Embedded Harm Reduction Full Evaluation

Interim Report: Resident Focus Group Findings

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Background

This study evaluated the implementation of embedded harm reduction services in congregate shelters, respites, and shelter hotels in the City of Toronto. During the COVID-19 pandemic, hotels were leased and converted into shelters wherein residents could physically distance in private or semi-private rooms. This shift in the shelter system's built environment has led to unique and specific overdose risks and vulnerabilities. As a result, the City of Toronto and partner agencies implemented overdose prevention and embedded harm reduction supports within sheltering places for people experiencing homelessness. Since December 2020, community organizations have been increasing access to naloxone and harm reduction supplies, providing certain intensive mental health case management, outreach, peer-based supports and overdose prevention services across these sites (Table 1).

Service	Description
Urgent Public Health Needs Sites (UPHNS)	Overdose Prevention Site
Integrated Prevention & Harm Reduction Initiative (iPHARE)	Embedded harm reduction/overdose response staff from partner agency
Toronto Public Health, The Works	Visiting harm reduction/overdose response staff from partner agency
Multi-Disciplinary Outreach Team (M-DOT)	Mental health case management outreach
Shelter Hotel Overdose Prevention Project (SHOPP/SafeSpot)	Peer-based harm reduction training and witnessing
Mobile Outreach Harm Reduction (MOVID)	Mobile harm reduction/overdose prevention supports

Table 1 – Embedded harm reduction services

What We Did

Researchers at MAP Centre for Urban Health Solutions partnered with the City of Toronto, shelter operators, and community agencies to conduct a mixed-methods study. Data was collected through multiple-site focus groups with residents, semi-structured key informant interviews with leadership (includes directors, presidents and CEOs) and front-line staff, and a front-line staff survey (n=384). This interim report presents analysis of resident focus group data only, including preliminary findings and recommendations. People were eligible to participate in these focus groups if they currently or previously used drugs and accessed

embedded harm reduction services in a shelter, respite, or shelter-hotel. Additional data from interviews and surveys will be analyzed and presented in forthcoming materials. Across nine focus group sessions, residents[1] were asked about their experiences in the shelter system, whether their needs were being met by existing embedded harm reduction and adjacent health/social services, and specific challenges faced by people who use drugs in these settings. Seven focus groups were mixed-gender; two were women-only. Focus groups were conducted at: 2 respites, 2 shelters and 5 hotels. Across the sites, an average of ten residents participated per group. Data collection took place between September and December 2022.

In order to analyze the data, the research team did the following:

- Developed a code-book by reviewing focus group transcripts;
- Conducted thematic analysis within each code to identify salient and recurring concepts;
- Compared and contrasted thematic analysis within and between codes to organize findings

<u>What We Heard</u>

Preliminary findings are organized into three main themes: staff-resident interactions, wellness checks and safety planning, and overdose response and preparedness. Each theme reflects aggregate input from residents across multiple focus group sessions, and direct quotes are included throughout to emphasize or highlight particular points. Recommendations associated with these categories are provided in the following section of this report.

1) Staff-Resident Interactions

Residents reported having relationships and interactions with staff that fall on a broad continuum of trust, respect, confidentiality, and comfort. In some cases, staff are regarded as helpful, supportive, and competent. As one participant shared: “Staff are doing a good job here because if it wasn’t for them, I wouldn’t be alive right now. They saved my life.” Another resident recounted the intimacy they feel with “certain employees [who are] sort of motherly; […] they know certain things about you.” While such meaningful and positive interactions with staff do occur, residents are clear about what qualities would increase their frequency. They asked for staff who are:

- compassionate;
- personable;
- non-judgmental;
- well-trained;
- and prepared to make effort to support them in meeting their needs

Staff who demonstrate these characteristics are known, and appreciated, among residents. One such staff member was described as follows: “She’s understanding. She talks to you. If

[1] Throughout this report, the use of ‘residents’ denotes those who participated in focus groups (i.e., those eligible by virtue of being people who use drugs and access embedded harm reduction services).

you want something or you need something, she'll help you." This sentiment is well summarized by one participant who shared, "the ones who genuinely care show it."

More often, residents reflected on interactions with staff as hostile, frustrating, and undignified. They reported experiences of being belittled, dismissed, harassed, and stigmatized for their drug use. While residents shared frustrating interactions with staff, they also recognized the difficult and traumatic nature of the work that staff are asked to perform —in some cases, they have been witness to staff "hav[ing] nervous breakdowns at work because of it." Even with respect to wellness checks (addressed more in-depth below), there is some understanding that staff "just [have to] do it. It's part of the job."

Some of the primary factors that contribute to these negative interactions include:

- high rates of **staff turnover**, which mean that relationships are difficult to maintain and strengthen, leading to feelings of inconsistency, unreliability, and unpredictability;
- variable levels of **staff training and supervision**, leading to divergent levels of trust based on highly discretionary practices;
- relational **power imbalances**, which prevent or interrupt residents from feeling safe and making autonomous decisions in collaboration with staff and community

First, with high staff turnover, residents shared a lack of comfort in seeking support from unfamiliar employees. One resident shared a common sentiment, "There's been a change in staff here in the last month. People that I don't even know and [have] never been introduced to." This leads to disconnection between residents and staff, with another participant reflecting, "I really haven't talked to [harm reduction staff] lately […] the ones who are up there right now I haven't talked to them because I don't know, I just don't feel comfortable as, personally myself." This was frequently contrasted by positive interactions with staff who have lived experience of drug use and the negative effects of their departure:

"The person that was here before, people talked to a lot because he was a user. And he's not here anymore, he quit. So I think now less people go and talk to people there, because they don't have that interaction with somebody that's an addict or has been an addict, has been through what they've been through."

Hiring practices contribute to these effects, with residents forced to adjust to constant changes when staff they perceived as 'good staff' leave: "So all the good staff went elsewhere and now it's everybody's friend and cousin and it's turned into a big shit show because... nobody's experienced."

Furthermore, high turnover also intersects with variable levels of training and supervision, which results in discretionary and inconsistent staff practices. Whether in relation to site policies on drug use, overdose response, or general support, residents shared that some staff "just look at you like 'duh… I don't know what you're talking about', and then there's some workers that know exactly what they're doing and they do their job very well but there's not many." These effects are largely felt in relation to drug use and overdose response, and are further elaborated on in the third thematic section (Overdose Response & Preparedness).

Violence Against Women and Gender-Diverse Residents

Women and gender-diverse residents who use drugs face additional challenges within the shelter system. Participant's revealed instances of violence's from both staff and other residents adding that their ideas of safety sometimes diverged from what was offered from the shelter site, but that they had little ability to influence change in their circumstance.

One woman's account of staff sexual harassment was exemplary of many women participants' experiences: "As soon as [my husband] was offsite and I went to use the washroom, [the staff member] is kicking open the door, with my overalls down, telling me to get into his office." Retaliation is also common; in this case, the resident and her husband were told "if I talked about sexual harassment again, we'd be out." Indeed, she shared, "we got kicked out that night when I told my husband." Other women reported being offered money for sex, having staff enter their rooms without consent, and living at sites with staff who are known sexual abusers. In general, there is a sense that hierarchy between staff and residents prevents meaningful accountability.

2) Wellness Checks & Safety Planning

Wellness check practices are generally regarded as disruptive, ineffective, annoying, and, in some cases, harmful. A majority of residents described them as traumatic or re-traumatizing, especially for those who suffer from post-traumatic stress syndrome (PTSD). Across nearly all focus groups, the following elements of wellness checks were raised as problematic:

- they are **inconsistent** and sometimes **unpredictable**;
    - "Everyone has a different mentality how to check on you and that is a problem"; "Sometimes every 15 minutes. Three times they come by. Sometimes three hours."
- they can be **aggressive**, **disruptive**, and **counter-productive** to their stated goals;
    - "At one point they were knocking on our door once an hour 24/7 for two weeks straight"; "It's really a mockery. The one-hour thing doesn't work because they have no idea of when you're using. And we have no trust in them to tell them when we're going to use."
- they are experienced as a **breach of privacy** and contribute to **traumatization**;
    - "Sometimes I'd be just coming out of the shower. I'd be hearing this male voice and I be like, wait is this, this man… like I thought a woman is supposed to be checking… and I'm naked."
- they can be used as a pretense to **harass**, **steal** from, or **assault** residents, especially women and non-binary people;
    - "They get advantage of that little power, power is responsibility. Don't come in my room. People missing everything. You're high, you pass out, they took everything from you. There's no questions asked. Your dope, your money, whatever you have. I've seen it with my eyes."

In large part because of the way wellness checks are practiced, residents reported feeling hesitant as to whether or not they should disclose their drug use. For residents, disclosure of drug use is experienced as an abdication of privacy and autonomy in their own safety

planning. Demonstrating the intersection of staff power, unethical discretionary practices, and wellness checks, one participant disclosed:

> "I didn't tell anyone I used. I kept it confidential. I caught weekend staff going through my drawers, they found my paraphernalia. Suddenly I'm on this one-hour check. Now, number one, that's a breach of my confidence. Number two, it's a defamation of my character because they come to my door and do not [do checks] quietly."

What's more, residents expressed frustration that wellness checks can be counter-productive when they regularly interrupt sleep, which can lead to unintended consequences: "If you're up all night you're using twice as much." Staff can wield power in deeply harmful ways. When asked whether residents can request when wellness checks are performed and how often, one participant shared, "No. They just come when they want to." In contrast, when staff work collaboratively with residents in a way that respects their agency, wellness checks are welcomed. One resident shared the positive effects when staff build trust, have adequate training, and take a flexible approach to wellness checks:

> "There's been times where my floor worker knows I've had a bad time and she's like, 'do you want me to get anyone to come check on you?' and she's called me and stuff to make sure I'm okay. You just have to ask and getting to know one of the staff members and being comfortable with them, they have no problem coming to check on you. It's also making sure that the staff that are checking on you know what to do if something does go wrong. A lot of them I know don't. And I've seen them where they're doing, you know, wrong things to revive people."

Residents care about their own and others' safety when using drugs and are interested in alternatives that can achieve the goal of reducing overdose risk and death. For instance, providing and using in-room phones or personal cellphones was raised on multiple occasions as an example of a different way to conduct wellness checks. In general, the desire to be consulted and meaningfully included in safety planning was a recurring topic of discussion.

3) Overdose Response & Preparedness

Experiences of overdose response and preparedness varied widely across sites and between staff. The availability of Naloxone on-site was viewed positively and people's lives have been saved because of the introduction of harm reduction services: "They've saved my life couple of times here." In many cases, staff are seen as well trained, although this is not always consistent. At one site, a resident shared, "the staff, they're well trained and everything, just some don't know everything. They never went through that experience [of responding to or experiencing an overdose]. The first time it's kind of understandable. They're like, oh my God… They get scared." Similarly, another participant reflected, "They carry around the Narcan kits and all that. So they're doing good on that. Most staff are good at it. Some, they're too scared to do anything." In more cases, residents reported negative experiences with staff failing to properly prepare for and respond to overdose events. A number of common themes were raised:

- staff are **inconsistently trained**, with many seeming to lack adequate training to respond to overdoses;
- **Naloxone** is generally accessible, although it is often the **sole intervention** applied to an overdose event, including in cases where it is applied excessively or inappropriately;
- **people with lived experience** are often the ones anticipating and responding to overdoses, although their knowledge and expertise is sometimes dismissed or responded to with hostility

In response to witnessing overdose response by staff, residents shared similar stories. For instance, one participant remembered seeing a person overdose and staff "waiting for EMS to get there … they could administer Naloxone but they don't have the Naloxone training to know what the fuck to do." In another case, a resident shared:

> I just see a bunch of staff members dressed in hazmat suits, all in white, run into a room and I'm sure there's maybe the occasional staff member that knows how to administer Naloxone if it needs to be administered. But in my opinion, I've also seen somebody who's OD'd and passed away because the staff neglected to get there fast enough. They don't know what the fuck they're doing.

As such, it is a similarly recurring experience for residents to witness or participate in peer overdose response. This was demonstrated by numerous experiences which involved "[seeing] staff members trying to respond to an overdose and the residents are the ones that actually do the work." One participant recalled a time when they responded to an overdose on site, saying "I've been there for 45 minutes before staff even got dressed up and then they all walk slow, the guy would have been dead by then." Another shared, "a couple in the bed behind us [was] choking on their throw up in their sleep and staff did nothing. It was me that got gloves on." In response to this work, residents often expressed interest in paid harm reduction employment only to face multiple barriers: "people that do have the training, they try to get hired… like I've been trying to get a position and I've been trained probably more than anybody in this building and I get told I have to go back to school."

Reflecting on when staff have responded to overdose events, many shared that it was often exclusively with the administration of Naloxone. Residents observed that Naloxone is frequently used inappropriately or unnecessarily. "Some of the times, [staff] don't even know when to administer Naloxone." For instance, one participant remembered staff attempting to give someone Naloxone after using crystal meth. They reflected, "[staff] need to know the difference and what needs to be done depending on the drug they're using or what the overdose is from." Multiple successive doses of Naloxone, above and beyond what is recommended or necessary, is also a common experience. The lack of alternative tools, like oximeters to monitor breathing or oxygen, were noted as deficiencies in overdose response protocols. Increasing access to supervised consumption spaces and safer supply programs were both also widely requested.

Finally, when deaths occurred on site, residents described how responses are secretive and callous—"Everybody is hush, hush, here. The staff try to hush, hush everything. Like the

deaths, the overdoses, they will not allow you to know, even if your friend has overdosed, they will not allow you to know anything." Residents also expressed fear of retaliation for 'prohibited' drug use and many people reported experiences of actual or threatened discharge if found out that their drug use is associated with overdose events.

Preliminary Recommendations

Overall, embedded harm reduction services provide residents with access to harm reduction supports that improve health. Congregate shelter, respite, and shelter-hotel residents have diverse and comprehensive suggestions for how to improve embedded harm reduction services in the places they stay.

Preliminary recommendations to improve shelter conditions and the services being offered in hotels, respites and shelters include:

- People with the lived experiences of homelessness, shelter living and drug use should be included in the service planning, design and implementation of embedded harm reduction

- Immediate hiring and training of staff is needed to support safer spaces for women and gender diverse people to prevent gender based sexual violence, exploitation and sexual harassment

- The sector must invest in and create hiring practices are sustainable; contract workers should be for relief only and not relied upon for regular staffing shifts

- Mandatory staff training for overdose prevention and response, including regular practice drills to build capacity, skills and confidence is required

- Training and audits around overdose response, trauma informed practices, gender based violence and anti-violence are needed across the sector to create supportive environments

- Overdose response interventions, should include pulse oximeters and the ability to administer oxygen

- Wellness checks and safety planning policies should be flexible, site-specific, and crafted in on-going collaboration with residents

- Harmful practices such as the use of discharge or bans from a site as a threat or intimidation tactic need to stop; policies around drug use, discharge and crisis responses must be safe and consistently followed across respite, shelter and hotel sites

- Supervision, monitoring, and systems of accountability to prevent abuse of power by staff need to be implemented across the sector

- Employment of residents in harm reduction roles for overdose prevention, response, secondary exchange and peer witnessing should be expanded

Conclusion

Our findings indicate an urgency to review hiring practices for this vulnerable sector, training, safety planning, and the practice of wellness checks to better support residents. The integration of harm reduction supports and services throughout the shelter system is a worthwhile endeavor that would benefit from sustained and increased funding. There is an urgent need to implement recommendations and scale-up embedded harm reduction supports and services that are consistent and accessible.

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