EVALUATION OF EMBEDDED HARM REDUCTION SERVICES IN TORONTO SHELTERS

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About this Report

This is an Embedded Harm Reduction services evaluation report. This report highlights the key findings and recommendations from the evaluation of Embedded Harm Reduction services offered in Toronto shelters, respites and shelter hotels. The views contained in this report do not necessarily express the views of any community partner, funding agencies, MAP, Unity Health Toronto, or any other organization with which MAP authors or project team members may be affiliated.

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Ethics Approval

We received approval from the Unity Health research ethics board (REB# 21-116).

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Land Acknowledgment

We acknowledge the sacred land on which MAP and Unity Health Toronto operate. It has been a site of human activity for 15,000 years. This land is the territory of the Huron-Wendat and Petun First Nations, the Seneca, and most recently, the Mississaugas of the Credit First Nation. The territory is the subject of the Dish with One Spoon Wampum Belt Covenant, an agreement between the Iroquois Confederacy and Confederacy of the Ojibwe and allied nations to peaceably share and care for the resources around the Great Lakes. Today, the meeting place of Toronto is still the home of many Indigenous people from across Turtle Island and we are grateful to have the opportunity to work in the community, on this territory. We are also mindful of broken covenants and the need to strive to make right with all our relations.

Report can be downloaded here: https://maphealth.ca/wp-content/uploads/Embedded-Harm-Reduction-Evaluation-Study-Report_FINAL.pdf

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Executive Summary

Toronto is experiencing parallel toxic drug poisoning and affordable housing crises, both of which have been made considerably worse by the COVID-19 pandemic. In response to the pandemic, the City established new shelter hotels to enable physical distancing. In part, this increased residents' vulnerability to overdose as more people used alone, while simultaneously attempting to manage the social, economic, and health effects of the pandemic. In partnership with shelter operators and community health organizations, the City of Toronto introduced a suite of embedded harm reduction services into shelters, respites and shelter hotels, including increased access to naloxone and harm reduction supplies, intensive mental health case management, outreach, peer-based supports, and overdose prevention services.

This report offers an evaluation of those services and recommendations for improvements across the sector related to embedded harm reduction, by asking the following research questions:

1. How have expanded and integrated harm reduction interventions established in shelters, respites and temporary shelter hotels during the COVID-19 pandemic impacted overdose response and prevention?
2. What are the impacts of embedded harm reduction services on the physical and mental health of residents, staff wellness, and sector partnerships and accountability?
3. What are the implications and lessons learned for establishing a continuum of harm reduction services into housing and community care more broadly?

This report draws on focus groups with shelter residents who use harm reduction services, in-depth interviews with front-line staff who work in the shelters and respites, a sector-wide front-line staff survey, and in-depth interviews with leadership involved in the planning and implementation of harm reduction services. Findings are organized and presented across several themes, with each integrating data from residents, staff, and leadership.

- **Overdose response** has changed since the onset of the pandemic, with uneven observations across the sector;
    - Overall, there has been a decrease in reported non-fatal and fatal overdose events at shelters, respites and temporary shelter hotels since 2021;There is an over-reliance on Naloxone as the sole overdose intervention, whereas sites that have introduced oxygen have significantly improved response;
    - Residents are often the ones responding to overdoses;
    - There is very little trauma and grief support offered in the aftermath of overdose deaths for either residents or staff;

- Although mandatory minimum **training** standards exist, there are significant gaps in staff knowledge and preparedness;
    - There is no oversight to ensure that temporary agency staff, in particular, have completed required training;
    - Filling knowledge gaps amongst certain staff relies on the *ad hoc* efforts of other front-line staff;
    - Residents report widespread experiences with untrained staff;

  - Staff with lived experience are cited as some of the most effective staff, but are not supported to do the work sustainably;

- **Wellness checks and discharge policies** are utilized inconsistently, unpredictably, and often with harmful consequences for residents;
  - Staff power and discretion to enact wellness checks, has resulted in sexual violence, abuse, and discrimination;
  - Resident safety plans that are collaborative and flexible have been successful;

- **Access to embedded harm reduction services** has improved, but can be inconsistent and insufficiently low-barrier;
  - Overdose prevention sites embedded in hotel shelters remain particularly underutilized, partly because of limited hours, lack of resident consultation, and preferences for using drugs in private resident rooms;
  - Certain UPHNs that have been set up, especially those in congregate shelter settings, have demonstrated positive effects and uptake;

- **Partnerships** between the City, shelter operators, and community health service providers played a critical role in delivering embedded harm reduction services, albeit with some challenges establishing clear roles, responsibilities, and shared understandings of harm reduction

Based on these findings, a number of overarching recommendations were made as well as specific recommendations related to overdose response and harm reduction policies, hiring, training, and competencies, and engagement of people who use drugs.

Overarching Recommendations

1. The toxic drug death crisis in shelters is an emergency; all levels of government need to properly resource and fund harm reduction and overdose death prevention across the shelter system
2. An outside investigation needs to be conducted immediately in to the deaths, violence and sexual violence in the shelter system
3. Staff, including security and relief, engaging in violence and sexual violence need to be investigated, reprimanded and terminated
4. Healthcare access, including safer supply requires expansion across the shelter system

Overdose Response and Harm Reduction Policy

5. Overdose prevention and response strategies need to be formalized into consistent data-driven policies across the sector, rather than be scattered across various guidance documents
6. Pulse oximeters and oxygen should be available at all sites 24/7
7. UPHNs should be expanded; particularly in congregate settings
8. Peer-to-peer support services, including spotting programs should be increased
9. Grief, loss, and trauma supports for residents and staff need to be expanded

Hiring, Training and Staff Support

10. The sector must invest in and create specific hiring practices for harm reduction roles, including additional supports for workers with lived experience
11. Contract workers should be for relief only and not relied upon for regular staffing shifts
12. Site-specific overdose response protocols that clearly identify roles, responsibilities, modes of communication, and sequence of interventions are needed
13. Training in trauma informed practices, anti-violence and anti-racism must be prioritized and made mandatory across the sector
14. Clear policies at all sites need to be established in order to ensure that staff unanimously understand policies regulating drug use on-site
15. Staff retention must be prioritized through investment in more salaried positions and staff benefits, including grief and trauma support

Safety & Violence

16. Wellness check practices need to be overhauled immediately, in on-going consultation with residents, with commitments to personalized resident safety plans
17. The number of women and gender-diverse people-only shelters and spaces needs to be increased
18. All residents must be provided with a transitional care plan at discharge

Engagement of People who Use Drugs

19. People with lived experiences of homelessness, shelter living and drug use need to be included in the service delivery, planning, policy, design and implementation of embedded harm reduction
20. Opportunities and safe spaces for dialogue and knowledge exchange between residents who use drugs and staff are greatly needed moving forward with any embedded harm reduction model
21. Supervision, monitoring, and systems of accountability to prevent abuse of power by staff need to be implemented across the sector

List of Acronyms and Abbreviations

EmbHR – Embedded Harm Reduction Services

iPHARE – Integrated Prevention & Harm Reduction Initiative

M-DOT – Multi-Disciplinary Outreach Team

MOVID – Mobile Outreach Harm Reduction

SHOPP – Shelter Hotel Overdose Prevention Project

TSS – Toronto Shelter Standards

UPHNS – Urgent Public Health Needs Sites

Background

The toxic drug poisoning crisis, the shortage of safe and affordable housing and the growing need for shelter supports during and following the COVID-19 pandemic represent overlapping and urgent public health problems in Ontario. In the months following the state of emergency declaration there was a significant increase in opioid overdose related deaths across Ontario; a 60% increase in opioid overdose-related mortality was reported for 2020, as compared to 2019.[1]

As of August 2023, the total population of people experiencing homelessness in Toronto is estimated to be 9,998.[2] For over a decade, this number has steadily increased as a result of rising housing costs and lack of funding for long-term and supportive housing options. Toronto's shelter system consists of emergency and transitional shelters, 24-hour respite sites and drop-ins, and warming centres during winter months. Currently, the occupancy of Toronto shelters is at 100% with over 9,000 people using the system as of October 10, 2023.[3] During COVID-19, new shelter hotels were set up to enable physical distancing and increase shelter capacity. The emergence of new built environments in the form of physical distancing sites and hotels created specific and new vulnerabilities for overdose because of the shift from congregate settings to private rooms.

During the pandemic, there was a significant rise in the number of fatal and non-fatal overdoses in the City of Toronto's shelter system, due in large part to the overdose crisis driven by drug toxicity.[4] Other reasons for this increase included changes in the drug supply, encampment evictions, extreme poverty and fluctuations in day-to-day opioid use and loss of tolerance, and disruptions to harm reduction and social services.[5,6] In response, starting in December 2020, the City of Toronto and partnered agencies began implementing access to healthcare, overdose prevention and Embedded Harm Reduction (EmbHR) services within shelters. This includes the Integrated Prevention & Harm Reduction Initiative (iPHARE): a multi-pronged effort by the City and community partners to address opioid-related deaths in Toronto's shelter system.[7] iPHARE includes Urgent Public Health Needs Sites (UPHNS) where residents can consume drugs under trained supervision on-site, as well as enhanced intensive mental health case management supports. EmbHR services were set up and resourced during the COVID-19 pandemic.

Although these services have expanded in certain places, and continue to operate in shelters, respites, and several remaining shelter hotels, long-term funding and infrastructure has not been established. Emerging data from specific locations where a UPHNS has been set up have shown significant decreases in overdose rates including the number of overdose related deaths. Overall, the rate of reported non-fatal and fatal overdoses in the shelter system has decreased since 2022. In 2021, the rate of reported non-fatal overdoses was an average of 125 per month compared to 74 in 2022 and 71 so far in 2023. These data reflect calls to emergency services; a reduction might therefore partly be accounted for by non-fatal overdoses being responded to within on-site supervised consumption sites that do not require a call to EMS. Concurrently, there was an average of 7 fatal overdoses per month in 2021, 5 in 2022, and 4 in the first half of 2023.[8] Further studies and analyses are needed to assess potential correlations and consider external variables that affect these rates (e.g., changes in the demographic composition of shelter residents from more to fewer people who use drugs).

For this study, a team of researchers and community partners led an evaluation of EmbHR services. The findings and recommendations are presented in this report.

What We Did

This study evaluated the implementation of EmbHR services in shelters, respites, and shelter hotels in the City of Toronto. Importantly, evaluating the effectiveness of these services includes understanding aspects of shelter practices, policies, and dynamics that do not fit neatly or exclusively into the box of 'harm reduction service delivery'. These include, but are not limited to, hiring and staffing practices, organizational culture, and interpersonal dynamics. During the COVID-19 pandemic, hotels were leased and converted into shelters wherein residents could physically distance themselves in private or semi-private rooms. Since December 2020, the City of Toronto and community organizations have implemented a range of EmbHR services including increased access to naloxone and harm reduction supplies, intensive mental health case management, outreach, peer-based supports and overdose prevention services including Urgent Public Health Needs Sites (UPHNS) (Table 1). EmbHR services operate within a larger system of policies and practices that dictate what, who and how harm reduction is understood and operationalized. We have included this broader context in our analysis because it is crucial for strengthening services.

Table 1. List of Embedded Harm Reduction (EmbHR) Services offered at shelters, respites and shelter hotels during study period

Service	Description
Urgent Public Health Needs Sites (UPHNS)	Onsite Overdose Prevention Sites
Integrated Prevention & Harm Reduction Initiative (iPHARE) Teams	EmbHR/overdose response staff from partner agencies (Street Health, Parkdale Queen West Community Health Centre, South Riverdale Community Health Centre, The Works)
Enhanced Overdose Prevention Outreach	Visiting harm reduction/overdose response staff from partner agency
Multi-Disciplinary Outreach Team (M-DOT) Hotel Program	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

Methods

Researchers at The MAP Centre for Urban Health Solutions partnered with the City of Toronto, shelter operators, and community agencies to conduct a mixed-methods study. We implemented a developmental evaluation of EmbHR services. Developmental evaluations take into consideration that 1) context is always changing in complex environments, 2) clients/populations/communities are also changing, 3) learning leads to change and 4) an innovative approach to a persistent challenge has emerged.[9,10] EmbHR services emerged in the context of the COVID-19 pandemic and an increasingly toxic drug supply, and they are continually undergoing adaptations across shelter settings. For these reasons, we selected this evaluation approach.

A Steering Committee and terms of reference were established at the onset of the project to inform study design, interpretation of findings, and communication of results to wider audiences.

Partners developed a logic model (Appendix A) to identify key outcomes such as prioritizing residents' care, overdose prevention, decreasing instances of unsupervised drug use, centering the experience of workers with lived experience of drug use, and standardizing overdose and harm reduction training for staff.

Existing Harm Reduction Policies, Guidelines and Shelter Standards

The research presented in this report was conducted within a complex environment of existing harm reduction policies and practices across the shelter system. These include the following:

1. Shelter Harm Reduction Framework (2018)
   https://www.toronto.ca/wp-content/uploads/2017/10/9791-SSHA-Harm-Reduction-Framework.pdf

2. Guidance Document for Harm Reduction in Shelter Programs: A Ten Point Plan
   https://www.toronto.ca/wp-content/uploads/2021/06/9633-10PointShelterHarmReduction210528AODA.pdf

3. Updated Harm Reduction Directive (June 2021) that has been integrated into Toronto Shelter Standards
   https://www.toronto.ca/wp-content/uploads/2021/06/8e6e-Harm-Reduction-TSSdirective-2021-01RESOURCESUPDATES.pdf

Core requirements listed in these documents include 24/7 access to harm reduction supplies, training of all staff in harm reduction and overdose response, no discharge or service restrictions for substance use among clients, assessment and creation of safe physical spaces, and grief and loss supports for staff and clients.

Research Questions

1. How have expanded and integrated harm reduction interventions established in shelters, respites and temporary shelter hotels during the COVID-19 pandemic impacted overdose response and prevention?

2. What are the impacts of EmbHR services on the physical and mental health of residents, staff wellness, and sector partnerships and accountability?

3. What are the implications and lessons learned for establishing a continuum of harm reduction services into housing and community care more broadly?

Data Collection

Data were collected through multiple-site focus groups with residents, semi-structured key informant interviews with leadership (includes directors, presidents and CEOs) and frontline staff, and a frontline staff survey.

Focus Groups

Residents were eligible to participate in focus groups if they currently or previously used drugs and accessed EmbHR services at a shelter, respite, or shelter-hotel in which they lived. Seven focus groups were mixed-gender; two were women-only. Women focused groups were added when it became clear there were issues related to equitable access specific to women. Focus groups were conducted at: 2 respites, 2 shelters and 5 hotels. Topics of discussion included experiences accessing harm reduction supports, social, and health services, overdose prevention, staff interactions, discharge, and housing needs. Across the sites, an average of ten residents participated per group. Data collection took place between September and December 2022. Throughout this report, the use of 'residents' denotes those who participated in focus groups.

Key Informant Interviews

Key informant interviews were conducted with frontline staff (n=11) and individuals in leadership roles (n=9). Frontline staff participants were asked about EmbHR services at their respective sites, overdose response, harm reduction supplies, training, and staff wellness. Frontline staff interviews took place between April and June 2023. In our analysis, where possible, we have specified the type of staff for context and accuracy (i.e., shelter workers employed by the site operator versus harm reduction staff employed by a community health partner). In some cases, staff roles are unspecified in order to uphold confidentiality or because the participant providing the narrative did not know the staff's specific role or title, as was common among residents. Leadership interview topics focused on partnerships within the Toronto shelter system, harm reduction policy, practice and uptake, and funding. Leadership interviews took place between December 2022 and March 2023. All key informant interviews were conducted and recorded on Zoom.

Staff Surveys

People were eligible to participate in the staff survey if they worked at a shelter, respite, or shelter-hotel offering one or more EmbHR service. An open survey link was distributed through our community partners' listservs and by a QR code on posters distributed at different sites. The survey was open from January to April 2023. After data cleaning, there were a total of 384 unique survey participants.

Analysis

Staff and leadership key informant interviews and resident focus group transcripts were reviewed by the research team to develop codebooks which were then used to code all of the data.[11] Thematic analysis was conducted across excerpts for each code to identify salient and recurring concepts. Through an iterative process, themes were compared and contrasted within and between codes to organize findings.[12,13] Quantitative analyses focused on descriptive frequencies of key variables.

Data from the focus groups, interviews, and surveys were first analyzed separately, and then were subsequently brought together through a process called triangulation. This involved the selection of key themes across all data sets using matrices to identify meta-themes and weave the narratives together.[14,15]

What We Learned

In the following sections, data from the staff survey is presented alongside quotes from interviews and focus groups. Table 2 highlights some of the key characteristics of staff members who participated in the survey.

Table 2. Key characteristics of staff survey respondents

Variable	Total N=384	%
Current primary role		
Harm reduction/overdose response staff/nurse	104	27
Case/Housing worker	69	18
Community Shelter worker	60	15.6
Manager or Supervisor	37	9.6
Security	37	9.6
Peer (iPHARE, SHOPP/Safespot, MOVID)	27	7
Shift lead	21	5.5
Front desk/Reception	19	4.9
Other	5	1.3
Prefer not to answer	5	1.3
Primary location		
Shelter	169	44
Respite	95	24.7
Temporary sheltering hotel	90	23.4
Prefer not to answer	30	7.8
Work at more than one site		
Yes	179	46.6
No	198	51.6
Prefer not to answer	7	1.8
Harm reduction part of current role		
Yes	307	79.9
No	69	18.0
Prefer not to answer	8	2.1
Amount of time working in harm reduction		
0 to 2 years	135	35
2 to 5 years	169	44
Prefer not to answer	3	0.8

Overdose Response

One of the primary intended outcomes of EmbHR services in shelters, respites, and shelter hotels was to increase best practice overdose response capacity and to decrease fatal overdoses. Among surveyed staff, 43% said that they have noticed a decrease in the number of resident overdose events since starting in their role. One frontline staff member's experience demonstrates the conditions surrounding overdose response at the outset of the pandemic:

When I started at [my organization], we just didn't have a handle on harm reduction and it was a pretty bad time. We had quite a few deaths; people were overdosing. Usually about on average we'd get five to seven overdoses on site a week. […] We weren't providing the training to staff that they needed. We weren't providing any of the follow-up or debriefing with staff. People were very angry, very upset, very, just not wanting to be there, not wanting to engage with harm reduction a lot.

The confluence of rising overdose deaths in shelters and shelter hotels during the COVID-19 pandemic facilitated collaborative action that had previously been absent. As one organizational leader shared: "the health and the shelter system came together very quickly to address COVID and then health and mental health and harm reduction… there was a rare, concerted effort to implement and put in place supports and programs and services that had not happened in the past." Some sites introduced oximeters and oxygen as a tool for overdose response, including training in how to deploy them. As a result of this specific change in protocol, one staff member observed, "the last time we checked we had reduced emergency responses by 70 percent and we're now at, on average, maybe one overdose a month. So, the change has been huge." Nevertheless, staff and residents frequently expressed concerns around overdose response, indicating that preparedness is inconsistent and unequal across sites. In part, this is because not all sites have access to the same services, training, or staffing.

Response Protocols & Roles: Who Does What?

Narratives across front-line staff interviews, leadership interviews, and resident focus groups all indicate that overdose response is not standardized, protocols are often unclear or inconsistently followed, and roles and responsibilities surrounding overdose response are transferred or offloaded from some staff to others without clear direction from management.

In many cases, harm reduction staff—especially, although not exclusively, those hired and funded by community health organizations—are poorly integrated with shelter staff, resulting in inconsistent and unpredictable responses. One staff shared that, although they were hired as harm reduction staff, they did not have a fixed and mutually understood role in responding to overdoses that occurred on site. Instead, their involvement depended on whether they happened to be paying attention to announcements on the walkie-talkie: "Sometimes they [shelter staff] call us, sometimes they don't call us, but we get to hear from the walkie. […] So I would say it's 50/50 really. Sometimes they call us, sometimes they don't, but because we happen to be paying attention to the walkie, we hear when an overdose is being called and we respond." A security staff recalled a similar sense of not knowing when they would be asked to participate in an overdose response at the multiple sites they have worked: "for some situations [staff] ask security to go with them and some situations they ask us to leave the area. So it's all up to the staff. We are just there to accompany them or listen to them… we are not autonomous, we don't make the decisions."

Staff from various sites shared how communication between teams is often limited. When asked if residents were allowed to use drugs on site, 81% of managers or supervisors said yes, while only 62% of shift leads, 58% of shelter workers, 52% of peers, and 30% of security staff concurred. According to the Toronto Shelter Harm Reduction Directive, staff cannot prohibit or confiscate substances. There was also variability in responses based on what type of site staff worked at, with temporary shelter hotel staff having the highest affirmative response rate (Table 3).

Table 3. Are residents allowed to use drugs on site, by location type and staff role

Are residents allowed to use drugs on site?	Yes	(%)	No	(%)
What type of location do you primarily work at?				
Shelter	89	(52.7)	66	(39.1)
Respite	48	(50.5)	41	(43.2)
Temporary sheltering hotel	59	(65.6)	25	(27.8)
Prefer not to answer	14	(46.7)	10	(33.3)
What is your current primary role?				
Manager or Supervisor	30	(81.1)	5	(13.5)
Shift lead	13	(61.9)	5	(23.8)
Community shelter worker	35	(58.3)	20	(33.3)
Case/Housing worker	31	(44.9)	33	(47.8)
Nurse/Harm reduction/overdose response staff	66	(63.5)	31	(29.8)
Peer (iPHARE, SHOPP/Safespot, MOVID)	14	(51.9)	12	(44.4)
Security	11	(29.7)	22	(59.5)
Front desk/Reception	4	(21.1)	12	(63.2)

This leads to staff using their discretion to enforce (or not) their own interpretation of rules: "we [staff] don't officially say you are allowed to [use drugs on site] but you are not reprimanded for using drugs on site either, unless there are other safety hazards involved." A staff member from another site similarly shared that drug use on site is "actually a grey area because some staff says it's okay to use inside the building, because we are a harm reduction site. But some staff say, because of fire harm, like due to fire and safety regulations, you are not supposed to light up crack pipe or anything inside your room. […] So actually, we are not sure." This is consistent with the Toronto Shelter Standards (TSS), which state that clients smoking substances must do so outdoors (i.e., in areas where smoking is allowed).[16] Breaches of this specific policy were commonly cited as the basis for service restrictions or discharge by both staff and residents. In the survey, when staff were asked how often policies regulating drug use are followed, 16% responded 'every time', 18% responded 'most of the time', and 14% responded 'some of the time'. Consequently, residents expressed on-going fears of retaliation for 'prohibited' drug use and many reported experiences of actual or threatened discharge based on unclear, inconsistently, and arbitrarily applied policies.

Some of the procedural inconsistency is linked to the formation of new inter-agency partnerships that emerged when setting up EmbHR services. As one leadership participant shared while describing the early days of setting up partnerships, "I think there was a lot of struggles around health service providers coming into another organization's space and rules and relationships not being well defined from the outset… then people tripping up as a result of that. You know, so that it's whose rules are we playing by?" This sentiment is echoed by another interviewee, who likened the planning phase of EmbHR services to "your typical stormy stages;" a period of partners "getting to know each other [and trying to] understand what the roles and responsibilities were, who was in charge, you know, in the sense of situations or policy reviews." Yet another concurred, noting the challenges that partnership produced,

> *Things were implemented and then certainly my conversations with some of the leadership in the shelter system was that there were struggles with the partnership. As there typically are when you don't spend a lot of time upfront figuring out your roles and responsibilities.*

This over-lapping and unresolved role delegation seems to persist at the level of on-site overdose response and discharge policy.

Best Practices: Naloxone and Beyond

In the context of shelters or spaces where staff are trained in overdose response, pulse oximeters can be used to accurately assess a person's oxygen levels and pulse rate. Based on this data—alongside what the intervening person is observing (i.e., pupil size, skin colour, level of alertness)—staff can administer oxygen to stabilize breathing before or at the same time as Naloxone. In many cases, an overdose can be safely reversed without the use of Naloxone, which avoids putting people into potential withdrawal. In the absence of these tools (especially oxygen), the use of Naloxone is preferable to doing nothing and saves lives.[16] In most sites, oxygen, and the training to use it, is not available to staff; Naloxone is therefore the primary overdose response intervention.

When staff have responded to overdose events, there appears to be high incidence of calling EMS and using Naloxone. When asked how often Naloxone is administered when someone overdoses, 63% of community shelter workers, 58% of front desk workers, and 57% of supervisors and managers answered "every time." This compares to 30% for nurses, harm reduction, and overdose response staff. This difference likely reflects higher comfort and familiarity with the overdose response practices among nurses, harm reduction, and overdose response staff. The availability of Naloxone at shelters, respites and shelter hotels is high: 91% of staff surveyed said that Naloxone is visible and accessible. One resident shared, "[staff] carry around the Narcan kits and all that. So they're doing good on that. Most staff are good at it." Another recalled, "They've saved my life a couple of times here."

Staff survey data indicate that just over half of staff—52%—have witnessed an overdose on site. Table 4 summarizes staff survey responses to the question, "Do you know how to reverse an overdose?" The percentage column indicates the ratio of staff within that specific role that answered yes.

Table 4. Knowledge of how to reverse an overdose by staff role

Do you know how to reverse an overdose? (Total N=384)	Yes	%
Current primary role		
Manager or Supervisor	35	(94.6)
Shift lead	20	(95.2)
Community shelter worker	54	(90.0)
Case/Housing worker	66	(95.7)
Nurse/Harm reduction/overdose response staff	93	(89.4)
Peer (iPHARE, SHOPP/Safespot, MOVID)	27	(100.0)
Security	28	(75.7)
Front desk/Reception	15	(78.9)
Other/Prefer not to answer	8	(80.0)

While, overall, 43% of staff said that Naloxone is administered every time someone overdoses, only 28% said that physical methods (like trap squeezes or sternum rubs) are used every time. Only 66% of staff reported being offered Naloxone training since the onset of the pandemic (compared to 61% prior to its onset). While training is available to staff, residents described significant discrepancies in staff competence. One shared, "I find a lot of the staff here, they're not even trained for overdose response. They have no idea. There are some that are more like… [they've] been working in shelters but there's

these [other staff], I think they're from agencies or something. They have no idea what to do like in a case of an overdose. And then when they call for help, they take their sweet, sweet time to get there."

Some sites have other tools apart from Naloxone to respond to overdoses, most notably, oxygen and training for staff to use it. In the words of one leadership interviewee, "some sites have oxygen and training to use it and where it is available it is a game-changer." At sites where oxygen is available, residents and staff agree: "Oxygen training has saved so many lives. […] Oxygen changed everything."

Resident First-Responders

One of the functional outcomes of the inconsistent and unpredictable overdose response protocols described above is that residents are often the ones anticipating and responding to overdoses. 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 resident recalled a time when they responded to an overdose on site: "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."

Many residents 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." What's more, when programs aimed at paying people with lived experience to do EmbHR work were attempted, they produced "tension" at certain sites where peers were "pinpointed as 'promoting substance use' inside the shelter residence. And/or they're 'encouraging substance use' as peers and therefore their tenancy, their residency tenancy inside the shelter was threatened." Consequently, "because we [health agency leadership] know the risk of losing a shelter bed and the risk of not finding shelter bed… we felt that it would be imprudent for us to continue in those settings."

It was notable that across all leadership interviews, there was very little mention of the inclusion of people with lived experience when discussing governance and response tables, partnership planning, and program implementation and review.

Full Circle: Overdose Response as Prevention & After-Care

Overdose response extends beyond the event itself and includes trauma and grief support for residents and staff. When deaths occurred on site, residents described barriers to accessing information about residents who had overdosed: "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." When asked if services were offered following a death, there was consensus among residents that no grief and loss supports were available. For instance, when asked if anything was done on-site following the death of a resident, one focus group participant replied, "no, nothing. [A resident] dies, I got a plant. That's it. […] They sent me a plant and there was no grief [support], like nothing."

Leadership recognized the weight of grief and trauma associated with working in these settings, and conceded that it is challenging to support workers. One interviewee reflected on the gaps and challenges, "expanding mental health benefits so that people can actually utilize them is really big. We try to have either harm reduction supervisors, or site supervisors and site managers to run debriefs after

traumatic events occur—like an overdose, a death or you know, a client being violent or throwing a chair at a staff or something—to try and help mitigate some of the harms and internalization of some of these things. We try but a lot is going on so it can sometimes be a little difficult to do."

Making grief and loss supports available to staff and clients "immediately following a client death or overdose related traumatic event, and in an ongoing manner following the event" remains a part of the City's June 2021 directive to shelter providers. Among staff, 63% indicated that their work offers support for work-related stress or trauma and 64% said they have paid sick leave. When asked about their greatest personal challenges doing this work, 33% of staff surveyed responded "increased or new feelings of burnout."

Staff Training

Many of the goals related to the introduction of EmbHR services partly rely on the rollout of more in-depth and consistent training for shelter and respite staff. These include responding to overdoses with best practices and clarifying discharge policies regarding substance use on-site. Direct outcomes also include standardizing training for all staff and increasing access to overdose training and support. Our findings suggest that while certain training, including overdose prevention and response, is mandated according to the Toronto Shelter Standards,[18] whether staff are adequately prepared and supported to work in shelters and respites varies greatly in practice. This section addresses these gaps, highlights what has worked well with respect to training, and addresses the particular role of lived experience and the hiring/training of peer workers.

Training in Theory versus Practice

In June 2021, the SSHA issued a directive (#2021-01) to shelter providers which included a requirement for them to ensure that "all staff have been trained in harm reduction and overdose recognition, prevention, and response." This document also directed operators to make "all staff available, according to operational needs, to attend harm reduction and overdose related training when it is offered." As part of the broader Toronto Shelter Standards, operators are also expected to meet a number of other obligations.[14-15] Notably, these include, but are not limited to, staff training related to Indigenous cultural safety, shelter standards, crisis prevention and verbal de-escalation, and anti-racism/anti-oppression.

Data from the staff survey suggest that mandatory training policies are not being fully implemented. Despite some staff indicating, "every year we have a refresher course. De-escalation, conflict resolution, trauma informed. Yeah, several trainings." They continued, "We haven't done any this year." The following table summarizes what percentage of staff responded affirmatively that trainings were offered *before* and *since* the onset of the pandemic, in Spring 2020 (Table 5).

Table 5. Availability of staff training prior to and since the COVID-19 pandemic

Training	Prior to the onset of COVID-19 in Spring 2020 which of the following trainings were offered	Since the onset of COVID-19 in Spring 2020 which of the following trainings have been offered	Change (in %)
Naloxone training for overdose response	60.7%	65.6%	+4.9%
Harm reduction training	57.6%	59.4%	+1.8%
Trauma informed care training	39.8%	39.1%	-0.7%
Cultural safety training	28.9%	30.5%	+1.6%
Anti-racism training	33.6%	34.1%	+0.5%

These data were corroborated by data from resident focus groups, front-line staff interviews, and leadership interviews. One of the challenges raised by all groups is the functional reliance on agency relief staff. As one leadership respondent outlined, this often means that minimum training standards go unenforced resulting in negative outcomes for residents:

> *We're very dependent on [agency staff] … we give them certain requirements, they have to do this harm reduction training, they have to read this and review it. And we have no way of validating that, the agency just says, 'yup, they did it. Yup, they looked at your policies.' And we have no way of double checking that. So, they most likely didn't it seems, they just come over to the site and do whatever they want to enforce along to their own personal values which in many cases is oppressive and stigmatizing.*

Often front-line harm reduction staff are left to fill in the gaps (or not). In some cases, these staff are motivated to support their colleagues in learning about harm reduction practices—albeit in an *ad hoc* and non-standardized way. One community health agency-employed staff shared, "I always ask people, 'hey do you know the difference between a long and a short needle kit?' You know, is it an intravenous? Is it intramuscular? And, you know, you find there's actually a lot of gaps in this knowledge. Alarmingly, actually, with some people." In certain instances, this mode of informal teaching and learning was effective. One shelter staff member shared,

> *The first shift I noticed working here was when we did have the MOVID program that was coming through here. They would actually sit down with us as staff and walk through the processes, just to keep us up to date, refreshed. We would take an orange from the kitchen and practice with the needle and naloxone. Like, 'okay this is what it looks like. Crack the tube, pull it out.' […] We'd sometimes do little exercises, like being able to carry someone to a safe place. Perform certain options. When and when not to use stuff like CPR. But yeah, it's a lot of those informal trainings.*

In other cases, efforts to train across teams were not always successful. One staff shared, "we [harm reduction workers] try really hard, in my experience anyways, in the shelters that I have been in, [and]

the [shelter] staff often aren't even willing to participate or take part [in learning/training sessions]." Instances of training being well received tended to be those where staff directly utilize the skills and experience meaningful improvements in their work as a result (e.g., oxygen training).

Relying on informal intra-team education leaves significant gaps in staff knowledge—either because the individuals or groups leading those efforts leave or because some staff choose not to participate. In interviews, staff themselves highlighted a lack of training and on-going team support. For instance, one security staff said, "in my two and a half years experience, I have never attended a meeting on safety or things like that." When asked in the survey, "Do problems arise with your coworkers being untrained in working with residents?", 33% of shift leads, 22% of shelter workers, 19% of managers or supervisors, and 11% of harm reduction, nursing and overdose response staff indicated 'often' or 'always'.

As a consequence, residents expressed frustration and dismay having experienced inadequate and incompetent overdose response, in particular. One recounted, "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."

Residents and staff both recounted that Naloxone was frequently used inappropriately or unnecessarily. "Some of the times, [staff] don't even know when to administer Naloxone." For instance, one resident 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. One staff participant shared, "By the time we [harm reduction staff] get there [to a potential OD] we see the [shelter] staff maybe has already given the client four nasal already. You know, no oximeter, no oxygen, nothing."

As noted in the previous section, staff and leadership have identified the provision of oxygen and training to use it as a particularly meaningful change in their work. In the words of one staff member, "Oxygen training. Oxygen changed everything. […] The training we got, we were able to assist guests on a different level of understanding of how we can revive a guest properly without being so rushed about it."

(De)valuing Lived Experience

Despite the recognition of lived experience as being invaluable to doing harm reduction work,[20] residents described barriers in receiving the support needed to succeed in paid employment and being integrated with non-'peer' staff. One leadership interviewee noted the importance of "training and building capacity" specifically for workers with lived experience, "because, for me, the idea is if you're running a peer program, to eventually get folks to a place where they're no longer labeled as peers, they're just people who have expert knowledge who are working in the field." Another leadership participant shared:

> *We very quickly we saw how incredibly important people with lived experience or peers or ambassadors, all the different titles that were out there, how incredibly important those roles are in organizations, not just around harm reduction, just in general, creating workplaces and workspaces where people who have lived experience can work and can be supported to do good work in a good way and recognizing that that's part of the service model.*

Staff with lived experience, typically hired through partner community organizations and not the shelters themselves, described how this has not yet been achieved. Many shared how they cannot consistently get the support needed to improve harm reduction services: "there's just not buy-in, like even if one supervisor of the frontline staff is supportive, the next one won't be." Staff in peer roles further elaborated on how a lack of urgency to learn and adopt the skills and approaches needed to deliver effective harm reduction services affects them:

> *It's like okay, well we'll talk about it next month, talk about it next month. Meanwhile, my people are fucking dying, and it's like okay, I do it [harm reduction education] informally as much as I can and it's like I'm stymied by the staff because you know, a lot of the frontline staff, like I said, they're very obstructive in a lot of ways. It's almost like they want us to die.*

Despite these challenges, workers with lived experience are highly valued by residents. Across multiple focus groups, they shared that many of their best relationships with staff had been with those who had lived experience. More often, they felt disconnected and untrusting of staff without lived experience, in part because of stigma and discrimination. One shared, "I have found that there has been countless staff members that have treated me or I've seen them treat other residents as if they're lower than them because of what we're going through." Another summarized the difference lived experience makes:

> *In a nutshell, it just feels like there are the occasional staff members that are nice and you know, you may have a good rapport with them but at least in my experience there's a lot of times where it just feels like you're standing on one side of the fence, they're standing on the other and... it's worlds apart. I think that has a lot to do with a difference between having knowledge from a textbook and real knowledge from real life experience, and the people that I've connected with the best obviously are the ones that have had the real-life experience. I'm not going to go to somebody who knows about addiction purely from reading it in a book. Or what it's like to you know, to be out on the street.*

In response, some residents suggested improved training for staff, including around specialized topics, "I think staff should be having more groups. […] Like how we're having a group right now, staff should be having groups just like this but being educated by whoever would deal with those kinds of things. Educating them in PTSD training, mental health training." Frustratingly, when such training opportunities are offered, staff shared that there are sometimes challenges getting total buy-in. One frontline staff member shared, "when I do the groups, like the healthcare education stuff, the harm reduction education stuff, any trainings, [shelter] staff are welcome to come. They don't often. I have had them come a couple of time, but often they seem upset that they have to be in a group with residents."

In summary, many, although certainly not all, staff fail to be appropriately trained and supported in learning the complicated and challenging skills needed to succeed in their jobs. Concurrently, people with lived experience are recognized as some of the best workers by residents but are unable to access or sustain paid employment that adequately supports them.

Wellness Checks & Discharge Policy

When the COVID-19 pandemic led to the rapid creation of isolated shelter spaces, overdose deaths spiked.[1] In response, a system of regular room checks—'wellness checks'—was established with the goal of reducing fatalities.[19] Although they vary by site, they generally have involved staff members knocking on residents' doors at regular intervals and entering their rooms if people are unresponsive. In reality,

wellness checks have often been carried out inconsistently, abusively and sometimes violently, and in ways that stigmatize and re-traumatize residents. During focus groups, residents shared a common desire to work with staff in making safety plans that are responsive to their actual needs and circumstances. This section addresses both the challenges and opportunities related to wellness checks. In parallel, it also includes discussion of discharge policy, a set of practices with similar dynamics to wellness checks. Although discharge is not included in the category of harm reduction services or interventions, it is nevertheless related to drug use and is an important component of residents' lived experiences as people who use drugs in the shelter system.

Inconsistency & Unpredictability

A leadership interviewee acknowledged this random and disorganized system when describing the roll-out of wellness checks at the onset of the pandemic—along with subsequent efforts to improve and standardize them.

> *Originally, you may have had three, four different teams doing wellness checks. And not necessarily timed. So you might have it ten minutes away from each other. You got the nursing team doing a check. You got the harm reduction team doing a check. You got the City staff doing a check. And sometimes even the peer team doing a check. So we realized that, you know what, this is causing an inconvenience, let's shift to just one team… it doesn't matter which team, as long as we were using the same kind of guideline in our wellness check. It really didn't matter which team would do it, but it would provide peace of mind and just a better service delivery for the individual by only having one point of contact versus multiple point of contacts throughout an eight-hour period or throughout the day.*

Staff Power & Discretion

In the absence of clear and consistent protocols, it has fallen to staff to determine what their site's (or shift's) wellness checks look like in practice. This has many effects, including making the experience of checks and discharge highly unpredictable and inconsistent for residents. As one participant shared, "Everyone [staff] has a different mentality how to check on you and that is a problem." Other residents explained, "Sometimes [staff come] every 15 minutes. Three times [they'll] come by. Then sometimes [every] three hours." Another shared, "I've never overdosed… I go on heavy nods but usually when I go on a heavy nod it's because I'm tired. And I've been awake for three days because of these assholes. At one point they were knocking on our door once an hour 24/7 for two weeks straight."

A reliance on staff discretion has opened the door for both wellness checks and discharge to be used arbitrarily, causing significant consequences. One resident shared the following story:

> *I asked [staff] to do a wellness check on my husband and he told me I had to leave the property for them to do wellness checks on my husband even though I lived downstairs right below him. He was 901. I was 801. […] But he said 'no, I'm not doing a wellness check.' He got on the elevator and I heard him say to the security guards, 'if there's a request to do a wellness check on 901, don't do it.' Yeah. So they're letting people die.*

Frontline staff confirmed in interviews that they work with people who make decisions that affect residents based on personal feelings that can often be discriminatory—like in the vignette shared immediately above. One staff member revealed, "there's personal favoritism staff show towards some people. Like if two different clients are doing the same thing, then the staff might show a different

approach. […] When staff takes [things personally], it's a whole different… you know, the staff can threaten clients with discharges, so that's... that's a bad approach. I have seen staff threaten people with discharges, for simple… I don't know if I can say this, for a simple curse word." In a separate interview, another staff answered, "yes, I have seen that," when asked if they worked with people who "make things up sometimes or exaggerate to strengthen the case for discharge?" Reflecting on their time working in various shelters, a third staff shared, "There were so many power trips, because different rules, different people, I mean some shifts followed different rules, some shifts follow a different set of rules." In the staff survey, only 54% of respondents said they "never" or "rarely" work with people who discriminate against people who use drugs. While these findings are not exclusively related to the provision of harm reduction services and reflect a broader challenge in the shelter system, they have specific negative impacts on the well-being of people who use drugs. Trust, which requires mutual respect and fairness, is a necessary foundational component for effective harm reduction work, and is significantly undermined when staff exercise power in the ways described above. Harm reduction services are undermined in such an environment.

On a larger scale, when residents need to leave a shelter—because it is closing, for example—discharge is sometimes used as a threat against non-compliance. When one harm reduction staff member's site closed, they witnessed, "residents were not given any kind of say or choice in what happened to them. Very few were housed, the ones that were had to sign agreements that they would go into whatever housing they were offered. Sight-unseen. They were only telling people a neighbourhood, not even an address. If they refused it they were kicked out." In practice, wellness checks and discharge seem to share the quality of being hierarchical tools that have been used to exert power over residents, without meaningful opportunity for them to seek accountability when harmed. This challenge is similarly symptomatic of larger shelter system issues, but is crucially related to drug use to the extent that residents report threats or instances of discharge related to substance use, even when that use does not involve smoking. The discretionary nature of this exercise of power is particularly dangerous to women, for whom wellness checks have been used to enact abuse. Many women stressed the violence that this system of wellness checks exposes them to. For instance, one resident shared, "Sometimes I'd be just coming out of the shower. I'd be hearing this male voice and I be like, wait is this man… I thought a woman is supposed to be checking… and I'm naked." Another resident explained what safety meant to her as: "not have people who work here have keys to open people's rooms. […] I think it should be women staff to women's rooms only, men staff to men's rooms only." Other residents shared instances of being robbed under the pretext of wellness checks. "They [take] advantage of that little power… power is responsibility. Don't come in my room. People are missing everything. You're high, you pass out, they take everything from you. There's no questions asked. Your dope, your money, whatever you have. I've seen it with my eyes."

Part of what contributes to negative experiences with staff is the reliance on under-trained agency staff who fill scheduling gaps. One leadership participant shared, "[sites have] got all these people that are coming in and maybe are not well trained, have a lot of stigma and discrimination about people who use drugs potentially because they're coming from an agency that maybe doesn't support them around that and they just need a warm body at the shelter." Furthermore, residents shared how little support was offered to address their mistreatment. When asked if there was anyone participants could go to with their concerns, one resident spoke about a complaint box. However, they cautioned, "If you put a complaint in, they could easily check the cameras, right." Due to the lack of anonymity residents fear repercussions for lodging complaints. Even without the fear of retaliation, one staff reflected, "I saw many times where residents' concerns were not taken seriously in any way."

Wellness checks are especially triggering for people who have Post-Traumatic Stress Disorder and can be stigmatizing. 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.”

Sexual & Physical Violence

This section is a brief expansion on the above in-depth discussion of wellness checks. It is vital to recognize the role of wellness checks—which were developed specifically as part of harm reduction efforts to reduce overdose deaths—in facilitating violence against residents. The intervention has been used to exercise power, particularly over women, which has allowed for the proliferation of gender-based violence to occur under the guise of safety and wellness. Women have reported rape and physical assault due to unannounced visits, and male staff have access to their rooms. It is difficult to track when and who is going in and out of residents’ rooms because of the inconsistency and reliance on staff discretion as to when wellness checks are conducted. As a result, many women recounted having either been a victim of sexual assault by staff and residents (sometimes on multiple occasions), or knowing someone who had this experience. Women who use drugs are especially vulnerable to sexual assault, violence, and intimate partner violence.[21.] For women residents, harm reduction was defined as safe conditions to use drugs in, without the threat of physical or sexual violence.

As one staff member described how current practices contradict and undermine harm reduction: “if a security guard comes in first, and it’s a male, and it’s 4:00 AM, and if you had past traumas with men, and a lot of homeless women do—they’ve been attacked, they’ve been sexually assaulted—and now some guy is walking in your room at 4:00 o’clock in the morning. How is that harm reduction?” While this participant acknowledged the unique circumstances faced by unhoused women, their trauma is disregarded on a larger scale as wellness checks continue. Residents urged awareness and change: “the people who prey on women and use that as an excuse for them acting like a total asshole, and you know, coming into our homes or our personal space and using their authority over us, it’s not right and I think that is something that also should be brought to awareness a lot more than it is.”

Women endure assault from male residents as well with little recourse; one resident shared, “we have other guys that are up there dragging people, like dragging their girlfriends down the hallway by their hair, punching them in the face and they’re still living in this building. And the person that raped me is still living in this building.”

One woman recalled an escalated mental health check where police were called and she ended up being thrown up against a wall and handcuffed:

> *Staff was aware, even the woman who she basically is like above all of them here, she was there too. The police officer had me on the ground and she’s looking at me and I’m begging her, ‘can you tell him to get off me, can you please tell him to get off me I don’t feel, I’m about to pass out, can you please tell him.’ She’s saying nothing, she’s doing nothing.*

Another participant affirmed, "They should have never called the police to begin with." The use of physical force against residents seems to be a common response, as one frontline staff recalled, "I saw a number of people be dragged out in handcuffs because they refused to leave and go to the other shelters or housing that they didn't want to go to. I've twice seen residents be assaulted by security, like quite badly, where both times the resident were injured and needed medical care."

Acts of physical violence are not simply isolated to discharge and wellness checks. Other participants, namely women and gender diverse residents revealed being punched or having their hair pulled by security staff. In a less direct and a more psychologically troubling offense, multiple women recalled having their food tampered with so that they pass out and find themselves awake with their clothing removed. This has led some residents who participated in focus groups to avoid eating at the shelter altogether.

Not all of these experiences are directly linked to EmbHR services. Nevertheless, whether staff, residents, or police perpetrate violence, it is an important element of women and gender diverse residents' experiences in shelters and overlaps with substance use. A holistic consideration of harm reduction in shelters is therefore incomplete without grappling with violence in the system.

Whose Wellness? Better Options for Safety Planning

Residents care about their own and others' safety. They are interested in alternatives that can achieve the goal of reducing overdose risk and death and expressed frustration that wellness checks are often counter-productive. Not only do they erode trust and sometimes cause harm in the ways described above, they also regularly interrupt sleep, leading to unintended consequences: "If you're up all night you're using twice as much." What's more, one resident shared, "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." Some leadership participants recognized the failure of the wellness check system to prevent overdose deaths: "a lot of people are dying in the hotels and the private rooms because if they're not on hourly checks *or even if they are, and they use right after the check*, there's a very high chance of death given this unpredictable drug supply." Nevertheless, wellness checks are seen as a necessary measure by leadership, even when residents do not consent to them:

> *It's this balance… You know, a client's using opioids regularly but they're like 'I don't consent to these hourly checks, they're intrusive, I hate them, I don't want them happening.' Even though the person has overdosed multiple times in the past week. It's like… to what extent, do we have to respect that person's wishes or try to find a solution, like, 'okay dude, every two hours we'll come in and check on you.' Even though it might not catch everything. I mean every overdose, it's like you got to weigh it out, and it's incredibly challenging to do that.*

In such instances, when staff have worked with residents to develop personalized safety plans—which requires some measure of relational trust-building—outcomes have been positive. One resident shared the effects when shelter staff prioritized building trust, had adequate training, and took 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.

Indeed, in discussing the changing nature of wellness checks, leadership participants noted the counter-productive nature of excessive checks in the absence of meaningfully co-created safety plans. One shared that, in attempting to balance "harm reduction principles" with a "risk aversive approach" to potential overdose, residents must be engaged "to make their own choices in their safety plan when they're using." This meant making changes to a system where "we're telling the individual hey, every so often we're going to come and check with you" because staff and leadership "realized that was causing some behaviours, which we were provoking, because again, knocking on the door every 30 minutes, eventually someone's going to lose it and react." Thus, blanket approaches to checks changed in some settings, with the intention of doing intakes with all residents that addressed their safety needs around drug use. "So we changed our approach to kind of say hey, you know what, let's do an initial assessment, which we have always done, but with input of the client. They'll tell us, you know, come check on me every so often if I'm a user." In another instance, staff were supported in shifting from in-person wellness checks to phone-based checks—an alternative proposed by many residents at various sites—in consideration of "looking at [checks] through different accessible points." In reality, many residents shared that intake processes remain inconsistent and frequently do not involve discussions about safety planning.

Unfortunately, struggling to receive flexible, responsive support seems to be more common than not. When describing an attempt to be removed from particular wellness checks, one participant shared, "My health team has repeatedly called them and told them take [me] off the wellness check list. 'Oh we can't, otherwise she has to leave.' I don't use fentanyl every day. They are of the assumption that because I use needles, I only use fentanyl." When asked whether residents can request when wellness checks are performed and how often, one participant replied, "No. They just come when they want to." Not only does this model rely on arbitrary attempts to predict when overdoses might occur, it critically undermines the trust required to develop alternative safety measures that actually work.

Access to Embedded Harm Reduction Services

This section summarizes evaluation results focused on access and barriers to EmbHR services as well as gaps in services from the perspectives of residents, frontline staff, and leadership.

Residents spoke about the different EmbHR services being offered at the shelters, respites, and hotel sites. Most commonly this included harm reduction kits, access to Naloxone, and the UPHNs sites. Additional services such as the peer-based programs (SHOPP/SafeSpot), outreach and mobile services (MOVID, MDOT), and primary health care (physician and/or nurses on site or through virtual appointments) were not widely accessed by residents. In many cases residents were not aware that these services were being offered at all. Leadership participants provided a more holistic perspective on the different EmbHR services being offered, including their expansion, reach, and impact both at the individual and system-level. For staff, there was much more variability in terms of their knowledge and understanding of the services being offered and this was highly dependent on the location of their employment and their specific role.

Access to Harm Reduction Supplies

Residents described a number of barriers accessing EmbHR services at shelters, respites and temporary hotel sites. These included hours of operation, accessibility due to harm reduction office location, supplies not being well stocked over weekends, insufficient or incorrect supplies, less access to crack pipes, and inconsistencies with kits when they come from different agencies versus when they are assembled on site. As one resident shared, "They get two people to make kits. Half the time the kits, the needles are barbed because they've been opened. Half the time there's not enough needles. Half the time there's no short kits." Another resident described what happens on weekends: "They go home on a Friday afternoon at 4:00 and they're not back until Tuesday, so if everyone goes and takes it all Friday afternoon, like if everyone gets paid and everyone goes and takes them, they're out all weekend."

There was strong consensus among residents who use drugs that a lack of anonymity when accessing supplies and overall stigma and discrimination for drug use were significant barriers to engaging with EmbHR services on site. One shared their hesitation, "if you go down to the office and ask [for supplies], they're writing your name and your room number down and then you're listed." However, even this practice caused confusion due to lack of consistency. There were instances when names and room numbers were not required, but other circumstances (at times in the same location) when staff were asking for this information before providing supplies. As one resident explained, "The [harm reduction room] is the only place that you can go where you can get kits and they're not writing it [name and room number] down. If you go to the main office and you ask for a kit, they're writing down your name, your room number, and then all of the sudden you're classified, even if you're getting it one time, like you just want to do something one time, all of the sudden you're classified as a user and they're checking on you and they're looking at you like you're a pariah." For many residents, asking for harm reduction supplies at a shelter, respite, or temporary hotel changed how they were treated by staff: "they begin to look at your different, they begin to classify you. And nobody wants to be like that, and no one wants to be in that situation." According to the TSS, operators are expected to provide harm reduction supplies 24/7 and through zero-barrier access.

Access to Urgent Public Needs Sites (UPHNS)

Among staff who worked at a site where there was an overdose prevention site (i.e., UPHNS) at the time of the survey, 60% felt that it met the needs of people who use drugs; however, 61% felt the hours of operation were not sufficient. This varied according to what site the staff worked in, as shown in Table 6.

Table 6. UPHNS and the needs of people who use drugs by location where staff worked

Location	Do you think UPHNS meet the needs of people who use drugs?					
	Yes		No		Unsure	
	N	%	N	%	N	%
Shelter	46	70	6	9	14	21
Respite	26	53	9	18	12	25
Temporary sheltering hotel	18	53	12	35	3	9

Leadership also observed that UPHNS access needs to be 24 hours with sufficient funding and staffing. One interviewee noted, “we need funding for UPHNS’ to run 24/7 to provide that specifically at our open dorm shelter sites. And as well as the semi-private ones as well.” Staff and leadership described the process of UPHNS implementation within residential settings, including the challenges, impacts, and potential for expansion. Several staff and leadership participants linked decreases in overdose fatalities with the establishment of UPHNS at certain locations.

Residents’ experiences using the UPHNs at different sites were mixed. Residents and people who use drugs were not engaged in the process of establishing these spaces and the policies that govern them, representing a missed opportunity. For many residents, even when a UPHNS was available on site, they continued to use drugs in alternative spaces like washrooms, private rooms, or outside. Barriers to using the UPHNS were also linked to drug use preferences and needing space for inhalation, overall stigma, and a lack of trust with the staff operating the sites. One resident described the experience of navigating service limitations alongside the persistent stigma:

> *Yeah, well like over the last year now they have the [UPHNS] inside the building. You know, it’s not open 7 days a week so two days out of the week you still go use in the bathroom, right. But I’m just saying, a lot of people might feel uncomfortable using there because of the stigma from before. You know what I mean? Yeah, you weren’t supposed to use at all before and now you’re able to do it. So it’s just people adjusting, I guess.*

In another focus group, when asked if anyone wanted to use the UPHNS, another resident affirmed the negative affects of stigma, saying, “no, because they judge.” They also noted that neither staff nor other residents are allowed to help assist in injecting drugs, which reduced the appeal of the service to them. Improving staff training, expanding inhalation space, and increasing access to safer supply were cited as areas for improvement that would strengthen the effectiveness of UPHNS.

Partnerships & Embedded Harm Reduction

One of the primary strategies used to implement embedded harm reduction services was to initiate and strengthen partnerships between community-based agencies, health services, and shelter operators. This involves both leadership and front-line staff working with partners or colleagues with whom they previously may not have had experience.

Leadership participants commonly described how EmbHR agency partners brought a variety of approaches and belief systems to this work: “We all had the same goal but, you know, how we got there is based on our philosophies, our ideologies, our culture, and as you can imagine, when you have several partners in the same workspace cohabitating with each other.” One leadership participant reflected on how partnerships exposed agencies to new ways of working, in a way that stimulated necessary collaboration:

> *[We] looked outwards and really wanted to figure out new ways of doing things and work with partners in different sectors that historically are pretty siloed. So it was exciting really to work together with everyone. I said there was urgency so it forced us to work through the challenges quickly or just move past them and get the work done.*

Some of the challenges that needed to be worked through or moved past were a function of certain organizations having historical experience working in harm reduction, while others had significantly less.

As one leadership participant noted, “there are agencies that have been doing harm reduction for 30 years now and then there are other agencies where harm reduction is a relatively new approach to the work.” At the level of front-line staff, this sometimes made it difficult to get everyone on the same page—and therefore delivering services and applying policies consistently. One staff member shared how this served to erode trust with residents:

> *For [harm reduction services] to work, we have to build trust, we have to have consistent policies. We have to have policies that are being consistently enforced and applied which is where things get a little dicey sometimes with some of the relief and some of the agency staff, and some of our old-school staff that are just not pretty much having it.*

Staff further noted that when policies are enforced inconsistently, “it really erodes the trust [and] reduces engagement with our case managers. It reduced engagement even with MOVID and iPHARE in different ways because they think that everyone is the same and everyone is on the same page with that.” In bringing such diverse partners together, there were opportunities for mutual growth and learning, as well as hurdles to overcome because of distinct organizational cultures, values, and perspectives on harm reduction.

Balancing Act

Navigating differences across partnerships impacted the day-to-day activities of many staff. As one staff member explained:

> *I think one of the things that has become particularly salient over the last little while is that we have this sort of vague prescriptive ten-point directive that came to us from the City maybe a year-and-a-half ago now. It’s interesting to me because those directives are interpreted by different agencies differently and I think that’s a real challenge for us.*

This was especially notable when partner agency staff were integrating into shelters. As one worker shared, “there are [pre-existing] harm reduction people [at an organization] and several other [new] organizations working in our site, and each organization has a different opinion.” Another staff shared how they navigated this difference, attempting to balance multiple perspectives, “some things may come at a cost, […] balancing those pieces out to say, ‘hey, there may be situations where there might be a risk but we’re not just going to use a health and safety lens. We’re also going to apply a harm reduction lens to things.’” This balancing act was not made easier by situations where staff roles and expectations were unclear. One staff described their struggles as such:

> *So it’s just kind of like ‘okay, we’ll just figure it out’. It’s just unclear what the role is sometimes, then also just with communication with management, I think they’re not really in touch with what is happening and don’t really listen to their staff, that’s what it seems like when we do the trainings and stuff.*

This and other challenges faced by staff in performing their work are summarized in Table 7. Staff provided suggestions on how leadership could bring more clarity and consistency to the delivery of EmbHR services: “I wish organizations would talk to the security, would talk to the cleaning staff, would talk to us. They talk to management. Management does management but they don’t see the whole picture because they’re management.”

Table 7. Personal challenges faced by staff

Greatest Personal Challenges	N	(%)
Increased or new feelings of burnout	125	(32.6)
Increased workload	114	(29.7)
Lack of leadership and accountability from people in leadership roles	100	(26.0)
Keeping work life separate from home life	90	(23.4)
Lack of support with emotional and mental stress	90	(23.4)
Lack of clarity around my role	83	(21.6)
Stress around job security	79	(20.6)
Divergent views about harm reduction within the shelter system	71	(18.5)
None	28	(7.3)
Prefer not to answer	18	(4.7)

Conclusions

The overdose and toxic drug death crisis is not as recent as the COVID-19 pandemic. Nevertheless, leadership participants described the pandemic as an opportunity to urgently introduce embedded harm reduction services into shelters. While the pandemic provided a unique opening to initiate a response, it was long overdue and remains incomplete. Frustration at this fact is widespread, with one interviewee decrying the situation:

> *I want to point out that the overdose crisis was happening in the shelter for many years and that [the City] were not prepared to support that crisis and ignored it and would have been better prepared to deal with it if they hadn't ignored it and probably would have had better staff retention and less people dying. [It] should not have taken COVID to address it more system-wide.*

Importantly, much of the funding that has been allocated for embedded harm reduction services is impermanent and tied to pandemic spending. Long-term funding of harm reduction services is far from guaranteed and leadership acknowledged that some services are already being retrenched. What's more, people are still overdosing, dying, and experiencing numerable other harms while staying in shelters, respites, and shelter hotels. Practices that are evidently not working to make residents and staff's lives better continue to be used. One frontline staff elaborated on the frustration and sadness this produces, saying, "what we're doing, and it's been years now, [isn't working.] We need to figure something else out and I don't know what that is necessarily but that's been really sort of sad."

Addressing overdose also includes changing programs and policies to anticipate and prevent future overdoses. For instance, recognizing the role that supervised consumption sites can play in reducing overdose risk, one staff reflected on the need for services to respond to residents' actual needs, "Of all the urgent public health needs sites, some of them go to 9:00 o'clock at night but nobody goes overnight but us, and in tracking when people are overdosing we were finding a lot of our overdoses were happening late, like 11:00 o'clock at night until 6:00 in the morning." Residents generally indicated a desire for more supervised consumption spaces—including for inhalation—as well as an expansion of shelter-based safer supply programs.

Broadly, two processes are therefore necessary to achieve better outcomes. First, policies need to be flexible and responsive to the actual needs and circumstances of residents lives—for instance, by changing how UPHNS operate or introducing oxygen at all sites. Second, those policies need to be well understood by all staff, consistently applied, and accompanied by adequate training, support, and oversight.

Leadership respondents pointed towards the Shelter Standards as the key mechanism for establishing and enforcing minimum standards of care. Two leadership participants explained the specific importance of transforming guidance into standards; one reflected,

> *So that's [the Shelter Standards] the only kind of, strong arm technique that's available, or mechanism that's available to them but it's a good one. We had said 'this is the way we should think it [harm reduction] should happen and it was embedded in the standards'. So SSHA took the steps. […] It was built into the standards, then there were meetings with the shelter operators to say, 'this is what's going in the standard'.*

Another highlighted,

> *That's why we built it into the standards. If we had just come out with a Ten-Point Plan and said, 'you should be doing this, […] that shelters should be doing that', you know they could take it or leave it. Which is why we wanted all of this built into the standards.*

When City policies are updated to reflect best practices or new evidence—and mandated as standards—they are often not implemented. The City regularly assesses TSS implementation through a Quality Assurance Team and undertakes Harm Reduction Overdose Preparedness Site Assessments to support shelter operators in adhering to and implementing harm reduction standards. The gap between these processes' intended outcomes (i.e., to ensure and support compliance) and site-level realities described by staff and residents is important to note. In the words of one front-line staff member, "I saw many times where residents' concerns were not taken seriously in any way. Staff being belligerent with residents, threatening them with restrictions for the smallest infractions or even straight up restricting them or phoning the police over nothing. And it seems like the Shelter Standards Act and the Ten-Point harm reduction plan isn't really being followed in most case." In reflecting on the relationship between policies and the reality of the shelter system, another interviewee shared, "I would love for the shelters to fully and properly follow the Shelter Standards act. That would be freaking awesome."

These dual challenges of both producing appropriate and effective policies, and then ensuring that they are enforced by competent and well-supported staff require a range of interventions. The recommendations for action outlined in the next section address these challenges, as elaborated and described in this report. Change is both necessary and possible.

Recommendations

Overarching Recommendations

1. The toxic drug death crisis in shelters is an emergency; all levels of government need to properly resource and fund harm reduction and overdose death prevention across the shelter system
2. An outside investigation needs to be conducted immediately in to the deaths, violence and sexual violence in the shelter system
3. Staff, including security and relief, engaging in violence and sexual violence need to be investigated, reprimanded and terminated
4. Healthcare access, including safer supply requires expansion across the shelter system

Overdose Response and Harm Reduction Policy

5. Overdose prevention and response strategies need to be formalized into consistent data-driven policies across the sector, rather than be scattered across various guidance documents
6. Pulse oximeters and oxygen should be available at all sites 24/7
7. UPHNs should be expanded; particularly in congregate settings
8. Peer-to-peer support services, including spotting programs should be increased
9. Grief, loss, and trauma supports for residents and staff need to be expanded

Hiring, Training and Staff Support

10. The sector must invest in and create specific hiring practices for harm reduction roles, including additional supports for workers with lived experience
11. Contract workers should be for relief only and not relied upon for regular staffing shifts
12. Site-specific overdose response protocols that clearly identify roles, responsibilities, modes of communication, and sequence of interventions are needed
13. Training in trauma informed practices, anti-violence and anti-racism must be prioritized and made mandatory across the sector
14. Clear policies at all sites need to be established in order to ensure that staff unanimously understand policies regulating drug use on-site
15. Staff retention must be prioritized through investment in more salaried positions and staff benefits, including grief and trauma support

Safety & Violence

16. Wellness check practices need to be overhauled immediately, in on-going consultation with residents, with commitments to personalized resident safety plans
17. The number of women and gender-diverse people-only shelters and spaces needs to be increased
18. All residents must be provided with a transitional care plan at discharge

Engagement of People who Use Drugs

19. People with lived experiences of homelessness, shelter living and drug use need to be included in the service delivery, planning, policy, design and implementation of embedded harm reduction

20. Opportunities and safe spaces for dialogue and knowledge exchange between residents who use drugs and staff are greatly needed moving forward with any embedded harm reduction model
21. Supervision, monitoring, and systems of accountability to prevent abuse of power by staff need to be implemented across the sector

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Appendix A

Embedded Harm Reduction Services Logic Model

Problem Statement

Overdose prevention and response and embedded harm reduction supports are needed within sheltering places for people experiencing homelessness. Expansion of services is urgent given the current environment of COVID-19, drug toxicity, lack of housing, poverty and mental health impacts. Carrying out this work requires a collaborative, integrated model that is safe and equitable for all staff and residents. We need to better understand how embedded harm reduction supports, that have been part of an emergency pandemic response, can be strengthened, expanded and appropriately resourced moving forward.

Context

- COVID-19 guidelines around physical distancing and isolation and new built environments in the form of hotels exacerbate the risk of overdose
- Ongoing and accelerated rates of overdose deaths
- Increase in drug toxicity
- Funding is not sufficient or sustainable; resources linked to COVID-19
- Provincial policy barriers such as capped number of CTS and no funds for UPHNS
- Challenges bridging health and social service sectors and jurisdictions
- Ongoing despair and anxiety around housing and uncertainty around future of shelter-hotels
- Staff shortages; increased turnover and burnout
- Lack of mental health supports for staff and clients
- Lack of trauma-based education
- Lack of harm reduction training
- Lack of surge capacity in addition to overall capacity mentioned above
- Limited model of Safer Opioid Supply and slow uptake and support among prescribers
- Fewer beds (detox and shelter) available and longer wait times
- Ongoing violence and thefts in shelter systems
- Geographical location of sites means isolation from other services and community
- Resources are mostly congregated in the downtown of the city
- Remote appointments are difficult for many without devices or data
- Premature or inappropriate referral to housing without supports which leave people vulnerable to harms
- Intake and monitoring procedures are outdated and not consistent across the sector
- Lack of culturally safe supports for Indigenous people
- Transphobia from staff, security, and residents leads to unsafe environments for trans people
- Insufficient ODSP and OW rates to support quality of life

Strategies

Partnerships

- New and stronger partnerships between harm reduction agencies and shelters have developed
- Partnerships have highlighted which agencies are more resistant and areas where they need to evolve
- Increased understanding of HR approach
- More access to training opportunities
- Identified where SSHA policy needs changing and where partner policy and approaches can integrate harm reduction more holistically

Staffing and Training

- More harm reduction workers and peers
- More case managers and staff support around housing applications
- PWLE informing aspects of client-centred care
- Training and education around cultural sensitivity
- Overdose recognition and response training, naloxone, oxygen and BMV training

Program and Service Changes

- Buddy System
- Onsite supervised and witnessed consumption
- Access to OAT, safer supply and HR supplies
- Referrals to managed alcohol, nicotine replacement, anti-craving medications
- Embedded nursing care and mental health supports
- Social recreational opportunities
- Connection to peer opportunities
- Access to food

Assumptions

- Allowing individuals to use drugs on site and supporting them directly on site will reduce risk of overdose and other harms
- Identifying shared values and goals at outset helped move through the difficult conversations
- Integrated services and multi-disciplinary knowledge exchange is a critical part embedded harm reduction in residential settings
- Partnerships and collaborative work require built in time to make sure there is a shared understanding of the vision and expectations
- Integrated model will require accountability around existing standards and practices and will support shelters to advance these practices as needed
- Service delivery is most effective when shelter and community organizations work together (e.g. a coordinated model may help clients get services faster)
- Long-term funding and planning is required for an effective response (as opposed to short-term emergency Band-Aids)
- Quick expansion of services means that t trusting relationships on the ground have not yet formed
- Clients avoid sites because of concerns about COVID-19
- Staff attrition and burnout have significantly impacted the quality of care and have been caused by the pressures frontline workers face during the pandemic
- Prioritizing client-centred care in substance use and shelter settings will have better outcomes
- When staff are better equipped to plan *with* residents, safety will improve for all

Outputs/Short-term Outcomes

Primary Program Output

- Increased capacity to respond to overdose using best practices
  - decrease in fatal overdoses
  - increase in aversion of overdoses
- Decrease occurrences of people using alone
- Eliminate instances of shelter staff discharging residents for using onsite
- Fewer drug-use related discharge
- More OPS that are supported by PWUD
- Increased access to case management and mental health support
- Increase access to the services, support and treatment *of their choice*
- Increased access to safer supply and drug checking
- Increased access to MAP
- Increased access to to HR supplies, overdose training, naloxone
- Increased standardized training for all staff including peers and people with lived experience
- Increased integration of peers
- Faster on-site referrals

Secondary Outcomes

- Less turnover and burnout of staff
- Increased mental health and grief support for staff
- Increased knowledge and skills for housing workers and case managers
- Greater opportunities to offer connection between residents, not with just staff but with other community members
- Increased funding and political support for long-term planning
- Break down siloes between clinical care and harm reduction

Anticipated Long-Term Outcomes

- Reduced overdose deaths in the shelter system
- Improve overall health outcomes for service users
- Increased centering of lived experience and experiential workers
- Informing harm reduction as a spectrum of supports, not just a singular intervention
- Developing enhanced harm reduction capacity (skills, understanding, confidence, leadership) among shelter providers (staff and management) at sites where programs were implemented
- Strong, trauma-informed harm reduction policies across all shelter sites that include human resources like hiring criteria, professional development requirements, job reviews, etc.
- Supporting the establishment of a community of practice among service providers
- HR services that are tailored to meet unique needs for all gender, sexual, racial, and ethnic identities
- Increased ability to advocate for decriminalization, decarceration, housing etc. through collaborations and partnerships
- Secure, flexible, long-term funding
- Increased public and political support (e.g. through anti-stigma and harm reduction education in our school systems)

Long Term Vision

- Expanded and diversified substance use services to provide holistic care and reduce fatalities
- Harm reduction approach embedded into community care and political arena, including but not limited to the decriminalization of drugs
- Continuum of HR into housing and community care
- Meaningful participation of PWLE in decision making on relevant issues e.g. HR and drug policy