Harm Reduction and Shelters:

A jurisdictional scan of harm reduction initiatives in Canadian shelters

Shila LeBlanc for Out of the Cold Emergency Shelter
K'jipuktuk (Halifax, Nova Scotia, Canada), November 2018

OUT OF THE COLD

Out of the Cold (OTC) Emergency Winter Shelter is a community-based, volunteer-run organization that works to provide shelter and community supports to people who are homeless and precariously housed. This shelter has been running since 2008 and operates for 5 months a year.

THIS PROJECT

The purpose of this jurisdictional scan is to ensure that OTC is using best practices in the area of harm reduction. This scan involved the following: a literature review of existing research on harm reduction, a review of available grey literature such as policies, procedures, and programs for shelters in Canada, a review of Canadian legislation relating to substances and sex work, interviews with 11 people who have specifically worked in a harm reduction model, and coding and synthesis of this information to create the action steps proposed below. Five recommendations are made based on what was found in this research.

This report also strives to be written in an accessible way, using plain language and hyperlinking to all supporting documents to increase the accessibility of sourced information. Language that reduces stigma is also used to support the humanization of all people, which means that this report will use only "people who use drugs", instead of "drug users" or other terms that reduce people to their substance use. Releasing this as a digital document also allows for flexibility in editing should updated information become available. Shila LeBlanc is a settler in K'jipuktuk (Halifax) and works as a restorative justice caseworker in the city. Correspondence can be sent to shilaleblanc@gmail.com.

For a shorter, bite-sized version of this report, read the **executive summary here.**

ACKNOWLEDGING THE LAND

It is vital to recognize that this report was written in Mi'kmaw'ki, the ancestral and unceded territory of the Mi'kmaq People who have lived on this land for over 13,000 years. We all have the privilege to live and work on this land, and we are all treaty people. This territory is covered by the Treaties of Peace and Friendship, which Mi'kmaq, Wəlastəkwiyik (Maliseet), and Passamaquoddy Peoples first signed with the British Crown in 1726. The treaties did not include surrender of lands and resources, but in fact recognized Mi'kmaq and Wəlastəkwiyik (Maliseet) title and established the rules for what was to be an ongoing relationship between nations. To learn more about reconciliation, there are 94 calls to action as outlined by the Truth and Reconciliation Commission of Canada.

INTRODUCTION

Understanding Harm Reduction

Harm reduction or harm minimization refers to policies, programs, and practices that aim to reduce adverse health, social, and economic consequences of harmful behavior. The Canadian Harm Network, The Canadian Drug Policy Coalition, The Canadian Mental Health Association, and Harm Reduction International are some examples of organizations advocating for increased harm reduction initiatives in all communities. Generally speaking, the medical profession itself works from a harm reduction model.

Harm reduction efforts most commonly focus on legal and illegal substance use, but can also be applied more broadly to situations that pose risk to community members. Harm reduction focuses on safety and does not necessitate a reduction in substance use or the cessation of risky behavior in order to access support. Instead, a harm reduction approach asks:

What are the risks and harms of a particular behavior (i.e. substance use)?
What causes those risks and harms?
What can be done to reduce these harms?

From this perspective, interventions are created to specifically target adverse outcomes.

Harm reduction policies are typically evidence-based, cost effective, and practical in their implementation. This view celebrates positive changes that individuals make, regardless of how small, and recognizes the importance of meeting people where they are in their lives instead of holding them to unrealistic standards. Respect for choice and agency is central. Harm reduction focuses on prioritizing urgent needs first (i.e. keeping people healthy) while still supporting less likely but important outcomes (i.e. abstinence with substances). Realistic interventions ensure that irreparable harm is minimized (i.e. avoiding HIV transmission) so that recovery is always an option down the road.

More broadly, harm reduction approaches strive to be person-centred, compassionate, and non-judgmental. People who engage in risky behavior are still valuable community members. People who take risks deserve to have their human rights defended. This approach works to reduce stigmatization and stereotypes by humanizing all people.

Harm reduction also values transparency and accountability for practitioners and decision makers regarding their interventions. Harm reduction initiatives are best when they encourage ongoing discussion, consultation, and debate, especially with people who engage in risky behavior themselves. Best practice in harm reduction initiatives are created in close conjunction with the people accessing the services.

In the broadest sense, effective harm reduction initiatives can work to challenge existing policies and legislation that may increase harm. As public support grows in support of harm reduction, more people are able to successfully implement their own models, increasing access to safe and sane initiatives for all.

Common examples of harm reduction

Harm reduction approaches can be applied in a wide variety of contexts. Some of the most common efforts relating to harm reduction are:

- *Needle exchanges, overdose prevention sites, and safe injection sites:* Harm reduction often focuses on ensuring people use drugs safely. This can include having access to clean needles (to minimize transmission of HIV, hepatitis, infections, overdose, and other harmful outcomes), support and education around safe injection, and the creation of safe/supervised injection sites to ensure that people are safe while using. CBC has reported about the difference between overdose prevention sites and safe/supervised injection sites, the main difference being that overdose prevention sites are not permanent.
- *Substance replacement therapy:* Replacement therapies are administered to replace illegal substances (highest risk) with legal, longer-lasting and less euphoric ones (lower risk) to limit negative health experiences in withdrawal and detox. It can help those struggling with addictions to find stability as this method works to slowly reduce dosages. This is often done with medical supervision. This can include interventions like nicotine patches for smoking addiction and methadone replacement therapy for opioid addiction.
- *Overdose prevention supplies:* There are many ways to reduce the likelihood of an overdose. Naloxone is a great example of a substance that is proven to block the effects of opioids during overdose and extends the time emergency medical services have to intervene. Naloxone has saved countless lives. Administering oxygen during overdose is another example of overdose prevention that can help mitigate negative health outcomes. Drug testing kits (such as Reagent tests) are also helpful, as they allow people to test pills to ensure that they are not laced with strong substances like fentanyl.
- *Safe sex supplies:* Having condoms, lube, and pregnancy tests easily accessible is a common way to ensure that people can have safer sex. Harm reduction in relation to sex work can also include access to rapid result HIV and STI testing.
- *Outreach, education, counselling and health promotion:* Making sure that people have accurate information to make informed choices is a cornerstone of harm reduction and can be implemented in wide-reaching ways.
- *Access to basic needs:* Food, clothing, drinking water, pads, tampons, and shelter can be important pieces in a harm reduction model. When basic needs are taken care of, individuals are more able to address broader issues they are facing.

Existing evidence versus critique

A common criticism of harm reduction is that it condones and enables "problematic" behavior and creates the perception that certain behaviors can be done safely which can encourage people to continue addictive behaviors without deterring them from it. A 2008 report by the Canadian Centre on Substance Abuse which looked at language around harm reduction stated:

> *"Harm reduction" has evolved into an emotion-laden designation that has polarized groups with a common goal and is interfering with opportunities to engage high-risk populations and the implementation of a range of substance abuse services and supports.*

The report also noted that it was vital to minimize harm due to misperceptions and inaccurate information around what constitutes harm reduction, and urged service providers to use evidence-based programs, policies, and interventions regardless of shifting labels applied to the work. There is extensive empirical evidence to show that harm reduction reduces negative outcomes and supports people in their recovery.

Research supporting harm reduction has been consistent in its findings since the 1980s. In 2003, Hunt looked at almost 300 studies related to harm reduction. He found that harm reduction interventions are proven to work and should be accessible to all. He concluded that harm reduction initiatives should be expanded with ongoing evaluations to make sure that efforts are meeting the needs of specific local contexts. In 2007, an extensive report by the Institute of Medicine found that contaminated injection equipment (i.e. dirty needles) were a driving force of the global AIDS epidemic and a primary mode of HIV transmission in many countries. This report advocated heavily for needle exchange programs. In 2016 The College of Family Physicians of Canada examined existing evidence on safe injection sites and found that they resulted in lower overdose death, 67% fewer ambulance calls for treating overdoses, and a decrease in HIV transmission.

The failed "war on drugs"

In Western society, the most common response to drug use has been increasing law enforcement. Yet extensive research has shown that this approach has done little to decrease substance use and illegal behavior. Kerr, Small, and Wood (2004) have shown that increased policing to address illicit substance use negatively impacts health and social outcomes, and can disrupt people in their recovery. Heavy policing has also been shown to increase risky behavior associated with infectious disease transmission and overdose, exposing communities to the harms associated with illicit drug use. These researchers found that the alternatives to targeted law enforcement have potential for less negative health and social consequences and greater potential for healthier communities. The report recommends harm reduction services as a way to

address drug-related harms, and recommends accessible addiction treatment as a way to reduce the demand for illicit drugs.

Because of overpolicing, fear of criminal involvement means that people who use drugs may be fearful of reporting overdoses. In May 2017, the federal government created the Good Samaritan Drug Overdose Act, which provides amnesty for people who overdose or who contact 911 to report an overdose. It means that those who report an overdose cannot be charged with possession and breach of conditions like parole or probation related to substance use. But as CBC reported in August 2018, people who use drugs are still scared of negative interactions with law enforcement.

In their case for reform, The Canadian Drug Policy Coalition states:

> *Canada still relies heavily on criminal law to deal with drugs such as cannabis, cocaine and heroin. Over the past century, successive federal governments have expanded the number of prohibited substances, removed procedural protections to make it easier to convict individuals of drug offences, and introduced mandatory minimum sentences for many drug offences. Parliament has enacted these measures despite the steady growth of compelling evidence that the criminal law increases many of the harms experienced by people who use drugs, and fails to stop the supply or demand of drugs.*

In 2016, The National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances reviewed a national substance use plan created in 2005 and found that although there has been some progress in changing perceptions around substance use in Canada in recent years, national and provincial legislation continues to view substance use as a criminal justice issue instead of a public health one. The updated vision for this national framework is of a society where people use substances safely, that a fair balance between safety and personal freedom is found, and that society ensures optimum health and happiness for those who use drugs.

In this study, multiple frontline workers discussed how challenging it is to work with people who are continually criminalized in periods of active addiction, particularly if they have probation or parole conditions barring substance use. One shelter worker explained that a man accessing their shelter had received almost 200 tickets for public intoxication, and was in a chronic cycle of jail to shelter and back. The criminalization of his addiction made recovery impossible, and his legal and financial troubles as a result of his criminalization compounded the barriers to him accessing the services he needed.

The physiology of addiction

It is important to remember that people who use drugs may have a physiological dependence on substances, and messaging about making better choices or "just saying no" is judgmental and unrealistic. There is ample research analyzing the transition from drug use to abuse to addiction, including many neuroscientific understandings of addiction, like research by Hermano and Roberto (2015). In 2010, Gould researched addiction and cognition and found that substance use can create future cravings and drug-seeking, and that continued use can result in cognitive deficits that negatively impact a person's ability to be abstinent from drugs, even after a long period of sobriety. He noted that developing brains (that is, prenatal, childhood, and teenage brains) are more susceptible to the impacts of drug use, and that people with mental illness are at a higher risk as well.

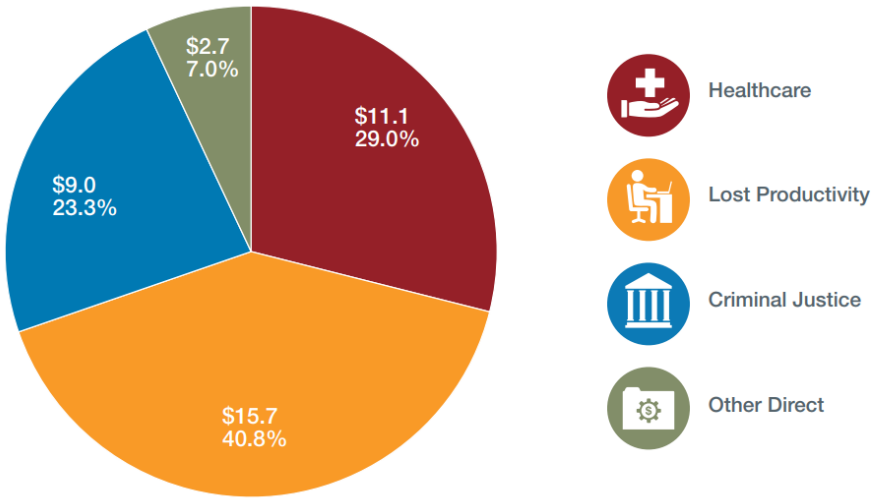
Any expectations of sobriety when people are addicted to substances is far from best practice and at worst, dangerous and life-threatening.

Government inaction despite evidence

Even for legal substances like alcohol, governments continue to uphold punitive approaches like taxation and controlled access, and investment in harm reduction initiatives, support, and treatment is marginal. This is despite explicit messaging from the federal Canadian government acknowledging that alcohol is an important public health issue for Canadians.

In 2012, the Canadian Centre on Substance Use and Abuse noted that because Canadian liquor authorities report to ministries of finance or economic development, focus on profit overshadows issues of public health and safety when making decisions about the supply and pricing of alcohol. This report shows that Nova Scotia has an alcohol regulatory system that is both public and private, and that liquor retailers report to the Ministry of Finance, not the Minister of Health. This report also found that most jurisdictions in Canada experienced a net financial loss due to alcohol when looking at not just alcohol revenues, but the cost of policing, healthcare, and loss of productivity. In 2015 The Government of Canada released a massive report on alcohol use, showing that alcohol is the most used substance nationally aside from caffeine.

The cost of substance use for Canadian taxpayers is staggering. A study by University of Victoria and the Canadian Centre for Substance Use and Addiction found that substance use cost $38.4 billion (CAD) in 2014. This table shows the breakdown of this cost:



Total cost: $38.4 billion

Canadian Centre on Substance Use and Addiction

The "other direct costs" category can mean things like fire damage and car crashes, but also direct costs like research and prevention. In 2014, only **0.5% of the 38.4 billion dollars for substance use was invested into research and prevention.** That same year, 67, 515 people died in relation to substance use. Of the 38.4 billion dollars spent, the vast majority of spending was on reactive and punitive measures (health care and criminal justice). Meanwhile, research demonstrating the cost-effectiveness of harm reduction initiatives continues to grow. One study by Bayoumi and Zaric (2008) showed that tens of millions of dollars and close to a thousand lives could be saved in Vancouver with a supervised injection facility. Another study by Jozaghi, Reid, and Andresen (2013) found that funding safe injection sites in Montreal would be an efficient and effective use of financial resources in the public health domain compared to status quo funding.

Changing politics, changing policies

The Government of Canada's national report on opioid-related deaths is astonishing. From January 2016 to March 2018 there were more than 8,000 opioid-related deaths. Statistics Canada released a report stating that from 2016-2018, 10 people died each day from an overdose due to illicit substances. The death toll is so significant that CBC reported that Canadian life expectancy may be decreasing as a result of opioid death. But political will is needed to change reactive funding structures. Despite decades of Canadian research supporting harm reduction, a change in political power can create chaos for existing harm reduction work provincially. This creates uncertainty for organizations providing important frontline services, and can mean life or death for a person who is using at the time of political change. In a 2017 study looking at the past, present, and future of Canadian supervised injection sites, Kerr, Mitra, Kennedy and McNeil found that despite extensive evidence in support of safe injection, **extraordinary and ongoing efforts were needed by local activists and health care workers in order to run and maintain safe**

injection sites. This report called for amended federal legislation so that safe injection sites do not face a constant uphill battle to simply exist.

Vancouver is leading the way for harm reduction in Canada, and in 2016 the BC Centre for Disease Control declared a state of emergency in response to an 80% jump in overdose deaths due to opiods. This declaration meant that it became easier to collect and analyze data in relation to opioid use and death and signaled a sense of urgency and support for harm reduction programs provincially. Today, information about harm reduction services is clearly listed on the city's official website, nested under the "Healthy Vancouver" label. Vancouver has many safe injection sites currently offering services, and has implemented progressive services like peer programming and drug testing, as reported on CBC (2017).

Yet in Ontario, there is ongoing conflict around harm reduction initiatives despite research showing that it is beneficial for the province. In 2006 an extensive report by Strike, Leonard, Millson, Anstice, Berkeley and Medd was written on best practices for needle exchange programs in Ontario. One report from University of Toronto (2012) found that Toronto and Ottawa would benefit from supervised injection sites and gave specific recommendations for how to implement them in local contexts. In 2017 a report written by Kerr, Scheim, Bardwell, Mitra, Rachlis, Bacon, Murray, and Rourke found that 86% of people injecting drugs in Ontario were willing to use a safe injection site, and 65% of their participants were injecting substances on a daily basis. There is a 2018 Ontario report by Taha for best practices for opioid treatment which includes emphasis on harm reduction initiatives. But as recently as August 2018 there was conservative political pushback against supervised injection sites, led by premier Doug Ford, with politicians inaccurately stating that the data on supervised injection was inconclusive. This created uncertainty for existing sites, like one in Guelph, Ontario, who feared that closing would mean an increase in overdose deaths. In August 2018, 120 organizations signed an open letter to Doug Ford urging him to support safe injection, and in September 2018 Canada's federal health minister publicly stated that she hoped Doug Ford would make an informed decision in support of safe injection. Luckily in October 2018 conservatives conceded that supervised injection sites will continue to be funded, but with a change in name to "Consumption and Treatment Services," perhaps to create distance between their initial campaign platform which was explicitly opposed to safe injection sites.

> In this study, respondents from both BC and Ontario discussed cutting edge harm reduction projects happening provincially. In BC there are exciting projects underway, including safe consumption sites for inhalation and peer-assisted injection support to minimize harmful injection.

Nova Scotia has consistently lagged behind in the area of harm reduction. In Halifax there have been attempts to set up safe injection sites for many years. In August 2018, CBC reported that

Direction 180 may finally achieve this, noting that previous attempts have consistently stalled. In September, Direction 180 led a community discussion about the site, as reported in The Star. The executive director Cindy MacIsaac of Direction 180 noted that from April to September 2018 (a six month period), 241, 854 needles were distributed in their needle exchange program. She also noted that peer backpackers (staff who do community outreach) find around 10-15 needles a day that are unsafely discarded out in the community. Some of those needles have been found around schools. When there are no safe spaces to use and no safe space to discard needles, they can end up in dangerous places. With the implementation of a safe injection site, people in Halifax will finally be able to use in a safe space, complete with sharps containers and other life-saving tools.

There is ample research showing that needle exchanges dramatically reduces unsafe needle disposal. In 2004, Ksobeich did a literature review titled "Return Rates for Needle Exchange Programs: A Common Criticism Answered", and found an overall worldwide return rate of 90% for needles. Another study by Tookes, Kral, Wenger, Cardenas, Martinez, Sherman, Pereyra, Forrest, Lalota and Metsch (2011) found that there were **eightfold** more improperly disposed needles without needle exchanges in San Francisco. Public spaces are safer with needle exchanges.

Federally speaking, there has been some movement to support harm reduction. Facing increasing pressure around the opioid crisis in Canada, the liberal government made significant changes to the application process for safe consumption sites in December 2016, shifting away from the conservative government's 26 point application process. Bill C-37 was amended so that organizations could get exemptions from the Controlled Drugs and Substances Act for safe injection sites. The application to open a site is now easily available online, requiring only five benchmarks:

1. Demonstration of the need for such a site to exist.
2. Demonstration of appropriate consultation of the community.
3. Presentation of evidence on whether the site will impact crime in the community.
4. Ensuring regulatory systems are in place.
5. Site proponents will need to prove appropriate resources are in place.

Additionally, some provinces are starting to allow overdose prevention sites, which are short-term, temporary sites that offer a range of services similar to safe consumption sites. These sites are easier to open when a public health emergency is called. Vancouver Coastal Health has a detailed manual for opening an overdose prevention site in BC (2017). Ontario's Ministry of Health and Long-Term Care released a similar guide in 2018. Nova Scotia has no such guide, but there are other ways that communities can prevent overdose. Pauly, Hasselback, and Reist with University of Victoria also released a public health guide (2017) to developing a community overdose response plan which guides community members to find safer ways to meet the needs of people using drugs, even if there is not an explicit overdose prevention or safe consumption site in operation. Community activism and organizing can reduce overdose risk.

The reality is that there are many safe consumption sites in Canada, and many provinces are working to increase this number, all backed by extensive evidence in support of this model. The Government of Canada has a list of all current sites including sites who are going through the application process currently.

Shelters and harm reduction

The Canadian Observatory on Homelessness found that in 2016, 35,000 Canadians were homeless each night. Homelessness can be greatly reduced, and Medicine Hat is a great example of what can be gained by implementing a housing-first strategy. Three years in, Medicine Hat has maintained its goal of ending chronic homelessness, and the project has had more benefits than even expected (as reported on CBC). Yet until governments start investing in housing first strategies, shelters will remain a primary service for people experiencing homelessness or precarious housing.

People who are experiencing homelessness may be experiencing addictions, mental health concerns, may engage in sex work, and may have a history of trauma. Because of this, harm reduction initiatives in shelters are vital. A 2017 report by the Shelter, Support and Housing Administration in Toronto stated:

> *Stigma, discrimination and the isolation of people who use substances has impeded important connections and relationships with service providers who play a crucial role in supporting people to access housing. This has created layers of additional barriers to housing for an already vulnerable and marginalized population.*

Additionally, shelters are part of broader systems in society, and these systems can perpetuate structural violence. Rylko and Farmer (2017) in Structural Violence, Poverty, and Social Suffering put it well:

> *[...] poverty is a complex phenomenon linked to other forms of social, political, and economic inequities and often rooted in long-standing, historically determined social structures. The analytic framework of structural violence focuses attention of mechanisms that support poverty and other forms of inequity, highlights the interdependence of these structural factors and their relationship to other forms of violence, and identified the ways by which they cause unequal distribution of harm.*

If shelters themselves are willing to acknowledge the systems they uphold, the capacity to improve services increases. As Taylor (2017) explored in a postdoctoral thesis about structural violence and street involved youth, using a structural analysis allows people to step back from an individual-level understanding and instead to macro-level analysis of systems and the harms they

may perpetuate. This view runs countercurrent to our dominant discourses which focus on singular people and individual failings in responsibility. A systemic understanding allows us to understand why individuals may end up in challenging situations. Shelters themselves must be willing to examine the social structures that create a need for shelters to begin with.

Even if organizations themselves are not considering opening an overdose prevention or safe consumption site, there are many barriers that can be easily reduced to make spaces safer and more dignified for people accessing them.

The evidence shows that harm reduction works, and that laws and policies designed to control substance use need to change. Many existing policies and laws in Canada intentionally or unintentionally create and even increase risks and harms for drug use and risky behavior. Punitive laws, criminalization of drug use and addiction, and the denial of life-saving harm reduction services are barriers to a safer society. Policies and legislation must support individuals in changing their behavior.

Trauma Informed

Although it is outside of the scope of this report, trauma-informed care goes hand in hand with harm reduction initiatives. The Nova Scotia Health Authority released a report in 2015 outlining ways to become more trauma informed in service delivery. A 2009 study by Fallot and Harris (2009) found that 55-90% of the Canadian population has experienced one or more forms of trauma in their lives, and individuals report an average of five traumatic events in their lifetimes. A trauma-informed approach works to create spaces and services that foster safety and connection, and assumes that people may have a history of trauma, unlike traditional approaches which assume the opposite and can be re-traumatizing. As found in the 2016 report from the Canadian Observatory on Homelessness, people experiencing homelessness have disproportionate exposure to traumatic events.

> In this study, one respondent put it well when discussing the connection between trauma and substances: "The key is to ask why the pain, not why the use."

It is vital that shelters and their staff use best practices in supporting people as they seek stability. This report will now explore what emerged from a series of interviews with 11 people who have worked within a harm reduction model.

RESULTS AND 5 RECOMMENDATIONS

We were grateful to hear from such knowledgeable people in this study. The respondents include experts in the field, academics, front-line workers, people with lived experience, and

people in the medical field (who are listed below). There were five main themes that emerged from the qualitative interviews. From these themes, this report makes five recommendations.

RECOMMENDATION 1: Reduce all barriers

The strongest theme that emerged in the interviews and research was that harm reduction initiatives need to be as barrier-free as possible. This means reducing physical barriers to supplies and also working to create streamlined services that meet the needs of the people using them.

Here are some commonly identified barriers in a shelter setting as found in the interviews and research, and ways to address them:

Barrier	Rationale	Solution
Having to ask staff to access harm reduction supplies (needles, condoms, lube, etc)	This common approach increases the risk of people not getting supplies they need. Limited staff availability and tense relationships between staff and clients are examples of avoidable barriers that may mean people miss out on supplies they need. Having a staff person hand a needle to someone from behind a counter erodes the agency of the person using the service and perpetures a "power over" relationship structure (where service providers have best knowledge, authority, and control). This can mean lost opportunities for safety, especially for people experiencing long term homelessness.	**Make all harm reduction supplies (needles, sharps containers, drug testing kits, condoms, lube, pregnancy tests etc) openly available at all times.** Having supply bins in communal spaces works well. In BC many places have supplies available to anyone, regardless of which services they are accessing, 24 hours a day.
Refusing services to people under the influence of substances	A condition of sobriety will result in missed opportunities for services for people who need them the most. A harm reduction approach understands that some people are physiologically addicted to substances, and encourages staff to work with people as long as they meet basic benchmarks for safety (for example, if they can walk independently, have a conversation, and are still behaving respectfully in the space).	**Create clear policies, considering the following:** - What behavioral cues indicate that someone is okay to access services? - What behavioral cues indicate that emergency health services need to be called? - What behavioral cues indicate that police should be called for a wellness check? - What behavioral cues indicate that someone is able to simply take a walk to sober up and return in a better state? - What are the policies for wellness checks when staff know someone is under the influence (i.e. how often are

		people under the influence monitored)?
Having a rigid entry process to access services	Things like extensive paperwork, need for multiple pieces of documentation, limited intake capacity due to scheduling, and rigid admittance criteria are a few examples of service structures that can be inaccessible to people who need them.	**Talk to people accessing the service to discuss entry barriers.** Do a walkthrough (from a new client perspective) with staff to unearth new ideas to make the entry smoother. Find ways to streamline the admittance process, and ask "who is excluded" at each criteria point for entry.
Having resistance within an organization to changing policies, or working only to maintain the status quo	In shelters, status quo means that you are upholding a system with well-researched gaps. Gaps mean that the most marginalized members of the community are not getting services they need. Harm reduction is evidence-based, and organizations have a responsibility to ensure that their services are using the best information available to inform their policies and procedures. There is always room to grow, and best practice is something that continually changes alongside society itself.	**Dedicate time at least annually to review existing research and literature in your field.** With new information comes new opportunities to improve services. New information should be shared with all staff and collaborative conversations should be held about ways to implement best practices. Shelter staff may find it difficult to carve out the necessary time or resources to do this background research. This report would recommend finding creative ways within the community to meet this need, such as checking in with local educational institutions or grassroots organizations to see if students or community members would like research or volunteering opportunities. **Make sure that staff are trained and supported in their understanding of harm reduction.** This theme is discussed in greater detail in recommendation 4.

Some other valuable ideas for reducing barriers are:

- Allowing people accessing shelters to store personal items in a brown bag that staff will not check (which allows people to store what they need, and can allow shelters to maintain a substance-free space inside the shelter itself if this is a policy). In this study, frontline workers found this initiative to be successful in many ways
- Having access to oxygen on site, which can help reverse an overdose and corresponding brain injury, especially in conjunction with naloxone.

It's also vital to recognize that marginalized groups have even bigger barriers when it comes to harm reduction as these groups have distinctive needs that mainstream services often lack. This report will now outline ways to support specific marginalized groups, as each group has unique needs.

Women in shelters

The BC Centre for Excellence in Women's Health has written extensively about women's experiences accessing services. In a 2009 guide about women-centered harm reduction, it notes that gender has a significant impact on the ways that women experience violence and trauma, pregnancy, mothering, criminalization, sex work, access to housing, and access to services. Women who use substances are more likely than men to experience sexual violence and other forms of violence. This guide notes that women who engage in sex work have increased barriers when accessing health, social, and needle exchange programs because of their need to avoid the risk of violence and policing in the physical environments of the services themselves. Additionally, this report called for the vital need of intersecting, streamlined services for women so that, for example, shelter and treatment programs work in conjunction with each other. A 2005 report by Stensrud looked at the needs of people using shelters in Saskatchewan and echoed similar findings, including gaps in services, ranging from unmet basic survival needs to broader systemic discrimination. The Canadian Network of Women's Shelters and Transition Houses released a report in 2016 which found that on any given day, a shocking 73% of women and children were turned away from shelters due to lack of resources and capacity nationally. The report also highlighted that based on Statistics Canada's 2014 homicide data, one woman is killed by her current or former intimate partner every six days. Women are often turning to shelters during the most high-risk times of their lives, and may be actively fleeing abuse. Additionally, as outlined in a 2017 report by Women's Shelters Canada, Indigenous women are 2.7 times more likely to be victims of violence than non-Indigenous women.

Yet there are ongoing challenges to supporting women who are victims of abuse. In Nova Scotia, for example, victims of domestic violence are able to get emergency protection orders to temporarily protect them from people abusing them, but women are often unaware of this service. A 2012 report by the Huron Women's Shelter showed that women who experience violence and are in shelters often need many supports: legal support (criminal and/or family law), financial support, access to health services, counseling services, and housing. In 2018, Nova Scotia passed legislation that allows victims of domestic violence to take 16 weeks of unpaid leave (as reported on CBC), which is a positive step, but still leaves women in financially precarious positions as this leave is unpaid.

Women accessing shelters need comprehensive support. It is important for shelters to recognize that women may be in high-risk situations.

ACTION STEPS

- Discuss with women accessing shelters if they feel safe, and what can be done to increase safety
- Make sure that harm reduction supplies like condoms, lube, and pregnancy tests are readily available (without a human barrier between supplies)
- In spaces where all genders are welcome, consider creating more private areas that women can access if they are feeling unsafe - do not assume that all women will want

this, and instead offer it as an option
- In gendered spaces (i.e. women-only spaces), ensure that your space includes all women, not just cisgendered women.
- Ensure that schedule and procedures of shelter is not in conflict with other services and programs for women
- Connect with other women-centered spaces in the community to discuss ways that services and gaps in services can be bridged
- Create readily available resource lists and handouts for women-centered services that people accessing shelters can easily find

Indigenous Peoples

Canada has a violent history of colonization and the impact on Indigenous Peoples is felt today. According to the 2016 report from the Canadian Observatory on Homelessness, Indigenous Peoples are disproportionately impacted, accounting for 28-34% of the shelter population while representing only 4.9% of the people in Canada. Indigenous Peoples face barriers in all areas of society due to a long-standing history of racism, and in 2015 the introduction from the Truth and Reconciliation Commission's report summarizes this succinctly:

> *For over a century, the central goals of Canada's Aboriginal policy were to eliminate Aboriginal Governments; ignore Aboriginal rights; terminate the Treaties; and, through a process of assimilation, cause Aboriginal peoples to cease to exist as distinct legal, social, cultural, religious, and racial entities in Canada. The establishment and operation of residential schools were a central element of this policy, which can best be described as cultural genocide.*

Canada's treatment of Indigenous Peoples fits well within the United Nations Convention on Genocide's definition for cultural genocide. The Canadian Government seized land illegally despite existing treaties of peace and friendship, forcibly removed Indigenous people from this land, created scalping bounties for Indigenous men, women, and children (for example, the scalping bounty instated by Edward Cornwallis), restricted the rights and movements of Indigenous Peoples, made Indigenous languages and cultural ceremonies illegal, persecuted Indigenous leaders, destroyed objects and locations of spiritual value, and created policies that actively prevented the transmission of culture from parents to their children (residential schools being a strong example of this). Although the Canadian Government did apologize for the residential school system, the impact of this cultural erasure is hard to comprehend, and results in racism and exclusion in all areas of Canadian society.

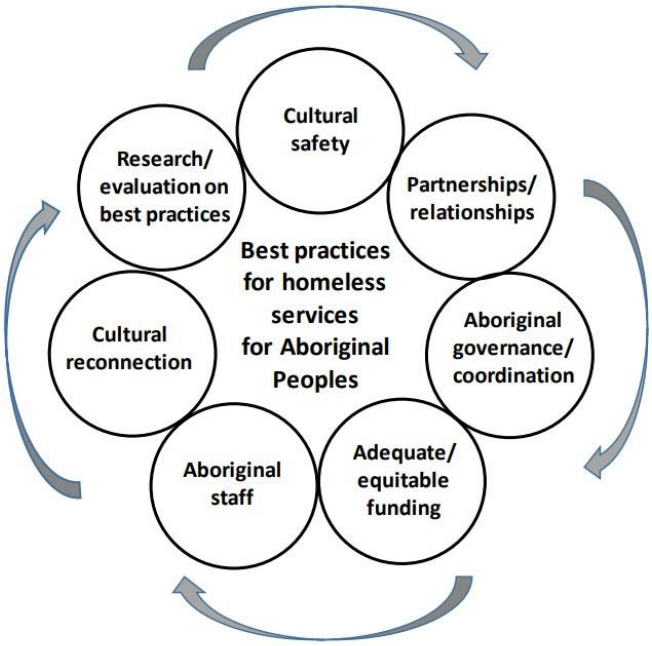
In the wake of the Truth and Reconciliation Commission and the 94 Calls to Action, only 10 calls have been completed (as shown on CBC's Beyond 94 website which monitors progress on the calls). We must take active steps to repair the relationship between Indigenous Peoples and

settlers in this country. We are all treaty people and we all benefit from the resource-rich lands we live on. Although Halifax has a smaller Indigenous population than other places in the country, novascotia.ca notes that 33,000 people in Nova Scotia are Indigenous, accounting for 2.7% of the provincial population.

Research shows that ongoing racism within Canadian systems continues to result in harmful outcomes for Indigenous Peoples. In a 2015 report titled "Canadian Drug Policy and the Reproduction of Indigenous Inequities", Marshall found that government policies around illicit substance use perpetuated racial inequalities for Indigenous Peoples and resulted in the overrepresentation of Indigenous Peoples in the criminal justice system. In another study titled "They Treated Me Like Crap and I Know It Was Because I Was Native: Healthcare Experiences of Aboriginal Peoples Living in Vancouver's Inner City" by Goodman, Fleming, Markwick, Morrison, Lagimodiere, and Kerr (2017), racial stereotypes negatively influenced the care that Indigenous Peoples get in healthcare settings. In 2011, Czyzewski studied colonialism in the context of a social determinant of health, and found that intergenerational trauma and colonization had significant negative impact on health, social, political, and economic outcomes for Indigenous Peoples. Czyzewski emphasized the importance for self-determination in Indigenous communities today. In 2014, Juutilainen, Miller, and Keikkilä found that Indigenous identity, culture, and language are key determinants of health for Indigenous Peoples, and that structural racism in residential schools created negative intergenerational effects such as fractured identity and negative self-worth. This report also found themes of resilience and cultural renewal in spite of this structural racism. The evidence is clear that cultural disconnection and racism has had significant impact on Indigenous communities.

Further, Canada's correctional investigator released a report in October 2018 looking at Indigenous overrepresentation in the justice system, stating that "little practical progress has been made." Indigenous Peoples account for 28% of the federal prison population, but account for only 5% of the population in Canada.

In terms of homelessness in particular, a study by Oelke, Thurston and Turner (2016) looked at structural violence and created a best practice framework for shelters by studying four western provinces. This report found that organizational policy significantly impacted the quality of service Indigenous people received. This report found gaps in cross-cultural collaboration and cultural safety, and outlined best practices which include Aboriginal governance and cultural representation in hiring decisions. Here is a helpful diagram from the report:



The 2016 Canadian Observatory on Homelessness report includes an excellent section on Indigenous Peoples and homelessness, and makes strong recommendations for improved service similar to the best practice report by Oelke, Thurston and Turner (2016).

The writer of this report, who facilitates with KAIROS, would also recommend ensuring that your organization has participated in the KAIROS blanket exercise, a powerful interactive exercise that fosters truth, understanding, respect and reconciliation among Indigenous and non-indigenous peoples. This exercise was created by the Royal Commission on Aboriginal Peoples in the 1990s, and continues to be a helpful tool in reconciliation work, as reported by CBC in 2016.

ACTION STEPS

- Develop an Indigenous homelessness strategy within your organization to ensure that concrete steps are taken to meet the needs of Indigenous people accessing services
- Ensure that staff have participated in the KAIROS blanket exercise or another culturally competent education session led by Indigenous Peoples
- Ensure that your organization is building relationships with Indigenous organizations and groups in your community
- Ensure that you consult with Indigenous Peoples directly about ways to foster culturally competent services
- Consider the Truth and Reconciliation Commission's 94 Calls to Action and discuss with your team ways that you may be able to meet one or more of those objectives
- Include a land acknowledgement in communications (releases, email signatures, etc)
- Ensure that your organization prioritizes diversity in hiring practices so that your staff reflects the people it serves

People Engaging in Sex Work

Sometimes people experiencing homelessness also engage in sex work. Stigma and judgment about people who engage in sex work is a significant barrier to accessing services. Although there are many moral positions on this issue, it is important to remember that these opinions do not change people's decisions to engage in sex work, and that sex work is happening today. The reasons people engage in sex work as are unique as the people themselves, and blanket assumptions about sex work are not helpful.

In 2009, Harding and Hamilton researched women who were experiencing homelessness and their motivations for engaging in sex work. They found that although women may have experienced systemic failures in relation to abusive families and partners, society's automatic assumption of victimhood does not support women, and minimizes the agency that women do have when engaging in sex work. Their research noted that it is unhelpful to assume that women engaging in sex work are necessarily abused and coerced.

Regardless of the unique reasons people engage in sex work, homelessness itself can make it more difficult for people to leave the industry. In 2010, Watson researched women who engaged in sex work as a survival strategy, and noted that these women are often finding individual solutions to broader systemic issues in an increasingly neoliberal and capitalistic society. Watson explained that in the context of homelessness, sex work may be one of few resources available to women. Research by Duff, Deeing, Tyndall, Gibson and Shannon (2011) in Vancouver found similar findings, noting that people using emergency shelters and engaging in sex work were more likely to experience violence and serviced a higher number of clients compared to women who had access to housing.

Mellor and Lovell (2012) also studied women who were homeless and engaging in sex work. They found that women's experiences of homelessness, addiction, violence, and social exclusion due to their engagement in sex work made it more challenging for them to access health and other services, as the services and professionals themselves were not equipped to meet their needs. This report found that service providers' poor understanding of the lives of women who engage in sex work negatively impacted their ability to serve these women.

Further, a study by Purser, Mowbray and O'Sheilds (2017) examined the connection between survival sex and homelessness. This report found that survival sex is associated with many health issues, including an increase in substance use and a higher risk for HIV transmission. Researchers found that the longer people were homeless and using substance, the greater the likelihood that people would engage in survival sex. This report supports the housing first strategy and calls for integrated services that address co-occurring substance use and mental health issues.

Men may also engage in sex work. A study by Lankenau, Clatts, Welle, Goldsamt and Gwadz (2005) examined the ways that homelessness, drug use, and sex work intersected for male youth

in New York. The youth in the study had diverse backgrounds and reasons for engaging in sex work.

A harm reduction approach understands that people may engage in sex work, and understands that there is a clear link between homelessness and sex work. It is vital for shelters themselves to be aware of this link, and to resist moralistic responses that do not meet people where they are. This only perpetuates stigma and judgment, minimizes the agency of people engaging in sex work, and lowers people's willingness to access services.

Instead, efforts must focus on supporting people in their current situation, which includes connecting them to safe sex supplies and community supports and resources.

ACTION STEPS

- Make sure that harm reduction supplies including condoms, lube, and pregnancy tests are readily available at all times without a human barrier
- Consider contacting the AIDS Coalition in your community to get information about services and discounted condoms
- Make sure staff themselves are aware that people experiencing homelessness may be engaging in sex work, and that there is a need for support and not judgment

LGBTQ+

Individuals within the LGBTQ+ community face significant barriers to services, particularly when it comes to shelters. A study in 2017 by Coolhard and Brown found that LGBTQ youth are 2-13 times more likely to experience homelessness than their straight counterparts. Another study by Ecker, Aubry and Sylvestre in 2016 found that queer youth are greatly overrepresented in the homeless population and require specialized services implemented by sensitive and knowledgeable staff. Ecker did another study in 2107 looking at LGBTQ adults experiencing homelessness, and found that the queer population faced extra risk in areas of HIV and substance use. A 2017 report by Women's Shelters Canada noted that lesbian and bisexual women are 3-4 times more likely to experience intimate partner violence than heterosexual women. Additionally, transgender and non-binary folks have an increased risk of experiencing violence. In 2017, a Women's Shelters Canada report noted that trans people are twice as likely to report intimate partner violence than their cisgendered counterparts.

Consider the shelters in your area- are most shelters either male or female? Shelters frequently uphold a gender binary that excludes trans and non-binary people. This perpetuates cissexism.

In Nova Scotia, the Department of Education released a 2014 report on how to support trans and gender-nonconforming youth, noting that 90% of trans youth experience transphobic comments daily or weekly, with a quarter of students reporting transphobic language daily or weekly. Three quarters of trans students (74%) reported being verbally harassed about their gender expression,

and an alarming 44% of trans students reporting being likely to miss school due to feeling unsafe. Statistics Canada has no information about rates of murder, violence, poverty, or homelessness faced by trans Canadians as the national census (last census in 2016) includes only male and female gender options.

It is also important to consider how shelters are often tied to faith communities, and may exist in explicit church spaces. Although responses from religious communities toward LGBTQ people vary from religion to religion, 67% of Canadians identify as Christian and many Christian denominations are critical of homosexuality. Human Rights Watch in the United States has researched how religious communities continue to discrimindate against LGBTQ folks. Queer people may not feel comfortable in a space that is financially or physically connected to a faith.

In this study, participants reported that respecting pronouns was sometimes the singular policy a shelter had to make a space queer-friendly. Frontline staff also shared that there is typically an assumption of straightness with people accessing shelters, which places responsibility on the individual (and not the shelter staff) to disclose their status in the LGBTQ+ community.

Shelters can do better on this front. Luckily Bardwell (2015) completed an LGTBQ+ needs assessment tool for emergency shelters in Ontario, which has simple and practical ways to better serve the needs of queer people at all organizational levels.

ACTION STEPS

- Read Bardwell's LGBTQ+ Needs Assessment (2015) for emergency shelters
- Create gender neutral washrooms
- Critically assess areas of the shelter that are within the gender binary (male or female) and ask if this division in gender is in service of any organizational goals, or exists only because of cissexism/the status quo. Consider ways to make the space more friendly to folks outside of the binary
- Consult with queer people about what can be done to improve services
- Ask "what pronoun do you use?" instead of "what is your preferred pronoun?" as the latter implies that it is a preference instead of a legitimate gender identity
- Make sure that intake procedures include questions about gender and orientation
- Provide explicit training to staff by working with local LGBTQ+ community organizations, and ensure that there is a section for Indigenous LGBTQ+ issues, including two-spirit people
- Make sure that policies around language and confidentiality are clear and enforced (to protect against outing people accidentally)
- Display visible LGBTQ+ signs (rainbows, flags, posters) throughout the shelter

Young People

Youth face the highest barriers to harm reduction due to general cultural resistance to youth using substances before they are legally of age. Most youth in Canada have the luxury of

experimenting with drugs and alcohol in private spaces, but youth experiencing homelessness are less likely to have a safe space to use which can dramatically increase risk.

Most harm reduction initiatives involving youth are controversial, but a 2012 report by LaMarre found that when implemented properly, harm reduction programs for youth help to reduce negative health outcomes related to substance use. This report also found that it is vital for programs to appreciate the social context of the youth they serve which means accepting the reality of their lives. This means, for example, understanding that youth experiencing homelessness use substances more than youth with secure housing. Further, Bonomo and Bowles (2001) found that **there is strong evidence that a zero-tolerance approach for adolescent substance use does little, and sometimes nothing to decrease use.** We also know from the National Youth Homelessness Survey that there are 35,000-40,000 young people without stable housing each year. Youth face a particularly challenging combination of social stigma against using substances, of exclusion from services due to their age, and of a general lack of youth-focused supports compared to services offered to the general public.

In this study, some organizations working with youth experiencing homelessness noted that they had an abstinence-only policy around substances in their shelters. Interestingly, all staff from organizations with zero-tolerance for substances reported that they knew youth were using in washrooms on site. A few interviews included concerning information that youth were barred from shelter services due to their substance use.

For shelters who were willing to support youth under the influence, respondents shared that the shift to serving youth under the influence meant that youth themselves became a lot more open with staff. Previously, youth hid their use as much as possible to avoid punishment from staff and losing their bed in the shelter. This meant that staff did not have as much information as they could in terms of where youth were in their use, addiction, or recovery. One respondent said that the culture in the shelter became a lot more open and supportive once youth could be open and honest about their use, and shared that staff are now better equipped to adjust wellness checks to the needs of the individual youth accessing the space. If, for example, a youth has expressed that they are actively injecting drugs, shelter staff monitor that youth more closely. The shift meant that there are fewer power struggles, less "cat and mouse" surveillance, and more honesty. This means service delivery is stronger.

Although public opinion may not support youth using substances, youth use substances and are more likely to do so if they are also homeless. Evidence shows that expectations of sobriety to access services is dangerous, and youth services must expand the ways that they work with young people instead of turning them away when they are already so vulnerable.

ACTION STEPS

- Understand that youth experiencing homelessness are more likely to use substances than their housed counterparts
- Ensure that youth have open access to harm reduction supplies like needles, condoms, lube, and pregnancy tests at all times without human or other barriers - even if your shelter has a zero-tolerance policy for substances on site
- Re-examine any policies and procedures that exclude youth who are under the influence of and/or are using substances

RECOMMENDATION 2: Assume bathrooms are injection sites and act accordingly

Another strong theme that emerged both in the literature and in the interviews is the importance of understanding that bathrooms are one of the most common sites for substance use. Safety policies for washrooms are of vital importance. The vast majority of Canadians use substances, and we ask readers of this report to reflect on their own substance use. What substances do you use? Are you able to drink or smoke in the privacy of your home? And if you couldn't, where would you go? These are the questions that people experiencing homelessness are faced with, and some people may have a physiological dependence on these substances, making the question around where to use even more challenging. The importance of a safe space to use applies to all people who use substances.

The Centre for Addictions Research in BC released a report in 2016 calling washrooms the de facto consumption site for substances due to gaps in safe injection sites and treatment services provincially. This report also noted that washrooms are a common site for overdose events, which results in staff having to administer Naloxone and call 911, increasing the likelihood of staff experiencing a traumatic incident while on the job.

A 2015 project by Centre for Addiction Research BC conducted focus groups with shelter workers, harm reduction workers, and people who accessed shelters to understand how homelessness impacts substance use. This report stated:

> *Shelter workers report that responding to overdose events in shelter bathrooms means that they feel responsible for the lives and deaths of shelter residents.*

A 2017 report written by Kerr, Scheim, Bardwell, Mitra, Rachlis, Bacon, Murray, and Rourke found that for people who were injecting drugs in London, Ontario, 48% had injected in a washroom in the last six months. In the study, shelter staff routinely responded to overdoses, and these events placed a heavy emotional burden on their staff.

Why washrooms? The report noted that people use washrooms due to privacy, accessibility, lighting, and availability. Washrooms can feel more safe than other spaces, although this perceived sense of safety is likely unfounded if organizations do not have consistent policies around washroom checks. By using in public (instead of a private bathroom stall), people risk police intervention, may overdose in a hidden location, and may be at a greater threat of violence. There is also environmental risk while using outside in colder temperatures.

> In this study, every single person doing frontline work reported that people were using in washrooms regardless of a zero-tolerance policy around substances.

Even if your organization is not a safe consumption or overdose prevention site, you can still take steps to make your washrooms safer. Vancouver Coastal Health has amazing recommendations for overdose prevention and response in washrooms, including helpful checklists about how to ensure safety. They recommend including signs in each stall with clear information about your bathroom policy so people accessing services have clear information.

ACTION STEPS

- Create a clear bathroom policy (consider this checklist from Vancouver Coastal Health)
- Ensure that staff are educated and trained on bathroom policy
- Make sure that harm reduction supplies are readily available (without a human barrier to accessing them)
- Make sure that there are sharps containers for needles in all stalls
- Ensure that staff are trained in overdose response

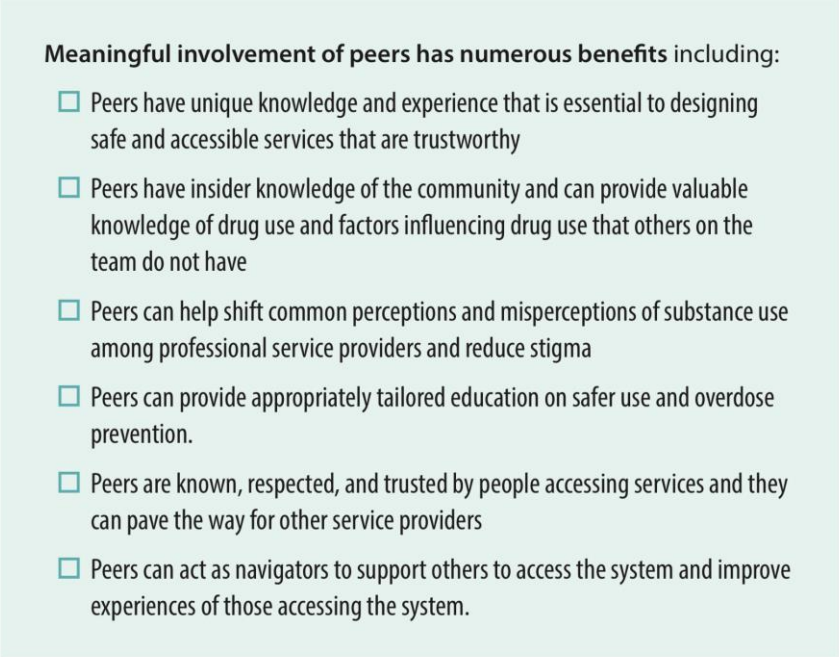
RECOMMENDATION 3: Peer-led programming is the future of harm reduction work

Progressive organizations both in Canada and internationally are increasingly leaning on peer-led initiatives. This approach is increasingly supported in the literature as well. Simply put, peer programming means a shift away from a service-delivery model which positions the service provider as having best knowledge, authority, and control and instead positions people who have lived experience (i.e. have used drugs) as the best people to work with others engaging in the same behavior. Peer support workers, and peer witnessing (for overdose prevention) are examples of peer-led programming that are supported by research.

University of Victoria and Centre for Addictions Research BC created an excellent community overdose response plan which centers peer voices and encourages a strength-based understanding of people in communities. The report reads:

> *Central to overdose responses is the important role that peers (people with lived experience and past or current substance use) play in contributing to the design, development and delivery of acceptable and elective overdose response strategies and harm reduction services. Peer engagement and peer- led services are a critical feature of an effective and efficient response.*

This report also includes this table which outlines the ways in which peer workers are useful:



Meaningful involvement of peers has numerous benefits including:

- ☐ Peers have unique knowledge and experience that is essential to designing safe and accessible services that are trustworthy
- ☐ Peers have insider knowledge of the community and can provide valuable knowledge of drug use and factors influencing drug use that others on the team do not have
- ☐ Peers can help shift common perceptions and misperceptions of substance use among professional service providers and reduce stigma
- ☐ Peers can provide appropriately tailored education on safer use and overdose prevention.
- ☐ Peers are known, respected, and trusted by people accessing services and they can pave the way for other service providers
- ☐ Peers can act as navigators to support others to access the system and improve experiences of those accessing the system.

There is also a growing body of research supporting peer-led programs. Bardwell, Collins, McNeil and Boyd (2017) looked at opportunities to implement safe consumption sites in BC and found that peer-led overdose response, such as naloxone training and distribution should be a public health priority, noting that there is a strong link between poor access to housing and overdose. In a study by Bardwell, Fleming, Collins, Boyd, and McNeil (2018), researchers looked at a tenant-led overdose prevention program in a housing unit disproportionately impacted by overdose in Vancouver's Downtown Eastside. Tenants participating in the program were trained to administer naloxone. Researchers found that peer-led overdose response interventions are effective tools in addressing overdose risk for single-occupancy rooms.

In 2018, Bardwell, Kerr, Boyd, and McNeil interviewed people involved in peer-led overdose prevention. This study found that people felt safer using substances with peer workers due to their shared lived experience, and that people preferred peer workers to non-peer staff due to a more equitable power dynamic. Peer supports were found to offer unique benefits.

The implementation of peer-led programming in emergency shelters has potential to improve overdose prevention efforts, especially since peer support can exist in spaces that traditional health care does not.

In this study, all respondents spoke in support of peer programming, and multiple frontline workers shared the successes of their organization in implementing these strategies. Respondents with lived experience of substance use noted the immense value of having peer supports as a part of their recovery. One respondent said that they were not able to imagine a life outside of addiction until someone close to them shared their own story of recovery. This gave them hope for change. Trust is easier to find when the person supporting you has lived experience with substance use.

Peers are invaluable resources in the community, and should be leading voices in decision making and implementation of harm reduction initiatives.

ACTION STEPS

- Center the voices of peers in all decision making and implementation of programs
- Talk to people using your services and work to identify peer leaders in the community
- Build a community overdose response plan that centers peer voices
- Consider ways that the community can work to disrupt social and personal stigma and discrimination associated with substance use and addiction

RECOMMENDATION 4: Training, policies, and education - a shift from staff discretion to a culture that upholds harm reduction

Training, policies, and education are the most vital pieces of successful harm reduction initiatives. Organizations must ensure that shelter staff understand not only the **what** but the **why** around harm reduction services.

A striking part of the interviews for this project was hearing how frequently conflict emerged due to individual staff members using discretionary approaches (for example, allowing a grace period for curfew, or working with people despite policies that would exclude them).

One frontline shelter worker shared a story about the difficulties of working with restricting policies. During a snowstorm, this worker realized that one of the people accessing the shelter was under the influence, and this was against shelter policy. Yet this worker decided against reporting, knowing that this person already had a contentious relationship with the police and may get more charges if discharged. The worker also worried about safety due to the storm. If this decision had become known, the employee could have faced disciplinary action.

Another shelter worker shared a striking story about having to discharge a man in mid-winter for bringing alcohol on site. This man ended up sleeping just outside the shelter building, and shelter staff brought him blankets and clothing throughout the night to keep him warm.

These types of decisions, often coming from a place of working to reduce harm, makes everyday operations more challenging and puts staff in difficult positions. It erodes trust and support between colleagues and sends mixed messages to people accessing shelters. Although management may view staff discretion as an issue of individual performance, the reality is that there may be a distinct pattern of discretionary behavior in relation to particular policies. If staff are consistently using discretion in specific areas, this may indicate that existing policies are not serving the needs of the organization.

Further, multiple respondents discussed the challenges of implementing new harm reduction initiatives within their organizations. Some interviewees shared that staff were sometimes resistant to change. Respondents gave mixed answers about how to ensure that all staff within an organization support harm reduction. One respondent stated that the solution was to "fire and rehire" whereas another respondent, who was a manager, noted that it was important to continue working with staff who are resistant, making sure to offer them ample opportunities to learn and grow, as those staff members may have other strengths that they are bringing to the table. This is why time must be spent educating on the **why** of new initiatives. All managers interviewed in this project reported that it was helpful to include evidence in the rationale for new initiatives. One respondent put it well:

> *It boils down to people's fears of the unknown, and what you can do to make sure they feel safe and supported in the changes.*

Two managers noted that in their hiring process, they used scenario-based questions in interviews to gauge people's comfort levels with the work itself. This was an explicit way to screen the willingness of prospective staff to uphold harm reduction initiatives on the job.

It's vital for organizations to work with, educate, and train staff on a regular basis. Organizations should not only have sit-down training, but drills as well to practice interventions with adrenaline pumping.

It's also important for organizations to have clear and flexible debrief options for staff who have experienced serious and stressful situations at work. Offering multiple debrief options (such as taking a walk, talking to colleagues or management, accessing counselling or taking some time off) can help staff feel supported in their work.

Additionally, the hidden benefit of harm reduction is that the work itself may become easier.

In this study, all frontline and management staff who had shifted from an abstinence-only model to a harm reduction one shared that it became easier to work with people when there was no longer resistance around policies that were rooted in controlling individual choice.

A harm reduction approach discourages secrecy and hiding and meets people where they are, which can mean that people accessing shelters are less resistant. There is more honesty, which can mean less conflict in an effort to uphold boundaries that are not serving people.

Vancouver Coastal Health has fantastic resources publicly available, including a comprehensive and practical manual for setting up overdose prevention sites in a supported housing context. This manual includes printable checklists and important considerations for overdose prevention. Vancouver Coastal Health also has an overdose and prevention response protocol which gives recommendations to service providers.

ACTION STEPS

- Talk to staff (either one-on-one, or with anonymous surveys) asking which policies are procedures are often bent, and what they would recommend to improve them
- Talk to people using the shelter to find out if they have experienced big differences in services based on who is working and use these responses to create system-level changes
- Update all policies and procedures so there is clarity and consistency
- Make sure that training involves not only sit-down sessions but regularly scheduled drills
- Ensure that staff training focuses not just on the **how** but the **why** as well

DOCS TO REVIEW

- Vancouver Coastal Health's guide for setting up an overdose prevention site
- Vancouver Coastal Health's guide for overdose prevention and response protocol

RECOMMENDATION 5: Do WITH

The title of a report by Jürgens (2008) beautifully titled "Nothing about us without us: Greater, meaningful involvement of people who use illegal drug use: A public health, ethical, and human rights imperative captures this final recommendation succinctly. Here is a striking excerpt from this report:

> *Most of the responses to drug related overdose, drug related crime, family breakdown, drug treatment, unemployment, etc, have been developed in isolation to people who use illicit drugs. We have been largely left out of responses to these issues because of a mistaken belief that we would be at best, disinterested, and at worst, incapable of participating in a meaningful dialogue on the issues that affect us. While we cannot single-handedly address the issues associated with illicit drug use in the community, our*

involvement in the response is critical. We are the people who use illicit drugs, access drug treatment services and educate and support our peers - we have direct knowledge and experience to offer.

As other themes have already touched on, it is vital to center the voices of people most impacted by services and programs. This includes clients, peers, and other community members connected to an organization's work.

In this study, organizations who are progressive in their policies consistently shared that they work with the people they serve, ensuring that the needs of their clients are at the forefront of decision making. One interviewee, when discussing the need to shift away from the service-delivery model and shift toward working with people, put it beautifully:

We must support, not save

Another respondent noted that grassroots initiatives are absolutely the singular greatest source of knowledge about what's going on in a community, as they are not as restricted as other organizations with strict funding structures.

"Doing with" means that open communication is central. One shelter in BC said that nothing is done behind the backs of the people accessing the the shelter. Even if they must call the police, they make sure that the clients themselves are aware that this will occur.

Organizations must work to change professional structures that include only other service providers. Gaventa's understanding of power (2006) states that existing power structures significantly impact the ways that policy and services serve the needs of community members. Gaventa suggests asking critical questions when implementing change:

- Are the spaces where decisions are made open or closed to outside voices?
- Have organizations invited voices in? Who remains excluded? What perspective may be lost?
- Will participation from community allow for a transformation of patterns that exclude and perpetuate social inequalities? What ensures that status quo is not perpetuated?
- Is the "power over" dynamic (as in, where only the powerful can affect change for the powerless) being disrupted?

A critical understanding of power dynamics can foster real change that works **with** people accessing services.

ACTION STEPS

- Include the voices of people with lived experience and who access services in the creation of any new programming, policies, or procedures

- Ensure that it is easy for people to give feedback. People accessing services should have many avenues to share their thoughts: informal discussions with clients (that staff can then share with management), formal discussions with clients, focus groups, community forums, anonymous feedback boxes, etc
- Ensure that staff are trained to value and seriously consider feedback from people using services
- Ask who is excluded when implementing new programming and policies

IN CLOSING

Harm reduction is beneficial, there is strong evidence to support it, and shelters have a responsibility to ensure that they are adhering to best practices in their work. Harm reduction saves lives and money. In the Canadian context, there are strong examples of successful harm reduction initiatives. Even if shelters themselves maintain a zero-tolerance policy for substance use on site, there are ways to support people using substances to ensure greater safety and protection from harmful outcomes. Shelters must recognize the gaps in their services, and work to disrupt status quo programming so that services are inclusive, supportive, dignified, and respectful.

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North End Community Health Centre (Halifax, NS)

Desiree Hosking - Associate Director, Program Services
Covenant House (Toronto, ON)

Kellie McLeod - Social Work Coordinator
Adsum House (Halifax, NS)

Dametre Peverill - Peer Support Worker
The Marguerite Centre & Out of the Cold Shelter (Halifax, NS)

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Rebecca Whitzman - Shelter Coordinator
Out of the Cold Emergency Shelter (Halifax, NS)

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Huronia Transition Homes (Toronto, ON)

REFERENCES BY CATEGORY

Evidence for Harm Reduction

A review of the evidence-base for harm reduction approaches to drug use by Hunt with contributions from Ashton, Lenton, Mitcheson, Nelles and Stimson (2003), Forward Thinking on Drugs

Preventing HIV Infection Among Injecting Drug Users in High-Risk Countries: An Assessment of the Evidence by The Institute of Medicine (2007), The National Academic Press

An External Evaluation of a Peer-Run "Unsanctioned" Syringe Exchange Program by Wood, Spittal, and Schechter (2003), Journal of Urban Health

Opioid overdoses in supportive housing facilities: how to keep people safe by Riley (2016), University of British Columbia Thesis Defense

Sheltering risks: Implementation of harm reduction in homeless shelters during an overdose emergency by Wallace, Barber, and Paula (2018) International Journal of Drug Policy

Harm Reduction: What's in a Name? by Beirness, Jesseman, Notarandrea and Perron (2008), Canadian Centre on Substance Abuse (2008)

Supervised injection facilities in Canada: past, present, and future by Kerr, Mitra, Kennedy and McNeil (2017), Harm Reduction Journal

Does evidence support supervised injection sites? By Ng, Sutherland, and Kolber (2017), Canadian Family Physician

Public Health and Public Order Outcomes Associated with Supervised Drug Consumption Facilities: a Systematic Review by Kennedy, Karamouzian, Kerr (2017), Current HIV/AIDS Reports

Needle Exchange Programs in a Community Setting: A Review of the Clinical and Cost Effectiveness by Canadian Agency for Drugs and Technologies in Health (2015)

Harm Reduction in Action: Supervised Consumption Services and Overdose Prevention Sites by Camille Arkell (2018), CATIE: Canada's Source for HIV and Hepatitis C Information

Opioid Overdose Prevention and Related Trauma: Incorporating Overdose Prevention, Response, and Experience into Substance Use Disorder Treatment by Doe-Simkins, Bell (2014), Illinois Co-Occurring Centre for Excellence at Heartland Health Outreach

The Cost-Effectiveness of Vancouver's Supervised Injection Facility by Bayoumi and Zaric (2008), Canadian Medical Association Journal

A Cost-Benefit/Cost-Effectiveness Analysis of Proposed Supervised Injection Facilities in Montreal, Canada by Jozaghi, Reid, Andresen (2013), Substance Abuse, Treatment, Prevention, and Policy

A Comparison of Syringe Disposal Practices Among Injection Drug Users in a City With Versus a City Without Needle and Syringe Programs by Tookes, Kral, Wenger, Cardenas, Martinez, Sherman, Pereyra, Forrest, Lalota and Metsch (2011), Dug and Alcohol Dependence

Return Rates for Needle Exchange Programs: A Common Criticism Answered by Ksobeich (2004), Harm Reduction Journal

Canadian Harm Reduction Research

A Public Health Guide to Developing a Community Overdose Response Plan by Pauly, Hasselback, Reist (2017), Canadian Institute for Substance Use Research, University of Victoria

A Systems Approach to Substance Use in Canada: Recommendations for a National Treatment Strategy by National Treatment Strategy Working Group (2008), Ottawa: National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada

What We Heard: Refreshing the National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada by The Canadian Centre of Substance Use and Abuse (2016)

Ontario Needle Exchange Programs: Best Practice Recommendations by Strike, Leonard, Millson, Anstice, Berkeley, and Medd (2006), Ontario Needle Exchange Coordinating Committee, Health Canada

Canadian Substance Use Costs and Harms Scientific Working Group by The Canadian Institute for Substance Use and Addiction and the Canadian Institute for Substance Use Research (2007-2014)

Report of the Toronto and Ottawa Supervised Consumption Assessment Study by Bayoumi, Strike, Jairam, Watson, Enns, Kolla, Lee, Shepherd, Hopkins, Millson, Leonard, Zaric, Luce, Degani, Fischer, Glazier, O'Campo, Smith, Penn, Brandeau (2012). St. Michael's Hospital and the Dalla Lana School of Public Health, University of Toronto

Best Practices across the Continuum of Care for Treatment of Opioid Disorder by Taha (2018), Canadian Centre on Substance Use and Addiction

Every Washroom: De Facto Sites in the Epicentre of an Overdose Public Health Emergency by Wallace, Pauly, Barber, Vallance, Patterson, Stockwell (2016), CARBC Statistical Bulletin #15, University of Victoria

Ontario Integrated Supervised Injection Services Feasibility Study: London Report by Kerr, Scheim, Bardwell, Mitra, Rachlis, Bacon, Murray, Rourke (2017)

Homelessness and Harm Reduction

The State of Homelessness in Canada by Gartz, Dej, Richter, Redman (2016), Canadian Observatory on Homelessness and Canadian Alliance to End Homelessness

National Final Report: Cross-Site At Home/Chez Soi Project by Goering, Veldhuizen, Watson, Adair, Kopp, Latimer, Nelson, MacNaughton, Streiner, Aubry (2014), Mental Health Commission of Canada

Harm Reduction Framework: Fostering dignity for people who use substances across housing and homelessness services by Shelter, Support and Housing Administration Toronto (2017)

Harm Reduction in Homeless Shelters: Preventing and Reducing Harms of Substance Use in Homeless Shelter Programs by University of Victoria - Centre for Addictions Research of BC (2015)

Toward a Better Understanding of the Needs of Shelter Users: A Consultation with Shelter Residents and Workers by Stensrud (2005), Provincial Association of Transition Houses and Services of Saskatchewan

Housing and Overdose: An Opportunity for the Scale-up of Overdose Prevention Interventions? By Bardwell, Collins, McNeil (2017), Harm Reduction Journal

Policing

The public health and social impacts of drug market enforcement: A review of the evidence by Thomas Kerr, Will Small, Evan Wood (2004), The International Journal of Drug Policy

Peer-led Programming

Characterizing peer roles in an overdose crisis: Preferences for peer workers in overdose response programs in emergency shelters by Bardwell, Kerr, Boyd and McNeil (2018), Alcohol and Drug Dependence

Characterizing Peer Roles in an Overdose Crisis: Preferences for Peer Workers in Overdose Response Programs in Emergency Shelters by Bardwell (2018), Drug and Alcohol Dependence

Addressing Intersecting Housing and Overdose Crises in Vancouver, Canada: Opportunities and Challenges from a Tenant-Led Overdose Response Intervention in Single Room Occupancy Hotels by Bardwell, Fleming, Collins, Boyd and McNeil (2018), Journal of Urban Health

Characterizing Peer Roles in an Overdose Crisis: Preferences for Peer Workers in Overdose Response Programs in Emergency Shelters by Bardwell, Kerr, Boyd, and McNeil (2018), Drug and Alcohol Dependence

Power and Inclusion

"Nothing about us without us": Greater, meaningful involvement of people who use illegal drugs: A public health, ethical, and human rights imperative by Jürgens (2008) , Canadian HIV/AIDS Legal Network, International HIV/AIDS Alliance, Open Society Institute

Structural Violence, Poverty, and Social Suffering by Rylko and Farmer (2017), The Oxford Handbook of the Social Science of Poverty

The Boundaries of the Social Work Relationship Revisited: Towards a Connected, Inclusive, and Dynamic Conceptualisation by O'Leary, Tsui, Ruch (2013), British Journal of Social Work

Effacing and Obscuring Autonomy: The Effects of Structural Violence on the Transition to Adulthood of Street Involved Youth by Susannah Taylor (2017), Postdoctoral Thesis, University of Ottawa

Finding the Spaces for Change: A Power Analysis by Gaventa (2006) Institute of Development Studies, IDS Bulletin

The Physiology of Addiction

The Addicted Brain: Understanding the Neurophysiological Mechanisms of Addictive Disorders by Herman and Roberto (2015) Frontiers in Integrative Neuroscience

Addiction and Cognition by Gould, (2010) Addiction Science & Clinical Practice

LGBTQ+

The need for safe spaces: Exploring the experiences of homeless LGBTQ youth in shelters by Coolhart and Brown (2017), Children and Youth Services Review

Queer, young, and homeless: A review of the literature by Ecker (2016), Child and Youth Services

Guidelines for Supporting Transgender and Gender-Nonconforming Students by Nova Scotia Department of Education and Early Childhood Development (2014)

Transgender People in Ontatio, Canada: Statistics from the Trans PULSE Project to Inform Human Rights Policy by Bauer, Scheim (2015), University of Western Ontario

A Review of the Literature on LGBTQ Adults Who Experience Homelessness by Ecker, Aubry, Sylvestre (2017), Journal of Homosexuality

LGBT Needs Assessment for Emergency Shelters in London, Ontario by Bardwell (2015), Unity Project for the Relief of Homelessness

Women

By the Numbers: Violence Against Women and Girls in Canada by Women's Shelters Canada (2017), Shelters and Transition Houses United to End Violence Against Women

Ontario Shelter Research: An Evaluation of Shelters as Service Navigation Hubs for Abused Women by Michele Hanson and Huron Women's Shelter (2012)

Women-Centred Harm Reduction by Poole, Urquhart, Talbot (2010) Gendering the National Framework Series, BC Centre of Excellence for Women's Health

Shelter Voices: Violence Against Women: A National Threat Requires a National Response (2016) Canadian Network of Women's Shelters and Transition Homes

Toward a Better Understanding of the Needs of Shelters Users: A Consultation with Shelter Residents and Workers by Stensrud, Tmira (2005), Provincial Association of Transition Houses and Services of Saskatchewan, Status of Women Canada

Young People

Syringe Sharing Among a Prospective Cohort of Street-Involved Youth: Implications for Needle Distribution Programs by Bozino, Wood, Dong, Richardson and Kerr (2017), AIDS and Behavior

Putting harm reduction into an adolescent context by Bonomo and Bowles (2001), Journal of Paediatrics and Child Health

Without a Home: The National Youth Homelessness Survey by Gaetz, O'Grady, Kidd, Schwan (2016), Canadian Observatory on Homelessness, A Way Home Canada, National Learning Community on Youth Homelessness

Indigenous Peoples

"They treated me like crap and I know it was because I was Native": The healthcare experiences of Aboriginal peoples living in Vancouver's inner city by Goodman, Markwick, and Kerr (2017), Social Sciences and Medicine

Aboriginal Homelessness: A Framework for Best Practice in the Context of Structural Violence by Oelke, Thurston, Turner (2016), The International Indigenous Policy Journal

Colonialism as a Broader Social Determinant of Health by Czyzewski (2011), The International Indigenous Policy Journal

Structural Racism and Indigenous Health: What Indigenous Perspectives of Residential School and Boarding School Tell Us? A Case Study of Canada and Finland by Juutilainen, Miller, Heikkilä (2014), The International Indigenous Policy Journal

Sex Work

Working Girls: Abuse or Choice in Street-Level Sex Work? A Study of Homeless Women in Nottingham by Harding and Hamilton (2009), British Journal of Social Work

Street Careers: Homelessness, Drug use, and Sex Work Among Young Men Who Have Sex With Men (YMSM) by Lankenau, Clatts, Welle, Goldsamt and Gwadz (2005) International Journal of Drug Policy

The Lived Experience of UK Street-Based Sex Workers and the Health Consequences: An Exploratory Study by Mellor and Lovell (2012), Health Promotion International

Understanding Survival Sex: Young Women, Homelessness, and Intimate Relationships by Watson (2010), Journal of Youth Studies

The Relationship Between Length and Number of Homeless Episodes and Engagement in Survival Sex by Purser, Mowbray, O'Shields (2017) Journal of Social Service Research

Homelessness Among a Cohort of Women in Street-Based Sex Work: The Need for Safer Environment Interventions by Duff, Deering, Tyndal, Gibson, Shannon (2011) BMC Public Health

Trauma Informed Approaches

Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study by Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, Koss, Marks (1998), American Journal of Preventive Medicine

Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol by Fallot, Harris (2009), Community Connections

Harm Reduction and Shelters - A Jurisdiction Scan for Out of the Cold Emergency Shelter

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