiencing homelessness means that these groups experience

unintentional overdose deaths at disproportionately high rates (BC Coroners Service, 2022; Fazel et al., 2014; First Nations Health Authority, 2023).

Stigma

Historically, the use of certain substances has been viewed as a moral failure, creating and furthering stigmatization (Lloyd, 2010; MacNeil & Pauly, 2011). The legal status of a substance often has an impact on the degree to which it is stigmatized. For example, the use of heroin or crack is often more stigmatized than the use of alcohol (Lloyd, 2010; Tyndall & Dodd, 2020; Wogen & Restrepo, 2020). Similarly, some modes of consumption are more stigmatized than others. For example, injection use is more stigmatized than inhalation or oral consumption (Ahern et al., 2007; Lloyd, 2010; McGinty & White, 2022; Room, 2005; Wogen & Restrepo, 2020).

> "The process of stigmatization of injection drug users contributes to those who use drugs being devalued, demonized and blamed for societal decay with illegal drug use viewed as a moral rather than a health issue, and injection drug users' viewed as undeserving or unworthy citizens" (MacNeil & Pauly, 2011, p. 27).

Consequently, there are many people, organizations, and systems that do not view people who use drugs as deserving of care, services, or basic human rights, which can have real and profound impacts on people's health (Ahern et al., 2007; Ezell et al., 2021; Fazel et al., 2014; Goodyear et al., 2021; Lloyd, 2010; Room, 2005; Wogen & Restrepo, 2020). The prohibition of substance use supports these problematic narratives with a focus on criminalization and moral failing.

Conversely, harm reduction as an approach or philosophy directly opposes these narratives and is rooted in dignity, justice, and human rights for people who use drugs (Harm

Reduction International). Harm reduction as both a paradigm and set of interventions, is an important tool in addressing and reducing stigma towards substance use and supporting the health and human rights of people who use drugs (Barber et al., 2020; Harm Reduction International, 2022; Iammarino & Pauly, 2021; Pauly, 2008a; Pauly et al., 2007).

Section 2.3- Harm Reduction

What is Harm Reduction?

Harm reduction is both a philosophy of care and a set of strategies that focuses on reducing the harms of substance use, without requiring a reduction in consumption per se (Harm Reduction International, 2023). The philosophy of harm reduction is grounded in justice and human rights, while focusing on non-judgemental care that is free from coercion, discrimination or requiring abstinence or reduction of use as a condition of care (Harm Reduction International; Iammarino & Pauly, 2021; Pauly, 2008a; Pauly et al., 2007). Harm reduction, as an approach, has been a grassroots, bottom up social movement to ensure the participation of those affected and a top down public health approach to reduce harms of drug use (Collins et al., 2012). The primary goal of harm reduction is to prevent harms of use, to keep people alive and support and protect their health (Harm Reduction International, 2023).

Harm reduction approaches to care support people in their self-identified goals and do not have predetermined expectations or outcomes that people need to achieve related to abstinence (Harm Reduction International, 2023; Pauly, 2008a). The key principles of harm reduction include: 1. A commitment to evidence, 2. Respecting the rights of people who use drugs, 3. A commitment to social justice and collaboration with people who use drugs, and 4. The avoidance of stigma (Harm Reduction International, 2023).

Harm reduction interventions, policies, and practices are informed by a strong body of evidence (BCCDC, 2018a; Harm Reduction International, 2023). These interventions have been shown to be cost-effective, practical, feasible and safe (Hedrich & Hartnoll, 2021; Kimber et al., 2010; Wilson et al., 2015). The evidence specific to supervised consumption and overdose prevention services are presented in their own section below, in section 2.4.

The harm reduction movement is grounded in social justice and addressing discrimination so that people can access the health and social services that they need. Reducing barriers is an essential component of the principle of social justice within harm reduction (Pauly, 2008a). Additionally, harm reduction acknowledges and values the lived experience of people who use drugs and promotes the meaningful inclusion of people who use drugs in the design, implementation and evaluation of programmes and policies (Barber et al., 2020; Greer et al., 2016; Hanson et al., 2020; Harm Reduction International, 2023; Parkes et al., 2022; Pijl et al., 2021). Lastly, harm reduction accepts people for who they are and where they're at and seeks to meet people without judgment (Harm Reduction International, 2023; Pauly et al., 2007).

Research suggests that harm reduction services can serve as sites of refuge within an otherwise unsafe world (MacNeil & Pauly, 2011). Harm reduction can help to shift understandings of substance use away from stigma-based stereotypes to reduce barriers to health and services (Iammarino & Pauly, 2021).

What is the History and Evolution of Harm Reduction?

The 1980s brought a shift within epidemiology that began to look beyond bio-medical understandings of health and acknowledged the social and environmental impacts on health (Rhodes, 2002). Around this same time, harm reduction developed largely in response to the discovery and development of HIV and AIDS. These parallel timelines greatly influenced the

early development of harm reduction principles and practice. Despite this growing acknowledgment of the social and environmental influences on heath, many if not most harm reduction programs and policies reflected an individualized focus of risks and harms and often only focused on reducing physical harms such as transmission of blood borne illness (BBI), in particular, the prevention of HIV transmission (MacNeil & Pauly, 2011; Rhodes, 2002, 2009; Rhodes et al., 2005).

For a long time, theories of individualized risk aversion have influenced harm reduction practices and programs. These theories are built upon the premise that people are inherently averse to risk and if given the choice, they would choose safer practices (Rhodes, 2002, 2009; Rhodes et al., 2005). This new perspective brought with it benefits and challenges. On one hand, it challenged existing negative narratives of people who use drugs as only caring about their next hit and instead, created a new narrative of people who use drugs as individuals capable of thoughtful action and decision making. However, this new conceptualization of risk aversion and individualized responsibility failed to consider the social, political, and economic contexts within which harms are produced, options are/are not made available and decisions are made (Rhodes, 2002). Critical analysis of the philosophical underpinnings of harm reduction often critiques harm reduction as further legitimizing discourses propagated by those institutions in power by becoming a means of surveillance and social control, and further emphasizing neo-liberal values that promote personal responsibility for use, including safer use of drugs (Elliott, 2014; Jiao, 2019; MacNeil & Pauly, 2011).

It is for these reasons that conceptual understanding and implementation of harm reduction must expand beyond individual behavior change and prevention of blood borne disease transmission, to include critical perspectives, advocacy for drug user rights, harm reduction as

relationship and anti-stigma approaches. As harms can be created within many social, political and structural contexts, it is important that interventions and opportunities for change also be identified within these spheres, and not only at an individual level (Rhodes, 2002, 2009; Rhodes et al., 2005).

Section 2.4- Supervised Consumption and OPS

This section will focus specifically on supervised consumption and overdose prevention services (OPS), including the evidence base supporting these services, the policy context of SCS and OPS in BC, the history of these services in BC, and current implementation of these services throughout the province. While SCS and OPS are simply one harm reduction intervention amongst many, due to the focus on OPS for this research, I have given SCS and OPS its own section within this chapter.

The Evidence Base for SCS and OPS

SCS and OPS each have their own, unique history within BC, which will be discussed later in this section. Supervised consumption and overdose prevention services are similar in that they both provide spaces for the witnessed consumption of substances, but they differ in that SCS require an exemption from the federal government (Section 56(1) of the Controlled Drugs and Substances Act) and in British Columbia, overdose prevention services are authorized through the Ministerial Order released in 2016 (Government of British Columbia, 2016a).

SCS and OPS have a strong evidence base demonstrating the important role they play in reducing harms, including preventing overdose death, abscess, blood-borne infections, reducing stigma, and addressing social determinants of health (Bardwell, Austin, et al., 2021; Bardwell, Boyd, et al., 2018; Bardwell et al., 2017; Bourque et al., 2019; Cassie et al., 2022; Foreman-Mackey et al., 2019; Galarneau et al., 2023; Gehring, Speed, Launier, et al., 2022; Government

of BC & BCCDC, 2020; Hawk et al., 2015; Holland et al., 2022; Ivsins et al., 2022; Ivsins et al., 2023; Johnson & Beletsky, 2020; Kennedy et al., 2017; Kerman et al., 2020; Kerr et al., 2017; Leece et al., 2013; Levengood et al., 2021; Lew et al., 2022; Magwood et al., 2020; McCann & Temenos, 2015; Nowell, 2018; Olding, 2022; Oudshoorn et al., 2021; Pauly et al., 2020; Pijl et al., 2023; Pijl et al., 2021; Potier et al., 2014; Rubin & Suran, 2022; Samuels et al., 2022; Shaw et al., 2015; Socia et al., 2021; Tyndall & Dodd, 2020; Wallace et al., 2019; Watson et al., 2013). OPS and SCS both support people to use substances in a safer manner, provide sterile substance use equipment, and provide witnessed consumption and immediate response in case of overdose (Bourque et al., 2019; Kerr et al., 2017; Levengood et al., 2021; Potier et al., 2014; Wallace et al., 2019). OPS have been established as important, life-saving services (Bardwell et al., 2017; Holland et al., 2022; Samuels et al., 2022; Shorter et al., 2022; Wares et al., 2021) and have been implemented into a variety of service delivery settings, including health and social services (Bardwell et al., 2017; Holland et al., 2022; Samuels et al., 2022; Shorter et al., 2022; Wallace et al., 2019).

OPS have been identified as safe spaces where people can experience a feeling of belonging and protection from discrimination (Foreman-Mackey et al., 2019). OPS are able to effectively provide physical safety through safer use practices and overdose response, and emotional/psychological safety through a harm reduction approach to care (Foreman-Mackey et al., 2019). One of the key benefits of OPS is the low-barrier nature of the service, often staffed by community members who are people who use drugs (Olding et al., 2023). Research has demonstrated a clear benefit of peer-led and peer-involved harm reduction services (Barber et al., 2020; Bardwell, Kerr, et al., 2018; Greer et al., 2016; Mamdani et al., 2022; Pauly, Mamdani, et al., 2021; PEEP, 2018; Ti et al., 2012), including OPS (Bardwell, Boyd, et al., 2018; Bardwell,

Kerr, et al., 2018; Gillespie et al., 2018; Greer et al., 2016; Mercer et al., 2021; Parkes et al., 2022; Perreault et al., 2023). While barriers to OPS do remain, some research suggests that the public are more supportive of OPS than they are of SCS (Socia et al., 2021). Public education related to the benefits of harm reduction and OPS can be effective for changing hearts and minds and cultivating greater support for harm reduction services; however, this can take considerable time and dedicated resources (Sherman et al., 2022), which are not always available.

The implementation of OPS into housing services, including emergency shelters has the potential to provide life saving interventions to those experiencing a disproportionate burden of harms, including death from overdose (Bardwell et al., 2017; BC Coroners Service, 2022, 2023a; Lew et al., 2022).

Due to the non-judgemental approach of harm reduction services, many people feel safe accessing OPS and SCS, whereas they might experience real or perceived discrimination from other health services (Foreman-Mackey et al., 2019; Ivsins et al., 2019). As such, OPS and SCS can reach those most marginalized in society and provide important opportunities for connections (Oudshoorn et al., 2021; Pauly et al., 2020). This can further serve as a gateway to other health, housing, and social services, including referrals to housing, income supports, detoxification, treatment, and counseling services (MacNeil & Pauly, 2011; Pauly et al., 2013; Wallace et al., 2019). The adaptability of OPS also lends itself to meet the needs of specific groups, including those often inadequately serviced through standard services. Research suggests that OPS designed specifically to support women can address the unique risks and harms that women often experience (Bardwell, Austin, et al., 2021; Boyd et al., 2018; Collins et al., 2020).

Despite the strong evidence in support, SCS and OPS often face opposition and illegal drug use remains highly stigmatized, especially for those experiencing poverty and homelessness

(BC Coroners Service, 2023a; Domanico & Malta, 2012; Ivsins et al., 2020; Ivsins et al., 2023; Lloyd, 2010; MacNeil & Pauly, 2011; O'Keefe et al., 2020; Perreault et al., 2023; Room, 2005; Winstanley et al., 2016). Even in British Columbia (BC), where harm reduction is included in BC health mandates, there is resistance to the implementation of harm reduction services and the establishment of services has faced barriers (Kerr et al., 2017; MacNeil & Pauly, 2011; Ministry of Health et al., 2022). Structural opposition towards harm reduction services, such as overdose prevention sites, has resulted in limited uptake and availability throughout BC despite provincial direction, dedicated funding, evidence-based guidance and enabling policies (BC Coroners Service, 2022; BCCDC, 2023e). In the next section, I discuss the policy context of SCS and OPS in more detail.

The Policy Context for SCS and OPS in BC

Supervised consumption (also known as supervised injection) and overdose prevention services offer the same service in essence (e.g., safer spaces where use is witnessed) but have different histories, policy and legal structures, and applications in BC. Supervised consumption services require a federal exemption from the Controlled Drugs and Substances Act by Health Canada. This process is very lengthy, complex, and can be cumbersome, which can create challenges and delays for implementation. Overdose prevention sites were established in BC in response to the unregulated drug policy public health emergency, and enabled by Ministerial Order M488 in 2016 (Government of British Columbia, 2016a). Due to the unprecedented rates of unintentional overdose and death, OPS are intended for rapid implementation and simply need approval and sign off from a Medical Health Officer.

History and Origins of SCS in BC

British Columbia has a long history with providing supervised consumption services (SCS), beginning in 2002 when the Dr Peter Centre opened a supervised injection site (SIS) as part of their program serving people living with HIV (BCCDC, 2018b; Buxton, 2022). In 2003, a peer-led unsanctioned SIS opened in the Downtown East Side (DTES), offering a drop-in services 7 days a week. In September 2003, Insite opened in Vancouver as a pilot study, with a temporary Section 56(I) exemption under the Controlled Drugs and Substances Act (CDSA) (BCCDC, 2018b; Buxton, 2022). In 2008, the Federal (Conservative) government declined to renew the Section 56(I) exemption and InSite entered a long court process to fight for the right to access SIS. In 2008, the BC Supreme Court ruled that it would be unconstitutional to close InSite, as it would infringe upon drug users' Charter Rights. The Federal government appealed this ruling and in 2011, the Supreme Court of Canada dismissed the federal government's appeal (BCCDC, 2018b; Buxton, 2022; McCann & Temenos, 2015), establishing InSite as a permanent service, with a secure legal footing.

History and Origins of OPS in BC

As outlined previously, starting in 2015, a significant increase in the presence of illicit fentanyl in the drug supply resulted in increased morbidity and mortality for people who use substances. This sharp increase in unintended overdose deaths further highlighted the need for supervised consumption services in BC (BC Coroners Service, 2023a; Wallace et al., 2018). However, with the lengthy and challenging process for obtaining a federal exemption, many barriers remained for those wanting to provide these services. In September 2016, in response to this increasing number of deaths, the Overdose Prevention Society opened an unsanctioned OPS in Vancouver, BC in the DTES after an initial attempt to do so in Surrey was closed down. In

December 2016, the Minister of Health released Ministerial Order M488, encouraging the implementation of overdose prevention sites (OPS) throughout the province.

Through Ministerial Order M488, BC sanctioned the operation and implementation of Overdose Prevention Sites. These OPS operate under the jurisdiction and powers of the Provincial Health Officer and Public Health Emergency declaration. OPS are much nimbler (Wallace et al., 2019) and have fewer bureaucratic or administrative barriers to setting up services than SIS/SCS have as they do not require a Section 56(I) exemption. Due to the nimble nature of OPS, these services were able to rapidly be developed by community from the ground up, in response to demonstrated need (Wallace et al., 2019). Throughout the province, OPS have opened in diverse models and settings (Bardwell, Boyd, et al., 2018; Bardwell et al., 2017; BCCDC, 2019, 2023e; Collins et al., 2020; Galarneau et al., 2023). Models have ranged from fixed site, brick and mortar OPS buildings, to temporary or portable structures, and have also included mobile sites (such as in a converted RV) (BCCDC, 2023e).

In Victoria, BC, three overdose prevention units were immediately opened in response to the overdose emergency after the release of Ministerial order M488. One of these was an OPS operating within the emergency homeless shelter where this research was conducted. These units were funded by the local health authority, but the service delivery was contracted to community organizations. In 2018, 2 years into the ongoing unregulated drug policy crisis, the regional health authority received a CDSA Section 56(I) exemption and opened a health authority-run supervised consumption site (SCS). In the time since OPS were first opened, several of the supportive housing sites implemented OPS into their services, but access has been restricted to residents or visitors of the facility. However, the number of OPS relative to need remains in question and there remains opposition to OPS in BC communities.

Section 2.5- BC Housing and Harm Reduction Policy

Previous research related to housing and harm reduction identified a BC Housing policy requiring shelter and housing providers to provide low barrier services as a condition of BC Housing funding (Pauly, Wallace, & Barber, 2018). Within that BC Housing policy framework, low barrier services were understood as people not needing to be abstinent to access services. At the time of writing, in Summer 2023, this requirement for funding appears to have been removed by BC Housing (BC Housing, 2018). In updating the literature for this chapter, I sought to review the BC Housing Program Framework that was used in our previous research. However, I found the link to be dead and it appears the framework has been removed by BC Housing. The current BC Housing Emergency Shelter Program Framework, updated in 2018, does not include this low-barrier requirement for funding. Additionally, the Framework does not include any information on substance use or harm reduction other to mention "addictions treatment" as an example of support services in the glossary. In conjunction with this new framework, BC Housing has available online, Sample Policies and Procedures for Emergency Shelters (BC Housing, 2013), which has two sets of sample policies. One set of is for minimal-barrier emergency shelters that do not require abstinence from alcohol and substance use, while the second are policies for high-barrier services that prohibit alcohol and substance use. These policy documents specify that services do not discriminate based on sexuality, racial identity, gender, religion, health status etc. and that the difference between minimal barrier and high barrier shelters is eligibility criteria related to substance use. It appears that the provision of low-barrier services is no longer a requirement for funding and BC Housing now supports both low and high barrier services. The provision of low-barrier services has shifted from a requirement of BC Housing to an option and is now up to the discretion of the service provider.

To add to this policy confusion, the BC Ministry of Housing website states that the Government of BC takes a Housing First approach, yet the BC Housing Emergency Shelter policy documents refer to "housing readiness" and programs to support people in becoming "housing ready" which do not align with Housing First principles, or best available evidence. Housing First is grounded in the belief that housing is a human right and people should not have to prove "readiness" to access appropriate housing. Additionally, people do not need to be abstinent or working towards abstinence to receive housing either (Mental Health Commission of Canada & Canadian Observatory on homelessness, 2023; Watson et al., 2017). Indeed, harm reduction is a first principle of Housing First (Kerman et al., 2021; Mental Health Commission of Canada & Canadian Observatory on homelessness, 2023; Pauly et al., 2013; Schiff et al., 2019; Watson et al., 2017).

Many cities in BC and the province of BC itself have adopted Housing First approaches to ending homelessness (Capital Regional District, 2017; City of Victoria, 2019; Government of BC, 2022; Hub, 2021). Yet BC Housing Policies include concepts and information counter to these Housing First commitments. The available policy documents outlined in the previous paragraph include references to "bridging services" such as substance use treatment that can support people in becoming "housing ready", but do not include harm reduction services or identify the important role that harm reduction can play in responses to homelessness (Pauly et al., 2013; Watson et al., 2017).

Harm reduction has been included in provincial health policy and guidance since 2005 (BC Ministry of Health, 2005), and the Ministry of Health has guidance for housing and shelters related to substance use and harm reduction (BCCDC, 2023d; Ministry of Health et al., 2022). Additionally, many housing and shelter programs have harm reduction services (such as needle

exchange and distribution programs, or OPS) as part of their service delivery. The inclusion of harm reduction services aligns with Housing First policy and approaches, evidence-based best practice, and is an important tool in supporting exits from homelessness (Pauly et al., 2013; Pauly et al., 2011). The inclusion of Ministry of Health guidance in the absence of formal, BC Housing policy contributes to the confusing policy context for housing providers as they're simultaneously being told that harm reduction services are best practice, but that they're not required by BC Housing.

This confusing policy context of housing and harm reduction wherein the provincial government has identified harm reduction and Housing First as best practice, and has committed to a Housing First approach, but has simultaneously removed the requirement for shelter providers to provide low-barrier services creates many challenges for navigating service design and delivery for providers. Despite the provincial and municipal policies and commitments to Housing First, dominant norms of abstinence often prevail and even within low-barrier services that do not require abstinence, individuals working towards abstinence or distancing themselves from substance use are often intentionally or unintentionally prioritized (Pauly, Wallace, & Barber, 2018). Within these settings, harm reduction is often not fully implemented or taken up, limiting the potential impacts these services have in supporting exits from homelessness (Kerman et al., 2021; Watson et al., 2017). As such, the implementation of harm reduction interventions and approaches, into responses to homelessness and housing services is an important area for further research and understanding to support more robust and evidence-based services.

Section 2.6- Implementation of Harm Reduction in Responses to Homelessness

Although permanent housing is both necessary and preferred, emergency shelters currently play a significant role in providing shelter to unhoused individuals, often due to a lack of available permanent housing. In many ways, homeless shelters can provide refuge and produce harms simultaneously. For example, while shelters provide protection from the elements for people experiencing homelessness, many shelters also enact prohibitive policies towards substance use that can create harms for the people accessing the shelter (Pauly, Wallace, & Barber, 2018; Wallace et al., 2018). Within the confusing policy context discussed in the previous section, where the requirement for low-barrier services has become optional, and provincial guidance and policy are contradictory, many people who use drugs face barriers in accessing shelter services. Additionally, while some shelters may provide physical access to low-barrier services, and access may be permitted for people who use drugs, organizational culture and policies can create barriers to access or harms for people who are accessing the shelter (Pauly, Wallace, & Barber, 2018; Wallace et al., 2016). Unfortunately, implementation is often an overlooked area of study, and much of the literature focuses on service outcomes, rather than implementation itself. As such, organizations wishing to implement harm reduction interventions into their existing housing or shelter services may face insufficient guidance to meaningfully inform their implementation planning. This incomplete understanding and implementation of harm reduction can create unintended harms including but not limited to risk of overdose and death (Pauly, Wallace, & Barber, 2018; Wallace et al., 2018; Wallace et al., 2016). In this sense, the shelter is both a place of refuge and a place of risk production.

Within the context of the urban city in which this study occurs, the implementation of harm reduction in responses to homelessness had previously been synonymous with and reduced

to provision of sterile injection supplies and condoms. The implementation of these programs often failed to provide a culture of harm reduction or truly embrace/ enact a philosophy of harm reduction. Additionally, these services were often lacking harm reduction policies, and so implementation was often not as robust as would be ideal and barriers to implementation and access often remained (Pauly, Wallace, & Barber, 2018; Wallace et al., 2018; Wallace et al., 2016). The opening of OPS in response to the unregulated drug policy crisis expanded these harm reduction services beyond supply distribution, to include Take Home Naloxone distribution and overdose prevention sites (OPS).

Previous research on substance use and harm reduction within a transitional housing program (Pauly, Wallace, & Barber, 2018) found that within the conflicting policy context of a low barrier service where substance use was prohibited onsite but harm reduction supplies were distributed, staff turned a blind eye to substance use in an attempt to reconcile these conflicting demands. The "blind eye" approach to substance use can be summarized as staff knowing that clients use substances within a prohibitive setting but believe it to be a safer alternative to clients using substances in public places or on the street, and so allow the substance use to occur, while looking the other way (Pauly, Wallace, & Barber, 2018). This approach emerged as the result of efforts by staff to incorporate harm reduction practices while having to provide service within a setting that prohibits substance use. While the "blind eye" approach is an attempt at a pragmatic solution to providing care within a paradox of policy, it creates issues, tensions, and challenges, and increases vulnerabilities and risks for both shelter users and staff. The blind eye approach to substance use highlights the need for a broader understanding of harm reduction that shifts from traditional ideas of provision of supplies or harm reduction interventions to a culture of harm

reduction, where clients can be honest with staff about substance use without fear of stigma or loss of service.

Subsequent research, conducted within the same emergency shelter program as this master's research explored issues and challenges related to substance use in an emergency shelter at the beginning of the toxic drug policy crisis (December, 2015-January, 2016) (Wallace et al., 2018). This research found many challenges related to implementing harm reduction into a low-barrier service without an expectation of abstinence, but with prohibitive policies that banned substance use on site. Within this context, harm reduction implementation was limited to distribution of sterile equipment, and harm reduction was only partially implemented (Wallace et al., 2018). Implementing harm reduction services such as needle distribution, supervised consumption /OPS, or drug checking, within a culture that does not align with harm reduction principles and is not grounded in harm reduction philosophy can result in barriers and issues of implementation, as well as less safety for people who use drugs and alcohol (Pauly, Wallace, & Barber, 2018; Wallace et al., 2018).

This master's research is an extension of this previous research on the implementation of harm reduction in responses to homelessness discussed above, (Pauly, Wallace, & Barber, 2018; Wallace et al., 2018) and focuses on the implementation of overdose prevention services within an emergency shelter, including the impacts of OPS implementation, implementation issues and recommendations, and how the meso-level context of the shelter influenced and was influenced by the implementation of the OPS.

The timing of this research is also highly relevant as the province of British Columbia is now in its 7th year of the unregulated drug policy emergency, with record high numbers and rates of overdose deaths, and limited implementation of harm reduction and OPS throughout the

province (BC Coroners Service, 2022; BCCDC, 2023e). Data for this research were collected in Spring 2018, which was two years after the declaration of the public health emergency, and a year and a half after the OPS was opened within the emergency shelter. Although data were collected approximately 5 years ago, this research is still highly relevant as the implementation of OPS has been slow to expand and the literature base related to implementation of OPS in shelter settings is limited.

There is little research about the implementation of harm reduction in responses to homelessness (Bardwell, Boyd, et al., 2018; Bardwell et al., 2017; Pauly, Wallace, & Barber, 2018). In recent years, some studies have been published internationally (Aronowitz et al., 2021; O'Carroll et al., 2021) and a more fulsome body of research exists specific to managed alcohol in responses to homelessness (Pauly et al., 2019; Pauly et al., 2016; Pauly, Vallance, et al., 2018; Podymow et al., 2006; Schiff et al., 2019). However, research pertaining to the implementation of OPS in emergency shelters and other responses to homelessness remains sparse (Bardwell, Boyd, et al., 2018; Bardwell, Kerr, et al., 2018; Galarneau et al., 2023; Wallace et al., 2018). Additionally, there is very little available literature looking at the implementation of harm reduction philosophy and culture, not simply the implementation of harm reduction interventions within these settings (Lew et al., 2022; Mancini et al., 2008; Wallace et al., 2018). At present, considerable gaps in the literature remain and little appears to be understood in terms of the implementation of harm reduction services, including harm reduction philosophy, and overdose prevention services, within shelter settings.

As such, this master's research provides an important opportunity to inform the expansion of OPS and harm reduction policy, philosophy, and practice into responses to homelessness and explore the unique challenges of embedding OPS into other services where the

existing organizational and operational culture might not yet align with harm reduction approaches. This research will identify recommendations to address barriers and facilitators of implementing an OPS into an emergency shelter. The findings and conclusions of this research can address some of the gaps in the existing literature and hopefully provide opportunities to support the expansion of OPS services as they continue to be implemented throughout BC.

Chapter 3: Theoretical Framework

Section 3.0- Introduction

For this thesis, I am using Rhodes' Risk Environment Framework, which is "a framework for understanding and reducing drug-related harm" (Rhodes, 2002, p. 85). In section 3.1, I will provide a summary of the Risk Environment Framework. I will outline the basic principles of the framework to sensitize the reader to their concepts for later application during interpretation of findings. In section 3.2, I will summarize how the Risk Environment Framework helps to identify some of the broader institutional and structural factors that produce harms, disease, and death so that appropriate interventions can be identified and implemented to try to ameliorate these harms.

Section 3.1- Risk Environment Framework

Rhodes' Risk Environment Framework (Rhodes, 2002, 2009) is a useful framework for understanding the levels and sectors in which harms can be produced, to better understand the appropriate levels and spheres for intervention. The original framework (Rhodes, 2002), identified two levels of risk environments: micro and macro. The micro risk environment is the individual level factors that impact how an individual uses substance, and the relative risks and harms that result. An individual's perception of risk is a complex interplay, and the product of many factors including "perceived social norms, rules and values, the nature and structure of injection drug use social relationships, and social networks, peer group and social influence, the immediate social settings in which drugs are used and the local neighbourhood and context in which IDUs [injection drug users] live" (Rhodes, 2002, p. 89). The macro risk environment is the public and legal context in which people live that can produce risks and harms. These can include gender, economic and ethnic inequities, laws, and policies criminalizing substance use,

economic policy, and the legal and social organization within which people who use drugs and alcohol live (Rhodes, 2002). Below, in Table 1, I present selected examples of risk and enabling environments relating to HIV and drug injection, as presents by Rhodes (2009).

Table 1
The risk and enabling environment: selected examples relating to HIV and drug injecting

	Micro-environment	**Macro-environment**
Physical		
Risk	Drug using, injecting and sex work locations Drug injection in public spaces Prisons and detention centres	Drug trafficking and distribution routes Trade routes and population mobility Geographical population shifts and population mixing Changes to trafficking interdiction policies
Intervention	Creating safer drug using sites (e.g., sharps disposals, lighting) Developing supervised injecting facilities Prison-based harm reduction interventions	Interventions at truck stops and train stations Cross-border interventions
Social		
Risk	Social and peer group 'risk' norms Local policing practices and 'crackdowns' Community health and welfare service access and delivery	Gender inequalities and gendered risk Stigmatization and marginalization of drug users Weak civil society and community advocacy
Intervention	Social network and peer-based interventions Police partnerships and training projects Developing low threshold accessible services for drug users	Fostering collective actions in combination with policy changes Mass media and social marketing of harm reduction Strengthening civil society infrastructure and self-help
Economic		
Risk	Cost of living and of health treatments Cost of prevention materials Lack of income generation and employment	Lack of health service revenue and spend Growth of informal economies Uncertain economic transition
Intervention	Subsidies and free treatment Distribution of free prevention materials Micro-economic enterprise and employment schemes	Increase investment in harm reduction relative to enforcement National health insurance schemes Laws governing employment rights
Policy		
Risk	Availability and coverage of clean needles and syringes Programme-level policies governing distribution of materials Access to low-threshold and social housing	Public health policy governing harm reduction and drug treatment Laws governing possession of drugs Laws governing protection of human and health rights
Intervention	Scaling-up pharmacy-based syringe distribution programmes Secondary syringe distribution programs Hostel-based and housing neighbourhood development	Public health policy governing harm reduction and drug treatment Laws governing possession of drugs Laws governing protection of human and health rights Legal reform enabling the scaling=up of harm reduction Legal reform enabling the protection of drug user rights National policy changes regarding public health strategy

*This table has been reproduced from Rhodes, T. (2009). Risk environment and drug harms: A social science for harm reduction approach. *The International Journal of Drug Policy, 20*(3), 193-201.

Subsequent work by Rhodes (Rhodes et al., 2005) added an additional level at which risks, and harms can be produced- the meso risk environment. The meso risk environment represents a level between micro and macro- frequently representing an institutional or organizational level that produces risks and harms. The meso-level risk environment can include anything at the organizational level, including cultural and social norms and values, economics, organizational policies, and policing and enforcement at an organizational level. The organizational policies and practices, economics, norms and expectations, organizational culture, and enforcement within the shelter are examples of meso-level risk environments specific to this study. Although harms are experienced for individuals at the micro-level, they are often produced at meso and macro-levels.

In addition to the levels at which risk environments can occur, there are different spheres for each level that can produce risks and harms for people who use drugs and alcohol. These distinct environments/spheres include the physical environment, the social environment, the economic environment, and the policy environment (Rhodes, 2002). These environments can also intersect with and influence each other. For example, the immediate physical environment within which people use substances, can intersect with the broader social and economic conditions that impact or produce substance use-related harms, or the meso and macro-level policy and economic environments that can influence the micro-level physical environment or micro-economic environment.

In addition to the identified risk environments above, the Framework also includes enabling environments. Enabling environments are the opposite of risk environments; they are settings that reduce the risks and harms for people who use substances and enable harm reduction practices and care (Rhodes, 2002). Risk environments identify the levels and

environments that produce risks and harms and so enabling environments identify the opportunities for intervention. Together, risk environment and enabling environment identification can ensure that interventions are geared towards the level and sphere where hams are produced, rather than focus solely on individual level interventions. For example, if social and economic conditions are the main determinants of harms, then responses to harms also need to be focused on social and economic conditions. If the harms of substance use are primarily produced at a macro and meso-level, then the interventions for reducing harms must also include interventions at a macro and meso-level, not only at a micro-level (Rhodes, 2002; Rhodes et al., 2005). The Risk Environment Framework can be a useful tool for moving away from the individualization of responsibility and recognizing and identifying the levels at which risks, and harms are produced. Focusing on the risk environment allows us to consider the social places and situations in which risks, and harms are produced or reduced to address stigma by shifting the focus of responsibility away from the individual alone. This focus also identifies opportunities for meaningful action.

Emergency shelters provide important shelter and other services for people experiencing homelessness, in the absence of adequate or appropriate housing options. However, there are also many risk environments within shelter services, particularly around substance use and harm reduction policy and practice. In this way, emergency shelters can represent meso-level risk environments for people who use drugs. For this reason, shelter settings are an important opportunity for intervention and an important focus of study.

Section 3.2- Summary

Without understanding the social and structural production of drug related harms, we cannot develop appropriate public health systems and/or interventions to support the health and

wellbeing of people who use substances. It is important to identify where and at what levels inequities, risks, and harms are produced so that interventions can be appropriately identified and targeted. The Risk Environment Framework is an important tool to shift the focus away from individual responsibility to a focus of social structures and the structural production of illness and health.

Chapter 4: Methodology

Section 4.0: Introduction

In this chapter, I will outline the methodology that informed the research design and the methods used to conduct this study. In Section 4.1, I will provide a high-level overview of Interpretive Description (ID), the methodology guiding this research. In Section 4.2, I will outline the ontology of Interpretive Description and why it's appropriate for this research, and in Section 4.3, I will outline the epistemology of ID, and why it aligns with this research. In Section 4.4, I will outline the research methods used in conducting this research, and finally, in Section 4.5, I outline the knowledge transfer and dissemination plan for sharing the findings of this study.

Section 4.1- Interpretive Description

For this study, I used Interpretive Description (Thorne, 2008, 2016; Thorne et al., 1997) as my methodology. Interpretive Description (ID) is a non-categorical, qualitative methodology developed for the pragmatic, applied research that occurs within practice-based settings. Often times, traditional qualitative methodologies do not easily lend themselves to applied research and so interpretive description seeks to create a methodological space that allows for philosophically congruent eclecticism while avoiding methods slurring (Thorne, 2008, 2016). Thorne's objective in developing ID was to create an intentionally eclectic methodology that could adequately be applied to pragmatic, applied research settings and questions while maintaining coherence of underlying philosophical tenets (Thorne, 2008, 2016). Interpretive description seeks to address the 'so what' of applied research, with the objective being to produce practice-relevant insights, rather than pure theory. For this reason, Interpretive Description was identified as an appropriate methodology for this applied and practice-relevant research study.

Section 4.2- Ontology

Ontology is the branch of philosophy that concerns itself with the nature of reality. How we understand and position reality has significant implications for how we conceptualize and conduct research. Within an ID methodology, reality is not viewed as an objective entity that exists external to human experience, rather, reality is viewed as socially constructed through those who experience it (Thorne, 2008). "With a philosophical alignment with interpretive naturalistic orientations, ID acknowledges the constructed and contextual nature of human experience that at the same time allows for shared realities" (Thorne, 2008, p. 3). Within an ID methodology, reality is viewed as complex, contextual, constructed, and ultimately subjective. Additionally, the researcher and participant, or practitioner and client, interact to influence one another. In this sense, the 'knower' and 'known' are inseparable (Thorne, 2008). Finally, as viewed within ID, a priori theories cannot possibly capture the multiple realities that exist and will be experienced throughout the research process. Therefore, theory must emerge from and be grounded in the data (Thorne, 2008).

Experiences of harm reduction and implementation of OPS, particularly within low-barrier emergency shelter services are subjective realities that exist within the context of the shelter specifically, and the social, economic, and political context of Victoria, BC more broadly. Within such settings, the identification and understanding of implementation of OPS are constructed within and between individuals. Though these experiences are subjective and contextually created, there are also many shared realities for individuals within these settings. This richness of experience and contextual positioning of reality within a practice-based setting makes ID an appropriate methodology for this research.

Section 4.3- Epistemology

Epistemology refers to the nature and scope of knowledge. Within ID, the 'interpretation' piece draws inspiration from formal hermeneutic interpretive tradition, while stopping short of full hermeneutic devotion (Thorne, 2008, 2016; Thorne et al., 1997). The pragmatic, practice-based nature of ID "is not satisfied with pure description, but rather seeks to discover associations, relationships and patterns within the phenomenon that has been described" (2008, p. 50). Description of phenomena within applied research is not simply for the purpose or satisfaction of having documented it; rather it acknowledges the implicit assumption that there are likely other cases with relevant similarity. By making one particular piece available, one is able to contribute to and advance towards general knowledge that can be drawn upon within practice-based settings of similar context (2008, 2016; Thorne et al., 1997). Producing knowledge for the sake of knowledge production is a worthy endeavor but has little utility within practice-based settings. Within applied research, knowledge and understanding are developed for the purpose of practical and practice-based utility.

> "The foundation of ID is the smaller scale qualitative investigation of a clinical phenomenon of interest to the discipline for the purpose of capturing themes and patterns within subjective perceptions and generating an ID capable of informing clinical understanding" (Thorne, 2008, p. 3).

Conducting applied research presents challenges that research for the sake of knowledge development does not have to contend with (Thorne, 2008).

Harm reduction itself is a pragmatic series of principles and practices aimed towards reducing the harms of substance use for people who use drugs. The implementation of an OPS does not occur within a vacuum; rather, it occurs in complex, practice-based settings. As such,

harm reduction and OPS research, and the methodology used to seek understanding of such practices need also be contextually subjective and applied. In this way, ID is a methodology that can be coherently used within a complex, contextual, practice-based setting, like an emergency shelter. Additionally, the limitations of time and resources that are associated with master's level research do not lend themselves to good quality ethnography or grounded theory. For these reasons, ID was determined to be a good fit for both the research question and setting, as well as the scope of master's level research.

Section 4.4 Research Methods

This master's research is a continuation of previous research exploring the implementation of harm reduction in responses to homelessness, including emergency shelters (Wallace et al., 2018) and a transitional housing program (Pauly, Wallace, & Barber, 2018). This previous research utilized a Community Based Research approach. While this current study is not community-based in a methodological sense, I did develop relationships with the shelter organization and staff, and people with lived and living experience throughout this research, as well as previous research in the field.

Within the shelter setting where recruitment and data collection occurred, there were approximately 80 shelter beds operational on any given day. Shelter residents were able to stay at the shelter for one month, before needing to leave or "time out" for a week before being eligible to add their name back to the list for a bed again. I interviewed 21 people accessing the shelter services across a 5-week period. The original sample size target was 20 participants, but an additional participant was added as one of the interviews ended up being quite short. A sample of this size ensured that enough individual experiences and voices were included to capture an adequate understanding of the complexities and context. Additionally, a sample size of 21

participants would meet the standards for publication in peer reviewed journals, while not exceeding the scope and resources associated with a master's research project. Participant demographics are provided in Chapter 5.

Ethics Approval

Ethical approval for this research was provided through the University of Victoria's Human Research Ethics Board (Ethics Protocol Number 15-304). The certificate of Ethical Approval is included in Appendix A. As this master's research was an extension of previous research, ethical approval was obtained through a modification to the existing protocol. The request for modification was completed by myself, and I developed all the materials and resources for the study. Ethical requirements and standards for research with human participants have been adhered to and maintained throughout the entire research process. Participant quotes have been anonymized for confidentiality and participant confidentiality has been maintained.

Sources of Data

For this study, I conducted semi-structured qualitative interviews (see Appendix B for Qualitative Interview Guide) with people who access shelter services and identify as using alcohol and/or other drugs. Additionally, participants completed a short questionnaire, primarily comprised of demographic questions and questions related to their current, and historical substance use (see Appendix C). In addition to the qualitative interviews and questionnaires, I recorded field notes of what I observed during my time in the shelter, and any reflections or important observations I had during data collection. The use of field notes aligns with an Interpretive Description methodology (Thorne, 2008, 2016). Combined, these sources of data have provided breadth and depth of experience and context relevant data. While designing this qualitative study, it was my intent to include a policy analysis of shelter and organizational harm

reduction and substance use policies as part of the findings. However, at the time of data collection, when I requested the policies from the shelter manager, I was informed that the shelter had removed the previous policies, but had not yet replaced them with new policies (Shelter Manager, 2018).

Participant Recruitment

Participants were recruited using third-party recruiting methods. Recruitment posters were developed for shelter staff to distribute to shelter residents and post within the shelter (see Appendix D). To protect participant privacy and confidentiality, shelter staff simply informed shelter residents of the study being conducted, and potential participants came to find out more information from me. To support a purposive sampling approach, at the start of each day of data collection, I would connect with the staff who were supporting participant recruitment and indicate which demographics I needed to prioritize to support breadth of experience. For example, intentionally including female or gender diverse participants, residents only using legal substances and people across various forms of illegal substance use, including polysubstance use. Not all shelter residents who approached me to participate were eligible to participate. Shelter residents seeking participation who could not be included as participants were kindly told that they wouldn't be able to, and I explained why. Additionally, some demographics (e.g., males, white ethnicity, etc.) were already quite prevalent within the sample and so intentional recruitment and inclusion/exclusion decisions were made to try and support a diverse and purposive sample. While shelter staff were supporting purposive sampling by intentionally extending invitations to specific groups, they were not asking residents to identify any specific demographic or substance use history information. All screening for participation was conducted by me. Invitations to participate clearly stated that residents were under no obligation to

participate and that their decision to participate would in no way impact their access to services or their relationships with shelter staff (see Appendix E for my recruitment and screening script).

Eligibility criteria for participation included anybody who identified as accessing shelter services (at that specific shelter) at the time of data collection and identified as having lived experience of alcohol and/or other drug use. Some participants accessed harm reduction and OPS services within the shelter, while others did not. The eligibility criteria were simply the use of any substances (legal/illegal) and accessing shelter services, Participants were not required to be using harm reduction services specifically. Some participants also volunteered in the OPS or had previous experience of being peer representatives on committees within the broader shelter organization. For greater clarity, the anonymized participant identifiers reflect this experience; however, these participants also accessed shelter services for themselves. Participants who are not peer workers within the shelter or OPS are identified as shelter residents only. Shelter staff were not included in the sample for this research study.

Sampling

For this study, I used a purposive sample with the goal of including participants with diverse backgrounds and lived experiences of homelessness and substance use. The experiences of people who access harm reduction and shelter services often differ depending on individual histories of substance use including types of substances used, frequency of substance use, and method of substance use. Participants also varied in experiences (or not) of accessing harm reduction services and/or other substance use services. Experience with harm reduction or accessing the OPS was not a criterion for participation. As such, it was important to include participants with a variety of experiences within the sample. However, I also recognize that there are likely common or shared experiences despite these differences. In designing this study, I

determined that semi-structured qualitative interviews would enable me to capture both differences and similarities of experience across participants.

Data Collection

Access to the shelter for participant recruitment and data collection interviews were negotiated with the shelter manager. I had an established connection with the shelter manager through previous research activities at the shelter and the shelter manager gave me permission and space within the shelter for data collection. I was given a private room within which to conduct interviews with shelter residents and maintain confidentiality. Once UVic HREB ethical approval was obtained and data collection was approved to begin, interview dates were coordinated based on the research timeline and availability of space within the shelter. At the time of data collection, I went to the shelter each day and staff would invite residents from the shelter by distributing the recruitment materials I provided them. Copies of the recruitment flyer were also posted on the wall to support people who might have been interested in participating but weren't comfortable approaching staff about it. Potential participants were invited to connect with me for further details and to determine eligibility. Due to confidentiality concerns, staff members only extended an invitation to participate and did not assess eligibility.

Once eligibility had been assessed and obtained, I discussed informed consent with the participants, and informed consent was obtained through a signed consent form (see Appendix F) and that consent could be withdrawn at any time. After informed consent was obtained, I reminded the participant that the interview would be audio recorded, and I also informed them when I was turning on the recorder. I then went through the demographic questionnaire with the participant and began the semi-structured qualitative interview.

To ensure internal confidentiality, demographic data from the questionnaire were aggregated and disseminated as larger groups to avoid potential identification of participants. Interviews lasted approximately 40-60 minutes and participants each received a stipend of $20 cash as compensation for their time.

Data Storage

Data, in the form of transcripts and audio files have been securely stored at the University of Victoria. Hard copies of signed participant consent forms and participant demographic and substance use questionnaires are securely stored in locked filing cabinets in a locked office at the Canadian Institute for Substance Use Research (CISUR). In order to protect participant confidentiality, documents containing participant identification (e.g., participant consent forms) are stored in a separate location from any documents containing participant data. Transcripts were anonymized and participant numbers were used in place of participant names in the transcripts and on the demographic forms. Upon completion of an interview, the audio file was uploaded off the recording device and stored securely on the University of Victoria's Nursing shared drive. Once uploaded, interview recordings were deleted off the recording devices to enhance data security. Transcripts are securely stored on the shared drive and the documents are password protected. Computers with access to the University of Victoria shared drive are encrypted and password protected.

Data files containing quantitative demographic information have been stored on the Uvic Nursing shared drive. Data files do not contain identifying information and adhere to the same confidentiality measures outlined above.

Data Analysis

Interpretive Description is both a methodology in its own right, and a framework for analysis that can be used within other qualitative methodologies so long as philosophical coherence is maintained. Immersion in the data is of critical importance within ID and researcher reflexivity throughout the analysis process is required. That being said, Thorne (Thorne, 2008) cautions against the tendency for "hyper-reflexivity" that can occur within qualitative research, wherein reflexivity borders on researcher self-absorption. This hyper-reflexivity detracts from the credibility of findings as the focus shifts from the experiences of the participant to the experience of the researcher in the co-construction of knowledge.

Immersion in the data occurred through many forms, beginning with data collection (conducting qualitative interviews with participants), transcription of the interviews, and transcript cleaning. Once transcription was complete, I cleaned every transcript to ensure accuracy and consistency, which had the additional function of providing further immersion within the data. Additionally, once all the data were prepared, I read through each of the transcripts one additional time for further immersion before initiating the coding process.

Once the data were collected, cleaned, and prepared, I began to code the data inductively into initial codes. The initial codes emerged from the data and were not pre-determined. Once the initial codes were identified, I shared this initial structure with my primary supervisor, and through her feedback, I reorganized and refined the coding framework. I then continued coding into the new organizational structure. As I coded, I compared the existing codes and moved towards higher levels of abstraction and identified provisional themes. Once provisional themes were identified, I organized and reorganized them through concept mapping activities to identify the clustering of themes, continuing to move to higher levels of abstraction. Throughout this

process, relationships between themes were identified and interpreted with context specific sensitivity. Further analysis and conceptualization occurred throughout the writing process and through feedback from my committee.

Data management and organization of qualitative interview data was achieved using the qualitative data analysis software program, NVivo, which is produced by QSR International. While Thorne (2008) rightfully cautions against an over-reliance on data analysis software, when strategically and judiciously used, it can serve as a good organizational tool. For the purposes of this research, NVivo was used solely for data organization, and not for automated analysis of any type. Data analysis using interpretive description is inductive and iterative, and this reflected the process I adhered to. As recommended by Thorne (2008), I developed notes throughout the analysis process and used them to ask increasingly complex questions about what the data meant throughout the data analysis process.

Demographic and substance use survey data were analyzed using Microsoft Excel and are provided in Chapter 5. Quantitative data analysis consisted of descriptive statistics (such as frequencies) with the aim of describing the sample. Quantitative demographic data have only been disseminated in aggregate form and any demographic information that could be potentially identifying has not be disseminated.

Timeline

Data collection for this research was conducted in March and early April of 2018, with all interviews conducted within a 5-week period. The interviews were transcribed verbatim immediately after the completion of an interview by myself and a research assistant I paid to support transcription. All transcripts were cleaned and validated by me and entered into NVivo for organization after completion of data collection. Initial immersion in the data and preliminary

analysis began in Summer of 2018, but then due to ongoing health issues I had to take several approved medical leaves from my MA studies. I returned from medical leave in Fall of 2021 and resumed data analysis but then experienced further delays due to health challenges. I returned to working on my thesis full time in December 2022. Due to this prolonged leave between data collection and data analysis, I took extra steps to re-immerse myself in the data. I began by re-reading every transcript to re-familiarize myself and although approximately half of the interviews had been coded, I had been removed from the research for an extended period and decided that it would be prudent to start over and re-code every interview, from the beginning. When I returned to analysis after my leave, I retained the initial coding framework that I had developed from my initial coding and identification of themes, and re-structured it based on insights from re-orienting myself to the data. This revised framework was again emergent from the data and evolved with the subsequent coding and analysis.

The introduction, literature review and methodology chapters were initially developed for my research proposal but were significantly revised upon my return to reflect changes in the harm reduction and OPS landscape since 2018. Writing of this thesis occurred from January 2023 to October 2023.

While I recognize the limitations of a five-year gap between data collection and completion of this thesis, this research remains highly relevant due to the ongoing unregulated drug policy crisis. Although British Columbia is in it's seventh year of this public health emergency, the rate of implementation of OPS throughout the province has not met the scope of the problem and ongoing deaths. Geographic inequities in access to OPS remain significant (BCCDC, 2023e). Additionally, as the health system attempts to implement harm reduction programs such as prescribed safer supply, there are insights from this research that could support

implementation of these other services. My hope is that we can see significant progress in expanding access and implementation of harm reduction services, including OPS, in the coming years, to reduce deaths and better support PWUD. The findings of this research have the potential to make an important contribution to inform the implementation of OPS and other harm reduction services into health and social systems. My primary motivation for returning to my master's studies, was knowing the importance of these findings and the potential they have for supporting meaningful OPS implementation and expansion of these services. There is much work yet to be done.

Section 4.5 Knowledge Transfer and Dissemination

Knowledge dissemination, knowledge transfer, and knowledge mobilization are important components of applied research and therefore, a key aspect of this study. Results of the study will be shared using knowledge dissemination, transfer and mobilization activities and efforts.

The Canadian Institute for Health Research (CIHR) defines knowledge dissemination as the active process of sharing results with knowledge users (Canadian Institutes of Health Research, 2013). For the purposes of this master's research, knowledge dissemination will occur via a written thesis and as academic papers submitted for publication in scholarly journals.

CIHR defines knowledge transfer (KT) as "a dynamic and iterative process that includes synthesis, dissemination, exchange and ethically sound application of knowledge to improve the health of Canadians, provide more effective health services and products and strengthen the health care system" (Canadian Institutes of Health Research, 2013, p. 1). For the purposes of this research, knowledge transfer activities will consider the limited resources associated with master's level research, while also seeking to utilize every available opportunity for knowledge

translation. KT activities will include presentations at conferences, with the strategic selection of conference presentation opportunities.

Conference opportunities will focus not only on contributing to developing knowledge and understanding in the harm reduction sphere, but also challenging the individualized understanding of substance use and harm reduction that is so often the dominant voice within much of the 'addictions' research community. The applied nature of this research lends itself to a practice-based audience and so harm reduction and substance use related conferences will be the priority as they are often directed towards academic, policy, and practitioner-based audiences.

I will also be presenting this research to partners in the health system through established partnerships with policy and practice sectors of the system. The BC Ministries of Health and Mental Health and Addictions are currently experiencing many barriers to implementing harm reduction and substance use-related services and the findings of this study could provide guidance on addressing existing barriers. Additionally, I currently work within Health Emergency Management and have strong working relationships with key stakeholders including Ministries of Health and Mental Health and Addictions, and the BCCDC. Opportunities to both integrate and share these findings in our harm reduction-focused work will be identified and leveraged, with a particular emphasis on the need for intentional implementation planning.

Chapter 5: Participant Demographics

Section 5.0- Introduction

This chapter provides participant demographic information to help contextualize experiences and describe the sample included in this master's research. In section 5.1, I provide basic demographic information, describing the sample. And in section 5.2, I provide high level aggregate descriptive information related to participant history of substance use.

Section 5.1- Participant Demographics

Participants ranged in age from 24 to 58 years, with a mean age of 41.5 years and a median age of 41. Fifteen participants (71%) identified as male, three participants (14%) identified as female, and two participants (10%) identified as either gender non-binary or other. While this sample includes significantly more males than females, this also reflects the demographics of people experiencing homelessness (Davis et al., 2023; Fazel et al., 2014; Government of Canada, 2021a; Rhoades et al., 2011) and who use substances (BC Coroners Service, 2023a; Davis et al., 2023; Government of Canada, 2021a, 2021c). Additionally, in my time conducting research in the shelter, and in conversations with shelter staff, it appears that significantly more males accessed the shelter than females. Seventeen participants (81%) identified as heterosexual, two participants (9.5%) identified as pansexual, and two participants (9.5%) identified as other. Sixteen participants (76%) identified as white, and five participants (24%) identified as Indigenous. There were no other ethnicities self-identified.

Fifteen participants (71%) identified as unemployed, four participants (19%) identified as employed, one participant identified as retired, and one participant declined to answer. Regardless of employment status, participants identified many sources of income including both formal and informal sources. Table 2 outlines sources of income identified by participants.

Participants were able to identify all sources of income and so cumulative proportions total more than 100%.

Table 2
Demographic Table Outlining Sources of Income

Source of Income	**n (%)**
Welfare/Income Assistance	8 (38%)
Informal/Street Income	8 (38%)
Disability Income	5 (24%)
Other	2 (9.5%)
No Income	1 (5%)
Decline to Answer	1 (5%)

N=21

Ten participants (48%) reported having lived in Victoria for more than 10 years, four participants (19%) had lived in Victoria for 7-10 years, four participants (19%) had lived in Victoria for 1-3 years, and two participants (9.5%) reported living in Victoria for less than a year.

All participants had reported experiencing homelessness in the past 12 months, and all had accessed shelter services in the last week.

Section 5.2- Participant History of Substance Use

All participants had lived experience of substance use in their life, but there was considerable variation in experiences of past and current substance use across participants in terms of types of substances, and modes of consumption. Variation in historic and current substance use was intentional to provide diverse perspectives for deeper understanding. Table 3 shows participant history of substance use including “past 30 days” and “past 12 months” substance use by substance and mode of consumption. Some participants reported having used substances, but not in the past 12 months, or having never used a substance. Those are also included in Table 3.

Table 3
Past 30 Day and Past 12 Month Substance Use by Type of Substance

Past 30 Day Use		**Past 12 Month Use**		**Yes, but not in past 12 Months**		**No, Never**	
Type of Substance	n	Type of Substance	n	Type of Substance	n	Type of Substance	n
Tobacco	17	Tobacco	--	Tobacco	2	Tobacco	2
Alcohol	12	Alcohol	5	Alcohol	4	Alcohol	0
Cannabis	13	Cannabis	2	Cannabis	6	Cannabis	0
Ecstasy	2	Ecstasy	3	Ecstasy	11	Ecstasy	5
Cocaine	3	Cocaine	6	Cocaine	11	Cocaine	1
Crack	4	Crack	2	Crack	12	Crack	3
Down	10	Down	2	Down	6	Down	3
Crystal Meth	15	Crystal Meth	--	Crystal Meth	2	Crystal Meth	4
Hallucinogens	1	Hallucinogens	9	Hallucinogens	10	Hallucinogens	1
GHB	3	GHB	7	GHB	4	GHB	7
Benzos	3	Benzos	3	Benzos	4	Benzos	11
Rx Opioids	5	Rx Opioids	5	Rx Opioids	4	Rx Opioids	7

N=21

The majority of participants identified having used legal substances (alcohol, tobacco, cannabis) in the past 30 days. Seventeen participants (81%) identified having used tobacco in the past 30 days, 12 participants (57%) reported using alcohol in the past 30 days, and 13 participants (62%) reported having used cannabis in the past 30 days. For illicit substances, crystal meth and down were identified as the most frequently used substances in the past 30 days, with 15 (71%) participants reporting crystal meth use, and 10 (48%) participants reporting down use. At the time of data collection, in 2018, illicit fentanyl was common in heroin. While some participants intentionally sought out fentanyl, most participants found it difficult to identify when they had used fentanyl vs heroin due to the contaminated nature of the supply, unless they experienced an adverse event. Participants identified that for those reporting heroin use, they reported the intention of purchasing heroin but that they didn't actually know if what they used was heroin, fentanyl, or a combination of the two. As such, while reporting on this substance use

above, I combined heroin and fentanyl into a combined category of “down” to better reflect participant experiences and the difficulties distinguishing between the two at the time of data collection.

Chapter 6 Findings: OPS Impacts and Implementation Issues

Section 6.0- Introduction

The analysis of qualitative interview data, using Interpretive Description methodology is presented in the next two chapters. Chapter 6 will focus on findings specific to the program description, impacts of the OPS, and implementation issues. In section 6.1, I will describe the OPS including the injection room and inhalation tent. In section 6.2, I will identify the impacts of the OPS, and in section 6.3, I will present the implementation issues and recommendations specific to the OPS. Then, Chapter 7 will focus on meso-level factors impacting the implementation of OPS within the shelter context and the influence of the OPS on the shelter.

Section 6.1- The OPS: Description of the Site

Following December 2016, when the Ministry of Health released Ministerial Order M488, encouraging the implementation of OPS, the organization operating the emergency shelter opened an OPS room to try and reduce overdoses onsite. This section will describe the OPS service that was implemented into the emergency shelter. Throughout the findings chapters, participants will often use the term "OPU" to describe these services. This stands for "overdose prevention unit". The nomenclature has changed somewhat since data collection in 2018, and so for the purposes of this thesis, I will use the term "OPS", which stands for overdose prevention site, but these terms are interchangeable.

The overdose prevention site is comprised of two components: a room for witnessing of injection use, and the inhalation tent set up in the courtyard.

The Injection Room

The OPS for witnessed injection was set up in what was previously the physician/nurse's office within the shelter. "Ah, yeah, that's a major change now that I remember that. There was,

it was a doctor's office in the corner [of the shelter] where the OPU is now (Participant 06)". This space is off the main drop-in area of the shelter, close to the washrooms and proximal to the exit to the courtyard where the inhalation tent was located. The OPS within the emergency shelter provided a designated space for the witnessed consumption of drugs and immediate response in case of overdose. Within this service, the witnessing was provided by either OPS staff (employed by the shelter) or peer OPS volunteers (people with lived/living experience who were paid a stipend for "volunteering" in the OPS). The OPS space was small, with three injection booths. The staff and Peer worker sat in a space adjacent to the room with the injection booths. Through a window, staff (including Peers) could directly witness consumption and immediately respond to an adverse reaction or overdose event if needed. Once people used their substance, they could move to the "chill out" space for a few minutes of observation as an extra precaution. This chill out space was within the same room as the staff desk and so this also allowed OPS staff (including peers) to engage with people after they had used or answer safer use questions, etc. Additionally, from the staff desk area, staff could look into the courtyard through a large window to observe consumption in the inhalation tent. Security cameras in the courtyard enabled further observation by staff, in case of overdose.

> The overdose unit is what I'm attached to. And it's an overdose prevention unit, it's called… What we do is we oversee people while they're, while they're injecting their drugs and we make sure that they're okay after they've done their shot or whatever. If someone ODs on us in there, we're trained to respond (Participant 21: Peer Worker and Resident).

Although participants varied somewhat in reporting the operating hours of the OPS, the greatest consensus by participants was that the OPS was open from approximately 7am until 8-

or-9pm. The OPS within the shelter utilized a shared staffing model where a peer and an OPS staff member, employed by the shelter worked together in the OPS and responded as a team in event of overdose or toxic drug poisoning events.

> [The shelter] has 2 separate first responders here. We work with 2 people, with a staff and with a peer. And the peer is a drug user that's maintaining a habit and/or has quit their habit but is experienced with drug use. So, the peer has a personal attachment to the people that are coming in there. And the staff is more of a medical end to it. Any of the peers that work in there goes through the naloxone course. Not the online one, we get someone from a certified doctor or a nurse or whichever to come in and give us the actual course. So, it is a really good place in regards to safe injection site. I know a couple of girls here that have responded to well over 2 dozen overdoses. I've attended well over, well over 20 myself (Participant 21: Peer Worker and Resident).

People with lived and living experience of drug use (peers), were integral to the operation of the OPS. The inclusion of peers aligns with the principles of harm reduction emphasizing the meaningful inclusion of people and networks of peers. Ideally, peers would be included in all levels of service design, implementation, and delivery. From participant interviews, it is unclear to what extent peers were included in the design and planning of the OPS.

The OPS staff (non-peer) appear to have been intentionally hired for their knowledge and ability to support harm reduction interventions.

> They're quite trained to deal with it. You know, in a pretty good manner. They don't seem to look down on anyone who uses drugs. There's, you know, we have the OPU room, I think it's called. And there's staff and clients that both work in there. And they need to be able to handle what they're going to see- a lot of intravenous use. And as far as

> I've noticed, they handle it quite well. They're trained to jump into action if something does happen or somebody does overdose. They know what to do. And you must have a bit of a stomach for something like that. They seem to all have the proper training (Participant 04: Shelter Resident).

Participant 04 identifies the unique staffing and experience within the OPS where harm reduction culture and practice align to provide non-judgemental care to support people who use drugs, and ultimately save lives. Participant 04 also identifies that the OPS staff have specific harm reduction training and education to be able to meaningfully support people in a safe way. While Participant 04 captured this succinctly, they were not the only participant to share this view. Indeed, several participants highlighted the unique staffing and non-judgemental care provided within the OPS space.

The Inhalation Tent

At the time of data collection, in 2018, the inhalation tent available at the shelter was one of, if not the first of its kind in BC and provided novel safer inhalation services for people accessing the shelter. The inhalation tent is a 10' x 10' pop-up tent and sits in the middle of the courtyard, so as to adhere to the smoking bylaw requirements of 7-meter clearance from any entrance or air intake.

> So, the tent is in the main back are of the courtyard. We're allowed to sit on either side of the tent and smoke [cannabis and tobacco] on either side of the tent. We just don't have to go in it, but we have to be beside it on either end. Smoking hard drugs has to be in the tent (Participant 06: Shelter Resident).

Some participants identified that initially, the shelter had two outdoor tents for inhalation, one was for tobacco and cannabis use, and one was for inhalation of illicit substances.

> We had a windstorm the year before last and both tents got blown off their moorings and ended up in some business's lot down the street and just the one got replaced. My thoughts are, there should be – there was at one time 2 tents. But yeah, bring the, bring the second tent back for inclement weather for other smokers [cannabis and tobacco] (Participant 19: Shelter Resident).

As this participant observes, the lost tent was not replaced resulting in one tent to serve all types of inhalation use at the time. The inhalation space within the courtyard of the shelter provided important inhalation services but the presence of only one tent contributed to tensions and challenges for people who smoke drugs. This will be further discussed in Section 6.3: Implementation Issues and Recommendations.

Section 6.2- Impacts of OPS Implementation

Participants reported several positive impacts associated with the implementation of the OPS. Participants did not identify many negative impacts of implementation even when directly asked during the interview. The primary negative aspects of OPS implementation related to continued substance use outside the OPS, fears of increased stigma, unmet needs for some residents, and challenges accessing other services. The positive impacts cluster into seven key themes. These themes include saving lives and providing novel inhalation services; preventing harms and complications; reducing criminalization; reducing stigma; improving relationships with staff; improving quality of care; and facilitating connections to care. The negative impacts of implementation will be presented under their respective topics in Section 6.2 to demonstrate the complexity of experience. The challenges related to implementation and recommendations for improvement are provided in section 6.3, following the presentation of the themes related to impacts.

OPS: Saving Lives and Providing Novel Inhalation Services

Almost every single participant spoke of the devastating losses they've experienced due to unintentional overdose since the increase in illicit fentanyl in the drug supply. For people who use drugs, peers, and community members, the tragic loss of life since the declaration of the Public Health Emergency isn't theoretical, or abstract, it is the daily, lived experience.

> When the fentanyl crisis first started, so many people were overdosing. Every month it was like taking a new tally of friends that, you know, I'll never get to laugh with, friends that I can never, you know, that aren't looking forward to trying to get clean and, you know, get back together with the ex one more time, right? You know, trying to sort their life out again. Like I can't ever, you know, wish them, wish them good luck, you know? It's game over for them. And so many lives have been saved because of the overdose prevention rooms that have been out there… Everybody has problems, some bigger than others. But you know, it's…lots of the time when I've seen people overdose, they use that as a wakeup call, whereas if they weren't in a place like one of the overdose prevention rooms, they wouldn't have had an opportunity to see it as a wakeup call because they never would have woken up (Participant 08: Peer Volunteer and Resident).

Everybody is deserving of life-saving care regardless of past or future substance use, and participants emphasized the role overdose prevention and response can play in keeping people alive so they can go on to live a life that is meaningful to them, whatever that may look like.

> And that's just…to me, it's worth all the funding, all the tax dollars in the world. Just to give those, you know, people who make it out of the drug world, just to give them that chance. You know? Because they're somebody's kid, they're somebody's brother, somebody's father (Participant 08: Peer Volunteer and Resident).

As Participant 08 powerfully continues above, “they’re somebody’s kid, they’re somebody’s brother, somebody’s father” and I would go further and say, they’re somebody. Every person is worthy of life-saving care, and OPS provides an important opportunity to save lives.

Regardless of participants’ personal experience and/or attitudes towards substance use, or understanding of harm reduction, all participants identified that OPS save lives and that OPS are important services for people who use substances.

> I see a lot of people using in the OPU rooms which is, you know, beneficial in a way. Because if they overdose from the fentanyl which happens all the time, due to the fact that – many factors – but, if it wasn’t for the OPU, there would have been a lot of deaths probably that took place. Because at least they’re being monitored, someone can watch them. So yeah, it’s a lot safer since then. And thank God for the OPU because with this fentanyl crisis coming, we know we needed it (Participant 18: Shelter Resident).

As Participant 18 identifies, having the OPS has provided opportunities for immediate response in case of overdose, saving many lives. The importance of OPS has increased with the ongoing public health emergency, and the increased risk of death.

Participants identified the important role that OPS can play in addressing the challenges of fentanyl and overdose within the public health emergency. Overdose prevention sites and witnessed consumption allow for timely response and resuscitation in case of unintentional overdose or toxic drug poisoning events. Access to these life-saving services is essential to prevent deaths in nearby areas.

> With the fentanyl, since that started up, they’ve introduced an OPU, an overdose prevention unit. It’s basically a room that drug users are requested to use their drugs in.

> Because you know, they tried forever just, you know, banning anyone either caught using in the bathrooms or up in their room, or over in the courtyard or anything. But people will always use substances. And when they're trying to hide it, they'll go off by themselves and all of a sudden if they overdose, when they get discovered; it might not be a person getting high, it might be a corpse (Participant 06: Shelter Resident).

The OPS provided a safe, and life-saving space within which people could use substances, without needing to hide their use. Being able to use substances while supervised creates opportunities for immediate response in case of overdose and saves lives. This is essential within the context of the public health emergency and contaminated drug supply. OPS services reduce micro-level risk environments for people and create enabling environments for harm reduction interventions and practices.

The inhalation space implemented within the courtyard of the shelter was one of the first of its kind. An important impact of OPS implementation within the shelter was the inclusion of inhalation services and the provision of safer spaces for people who smoke. Participants identified that safer inhalation spaces were an important and needed service.

> The OPU is a good thing to have, to be allowed to smoke. I think some nurses around would be nice, or volunteers. As it is now, I think what we're seeing is, I see more drops outside by the tent than I do drops in the OPU. Now, I've not been in the OPU, so I'm not too sure of how many actually go in there, but I've seen a lot of people drop in the tent (Participant 01: Shelter Resident).

As Participant 01 highlights, due to the contamination of the illegal drug supply with fentanyl and other contaminants, people who smoke drugs are also at a high risk of toxic drug poisoning and death. By providing a novel inhalation space, people who smoke drugs were able

to be witnessed during consumption and tended to immediately in case of overdose or adverse reaction. However, Participant 01 also identifies the need for additional staff to directly observe the inhalation space due to the high number of overdose events from inhalation.

OPS are sanctioned through provincial powers, including Ministerial Order M488. However, participants identified that providing OPS is important for saving lives, regardless of the legal framework.

> I think it's a great idea. 100%. I think without them, I think the overdoses would be 110% higher than what it is right now. I mean, it's unfortunate what it is right now, but I definitely think that ever since they've been implemented, illegal or legally, it doesn't matter, it's been saving people's lives (Participant 02: Peer Worker and Resident).

As Participant 02 identified, OPS are important, and much-needed services that save lives and prevent or reduce harms of substance use for people, and without these life-saving harm reduction interventions, the number of overdose/toxic drug deaths would be even higher than what they currently are. Macro drug policies and drug laws produce macro-level policy, economic, and social risk environments for people who use drugs. OPS provide micro-environments that reduce risk for individuals, regardless of the macro or meso-level risk environments that remain.

OPS is One Intervention, but More Are Needed. Many participants identified that while OPS services are an important intervention for saving lives, they are but one tool and more options are required to meaningfully reduce the number of preventable deaths we see every day.

Some participants identified the importance of interventions designed to separate individuals from the toxic drug supply, such as pharmaceutical alternatives or substitution programs.

> Some progress is being made. It's slow- not enough. Now I'm sure you've heard that there's also other options for people that want to use but don't want to be using dirty supply… And stuff like that would probably be another step in the right direction. But I don't want to just tell everyone to just smoke pot and blanket fix your problems. But like, harm reduction- by using more pure options would be the best option. If they want to use opiates, I think they should make opium, pure opium itself, a harm reduction alternative. Because the person still gets their fix, but the person's not going to drop dead like a fly because they don't know what's in it. Oh, that's what I kind of see pure opium as, is like pharmaceutical grade heroin. So. There's a clinic in Vancouver that will prescribe prescription grade heroin to anyone that walks in (Participant 06: Shelter Resident).

Participant 06 identifies the key limitation of OPS- while OPS services do save lives, they do not replace the contaminated drug supply. The need for interventions and options to separate people as much as possible from the unregulated drug supply is significant and has become even more significant in the intervening years since data collection for this study occurred. The unregulated, contaminated drug supply reflects macro-produced policy, social, and economic risk environments that create profound impacts and micro-level risk environments for people who use drugs. Harm reduction programs that separate people from the unregulated supply reduce the risks and harms associated with these risk environments and important adjunct interventions for saving lives.

Another participant discussed a new (at the time) cannabis substitution program available in the city where this research was conducted, and the benefits they've seen for themselves and others as a possible opportunity for separating people from the toxic drug supply.

> I have friends in Vancouver and Victoria, so if you hear about people getting free pot for harm reduction, my friends [at organization] are doing that. [Person in community] got clean off of heroin from smoking pot. So that's kind of like, everyone's been going around, everyone's been realizing that. I got clean off of meth smoking pot. Like I mean I smoke pot for my medical problems and then I was addicted [to crystal meth] too at the same time. And then I started smoking pot to get high and then I realized "Holy shit, like I can get clean with this." (Participant 08: Peer Volunteer and Resident).

While cannabis substitution programs are often considered less conventional than other "substitution" programs such as methadone, recent research suggests the potential for significant benefits in the "treatment" of substance use disorders or distancing from the toxic supply (Lucas, 2017; Lucas et al., 2019; Pauly, Brown, et al., 2021). During a time of unprecedented death and record high rates and numbers of toxic drug poisonings, innovative approaches should be considered.

Preventing Harms and Complications

Safer Use Supplies. Harm reduction as a movement developed out of, and in parallel to the HIV epidemic in the 80s and 90s, and has since expanded to include safer use interventions, including OPS.

> Well, what it meant to me originally was trying to stop the spread of AIDS and, you know, needle-borne viruses. But I can see there's other ways to look at it too. Like somewhere safe to use the drug as well (Participant 03: Shelter Resident).

While harm reduction goals and priorities have grown to include services such as OPS, prevention of blood-borne infections (BBI) remains a significant priority for and benefit of harm reduction services (BCCDC, 2023a, 2023b). Preventing the transmission of BBI's is important

for individual's health, as well as population health. The OPS goes beyond providing safer supplies by also including safer spaces to use drugs and prevent/respond to overdoses. OPS provide an important extension of harm reduction interventions and expands the range of harms that can be reduced.

Several participants identified the role harm reduction and OPS can play in preventing infections and other medical complications. Sterile injection and inhalation equipment, provided in OPS, combined with a safe, and sterile environment for use, help people to prevent many health and medical complications.

> Harm reduction means that people should have places like the OPU everywhere. When I lived in Vancouver, I used [harm reduction service] because I personally wanted to stay clean and didn't want transmittable diseases. I wanted somebody that was there to help me with stuff, and that's what I think that these people deserve too, right? Like they're not any different. They're really the same thing, they're just fighting probably deep-rooted trauma like most addictions. So, I mean, you shouldn't treat them any differently (Participant 06: Shelter Resident).

Participant 06 highlights the deeply held values of preventing harms and protecting health that many people hold. Harm reduction and OPS services support these individual goals and provide practical tools and supplies for people to make choices to support their health and prevent transmission of blood-borne infections. Safer use supplies, and OPS provide important opportunities for mitigating micro-level physical risk environments for the individual.

Safer Use Spaces. Participants identified that having the OPS has helped to reduce (but not eliminate) substance use in less safe spaces, such as in bathrooms, bedrooms, or other places in the shelter.

> Before the OPU, it was a freaking nightmare. It was 10 to 15 people in the men's washroom and 10 to 15 people in the women's washroom. Men's and women's. Every night of the week it was people shooting up anywhere they wanted to, all over the place. It was dirty needles everywhere, all over the place. (Participant 21: Peer Worker and Resident).

Implementation of the OPS has supported shelter residents to use in safer ways, and in safer places, by providing a designated space for witnessed consumption. While substance use did continue outside of the OPS due to access limitations, the progress made with the implementation of the OPS was identified by some participants as significant. The reduction in substance use in shared spaces such as bathrooms and bedrooms mitigated risk environments for all shelter residents. Further discussion of the issues and challenges related to substance use outside of designated OPS and inhalation spaces will be discussed in Section 6.3: Implementation Issues and Recommendations.

Some participants identified the continued substance use outside of the OPS spaces as a negative aspect of implementation, in that the implementation wasn't fully addressing the issue.

> Oh, they go in the bathroom upstairs at 3 in the morning right? Just fucking walk inside there. I won't even go in there! Like, it's crazy! There's 10 people in there, all doing drugs. Puke all over the floor. Like it's not a happy place (Participant 03: Shelter Resident).

Supporting shelter residents to use in safer spaces reduces micro-level risk environments and harms for people. Sufficient access to safer spaces is essential in addressing this unmet need and continued use in less safe spaces. The implementation issues and recommendations specific to OPS access are discussed further in Section 6.3.

Additionally, while the OPS provided important supports and risk mitigation interventions for people who use illegal substances, shelter residents who used alcohol and/or cannabis, or who were trying to distance from substance use identified that their needs were often not met.

> You go in the bathroom and it's just prolific drug use everywhere. The stuff they should be doing in the OPU! And the staff doesn't say "hey, you should be doing this in the OPU". They just walk in and go "okay" and turn around and walk away. You know? Rather than saying "this is a bathroom", you know, "this is for people to use as a bathroom. Not to sit there and shoot up drugs, and smoke drugs, and snort drugs." That is what the OPU is for. Literally unless they're like smoking it right inside, then they [staff] say "take that outside" otherwise they pretty much just ignore it. We tenants here, we speak about it almost on a daily basis, this whole thing we're talking about now. Like those of us who don't do drugs, or just basically do cannabis and a little drinking, we talk about it almost on a daily basis on really what needs to be changed. And I've gone to their meetings they've had here and made recommendations, and just nothing (Participant 12: Shelter Resident).

One of the complex challenges of serving a diverse population, such as within an emergency shelter, is that there are tensions between risks and harms, and safety across different groups, with different, often opposing needs. This tension highlights one of the challenges of implementing OPS into existing services [such as an emergency shelter] that serves a diverse group of people with diverse experiences of substance use (or non-use). How to create enabling/safe environments for different kinds of substance use, including non-use is a complex and challenging issue. While the implementation of an OPS provided important opportunities for

safer use for many people who inject or smoke illegal substances, risk environments often remained for people who use alcohol or cannabis, and people who were seeking to distance themselves from substance use.

Safer Use Education. Harm reduction services, including OPS, can provide opportunities for important education and information on safer use, that includes safer injection practices, and how to use substances in a way that have fewer negative physical impacts on the body.

> I'm 57 now and I started running into medical problems- blood problems, bone problems, and muscle problems, stuff that doesn't hit most people until they're over 50. And harm reduction is having knowledge of how the body works, and how each part works, and how to keep care of it properly and be safe [when using substances]. And it means less trips to the hospital, and it hopefully means a longer life and a healthier life. You know? (Participant 21: Peer Worker and Resident).

Harm reduction services, such as OPS provide safer use supplies, a safer space as well as safer use education. These strategies can prevent other medical complications such as lung infections from inhaling impurities from unsterile supplies, reduce risk of anoxic brain injury from non-fatal overdose by providing immediate overdose response, and reduce risk of complex illnesses such as HIV or HCV. All of these mitigate micro risk environments and create important enabling environments for harm reduction intervention that improve health for the individual. OPS are an important opportunity for provision of health services outside of the health care system, which helps to further ameliorate some of the economic, social and policy harms produced at macro and meso-levels. Safer use education is an important component of this work.

Community Safety Through Recovery of Supplies. Participants who were also peer workers in the OPS identified the role OPS staff and volunteers had in supporting sharps recovery throughout the shelter, and community.

> I volunteer for the OPU, so I don't access the [OPU] services at the shelter. I just help with the services. I do the Clean and Safe, so I go around the community, and I clean up needles, pipes, and cookers, and whatever people have left around that shouldn't be there because the neighbours complain (Participant 02: Peer Worker and Resident).

The OPS provided opportunities for preventing harms and complications associated with substance use for individuals, and for the broader community. In addition to preventing infections for individuals accessing the service, the OPS also provides an important opportunity for reducing community tensions by supporting additional services such as sharps recovery. Sharps recovery supports a safer physical environment for people accessing the OPS, people staying in the shelter, and community members in the area surrounding the shelter.

Reducing Criminalization

During data collection, I spent considerable time within the shelter space, and I observed that police were frequently within the shelter (not the OPS, but the broader shelter). Many participants also alluded to a frequent police presence within the shelter, citing various reasons for this.

> And the cops come here, right? They just walk right on through [the shelter]. And, you know, and they never did that at [another shelter service]. They can't even go on the property there, right? (Participant 16: Shelter Resident).

During my time in the shelter, I observed staff calling the police for challenging behaviour, incidents of theft, or other difficult situations. Additionally, several participants

identified that staff had either called police or threatened to call police for substance use outside of designated spaces (this is discussed further in Chapter 7).

Although there was a consistent police presence within the shelter space, residents report that the police stayed out of the OPS space itself.

> Not much has changed. It's just kind of…gave the drug users – the IV users a safe place to be without worrying about the cops walking in on us. So, we don't have to look over our shoulder, that's about it. I mean, of course it would make you feel a little more safe than, you know, "if I do a smash, I'm going to go to jail" (Participant 10: Shelter Resident).

Participants who only used the inhalation tent, and not the OPS injection space, identified that there was some protection and safety from criminalization within the inhalation tent space as well.

> Like if you, if you're in the tent and you've got a consumer amount of drugs on you, and the cops do come in back there; you're not going to pick that shit up, right? You know, to that extent, you're safe here. So, it creates this very safe place. And so that's a very, it's a place a lot of people want to go. A place where a lot of things happen; a lot of conversations happen, a lot of interaction with human beings and all that kind of thing (Participant 07: Shelter Resident).

Within the OPS, some participants identified both the real and perceived safety from policing.

> They've got a tent set up outside for people to smoke in. So, it's also, it's also well put together for people that are smoking crystal meth. And one of the issues I think, some of the people do like is that the local RCMP or the local Victoria Police maintain their

> distance. They don't walk in and arrest people. It's a safe, it's a safe place for people to use drugs. It's not like, "Hey, let's go there and use drugs." It's a safe place where they can look after each other and make sure that each other is safe. You know, as in overdosing, or as in, getting a bad batch of something; or just to be with friends and not have to look over your shoulder all the time you know, scared that you're going to get arrested (Participant 21: Peer Worker and Resident).

Not having to fear criminalization by police is an important protection and opportunity for safety for people who access the OPS and/or inhalation tent. The OPS and inhalation tent provided some protection from criminalization and police interaction as long as residents remained in those spaces. This increased safety supported opportunities for peer support between people using the services as identified by Participant 21 above, and reduced the policy, social and physical risk environments for individuals.

Criminalization outside of these spaces did continue in many ways. For example, substance use outside of designated spaces was sometimes responded to through calling the police, or threats of calling the police.

> Making sure that those people use those places. And if they don't, they definitely get, they know that they have a ban coming or will be asked to leave or even have the police called if they're not using in the appropriate place (Participant 08: Peer Worker and Resident).

Fear of criminalization has a long shadow and creating spaces where people can be protected from real or perceived criminalization, and threats of criminalization is important for reducing risk environments and supporting access to services.

> What they're doing [within the OPS] is trying to deal with a health and drug crisis. And what they're doing is saving lives and reducing the number of hospital visits necessary and the amount of damage done in other ways. And even they're reducing vastly the number of police interactions with both drug using and non-drug using residents by what they're doing with the tents – the tent and the overdose prevention room (Participant 08: Peer Volunteer and Resident).

While criminalization remained to some degree in the shelter generally (outside of the OPS), implementing the OPS, including inhalation tent, created a protected space from criminalization and threats of criminalization, supporting people to use in a safer manner and encouraging use of the OPS. OPS provide an important opportunity to mitigate the harms of criminalization by creating micro-level enabling environments of harm reduction and protection from meso and macro-level risk environments. Within the setting of the shelter, the OPS served as a micro-level pocket of safety within a meso-level risk environment. Challenges related to ongoing criminalization within the broader shelter are identified in Chapter 7.

Reducing Stigma

Harm reduction as an approach to care or philosophy is an important tool in addressing stigma towards substance use and people who use substances.

> Well, I think the thing with harm reduction, there's no stigma between people. There's definitely the stigma of drug users versus regular people. But when you start making harm reduction, people start seeing each other the same. They realize that, you know, it's not all stigma. If you look at Portugal, they've decriminalized everything. And people look at each other snorting lines off tables and look at each other like it's perfectly okay.

> Because they have a harm reduction approach to it; that it's a medical issue, not anything but (Participant 06: Shelter Resident).

In the above quote, Participant 06 identifies the role harm reduction interventions, such as OPS, can play in addressing stigma. OPS can serve as an important tool for normalizing substance use and reducing the "othering" of people who use certain substances. Many drugs, such as caffeine, alcohol, and tobacco are legal, with safe spaces for use while having significant health, economic, and social harms that accompany use. However, as these substances are not criminalized, there is often less stigma than illegal substances such as crystal meth, heroin, or crack. As Participant 06 identifies, harm reduction services, including OPS, can provide an important opportunity to shift the understanding of substance use away from criminalization towards conceptualization as a health or medical issue, which is an important tool for reducing stigma, and harms for people who use drugs. These conceptual shifts can reduce both micro and meso-level risk environments caused by the macro-level criminalization of drugs and can provide important opportunities for cultivating micro-level enabling spaces for harm reduction policy, practice, and philosophy within the OPS.

Some participants reflected on the role the OPS has played in addressing stigma and changing attitudes towards substance use.

> I think it's a good thing, definitely, by a long shot. I don't want people dying in alleys or bathroom stalls because somebody said "Oh, that's a horrible thing." It's not fair to anybody. I grew up in the age when drug use was very, very, very stigmatized. I'd get arrested for being on drugs, I'd get arrested for looking like I had them on me. It was bad, bad times and people were dying by the hundreds. And people never heard about it. Nobody cared. It wasn't newsworthy for them, so only when harm reduction comes

> around do people realize “holy crap, a lot of people are dying” and “holy crap, this isn’t their faults after all” and like “something’s not right here.” So, I definitely see the need for it [OPS]. I want people to have what I didn’t have when I used (Participant 06: Shelter Resident).

Participant 06 identifies their experiences of not only criminalization of substance use (arrested for being on drugs) but criminalization for simply having the appearance of a “drug user”. Although substance use is common across all demographics and all societies, the criminalization and harms experienced is often determined by intersecting factors such as race, socioeconomic status, gender, and sexuality. Not everybody who uses substances experiences the same harms of substance use, even if they’re using the exact same substance, in the exact same way. Harm reduction as a philosophy of care and the implementation of harm reduction interventions such as OPS, can help to reshape attitudes towards substance use from a criminal issue to a social issue as there is an implicit nonjudgement of substance use.

While the reduction of stigma was a marked positive impact of OPS implementation, one or two participants identified fears that implementing the OPS into a homeless shelter would increase the stigma homeless people face. This fear of stigma was one of few negative impacts of implementation.

> But that said, you know, in the shelter setting, I don’t know, I don’t know. I still have a problem thinking of the shelter setting as the place for it, because almost in a way, it stigmatizes those individuals who are affected by the social issue of homelessness by saying that we’re all drug users just by having it here. I agree with harm reduction tools and all that sort of thing. But the super presence of all of that, or whether it’s my own,

> interpretation and my own getting used to it in this type of a setting… there are other places where it isn't like that (Participant 01: Shelter Resident).

Both homelessness and substance use are highly stigmatized within our society. The combined stigma of these two lived experiences was a concern for some participants accessing the shelter and impacted their views on the appropriateness of co-locating overdose prevention services within an emergency shelter. The role of stigma within the broader context and organizational culture of the shelter, and its impact on implementation is discussed in Chapter 7.

Improving Relationships with Staff

Participants identified many unique aspects to the staffing of the OPS compared to general shelter staff that cultivated strong relationships.

> The relationships between the staff, the staff in there, and our people is just, there's a bond, you know? Like I can see the staff's face light up when certain people come 'round because they're genuinely happy to see this person. It's just, it's not another number of in-and-out, "bye." It's their friend. It's, you know? (Participant 20: Shelter Resident).

The example above illustrates the importance of harm reduction principles, such as non-judgemental and supportive care from OPS staff, and the important role these can play in reducing social risk environments and supporting safety for people.

These non-judgemental and supportive relationships are important for clients asking for help and accessing other services, including treatment and recovery services.

> Oh, definitely. Because if you're, if you don't feel close to that staff member, why would you confide in them about these feelings, right? You're not going to, right? You'll feel like talking to them is almost betraying yourself or going to the other side even though the other side is where you want to get to. By thinking that you want to get clean, you

> know, that's where you want to go; but, you know, by then looking at this person that you've had conflict with in the past, all of a sudden that turns you off the idea of getting clean, right? Without even realizing it. Now all of a sudden that's a friend that can help you right? So, you feel, you're more encouraged to take that step. I know that has encouraged more than a couple people to try and seek treatment (Participant 08: Peer Volunteer and Resident).

Trusting relationships, grounded in dignity and respect, are central to a philosophy of harm reduction, and can become transformative for people. Strong relationships between staff and people accessing the OPS can create opportunities for safety and enabling environments.

Improving Quality of Care

Participants identify the importance of having staff that can relate to what they are going through and how that can improve quality of care.

> Yeah no, it's definitely a big thing. You know, if you haven't been there and you haven't been through what we go through, you're not going to know exactly what it is, what it's like, how we feel, the emotions that we go through. It's hard, it sucks, it's very damaging, it's depressing, and you know, we're discriminated against a lot. But you know, there's ways to get around it and get out of it. And you know, if the staff can help, they will give you their opinion or their, you know, input on how you can go about doing that, and doing it safely, and you know, swiftly if need be (Participant 04: Shelter Resident).

Having staff who have "been there" can be important for relationship building and developing trust, which ultimately improve the quality of care that people receive. The inclusion of people with lived and living experience in staffing the OPS provides important enabling environments for harm reduction approaches to care.

The staff hired within the OPS, whether fulltime staff, or peers who worked shifts for a stipend, appear to have been intentionally hired for their knowledge and grounding in harm reduction, and often their own lived experience of substance use.

> Front desk staff can, sometimes [be knowledgeable about harm reduction]. But a lot of times I find it's mostly OPU, the OPU is a lot more useful for that. It's, they generally hire people that have lived the life. So, they don't look like "I don't know what's going on" when you ask a question (Participant 06: Shelter Resident).

Participants consistently agreed that the staffing in the OPS was unique and appeared to be intentional. This appears to be different to the staffing for the rest of the shelter, where participants report more of a mix of experience, orientations, and backgrounds. Having people who have "lived the life" can provide important opportunities for connection and shared experience between OPS users and staff.

Many participants identified how important it is having people with lived experience (PWLE) of substance use working in the OPS.

> Ninety percent of them are ex-addicts. I think a lot of people who go through what we go through and then make it out, we find it, you know, we're easily persuaded to take this kind of job. Because we're very, you know, we're concerned about the lifestyle and the way things are going and we try to make a difference. Yeah, they know, they know their shit (Participant 04: Shelter Resident).

Experience is invaluable and the advice and guidance that can be given and received between peers can be much more accessible than that given within a power differential relationship of staff to client. The inclusion of PWLE or peers in service delivery is an important

opportunity for providing safe and appropriate care and improving overall quality of care for people accessing the service.

Knowing the potential for stress and trauma that can come with being a first responder, there are often additional stressors and complexities for peers as the people they're responding to and trying to save are often their friends and are part of their community. Organizations benefit from the expertise and experience of peers, and it is incumbent upon them to ensure adequate resources and supports are provided to PWLLE to ensure they're being fairly compensated for their skills and expertise, and not being harmed in their work.

While the inclusion of peers at a service delivery level resulted in improved quality of care for people accessing the OPS, several participants identified limitations when people with lived and living experience were not included in in service planning in a meaningful way. As Participant 11 explains below, they were invited to attend organizational planning meetings but didn't feel they had any meaningful influence.

> The reason I left is because I don't believe no more that even if I go to those meetings at [Organization that runs the shelter] or whatever, that it's going to change what-so-fucking-ever. Because if you take a look at the way that they, that the business is run, they have workers behind the front desk that are free to do whatever they want to do. Then on the top of them they have boss that they get paid for God knows what. Then you got the big boss that actually his boss is from the City (Participant 11: Shelter Resident).

While people with lived and living experience are included at a service delivery level in the OPS to great success, it is important that inclusion of peers goes beyond service delivery to also include service development and design. So often, as identified by Participant 11, clients, or people with lived and living experience may be "included" in planning and development, but in a

very tokenized way where their input does not feel valued or does not impact change. An essential component of the meaningful inclusion of people with lived experience is making every effort to have people's input included in responses to ensure they know their input is valued. It appears that the organization running the shelter lacked the organizational supports to support the inclusion of people with lived and living experience at all levels of service design and development, which resulted in feelings of tokenism by some peers.

Facilitating Connections to Care

Many participants identified connection into other services or care as an important component of accessing OPS. Some participants identified opportunities for connections to other shelter services that they received by accessing the OPS. These connections into other services supported their health and wellbeing.

> My doctor assures me that I should be on disability because right now I'm not taking medications that really, I need. But simply because I can't afford them. So, I've asked for help out with the client service workers- CSWs. The OPU staff connected me to them. And ah, so they, they've been really huge in helping me to first apply for income assistance. Because not having access to a computer or phone has really made it hard for me to even try and apply for income assistance. But fortunately, the CSWs helped me use a computer system I wasn't familiar with; helped me not only fill out my welfare application but fast-track it. Then once I'm on that income assistance, then doctor's visits are paid for. So, I can go back and have an appointment with my doctor and have him approve me for disability and then I can get the medications I need (Participant 08: Peer Volunteer and Resident).

One of the benefits of harm reduction and OPS services can be providing a point of contact for individuals who otherwise might not access health or social services. In the example above, accessing the OPS provided the individual with an opportunity to access the client support workers within the shelter, which they otherwise would not have done. CSWs are shelter employees who provide social work services to clients. These connections can provide opportunities to access supports to which many people are entitled but have often faced barriers in accessing. Access to these additional services can reduce the micro-level impacts of economic, social, and policy risk environments and address the social determinants of health.

While many participants identified connections into other services as a positive impact of OPS implementation, there were some participants that questioned the strength of this function. Although this was a minority perspective, these participants identified challenges with connecting into other services as a negative impact or challenge of OPS implementation due to unmet needs.

A few participants identified limitations in the OPS staff's ability to provide referrals into other services.

> Out here you got the OPU for 12 hours. They do have somebody that's experienced the life; but they don't have the proper medical staff; they don't have the proper referral power; they don't have, they don't have any of that (Participant 06: Shelter Resident).

These participants felt that the types of staff hired to staff the OPS lacked the referral power needed to provide referrals into other health and social services.

Some participants identified the importance of direct referral into other services and recommended that staff facilitate these transfers.

> I think there should be a trained doctor or nurse on site to help in the OPU. And that way they can refer people for the right services if they ask for it. And not just get "oh I'll write a phone number down on a piece of paper and know you will never call it anyways because you're pretty much asking us to do it for you. And we know if you're left on your own devices, you're not going to do it." I know that from personal experience. I've been to rehab 5 times and that's staff in [large urban city] all the time. "Oh, can you write me a number? Can you write me a number?" I'd never call. Unless someone sat down and called for me and dragged my ass in there, with me telling them that's what I wanted them to do, I wouldn't do it (Participant 06: Shelter Resident).

There are many staffing models that can run OPS services, and having registered professionals such as RNs or MDs are not required for providing effective harm reduction education, and overdose prevention and response. However, how services are staffed can impact the referral power of the service. Having connections into primary care, social services, housing organizations, and other basic supports can support the broader health needs of people who access OPS services. Navigating the health and social service sectors can be incredibly challenging and very unpleasant for many people, especially for those with previous negative experiences. Having staff complete a direct referral rather than simply providing a client with a phone number can be the difference between accessing that service or not. While the degree to which this is possible can be impacted by many factors, several participants identified this as an important recommendation for improving the OPS implementation. Additionally, the co-location of primary care and other health services within the shelter could address many of these unmet needs. As described in Section 6.1, the space used for the OPS had previously been the physician and nursing offices. While the OPS was an important and life-saving intervention, its

implementation meant the loss of a primary care space within the shelter. Prioritizing the co-location of these additional health services within another shelter space, rather than losing the service, could better support the full health needs of shelter residents.

Harm reduction as an approach and interventions such as OPS can be important tools for combating stigma, humanizing people who use drugs, and saving lives. The implementation of this OPS and the impacts of the OPS for people accessing the shelter provided important enabling environments for people who use drugs by mitigating the micro-level risk environment. Regardless of whether the harms were produced at micro, meso, or macro levels, the OPS provides a pocket of safety within the meso-level risk environment of the broader shelter setting.

Section 6.3- Implementation Issues and Recommendations

Above, participants identified the value and importance of OPS services. Participants highlighted the important, positive impacts of implementation and the few negative impacts, which reflected a minority opinion. Participants also identified some challenges related to implementation and opportunities where changes could maximize implementation. The success of an intervention is of course impacted by access and utilization of the service. Participants shared insights on how services could be improved, and the alterations in service delivery or design that could better meet user needs. Recommendations for implementation, included hours of operation, physical space, privacy, and the tokenized role of peers. These implementation issues and recommendations will be outlined in this section.

Hours of Operation

Participants identified that while the OPS is a useful and important service, it is not open enough hours in the day to fully meet the need of shelter residents who use substances. As the inhalation tent is outside in the shelter courtyard, and not directly staffed like the OPS injection

room, it is available to people 24/7. While the inhalation tent was not directly supervised, there were security cameras set up outside to support supervision and safety within the tent. It is unclear however, if front desk staff were able to observe the inhalation space, or if the digital supervision was only possible during OPS injection room hours of operation. Challenges related to observation with the inhalation tent will be discussed later in this section.

All participants identified that the OPS hours did not fully meet the needs of people accessing the shelter, and as such, substance use outside these designated spaces continued when the OPU was not open.

> Don't get me wrong, I'm not against the idea of having an OPU. But it needs to be run some other way. To begin with, the people have to have the OPU because before the OPU when the building let people come in 24 hours and everything and the bathroom was open 24 hours, people were using the bathroom as their shooting gallery. So, because of this they then, you know because of the number of deaths and this and that, they need to be supervised. So, it did open. I do agree with that. Problem is, they're still using the bathroom for the very same reason that we have asked to begin with to have the OPU (Participant 11: Shelter Resident).

While Participant 11 expressed their support for OPS and identified the importance of the service, they recognized that the implementation was not completely meeting the needs of the people who use the service due to the limited hours. This implementation issue also reflects one of the negative impacts of implementation in that substance used continued outside the OPS despite implementation.

Participant 09 identified one of the implementation challenges whereby people are provided with safer substance use supplies 24 hours a day, yet there is not a safe space to use their substances 24 hours a day.

> There's always paraphernalia and clean stuff to use. And the OPU's open basically all day, but it closes kind of early. Usually it closes at about 8 PM, and people use 24 hours a day, so… the hours should be 24 hours (Participant 09: Shelter Resident).

While having 24/7 access to safer injection and inhalation supplies is an important harm reduction intervention, it is equally important that people have access to a safe space for supervised injection and/or inhalation. Inadequate hours of operation limited the full impacts of the OPS and created risk environments for people while the OPS was closed.

Further to the above point, Participant 06 identified many of the issues that arose due to the challenge of requiring use within a service with limited hours, and the issues and tension this created.

> The outside tent's open 24 hours a day. That's why I don't think it's fair the OPU's only open hour to hour, when you're basically telling people that it's okay if you go outside and smoke. "Even, we're harm reduction, but we won't let you use your harm reduction between these hours." And like, it's not really fair. How are you going – how are you going to tell people you're not supposed to use, inject in the building, and then turn around and tell them "Well you can't inject in the OPU." Like that's not really fair to them (Participant 06: Shelter Resident).

Participant 06 highlights an ongoing safety tension within the shelter, related to substance use outside of the OPS. As discussed above, the OPS was opened to reduce the number of overdose deaths and adverse overdose events within the shelter. However, the need for an OPS

did not only exist for 12 of the 24 hours in a day. Access being limited to approximately 12 hours a day reflects meso-level risk production and contributed to risk environments for individuals as people had to use in less safe environments, outside of the OPS. This could include using in prohibited areas within the shelter, which created additional risk environments related to increased risk of overdose death, shelter bans, and possible criminalization.

Additionally, the inhalation tent being available 24/7 (though with less supervision outside of OPS hours) created feelings of "unfairness". The challenge of requiring use in designated spaces, while not providing access to those designated spaces created feelings of vulnerability and contributed to the creation of risk environments where these services were not available. Increased hours of operations for the OPS was a clearly identified need for supporting safety for people who use drugs and supporting harm reduction practice within the shelter.

While access per say was not a barrier for the inhalation tent, as it was physically available 24/7 in the courtyard, safe access or supervised access to the inhalation tent did appear to have been limited. While the inhalation tent itself created an important enabling environment for harm reduction intervention, the tension between access and safety that resulted from the periods of reduced supervision, created risk environments for people who smoke drugs. Several participants identified that users accessing the tent would look out for each other during hours where the tent was not supervised by staff, but the ability to do so was impacted by time of day/night and if there were other people around at the time.

Hours of operation are of course impacted by many factors, including funding and budgets. As participant 15 identified below, funding is likely a significant factor in what was limiting access to the OPS.

> Yeah, it only goes 'til like 9 o'clock, I think probably funding is what's holding that back. But I really think they should be open later. Because, you know, then people are doing it elsewhere. You know? They do that because – I presume – because the shelter's then closed, but if they're going to shoot up, the bathrooms are now closed. And if the OPU is closed, that little vestibule place beside the office can get pretty full. So, they're going somewhere else to do it. You know? And let's face it, addicts don't sleep that much [laughs]. So, you know, even if it could go to – I don't know how, whatever they could afford, but you know, 11pm, 12am, that would be a help, I'm sure. Because you know, a lot of it doesn't happen until like, you know, 10, 11 o'clock at night (Participant 15: Shelter Resident).

While there are very real budgetary limits that organizations face, there are often opportunities that can be identified to expand access, even if services cannot be provided 24/7. When 24/7 operations are not feasible, the hours of operation could be shifted to better align with patterns of drug use. This could include opening later in the morning and staying opening later in the evening/night. For example, Insite, in Vancouver is open 9:00am to 2:00am. Working with people who access the services to identify ideal operating hours is recommended to ensure responses are aligned with actual need.

Physical Space

Due to the limited space, Participant 04 highlights the importance of getting in and out, and not taking too much time, to maintain client flow.

> It's only got 1, 2, 3… 3 spots in it, so you do definitely have to wait your turn; it can get crowded. But as long as you just go in, do your thing, and then get out, then it works out pretty good (Participant 04: Shelter Resident).

Limited or insufficient space in the OPS can create conditions within which clients can feel they need to hurry or rush, which can create risks of harm and injury for individuals. Additionally, limited space can also act as a barrier to use of the OPS as people may not want to or be able to wait for an open booth. These harms are produced at the meso-level, as they result from organizational level implementation factors, but they create harms and micro-level risk environments for individuals.

While some clients were easily able to stick to a quick timeline, or do a speedy shot, some people required significantly more time.

> Space is an issue; it is an issue here I know. Because we've only got 3 tables here. And that might sound "Oh, 3 tables!" You know, "How many do you need?" Well, I went to the, into the [harm reduction service] in [major urban city] for the first time in my life this year and they've got about 20 some odd tables there and they're all full all day long. Okay? Well for instance, some people, some people – okay, take me for instance. I can go and sit down and get my shot of heroin ready and do my shot and be out of my chair in like less than 3 minutes. Whereas some people can't hit their veins and it takes them – a couple of the people that are there every day, it takes them up to half an hour, 45 minutes sometimes to do a shot. So, you need to have patience while other people are waiting to get in there (Participant 21: Peer Worker and Resident).

As Participants 04 and 21 identified, the limited space created a need to be fast and efficient, but people accessing the OPS had a range in experiences and abilities to adhere to these timelines. Often it was people with existing health challenges or considerations, such as difficulties accessing a vein, who needed more time. Having such limited space can have unintended consequences of clients feeling rushed, resulting in potential health risks, or them not

using the OPS at all. Additionally, the challenges some people experienced, that resulted in extended timelines for completing their injection limited or reduce the number of clients going through the service, which likely resulted in people using outside of the OPS due to lack of access.

Because of these challenges, participants identified the need for a larger OPS that could serve more clients at one time. The physical space constraints of the OPS and inhalation tent limited the number of people that could access the services.

> Needs to be bigger. There's not enough space for…I mean, if they're getting, like, roughly like 200 people coming in there within a week, and they've got 4 spaces to use in there. You know, and then they wonder why people are using in other parts of the building. Yeah, definitely need bigger space. It needs to be, I think they should have like a drop-in centre where it's like specified just strictly for overdose use and for preventing overdose and stuff like that. Yeah, I think the pods [OPS] need to be bigger (Participant 02: Peer Worker and Resident).

As participant 02 identifies, the number of spaces available in the OPS was not sufficient to meet the need or the number of people who accessed the services. While Participant 02 indicated there were 4 spaces in the injection room, there were in fact only 3 spaces. Insufficient physical space was a barrier to access and utilization of the overdose prevention site and contributed to ongoing substance use outside of the injection room and inhalation tent. The continued substance use outside of the injection room and inhalation tent contributed to risk environments for all shelter residents, including people using legal substances, and people seeking to distance themselves from substance use. Acknowledging that space is a limited resource, and the shelter space had physical limitations, identification of alternate locations or

sites for the OPS that could accommodate additional clients and meet greater need would support expanded access and utilization of the service. Many participants identified the possibility of having an OPS outside of the regular shelter space, possibly in a portable structure, similar to a seacan or other temporary structure. Additionally, expanding the number of OPS throughout the city could help provide additional options for people who use substances and would reduce the amount of demand on each singular service.

Supervised inhalation services often face challenges that supervised injection does not, such as concerns around second hand smoke and possible staff exposure to inhalants (and the resulting WorkSafeBC requirements). As such, cameras were used to support witnessed consumption by staff in the OPS without staff having to be directly in the tent.

> I know they've got cameras set up and they keep a watchful eye over what they can. I don't think they're really looking for people doing illegal things, I think they're looking to make sure people are being safe (Participant 04: Shelter Resident).

This novel service was an important opportunity to provide harm reduction services for people who smoke drugs. The physical location and set up of the inhalation tent in the shelter courtyard meant that people using in the tent were not directly witnessed while using, as people were in the OPS, but it appears that OPS staff made every effort to observe people using in the tent, either watching from the OPS or via video cameras. My understanding, from participant observations and conversations with shelter management at the time of data collection, was that the use of security cameras for witnessing consumption in the tent, rather than staff physically being in the courtyard, was to ensure compliance with WorkSafe BC requirements and reduce risk of second-hand smoke exposure for staff. While some risks or potential harms may have remained for the inhalation tent compared to the injection room inside the shelter, the design of

the inhalation tent, and the use of cameras for monitoring consumption sought to create enabling environments for harm reduction.

Due to the nature of combustion and inhalation, providing safer spaces for inhalation use can be more challenging than for injection use and consequently, inhalation services are not as widely available. The number of people who experience unintended overdose (drop) through inhalation can be significant and the provision of a safer inhalation space within the shelter courtyard was an important opportunity to reduce harms of macro and meso-level produced risk environments and provide enabling environments for harm reduction.

Despite the many positive aspects of the safer inhalation space, several participants identified that similarly to the OPS, the space in the inhalation tent was insufficient for the need.

> And when it's really lousy out the tent does get very full. Because people go in there and sit and, you know, with their dogs and what not. And it's not really big enough for the inhalation. We've tried going, you know, like in where the bikes are past that vestibule. And you know, been told "you're not supposed to do that." We thought we were supposed to stay away from the windows and whatnot, but... So still needs some more space (Participant 15: Shelter Resident).

Due to the space limitations, the inhalation tent was both a place of safer use, and a source of conflict between groups with varying types of substance use and needs in the shelter.

> No, because you put people like me or other people that I know that are using only weed and this and that into jeopardy. When we go in the bathroom, we have to deal because if I don't live in the building – and like I said I use, I still use it, I still have to go pee, I still have to go wash my hands, I still have to…so you go there, so you go there and you're going to walk into second hand smoke and when I talk to the staff about it, I've been told

> that we should go smoke in the tent. Not close to the window, not close from the door. We should smoke outside, in the tent. But if I go sit in a tent with people who use, I'm going to be exposed once again to secondary smoke. Where is that going to leave me? To relapse, so I don't think so. So, I'm not against it, it's just that it's not done the way it should be (Participant 11: Shelter Resident).

Participants identified this tension between people using different substances sharing one inhalation tent. Some participants who identified using legal substances and/or wanting to distance themselves from illegal substances reported that they felt their needs were often unmet. Participants recommended having a second tent so that there could be a division of space between types of substances and reduce experiences of second-hand smoke for people wanting to avoid contact with specific substances.

Privacy

While people identified the OPS as a welcoming and safe space to use substances, some participants identified a lack of privacy as a barrier to access. These participants identified that the location of the OPS, within the main shelter space, was not optimal for them due to a lack of privacy when accessing the service.

> I like it, but I think it should be a separate building. Like I think that they should have it, but it should be a little bit more private. Because you know what, I think the people that are using would prefer a little bit of privacy. And when they have people coming in here [the shelter] for tours and stuff, people don't want to sit there and be injecting and watch people stare at them with those judgmental looks that people give, right? (Participant 02: Peer Worker and Resident).

The location of the OPS, right off the main drop in area of the shelter, had many challenges in terms of space and privacy. As Participant 02 identified, people using the OPS may have felt "on display" and may have experienced real or perceived stigma and/or judgement due to the visibility of using the service, which could be a barrier to access for some residents.

Some people who use substances prefer to use substances alone. To meaningfully support people who use substances, and promote safety, it's important to recognize that not everybody will feel comfortable using an overdose prevention site, especially it it's set up in a very open and communal way.

> I'm like the total opposite. I like to be alone. Like I don't need people around. You know, when I was doing dope, I was off by myself every day. I wasn't around anybody else. I'd go and I'd buy crack and I'd buy heroin, I'd go sit in the woods, or I'd walk around, or I'd be in my apartment locked up alone (Participant 03: Shelter Resident).

Like with any activity, there are a range of experiences when using substances and different people have different preferences and needs. For some, they enjoy a more social or communal setting, and for others, they prefer a quiet and solitary experience.

> I notice that some users hide when they do it. They'll lock themselves in a stall in the bathroom or they'll go into some corner and fix or smoke. And then they're almost…they don't look at it as being social. There's 2 different types- I've noticed that even though they're using the same drug, there's the social drug users and the ones that are not, and the ones who are not will go off by themselves and do it. My roommate is a heroin addict and he's overdosed twice since I've been back. And, and he's a closet user too. Doesn't want anybody to know and does it by himself. Which is very dangerous (Participant 19: Shelter Resident).

Often stigma can be an additional layer that can impact how "visible" people are comfortable being while using substances or accessing services. For many people, their substance use was hidden from other people in their lives and so accessing substance use-specific services did not feel safe for them. Supporting options such as peer witnessing for people who are not comfortable accessing the OPS is important for reducing risk environments outside of the OPS.

Where physical space and staffing levels are available, creative options for supporting more private, but safer use can be possible.

> I've seen other use sites where you actually, they take you to a room. And you're monitored but you're not in a group, you're by yourself doing it. So, it's more private (Participant 19: Shelter Resident).

Participant 19 identified the important role peer witnessing or episodic OPS can provide either in conjunction with OPS or where formal OPS are not available. Peer witnessing in essence is an initiative to support people who use drugs to use safely by having a peer, who is trained in overdose response, present to witness consumption and respond in case of adverse events. Peer witnessing is an important and relevant intervention for supporting overdose prevention and can be easily implemented into responses to homelessness. Wherever possible, it is helpful to identify other interventions (outside of brick-and-mortar formal OPS) that can support people who are not comfortable accessing the OPS to ensure their safety is also supported and responses can be provided in a timely manner in case of an unintentional overdose.

Other participants identified the safety challenges or concerns that can accompany increased privacy, and the tension between safety and privacy. The witnessed component of

witnessed consumption, the essence of an overdose prevention site, is what allows for timely response in case of overdose, adverse reaction, or toxic drug poisoning event.

> Well, you can't really allow privacy if it's harm reduction. Like you can't be doing fentanyl by yourself. Like I just OD'd like a week and a half ago and it was off of 2 puffs (Participant 03: Shelter Resident).

Identifying opportunities for increasing privacy or establishing compatible services to support people wanting to use alone can augment OPS services and provide important supports for meeting a range of needs and creating enabling environments for harm reduction. Options such as safety check apps (e.g. Lifeguard App), peer witnessing, or episodic OPS services in a client-identified space could be explored to support people who are not comfortable accessing an OPS.

In the next chapter, I will present the findings related to the meso-level context of the broader shelter and the bidirectional influence of the meso-context on the micro-environment of the OPS and vice versa. Additionally, I will identify the implementation issues and recommendations for the meso-level shelter environment and the interplay between the broader shelter culture and the uptake of harm reduction philosophy, policy, and practice.

Chapter 7 Findings: Contextual Influences on Implementation

Section 7.0- Introduction

This chapter focuses on findings related to the broader context of the shelter that both influenced and were influenced by the implementation of the OPS from the perspectives of the participants. In section 7.1, I will outline the policy context within the shelter and how this influenced OPS implementation. In section 7.2, I will describe the organizational culture of the shelter and how this influenced the implementation of the OPS and was influenced by the implementation of the OPS. Finally, in section 7.3, I will highlight the meso-level economic context and its role in implementation.

Section 7.1- The Shelter Policy Context

The shelter organization began distributing safer use harm reduction supplies a few years before the implementation of the OPS. My understanding from previous research with the site and in speaking with shelter management is that the addition of supply distribution was in response to a recognized need and the known harms associated with reusing substance use supplies (Shelter Manager, 2018). Previous research conducted within the emergency shelter in the fall of 2015 (Wallace et al., 2018), identified the addition of naloxone administration and overdose response by staff as additional harm reduction interventions within the shelter. The addition of these services was due to the marked increase in overdose events occurring within the shelter, due to the increase of illicit fentanyl in the drug supply. However, the 2015 research also identified that prohibitive substance use policies remained and the shelter lacked a harm reduction philosophy, which was understood in the 2015 research as incomplete implementation of harm reduction (Wallace et al., 2018). In this previous research, staff, and residents both identified the challenges of distributing harm reduction supplies but not providing a safer space

for consumption. Additionally, while staff were responding to overdose events in the shelter, there was no witnessed consumption at the time and so staff were coming upon residents who were already experiencing an unintentional overdose and so staff were having to respond to a crisis event. The marked increase in overdose events due to the increasingly contaminated illicit drug supply resulted in many deaths and was creating significant harms for both shelter residents and shelter staff.

In December 2016 when the Minister of Health released Ministerial Order 488 (Government of British Columbia, 2016a), the shelter quickly moved to establish an OPS. The intention of the shelter organization to rapidly implement an overdose prevention site at the first opportunity appears to have come from a place of wanting to prevent deaths. While the implementation of the OPS itself appears to have been grounded in harm reduction philosophy and practice and created an important enabling environment for harm reduction interventions and practices, specifically supervised injection and inhalation, policy challenges and other factors within the broader shelter impacted the implementation of the OPS. In this section, I will describe the informal policy and substance use rules within the broader shelter, the constantly changing policy environment, seventy-five ways of ruling: inconsistency in the application of rules, the consequences of the inconsistent application of rules, and a desire for consistency in the application of rules.

Informal Policy and Substance Use Rules

At the time of data collection for this study, in Spring 2018, approximately 16 months after the shelter opened the OPS space, I requested copies of shelter policies and practices related to substance use and harm reduction and was told by the shelter manager that the shelter did not have any formal or written policies at that time (Shelter Manager, 2018). Previous research

(Pauly, Wallace, & Barber, 2018; Wallace et al., 2018) within the transitional housing program run by the same organization identified previous substance use policies that prohibited substance use on site. When I requested copies of the shelter policies, the shelter manager identified that the previous, prohibitive substance use policies had been removed, but new policies were not yet in place (Shelter Manager, 2018). It appears that at the time of data collection for this study, the shelter and organization were in a period of policy transition. Policies impact if and how a service or program is implemented and so the paucity of written policies within the shelter created several implementation challenges, which influenced the implementation of the OPS as well as how the OPS was able to influence changes within the broader shelter culture.

Substance Use Rules in the Absence of Formal Policy. Rules are commonly defined as formal or informal standards that inform what people can or cannot do (individual conduct) within a particular setting. Policies are typically established by the top-level management of an organization and act as a guide for decision-making under specific circumstances. Policies guide the implementation and application of rules. However, informal policies and practices often guide implementation both in the presence and absence of formal written policy.

Although there were no written or formal policies related to substance use, as reported by the shelter manager, participants did identify some rules that they had either been told, or assumed, based on staff practices that they had observed.

> So, the OPU's supposed to be the only place you're supposed to inject. You're not supposed to actually inject in your rooms, or anywhere else… Yeah, as long, as long as they're not leaving rigs laying around. Most people are very clean about it and keep to themselves about it. So, I'm a little okay with that. Like you're not harming anyone else, you know? Ah, the smoking's supposed to stay outside. There's the tent where, it's like

> kind of chopped off so they can sit in there and smoke whatever and be safe there. Have a cup [of alcohol], they don't care (Participant 06: Shelter Resident).

While there were some commonly identified shared understanding of rules around substance use in the shelter, other participants didn't have any knowledge of substance use rules. Often this knowledge was influenced by how long a person had been accessing the shelter or services within the shelter or which substance was being used. Generally, those who had been accessing the shelter for a long time felt they had a better understanding of the rules compared to those who were new to the shelter. Additionally, in the absence of written policies, many participants found themselves guessing at what the substance use rules were, based on how staff responded or reacted to people using substances outside of the injection room and inhalation tent.

The broader shelter's substance use rules largely focused on approved and prohibited spaces for substance use or safer substance use supplies. During this transitional period, participants identified what they perceived as conflicting messages that contributed to confusion around substance use rules.

> Injecting should be in the OPU but there's still in the bathrooms, there's still, they still want to prepare it for harm reduction, so you still have the needle dispensaries. Sorry, not dispensaries but sharp boxes in all the bathrooms. So that makes it kind of look like you can still use in there. And they do use in there all the time. When the OPU is closed, it's large bathrooms upstairs and there's always needles on the floor. It's frustrating (Participant 01: Shelter Resident).

Participant 01 highlights some of the challenges and conflicts within the broader shelter that influenced the implementation and impacts of the OPS. The continued use of substances in bathrooms and other spaces outside of the OPS was largely influenced by the limited access of

the OPS. In this way, the hours of operation of the OPS impacted the whole shelter, and all shelter residents, regardless of whether they accessed the OPS. Additionally, the tension between supporting harm reduction efforts by providing sharps containers in the bathrooms, and the perception of this as sending mixed messages about allowing use outside the OPS, was common across many participants. These tensions were the result of meso-level social and policy risk environments within the shelter.

Although the OPS and inhalation tent supported safer substance use within the shelter, including the distribution of sterile supplies, the shelter appeared to still have a firm rule around no visible substance use supplies in resident bedrooms.

> So, there's no paraphernalia in the rooms, and no smoking in the rooms. Those are 2 pretty big rules. Well, I've got paraphernalia in my room all the time, right? But not visible- it's not supposed to be visible (Participant 16: Shelter Resident).

Visible injection or inhalation equipment, regardless of whether it had been used, would typically result in a ban from the shelter, as stated by several participants. The distribution of harm reduction supplies and provision of OPS services within the shelter space while prohibiting the visibility of substance use supplies in bedrooms contributed to tensions and harms for people. This prohibitive approach to visible injection or inhalation supplies created social and physical risk environments for shelter residents.

Constantly Changing Policy Environment

The formal policy context and the informal policy and substance use rules within the shelter appear to have changed significantly in the time that many participants had been accessing the shelter. The formal policy changed from prohibitive to non-existent (Shelter

Manager, 2018), and the informal policy and substance use rules appear to have changed frequently in response to issues and challenges within the shelter, as reported by participants.

The participants who had been accessing the shelter for several years reported that substance use rules were constantly changing.

> Hmm. Well, it's a constant learning experience. It's a constant. They're always changing the rules and trying to improve things and see what works. Like, for example, there have been problems with people smoking in the bathroom, or smoking drugs. When they smoke cigarettes though, it sets off the fire alarm. They couldn't figure it out because people kept doing it when they were sitting on the can, or just hanging out in there talking and having a cigarette in the bathroom because it was raining. Whatever the reason was, people were constantly smoking in the bathroom. And it sets off the fire alarms, so now if the fire alarm goes off, the staff are immediately in the bathroom. And they take the names down of everybody who's in the bathroom, to try and figure out who was smoking. And if they see somebody smoking with a cigarette, that person gets banned. But if nobody owns up to it, they take the names down of everyone. And they close the bathroom down for 3 or 4 hours. And with no other bathroom available, that kind of punishes everybody. And everybody whose name was taken down, if they're in the bathroom 2 or 3 times when the fire alarm goes off, they get banned, regardless of whether or not they were actually smoking in the bathroom. It could be just coincidence that you and a couple other people were in there when the smoke alarm went off 3 times in a row. But you'll get, you'll lose your bed, you'll get a weeklong ban (Participant 08: Peer Volunteer and Resident).

As Participant 08 highlights, the substance use rules and practices in the broader shelter were frequently changing. While the intention behind this appears to be an attempt to adapt to changing circumstances and contextual factors, the way in which it was done, appears to have created additional challenges and confusion. The consequences of these changing rules appear to have left shelter residents unclear about what was or was not considered acceptable.

Participant 19 identified how the rules around smoking and cannabis had changed since the OPS was implemented.

> [in response to being asked where people go when smoking or vaping] Outside the tent and in the smoking area that's non-CRD. It's not terribly huge. But the 7 meters along the wall doesn't take up that great deal. It's probably to the edge of the stairs. And then from the stairs on, you can smoke. And the only place we can't smoke marijuana is in, in their tent [the inhalation tent]. I've never seen formal rules and the rules evolve here over time. Before we used to have to smoke marijuana in the [inhalation] tent. Smokers [tobacco] could smoke anywhere in the courtyard, but if you're going to smoke any substance – illicit substance – it had to be in the tent. But I guess now that marijuana's basically legal, now we're with the tobacco smokers (Participant 19: Shelter Resident).

Since the OPS was opened, shelter staff and management appear to have further changed rules to try and refine them and address some of the challenges seen within the shelter. The introduction of the OPS appears to have initiated a period of transition within the shelter, for both policy and practice.

Seventy-Five Ways of Ruling: Inconsistency in Application of Rules

Participants reported a lack of consistency in the application of rules by staff, within the broader shelter, outside of the OPS.

> Let's put it this way: for every rule that you've got, you've got just about let's say, just for a number, 75 workers altogether, 75 ways of ruling the place (Participant 11: Shelter Resident).

Organizational policies inform how rules are applied and guide staff practice in various situations. However, as identified above, in the absence of formal, written policies, staff lacked the guidance and policy foundations to consistently work with residents and respond to substance use or any other identified challenges in a consistent way. The result was significant variation in how staff responded to substance use within the shelter. This variation and inconsistency in practice created social and policy risk environments, which undermined broader, organizational shifts away from prohibition.

People accessing the shelter reported experiencing different rules or different application of rules depending on which staff were working.

> Wow! Pff. Well, the main one is staff [needing to] all be on basically like the same team following the same rules. I think it's hurting the drug users as well. Because they need structure in their life. I mean, because that's what's gotten them to this spot is lack of structure and stuff in their life. So, they need that structure and rules. You know? And yeah, just one staff will, will follow one rule and then 10 minutes later another staff will come by and just go "Oh, that's okay." No, well 10 minutes earlier one staff said, "that's not okay, you can't be doing that." And then another staff comes along and goes "Oh, I don't care. Go ahead." You know? [Laughs]. How is anybody supposed to know what's right or wrong when nobody follows the same rules? (Participant 12: Shelter Resident).

This lack of consistency in application of rules had many consequences for people accessing the shelter. This lack of consistency exacerbated existing tensions while setting

residents and clients up for failure as they didn't know if or when rules would be applied, or even what the rules were.

Participants also identified that the application of rules changed depending on who the shelter resident was, not only by who the staff person was.

> What doesn't work is doing certain enforcement for one group of people and not enforcement for the other. And not letting people get away with one thing and then being super lenient about it the next day and not really helping the person in any way (Participant 06: Shelter Resident).

This inconsistency created an environment of risk and emotional unsafety for people accessing the shelter as they didn't know moment to moment if the same behaviour would be viewed as acceptable or would have significant consequences.

Participants reported that shelter staff's application of substance use rules was highly variable and often changed day by day, even for the most established rules, such as not using outside of designated spaces.

> I think staff try to stop you [using] it if it's not in a designated area. If [you're using] outside of the OPS, they'll give you a warning usually or a ban depending on the day and what kind of mood they're in. They may just give you a ban. It's not acceptable. I don't think they're trained properly here at all. I don't think this place [the shelter] is very good. It's not structured very well. I mean, it's easy going and a big party. That's all it is (Participant 10: Shelter Resident).

The above quote by Participant 10 captures the dual perspectives that many residents held where on one hand they identified the harms of banning people and the conflicts with staff around bans, and on the other hand, they understood shifts away from prohibition as the shelter

space becoming a “big party”. These meso-level risk environments impacted the implementation of the OPS because they impacted how people understood substance use in the shelter and how and where use should occur. In contrast, the OPS appears to have had a consistent and clear harm reduction approach and practice that helped people accessing the services to know what to expect when they were in the space. Within the OPS, staff practice appears to have been much more consistent than in the shelter generally. The inconsistency in staff responses to substance use in the shelter largely reflects the transitional period of policy and practice within the broader shelter, since the implementation of the OPS. Organizational policies that clearly outline guidance for staff responses to substance use, grounded in principles of harm reduction are important tools for further supporting this shift.

Consequences of Inconsistent Application of Rules

Participants identified several consequences of the inconsistent application of rules and responses to substance use by staff. These consequences included feelings of favouritism amongst shelter residents, and different rules and consequences for different substances.

Feelings of Favouritism. These experiences of the inconsistent application of rules created feelings of “favouritism” between groups accessing services in the shelter.

> Stop turning a blind eye to people smoking and actually give them bars just because they’re your favourites. Because other people are being harmed by it. I haven’t used heroin in almost 4 years, and for the first time in 4 years, last month I got high on it because people were smoking it in my room so much that I couldn’t breathe without breathing it in. And I got dope sick for 3 days and I was a pissed off person. So definitely need to enforce the rules a lot more on safety for other people as well (Participant 02: Shelter Resident).

The differential application of rules by shelter staff compounded tensions and issues within the shelter by creating feelings of inequality between people accessing the shelter. Some participants who were seeking to distance themselves from illegal substance use identified feeling as though their needs did not matter and that their needs remained unaddressed after OPS implementation.

Favouritism, or preferential treatment of some residents by shelter staff also influenced the degree to which the resident sought staff approval. This preferential treatment impacted the application of rules and the preferential treatment of some residents but not others.

> Because it is a very social interactive community, they do play the favourites a bit, right? Like the people who are known troublemakers and don't get along with the staff will receive a ban a hell of a lot faster than somebody who they like. I don't know, I get away with a little bit of shit here and there because, you know, I always try and tidy up and I try and be polite. I try and be polite with other residents and the staff. I brownnose a little bit, basically. But you know, I get along with everyone because of that. You know, a couple times when I was sneaking in here at night when I don't have a bed, they've let that fly for a little while; let me warm up and stuff, right? So, they definitely do play the favourites a little bit. And bend little rules (Participant 08: Peer Volunteer and Resident).

In many ways, the inconsistency in application of rules appears to reflect the transitional culture of the shelter at the time, and likely many staff trying to be responsive to the changes and challenges within the shelter. However, risk environments often remained, and shelter residents reported tensions across different groups with different needs.

Different Rules and Consequences for Different Substances. Participants identified that different types or modes of substance use resulted in the different application of rules by

staff and often different punishments. It appears that shelter staff were generally more accepting of and less likely to punish visible illicit substance use.

> Definitely been there. I've been outside smoking a cigarette and got in trouble for sitting too close to a door. Meanwhile, someone's standing, holding the door open, smoking crack and they don't say anything to that person. I'm like "Well that's not kind of fair at all either." (Participant 06: Shelter Resident).

Substance use outside of designated spaces created physical and social risk environments, particularly in relation to the inhalation of substances. One of the biggest challenges with the inhalation of substances was that second-hand smoke could create harms for other people. Implementing inhalation OPS services was an important tool in addressing this delicate and complex balance of rights and harms across differing needs. The challenges identified in Chapter 6, related to the limitations of having only one inhalation space for both legal and illegal substances, contributed to the physical, social and policy risk environments that resulted from navigating these challenges. As outlined in Chapter 6, adding a second space could support efforts to mitigate these risk environments.

While some rules were fairly consistently understood (e.g., no use in bedrooms or bathrooms), participants had quite divergent understandings around alcohol use largely due to the varied responses by staff. While some participants identified staff being completely okay with visible alcohol consumption in shared spaces…

> Alcohol, they don't look bad at alcohol use. People can drink here. You can drink in the common areas, you can drink in your room, you know. It's not frowned upon, which is nice. I like that (Participant 01: Shelter Resident).

others reported staff tolerating alcohol use if it was hidden in another container…

> I mean, you can't openly drink it. If you pour it in a cup and you're being discreet about it, yes it's okay (Participant 02: Shelter Resident).

or depending on the type of alcohol…

> [When asked if alcohol can be visible] It's 50/50. Most times they'll just tell you to pour it out of the can, sometimes they just don't even care. If I'm sitting there with a big 2-liter bottle [of cider] they're not usually concerned, but the minute there's hard liquor involved, there's never a blind eye. So. Yeah, you just can't have it – you can't be sitting on the table with like a big bottle or something, but like, if they see you pouring hard liquor in your coffee, they don't care as long as you put the bottle away when you're done, right? (Participant 04: Shelter Resident).

Staff responses to visible alcohol use in the shelter reflect the lingering organizational culture of prohibition towards certain types and forms of substance use. The inconsistent approaches, practice, and application of rules made it difficult for residents and people accessing services in the shelter to know what was allowed, and what was not, which fueled tensions within the shared space. This lack of clarity around rules of accepted and unacceptable substance use in the shelter contributed to social risk environments that created conflicts between staff and shelter residents, often with risks and harms for residents (for example, bans from services, and strained relationships).

Several participants identified that shelter staff responses towards legal substances such as alcohol, tobacco, and cannabis were often met with the strictest application of rules and often the most prohibition-based or criminalized approaches.

> I actually find that tobacco is the most harshly criticized in here. The only, the only legal substance other than alcohol and it's the – and then alcohol's number 2. Can't have it out

> in the open, but someone can sit there with half an ounce of heroin on the table and cut it with a fucking knife right in front of everyone. No problem there, but God forbid someone sees your bottle of booze. Same with the cigarettes, can't be anywhere near doorways, blah, blah, blah. And like, but if you get caught smoking an illegal substance in the building, oh well (Participant 07: Shelter Resident).

As demonstrated above, across the various participant quotes related to alcohol, many participants held very different perspectives and experiences in how shelter staff responded to the use of different substances within the shelter. While some participants had experiences of staff accepting visible alcohol use in the shelter, other participants had experienced significant consequences of visibly consuming alcohol in the shelter. Not only did participants have different experiences, but because of the role staff responses had in participants understanding shelter rules, shelter rules around alcohol were the least consistently understood across participants.

With the introduction of the OPS and the transitional period of the shelter service and organization, it appears that some staff began shifting away from prohibitive approaches for illicit substances while others did not. However, it appears that for legal substances, these changes had not yet been made, or were slower to be made. In many ways, the risk environments for people who used alcohol and/or cannabis or were abstaining from substance use remained. While the OPS provided important mitigation of risk environments for people who used illicit substances, harm reduction for legal substances was not available.

The combination of harm reduction and prohibitive approaches within one service (the broader shelter) created risk environments for people accessing the shelter and contributed to

tensions between residents and staff, and across groups of residents with diverse and often divergent needs.

A Desire for Consistency in the Application of Rules

Within the transitional policy and practice context of the broader shelter, staff appear to have been in the position of having to use their own discretion in responding to substance use in the shelter. Participants identified a desire for consistency in shelter staff's approach and responses to substance use within the shelter.

> So, they need more, like, rules. And enforcement of more rules. Because I know other places where it's a drop-in centre- there is a homeless shelter and everything, but because all the staff works the same way and all the staff enforce the rules the way it's supposed to, they'll get none of this. But anything goes for the people who are addicts to start with. I'm not against it, it's just there's another way of processing that they – I think they've been overwhelmed by the problem of the death, the ODs and everything. And when you start something like this, and you have no background where to look how it's going to work and how should we do it; well, you end up with a little bit like this. And I cannot blame the worker. They're left, they're left to themselves (Participant 11: Shelter Resident).

As Participant 11 identifies, shelter staff were in a difficult position of trying to support the diverse needs of diverse groups of people within one service, while also trying to reduce risk of overdose and death for people who use illicit drugs.

Other participants identified that most staff were trying to do a good job, but the absence of policies created issues and challenges.

> I think they just need to have their policies changed, not the staffing. The staff are doing good, it's the policies that need to change (Participant 02: Shelter Resident).

The transitions within the shelter, at the time of data collection reflect initial movements away from prohibition. During this transitional period, staff appear to have been "left to themselves" in responding to substance use in the shelter. The emergency shelter provided services to diverse groups of people, including people who didn't use any substances, and/or people identifying as in recovery or wanting to distance from substances, people who use legal substances, people who use illegal substances, and people who use a combination of substances. The risk environments and enabling environments of safety for these diverse groups were often at odds with each other, and staff were in a difficult position of having to navigate very challenging dynamics within the shelter. While the risk environments for some were mitigated, the risk environments for others remained.

Section 7.2: Organizational Culture of the Meso-Level Shelter Environment

The implementation of the OPS had many important impacts as identified in Chapter 6 and was an important tool for mitigating micro-level risk environments and creating enabling environments for safer injecting and smoking. The absence of policy, constantly changing rules, and inconsistent application of rules by staff, and the consequences of inconsistent application of rules, as identified in Section 7.1, impacted the implementation of the OPS. The broader shelter culture and context both influenced and were influenced by the implementation of the OPS. Although the implementation of an OPS made important steps toward the broader uptake of harm reduction philosophy, policy, and practice in the shelter, outside of the OPS, the broader shelter culture was one of transition and challenges remained outside of the OPS. In this section, I will describe the organizational culture of the meso-level shelter environment. I will describe

the organizational culture in transition, staffing within this transitional culture, the criminalization of substance use, and stigma, as well as how these themes influenced and were influenced by the implementation of the OPS.

Organizational Culture in Transition

Historically, the organization running the emergency shelter had prohibitive substance use policies for both the emergency shelter, and the transitional housing program located within the same building (Pauly, Wallace, & Barber, 2018; Wallace et al., 2018). Any substance use or visible paraphernalia on site would result in service bans. At the time of data collection for this master's research, it appears that not only was the policy and practice context within a period of transition, but so too was the organizational culture. Although the OPS provided an enabling environment for harm reduction, outside of the OPS, in the broader shelter, challenges and risk environments remained.

Preferencing of Abstinence. Several participants identified that outside of the OPS the preferencing of abstinence, or expectations of abstinence were still common within the shelter.

> So, there's harm reduction services, but that's seen as, like, "that's where you use." But the overall expectation is still "we don't want you to be using" (Participant 02: Shelter Resident).

Outside of the OPS, participants reported that abstinence was still viewed more favourably than active or visible substance use. While these attitudes were not present within the OPS, several factors identified in section 7.1 contributed to the impacts of implementation not being fully felt outside of the OPS. The preferencing of abstinence by some shelter staff reflects the transitional culture of the organization and aspects of a legacy culture of prohibition, which

had not yet fully shifted. These lingering values limited the uptake of harm reduction policy, philosophy, and practice outside of the OPS.

While harm reduction and abstinence-based approaches to substance use sometimes co-occur within one service or organization, there are often challenges with philosophical alignment and approaches, and tensions often ensue. Where abstinence-based approaches are co-located with harm reduction services, abstinence is often intentionally or unintentionally privileged.

> [When asked about tensions in the shelter] Um, between harm reduction advocates and AA, NA. Yeah, very, it's just like "You're a threat." We're toxic, we're a threat, we're all those things of which, you know? And I mean that entire system is based on power and, abuses. I think they [NA, AA] abuse power, they don't listen- I mean, it's, there's no credibility unless "Oh, hi, my name is…and I have this many days clean." You know? Unless you have such and such day clean, you're ignored. You know? It's just this horrible... And abstinence doesn't work for everyone! Because, again, they still – a lot of those places look at abstinence like AA or NA as better and, you know, [sighs] it's just frustrating (Participant 01: Shelter Resident).

While provision of harm reduction interventions within the shelter had changed over time, the organizational culture was in transition between prohibition and harm reduction and attitudes valuing abstinence-based approaches appear to have remained for some.

Many participants had internalized these attitudes of prioritizing or more highly valuing abstinence themselves.

> Well, I think a lot of people are confused that a shelter is also a treatment centre. You know? I don't think a lot – and that comes from clients as well. But see, I think a lot of staff have also gone through those programs. And we all have! And are still oriented to

> that way of thinking, kind of and I've worked hard at getting rid of that thinking [laughing] and it's a hard thing to do. But it's also a hard thing to be accepted by community once you've gotten that. Because suddenly you accept everything, and where are your boundaries? And where are your – what will you not accept? And you know? There's still a lot of things to think about (Participant 01: Shelter Resident).

The preferencing of abstinence over substance use is pervasive within society and these views appear to have been internalized by many shelter residents. The ongoing prioritization and valuing of abstinence reflected the transitional nature of the organizational culture wherein initial shifts away from prohibition had occurred, but there wasn't yet a culture of harm reduction within the broader shelter.

Being Discreet and Hiding Use. Several participants observed a preference by some staff to have certain substances hidden or not be visible. This was often spoken of in relation to alcohol consumption within the shelter.

> I mean I don't know what they're supposed to be [substance use rules]. And it also depends on which shift group is working too as to what gets enforced. When [staff member]'s working, he's a real stickler on the 7-meter thing [for inhalation]. Sometimes if we're drinking in the common room, it's not that we can't drink. They don't want us to have it – empty can. Like they want it poured in a cup. They want it…I don't know, hiding it I guess is the end result of it. But they don't have any problems with it, they just don't want it visible (Participant 19: Shelter Resident).

This approach to substance use, where use is allowed but it is expected, or preferred to be hidden created risk environments and harms for people and reflects a lingering culture of prohibition. Hiding use and "being discreet" also appears to have intersected closely with

inconsistencies in staff's application of rules, whereby the acceptability of visible substance use varied across individual staff persons, which further contributed to the development of risk environments for clients within the shelter.

By implementing the OPS, substance use had in many ways moved out of the shadows and had become more visible and acknowledged, which was sometimes met with challenges, due to mixed attitudes towards substance use.

> So, I think maybe some of the substance use is more visible now because it's kind of condensed to certain areas. It's, my awareness of it is a bit higher now, since the OPU. And that's going to be anybody who comes in here. I mean, they're going to see this now that it's not hidden and they're going to be like "holy fuck! What's going on?" It may have always been like that. It may always have been like that. We don't know (Participant 01: Shelter Resident).

Several participants initially stated that substance use had increased in the shelter after the implementation of the OPS. However, when probed further for information during the interview, they stated that the level of substance use had most likely always been occurring but that they simply were more aware of it since the OPS opened, as it had moved out from the bathrooms and bedrooms and into the designated spaces, which were visible to all within the shelter.

The long history of prohibition and stigma towards substance use continued in both subtle and overt ways, even for people who actively supported and acknowledged the importance of harm reduction interventions such as OPS. We see these conflicting attitudes and tensions being playing out in these understandings around visibility of substance use vs safety. While the organizational culture of the broader shelter appears to have been in a state of transition, and

implementation of the OPS appears to have supported shifts towards harm reduction, culture change takes time.

Staffing Within a Transitional Culture

As mentioned previously in Section 7.1, there was significant variation across staff in terms of approaches and response to substance use in the shelter. The transitional nature of the organizational culture is reflected in the staffing of the shelter service. Staff approaches and staff orientation and education both reflect this transitional blend of prohibition and harm reduction.

Staff Approaches Within a Transitional Culture. Participants identified three approaches in how staff responded to substance use in the shelter, outside of the OPS spaces. These approaches reflect the transitional nature of the organizational culture of the broader shelter.

Prohibitive Approach to Substance Use. Despite the initial shifts away from prohibitive policies, some staff appear to have maintained a prohibitive approach to substance use and the application of substance use rules in the shelter. This also reflects the legacy pieces of the previous culture of prohibition described above.

> So, you get kind of used to it being "okay, well, you know, da, da, da. I'm going to go light my cigarette over here." Not realizing that one of the staff – and there's one staff, he's a prick, man! He fucking hides down behind the little wall, like you know where like the windows start. And he'll go down and he'll wait for fucking, he'll go "baa!" And he'll be trying to catch the guys fucking lighting a cigarette or whatever. And he'll go "Ah, got you! 24 hours! Get the fuck out man!" He is a prick, man! I know! And like he's never caught me because I don't, I hardly smoke cigarettes or whatever, but he doesn't care. He's just a little guy. And fuck man! I've been like stunned because they're kicking

> girls out at like 2 or 3 in the morning, man. And it's fucking cold, they've got nowhere to go. And that is wrong, man! That's putting those girls at risk, you know? (Participant 16: Shelter Resident).

Intentionally trying to "bust" or enforce prohibitive punishments for specific types of substance use reflects lingering components of the previous prohibitive culture. These prohibitive approaches toward substance use created social risk environments for people who use substances. This approach also created physical risk environments for people as it impacted their access to shelter services and often promoted hiding substance use, which is associated with many harms, including death.

Blind-Eye Approach. Within the transitional, and often unclear organizational culture of the broader shelter, participants reported that instead of taking a prohibitive approach, some shelter staff turned a "blind eye" to substance use outside of the OPS spaces. In the absence of written policies, unclear practice guidance, and an organizational culture in transition, some staff simply ignored substance use within the shelter.

> [regarding staff responses to substance use in the shelter] Um, well like I said, it's just that they turn a, turn an eye. You know (Participant 13: Shelter Resident).

While a prohibitive approach to substance use that banned residents caught using outside of designated spaces had its own associated risks and harms, a "blind eye" approach where substance use was simply ignored by staff resulted in its own range of risks and harms for people who used drugs and alcohol within the shelter.

> So, the OPU's supposed to be the only place you're supposed to inject. You're not supposed to actually inject in your rooms, or anywhere else. But like, that's one of those

> ones where there's the major blind eye turned to. And I don't see a problem with that, really (Participant 06: Shelter Resident).

As participant 06 implies a "blind eye" approach to substance use is in many ways, viewed more favourably than a prohibitive approach that punishes people for using substances. However, within the context of illicit fentanyl in the unregulated drug supply and the ongoing public health emergency, a blind eye approach to substance use can result in people using in less safe ways and less safe spaces and can result in delayed response in case of overdose. Using substances alone is an identified risk factor for overdose death.

Some participants identified that the "blind eye" approach was sometimes applied to people injecting within visible spaces in the broader shelter.

> You see smoking, you see smashing. A lot of people turn a blind eye to the smashing. I don't really care because I'd rather they be out in the open, knowing that if something goes wrong, that someone's going to find them there fast enough. Versus them in a bathroom stall and dead for 10 minutes, not cool (Participant 06: Shelter Resident).

While some of the substance use outside of the OPS spaces may have been in visible places where people would be seen if they "dropped", a "blind-eye" approach cannot assume that people would be noticed in case of overdose. Hidden and/or ignored substance use can create physical risk environments for people and can fail to provide lifesaving supports to those who may need them, when they need them. The implementation of the OPS and inhalation site were important tools in supporting shifts away from a blind-eye approach, towards harm reduction-oriented approaches.

Anything Goes. Some shelter residents viewed the absence of policies and an unclear organizational culture as meaning "anything goes" and that shelter staff did not respond to challenging behaviour or substance use within the broader shelter.

> Well, it's, everything, this is supposed to be a safe place, which means anything goes. Well like I say, it's the wild west here. People just kind of, it's literally they think it's just kind of funny. That this is just an "anything goes" area. And I mean I even joke with the police that, when they come in, I always make a joke, "dare you to go in the bathroom" And they just look at me and shake their head. It's just like "No, we know what's going on there and we don't even want to see it." (Participant 12: Shelter Resident).

The complex combination of no formal policies, inconsistent staff approaches, and a transitional culture where shifts away from a culture of prohibition had begun, but aspects of prohibition had remained, appears to have created challenges in some shelter residents' understanding of approaches to substance use in the shelter. This gap between resident expectation and organizational culture appears to have created micro and meso-level social risk environments outside the OPS. The apparent transitional period within which this research was conducted reflected a moving away from the rigid prohibitionary approach and culture but had not yet supported knowledge sharing and education to all staff and residents on the rationale behind some of these changes. This appears to have resulted in some misunderstandings and negative perceptions of some of the changes observed.

Staff Attitudes and Knowledge Within a Transitional Culture. Shelter staff are the interface with shelter residents, and the training, education, philosophical alignment, and approach to care staff hold either support or undermine the implementation of services and broader culture change. Additionally, the staff selected and hired to work in a service reflects the

organizational culture of that service at the time of hiring. As identified in Chapter 6, the staff within the OPS appear to have been intentionally hired for their non-judgemental attitudes towards substance use, their alignment with harm reduction principles and practice, and for peers, their lived experience. This did not appear to necessarily have been the case for the rest of the shelter staff. Much of the shelter staff had been hired when the organizational culture was closely aligned with prohibition and before the implementation of any harm reduction approaches or interventions. Newer staff appear to hold attitudes and understanding more in alignment with harm reduction principles and approaches. Because of this, there was significant variation across shelter staff in attitudes toward and understanding of substance use.

Shelter Staff Attitudes and Orientation. Participants identified that shelter staff's attitudes towards substance use varied significantly across staff. While participants identified that staff within the OPS were aligned with harm reduction principles and practices and provided non-judgemental care (as outlined in Chapter 6), outside of the OPS, in the broader shelter, there remained significant variations in attitudes and approaches.

Participants identified that some shelter staff provided excellent support and care for people staying in the shelter.

> The services here are wonderful. Like the staff, like they really try to go out of their way to take care of you and make you feel like you're at home (Participant 03: Shelter Resident).

These practices that supported residents and made them feel welcomed and valued mitigated the risk environments that were created by some of the policy challenges and lingering prohibitive culture.

Other participants identified that certain staff within the broader shelter held judgemental attitudes or inconsistent practices that negatively impacted shelter residents' experiences of safety.

> It's their attitude and their tones. It's the way they come about things and the way they portray themselves. They walk, they kind of walk around here like they know they're better than us. And I think they need to be more…There's got to be more empathy (Participant 02: Shelter Resident).

How shelter staff engaged with clients, whether they operated from a place of compassion and acceptance or a place of judgment either created opportunities for safety or risks of harm for people accessing the shelter. When staff held judgemental attitudes towards people who use substances, it created social risk environments that in turn created barriers to accessing or requesting supports.

Participant 02 further identified the importance of staff not holding stigmatizing attitudes.

> [In response to a follow-up question asking if some staff have an attitude that "substance use is wrong"] I definitely do and I honestly think that if you have that view, you should not have this job. Because the whole point of this job is to have compassion and understanding and to help people, not to worsen it and to make things worse for them (Participant 02: Shelter Resident).

Stigma and stigmatizing attitudes can create risk environments and harms for people who use drugs and alcohol. Harm reduction as a philosophy, or approach to care is an important component of an organizational culture for mitigating risk environments and supporting robust implementation.

Shelter Staff Knowledge and Experience. As with attitudes towards substance use, the shelter staff outside of the OPS varied in their knowledge and experience of substance use.

> You would think that with a job like that, there would be kind of a little bit of a requirement to have a little bit of knowledge of resources to help people. If you can't help them with it, well then someone somewhere that will help them with it, right? (Participant 06: Shelter Resident).

Hiring staff with knowledge and experience around substance use can provide important supports for people who use drugs and alcohol.

Several participants identified that sometimes there were shelter staff available to help, but that outside the OPS, staff didn't always have the knowledge or training to provide residents with the appropriate supports.

> And I mean, sometimes that, people, I've seen people ask for help. And the staff haven't helped them. They're like – and I'm not talking about drug use, I've seen people try to get into rehab or something, and the staff will sit there with the finger up their ass and pretend they don't know how to help them. There's people coming back from rehab, I've known 3 people that have come back here. One month sober, come out of rehab, tell staff "don't put me in a room like this. I feel uncomfortable, help me move." and all 3 of them have relapsed since they've been here because staff are inconsistent with applying policies fairly. It's pretty much whatever type of mood the staff's in and what the relationship with the person is (Participant 06: Shelter Resident).

Shelter staff not having the tools and training they needed to support residents contributed to risk environments within the broader shelter and created missed opportunities for supporting people and addressing their health and social needs. This undermined the full

potential for the impacts of implementation of the OPS as the approach to staffing that was in the OPS, that supported this work, was not extended to the rest of the shelter.

While many participants identified opportunities for improvement with staff in the broader shelter, several also identified that some improvements had been made since the OPS was implemented.

[when asked in a follow up question if staff are more knowledgeable about harm reduction and substance use since the OPU opened] I think so, yeah. The OPU staff are the most knowledgeable, and then the front desk staff. They're pretty good now (Participant 18: Shelter Resident).

While I did not have direct knowledge or confirmation from shelter management about any staffing changes or changes in hiring practices, participant comments suggest that the newer hires for shelter staff appear to have greater substance use and harm reduction knowledge than previous staff. Although people with lived and living experience appeared to have been intentionally hired for the OPS (whether as full-time shelter staff or as peer workers), it is unclear the degree to which this intentional hiring of experiential staff occurred outside of the OPS. In general, participants spoke of shelter staff as being less knowledgeable or relatable compared to the OPS staff. While this was a majority opinion, it wasn't a universal opinion.

As we saw in Chapter 6, one of the important impacts of implementing the OPS was the OPS staff's ability to connect with clients, build strong, trusting relationships, and connect residents to other services. Supporting people in this way helped to mitigate the social, economic, and physical risk environments for people who accessed the OPS. The intentional staffing of the OPS supported this work. In contrast, outside of the OPS, in the broader shelter, there was a blend of staff, hired during various phases of organizational culture. The

inconsistencies in staff approaches, orientation and knowledge/experience reflects the transitional period of the organization and contributed to the shelter remaining a meso-level risk environment.

Criminalization of Substance Use

The OPS injection room and inhalation tent provided pockets of safety for people who use drugs, where participants reported they were less likely to be criminalized for their substance use. However, outside of the OPS, many participants reported that real or perceived criminalization of substance use did continue.

Many participants identified improvements and progress away from criminalization since the implementation of the OPS.

> It's totally different staff now than it was a year ago. They were dealing with some of the biggest drug heads you've ever seen in your life. People laying in the middle of the floor doing drug shots at 3 o'clock in the morning, and people running around screaming at 3 o'clock in the morning. And these guys have to deal with it. And they have to deal with it without phoning in police every time, or else the cops would be setting up shop here. You know? It's, like I said, it's a lot cleaner now and a lot quieter now. It's not like it was. It was, it was a, it was a fucking nightmare here a year ago [before the OPS]. It was. I've never seen anything like it (Participant 21: Peer Worker and Resident).

However, despite these improvements, criminalization or threats of criminalization remained a response to some substance use within the shelter, outside of the OPS.

> It's, ah, what they're doing is trying to make sure people are aware of…that there are safe places – saf*er* places to use that are less harmful to the people around them and to the drug users themselves. And making sure that those people use those places. And if they

> don't, they definitely get, know that they get – they have a ban coming or will be asked to leave or even have the police called if they're not using in the appropriate place (Participant 08: Peer Volunteer and Resident).

Despite important steps made towards the mitigation of risk environments and the protection of residents from criminalization within the OPS, outside the OPS, participants identified criminalization and threats of criminalization remained as part of the response to substance use by some staff.

While the OPS had provided some opportunities for improvement in staff responses to substance use, police were still a tool used by staff to address challenging situations when they couldn't identify other solutions. The transitional state of the organizational culture, with legacy aspects of prohibition and criminalization limited the uptake of harm reduction policy, philosophy, and practice into the broader shelter space. However, as Participant 08 identified above, the implementation of the OPS and other service changes made in response to the overdose emergency had created some opportunities for positive change.

Several participants identified that cannabis was frequently responded to in a criminalized manner. It is important to note that these interviews were conducted in Spring 2018 and cannabis was not legalized in Canada until October 2018. Although legalization had been announced and was being planned for, the shelter continued to have a prohibitive approach to cannabis use and appear to have utilized threats of criminalization as a tool for responding to cannabis use.

> So, the tent is in the main back area of the courtyard. We're allowed to sit on either side of the tent and smoke on either side of the tent. We just don't have to go in it, but we have to be beside it on either end. So, I mean, that is a problem. There are people that just

> sit there and smoke a joint and they can literally turn their head like this [turns head slightly] and someone's smoking a meth pipe in their face. And it could be very, very triggering for somebody. There's no exception for that. If you don't smoke there, you get thrown out. I've had cops called on me – or threatened to be called on me, because I've been smoking a joint in the middle [of the courtyard], away from the tent. Because I didn't want to smell it. And that's were, once again, that policy enforcement's not fair. You can't threaten to call the cops on someone for a joint and let someone smoke inside the building and not do anything about it (Participant 06: Shelter Resident).

The use of threats of criminalization by some staff for substance use outside of the designated spaces failed to identify or understand residents' reasons for using substances outside of these spaces and created risk environments for individuals. Threats of criminalization as a tool of enforcement reflects a meso-level production of harms in that these choices made at the organizational level can create worse health outcomes for people who use alcohol and other substances within the shelter.

One of the challenges with criminalization is that it is so deeply ingrained in people's understanding of how to respond to substance use, that often people who use substances themselves have internalized these views and advocate for prohibitive approaches that can produce harm for themselves and others.

> Not that I personally want it there because it would ruin whatever I had going for myself and my friends and family or whatever here; but like, for the people that don't use drugs and actually want to have a safe [abstinent based] place to be I think there should be security inside and out. And maybe even a police officer too, to stop the drug use and the dealing. It shouldn't be so glorified here. Because basically, I mean it's not even a

> stereotype anymore. It's literally just if you're homeless, you're a drug addict. Like there's no in between. And they kind of force it on you now because it's everywhere. And you can't get away from it (Participant 10: Shelter Resident).

Participant 10's experience above highlights the depth of belief that policing, criminalization and prohibition will stop what some consider undesirable behaviour. This internalization of criminalization by some participants reflects a micro-level production of harm but has been learned from criminalization at meso and macro-levels throughout their lives. Within a setting that had effective harm reduction interventions and services such as the OPS, but a broader organizational culture still in transition, without the full uptake of harm reduction philosophy, policy and practice, these tensions became more visible.

Participants noted that further criminalization would not address the issues and challenges seen.

> But you don't know what to do about, you know, the businesses in the area complaining about, you know, drug use, and drug paraphernalia, and people being messed up in the area. That's a very real problem at the same time and you can't just simply say "throw more funding at police" because there's a near-constant police presence in that area and it doesn't help, right? (Participant 08: Peer Volunteer and Resident).

Many individuals, organizations, and governments believe that further criminalization of substance use and people who use substances will resolve substance use issues and reduce or eliminate what they might consider "wrong" substance use. However, criminalizing approaches only further marginalize and harm people who use drugs. The criminalization of drugs creates risk environments at macro, meso, and micro levels, which can create barriers to health and care for people who use drugs.

Despite the implementation of an OPS, at the time of data collection, approximately 1.5 years after the OPS opened, aspects of an organizational culture of prohibition and criminalization remained in many ways. In this way, many of the benefits of the OPS had been siloed within the walls of the OPS. However, progress was being seen in many small ways and shifts away from criminalization and prohibition, towards approaches more in alignment with harm reduction philosophy, policy and practice were happening, it was simply slow in relation to need.

Stigma

Stigma towards substance use was an important component of the context within which the OPS was implemented. Stigma can occur at the individual level, the organizational level and at the structural level. All three levels of stigma can negatively impact implementation in various ways. This section will focus on stigma at the organizational (meso) and individual (micro) levels, with the acknowledgement that the root of most stigma is created at the macro level.

Some participants identified fear of stigma as a barrier to using the OPS injection room or inhalation tent as use in these spaces was more visible than in other spaces, such as bathroom stalls.

> I'd always smoke my pipe in the bathroom. You know? Always. I'd be smoking it in there because I didn't want to smoke it outside in the tent. And you just, because there is a fuck of a lot of stigma around side use, right? (Participant 01: Shelter Resident).

Stigma and fear of discrimination can create risk environments for people who use drugs as people may use in less safe spaces and in less safe ways to hide substance use out of fear of negative repercussions and judgment if seen. Despite the clear, positive impacts of the OPS injection room and inhalation tent, stigma and fear of stigma were also identified as a negative

impact for some. Stigma remained as a barrier to access for some people accessing the shelter. This is a clear example of the importance of having a culture of harm reduction within the broader shelter, and not only within the OPS injection room and inhalation tent.

Some participants identified their own internalized sigma as well as judgment from shelter staff as a barrier to accessing important services.

> I would make sure I told them- so I still have my own stigma toward- because I don't want to be known as, and I don't know how it works within the hierarchy or the staffing, you know? Maybe they talk between each other. You know what I mean? So, it's like, even though it's harm reduction, I still don't want to be known as an intravenous drug user. And I'm not. You know what I mean? There's still that, I don't judge others who are, but I don't want to be one. I don't want to be judged on, because the real world is, we judge. We judge everything. And you know, you just don't, you want to take as much precaution on that as possible (Participant 01: Shelter Resident).

To access the OPS injection room or inhalation tent, shelter residents had to "out" themselves as drug users. The real and perceived stigma and discrimination created risk environments for people and likely limited the full impacts of OPS implementation. This same barrier existed for people accessing harm reduction supplies from front desk staff within the broader shelter. Indeed, due to the variation in attitudes towards substance use held by staff outside of the OPS, stigma appears to have contributed to risk environments within the broader shelter more than within the OPS spaces.

While participants understood that having an OPS or designated space for witnessed consumption was safer for people, they often expressed conflicted ideas or understanding of whether it was right or whether it "encouraged" substance use.

> Well actually it's sort of a catch-22, right? To have that room, that OPU room, accessible. Like, having it going. Because it's, like, encouraging it and it's making it okay. But it's bizarre because it's illegal. So, it's like, how's that work, you know? Like how is that okay? I realize they want to have…yeah, I don't know. It's a safe place for people to do it. But, you know, you see people on the streets, you see people everywhere – or like, or I have been doing it [using drugs] and not needing a special room for it, you know? So, I'm not sure (Participant 05: Shelter Resident).

Stigmatized attitudes towards substance use are often so deeply ingrained that supporting the health needs of people who use substances is commonly viewed as encouraging or enabling substance use, and therefore viewed negatively. This research included participants with a wide range of substance use history including people with experiences of recovery, illegal substance use, and legal substance use. Even participants who identified as using illegal substances at the time of interviews had challenging internal conflicts around "enabling" people due to deeply internalized stigma. Shifts away from stigmatizing conceptualizations of substance use are important and can be supported through harm reduction education.

Many participants identified interpersonal stigma as a barrier to health. This interpersonal stigma is an example of a micro-level social risk environment and harm.

> And this is getting to be bigger and bigger and bigger, and it's hurting the community. Instead of them [staff] actually learning about addiction, accepting people for who they are because that's part of the reason they're staying in their addiction, because they're being ostracized and belittled daily. And you know, all that sort of thing (Participant 01: Shelter Resident).

Providing non-judgemental care and acceptance is essential for supporting people who use drugs to access services. While a harm reduction approach to care was present within the OPS, the broader context of the shelter appears to have limited the extent to which a harm reduction approach extended beyond the OPS itself. As such, the broader shelter remained a meso-level risk environment.

Unhoused people who use substances can experience increased and compounded discrimination due to the intersecting stigmas of substance use and homelessness. These stigmas produce social risk environments at a meso-level within the shelter and at individual, micro-levels. Macro-level stigma influences social, policy, and economic risk environments at macro, meso and micro levels through prohibition and criminalization of substance use.

Section 7.3: Meso-level Economic Context

Most participants identified insufficient resources in the shelter, largely impacting staffing levels, access to services, and safety within the broader shelter. These budgetary restrictions provided an important economic context for the meso-level environment of the shelter and impacted the implementation of the OPS.

A Need for Increased Resources

The natural, but unfortunate consequence of reduced or inadequate funding is a reduction of already limited services.

> And funding, from what I understand, funding is being cut back so much, they've had to cut back the number of staff working. So, they're not even able to open the main room for residents – or non-residents, people that use the services but don't stay in a bed here. They aren't even able to come in here after 6 PM and stay warm or whatnot. Like often there's people freezing, freezing outside (Participant 08: Peer Volunteer and Resident).

Underfunding interventions can influence implementation and compromise the full impact and potential of the services. For services such as OPS where they're essential in mitigating risk environments and reducing harms for people, underfunding can not only reduce these important impacts but also create their own meso-level risk environments due to unmet needs.

Participants expressed appreciation for the level of service that they did receive and had access to, even if was not ideal or adequate.

> I happen to agree, they do need more. But, you know, with funding and what not, at least we have what we have (Participant 15: Shelter Resident).

Within a scarcity model of services, people are often grateful for the limited resources and/or services they do have access to, even if it's not fully meeting their needs, or adequate for the demonstrated need. While it is important to identify and appreciate progress, even if it's not fast enough, or even just, enough, further progress is still required to meaningfully reduce risk environments and expand access to services.

A Need for More Staff. One specific component of needing more resources was the need for more staff within the shelter. Outside of the OPS, within the broader shelter, many participants identified a shortage of staff as a significant barrier to accessing offered or available services and developing relationships with staff.

> They're way understaffed. You ask them for anything, it's "Okay, it will be half an hour. You know, we need to do this, this, and that". I don't bother them with anything anymore. Like once, once a week I'll ask them a question, basically (Participant 03: Shelter Resident).

Insufficient staffing levels can create many challenges and barriers to successful implementation, as well as risks for both people accessing the shelter, and staff within the shelter. Insufficient staffing levels, that can't meet client needs, can create risk environments at the meso-level for people who use alcohol and other substances and can fuel tensions between different groups within the shelter. Additionally, insufficient staffing levels can also create harms for the staff as they may become overworked, more prone to burnout, and more likely to experience a traumatizing event due to the safety implications of understaffing. Adequate staffing of services is essential for the meaningful implementation of OPS and other harm reduction interventions.

The Economic Context and Safety

While the OPS was identified as a pocket of safety within the shelter, outside the OPS some safety concerns remained.

> I don't think they do enough safety checks to make sure people haven't dropped. I don't know, I feel that they don't really leave the desk enough. I think that they should be going and doing a lot more checks than what they're doing. Because, like, anything can happen within a 3-hour period that they're going upstairs (Participant 02: Shelter Resident).

Participants reported that staff were conducting infrequent safety checks within the shelter space, outside of the OPS. While staff time is of course limited, with the toxic drug supply, the infrequency of these checks can create very dangerous risk environments for clients and be potentially traumatic for staff. The insufficient levels of safety outside the OPS prevented the impacts and benefits of the OPS implementation from being fully experienced outside of the

physical OPS spaces. These safety concerns likely reflect inadequate funding and staffing levels and reflect the economic context of the broader shelter.

Although it was generally understood by shelter residents that substance use was to be limited to the designated spaces of the inhalation tent, and injection room, and was not to be used in bathrooms or bedrooms within the shelter, the reality was that need exceeded capacity and access to the OPS, and so substance use did still occur in shelter spaces outside of these designated spaces.

> I don't think they'll ever…Like I don't think you can ever take drugs, like, have a place like this and expect people not to get high in their rooms and not to get high in the bathrooms every night. They're going to get high wherever they go (Participant 03: Shelter Resident).

While substance use in designated spaces was an ideal situation, the reality was that, for a multitude of reasons, not everybody utilized the OPS services. Promoting safety for all residents, regardless of whether they use the OPS should be built into resource allocation plans, staffing models, and shelter policies. Concrete options for supporting people outside of the OPS spaces could include peer witnessing and/or episodic OPS (eOPS). Without these adjunct services, significant physical, social, and policy risk environments remained, and people were potentially at risk of significant harm or death. Supports outside of the OPS would require additional resources but could also provide expanded access to OPS outside of the existing hours of operation.

Participants also identified that harm reduction interventions should include prioritizing safety within the broader shelter, not simply within the walls of the OPS.

> Harm reduction is really keeping their eyes open. Looking for people that just don't look like they're doing all that well. And you know, I've seen them, you know, go up and say, you know "Are you okay?" And you know, "are you just sleeping" or something. You know. But I know they've had a couple times up on third floor where, you know, someone's been doing something in their room. And somebody notices, hopefully in time. And, you know, if not, then that's probably pretty stressful on the staff. But yeah, they're great for, you know, handing out the foil and, and the bags if people need them. So, like after hours, maybe just a little more viewing in on that little – I don't know what you call it, but the little vestibule there. Because, you know, there could be 6 people in there. And they're very good about monitoring each other as well, but just so the staff knows what's going on too (Participant 15: Shelter Resident).

Participants identified the need for regular safety checks throughout the shelter, including in bathrooms, resident bedrooms, and the "vestibule", which is a covered area between the shelter drop-in space and the exit to the courtyard, near the main staff desk area. This vestibule appears to have been some shelter residents' solution for using substances as safely as possible when the OPS was not open. The harms people experienced due to a lack of safety checks is an example of a meso-level production of harms and reflects a meso-level economic context impacting implementation.

In Chapter 7, I outlined the meso-level context of the shelter environment and how the policy context, the organizational culture, and the economic context of the shelter influenced the implementation of the OPS, and how the implementation of the OPS also influenced these broader contexts. The transitional nature of the organizational culture resulted in ongoing risk

environments within the broader shelters, while also reflecting important moves away from the previous culture of prohibition.

Chapter 8: Discussion

Section 8.0- Introduction

In this chapter, I discuss some of the key findings presented in Chapters 6 and 7 and provide interpretation within the context of the existing literature to address the research questions proposed at the beginning of this thesis. In section 8.1, I reiterate my research questions and summarize my key findings, and in section 8.2, I discuss the key findings in relation to the existing literature.

Section 8.1- Summary of Key Findings

This research sought to understand the impacts of implementing overdose prevention services (an injection room and inhalation tent) within a homeless shelter and how the implementation impacted participants and contributed to the uptake of harm reduction policy, philosophy, and practice within the shelter setting.

My research questions for this study were: How has the implementation of an overdose prevention site (OPS) contributed to responses to substance use and the uptake of harm reduction policy, philosophy, and practice in an emergency shelter, from the perspective of people accessing the shelter? What were the impacts of implementing an overdose prevention site for people accessing the shelter?

To answer these overarching questions, I asked four sub-questions:

1. Has the implementation of an OPS influenced responses to substance use in a shelter setting?
2. Has the implementation of an OPS reduced the harms experienced by people accessing the shelter?

3. How have the policies and practices within the shelter and organization impacted the implementation of the OPS?
4. Has the implementation of an OPS influenced the broader uptake and implementation of harm reduction policy, philosophy, and practice within the shelter setting?

The implementation of an OPS, into an emergency shelter, was an important tool for creating pockets of safety and mitigating micro-level risk environments for people who use drugs. The positive impacts of the OPS included saving lives and providing novel inhalation services, preventing harms and complications, reducing criminalization, reducing stigma, improving relationships with staff, improving quality of care, and facilitating connections to care. Combined, these impacts contributed to mitigating risk environments and reduced harms for people who use drugs. A minority of participants identified some negative impacts of implementation including the continuation of substance use outside of OPS spaces, fears of stigma, and challenges accessing other services. These negative aspects largely resulted from implementation challenges that limited the positive impacts and left some participants with unmeet needs. Participants identified several key issues that if addressed could further enhance the impact and implementation the OPS. The hours of operation, the physical space, and increased privacy were all areas that could be addressed to maximize implementation and further reduce risk for shelter residents.

The implementation of harm reduction culture was achieved within the OPS. Indeed, the OPS became a micro-level pocket of safety for people accessing the service and reflected harm reduction philosophy, policy, and practice. However, this culture of harm reduction did not necessarily extend to the meso-level environment of the broader shelter, where there were ongoing challenges related to a lack of harm reduction policy, a transitional organizational

culture that had retained elements of prohibition and criminalization, and the economic context of implementation. The implementation of the OPS within the shelter service appears to have had a positive impact on the broader organizational culture, but the shelter itself was in a period of transition, shifting from prohibition to harm reduction, which limited this culture change within the broader meso environment of the shelter.

The implementation of the OPS provided an important alternative to the prohibitive responses towards substance use previously seen within the shelter. The OPS staff appear to have been grounded in and aligned with principles of harm reduction and practiced within a culture of harm reduction. Outside of the OPS, within the meso environment of the broader shelter, staff varied in their orientation towards and understanding of harm reduction, which reflects the transitional stage of the shelter's organizational culture. The implementation of the OPS did, however, provide an important opportunity for responding to substance use in the shelter, and staff who were more harm reduction-oriented could encourage residents to use their substances within the OPS rather than handing out bans.

The policy context of the meso environment created barriers for culture change within the broader shelter. Outside of the OPS, a paucity of formal policy, combined with constantly changing informal policies and rules, and inconsistency in staff's application of rules resulted in many consequences for people accessing the shelter. Most participants identified a desire for consistency in the application of rules within the broader shelter, so they knew what to expect and when. Harm reduction-oriented policies and practices are important for supporting enabling environments of harm reduction that reduce harms for people who use drugs and alcohol. The value of harm reduction policy, philosophy, and practice is clearly demonstrated in the positive impacts of the OPS, and the positioning of the OPS as a safe micro environment within the

meso-level risk environment of the broader shelter.

Section 8.2- Discussion of Key Findings

OPS as a Pocket of Safety in a Meso-level Risk Environment

The findings in Chapters 6 and 7 identify and position the OPS as a pocket of safety within the meso-level risk environment of the broader shelter. The OPS was an important intervention and service for supporting people to use substances in a safer way and save lives. These findings align with the previous body of research on SCS and OPS (Bardwell, Boyd, et al., 2018; Bardwell et al., 2017; Foreman-Mackey et al., 2019; Galarneau et al., 2023; Holland et al., 2022; Leece et al., 2013; McCann & Temenos, 2015; Olding, 2022; Oudshoorn et al., 2021; Pauly et al., 2020; Samuels et al., 2022; Wallace et al., 2019).

At the time of data collection for this Master's research, there was very little research available on the implementation of OPS in emergency shelter settings (Pauly et al., 2020). Since that time, some researchers have explored the implementation of harm reduction and OPS in responses to homelessness (Bardwell et al., 2017; Collins et al., 2020; Pauly, Wallace, & Barber, 2018; Wallace et al., 2018). While some literature has become available in the intervening years between data collection and the final writing of this thesis, there is still little research available on the implementation of OPS into shelter services (Bardwell, Boyd, et al., 2018). With the intersecting unregulated drug policy emergency and the COVID-19 global pandemic, research exploring implementation within unhoused populations, and responses to homelessness, has increased some (Aronowitz et al., 2021; Galarneau et al., 2023; Government of BC & BCCDC, 2020; Hyshka et al., 2020; Johnson & Beletsky, 2020; Lew et al., 2022; O'Carroll et al., 2021). Below, I will discuss the findings related to OPS as a micro-level pocket of safety within the meso-level risk environment of the broader shelter and I will draw upon the broader evidence

base, not only the literature specific to emergency shelters.

Supervised consumption and overdose prevention services can support shifts away from risk and harms for people who use drugs, and towards spaces of reduced risk and safer environment interventions. This important finding aligns with existing research on OPS/SCS services and the impacts for people accessing these services (Ivsins et al., 2023; McNeil & Small, 2014; Rubin & Suran, 2022). Additionally, a recent scoping review on barriers and facilitators to use of supervised consumption services found that how consumption services were designed and implemented impacted the benefits and challenges of the service (Ivsins et al., 2023). For example the operating hours and wait times of supervised consumption services were a primary factor in whether people were able to access the service and receive the benefits of the SCS (Ivsins et al., 2023). This finding aligns closely with many of the core themes identified in this master's research in that the hours of operation, the physical space of the service and other access factors including privacy were all identified as key issues of implementation and contributing factors in the continued use of substances outside of the OPS. The OPS was an important micro-level enabling place for harm reduction, but these protective benefits could only be experienced if accessed.

It is important to also note, that while the OPS was important for mitigating the risk environment for people who use illegal drugs and accessed the service, in the emergency shelter setting, where there are diverse groups of people with diverse and often divergent needs, the risk environments for some shelter residents remained, even after the implementation of the OPS. Specifically, the needs of people who smoked cannabis where often at odds with the needs of people smoking illicit substances in the tent. The needs of shelter residents who were seeking to distance themselves from substance use were often unmet due to the continued substance use

outside of the injection room and inhalation tent. These tensions between the risks and harms for different groups with different needs identify one of the challenges of implementing an OPS into an existing service that serves both substance use and non-substance using populations. This remains a complex issue for how to create enabling/ safe environments for different populations within one service. Within the emergency shelter, many types of substance use existed, including non use, and while the OPS was able to effectively respond to many risks and harms, it could not ameliorate risks and harms for others. Future research should further explore this tension to identify solutions and other options to support the needs of people who do not access OPS. Perhaps it may not be possible to meet the needs of all people within one setting.

In contrast to the meso environment of the broader shelter, the staff in the OPS appear to have been hired specifically to provide harm reduction and OPS services and reflected a culture of harm reduction. This allowed strong relationships to develop between OPS staff and residents, and trust was built. Participants identified these relationships as being important for requesting access or referrals to other services, including substance use treatment. The important relationship-building opportunities present with OPS and SCS have also been identified in other research (Ivsins et al., 2020). Indeed, much of the literature identifies OPS and SCS as spaces that cultivate a sense of community, comradery, connection, and belonging for people who use drugs (Ivsins et al., 2020; Jozaghi & Andresen, 2013; Kerman et al., 2020; Oudshoorn et al., 2021) and that these connections can be important opportunities for helping people access other health and social services (Krüsi et al., 2010; Oudshoorn et al., 2021).

One of the positive impacts of the OPS implementation identified in Chapter 6 was the protection from criminalization people experienced while in the injection room and/or the inhalation tent. This finding aligns with other research on SCS that found these spaces provided

protection from criminalization, especially when using in highly surveilled or heavily policed areas (Bardwell et al., 2019; Duncan et al., 2017; Duncan et al., 2020; Foreman-Mackey et al., 2019; Ivsins et al., 2023; Jozaghi & Andresen, 2013). In this way, the positive benefits of OPS can be especially pronounced within broader meso and macro-level risk environments.

The meso-level risk environments seen within this study included policy, social, economic, and physical spheres, each producing and contributing to risks and harms for people who use drugs. For example, the absence of formal, written policy, and not having shelter staff alignment on informal policy or substance use rules, resulted in considerable variation across staff in how they responded to substance use. While some shelter staff responded in supportive ways by requesting people use in the OPS, others it appears went out of their way to "bust" people using outside of these designated spaces and reinforced prohibitive approaches to substance use. These inconsistencies created social risk environments for people within the shelter as they didn't know from one moment to the next whether an action would be accepted or punished. Additionally, prohibitive and blind-eye approaches created physical risk environments for people as they were left to use in less safe ways, and in less safe spaces (Pauly, Wallace, & Barber, 2018; Wallace et al., 2018). The absence of policy created policy risk environments for residents and several participants identified insufficient staffing levels and inadequate resourcing within the shelter as contributing factors to continued risk environments.

While the staffing in the OPS appears to have been intentional, the staff in the broader shelter varied significantly across attitudes towards substance use and harm reduction as they had been hired throughout different stages of the organization's development. Without clear policies guiding practice, these personal attitudes appear to have significantly impacted how staff interacted with residents and responded to substance use outside of the OPS. Interventions at the

meso-level, to directly address some of these risk environments, could include introducing intentional staffing choices to ensure new staff align with a harm reduction philosophy or approach (Barber et al., 2020; Woolley, 2023) and supporting training and education opportunities for existing staff (Barber et al., 2020; Deren et al., 2011; Jordan et al., 2023). The staffing situation within the shelter is a good example of the intersections between different risk environments, as some of the challenges participants identified included a combination of policy, social, and economic risk environments at the meso-level.

The transitional policy context of the shelter, wherein movement towards harm reduction had begun, and formal prohibitive policies had been removed, but new policies had not yet been developed, created challenges between staff and residents. Within this transitional period, harm reduction services had been expanded and implemented through the OPS and outdoor inhalation tent, but criminalization was still a tool used to respond to substance use outside of the OPS by some staff, and in some situations. This lingering culture of criminalization and the use of police as a response to substance use created social, policy, economic and physical risk environments for people accessing the shelter. These findings align with a significant body of literature demonstrating the harms of criminalization as an approach to substance use (Carroll et al., 2021; Cooper et al., 2005; Frank, 2018; Kleinman & Morris, 2021; Martin et al., 2023; McGinty & White, 2022; Moniruzzaman et al., 2022; Pamplin et al., 2023; Tyndall & Dodd, 2020; Wogen & Restrepo, 2020) and the need to move towards harm reduction-oriented responses. My research builds on the existing literature in that the implementation of an OPS in response to the unregulated drug policy crisis did support harm reduction policy and culture within the OPS. While the broader shelter environment had not yet fully transitioned to an organizational culture of harm reduction due to several implementation barriers including a lack of policy guidance,

important shifts had begun. The OPS provided an important starting point for the further expansion of harm reduction policy, philosophy, and practice within the larger, meso environment of the emergency shelter.

The implementation of the OPS injection room and inhalation tent provided important opportunities for staff to move towards and utilize responses to substance use that were more in alignment with harm reduction principles and practice. Participants identified that having the OPS and inhalation tent meant that staff had an alternate option to bans when they found people using substances outside of the designated spaces. Having the OPS on site meant that staff were able to request that residents use within the OPS spaces, which supported residents in using substances within safer, supervised spaces and expanded staff options for how to respond in less punitive ways. In this way, the addition of the OPS and inhalation tent provided important enabling environments for supporting harm reduction practice and reducing risks and harms for people who use substances in the shelter. This finding contributes new information to the literature and identifies important benefits of embedding OPS into other health and social services. While some responses and approaches to substance use within the broader shelter reflected a lingering organizational culture of prohibition and criminalization, having harm reduction-oriented options available to staff supported opportunities for further culture change within the broader shelter.

While this master's study focused on the intersections of the micro and meso-level risk environments within the shelter, it is important to acknowledge that these meso-level risk environments were in many ways created or influenced by macro-level policy, economic and social/structural decisions. For example, the macro policy and economic environments of the criminalization of drugs has been driving the unregulated drug policy emergency and influences

the distribution of harms (Bonn et al., 2020; Cowger, 2022; Park et al., 2020). The social, policy, and economic decisions at a macro-level have resulted in the housing crisis within BC (Aßmann et al., 2013; Collins et al., 2018; Fleming et al., 2019). The macro-produced crises of housing scarcity and high housing costs are significant factors in experiences of homelessness and barriers to exiting homelessness (Davis et al., 2023). Stigma at a macro-level through the criminalization of drugs and the War on Drugs contributes to policy, economic and social decisions at all levels that impact what services are available and how those services are provided (Bonn et al., 2020; Cowger, 2022).

Within the context of an unregulated and contaminated illicit drug supply, people who use drugs and experience homelessness also experience an increased burden of harm, including unintentional overdose death (BC Coroners Service, 2022, 2023a). The OPS spaces within the shelter provided an important pocket of safety in which people could use substances with minimized harms and be immediately tended to in case of adverse reaction or overdose, despite the ongoing risks of the meso and macro environments.

Inhalation Services as Both Spaces of Safety and Lingering Risks

As reported by the BC Coroners Service, inhalation is a primary mode of consumption for people who have died from unintended drug toxicity in BC (BC Coroners Service, 2023a). In all health authority regions, inhalation is the majority mode of consumption of people included in Coroners data (BC Coroners Service, 2023a). BCCDC public health surveillance data also suggest a preferencing of inhalation throughout BC (BCCDC, 2021; Bourque et al., 2019; Gehring, Speed, Wild, et al., 2022). Despite this preferencing of inhalation as a primary mode of consumption, inhalation services remain limited throughout the province (BCCDC, 2023c). Indeed, as of July 2023, there are only 19 inhalation sites throughout all of BC. As identified in

Chapter 6, there are some unique challenges associated with providing inhalation services, which aligns with both existing literature and OPS guidance (Bardwell, Austin, et al., 2021; BCCDC, 2019; Collins et al., 2020). I will discuss some of these challenges in more detail below.

Second hand smoke, also known as passive inhalation, for both service users, and staff is a significant implementation barrier for inhalation services (BCCDC, 2019; Gehring, Speed, Launier, et al., 2022). Additionally, within the BC context, there are strict smoking bylaws and WorkSafe conditions that can create additional challenges for service design and implementation (BCCDC, 2019). Despite these unique challenges, inhalation services remain an important aspect of overdose prevention, as clearly demonstrated in the literature (Bardwell, Austin, et al., 2021; Bourque et al., 2019; Galarneau et al., 2023). The BCCDC's BC Overdose Prevention Services Guide (BCCDC, 2019) and Provincial Episodic Overdose Prevention Service (eOPS) Protocol (BCCDC, 2023d) both provide important guidance for designing and implementing overdose prevention services, including inhalation services. The newly released eOPS protocol (BCCDC, 2023d) includes considerations for specific populations/settings, including providing eOPS within responses to homelessness.

Within the shelter where this research was conducted, the inhalation tent provided important opportunities for safety and protection for people accessing the service; however, some safety concerns remained due to the challenges of direct observation 24/7, and challenges of having licit and illicit inhalation within one space. These tensions between risk and safety reflect the importance of identifying opportunities for change at the level in which the risk environment is produced. The risks associated with the inhalation space at the shelter occur at the meso-level, and so interventions at the meso-level are also required in order to adequately ameliorate these risk environments and ultimately create enabling environments for harm

reduction and safety (Rhodes, 2002, 2009; Rhodes et al., 2005). Additionally, a key finding from this thesis was that while the inhalation tent provided many important safety improvements and opportunities for people who smoke, some risks and potential harms did remain. This finding aligns with Duff's concept enabling environments and how one place can be both a place of safety and/or a place of harm (Duff, 2011). This an important consideration when designing and implementing services; especially services that are designed to reduce harms. The inhalation space within the shelter provided important, life-saving services. However, the study participants also identified the importance of staff observation/witnessing of the space and the challenges people faced when the use of both licit and illicit substances were restricted to one space. Providing adequate and separate spaces for legal and illegal substances was identified by participants as being important for reducing harms, reducing conflicts, and adequately addressing residents' needs.

Peer Witnessing and eOPS as Important Adjuncts to OPS

In 2020, in response to the intersections of the ongoing unregulated drug policy public health emergency and the COVID-19 pandemic, public health interventions aimed at protecting people from COVD-19 had unintended consequences of creating and increasing barriers to access for OPS and SCS services (Cassie et al., 2022). As previously identified, these intersecting public health emergencies also had a profound and tragic impact on numbers and rates of unregulated drug poisoning deaths in BC (BC Coroners Service, 2022, 2023a). In response to these increased deaths, the BC Ministry of Health and the BCCDC released a protocol document to support continuity of access to OPS through episodic overdose prevention services (eOPS) within a variety of health and social settings (BCCDC, 2023d). The aim of these guidelines was to support OPS access for people who may be having to adhere to COVID-19

protocols and were unable to attend an OPS. E-OPS are overdose prevention services that are provided to people outside of a traditional or existing OPS/SCS location (BCCDC, 2023d; Government of BC & BCCDC, 2020).

Although SCS and OPS have a robust evidence-base demonstrating their effectiveness and importance for saving lives and preventing harms (Bardwell et al., 2017; Bourque et al., 2019; Foreman-Mackey et al., 2019; Gehring, Speed, Launier, et al., 2022; Kennedy et al., 2017; Kerman et al., 2020; Kerr et al., 2017; Levengood et al., 2021; Lew et al., 2022; Pauly et al., 2020; Potier et al., 2014; Rubin & Suran, 2022; Wallace et al., 2019), there are many reasons why some people are not comfortable accessing these services. Stigma towards substance use is still pervasive within our society, including health and social services, and accessing harm reduction services can require people to "out" themselves socially as drug users (Ahern et al., 2007; Ezell et al., 2021; Goodyear et al., 2021; Tsai et al., 2019). The impact of stigma as a barrier to accessing services is well established in the literature and was also a key finding within this research study. Participants expressed concerns related to having to expose themselves as drug users or intravenous drug users to access the OPS, which for some was a barrier to access. Some participants feared they would be treated differently or worse by staff if they were identified or labelled as a drug user. Additionally, other participants identified their concerns related to the intersecting stigmas of drug use and homelessness and worried that having an OPS at the shelter would result in more stigma and possible discrimination for people accessing the emergency shelter. As such, stigma can create barriers to OPS access for many people, so even in communities where OPS are physically available, barriers to access may remain. Addressing stigma is an important step in reducing barriers to life saving OPS services (Ahern et al., 2007; Tsai et al., 2019; Tyndall & Dodd, 2020). An organizational culture of harm reduction that aligns

with and supports principles of harm reduction can help to reduce stigma and fear of discrimination, thus supporting implementation and access (Barber et al., 2020; Hawk et al., 2017; Ivsins et al., 2023; Pauly, 2008b). Where access barriers remain for brick-and-mortar OPS services, peer witnessing or eOPS services may be an important opportunity to provide more private care.

As participants identified in Chapter 6, different people have different preferences for the social and physical environment within which they use substances. For some, they enjoy the social environment that an OPS or SCS can provide (Ivsins et al., 2023). Many people enjoy the opportunity to connect with fellow users and peers or other staff and develop relationships and share knowledge (Ivsins et al., 2023). Others prefer to use substances alone or in a private setting (Collins et al., 2020). For these populations, it can be more challenging to adequately meet the safety needs with traditional OPS. Peer witnessing, and episodic OPS (eOPS) can be important tools for supporting people to use safely outside of a traditional OPS setting. Peer witnessing and eOPS are interventions that can be used in a variety of settings and are important interventions in their own right. However, they could also be utilized to supplement traditional SCS or OPS within shelter settings.

In 2023, the updated eOPS Protocol Guidelines were released, and included specific considerations for particular populations and settings (BCCDC, 2023d). The revised document includes considerations specific to supportive housing and emergency shelters. These guidelines emphasize the importance of supporting people who choose to use in their rooms through peer witnessing and/or eOPS (BCCDC, 2023d). Participants identified the continued use of substances outside of the OPS and inhalation tent even after implementation, which occurred for many reasons. While the prevalence of use within other shelter spaces appears to have decreased

since the OPS and inhalation tent opened, some use remained. Many of the implementation challenges identified in Chapters 6 and 7 (e.g., hours of operation, physical space, stigma) contributed to ongoing substance use in shelter bedrooms and bathrooms. Where shelter residents are unable or unwilling to use the OPS, peer witnessing or eOPS could be important safety interventions.

In Chapter 7, participants identified a lack of safety checks as a significant concern and risk for people who are using in spaces outside of the designated OPS and inhalation tent. Participants reported the dangers of infrequent safety checks for both staff and residents. The infrequency of safety checks produced significant risk and potential harm for people who use drugs who are either unable or unwilling to access the OPS or inhalation tent. The updated eOPS guidelines also emphasize the importance of wellness checks, ensuring the wellness checks are grounded in a trauma-informed approach that is intended for supporting people, and not as a punitive approach (BCCDC, 2023d). The development of wellness check policies should be in partnership with residents and shelter users and consideration should be given to peer-led wellness checks (BCCDC, 2023d).

People with lived and living experience have always been at the forefront of harm reduction practice and innovation through advocacy and action. Research shows that peer-provided overdose prevention and response services are highly effective and often preferred (Bardwell, Kerr, et al., 2018; Greer et al., 2016; Hanson et al., 2020; Pauly, Mamdani, et al., 2021; Perreault et al., 2023). This finding aligns with participant experiences within this study as many participants identified the value and importance of having people with lived experience within the OPS. Peer witnessing is a tool that can be used to support people who use drugs in diverse locations. Many peer organizations provide peer witnessing within their services or

through outreach services, with great effectiveness. Participants in this study clearly identified the trusting relationships and positive experiences they've had in the OPS with the peers who work within the service. Participants also identified that not everybody is comfortable or able to access the OPS and so peer witnessing is an important tool that the shelter could implement to address the needs of people who use drugs outside of the OPS and mitigate risk environments and harms for people. By supporting these adjunct interventions, the shelter organization could reduce and mitigate the risk environments that exist within the shelter, for all residents. Participants identified that substance use within shelter bedrooms and bathrooms was a particularly contentious area and created the most risk of overdose complications or death. Peer witnessing and eOPS could be implemented to support harm reduction and reduce meso-level risk environments within these spaces.

Confusing Policy Climate as a Barrier to Culture Change

The policy context of the shelter service within which the OPS was implemented was in a transitional period. The previous prohibitive substance use policies had been removed, but new, harm reduction-oriented policies had not yet been established (Shelter Manager, 2018). Additionally, it was unclear the extent to which shelter staff and residents had been educated or trained on these formal and informal policy changes. As outlined in Chapter 7, most participants assessed informal policy and rules based on how staff responded to substance use within the shelter. However, as identified in Section 7.1, there was considerable variation across staff in terms of practice. Indeed, one participant highlighted that for 75 workers, there were 75 different "ways of ruling". This confusing and unclear policy context created challenges for implementation while also creating barriers to culture change within the shelter program. Conversely, within the OPS itself, there were clear harm reduction policies and practices, and a

strong philosophy of harm reduction appears to have guided how staff provided care. This alignment of policy, philosophy, and practice supported a strong culture of harm reduction within the OPS that was not yet fully seen within the broader shelter.

The provincial substance use and housing policy context within which the OPS and shelter are situated is unclear and often very confusing. Organizations, including housing organizations, community organizations and even regional health authorities are often unclear as to whose responsibility it is to implement harm reduction services, including overdose prevention. For example, while harm reduction has been included in health policy for many years (BC Ministry of Health, 2005), and the provision of harm reduction services is included in both Ministry of Health (MOH) and Ministry of Mental Health and Addictions (MMHA) mandates and service plans (Eby, 2022a, 2022b; Ministry of Health, 2023; Ministry of Mental Health and Addictions, 2023), neither MOH nor MMHA have formal harm reduction policies. Similarly, as discussed earlier, while BC Housing states a commitment to Housing First, and harm reduction is a first principle of Housing First, BC Housing does not have a harm reduction policy, nor does it state if and how housing organizations are to provide harm reduction services. When organizations, including health authorities and housing organizations, seek to implement harm reduction interventions, they're often faced with unclear mandates and a confusing policy context.

In December 2016, the Minister of Health released ministerial Order No. M488 (Government of British Columbia, 2016a), enabling the expansion of OPS throughout BC. Despite this ministerial order, the expansion of OPS throughout BC has remained limited (BCCDC, 2023e), and the availability of services does not meet the demonstrated need (BC Coroners Service, 2022, 2023a). In personal conversations I have had with many harm reduction

program staff within the regional health authorities, one of the barriers to broader expansion of OPS services is the unclear policy context, the lack of clear harm reduction policy from the provincial government, and a lack of provincial position statement supporting harm reduction. This unclear policy context at a provincial level contributes to barriers to culture change towards harm reduction within individual health authorities and throughout the health system (Hyshka, Anderson-Baron, et al., 2017). Without these strong policy tools, organizations often face difficulties moving harm reduction forward if the broader organizational culture is not in alignment or support.

A 2017 paper assessing harm reduction policies in Canadian provinces and territories (including BC) found that where harm reduction policies did exist, definitions of harm reduction were typically either excluded or unclear and they lacked in-depth discussion of what constitutes a harm reduction approach (Hyshka, Anderson-Baron, et al., 2017). Additionally, the longstanding history of moral conflict in Canada (and BC) over harm reduction and drug policy has impacted and continues to impact the provision of clear policy and opposition towards harm reduction services (Hyshka, Anderson-Baron, et al., 2017). The moral conflict around homelessness and housing and the increased visibility of homelessness and poverty in BC further complicates the matter and exacerbates these challenges. Unfortunately, this moral conflict is often seen within health and housing organizations, within local governments and other social sectors, and it is difficult to overcome or navigate through this opposition towards harm reduction without clear policy direction from provincial bodies.

As seen with the OPS and shelter, it is important to have clear policy direction as this can serve as an anchor in navigating challenges of implementation. Clear policies combined with adequate education and training to support staff knowledge, and awareness of said policies is

important for supporting uptake within an organization or service. While culture change requires more than policy, having a firm policy foundation is important for supporting organizational culture change. We see the barriers to culture change created from a confusing and unclear policy context within the shelter specifically, but also within our health and social services more broadly. Clear policy is an important component for guiding strong implementation and facilitating organizational culture change.

Organizational Culture Change Takes Time

Organizational culture change takes time. While the overall organizational culture of the shelter had not yet fully shifted from one of prohibition and criminalization to one of harm reduction, the implementation of the OPS itself suggests some level of commitment to providing harm reduction interventions on the part of the shelter organization. There are many organizations that serve people who use drugs and do not provide these services, so the inclusion of the service does suggest a certain level of willingness on the part of the organization to align with harm reduction. Additionally, the OPS itself demonstrates a micro level culture change in that people feel safer there. Having the OPS provided an opportunity to begin shifting attitudes towards substance use within the shelter organization. However, several barriers, including a lack of harm reduction policy, the transitional state of the organization, and inconsistent practice limited widespread culture change within the broader organization.

At the time of interviews, the shelter was in a state of transition for both policy and organizational culture. While initial steps had been made away from prohibition, aspects of the legacy culture of prohibition and criminalization remained. However, positive shifts towards harm reduction within the broader shelter were identified by participants and the OPS itself was a clear example of both harm reduction practice and culture. Within the transitional culture and

context of the meso-environment of the shelter, the combination of prohibitory and harm reduction-oriented approaches created tensions between staff and clients. The implementation of the OPS provided an important opportunity to begin shifting the relationships between clients and staff and shifting responses to substance use within the broader shelter. While time and intentional implementation planning is likely required to see a complete organizational shift towards harm reduction and away from prohibition, it is encouraging to see the role the OPS has played in creating some initial enabling environments that could be further built upon. In this way, it appears that the implementation of an OPS can act as an enabling intervention that could support broader changes, even if that change is slow.

It can take time to shift individual attitudes towards substance use and harm reduction, but it can and does happen every day (Deren et al., 2011; Ezell et al., 2021; Watson & Hughes, 2012; Woolley, 2023). Organizational culture change is even more complex and can be even more difficult to change (Heller et al., 2004; Lyons et al., 2017; Rosenberg & Mosca, 2011). Shifting from an organizational culture of criminalization and prohibition to one of harm reduction is a significant change and takes time. Even though the shelter organization had not yet completed this organizational culture change when they implemented the OPS, they saw the need and the potential for the OPS to save lives and help people and moved quickly to implement. As such, while the OPS was implemented into an organization culture that did not yet fully align with harm reduction, implementing the OPS was also an important opportunity to begin shifting attitudes towards substance use and supporting culture change that included the uptake of harm reduction of policy, philosophy, and practice.

In 2020, the Canadian Institute for Substance Use Research released a harm reduction implementation framework developed from a review of the evidence at that time (Barber et al.,

2020). The framework identifies several important components for supporting the robust implementation of harm reduction services, either as stand-alone services, or embedded within other services. The findings of this master's study align with many of the components of this framework. Step 3 of the framework focuses on developing an organizational culture of harm reduction and speaks to the importance of leadership and staff receiving training and education to enhance knowledge of harm reduction and support organizational shifts (Barber et al., 2020). In Chapter 7, I outlined some of the challenges experienced with staff in the broader shelter, which when compared to the staff in the OPS highlights the important role staff orientation, training, and knowledge can play in cultivating a culture of harm reduction (Hyshka et al., 2020).

My observation within the years I have worked in the health system, whether providing front-line care, developing programs, or creating policy is that the implementation of new services does not often include a fulsome implementation plan. In my experience, this lack of implementation planning has resulted in incomplete implementation and many challenges and barriers throughout the process. This observation aligns with public health implementation research (MacDonald et al., 2016; Travis et al., 2002). Similarly, my observation within the shelter during data collection was that shelter management were working to try and improve conditions for shelter residents, but without the clear roadmap of an implementation plan. The development of an implementation plan that addresses facilitators and barriers, and not simply outcome metrics is important for supporting robust implementation (Allio, 2005; Barber et al., 2020; Bhattacharyya et al., 2009; Damschroder et al., 2009; Love, 2004; MacDonald et al., 2016). The lack of implementation planning is an identified Achilles heel of implementation within the literature (Bhattacharyya et al., 2009; MacDonald et al., 2016; Stetler et al., 2008).

In this chapter, I have provided a summary of the findings from Chapters 6 and 7 to answer my research questions. Additionally, I have highlighted key findings, including the role of OPS as a pocket of safety within a meso-level risk environment, inhalation services as both spaces of safety and lingering risks, the role of peer witnessing and eOPS as important adjuncts to OPS for people unable or unwilling to access traditional OPS services, a confusing policy climate as a barrier to culture change, and that organizational culture change takes time. I have discussed these key findings in relation to the available literature and within the context of both the shelter and the broader social and policy context of BC.

In Chapter 9, I will discuss the strengths and limitations of this research, provide recommendations for programs seeking to implement OPS, recommendations for policy, and recommendations for future research. Following this, I will provide my concluding thoughts for this thesis.

Chapter 9: Conclusions

Section 9.0- Introduction

This research makes several important contributions to the literature concerning substance use, harm reduction, OPS implementation, overdose prevention services, harm reduction and homelessness, and substance-use related harms. Firstly, it highlights the important impacts that OPS can provide as a micro-level pocket of safety within a meso-level risk environment, and the important role OPS can play in mitigating micro-level risk environments. Secondly, this research explores the implementation issues experienced in providing OPS services within a shelter setting and identifies recommendations to improve services and support robust implementation. Thirdly, this research helps us understand how the implementation of specific harm reduction interventions can contribute to broader organizational uptake of harm reduction and the implementation complexities and barriers that may exist. Lastly, this research helps us to understand organizational culture change, the inter-relationship between policy and organizational culture, and that culture change can take time.

In Section 9.1, I outline the strengths and limitations of this study. In Section 9.2, I provide some recommendations for programmes interested in implementing OPS. In Section 9.3, I provide policy recommendations and in Section 9.4 I outline recommendations for future research. Finally, in Section 9.5, I provide some concluding remarks.

Section 9.1- Strengths and Limitations

The data collection for this research study was conducted in Spring of 2018. Although it has been several years since these data were collected, they're still highly relevant as OPS have not yet been implemented into many settings and many communities still lack these life-saving services. Additionally, while the intersecting public health emergencies of the overdose crisis

and COVID-19 did result in some expansion of the evidence, there is still limited research on the implementation of OPS in homeless serving organizations such as shelters. The number of organizations in the health and social services grappling with challenges related to substance use and facing challenges with implementing OPS remains significant. Indeed, many of the barriers and issues identified in this research are the very same barriers currently facing the health system as they attempt to expand access to harm reduction services, including overdose prevention. As OPS continue to be implemented in more communities, and access to OPS expands, these findings are relevant and important for informing the planning and implementation of services.

A primary strength of this research is that it is from the perspective of people who use drugs, and people who accessed services at the emergency shelter. People accessing services provide important insights into the benefits, challenges, and harms that they experience directly. The inclusion of those affected by implementation is important for meaningfully understanding the issues. While the scope of this master's study didn't allow for the inclusion of shelter staff perspectives, future research could include both shelter residents and staff to further explore the impacts and challenges of implementation.

Another strength of this research is that it was conducted during a period of transition for the service organization. The timing of this research allowed many of the complexities of implementation and culture change to be identified. Additionally, the transitional period within which this research occurred highlighted the important roles that policy, practice, and organizational culture play in the success of implementation for harm reduction services such as OPS.

While this study did not specifically look at gendered considerations as access facilitators and barriers, the literature does note some specific challenges women often face accessing

OPS/SCS services, and the need for services specifically for women (Bardwell, Austin, et al., 2021; Cheung & Hwang, 2004; Collins et al., 2020; Ivsins et al., 2023). Gendered health disparities can be better addressed by providing more inclusive service planning, and this is an important area for future research.

The sample for this study included mostly men, and most participants identified as heterosexual. None of the participants identified as homosexual but two participants identified as pansexual, and two participants identified as other. The sample for this study included participants who identified as white and participants who identified as Indigenous. There was no self-identified ethnic diversity outside of these two ethnicities. This study did not explore differences in experience across gender, sexuality, or ethnicity; however, future research would benefit from an intersectional analysis of the benefits and harms of implementation for these groups.

This study did not utilize an Indigenous methodology or explore experiences of cultural safety for people accessing the shelter. Given the significant harms produced through colonisation and systems of oppression that impact Indigenous peoples, future research should explore Indigenous-specific experiences of safety and harm within OPS and homeless serving organizations, with an eye to improving cultural safety within these spaces and identify ways of decolonizing health and social service delivery.

Harm reduction services are often clustered within larger cities, or urban centres, and smaller communities or rural and remote communities often lack access to these important and life saving services. Unfortunately, communities of all sizes and in all regions of the province have experienced profound loss since the declaration of the overdose emergency 7 years ago. There are no communities that have remained untouched and the need for services is present in

communities of all sizes, not only urban settings (BC Coroners Service, 2023a). While there remain many barriers to implementing harm reduction services in many communities, it is important that geographic access considerations be included in implementation planning. Rural services likely face different barriers, challenges, and facilitators than urban services do, and so regionally specific considerations can support implementation. In communities or services where fixed-site OPS are not an option, e-OPS and witnessed consumption are important options that should be considered. This study occurred within an urban centre and so issues of geographic equity or the unique challenges of implementation within small communities, or rural and remote settings were not addressed.

This research is qualitative and so is not seeking to identify universal truths, but rather, understand the experiences of people accessing the shelter to better identify and understand the implementation process and outcomes. While we do see very similar experiences in other settings, the application to other settings is not a given due to the nature of qualitative research. However, the findings of this thesis can provide important information on facilitators and barriers of implementation that could inform the planning and implementation of other services, especially the implementation of OPS in other emergency shelters or responses to homelessness.

Section 9.2- Recommendations for Programmes

Participants identified several important recommendations for supporting access. Supporting physical access to a service through expanded/adequate hours of operation, and providing sufficient physical space to meet service demand are both important for supporting robust access to services (Ivsins et al., 2023). Physical access also includes sufficient hours of operation to meet the needs of people accessing the service. Where 24/7 access is not feasible, shifting the hours of operation to best align with patterns of drug use, would support maximum

access without additional financial impacts. Additionally, supporting access by reducing stigma, including people with lived and living experience, and providing client-centred approaches and supports helps to ensure people feel safe to access a service. It is important to not only focus on the physical access components, but ensure the necessary safety is in place to support equitable access.

For optimal implementation and successful outcomes, harm reduction services and interventions should focus on equity to ensure access to a broad range of people who use substances (Barber et al., 2020). The harms of substance use often intersect and are impacted by systemic discrimination including sexism, racism, ageism etc. An equity orientation in implementing harm reduction services can help to address the diverse needs of people who access services (Bardwell, Austin, et al., 2021; Cheung & Hwang, 2004; Collins et al., 2020). Similarly, harm reduction interventions should focus on reducing harms associated with a range of substances and modes of consumption (Barber et al., 2020; Bardwell, Austin, et al., 2021). The inclusion of inhalation services is an important component of OPS and the expansion of inhalation services throughout BC is needed.

Many harm reduction services, including OPS, are moving towards models that include peers. While hiring peers for service delivery can support the important development of trusting relationships, it is equally important that peers are included in all levels of service development, design and implementation, not only service provision (Greer et al., 2016; Ivsins et al., 2023). Often, this is overlooked, and peers can be tokenized in their role and involvement. This finding has also been identified in other research focused on the inclusion of peers in overdose prevention services (Barber et al., 2020; Greer et al., 2016; Mercer et al., 2021; Miler et al., 2020; Pauly, Mamdani, et al., 2021). Unfortunately, participants in this research, who also

worked as peers in various capacities within the shelter, often reflected this tokenized and limited role that they experienced. This can create harms for the peers and can cause implementation barriers which can limit service impacts. Research on the role peers take on as front-line responders in the unregulated drug policy crisis has also identified the importance of adequately resourcing peers, and providing the necessary supports to facilitate their work (Mamdani et al., 2022). Ideally, peers should be hired as full employees, with a living wage, and not simply provided a stipend for their "volunteer" time as service providers. The financial support and access to extended benefits that full employees receive are important for reducing some of the trauma and harms that peers are often exposed to while providing care to people in their own community (Mamdani et al., 2022; Pauly, Mamdani, et al., 2021). People with lived and living experience are essential in providing meaningful services and should be fully compensated and supported (Barber et al., 2020; Greer et al., 2016; Mamdani et al., 2022; Mercer et al., 2021; Miler et al., 2020; Pauly, Mamdani, et al., 2021).

The adequate resourcing of interventions is essential for meaningful and complete implementation (Barber et al., 2020; Finlayson et al., 2012; Pegg et al., 2021) yet this remains an under-studied area of implementation. While all organizations face budget constraints, underfunding the implementation and operations of a service undermines the impacts and outcomes of that service. Adequate funding is also important for supporting the physical, emotional, and psychological safety of both staff and clients. Where budget restraints limit the hours of operation, service providers should consult people who use drugs to identify the most appropriate hours and the hours that would best align with drug-using patterns. Adequate resourcing should include providing staffing at a level that supports safety for all. Additionally, staff should receive training and education as needed to support harm reduction practice and

orientation (Barber et al., 2020; Deren et al., 2011; Matheson, 1998; Perreault et al., 2023; Watson & Hughes, 2012; Woolley, 2023).

The successful and robust implementation of harm reduction, including OPS, requires dedicated planning and resources (Barber et al., 2020). Ideally, harm reduction interventions would be implemented into a setting with an existing organizational culture of harm reduction or where a focus on harm reduction education and training is part of the organization's implementation plan. However, as harm reduction expands into novel settings, this is often not the case. With the intersecting public health emergencies of the toxic drug crisis and the COVID-19 global pandemic, harm reduction and substance use services were expanded into many settings that had previously been without (Acuff et al., 2021; Aronowitz et al., 2021; Bonn et al., 2020; Cassie et al., 2022; Galarneau et al., 2023; Government of BC & BCCDC, 2020; Hyshka et al., 2020; Lew et al., 2022; McNeil et al., 2022; O'Carroll et al., 2021). In these situations, the immediate need to provide life saving services to people who use drugs does not allow for the time it would take for the organization to shift its culture to fully support implementation. Developing a written implementation plan that supports culture change in parallel to service/intervention implementation is important for reducing barriers and supporting the complete implementation of harm reduction (Barber et al., 2020). Insufficient implementation planning is an identified limitation of most service implementation.

Section 9.3- Recommendations for Policy

Having written, clear, harm reduction and substance use policies that are grounded in international principles of harm reduction are necessary for complete implementation of OPS and other harm reduction services (Barber et al., 2020). It is essential that these policies be grounded in human rights and regularly communicated to staff and clients/residents. These policies should

inform practice, and practices, should be consistent, and aligned with harm reduction philosophy and principles (Barber et al., 2020).

While implementation requires far more than policies, policies can often act as the anchor for implementation and as discussed in Chapter 8, a confusing policy context can create barriers not only for implementation but also for organizational culture change. People with lived and living experience, and people impacted by policy decisions should be included in the development and refinement of program policies (Barber et al., 2020; Greer et al., 2016; Mercer et al., 2021). Additionally, the training and education of staff to support the uptake of harm reduction policy, philosophy, and practice is important for supporting robust implementation (Barber et al., 2020; Deren et al., 2011; Perreault et al., 2023).

Section 9.4- Recommendations for Future Research

As identified in Chapter 7 and further discussed in Chapter 8, organizational culture change can take time, and benefits from dedicated resources and implementation planning. Data collection for this research occurred approximately 1.5 years after the OPS was first opened. At the time of data collection, the shelter organization was in a period of transition wherein it was moving away from the previous culture of prohibition and taking initial steps towards a new culture of harm reduction. While the timing of this research was not able to provide insights into the final outcomes of this transition, initial shifts in organizational culture, policy, and practice were observed. Future research could explore the impacts and challenges of OPS implementation within the shelter after a longer interval to better understand some of these transitions over time.

The scope of this research was limited to the appropriate size and complexity of a master's level study. While this study had many important findings, there were also perspectives not included. As identified in the strengths and limitations section, future research should include

both shelter residents and shelter and OPS staff to capture a more fulsome understanding of implementation. Additionally, future research should also include other perspectives such as gendered perspectives, Indigenous perspectives, and perspectives of diverse sexual orientations. An intersectional analysis of OPS implementation within harm reduction and homeless serving organizations would be an important addition to the scant literature.

Section 9.5- Concluding Remarks

Overdose prevention sites, including inhalation services, are important harm reduction interventions that saves lives. At the time of writing, in Summer 2023, BC is in its seventh year of the unregulated drug policy public health emergency, which has claimed the lives of over 13,000 individuals. The impacts of the implementation of an OPS into an emergency shelter were positive and provided micro-level pockets of safety within the meso-level risk environment of an emergency shelter. Organizational level barriers to implementation included policies and practices, an organizational culture in transition, staffing, legacies of the previous culture of prohibition and criminalization, and the economic context of implementation.

While the OPS reflected an excellent example of harm reduction policy, philosophy and practice, and some initial organizational changes were seen in the broader shelter, the meso-level barriers limited the full uptake of harm reduction policy, philosophy, and practice outside of the OPS. Although there appeared to be a commitment to harm reduction by the organization, and culture change efforts appear to have been started, culture change takes time, and it does not appear that the organizational culture had yet fully shifted to one of harm reduction. Culture change also requires dedicated resources and planning, that include plans for change management. These could further support implementation efforts for services seeking to implement OPS. Within this meso-level risk environment of the broader shelter, the OPS was an

important enabling environment of harm reduction policy, philosophy, and practice. The OPS provided an important micro-level pocket of safety within the broader meso-level risk environment, of an emergency shelter.

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Appendix A
Ethics Protocol Approval

University of Victoria
Office of Research Services | Human Research Ethics Board
Administrative Services Building Rm B202 PO Box 1700 STN CSC Victoria BC V8W 2Y2 Canada
T 250-472-4545 | F 250-721-8960 | uvic.ca/research | ethics@uvic.ca

Modification of an Approved Protocol

PRINCIPAL INVESTIGATOR:	**Bruce Wallace**	**ETHICS PROTOCOL NUMBER:** Minimal Risk Review - Delegated	**15-304**
UVic STATUS:	**Faculty**	ORIGINAL APPROVAL DATE:	09-Oct-15
UVic DEPARTMENT:	**SOCW**	MODIFIED ON:	09-Mar-18
		APPROVAL EXPIRY DATE:	08-Oct-18

PROJECT TITLE: **Harm Reduction in Shelter Settings**

RESEARCH TEAM MEMBER Co-Investigator: Bernie Pauly (CISUR, UVic);
Graduate Researcher (UVic): Katrina Barber (CISUR, UVic)

DECLARED PROJECT FUNDING: **Vancouver Foundation Development Grant; AIDS Vancouver Island; Providence Health Centre**

CONDITIONS OF APPROVAL

This Certificate of Approval is valid for the above term provided there is no change in the protocol.

Modifications
To make any changes to the approved research procedures in your study, please submit a "Request for Modification" form. You must receive ethics approval before proceeding with your modified protocol.

Renewals
Your ethics approval must be current for the period during which you are recruiting participants or collecting data. To renew your protocol, please submit a "Request for Renewal" form before the expiry date on your certificate. You will be sent an emailed reminder prompting you to renew your protocol about six weeks before your expiry date.

Project Closures
When you have completed all data collection activities and will have no further contact with participants, please notify the Human Research Ethics Board by submitting a "Notice of Project Completion" form.

Certification

This certifies that the UVic Human Research Ethics Board has examined this research protocol and concluded that, in all respects, the proposed research meets the appropriate standards of ethics as outlined by the University of Victoria Research Regulations Involving Human Participants.

Rachael Scarth

Dr. Rachael Scarth
Associate Vice-President Research Operations

Certificate Issued On: 09-Mar-18

15-304 Wallace, Bruce

Appendix B
Qualitative Interview Guide

Interview Guide

Introduction

You have consented to participate in a research study called "The Role of Overdose Prevention Units in Responses to Substance Use and Implementation of Harm Reduction in Shelters: A Qualitative Study". The aim of this research is to explore how the implementation of an overdose prevention unit influences responses to substance use and broader implementation of harm reduction within a shelter setting.

Research Questions

1. How does the implementation of an overdose prevention unit influence responses to illegal substance use within a shelter setting?
2. How does the implementation of an overdose prevention unit influence implementation of harm reduction policy, philosophy, and practice within a shelter setting?

Interview Questions

Shelter Experience

1. Tell me about your experiences accessing RBL
    a. Are you currently staying at RBL?
    b. How long have you been staying at RBL?
    c. How often have you stayed at RBL?

Substance Use in Shelters

2. What type of substance use do you see in the shelter? (This could include different substances or forms of use etc.)

   a. From your perspective, what are some of the issues related to substance use in the shelter?

3. From your perspective, how is substance use handled by shelter staff?
   a. What are the policies related to alcohol, illegal drugs, injecting, smoking etc.?
   b. What do you think works?
   c. What does not work?
   d. What would you like to see done differently?

Harm Reduction Services

4. What does harm reduction mean to you?
5. Have you accessed harm reduction services at Rock Bay Landing?
   a. If yes, which harm reduction services have you accessed? (e.g. OPU, harm reduction supplies, inhalation tent, other)
   b. What have been your experiences with these services? (positive or negative)
6. From your perspective, how do you think harm reduction is practiced by staff at RBL?
   a. What does it look like?
   b. What are some examples of good harm reduction practice that you've either seen or experienced at RBL?
      a. Prompt: how does this compare to HR at other locations/ agencies?
   c. What do you think management or staff could do differently to have harm reduction better practiced in the shelter?
7. What was substance use in the shelter like before the OPU?
   a. What changes have you seen since the OPU?

   b. Prompt types of responses to substance use (e.g. prohibit use, ban from shelter for use, allow use, allow certain types of use, what about substance use in washrooms?), etc.

8. What do you think about overdose prevention services?
9. What do you think about having an OPU in a shelter?
10. If you accessed RBL shelter services before the OPU was implemented, what can you tell me about how harm reduction has changed in the shelter since the OPU?
    c. How have staff and management changed in how they practice harm reduction?
    d. From your perspective, are management and staff more knowledgeable about safer substance use practices?
        i. If so, which staff (e.g. CSWs, front line staff, social workers, OPU staff, etc.)?
        ii. If not, in your view, in which ways could they be more knowledgeable?
        iii. What does this look like? How do staff engage with shelter clients related to substance use and harm reduction?

Appendix C
Demographic and Substance Use Questionnaire

Date: _____ Participant # _____

Demographic Questionnaire and Substance Use History

(to be completed by interviewer)

Demographic Information

1. Age (in years): _____
   - ☐ Don't know
   - ☐ Decline

2. What is your current marital status?
   - ☐ Married
   - ☐ Common-law (living with partner)
   - ☐ Separated
   - ☐ Divorced
   - ☐ Widowed
   - ☐ Single, never married
   - ☐ Don't know
   - ☐ Decline

3. Which gender do you identify as?
   - ☐ Male
   - ☐ Female
   - ☐ Transgender
   - ☐ Gender non-binary
   - ☐ Other: (specify) _____
   - ☐ Don't know
   - ☐ Decline

4. How would you describe your sexual orientation?
   - ☐ Heterosexual
   - ☐ Homosexual
   - ☐ Bisexual
   - ☐ Pansexual
   - ☐ Asexual
   - ☐ Other: (specify) _____
   - ☐ Don't know
   - ☐ Decline

5. What ethnic group or family background do you identify as?
   - ☐ Indigenous (e.g. First Nations, Metis, Inuit)

- ☐ White
- ☐ Chinese
- ☐ South Asian (e.g., East Indian, Pakistani, Sri Lankan, etc.)
- ☐ Black (e.g. African, Jamaican or Caribbean)
- ☐ Filipino
- ☐ Latin American
- ☐ Southeast Asian (e.g., Cambodian, Indonesian, Laotian, Vietnamese, etc.)
- ☐ Arab (e.g. Arabic speaking, Maghrebi)
- ☐ West Asian (e.g., Afghan, Iranian, Israeli, Turk, etc.)
- ☐ Japanese
- ☐ Korean
- ☐ Other (specify) _____
- ☐ Don't know
- ☐ Decline

6. What is your current PRIMARY employment status?
   - ☐ Unemployed
   - ☐ Employed (incl. self-employed)
   - ☐ Volunteer work, unpaid
   - ☐ Employed in a special work program
   - ☐ Retired
   - ☐ Student
   - ☐ Housewife/husband
   - ☐ Other (Specify):_____
   - ☐ Don't know
   - ☐ Declined

7. What are your current sources of income?
   - ☐ Earnings from full time work
   - ☐ Earnings from part-time work
   - ☐ Earnings from casual work
   - ☐ Earnings from seasonal work
   - ☐ Welfare/income assistance
   - ☐ Disability income
   - ☐ Long-term Disability (Private Insurer)
   - ☐ Employment insurance (EI)
   - ☐ Pension (incl. Old age security, CPP, veteran's pension)
   - ☐ Informal/ street income
   - ☐ Other: Other (specify) _____
   - ☐ Don't know
   - ☐ Decline

8. How long have you lived in Victoria?
    - ☐ Less than a year
    - ☐ 1 to 3 years
    - ☐ 4-6 years
    - ☐ 7-10 years
    - ☐ More than 10 years
    - ☐ Don't know
    - ☐ Decline

9. Which of these shelters (if any) have you accessed in the past?
    - ☐ Sandy Merriman House
    - ☐ Rock Bay Landing Emergency Shelter
    - ☐ Rock Bay Transitional Shelter Program
    - ☐ Next Steps
    - ☐ Other _____
    - ☐ Don't know
    - ☐ Decline

10. Have you experienced being homeless ever in your life?
    - ☐ Yes, in the past 12 months
    - ☐ Yes, not in the past 12 months
    - ☐ No, never
    - ☐ Don't know
    - ☐ Decline

Substance Use History

Have you used or tried?	**Yes, in the past 12 months**	**Yes, in the past 30 days**	**No, Never**	**Prefer not to say**
Tobacco products				
Alcohol				
Marijuana/ Cannabis				
Ecstasy/ MDMA/MDA/ MDEA				
Cocaine Powder				
Crack				
Heroin				
Fentanyl				
Crystal Meth				
Hallucinogens				
GHB				
Benzos (without Rx or not used as Rx)				
Rx Opioids (without Rx or not used as Rx)				

Have you?	**Yes, in the past 12 months**	**Yes, in the past 30 days**	**No, never**	**Prefer not to say**
Smoked illicit drugs?				
Snorted or sniffed illicit drugs or other substances?				
Injected illicit or non-prescribed drugs?				
Taken pills to get high or for reasons other than why they would be prescribed?				
Consumed non-beverage alcohol?				

Appendix D
Third-Party Recruitment Invitation to Participate

Invitation to Participate in a Research Study on Responses to Substance Use and Harm Reduction in Shelter Settings

My name is Katrina Barber and I am a graduate student with the Canadian Institute for Substance Use Research at the University of Victoria. I am conducting a study on substance use and harm reduction in shelter settings.

You are invited to participate in an individual interview because you are accessing shelter services.

To compensate individuals for their participation, a stipend of $20 cash will be provided.

The purpose of this study is to better understand how initiation of an overdose prevention unit has impacted substance use and harm reduction in a shelter. This research is being conducted as partial fulfillment of a Master of Arts degree in the Social Dimensions of Health program at the University of Victoria.

If you are interested in participating, the next interviews are schedule for:

DATE, TIME, ROOM

The interview will be conducted in person by myself. At the start of the interview, I will provide an overview of the project and process and welcome your questions or concerns. Consent forms will also outline the research specifics, including how participation is voluntary and how confidentiality is maintained, among other issues. To enable transcription, the interview will be audio recorded. Information from the interview will be kept confidential and all names and identifying information will be removed. Participation in an interview is completely voluntary and seeking further information does not mean you have to participate.

If interested please connect with Katrina near reception on ____ (date) at ____ (time) to discuss further.

Katrina Barber
250-896-8131
kbarber@uvic.ca

Approval for this Study:
You are welcome to inquire about the project's ethics approval by contacting:
Uvic Human Research Ethics
250-472-4545 or ethics@uvic.ca

Appendix E
Recruitment Script

Recruitment and Screening Information

I am a graduate student in the Social Dimensions of Health MA program at the University of Victoria. This research is conducted under the supervision of Dr. Bernie Pauly (bpauly@uvic.ca) and Dr. Bruce Wallace (barclay@uvic.ca) at the University of Victoria.
I am very fortunate to have the opportunity to conduct my thesis research here at Rock Bay Landing. The purpose of my study is to better understand how the implementation of an overdose prevention unit contributes to responses to substance use and broader harm reduction policy and practice within a shelter. Thank you for assisting me in this research process. I will be conducting a series of individual interviews with clients who access shelter services (e.g. not transitional housing). This paper provides you with essential information to assist in the recruitment of individuals who have accessed shelter services.

Screening:

I recognize the vulnerabilities among those who are, or have, accessed shelter services. It is critical that I seek to avoid any potential risks of harms related to these vulnerabilities. I am not able to interview people who cannot give consent due to cognitive, mental health or substance use issues. People who are under the influence of a substance can participate as long as their ability to consent is not impacted. Also, for those who may become distressed or triggered by talking about their experiences related to substance use, and harm reduction, I will be sure to debrief with the participant and identify the best support for that person. Participants will be reminded that they are able to skip any questions that they're not comfortable answering and that they have the right to stop the interview at any time. I also have a referral card with the crisis line number that will be given to every participant at the end of the interview as an extra precaution.

I will be conducting a total of 20 individual 45- 60-minute interviews on the dates listed below. I will be able to do a maximum of 3 interviews in one day.

For my study, I am seeking participants with a range of perspectives and experiences with substance use and harm reduction services at the shelter. Potential participants can include those who may be committed to abstinence, those 'in recovery', people who are actively using substances and those for whom substance use may be problematic. I hope to get a diversity of perspective on specifically illegal substances and harm reduction regardless of the particular use or non-use of substance. As a recruiter I seek your input in finding participants who access RBL shelter services and who have enough experience accessing shelter services that they can potentially speak to changes they've noticed since the implementation of the OPS. **In order to be eligible, participants must have accessed the shelter for a minimum of one week** and potential participants must be accessing shelter services (e.g. not transitional housing services).

Risks:

Though I do not anticipate any issues, I am requesting that I be able to access a walkie talkie during my time in the shelter in the unlikely event of an emergency. Similarly, I am also requesting access to

contact information for the appropriate staff person to connect with in the unlikely need for support should a participant become distressed.

Process:

Please review the recruitment form with me to review the recruitment and research process.

Thank you for your critical role in this project!

Katrina Barber
kbarber@uvic.ca

Approval for this Study:
You are welcome to inquire about the project's ethics approval by contacting:
Uvic Human Research Ethics
250-472-4545 or ethics@uvic.ca

Interviews will be conducted on the following dates and data collection will end once 20 individuals have participated:

Appendix F
Participant Consent Form

The Role of Overdose Prevention Units in Responses to Substance Use and Implementation of Harm Reduction in Shelters: A Qualitative Study.

University of Victoria

Individual Interview Consent Form

Researchers

Graduate Researcher: Katrina Barber, University of Victoria, kbarber@uvic.ca

Faculty Supervisors: Dr. Bernie Pauly, University of Victoria, bpauly@uvic.ca; Dr. Bruce Wallace, University of Victoria, barclay@uvic.ca

Purpose of the Research

I am a graduate student in the Social Dimensions of Health program at the University of Victoria. This research is being conducted as my Master's research, in partial fulfillment of my program requirements.

In response to the overdose emergency in BC, harm reduction services such as overdose prevention units (OPU) have been implemented into social service agencies, including emergency homeless shelters. Previous research has shown issues and challenges related to substance use in shelter settings, as well as challenges related to harm reduction implementation into shelter settings. How does the implementation of an OPU influence how substance use is responded to in a shelter? How does having an OPU influence harm reduction implementation in a shelter? In order to begin answering these, and other questions l will be conducting interviews with people with lived experience of homelessness and who access shelter services.

Participation

You are invited to participate in a study called "The Role of Overdose Prevention Units in Responses to Substance Use and Implementation of Harm Reduction in Shelters: A Qualitative Study". This research is being conducted by Katrina Barber at the University of Victoria, under the supervision of Dr. Bernie Pauly and Dr. Bruce Wallace at the University of Victoria.

I am inviting you to participate in an individual interview. As a participant, your knowledge and lived experience are vital to generating understanding and responsive research

Your participation in the study is **voluntary**.

- You may choose to stop participating at any time.
- You may also choose not to answer any question(s) you do not want to answer.