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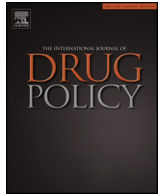
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Research Paper

Sheltering risks: Implementation of harm reduction in homeless shelters during an overdose emergency

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ABSTRACT

Background: The current opioid overdose crisis in North America is heightening awareness of the need for and the challenges of implementing harm reduction, notably within complex and diverse settings such as homeless shelters. In this paper, we explore the implementation of harm reduction in homeless shelters during an emerging overdose emergency.

Methods: The objective of this qualitative study was to identify and understand micro-environment level factors within emergency shelters responding to homelessness and substance use, and the macro-level influences that produce and sustain structural vulnerabilities. We conducted eight focus groups with a total of 49 participants during an emerging overdose emergency. These included shelter residents (n = 23), shelter staff (n = 13), and harm reduction workers (n = 13).

Results: The findings illustrate the challenges of implementing an overdose response when substance use is prohibited onsite, without an expectation of abstinence, and where harm reduction services are limited to the distribution of supplies. In this context, harm reduction is partially implemented and incomplete. Shelters can be a site of risks and trauma for residents and staff due to experiencing, witnessing, and responding to overdoses.

Conclusion: The current overdose crisis heightens the challenges of implementing harm reduction, particularly within complex and diverse settings such as homeless shelters. When harm reduction is limited to the distribution of supplies such as clean equipment and naloxone, important principles of engagement and the development of trust necessary to the provision of services are overlooked with negative implications for service users.

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Opioid overdose deaths and non-fatal overdoses have increased significantly in recent years across Canada and the United States (Fischer, Murphy, Rudzinski, & MacPherson, 2016; Rudd, Aleshire, Zibbell, & Matthew Gladden, 2016). Fentanyl and fentanyl derivatives have been recognized as a key factor in the recent surge of overdose deaths (Frank & Pollack, 2017; Misailidi et al., 2017). In response, public health is rapidly scaling-up naloxone programs (Fairbairn, Coffin, & Walley, 2017; Kerensky & Walley, 2017). The provision of naloxone and naloxone training to people who use drugs, harm reduction and social service workers, police, paramedics, and others has meant the reversal of countless overdoses and prevention of death. Evidence-based harm reduction responses that prevent overdoses are well supported by

research (Darke & Hall, 2003; Marshall et al., 2011; Stancliff, Phillips, Maghsoudi, & Joseph, 2015). However, questions remain as to the benefits and limits of the distribution of naloxone in specific settings, and the need for implementation of a more comprehensive response (Fischer et al., 2016; Hawk, Vaca, & D'Onofrio, 2015; Kerensky & Walley, 2017).

At the time of this research (December, 2015–January, 2016), unintentional illicit drug overdose deaths were reaching crisis levels in British Columbia (BC), Canada. In April 2016, the BC public health officer declared a public health emergency. By the end of 2016, there were 978 confirmed illicit overdose deaths, and illicit drug overdose deaths became the leading cause of unnatural death in the province (BC Coroners Service, 2017). That year, the rate of illicit drug overdose was approximately 20 deaths per 100,000 individuals, and the city in which the research took place was one of the top three townships in the province for numbers of overdose deaths (BC Coroners Service, 2017). At the end of 2016, fentanyl

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was implicated in almost 60% of illicit drug overdose deaths, and by fall, 2017, 80% of deaths were attributed to illicit fentanyl. In BC, the death count continues to rise monthly in 2017, with reported deaths continuing to be higher in each of month of 2017 than the same month in the previous year (BCCDC, 2017).

While an overdose can impact anyone who uses illicit drugs, it is clear that people who experience socio-economic disadvantages such as poverty and homelessness and use drugs bear a disproportionate burden of risks and harms due to the social and economic conditions in which they live. Substance use is often a response to difficult life circumstances, and illicit drug use, particularly the use of opioids, can be a response to dealing with chronic pain, loss, grief, multiple life traumas and stress (Maté, 2008). While causation is complex, there is a clear association between homelessness and increasing use of substances as a way of coping (McVicar, Moschion, & van Ours, 2015). As shelters provide a response to homelessness, these sites may exacerbate risks related to substance use through policies prohibiting use that contribute to secrecy and concealing use. They also increase exposure to pervasive illicit drug selling for all residents and staff, and become sites of illicit drug consumption (Briggs et al., 2009; Wadd et al., 2006). In spite of the fact that there are often high rates of illegal substance use and increased substance related harms among the homeless population, there is a lack of knowledge about the implementation of harm reduction strategies within shelter settings.

Rhodes' (2009) Risk Environment Framework provides a useful model for understanding the role that social environments play in the production of risks and harms, as well as how safer environment interventions can potentially reduce the risk of harms of drug use for people who use drugs (Rhodes et al., 2005; Rhodes, 2009). According to Rhodes (2009) "a risk environment framework envisages drug harms as a product of the social situations and environments in which individuals participate. It shifts the responsibility for drug harms, and the focus of harm reducing actions, from individuals alone to include the social and political institutions which have a role in harm production" (p. 193). At both the micro and macro level, Rhodes focuses on the political, social, economic and policy related factors that are either harm reducing or harm producing (Rhodes et al., 2006; Rhodes, 2002).

McLean (2016) utilized Rhode's risk environment framework to describe how a naloxone distribution policy that ignored contextual factors had limited impact for people who used drugs experiencing poverty due to cost and transportation barriers to obtaining Naloxone. This author recommended interventions to address poverty and isolation as the unaddressed roots of the overdose epidemic (McLean, 2016). Other authors have utilized Rhode's risk environment framework to analyze how people who use drugs perceived an overdose warning campaign. The campaign's weakness was the focus on individual behaviour and lack of acknowledgment of the strong social, economic and structural forces that undermined the impact of the intervention. These included sales tactics, cost and availability of heroin, as well as factors such as trauma, emotional suffering, routine behaviors, and withdrawal (Kerr, Small, Hyska, Maher, & Shannon, 2013). Similarly, Take Home Naloxone programs constitute a vital public health response focus, but are implemented by placing responsibility for responding to overdoses on people who use drugs (Farrugia, Fraser, & Dwyer, 2017).

The objective of this qualitative study was to identify and understand micro-environment level factors within emergency shelters responding to homelessness and substance use, within the macro-level influences that produce and sustain structural vulnerabilities during an emerging overdose crisis. The results are intended to provide practical knowledge and insights to inform

shelter based strategies to mitigate the risks associated with substance use, particularly overdoses, and enhance the implementation of harm reduction within homeless shelters.

Methods

Data collection

Focus groups exploring issues related to substance use and harm reduction in shelters were conducted from December, 2015 to January, 2016. A total of 49 participants participated in eight focus groups that included shelter residents ($n = 23$), shelter staff ($n = 13$) or harm reduction workers ($n = 13$). Each focus group lasted between 40 and 60 min, and was conducted by experienced researchers who have long-standing collaborations with individuals and agencies responding to homelessness and substance use. Focus groups were selected as a method well-suited to exploring experiences with substance use and harm reduction within shelters in order to illuminate a range of individuals' perceptions and experiences, as well as garner insight into possible responses to persistent challenges. Topics for focus group discussions included prevalence and types of substance use, issues arising from substance use in shelters, agency responses to substance use, and specifically the implementation of harm reduction within these settings. All focus groups were audio recorded and the audio files were transcribed. Ethical approval for the study was obtained from the University of Victoria Human Research Ethics Office (#15-304).

The research took place in a large urban center and participants were drawn from two emergency homeless shelters. One shelter is for those identifying as female while the other shelter serves all genders. Both shelters are designated as low-barrier shelters as required by the government funder. Low barrier shelters do not require individuals to abstain from using alcohol or other substances to stay or receive services, but often prohibit substance use onsite (Pauly, Wallace, & Barber, 2017).

Shelter resident participants were recruited by notifications, handbills, posters, or word of mouth by staff. Stipends of \$20CDN were provided to shelter resident participants. Focus groups were conducted with individuals that identified as active in their substance use, as well as those that identified as non-using, in recovery, or abstaining from substance use. An email was sent by the shelter manager to all shelter staff inviting them to participate during work time. Shelter staff focus groups were held at the shelter, and scheduled when both frontline staff and case workers could be most available to participate. Additionally, two focus groups were conducted with harm reduction workers who had experience in the provision of harm reduction services within shelters. Harm reduction staff were invited to participate through a third-party email and the agency was supportive of focus groups being scheduled during working hours. Stipends of \$20CDN were provided to any staff participants if they participated outside of paid time.

Data analysis

Within social and health sciences, there is an increasing emphasis and recognition of the importance of everyday experiences of people, multiple constructions of reality, and the complexity and ambiguity in everyday life and research processes (Lowenberg, 1993). Interpretive description (ID) is an approach to qualitative data analysis that acknowledges the constructed and contextual nature of reality, while allowing for shared realities (Thorne, 2008; Thorne, 2016). ID begins with real world questions, builds on existing knowledge in the field, and situates new

knowledge within a constructed and contextual context addressing the ‘so what’ of the findings.

The goals of ID are to generate practical and applied knowledge and recommendations for practice rather than to build, extend or generate theory (Thorne, 2016). Analysis is a process of inductive data analysis that moves the analysis through higher levels of abstraction (Thorne, 2016). The three authors collaborated on the analysis, which included each reading and independently coding transcription files. NVivo (QSR, 2015) was utilized to organize data and assist in coding processes. Through regular analysis meetings, emerging themes were identified, compared and refined. Using an iterative process, the final themes were created and refined with an objective of generating insights related to experiences, issues, and challenges around substance use and harm reduction practices in shelter settings.

Participant characteristics

Participant characteristics are presented in Table 1. Almost a third of shelter resident participants (31%) identified as Indigenous (First Nations, Metis, Inuit). More women (n = 14) than men (n = 9) were included as we conducted two focus groups at a shelter solely for women, and women also participated in the focus groups at the mixed gender shelter. All participants were adults ranging in age from 32 to 69 years. Substance use was not a criterion for participation, and shelter residents reported both use and non-use of substances (Table 2). The majority of shelter residents reported smoking cigarettes (78%) and drinking alcohol (74%) in the last year. Approximately, half (52%) of the participants reported using marijuana or hashish. Forty-eight percent reported smoking other illegal drugs (such as meth or crack), with a smaller number reporting snorting/sniffing (39%) or injecting (22%) illegal drugs (such as heroin or cocaine). None of the participants reported consumption of non-beverage alcohol (such as rubbing alcohol, mouthwash, or alcohol-based hand sanitizers).

The shelter staff participants were comprised of two-thirds women (77%, n = 10) and one third (23%, n = 3) men with ages ranging from the early twenties to almost retirement age. No shelter staff identified as Indigenous. Almost all shelter staff were full-time employees, currently working days rather than nights, from a diversity of shelter positions including front-line workers, client support workers and team leaders. Shelter staff had worked on average six years in the shelters, with the newest staff member reporting two years of experience, and another reporting over twenty years of experience.

Harm reduction workers were employed by community non-profit agencies. Among those interviewed (n = 13), seven identified as female (54%), two as male (15%) and four (31%) identified as outside gender-binary terms or preferred not to identify by gender. The ages of harm reduction participants ranged from the early twenties to sixties. Two participants identified as Indigenous. Harm reduction participants were employed as harm reduction

support workers, or held coordinating and managing roles. All but two workers reported working in the shelters as part of their harm reduction roles.

Results

Overdoses were identified by all groups as the most significant concern associated with substance use in shelters. Below we outline four themes that describe the shelter as a micro-environment in which harms may be mitigated or exacerbated by policy and political processes in the macro-level environment.

Clean gear: harm reduction policy during prohibition

Homeless shelters in this study had two simultaneous mandates related to substance use: (1) the distribution of safer use supplies such as needles and crack pipes as public health policy related to reducing the spread of blood borne diseases and (2) providing ‘no’ or ‘low’ barrier shelter services inclusive of people using substances as part of housing policy related to ending homelessness. Hidden, discrete use was generally permissible; however, shelter policies prohibited use of substances onsite with consequences of use including bans and restrictions on access to services (Pauly et al., 2017). The banning of individuals from shelters highlights the way in which prohibition and criminalization are taken up within organizational policies that often conflict with other public health policies such as harm reduction.

Shelter residents noted that providing harm reduction supplies when drug use was discouraged or prohibited left people feeling unable to access the needed clean supplies from staff for fear of repercussions. One shelter resident stated: “*Yeah you stay under their radar . . . if you’re a heroin addict like me you’re thinking okay I gotta borrow some off somebody . . . I can’t ask them cause I can’t risk losing my bed.*” Another resident described:

I’m not a needle poker, but I have done that for a buddy beside me, he’s like well if I go ask for all the gear then they’re gonna kick me outta here right? so it’s like I’ll go up there and say hey can I have like a package or like I don’t even know what I’m asking for right cause I’m not, I don’t do heroin, I’m not a needle poker right, I’m an alcoholic. I have no problem saying that but that’s just the way it is and it’s like holy shit okay here bro, and he fuckin go get it, but now I’ve got a little X beside my name because they think that I shoot up, but I didn’t shoot up, I’m just giving it to somebody

Shelter staff also recognized that even when the organization has a harm reduction policy and staff embrace harm reduction, there are tensions if the organization is governed by an abstinence based policy that restricts, and even punishes, substance use onsite. One shelter staff referring to the zero tolerance for substance use onsite stated: “*I think a lot of us are the same mindset that it is really difficult handing out harm reduction supplies at a homeless shelter, like it’s like here you go but not here . . . it’s not supposed to be something that we condone or allow.*”

Table 1
Participant demographic information.

Participant Characteristic	Shelter Residents n = 23	Shelter Staff n = 13	HR ^a Workers n = 13
Age (mean age in years)	47	41	39
Gender			
Male	9 (39%)	3 (23%)	2 (15%)
Female	14 (61%)	10 (77%)	7 (54%)
Other (or missing)	0	0	4 (31%)
Identified as Indigenous	9 (31%)	0	2 (15%)

^a Harm Reduction.

Table 2
Shelter Residents' Self-Reported Substance Use^a n = 23.

Type of Substance Use	Frequency ^b
Smoked cigarettes	18 (78%)
Drank alcoholic beverages	17 (74%)
Often drank 5 or more alcoholic beverages at one time (weekly or more)	9 (39%)
Smoked illicit drugs	11 (48%)
Snorted/sniffed illicit drugs	9 (39%)
Injected illicit/non-prescribed drugs	5 (22%)
Used marijuana or hashish	12 (52%)
Taken pills to get high/other than prescribed reason	5 (22%)

^a Substance use in the past 12 months.

^b Number of participants identified having used the substance in the past 12 months.

Overall, there was recognition from staff that while the agency had a clear harm reduction policy, it was not widely shared by all staff, and the inconsistency for residents was problematic:

... the staff doesn't necessarily agree, some staff may but some staff don't. I know my experience with that was just constantly feeling awful for the clients as they expected one thing and were treated another way because they were getting, you know, they understood there was a harm reduction policy but it wasn't actually at all harm reduction in reality

The conflict between harm reduction and prohibition of substance use policies onsite contributes to a micro environment in which harm has the potential to be increased when residents do not feel safe to access supplies and fear repercussions or punishment for use. This environment also increases risks of concealed or hidden use.

Partial implementation of harm reduction

Harm reduction workers employed outside the shelters depicted the shelter as a place where harm reduction was enacted through the provision of supplies, but without enactment of a harm reduction philosophy. These harm reduction workers were clear that *"the provision of supplies is secondary to the ideology"* and that within shelters *"the culture doesn't reflect harm reduction"*. As one harm reduction worker explained, *"you've given them clean supplies but that's not harm reduction, right. It's really defining, like, what is a harm reduction philosophy of care, and how does it operate at all levels of engagement. Not just in the provision of supplies"*.

The distribution of clean supplies is rooted in a biomedical HIV discourse emphasizing and prioritizing the interruption of the transmission of blood borne diseases. Thus, the act of handing out syringes is instrumental and symbolic of harm reduction, but not necessarily with attention to the principles and practices of harm reduction related to respect, dignity and compassion. Policies consistent with these principles and practices are required for full implementation.

As a result of primary practices of harm reduction as the distribution of supplies, there was a lack of specific harm reduction training for shelter workers, and a corresponding feeling of limited knowledge among workers. A staff member made the point that *"we give out harm reduction supplies, so if we're gonna give them out we need to know how to use them and be forced to know how to use them ... I think if we're gonna dabble and we're gonna say okay we're gonna try to help, we need the training to actually be able to help"*.

In the absence of training, one staff member suggested that harm reduction within the shelters is dependent on the *"champions of harm reduction"* within staff *"who take it upon themselves to promote a harm reduction approach, and educate their coworkers and you know, push for initiatives like better access to naloxone and better*

access to safe supplies and sort of take a more practical approach to sharps management and that kind of thing ... but it's kind of left up to the individuals to do that". Thus, the need for training related to substance use, harm reduction philosophy, and use of life saving supplies (e.g. naloxone) was heightened in the urgent wake of increasing overdoses, as was the corresponding need to respond to overdoses to prevent overdose deaths.

Supplies are not enough: lack of safe spaces for use

Although drug use was prohibited on site, shelter washrooms were widely recognized to be sites of drug use and frequent overdoses. A staff member described the shelter washroom situation as *"Without actually have anyone be there watching you, it's like a half assed safe injection site"* while another staff member declared *"We are actually a very unsafe consumption site to be honest"*.

The staff expressed the challenge of responding to conflicting priorities, stating *"Though it is against our policies to use in our bathroom and we'll discourage that behavior, when everybody was potentially dying in other places, it was much easier to have them use in here"*. Another staff similarly described how *"right now when ... I look at somebody and I say 'you're using here, and it's not safe and you shouldn't be using, get out', and they're like 'where am I gonna go? Do you want me to go find a dumpster and sit inside and use there so I can overdose with nobody around? right'".* One experienced staff person described the evolution of *'bathroom checks'* from preventing drug use to now preventing overdose deaths, stating *"the safety checks weren't originally to check if people weren't overdosing, they were checks to make sure that no one was using in the bathrooms, or people weren't dealing in the bathrooms, or people weren't collecting or enforcing"*.

Shelters exist as a space where low-barrier housing policies dictate sheltering people who use drugs, while public health policies limit harm reduction responses to the distribution of supplies without the creation of safer spaces for use. Not surprisingly, staff are making difficult decisions about allowing use onsite, or more accurately out of sight, while recognizing that banning people for use could contribute increased harms associated with using in public spaces.

Shelters provide the first line response to overdose

The limits of existing harm reduction policies and services that primarily focused on distribution of supplies was apparent in the wake of an emerging overdose emergency. The availability of naloxone, and the expectation that shelter staff and residents are trained in the use naloxone as a response to overdose, significantly expanded harm reduction services. While this likely has saved countless lives, an experienced shelter worker explains the increased responsibility and burden for administering naloxone:

“Before we ever had naloxone that’s what we’d do, we’d call 911 you give ‘em as much information as you can. But now we are being required to train in the naloxone, so it’s added burden, an emotional burden, and you know”. The trauma of responding to overdose events as part of working in the shelters was a major topic. One staff member expressed: *“We’re not paramedics but we’re first responders a lot of the time.”*

Other staff members described how it can be more traumatic for shelter workers than paramedics who may *“pick ‘em up, you go drop ‘em off and that’s it”.* While for shelter workers it was more personalized: *“we’re watching our community, we’re watching people we would consider, community’s a good word, but like our community hitting the floor and potentially nearly dying on us a lot and it probably does leave a lot more trauma within staff than we necessarily recognize or have talked about maybe”.* Similarly, a shelter worker described: *“We care, like we’re supporting that person, we’re making goals with that person, we’re like having day to day interactions, and then that person’s on the floor almost dying right”.*

The threat of death and the responsibility to administer naloxone was identified as stressful. *“I think that’s too overlooked, like actually the trauma, you know, the staff actually through all of these experiences, that’s not addressed near enough, near enough”* stated a staff member, while another staff member expressed *“Yeah I’m sure we can all remember the first time we shot somebody with Narcan”.* The strain faced by shelter workers was described by one worker: *“if you panicked if you were faced with administering naloxone and you panicked, then you would feel responsible for that person’s death”.*

The trauma for staff was described as *“you come into work wondering if you’re going to have to try to save someone’s life and the emotional impact that has on you and people, we, there’s very little support offered”.* While staff further recognized *“we’ve had a lot of people like going home or calling in sick for shifts. And a lot of people will call in sick as a mental health day, because it’s just too much to have to deal with it so much, and I think that’s one of the biggest concerns recently with opioid use”.* While staff may face trauma they still had to support residents also facing trauma from overdoses in the shelter:

And the extra support that you need to give the extra clients too who witnessed someone that’s been naloxoned, and it terrifies them as well. It scares the living bejesus out of them, and then the staff need to support them emotionally while they’re trying to deal with their trauma as well.

These findings highlight how staff and other residents trained to administer naloxone act as ‘first line responders’. They are often on the scene before recognized and clinically trained first line responders such as EMT’s and paramedics arrive. Implementation of harm reduction was expanded to include naloxone to address the ‘new harm’ of overdose, but not necessarily the needed social supports, or the necessary training and cultural shifts to fully implement harm reduction philosophy. Shelters did not have clinical staff such as nurses or other health care professionals on site routinely. These findings raise important issues related to trauma, loss, and grief for residents and staff associated with the implementation of lifesaving overdose prevention.

Limitations

The qualitative focus groups for this research were limited to two homeless shelters within a single city. This study, of shelter staff and residents during an emerging opioid overdose crisis is uniquely positioned to gather rich and timely data on substance use issues. While generalizability is not the objective of qualitative research, one limitation of this study is that the

findings may not reflect experiences within different contexts. Although our sampling sought to include a diversity of substance use experiences, the sample size limits its reach and we specifically noticed that we did not reach those reporting consuming non-beverage alcohol. Additionally, our focus groups of shelter residents would not adequately reflect the experiences of people who experience homelessness and do not access shelters due to being barred, or who perceive shelters as an inappropriate option for them.

The inclusion of shelter residents, shelter staff, and harm reduction staff from the same shelters offered the opportunity to explore issues from multiple perspectives. However, because substance use and homelessness are both stigmatized we expect that personal disclosures of information from some research participants may have been limited or sanitized. While the researchers sought to create non-judgemental settings, and facilitate a safe place to engage in discussions, we note the larger context in which these focus groups take place that may limit truthful discussion of substance use and homelessness. Further, the experience of focus groups rather than individual interviews may discourage disclosure, and the dynamics of differing power relations within the group may impact participants’ willingness to be forthright.

Discussion

Our findings indicate the inadequacies of harm reduction responses that focus primarily on the distribution of supplies within settings prohibiting use. Risks related to incomplete implementation of harm reduction include concealing use within a setting that prohibits use, and tragically, frequent overdoses, notably within the shelter washrooms that become de facto unsupervised consumption sites (Wallace et al., 2016). A distribution model of harm reduction within shelters are micro environments in which risks related to injection drug use and overdose are escalated. This is in stark contrast to settings in which the provision of supervised injection services mitigates the harms of the micro-injecting environment (Briggs et al., 2009).

Within the context of an escalating overdose crisis, the availability of naloxone is an important harm reduction intervention. However, the implementation of naloxone replicated a distribution model similar to that of safer supplies. Harm reduction strategies such as naloxone that serve to save lives are also associated with trauma for shelter workers and clients due to the frequency of overdose events and administering of naloxone. The shelter was identified as a site of risks and trauma as experiencing, witnessing and responding to overdoses becomes entrenched through the distribution of naloxone (Faulkner-Gurstein, 2017).

Needle exchange services have been described as a safe haven in an unsafe world as they provide reprieve from the ‘grind’ of the streets (Macneil & Pauly, 2011). In other research, shelter settings have been described as places of “relative risk” as such settings are characterized as being both a “safe haven” and a “risk environment” at the same time (Briggs et al., 2009). Shelters provide a safe haven from the risks associated with being homeless and public injecting. However, they are also risk environments, with drug use being extensive yet hidden in shelters that prohibit use, and impacts for other residents, notably those seeking to distance themselves from drug use (Briggs et al., 2009; Pauly et al., 2017).

Our findings illustrate how washrooms in shelters operate as both a perceived safe haven and a risk environment. In this study, frequent overdoses in washroom stalls occurred due to lack of safer spaces for use, as they were within the relative safety of staff responding with naloxone. This in turn placed risks on staff as well as clients who experience trauma in these settings. With provision of naloxone, staff and clients are the ‘first responders’, but not

necessarily with access to resources and supports available to other first responders. The unimaginable trauma, loss and grief associated with responding to both fatal and non-fatal overdoses cannot be overemphasized, and the importance of mental health debriefing and support are a central issue in responding to overdoses. While health care providers such as paramedics, ambulance personnel and police often have access to employer assistance programs, this is less likely for many shelter staff and residents who are saving lives and intervening early to prevent deaths. Thus, there is a lack of resources and supports for this group that is urgently required.

A broader understanding and operationalization of harm reduction would seek to move beyond distribution of clean needles, and now naloxone, to safer spaces for use, and would incorporate people who use drugs in the provision of harm reduction services. The current shift in harm reduction from clean needles as a response to HIV, to naloxone as a response to overdose, resembles what has been described as decontextualized health responses within the macro contexts of vulnerabilities. This poses the risk of continuing “unintended consequences of well-intentioned interventions” (Ciccarone & Bourgois, 2016, p. 42). In essence, the practice of harm reduction has extended beyond HIV to include an additional harm of substance use (overdose), but has not fully embraced comprehensive harm reduction or recognition of the contextual and situated nature of harms in both the micro and macro environment.

While HIV prevention and the distribution of supplies to prevent blood borne infections including HIV and the hepatitis C virus (HCV) was clearly understood, an unintended consequence of this harm reduction approach is that supply distribution was implemented albeit unintentionally within a prohibition environment. This contributes to risks related to overdose and concealing of use due to stigma and fear of repercussions. It is clear that such criminalization extends from the current prohibition of drugs and substances deemed illegal at the federal level. Clearly the societal context permeates the shelter and escalates harms of drug use. The primary harm of a toxic illegal drug supply is the resulting rising numbers of overdose deaths. Distribution of safer supplies, to bathroom checks and the distribution and administration of naloxone, are implemented within a macro-environment of ongoing criminalization that can be perpetuated by shelter policies. This draws attention to the macro policy context (McLean, 2016) and the criminalization of illicit substances under prohibition, and the need to revisit and redress the current drug policy context and move to decriminalization and regulation (Farrugia et al., 2017).

A central theme from this research is how harm reduction is incomplete when harm reduction mandates are perceived as the distribution of supplies, in the absence of a harm reduction philosophy. These findings echo observations elsewhere that caution that needle distribution programs are less than optimal when restricted to supply distribution, without also responding to service users' broader needs (Treloar, Mao, & Wilson, 2016). Furthermore, these findings illustrate, as others have noted, that harm reduction overall requires more than addressing drug-related risks and that it is necessary to create safer environments, and indeed refuge, for service users (McNeil & Small, 2014). Previous examination of harm reduction within housing has noted that harm reduction may be less about the product (e.g. injection supplies) and much more about the process of the program, notably the interaction between staff and residents (Pauly, Reist, Belle-Isle, & Schactman, 2013; Tiderington, Stanhope, & Henwood, 2013). This highlights the critical importance of staff training and education, not simply in the administration of naloxone, but related to the philosophy and principles of harm reduction. Furthermore, a corresponding

shifting of attitudes and understanding of substance use as a feature of society is required. (International Harm Reduction Association, 2010).

Our findings indicated that shelter staff maintained a diversity of views towards substance use and harm reduction. Harm reduction was often stigmatized, with indications that residents felt judged and potentially penalized when accessing supplies as this service identified themselves as using substances to shelter staff, and therefore increased risks (Wilson, Brener, Mao, & Treloar, 2014). The lack of a culture of harm reduction was identified as a challenge to implementing harm reduction services, and contributed to these risks (Pauly, 2008). Within this context, harm reduction champions within the shelter were recognized as important to shifting the culture. While the shelters did not require abstinence, the policy of no substance use onsite, with potential banning for use, limits both access to harm reduction supplies and services. Further, it impacts trusting relationships between shelter staff and residents that are central to harm reduction practice (Edland-Gryt & Skatvedt, 2013; Treloar & Rance, 2014).

Harm reduction cannot be fully realized within the contextual forces of prohibition and stigma. Specific to overdose prevention, as Moore (2004) Moore contends (2004), harm reduction requires more than behavioral strategies, it requires attention to the macro-level responses such as poverty, homelessness and criminalization. While arguably the shelter does indeed respond to some of these macro-level factors, these responses are perceived as distinct from its harm reduction responses.

Conclusions

The current illicit drug overdose crisis heightens awareness of the challenges in fully implementing harm reduction responses, notably within complex and diverse settings such as homeless shelters. This study found a combination of low-threshold service delivery, and distribution of harm reduction supplies with prohibition of use on-site, which was described as a context of mixed messages and competing priorities. The shelter is identified as a site of risks and trauma, as experiencing, witnessing, and responding to overdoses becomes entrenched in this harm reduction model. Harm reduction in these contexts can be described as incomplete harm reduction. Comprehensive harm reduction is much more than the provision of a supply or service, and cannot be realized within the contextual forces of prohibition and stigma. Attention to and understanding of the broader context in which harm reduction is being implemented, as well as the philosophy, principles and practices of harm reduction that emphasize the development of trust and engagement of people with lived experience, are essential.

Conflict of interest

The authors report no conflicts of interest to declare.

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