Recommendations for Building a

Harm Reduction & Substance Use Continuum of Care

Ontario
Toronto Central Local Health Integration Network

DEVELOPED BY GILLIAN KOLLA FOR THE TC LHIN | MARCH 2018

Acknowledgements

Project Advisory

This project was guided by input from the project advisory panel. Co-chairs were Angela Roberston (Parkdale Queen West Community Health Centre) and Lynne Raskin (South Riverdale Community Health Centre), and advisory members included Keddone Dias (LAMP Community Health Centre), Paulos Gebreyesus (Regent Park Community Health Centre), and Michelle Joseph (Unison Health and Community Services). All members of the project advisory panel contributed to the development of the consultation structure, and reviewed and provided feedback on preliminary drafts of the report.

Project Respondents

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Project Team

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Executive Summary

Background

Over the last 5 years in Canada, opioid-related overdose deaths have dramatically increased. Recently released preliminary data for Ontario reveals that from January-October 2017, there were 1,053 opioid-related deaths, an increase of 52% over the same period in 2016 (1). In 2016 in Ontario, 865 people died from opioid-related overdose, which was an increase of 19% since 2015, and 136% since 2003 (2). Across the country, the number of people who died of opioid-related causes in 2017 is likely to be well over 4000 people.

Much of this increase in overdose is due to the presence of fentanyl (or closely related fentanyl analogues) in the illicit drug supply. While it is impossible to know the true extent of fentanyl penetration into the illicit drug supply, results from Health Canada's Drug Analysis Service provide a clue. In 2012, 0.08% of the 2,337 heroin samples tested contained fentanyl and/or its analogues. By 2016, 39.4% of 3,658 samples tested positive, and by 2017, 60.1% of the 3,337 heroin samples tested were positive for fentanyl (3). While pharmaceutical fentanyl is a useful medication in medical settings, illicitly-produced fentanyl is an extremely strong opioid that can rapidly lead to overdose when it is added to and consumed as part of the illicit drug supply, where the dose is unregulated and drug composition can be haphazard.

Response from the Toronto Central LHIN

In response to the overdose crisis, in September 2017 the Toronto Central Local Health Integration Network (TC LHIN) approved a short-term increase to base funding for five community health centres (CHCs) in the five TC LHIN sub-regions: LAMP Community Health Centre, Parkdale Queen West Community Health Centre, Regent Park Community Health Centre, South Riverdale Community Health Centre, and Unison Health and Community Services. These funds were to be used in the 2017/2018 fiscal year to support harm reduction service expansion, in alignment with Ontario's *Strategy to Prevent Opioid Addiction and Overdose.* All five CHCs used the funds on health human resources, to increase outreach support to people who use drugs in identified high-need areas, scale-up overdose response and naloxone training, and support education and harm reduction service delivery within overdose prevention sites.

Additionally, the TC LHIN provided funding to support the CHCs to engage in a collaborative process to develop recommendations to guide the deployment and utilization of resources in the area of harm reduction over the longer term. From January to March 2018, consultations were held with 125 people who use drugs and use harm reduction services, harm reduction service providers, and key informants who provide a variety of aligned health and social services. This consultative process led to the development of this report, which provides a series of recommendations for developing a Harm Reduction and Substance Use Continuum of Care. In this report, a continuum of care refers to a comprehensive set of wrap-around services and care for people who use illicit drugs, delivered in alignment with consistent harm reduction principles and values.

Harm reduction in the response to the overdose crisis

Harm reduction programs and services have been a core part of the response to substance use in our communities for over 20 years. They are backed by an impressive array of evidence (4-7), and are particularly adept at creating links and building relationships with communities of people who use drugs (8). In seeking to respond appropriately to the opioid-overdose crisis, there is a strong base of evidence supporting two key harm reduction programs and services - naloxone distribution programs and supervised consumption sites - as key interventions to reduce overdose-related morbidity and mortality, (9-13). In addition to these two interventions, there are innovative practices that hold promise and merit further exploration, but which currently lack a formal evidence base, such as in-person or phone/text-message-based 'check-in' systems. Many of the newer practices are informed by the experiences of people who use drugs and frontline service providers. Their accumulated expertise, combined with evidence from the scientific literature, suggests that creating a continuum of care for harm reduction and substance use, where comprehensive, well-resourced programs offer wrap-around services, care and support to people who use drugs, holds the key both to intervening effectively in the overdose crisis, and to ensuring the broader health of people who use drugs.

Harm reduction programs are well-placed to lead the response to the overdose crisis because of their origins in the grassroots community response to harms related to substance use. One of the major strengths of harm reduction is that it prioritizes the perspectives and active participation of people who use substances in the development of a response to the harms that can emerge from drug use; this includes a focus on the harms related to the social and societal responses to drug use such as criminalization and stigmatization. Privileging and centralizing the voices of people who use substances has been a major gap in both the provincial and federal responses to the overdose crisis to date. Both the *Ontario Strategy to Prevent Opioid Addiction and Overdose* and the Government of Canada's *Federal Action on Opioids* pay only limited attention to the potential for both people who use drugs and harm reduction approaches to address the overdose crisis.

In an attempt to redress this, the consultation process for this report prioritized hearing from people who continue to actively use drugs and access harm reduction programs, in an attempt to build on their knowledge and expertise in the development of these recommendations. This was supplemented by extensive consultations with harm reduction

service providers, and with key informants working in complementary sectors such as public health, mental health, shelters, and housing. An extensive review of the literature was also conducted. This process allowed for the development of a targeted set of recommendations, focused on the key elements necessary to build comprehensive harm reduction programs and services. The recommendations focus not only on the programmatic and organizational-level elements necessary to enhance harm reduction service delivery, but also on the broader changes necessary at the policy-level. Finally, the targeted focus on harm reduction within this report means that it does not examine the impact of other types of responses to drug use, such as prevention, treatment, and enforcement measures, as this was not within the scope of the report.

Major findings of this report

This report makes the case for a rapid expansion of harm reduction programs and services as a critical health equity issue. There is compelling evidence from front-line service providers, backed by the public health and health services research, to support the contention that harm reduction programs and services are well-placed to lead the response to the overdose and health equity crises. Twelve recommendations for building a harm reduction and substance use continuum of care are presented in this report *(see table: Complete List of Recommendations).* Each recommendation is elaborated upon in the report: a brief background is provided to outline the context and issue that the recommendation aims to address, and evidence from consultation respondents and the scientific literature is provided. Each recommendation concludes with concrete actions to implement and scale-up the recommendation.

However, there are 3 key recommendations that clearly emerged from the consultations, and one major, over-arching recommendation that underlies all others that need to be highlighted here.

Major recommendation:

Increased, sustained and dedicated funding for harm reduction program and service expansion is necessary

The consultations for this report found that the funding provided by the TC LHIN for human resource expansion in harm reduction was immediately put to use within CHCs to fill gaps in harm reduction service delivery. These gaps had been progressively developing in an environment of severe and consistent underfunding. This report identifies how haphazard funding, cobbled together from funding bodies at the municipal, provincial and federal levels, and often delivered as project-based, time-limited funding packages with high reporting requirements, led to an overstretched workforce that was already overcapacity when the overdose crisis began. Each CHC that received the TC LHIN funding put it to use in their individual areas of greatest need, primarily in continuing to build and enhance access to baseline harm reduction services *(see recommendation 4),* and to expand access to overdose prevention sites and supervised consumption services *(see recommendation 5).* The major recommendation from this report is not only for this particular funding to be maintained, but to quickly extend additional funding to allow harm reduction programs and services to meet the urgent needs revealed by the overdose crisis. Specifically, sustained and sufficient funding is required to increase access to harm reduction programs and services that are low-threshold, and informed by the perspectives of people who use drugs. This funding should be channeled directly to harm reduction programs that are community-based and already working with people who use drugs, rather than being subsumed into the larger mental health and addictions sector. People who are actively using drugs often feel alienated from the mental health and addictions sector, because they feel that it is too medicalized, and does not adequately respond to their needs. Distinctions between the harm reduction sector and the mental health and addictions sector should be maintained to ensure that the needs of people who use drugs are effectively served.

Top three priority recommendations:

The following three recommendations are highlighted because they were consistently discussed in the consultations, and voiced by all types of respondents. Participants in the consultation groups and key informant interviews identified these recommendations to be "the most urgent need in harm reduction now" *(see Appendix 2).* While certain policy recommendations may seem to be outside the purview of the TC LHIN, they are included here because they were consistently identified by respondents as being key factors necessary for achieving health equity for people who use drugs, and in creating sustained impacts on their health outcomes. The 3 top priorities identified are:

1) **Rapid scale-up of overdose prevention sites (OPS) and supervised consumption services (SCS)**

   - This recommendation is supported by strong evidence from the public health research literature.
   - The TC LHIN can support this priority by ensuring that adequate support and funding, including funding for infrastructure, is deployed to organizations that work with people who use drugs.

2) **Urgent reform in the area of drug policy**

   - Respondents overwhelmingly identified the continued criminalization of drugs and drug use as a major factor contributing to harms resulting from drug use, which is backed by scientific research.
   - Respondents identified decriminalization of currently illicit drugs a key priority, and a necessity to achieve public health policy goals.
   - The TC LHIN can support this priority by ensuring that human rights and public health principles are promoted when working with people who use drugs, and by supporting calls for evidence-based drug policies.

3) **The systematic poisoning of the illicit drug supply demonstrates the need for a safer, non-toxic drug supply for people who will continue to use drugs**

- Managed opioid programs, managed stimulant programs, and managed alcohol programs should be explored, developed and expanded. These programs provide people with pharmaceutical alternatives to illicit substances.
- People who use substances should be key partners in the design and development of these programs, to ensure that they are low-threshold options that meet the needs of the target population.
- The TC LHIN can support this priority by supporting the development and implementation of managed opioid, stimulant and alcohol programs that reflect local priorities and needs.

A note on terminology

In this report, the terms "substance use" and "drug use" are used somewhat interchangeably, with the term "substance use" referring to the use of any psychoactive substance, including ones that are legally available such as alcohol, and the term "drug use" referring to the use of drugs that are currently illicit or being used not as prescribed, such as heroin, opioids, cocaine, crack cocaine, and crystal methamphetamine.

In line with the statement from the International Network of People who Use Drugs (INPUD), the terms "people who use drugs" or "people who inject drugs" are privileged in this report (14). The term "addiction" is also avoided, as its use has been problematized by people who use drugs for propagating an "addiction as disease model" which risks pathologizing all drug use (15), and due to the difficulties of clearly defining addiction consistently and in a way that is non-stigmatizing (16).

Complete List of Recommendations: Building a Harm Reduction & Substance Use Continuum of Care

RECOMMENDATIONS FOR **RESOURCING THE HARM REDUCTION SECTOR**

Recommendation 1:	Actions:
Increase and stabilize funding for harm reduction programs and services	1) Increase core funding support to allow for expansion of harm reduction programs and supports within agencies. 2) Provide funding commensurate to the number of harm reduction program staff needed for the effective delivery of programs and their development. 3) Integrate OPS/SCS funding into core funding packages, and ensure that the funding provided is sufficient to provide the necessary services. 4) Develop a mechanism to ensure that successful project-specific funding can be easily rolled into core funding packages. 5) Address the pay disparity for peer positions or for positions reserved for people with lived experience; ensure these positions pay a living wage and provide necessary benefits. 6) Maintain funding for harm reduction programs and services separate from funding dedicated to mental health and addictions initiatives to ensure both accountability and dedicated harm reduction programming. 7) Ensure that infrastructure funding is available to organizations for renovations or expansion of physical spaces that meet the needs of the harm reduction programs. 8) Ensure that funding for renovations and infrastructure improvements that are necessary to open OPS/SCS are available.
Recommendation 2:	**Actions:**
Create a Harm Reduction Lead at the LHIN sub-region level to enhance coordination, training and support, and create a Harm Reduction Collaborative	1) Create and provide funding for a Harm Reduction Lead at the LHIN sub-region level. 2) Support inter-agency partnership initiatives by creating a Harm Reduction Collaborative at the LHIN sub-region level. 3) Explore ways that Harm Reduction Leads from across the province can come together and engage in cross-LHIN discussions and sharing of expertise (e.g., a province-wide Harm Reduction Collaborative).
Recommendation 3:	**Actions:**
Fund and support the opening of a Resource Centre for People who use Drugs	1) Consult with people who use drugs to learn about their vision for a Resource Centre for People who use Drugs. People who use drugs must take the lead in the design and development of a Resource Centre for People who use Drugs, its programs and services, and organizational culture/governance. 2) Capitalize on existing community organizations and on programs that have thriving peer programming. 3) Ensure that there is representation and leadership from key populations among people who use drugs (e.g., women, transgender people, people experiencing homelessness, Indigenous population). 4) Explore the possibility of an Indigenous Resource Centre for People who use Drugs. Engage in further consultation with Indigenous people who use drugs and Indigenous-led organizations to learn what resources and infrastructure are needed to support their work. 5) Provide sufficient funding to compensate the labour and expertise of those employed at the Resource Centre for People who use Drugs with a living wage.

RECOMMENDATIONS FOR **ENHANCING HARM REDUCTION PROGRAMS & SERVICES**

Recommendation 4:	Actions:
Continue to build and enhance access to baseline harm reduction services	1) Continue to provide resources and support the expansion of the harm reduction work force. 2) Continue to support programs as they develop innovative ways to expand hours of operations and service delivery. 3) Ensure that organizations working on harm reduction within the prison system are supported, and that harm reduction programs for people who are leaving the prison system and use drugs are developed and supported. 4) Provide financial and human resource support to partner agencies to develop harm reduction programming and policies. 5) Support communication and partnerships between allied organizations.
Recommendation 5:	**Actions:**
Scale-up overdose prevention sites & supervised consumption services	1) Support the immediate scale-up of overdose prevention sites and supervise consumption sites. 2) Support organizations that provide dedicated services to women and/or Indigenous populations to open an OPS immediately. 3) Encourage and support organizations that provide shelter and housing to people who use drugs to open an OPS immediately to address the high levels of overdose happening in shelters and in housing complexes. 4) Ensure that organizations have access to sufficient funding for infrastructure improvements to provide adequate space for OPS/SCS. 5) Ensure that OPS/SCS are sufficiently staffed by well-trained harm reduction teams that include people who use drugs and who reflect the communities that are being served.
Recommendation 6:	**Actions:**
Support the implementation of low-threshold managed opioid programs, managed stimulant programs, and managed alcohol programs	1) Facilitate and support the implementation of managed opioid programs using injectable prescription opioids. 2) Facilitate and support the implementation of managed opioid programs using oral hydromorphone. 3) Facilitate and support organizations who wish to partner with a research study on a vending machine dispensing model for managed opioid programs. 4) Facilitate and support the implementation of low-threshold programs for stimulant use. 5) Facilitate and support the implementation of managed alcohol programs. 6) Ensure that people who use opioids, stimulants and alcohol are key voices in the development and implementation of managed programs.
Recommendation 7:	**Actions:**
Scale-up integrated case management and medical service provision within harm reduction programs for people who use drugs and have multiple, complex health and social needs	1) Ensure the provision of comprehensive services and support, including dedicated case management and primary medical care, within harm reduction programs and in other programs where people who use drugs and have complex needs receive services. 2) Explore the delivery of low-threshold, de-medicalized mental health services and supports for people who use drugs and have concomitant mental health challenges. 3) Provide system navigation support to services users when necessary, including one-on-one accompaniment to help people access specialized housing, medical and social services, including psychiatric care.

RECOMMENDATIONS FOR **INTEGRATING HARM REDUCTION THROUGHOUT AGENCIES**

Recommendation 8:	Actions:
Focus on building harm reduction agencies	1) Ensure that the organization's mission, values, and strategic planning are aligned with a harm reduction philosophy. 2) Foster the development of organizational policies that are consistent with and reflective of a harm reduction philosophy. 3) Ensure that all programs within an agency (not simply harm reduction programs) are implementing harm reduction philosophies and frameworks.
Recommendation 9:	**Actions:**
Build the capacity of the harm reduction workforce through training & support	1) Ensure that all staff within agencies receive training on harm reduction. 2) Establish and support a province wide training program on harm reduction. 3) Ensure that management-level staff receive harm reduction training adequate to their role and the positions they supervise. 4) Support the development of targeted grief and loss-related supports for people who use drugs and harm reduction service providers on the front-lines of the overdose crisis. 5) Foster safe, healthy workplaces that are also "grief-aware" communities.

RECOMMENDATIONS FOR **SUPPORTING PUBLIC HEALTH POLICY AND SYSTEMS-LEVEL ADVOCACY**

Recommendation 10:	Actions:
Support advocacy for rapid change in drug policy	1) TC-LHIN should support health and social service organizations, particularly those that provide harm reduction programs and services for people who use, that advocate for evidence-based change to current drug policies. 2) TC-LHIN should provide support for using strong evidence and best practices to build policy and to inform changes to drug laws, including emphasizing that policies and laws should promote health equity and human rights.
Recommendation 11:	**Actions:**
Address stigma and discrimination against people who use drugs	1) Ensure that training to reduce discrimination and stigma against people who use drugs is provided to all health and social service providers. 2) Ensure that supports are in place to help organizations in multiple sectors (shelter, housing, mental health, drop-in programs) become more accessible to people who use drugs. 3) Support the development of broad-based drug education campaigns to reduce stigma.
Recommendation 12:	**Actions:**
Support measures to increase access to housing and adequate income for people who use drugs	1) Support TC LHIN funded supportive housing services in the development of harm reduction-based policies and guidelines, that can serve as a model for other shelters and housing service providers. 2) Provide support to shelters and housing service providers to rapidly implement overdose prevention sites to address the overdose crisis. 3) Support calls to raise social assistance rates for both Ontario Works and the Ontario Disability Support Program. 4) Support advocacy for more harm reduction shelter beds to be opened in the TC LHIN area. 5) Support efforts to increase availability of low cost and low-threshold housing.

Introduction

Definition of Harm Reduction

One of the most comprehensive definitions of harm reduction comes from Harm Reduction International, and states that: "Harm reduction refers to policies, program and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs, without necessarily reducing drug consumption" (17).

There are several key elements that underlie the harm reduction approach, and that are used to formulate the recommendations in this document.

A harm reduction approach puts people who use drugs at the centre

A harm reduction approach meets people who use drugs where they are, without judgement, and treats them with dignity and compassion (17,18). Crucially, it must also listen carefully to the priorities and needs that people who use drugs articulate for themselves (19). Sometimes, these priorities may align with the priorities of public health. For example, both people who use drugs and public health authorities want to avoid the transmission of bloodborne viruses like HIV and hepatitis C by distributing and using sterile injection equipment. But sometimes their priorities may also diverge. For example, people who use drugs have long prioritized obtaining a safe and reliable source of drugs, sometimes above other health concerns (19). It is only recently that public health authorities are beginning to explore this (20). This illustrates the importance of ensuring that the perspectives and voices of people who use drugs are central in the process of harm reduction program design, delivery and evaluation.

A harm reduction approach is based on a strong commitment to public health and human rights

A harm reduction approach prioritizes the human rights of people who use drugs, by emphasizing that human rights apply to everyone, at all times. People who use drugs do not forfeit any of their human rights, including their legal rights, their right to access health care and social services, or their right to be treated with dignity and respect, because of their drug use (21). A focus on ensuring the protection of the human rights of people who use drugs is key to a harm reduction approach.

A public health approach to drug use and the harm reduction approach are very compatible (22). Both approaches focus on reducing the harms associated with drug use by identifying and targeting potential harms, and developing interventions to address them. Both approaches focus on using evidence to develop programs, policies and practices. Additionally, a public health approach is concerned with person-centered and population health outcomes; preventing infection and disease by targeting individuals who are at high risk of health harms, while also aiming to promote health and improve wellness among the population as a whole, through the widest possible access to high-quality interventions and services. A public health approach also focuses on the need to achieve health equity, by paying attention to the situation and needs of groups that may be more vulnerable to health harms due to factors such as gender, race, history and experience of colonization, lack of housing and adequate income, for example.

Social policies and organizational practices can cause harm to people who use drugs

An exclusive focus on the behaviour of individuals perceived to be causing harm can obscure the ways in which policies and practices at the organizational and government level, including the laws in place within our societies and the policies in our organizations, can create and exacerbate harms for people who use drugs (23). Laws that criminalize drug use, rules and regulations that punish people or exclude them from services based on intoxication, drug use, discrimination against people who use drugs, and denial of proper medical care or access to harm reduction services are all examples of the ways that policy and practices can harm people who use drugs. An essential part of the harm reduction approach is to challenge policies and practices that contribute to drug-related harm, from international and national laws, to institutional practices such as denial of service based on intoxication, or barring someone for on-site drug use.

Use of the term 'harm reduction' within this report

In this report, the term 'harm reduction' will be used to talk about the ensemble of programs and services that focus on providing targeted services to people who use drugs, including the distribution of equipment for drug use and the creation of purpose-built spaces for people to use drugs in (such as overdose prevention sites and supervised consumption services). However, harm reduction is also used as a term to denote a philosophical approach to providing these services to people who use drugs. This philosophical approach is based in the values described above, where the humanity and autonomy of people who use drugs is respected. Additionally, the needs and perspectives of people who use drugs are centralized not only within the provision of services, but in the development of organizational policies and practices, with the aim of improving access to equitable health outcomes for people who use drugs.

History of Harm Reduction

Many harm reduction interventions started out as grassroots interventions run by people who use drugs, for other people who use drugs. It was in response to the threat posed by hepatitis B that people who injected drugs started the first needle and syringe distribution programs in the Netherlands in the 1980's, an intervention that was then scaled-up

by people who inject drugs and their allies in response to the emergence of the HIV epidemic (24). Medical and public health authorities were much slower to be convinced of the value of harm reduction interventions, in spite of strong evidence as to its effectiveness (24-27).

Worldwide, the coverage of harm reduction programs for people who use drugs remains sub-optimal; however, harm reduction interventions such as needle and syringe programs, supervised injection services and, more recently, naloxone distribution for the reversal of opioid overdoses, have been increasingly implemented, particularly in Canada, Australia, and in Western countries by progressive public health authorities over the last 25 years (28,29). The strong evidence for the effectiveness of harm reduction programs from both a public health and a cost-effectiveness perspective have led to support for harm reduction programs and services from both the medical and public health sectors, including major health organizations such as the World Health Organization, which considers several harm reduction interventions to be priority interventions for the prevention of HIV (30). Based on the accumulated evidence of its effectiveness at reducing the impacts of drug-related harms, harm reduction approaches should be considered an essential and crucial part of the comprehensive response to drug use within a community.

One of the major issues that harm reduction programs and services have faced is opposition from political leaders, and certain community groups (31,32). Due to deeply ingrained stereotypes and myths about drug use that stem from its criminalization, drug use is often framed as a moral failing, with harm reduction positioned as 'enabling' use (33). This has often led to sustained opposition to the scale-up of new types of services, such as the opposition that supervised injection services (SIS) has faced for years, and continues to face in most parts of the world (34-36). For example, opposition to supervised injection sites persists despite the overwhelming evidence that demonstrates their effectiveness in reducing drug-related harms, that they do not lead to increases in drug-related crime or public order concerns, and that community sentiment towards supervised injection sites is positive after they open (37-41). Occasionally, governments with philosophical objections to harm reduction services have attempted to interfere with the provision of these services, leading to protracted legal battles and sustained media coverage. In the Canadian context, this led a legal challenge to Insite, Vancouver's supervised injection site, and an affirmation by the Supreme Court of Canada of the constitutional right to health of people who use drugs, and their right to receive health services.

The persistence of stereotypes and myths about drug use and people who use drugs is fueled by the criminalization of drug use. As mentioned above, there is a substantial evidence base that demonstrates the efficacy of harm reduction in reducing drug-related harms, both for people who use drugs and for their larger communities. In contrast, and as will be explored in recommendation 4, there is no scientific evidence base that demonstrates a positive impact or outcome for enforcement measures in addressing the harms associated with drug use. In fact, there is no evidence that the broad array of measures often referred to as 'drug prohibition', including the criminalization of drug use, incarceration of people who use drugs, or longer sentences for drug-related offences have any impact on rates of drug use or availability of illicit substances, or work to decrease the harms related to drug use in any way (42-46). In fact, there is substantial evidence pointing to the contrary, that initiatives led by law enforcement and focused on arresting and charging people within the criminal justice system exacerbate drug related harms, including but not limited to hurried drug preparation and riskier use, and the avoidance of health and social services – including refraining from calling 911 in overdose situations for fear of legal sanctions (45,47,48). The failure to shift understandings of substance use from a criminal frame to a health-related frame may be continuing to contribute to harms from stigma and discrimination for communities of people who use drugs. This has resulted in years of partial or incomplete implementation of harm reduction, which has left communities without the necessary infrastructure to respond quickly and appropriately to the current overdose crisis.

Substance use

The stereotypes surrounding psychoactive substance use persist despite historical evidence that this substance use is very normal, having been present in cultures around the world throughout much of human history (49). Substances that were once legal and widely available without a prescription, like opium and cocaine, are now illegal and only available from illicit markets. Other substances, like alcohol, were prohibited in both Canada and the US during the 20th century, only to have substantial illicit markets fill the gap, before their legal use was reintroduced and regulated by the government (49). Rates of drug use have varied, and the popularity and legality of different types of drugs have also varied widely. More importantly, the way that we conceptualize substance use, whether as something pleasurable or harmful, innocuous or noxious and in need of regulation, has also experienced shifts in different cultures, and at different moments in time (50).

Research shows that the use of both licit drugs, such as alcohol or tobacco, and illicit drugs is relatively common, with most people trying at least one in their lifetime; problematic patterns of substance use are considerably rarer (49,51). For example, according to a recent survey of adults in Ontario, 80% reported consuming alcohol in the previous year, while only 7.2% met the criteria for "alcohol dependence"; for cannabis, 45.3% reported ever using cannabis in their lifetime, 14.5% used cannabis in the previous year, and only 7.5% reported moderate or high risk of problems from cannabis use; for cocaine, 8.3% of adults reported ever using in their lifetime, and 1.6% in the past year (52). For substances with lower lifetime prevalence rates, like opioids and cocaine, it is difficult to calculate the rates of problematic patterns of substance use at the population level with much precision. What is clear is that the number of people who develop problematic patterns of substance use are a small percentage of the overall number of people who use recreationally.

Substance Use Treatment

For people who develop problematic patterns of substance use, a minority will seek out some form of formal assistance or treatment to attempt to reduce their use (53). In fact, most people who develop

problematic patterns of use of a substance end up moderating or completing stop use of this substance on their own, without any type of formal intervention or treatment, a phenomena known as natural recovery (54,55). And while there is a vast literature available on the different modalities of treatment for substance use, ranging from psycho-social approaches to biomedical and medication-assisted treatments, an examination of their relative merits and drawbacks are beyond the scope of this report, which will focus on harm reduction approaches. However, it is important to note that, while often framed as a panacea to the problems associated with problematic patterns of substance use, the rates of relapse following treatment are high, ranging from 40-60% depending on the report and type of treatment (46,56). This does not negate the value of these forms of treatment. Recent recommendations to the TC LHIN on the subject of treatment (57), along with a broad range of academic and medical commentators all emphasize the need to scale-up the availability of high quality, evidence-based substance use treatment so that it is available for those who need and want it (58,59). But it is also important to recognize that treatment may not be appropriate for all people, and that like patterns of substance use, patterns of treatment success vary widely.

It is also important not to create an artificial distinction or opposition between harm reduction and treatment for substance use. Since harm reduction approaches support the needs of people who use drugs and meet people where they are, harm reduction also supports assisting people to seek out treatment when and if they feel that they might benefit from it. In fact, the success of harm reduction programs at helping people who use drugs to access treatment has been documented (60,61). It is also important to distinguish a harm reduction framework from a mental health and addictions framework, often called the 'brain-disease model of addiction' for understanding substance use (62). Harm reduction can be conceived of as a framework for providing person-centred care and increasing population health of people who use drugs, regardless of the type of drugs, the way that they choose to use, or whether they feel that their use is problematic or not. Seeing drug use solely within a mental health and addictions framework can limit the reach of programs to people who use drugs, because while some people who use drugs may also have mental health challenges, many will not (52). And depending on where they fall on the continuum of use, the majority of people who use drugs will not identify with the term 'addiction', nor meet the clinical criteria for drug dependency or problematic drug use (53).

Impacts of the Social Determinants of Health on Substance Use

There are numerous complex factors that influence the initiation and continuation of substance use, including individual, social, cultural, economic, political and socio-structural contexts. These factors are often referred to as the social determinants of health, and they account for the ways in which some people who use substances experience extreme marginalization, both due to their substance use and to its intersection with multiple other factors including poverty, housing instability or homelessness, food insecurity, gender, race and experiences of colonialism (63). These factors can have a strong influence on health, and the intersection of these factors can greatly affect the availability of resources and access to health and social services for people who use drugs, thereby creating a major health equity issue (64). Any interventions that attempt to improve the health of people who use drugs must engage with the social and structural factors that contribute to worsening the health consequences of populations already experiencing marginalization. These interventions must be attuned to how social determinants of health impact access and uptake of health care services, including harm reduction, and develop appropriate strategies for reaching priority populations. The needs of these key populations must be highlighted in the harm reduction response, to attempt to redress inequities in health outcomes that may be due to different needs or access considerations due to poverty, housing status, gender, sexual orientation, gender identity, gender expression, race, and experiences of colonialism.

The creation of enabling environments for harm reduction as key elements of a continuum of care for harm reduction and substance use

One of the ways to ensure that the social determinants of health are accounted for in the response to substance use is to focus on the environments in which drug use occurs. These environments, which are sometimes called "risk environments", focus attention on the physical, social, economic and structural environments that create risk or harm for people who use drugs (65,66). Risk environments include those created by laws that criminalize drug use, policies that are unfriendly to people who use drugs, and a lack of safe space for people to use drugs. Key to this approach is changing the locus of attention when intervening from the individual who uses drugs, to the social situations, structures and spatial environments in which people who use drugs find themselves (66). By focusing on creating enabling environments for harm reduction, this approach can be useful as it allows for harm reduction interventions to be adapted to the local context, and for consideration of elements that are unique to the local environment, while ensuring that focus remains on improving the environment in which people use drugs, thereby improving their health.

Building a harm reduction and substance use continuum of care

This report provides recommendations for building a harm reduction and substance use continuum of care, where a broad array of comprehensive, well-resourced harm reduction programs and services offer wrap-around services, care and support to people who use drugs, underpinned by a philosophical approach that respects the dignity and autonomy of people who use drugs, and centralizes their perspective and voice throughout. However, a comprehensive continuum of care is not limited to program and service provision. Several recommendations in this report emphasize the need for coordinated support for advocacy and action in order to transform our health and social service systems into responsive, inclusive, low-threshold sites in which every door is the

right door, welcoming to all people who use drugs. Additionally, it engages with the legal and policy environments in which programs and services are offered. Importantly, this includes addressing the harm caused by drug policies that criminalize drug use and contribute to stigma and discrimination against people who use drugs.

Overall, this report will explore the strengths of the current system, which provide a solid foundation on which to build. This includes passionate service providers who are committed to providing comprehensive services to their community members, who are innovating service delivery methods in environments where scarcity of funding is the norm, and who are engaging in advocacy for policy changes in a desperate attempt to turn the tide of the overdose epidemic. The report will then move to highlighting the areas where change is needed. What is most lacking is a strong financial commitment and the effective coordination necessary to oversee harm reduction efforts to quickly scale-up evidence-based programming to address the overdose crisis. Finally, the report will outline recommendations for the creation of a harm reduction and substance use continuum of care that integrates a coherent, cohesive philosophical approach, a comprehensive model of programs and services, with adequate funding, space, training, support and coordination across the sector.

Methods

Research Framework

A research framework was developed to guide the data collection and analysis, and to frame the development of the recommendations *(see diagram in Appendix 4).* It also summarizes the next steps that should be taken to ensure that the recommendations achieve their maximum effect; specifically, their implementation and an evaluation of their effectiveness.

Consultations to gather evidence from front line service providers, service users, and key informants

Development of the consultation structure

In consultation with the advisory panel, a consultation plan was developed. People who use drugs and access harm reduction services (service users), as well as service providers involved in the delivery of front-line harm reduction services were prioritized for engagement. These two groups were specifically prioritized in order to draw upon the first-hand, experiential knowledge and expertise that they possess. Care was taken to design a consultation group format that would be participatory. While the consultation groups loosely followed a focus group format, a series of 5 activities were used in each group to incite participation from all group members. The activities were designed specifically for this consultation, both to elicit the desired information on harm reduction programming, but also to ensure that all individuals would participate and no single voice would dominate.

Consultation groups

In January and February 2018, 14 consultation groups were held across the city, with at least 2 groups in each of the LHIN sub-regions. Overall, the consultation process engaged with 108 service users and service providers. 7 groups were conducted with service users, 5 groups were conducted with service providers, and 1 group was held with Indigenous community members. One group was also held with executive team members and harm reduction program managers drawn from the 5 community health centres involved in the project.

To ensure that key partners in the community were also engaged, each of the 5 community health centres was asked to nominate their 5 top partners in the community. Based on these nominations and feedback from the ED advisory group, a list was compiled for key informant interviews. Care was taken to ensure that all geographic areas of the TC LHIN were represented, and that a broad array of sectors and providers were consulted. Interviews with 17 key informants across the city were completed.

Altogether, a total of 125 respondents were involved in the consultations and key informant interviews. They were drawn from organizations working in: healthcare and public health (including healthcare and social service providers in both community health centres and hospital settings), agencies working with the corrections system, community organizations addressing mental health and homelessness, and shelters and housing providers.

Evidence from the research literature

To ensure that the recommendations in this report reflect the best available evidence in the field of harm reduction and substance use, a broad search of the research and academic literature was performed, focusing on the evidence underlying the harm reduction interventions most commonly deployed. Where available, systematic reviews were consulted. Additionally, best practice guidelines, program reports, and government reports were also used.

Analysis

With the consent of respondents, the consultation groups and key informant interviews were audio-recorded and transcribed. Thematic analysis was used to identify key themes that emerged in the discussions in the consultation groups and key informant interviews. The research evidence was synthesized simultaneous with the analysis of the themes emerging from the consultations, to allow for the evidence to inform the development of the recommendations. A preliminary version of the recommendations was provided to the advisory panel members for comment. Feedback was used to structure the final version of the recommendations in the report.

A more detailed overview of the methodology, including a diagram of the research framework that guided the process, is presented in Appendix 4.

Strengths of Current Harm Reduction Programs and Services

In the consultations for this report, respondents were asked to identify the major strengths, both of harm reduction generally, and of the harm reduction programs that they accessed and/or worked with. Overall, five major strengths of harm reduction programs and services were identified:

1) Supportive and welcoming staff in harm reduction programs;
2) Staff create spaces that are safe and accessible for people who use drugs;
3) Integration of people with lived experience into teams of service providers;
4) Positive effects on access to harm reduction equipment and supports;
5) Positive impacts on social determinants of health for people who use drugs.

This section provides an overview of these strengths, as enumerated by service providers and service users.

Strength 1: Supportive and welcoming staff in harm reduction programs

When discussing strengths, respondents repeatedly returned to discussing the high quality of the staff within harm reduction programs. Both service users and service providers highlighted the dedication of harm reduction service providers, and how they went out of their way to provide supportive, non-judgmental care for people who use drugs. Service users felt welcomed and respected:

> "I think one of the strengths is that you really do feel welcome. It really is accessible to anybody and to everybody. You know? I never come here and feel that anybody's judging me or looking at me funny, or you know shaming you." (Service user)

> "There's a lot of access to people that are willing to help you out. You know, no matter what the problem is, they're here for you. They don't really, you know, turn away. They always open the door to you." (Service user)

A new employee (hired with the TC LHIN funding) cited the team of harm reduction service providers as the major reason they wanted the job:

> "I'm super excited. I applied to this job, because - I'll just go to the strengths - but because of the people. And coming to the drop-in, I just had a great time. I'm like, 'Yes, I would want to work here.' I think the clients that they serve, they have their best interest in mind, which is really important. It feels more holistic and it feels very genuine. There's not a lot of a power imbalance struggle here. So those would be strengths for me." (Service provider)

Respondents also emphasized how the quality of staff members affected retention, allowing people to build long-term relationships among people who use drugs, as well as with service providers at other agencies in the community:

> "I think a strength that *(organization)* has across sites is the long-term relationships people have, and it affects staff retention here. It's got a good reputation amongst people who access services. And a lot of people have very long-time relationships with other folks in community, so I think that's one of the best things." (Service provider)

Strength 2: Staff create spaces that are safe and accessible for people who use drugs

Respondents highlighted how staff went out of their way to create programs and spaces that were low threshold, holistic, and genuinely-client focused and driven:

> "I think one of the strengths at *(harm reduction program)* is its openness to accept people where they're at. It's open to anybody who cares to enquire, right? And everybody is accepted equally, in a welcoming, non-judgmental way." (Service user)

> "One of the strengths here is the multidisciplinary aspect, the holistic and multidisciplinary aspect of the programs. In terms of the history, what I see is a lot of kind of courage, bravery to do whatever it takes. Say something like a program is unpopular, well they push it, because, it's the right thing to do." (Service provider)

There was concern though, that while harm reduction programs were providing a welcoming and supportive environment for service users, that this didn't necessarily translate into safe and accessible services across the organization:

> "So within our team, I think we're doing an awesome job, and I think that we all support participants well. But, I don't think that's translated in other areas of the actual community health centre. So, it's not a cohesive service model. I think at in in our area, and even with the social work team, we're good. But I think beyond that, there needs to be training." (Service provider)

"The strength is people that listen, I guess. But sometimes, there's too much judgment. By some of the staff that work here, not the harm reduction staff, but some of the people that work in the building. Like, "you're junkies" or whatever, right? They look down on you." (Service user)

Strength 3: Integration of people with lived experience into teams of service providers

An important strength mentioned was the steps that harm reduction programs were taking to train and hire people with lived experience of drug use as service providers, both in "peer" positions, as well as into more permanent roles. This emphasis on allowing programs to be "by and for drug users", is well reflected in the statement that one service provider attributed to harm reduction champion Raffi Balian, that "every service user is a potential service provider" in harm reduction programs. There was also a feeling that people with lived experience could be more open about this as an asset they were bringing to their role, rather than as a drawback that had to be hidden:

"I'd say that one strength is that there's been a shift in a larger way towards increased roles for people with lived experience. Our organization, actually, through design or accident, ended up with more folks who started off as peer workers and identify as people with lived experience. So, I'm not going to say that people didn't have lived experience before, but the ability to identify that publicly was not there. And it's not just identifying as a person with lived experience with a service user sort of quietly, cause you don't want the ED *(executive director)* to find out you're doing it. We can say that in the meeting and the ED will back that up, and that's been, I think, a great strength." (Service provider)

The impact of having people with lived experience, including people who openly identify as currently using drugs, should not be under-estimated. Having people who use drugs working openly in key roles in community health centres provides strong, positive role-modeling for service users:

"Everything that they do here is really great. Like, I think the staff that work in harm reduction - they are pretty awesome. And it's nice that they are users too, you know what I mean? They know what they are talking about. And it changes the atmosphere, you know? Like I watch everybody interact with people who come in. They're really trying to do their best here. So, it's really great. You can tell by the way everybody treats everybody else." (Service user)

Strength 4: Positive effects on access to harm reduction equipment and supports

The purpose of harm reduction programs has been to provide sterile equipment for drug use, to prevent the transmission of bloodborne disease among people who use drugs, and to reduce the negative health outcomes for this population. Respondents described how harm reduction programs were not only meeting this need, but that they had rapidly expanded in the context of the overdose crisis to work on overdose prevention and response as well:

"They hand out all kinds of kits, you know what I mean? Yeah, like needle kits, stem kits. And then the meth kits. And the condoms and everything else. I don't know where I'd be without that." (Service user)

"One strength of *(organization)'s* harm reduction program is safe use. It's my backbone. It's my home away from home. It's saved my life, *(name of organization).* Like literally, they gave me the *(naloxone)* kit that got used on me when I ODed. It's got lots of strengths and lots of good workers." (Service user)

Strength 5: Positive impacts on social determinants of health for people who use drugs

In addition to reducing the risk of negative health outcomes like the transmission of HIV and hepatitis C, and from overdose, respondents also highlighted how they understood their work as going beyond the provision of health-related services to people who use drugs, to include working towards addressing health equity issues:

"I think there's a real solid understanding in our team of harm reduction as a social justice movement." (Service provider)

"I think one of the strengths, I do agree, again, that our staff is very passionate. Like, we are very committed to the work. Very innovative and always trying to really meet the needs and the gaps that we have in the community. Not just the health needs, but the other needs too – housing, food, even helping with police-related issues." (Service provider)

Respondents pointed out that harm reduction programs provided low-threshold access to services that went beyond their mandates (such as in helping with housing issues), and workers persisted in providing support, even in difficult moments:

"Strengths for the *(harm reduction program)* is their compassion and their willingness to always be there for you, no matter what, you know? You can be an asshole one day and they treat you the same way the next day. And on all kinds of issues, not just the drug stuff. They got me sorted when I was going to lose my place." (Service user)

Impacts of the funding from the TC LHIN

The funding provided to five community health centres in 2017 by the TC LHIN went into expanding baseline harm reduction services – particularly into hiring workers for basic service delivery, including expansion of outreach efforts. This funding allowed organizations to quickly scale-up baseline service delivery in the areas of highest need:

> "Getting the funding was nice. Because even in funding, it's been very difficult to try and find funding to put together some services, some basic services. We struggle here quite a lot just trying to find funding. We had some great programs and can certainly demonstrate it works." (Service provider)

The funding from the TC LHIN has meant that organizations have the ability to hire new staff:

> "We are in a period of expansion right now. We are bringing in new staff, training them up, which is great." (Service provider)

The funding also allowed organizations to quickly scale-up interventions to reach populations of people who use drugs and are at high risk of negative health outcomes, including overdose, who are not necessarily coming into CHCs and harm reduction programs located within health and social service organizations *(see recommendation 4 for more information).*

> "We've been able to scale-up, finally. Start offering naloxone training, giving out the naloxone kits. We've wanted to do that for awhile, and there was a huge demand. And we just couldn't fit it in, with the staff complement that we had." (Service provider)

However, and as will be explored in recommendation 1, the time-limited nature of the funding makes it difficult for organizations to engage in long-term planning and program development. Additionally, respondents highlighted that a huge need still exists, particularly in building long-term efforts to reach people who are precariously housed, or who are live in apartment buildings with high rates of overdose.

> "So we are doing more outreach. And we are starting to build relationships with people in *(address of apartment building)* and *(address)*. There are a lot of ODs there. There is so much need. And it takes time to build those relationships, to build trust." (Service provider)

> "You know what we need? Like a bus. A health bus, that will come to you at night. Or someone you could call to come by. And bring you kits, and show you how to use Narcan, at home, where it's comfortable." (Service user)

There was a sense of frustration voiced by some respondents, that the work done in harm reduction programs was very challenging, and was not properly supported *(see recommendation 9)*. While the respondent in this quote acknowledges that some support has been forthcoming, like the funding from the TC LHIN, there was clearly a belief that supports were not addressing the current level of need:

> "But I'd also like to just have the piece around acknowledging that it's very challenging and difficult work, and that we need to push through that. Like, you know, I'm not saying anyone around this table would say this, but just that 'Oh just get going.' I mean, it's very, very, very hard, challenging work, particularly for folks on the frontline, and for those folks that they're trying to work with. And I think some acknowledgement of that. And some support for that. I think that we are starting to see some acknowledgement of that, with this new money. At least I hope so." (Service provider)

Overall, the recommendations in this report will illustrate how the increase in funding has been used to support efforts to scale-up baseline harm reduction programming and supports for overdose prevention sites *(see recommendations 4 & 5).* However, as will be shown in recommendation 1, this funding increase must be sustained, and increased to allow for harm reduction programs and services to meet the high level of need that currently exists, and that harm reduction programs and services are attempting to address:

> "There's always a crisis for people that are living in poverty. They're always going to be dying. We've lost them. We lost, one summer here, eleven clients in three months. It was horrible. And a couple of things they had in common: they were all Indigenous, and they were all poor. And that's part of the opiate crisis. Most of the folks that have died of opiate overdoses, are people living in poverty." (Service provider)

RECOMMENDATIONS FOR **RESOURCING THE HARM REDUCTION SECTOR**

Recommendation 1:

Increase and stabilize funding for harm reduction programs and services

AT A GLANCE:

THE CHALLENGE:

- The lack of dedicated harm reduction funding is a significant challenge in trying to provide harm reduction programs and services.
- Funding for harm reduction programs and services is haphazard, and cobbled together from a mix of municipal, provincial and federal sources.
- The current funding model relies largely on project-based rather than core funding, meaning staff dedicate significant time to onerous application and reporting processes, rather than spending time on providing services to people in need.
- Program delivery often relies on the un- or under-paid labour of peer workers.
- A lack of funding for renovations and infrastructure improvements impedes the ability of organizations to meet the needs of all service users.

THE SOLUTION:

- Increase and stabilize funding for harm reduction programs and services.
- Dedicate funding to scaling up front-line programs and services that have the strongest potential to effectively intervene in the overdose crisis, e.g., Overdose Prevention Sites (OPS) and Supervised Consumption Services (SCS). Ensure that successful project-specific funding in harm reduction can be easily rolled into core funding packages to allow for stability in program planning.
- Provide funding necessary to pay all workers, including peer workers, a living wage and benefits, including necessary remuneration for team meetings and professional development.
- Provide funding for renovations, expansion or infrastructure improvements to allow for harm reduction programs to be accessible, and to protect the privacy and confidentiality of service users.

Background:

Historically, dedicated funding for harm reduction programs has often been low, despite the substantial evidence base demonstrating these programs' capacity to prevent transmission of blood-borne diseases, prevent and intervene in overdoses, and integrate people who use drugs into the health and social service systems. Additionally, funding for harm reduction programs and services is often drawn from a mix of municipal, provincial, and federal programs, with few funding envelopes providing long-term, base funding that is reliable and long term. Not only does insufficient, unstable funding and onerous funding requirements from multiple funders increase complexity and limit the potential reach and effectiveness of programs, it also creates equity issues and workplace concerns. Frontline workers are working beyond capacity to juggle multiple tasks and perform work that goes unrecognized or beyond their job descriptions. Programs are often dependent on the un/under-paid labour of people who use drugs, often called 'peer workers', who do instrumental tasks that formally employed staff do not have time to perform, such as assembling kits, doing outreach, or facilitating drop-in services. Management and program staff do not have the time to do the necessary policy development, program planning, training, and supervision to support their programs and workers.

Additionally, a major issue confronting harm reduction programs is the lack of physical space to accommodate program needs within their current buildings. Several agencies discussed the need to expand their harm reduction programs to include OPS/SCS, but stated they do not have the space or resources to implement these lifesaving programs. Without sufficient funding for renovations and infrastructure improvements, organizations are hampered in their ability to meet the needs not only of their harm reduction service users, but of all the service users in the agency more generally.

What we heard from respondents:

Insufficient and unstable funding is the primary weakness

Overwhelmingly, respondents felt that a lack of funding dedicated to harm reduction programs, services and initiatives was the major weakness relating to harm reduction. Further, chronic underfunding of harm reduction programs has created a situation where existing programs were stretched too thin to properly respond to the additional demands created by the overdose crisis:

"We don't have all the program funding we need. We fight and struggle against it all the time." (Service provider)

"This was a system that was totally under-resourced already. There was absolutely no excess capacity. And then the *(overdose)* crisis hit, and it rapidly became clear just how badly underfunded everything was." (Key informant)

Respondents frequently spoke of the daily struggles of working in an under-funded environment:

"So we're asked to do more stuff around overdose, HIV and Hep C prevention, dealing with some of the most difficult clients, having the highest de-escalation skills on staff. But then to do case management, counselling, make sure people are appointment-ready, stats, running groups. Then answering to funders, we're on project money, so we have to do NEO and all that crap on top of all the funder stats and the funding applications that come in to us. Thus, giving zero time for like, supervision, the nitty gritty of our jobs, all of that." (Service provider)

Over-reliance on program and project funding

Respondents emphasized the need for stable funding for harm reduction programs to be included within organizations' core funding packages. Respondents described the challenges of working with time-limited funding or one-off project-specific grants, many of which carry a high burden of reporting. Time spent on funding applications and reporting detracts from time available for service delivery. This funding reality exists in stark contrast to clinical programs, whose funding is included in core funding packages. Ensuring stable funding and reducing extraneous reporting requirements is of key importance to this endeavour.

"I can't even tell you how many amazing programs that we've developed over the years, that went away because the funding went away." (Service provider)

Impact of TC LHIN funding

The funding that was quickly rolled out in fall 2017 was mentioned by respondents, as it allowed them to quickly scale-up much-needed programs. However, the time-limited nature of the funding was mentioned as a drawback. Given the urgency of the current overdose crisis, human resources need to be focused on effectively and efficiently delivering services, and needs to be sustained in the long-term to be able to have a lasting impact.

"It's so hard to do proper program planning. Because of the funding inconsistencies. Like, I know we have money to pay harm reduction workers until March, but then what?" (Service provider)

And while organizations appreciate the funding for human resources that was received, it also highlighted that lack of infrastructure support that can impede program expansion:

"Getting funding to hire harm reduction workers is great. But we don't have anywhere to put them. We just don't have the space to expand the harm reduction program." (Service provider)

Lack of physical space and infrastructure necessary to provide harm reduction services:

A lack of funding for physical infrastructure (renovations to existing buildings, expansions, rental of additional locations for service delivery, or temporary units such as trailers) hampers the ability of organizations to expand harm reduction programs and services:

"People using the harm reduction program come here to shower, have breakfast in the morning, to meet with peers, and it doesn't happen without space. They are currently sharing space with youth programs and it is very difficult." (Service provider)

Without the necessary program space or staff hours, many agencies rely on front desk/reception staff to distribute harm reduction equipment and supplies to service users. While this is an adequate method of ensuring the availability of harm reduction equipment, it does not enable people who use drugs to have access to dedicated harm reduction workers who act as first points of contact for entry into the health system, and to build the relationships of trust necessary to improve health outcomes. Further, the lack of privacy may dissuade service users from asking for supplies:

"The weakness is the, the stigma side of it, see. We don't want to walk in to the front desk, where there's doctor's appointments – there's, like, five receptionists, all kinds of people. And everybody watching you. And you know, you gotta explain yourself. You know, those bags *(that harm reduction supplies)* come in, everybody knows that, so there's no privacy." (Service user)

Reliance on un- or under-paid peer workers to perform instrumental program tasks

Underfunded and overextended harm reduction programs have frequently relied on the un- or underpaid labour of service users and community members as peer workers. There is growing awareness of the inequities that peer workers face in their workplaces and across agencies. For example, some agencies compensate peer workers with pizza and tokens, others pay honoraria ranging from $11-15 per hour or per shift, while others formally employ workers with lived experience as casual employees, paying them over 15$ per hour.

"Value lived experience: pay people like you would 'formally' educated people. We need lived experience pay equity. And remove the post-secondary education requirements in hiring practices." (Service provider)

The challenge to provide sufficient services outside of the downtown core

Respondents discussed the difficulties in providing harm reduction services outside of Toronto's downtown core. Many noted the lack of programs and services in the east, west and northern parts of the TC LHIN.

> "And a gap is always lack of resources and services, right? There's some strong gaps in the west, because many of the services are downtown-centric." (Service provider)

> "We need to build capacity and support in Scarborough. There are funding calls, but no one responds. I think there is sometimes a lack of capacity, and a lack of comfort with harm reduction outside of the downtown core. A lot of organizations aren't committed to providing HR services. It needs be both the right idea and the right model." (Key Informant)

Under-resourced programs located outside the downtown core are expected to serve a very large geographical area:

> "We'd love to have more hours for the harm reduction office here to be open. But up until recently, we have one worker, who has to cover three sites, and do outreach. And do community partners, work with them in their spaces. And do reporting." (Service Provider)

Actions:

1) **Increase core funding support to allow for expansion of harm reduction programs and supports within agencies.**

2) **Provide funding commensurate to the number of harm reduction program staff needed for the effective delivery of programs and their development (including adequate time for supervision, professional development, policy development, reporting, peer support, etc.).**

3) **Integrate OPS/SCS funding into core funding packages, and ensure that the funding provided is sufficient to provide the necessary services.**

4 **Develop a mechanism to ensure that successful project-specific funding can be easily rolled into core funding packages. Project specific funding should be maintained to allow agencies to promote innovation, to nimbly respond to crisis situations, and to develop projects specific to their particular neighbourhoods, circumstances and needs of their clients.**

5) **Address the pay disparity for "peer" positions or for positions reserved for people with lived experience; ensure these positions pay a living wage and provide necessary benefits.**

6) **Maintain funding for harm reduction programs and services separate from funding dedicated to mental health and addictions initiatives to ensure both accountability and dedicated harm reduction programming.**

7) **Ensure that infrastructure funding is available to organizations for renovations or expansion of physical spaces that meet the needs of the harm reduction programs. These spaces must be easily accessible and provide privacy and confidentiality to service users. Consult with service users and people who use drugs to learn which features or layouts would be most effective for meeting access needs.**

8) **Ensure that funding for renovations and infrastructure improvements that are necessary to open OPS/SCS are available (including the ventilation systems required for inhalation sites to open). Ensure that organizations that need to move harm reduction programs to new locales (particularly if programs are expanding to accommodate OPS/SCS) have access to the financial support for rent, renovations and moving costs.**

Recommendation 2:

Create a Harm Reduction Lead at the LHIN sub-region level to enhance coordination, training and support, and create a Harm Reduction Collaborative

AT A GLANCE:

THE CHALLENGE:

- There is a lack of coordination, training and support for harm reduction initiatives at the LHIN region and sub-region level.
- This lack of coordination makes it difficult for existing harm reduction programs to work to their full scope, and means there is insufficient guidance for services and organizations attempting to launch new harm reduction initiatives.

THE SOLUTION:

- Create and fund a Harm Reduction Lead (FTE) within each sub-region in the TC-LHIN to convene, coordinate and support inter-agency partnership initiatives to address the overdose crisis, and to focus on improving health equity and population health outcomes among people who use drugs.
- Convene a Harm Reduction Collaborative to provide a space for information sharing, facilitate coordination across the LHIN sub-regions, and to ensure effective collaboration among agencies.
- Explore whether the appointment of a Harm Reduction Lead Agency would be effective in the context of sub-region planning and coordination efforts.

Background:

Throughout this consultation, stakeholders consistently cited the lack of coordination within the harm reduction sector as a central challenge that limits the effectiveness of harm reduction programs and services, particularly during a crisis situation. Respondents voiced frustration that there is neither clear leadership or coordination, nor formal inter-agency partnerships for training and support, to address the current overdose crisis. Organizations with strong backgrounds providing harm reduction programs and services have attempted to meet the increasing demand for expertise and support from other community service providers, while also attempting to scale-up their internal capacity to respond to the crisis. Community organizations, including both those that traditionally provided harm reduction services and those that provide allied services (in the mental health and homelessness sectors, for example) want information and leadership on how to build a coordinated response to the overdose crisis. This is a prime moment for the LHIN to take a leadership role to provide support for leadership and capacity-building, and establish coordination across the sector.

What we heard from respondents:

Respondents highlighted the lack of clear responsibility for coordination:

> "We live in a patchwork healthcare system as it relates to this *(substance use)* issue, with no entity that has clear responsibility for coordination, for policy direction, so we all work within our own domains of responsibility and jurisdictions. And we rely on good will and collaboration, and sometimes it's messy, and sometimes it doesn't work well, and sometimes we screw up and have to start it over again." (Key informant)

Respondents described how agencies who are attempting to build their internal capacity for providing harm reduction programs and services, turn to larger, more established harm reduction programs:

> "Smaller organizations are turning to the larger CHCs for support as they try to build programs and capacity. So, then these larger programs start to overstretch themselves. They need to keep providing services, while now being in a role where they are providing advice and capacity building and support to smaller organizations. It's a lot to juggle." (Key informant)

Actions:

1) Create and provide funding for a Harm Reduction Lead (FTE) at the LHIN sub-region level

- The Harm Reduction Lead would be responsible for convening community partners, facilitating inter-agency collaborations, and the transfer of expertise and knowledge in responding to the health needs of people who use drugs, with a particular emphasis on addressing the overdose crisis and ensuring the meaningful participation of people who use drugs in the response.
- The Harm Reduction Lead would be located at the community-level, within a community organization with demonstrated expertise in harm reduction and working with people who use drugs.

2) Support inter-agency partnership initiatives by creating a Harm Reduction Collaborative at the LHIN sub-region level

- The Harm Reduction Collaborative would address the need for a way to facilitate inter-agency partnerships and the exchange of knowledge and expertise on Harm Reduction.
- The collaborative can capitalize on the strengths of agencies within the TC LHIN who have knowledge and expertise in harm reduction.
- Membership in the Harm Reduction Collaborative would consist of community-level organizations that work directly with people who use drugs, whether or not this is the primary focus of their organizational mandate, e.g. CHCs, community organizations working in mental health, housing and in providing medical services to people who use drugs, street-involved populations, or populations with complex needs, organizations that provide drop-ins or outreach services, and those that provide low-threshold, community or supportive housing, shelters, and warming centres.
- As part of a phased process that begins with the creation of Harm Reduction Leads, and the creation of a Harm Reduction Collaborative, partners in the Collaborative should explore whether appointment of a Harm Reduction Lead Agency would be an effective model in the context of sub-region planning and coordination efforts.

3) Explore ways that Harm Reduction Leads from across the province can come together and engage in cross-LHIN discussions and sharing of expertise (e.g., a province-wide Harm Reduction Collaborative)

- Province-wide collaboration and support is essential for building capacity across the sector in order to rapidly scale-up harm reduction programs and services, particularly in the form of Overdose Prevention Sites.

Recommendation 3:

Fund and support the opening of a Resource Centre for People who use Drugs in the TC LHIN

AT A GLANCE:

THE CHALLENGE:

- Harm reduction programs and services within Toronto are generally delivered within health-related agencies such as community health centres. The clinical and medicalized environment can dissuade some people who use drugs from accessing harm reduction services.
- Grassroots groups of people who use drugs lack financial support and other resources, which limits their potential effectiveness as partners in the health response to drug use.

THE SOLUTION:

- Fund the development of a Resource Centre for People who use Drugs, a space run by and for people who use drugs.
- A Resource Centre for People who use Drugs will provide a central hub for people who use drugs and organizations working with them to meet; organize; access and share resources and services; reduce social isolation; build community capacity to provide critical expertise in the development of public policy and program development.

Background:

In Toronto, grassroots groups established by people who use drugs and their allies work to address unmet health and social needs within their communities. Groups such as Toronto Overdose Prevention Society, Toronto Harm Reduction Alliance, Toronto Drug Users Union, Toronto Harm Reduction Workers Union, and the Frontline Workers Support Group have been operating outside of any formal institutional support in order to respond to issues such as the overdose crisis, the housing crisis, work conditions, stigma and discrimination, and harms associated with drug policy that criminalizes drug use. These groups advocate for the rights of people who use drugs and develop innovative ways to address gaps in health and social services. Their efforts are hampered by a lack of resources and support, and there is missed potential to harness their considerable expertise, knowledge, and experience.

Organizations operated by and for people who use drugs (sometimes called Drug User Resource Centres) provide a much-needed alternative to clinical and medicalized environments. People who use drugs may be fearful and untrusting of conventional health and social service organizations because of the stigmatization and discrimination that they have encountered previously at the hands of service providers. A Resource Centre for People who use Drugs would provide a valuable opportunity for people who use drugs who are unconnected or mistrustful of traditional health and social services to receive the care they desperately need and deserve. This is a critical health equity issue.

What we heard from respondents:

Respondents highlighted the need for spaces that are designed specifically for people who use drugs, including spaces that provide a safe haven for people when they are intoxicated. They would like to see spaces that are multi-purpose: offering harm reduction programs and services, including overdose prevention site and/or supervised consumption services, health or social services, as well as recreational activities.

> "I think my blue sky would be a place for drug users, by users. A real place of their own, not just a room inside a CHC. Not that our programs aren't great *(laughs)*. They are. But it's really hard to get ownership and buy in from our service users, because they are always going to be a smaller part of a larger organization, that has multiple priority groups that they are trying to balance." (Service provider)

The need for dedicated spaces was also highlighted by people who use drugs in the consultation for Indigenous service users:

> "We need a safe space that they could hang out when they're under, and there's things you could do there, you know, like, just like doing some kind of art. Smudging. To be able to receive some teachings on the seven grandfathers or something. You know? Cause I feel like, when they receive those things, it really helps to open up their eyes. Even though struck in the streets. They're at least able to carry those teachings with them, when they're in their most darkest place. For me, I think that's very good harm reduction." (Indigenous service user)

Spaces that are by and for people who use drugs was considered to be a crucial need:

> "This has to be drug-user driven. Sex worker driven. Peer driven, whatever you want to call it. It has to actually be client-centered in a way that is about supporting people regardless of rule or law-breaking. But with accountability." (Service provider)

> "We need a network of safe, accessible spaces for people who use drugs, preferably staffed by people who use drugs" (Service provider)

Additional evidence from the literature

Organizations of people who use drugs have developed innovative responses to public health threats to their communities

Organizations of people who use drugs have been instrumental in advocating for the rights of people who use drugs, and developing and delivering innovative services. For example, needle and syringe distribution programs (NSP, or 'needle exchange') – a key harm reduction intervention - were first started by people who injected drugs in the Netherlands in the 1980's to address the threat of hepatitis B transmission (24) . Injection drug use was recognized as a prime method for the transmission of HIV (and later, hepatitis C), leading to the gradual scaling up of NSP, first by people who inject drugs and their allies, and later by public health authorities as a method of reducing the transmission and burden of these diseases (24).

Organizations of people who use drugs are more effective at reaching a larger group of people who use drugs than traditional health and social service providers.

There is strong evidence that peer-led initiatives (such as organizations of people who use drugs) are effective at mobilizing the first-hand, experiential knowledge of people who use drugs, and can expand the reach of health and social services. Initiatives driven by groups run by people who use drugs have been recognized in the public health literature for their impact on reducing overdose mortality and the transmission of bloodborne diseases, while also building community capacity, reducing social isolation, and connecting people who use drugs to social and health services (67-70).

The Vancouver Area Network of Drug Users (VANDU) is a grassroots organization of people who use drugs that provides peer education, distributes harm reduction equipment and supplies, and has operated unsanctioned supervised injection sites to address overdose, and epidemics of HIV and hepatitis C (25,71,72). In recognition of the critical role that VANDU plays in responding to the health crisis, Vancouver Coastal Health (the local health authority) has provided funding for VANDU's activities since 1999.

Opportunities for employment and participation in collective advocacy efforts reduce social marginalization, increase income security and improve health outcomes

Organizations of people who use drugs also provide a space for people who use drugs to engage in meaningful community connections and paid work. Research has recognized how the multiple layers of marginalization experienced by people who use drugs (such as poverty, precarious housing situations, stigma, and the impacts of the criminalization of drug use) can influence their ability to integrate into the labour force (73,74). Providing adequate financial support for people who use drugs and organizations of people who use drugs is key to their success. Participation in civic engagement and collective advocacy initiatives also provide demonstrable health benefits for communities dealing with health inequalities and social marginalization. Further, ensuring that people who use drugs have access to well-paying, low-threshold employment opportunities may provide strong individual and public health benefits (75).

Actions:

1) **Consult with people who use drugs to learn about their vision for a Resource Centre for People who use Drugs. People who use drugs must take the lead in the design and development of a Resource Centre for People who use Drugs, its programs and services, and organizational culture/governance.**

2) **Capitalize on existing community organizations and on programs that have thriving peer programming. Currently in Toronto, there are several community groups that are either driven by people who use drugs, or closely allied with them. There are also agencies with strong peer programs that are service user-driven. These groups have knowledge, skills, and experience that may be harnessed to develop an effective Resource Centre for People who use Drugs.**

3) **Ensure that there is representation and leadership from key populations among people who use drugs (e.g., women, transgender people, people experiencing homelessness, Indigenous population).**

4) **Explore the possibility of an Indigenous Resource Centre for People who use Drugs. Engage in further consultation with Indigenous people who use drugs and Indigenous-led organizations to learn what resources and infrastructure are needed to support their work.**

5) **Provide sufficient funding to compensate the labour and expertise of those employed at the Resource Centre for People who use Drugs with a living wage. Although the Centre may offer a variety of ways that people may participate beyond formal fulltime employment, workers must be adequately compensated. Policies and sufficient resources are needed to reduce barriers to participation and employment.**

Recommendation 4:

Continue to build and enhance access to baseline harm reduction services

AT A GLANCE:

THE CHALLENGE:

- Funding for baseline harm reduction services such as the distribution of sterile equipment for using drugs and outreach activities comes from a wide range of sources, leading to difficulties ensuring adequate staffing and programming.
- Access to harm reduction equipment and services is hampered by limited agency hours and locations, particularly outside of the downtown core.
- The lack of harm reduction programs within prisons and targeting people who are leaving the prison system puts this group at high risk of negative health outcomes, including overdose.
- There are many community organizations that provide services to people who use drugs (e.g., shelters, housing, drop-ins, mental health agencies) that offer minimal or no harm reduction equipment or services, and whose staff have little to no training in harm reduction.

THE SOLUTION:

For programs that currently offer harm reduction programs and services:

- Fund the expansion of human resources and service delivery to ensure that harm reduction equipment and supplies are available outside of regular service hours;
- Support and promote the involvement of people who use drugs in service planning and delivery;
- Encourage and support agencies to explore alternate models of service delivery, particularly those that deliver services directly in the spaces where people gather to use drugs, including: satellite sites, mobile services/delivery of equipment, vending machines for equipment, and outreach programs.
- Support organizations that currently work on harm reduction within the prison system, and ensure that adequate programs exist for people who use drugs who are leaving the prison system.
- Immediately scale-up overdose intervention training and naloxone distribution, to both agency staff and community members.

For programs that currently offer minimal or no harm reduction programs and services, particularly those that run programs for people dealing with mental health challenges, drop-ins, or provide housing and shelter services:

- Integrate harm reduction philosophy into organizational guidelines and develop policies that allow for low-threshold access for people who use drugs.
- Increase the involvement of people who use drugs in service planning and delivery.
- Integrate harm reduction equipment distribution (including naloxone distribution) into drop-ins, shelters & housing complexes where drug use is present.

Background:

The provision of harm reduction equipment to people who use drugs is a baseline harm reduction service, and is offered in locations across the city. Locations with a contract for harm reduction equipment distribution can be seen in a list provided by Toronto Public Health (76). Despite the widespread roll-out of harm reduction equipment distribution, people who use drugs continue to experience difficulties with access, particularly during evenings and on weekends, and outside of the downtown core. Additionally, people who use drugs benefit from a wide range of health and social services, beyond harm reduction services, and harm reduction programs can function as service delivery hubs to provide needed connections into the health and social service system.

In fall of 2017, several CHCs in the TC LHIN received funding for harm reduction human resources. This allowed harm reduction programs within these CHCs to quickly scale-up their baseline harm reduction service delivery in their local areas of greatest need, by providing resources for hiring harm reduction workers. However, these areas of highest need were longstanding, due to long-term underfunding of harm reduction programs. While the TC LHIN funding was useful, the long-term underfunding and the continued growth in overdose death rates demonstrate a long-term need for continuing to scale-up funding within this sector.

Additionally, there are not enough truly low-threshold programs and services across health and social service organizations, such as mental health programs, drop-ins and respite centres, shelters and housing providers. Employees of these agencies do not necessarily have training in or understanding of harm reduction, and agencies may not have the organizational policies to implement low-threshold services to people who use drugs. Support and training for these allied health and social service organizations is needed to reduce barriers to service access for people who use drugs.

What we heard from respondents:

Increasing access to harm reduction equipment, programs and education is necessary

Respondents, particularly service user respondents, reported that a significant weakness of the current program models is that harm reduction equipment and services are only available during the hours of operation of the larger community health centre or agency:

> "Six o'clock comes, it's gone. They are closed. We have to go to the black market, and the stems that we get on the black market is not the proper ones. They're crap." (Service user)

Due to a lack of funding for harm reduction workers, some agencies (particularly those with multiple locations) can only have a harm reduction worker onsite part-time. While other mechanisms are developed to ensure distribution of harm reduction equipment in the absence of harm reduction workers, this does not lead to education or information sharing, or to the development of long-term relationships that can be key to connecting people to health and social services:

> "And it's only one day a week that there's a harm reduction worker here, right? And how it works is there's a (housing) office, you can go and grab it from them. Or they can go to the main floor, the front desk and they have it in the back. So those two places will give it to you, but it's only until four o'clock. And you can't ask them questions. They don't know about drugs, right? So we need something after, at night." (Service user)

Respondents were particularly interested in service delivery models that would be available at night, outside of regular business hours, and that would provide harm reduction equipment and support in the community:

> "A weakness? Not being out there for people. Like, harm reduction on the street means a lot to people. There's nobody out there. And I keep saying that. They need people out there at nighttime, you know, the kits and people." (Service user)

There was recognition that the TC LHIN funding that was recently provided has allowed organizations to scale-up much needed services, including extending the hours of harm reduction programs, and in offering outreach services:

> "Because we've been able to hire, we can staff those locations now. So that's a big plus, being able to offer services at all of our sites, consistently. And that also frees up *(Harm Reduction Worker)* to be on outreach, to be out in the community, which is so important. (Service Provider)

Increase access to Indigenous outreach workers and harm reduction workers

Participants in both the Indigenous community group and in the service provider groups raised attention to the need for Indigenous outreach workers, to bring Indigenous people who use drugs into harm reduction programs, and for Indigenous workers to be providing harm reduction programs and services:

> "I personally think there needs to be more Indigenous outreach workers in this community as well." (Indigenous service user group)

Increasing access to naloxone training and distribution is necessary

Respondents expressed a clear desire for more access to naloxone training and distribution. While people often recognized that it may be available at pharmacies, this was not always seen as a low-threshold option:

> "Service user 1: And we can't get naloxone here right now. We need it. If you want it, if you wanted those, you can ask for free at the pharmacy. Supposedly. That's what I hear on the news.
>
> Service user 2: Well, it's hard, right? They need to, like, show you. They have to teach you how to use it. You can't just go in and say 'I want one.'" (Service user)

While many harm reduction programs now offer training and distribution of naloxone, not all do. There was interest in training sessions:

> "We need to get a class, go in for all, for all people who visit the harm reduction, people who are on the street, like, hands on. So you offer us a course, that we can learn how to use it." (Service user)

This was another area where respondents noted that the TC LHIN funding had allowed for services to be scaled-up:

> "There has been such pent-up demand for naloxone trainings. And we finally have the staff now, to be able to offer them." (Service provider)

Additional evidence from the literature:

Distribution of harm reduction supplies for injection, smoking and inhalation of drugs are critical programs to ensure the health of people who use drugs, due to their ability to prevent transmission of HIV and other bloodborne viruses like hepatitis B and C (4,6). These programs not only decrease the potential for disease transmission among people who use drugs, but also increase contact with service providers in harm reduction programs. In this way, distribution of harm reduction supplies facilitates the development of relationships that serve as a key linkage tool to increase access to healthcare and social services for people who use drugs (77,78). For these reasons, they should be considered a key service, and access should be facilitated by ensuring these supplies are available in a wide variety of environments that people who use drugs frequent, including drop-in programs, housing and shelters services, healthcare and social service providers and in community health centres (78). It is also important to ensure that harm reduction supplies are available within the spaces where people gather to use drugs. Community-based outreach is one method for accomplishing this, where outreach workers go out into the community to locate, make contact and build relationships with otherwise hidden populations of people who use drugs (70,79). Support is necessary for organizations that are working with people who use drugs inside the prison system, and particularly for organizations and harm reduction programs that work with people upon release from prison, as this is a very high risk time for overdose (80).

Another method of increasing the geographic and temporal reach of harm reduction programs is to create satellite sites. Community health centres that run satellite site programs employ people who use illicit drugs to run satellite harm reduction programs within their own homes (81). Using people who use drugs to distribute harm reduction equipment and supplies within the spaces where people are already gathering to use drugs not only increases the reach of harm reduction programs, but may help connect isolated people who use drugs to health and social services (82).

Naloxone availability is a key intervention in reducing morbidity and mortality associated with opioid overdose. The widespread distribution of naloxone without a prescription is a relatively new program development that needs to be immediately and rapidly scaled-up. The available evidence base suggests that people who use drugs, and their families and friends, can be quickly and effectively trained to identify overdose situations, and to administer naloxone (11,83). Pharmacies may offer naloxone and training on how to administer it, but people who use drugs may be hesitant to access a pharmacy because of past experiences of stigma and discrimination in health care settings, as well as current requirements to show an OHIP card.

For programs with minimal previous experience in harm reduction, the development of internal policy and practice guidelines may be helpful, by providing a template to inform decisions and direct practice (84). Guidelines may also be useful when evaluating programs and identifying areas for improvement. Comprehensive best practice guidelines for needle and syringe distribution programs exist in Canada, which provide extensive information on the different service modalities that may be useful in different contexts, as well as valuable insights for scaling-up programming (78).

Involving people who use drugs in the delivery of harm reduction services is an effective way of expanding the reach of programs, particularly to those who are reluctant to engage with health care professionals. There are different models of engaging people who use drugs in day-to-day running of harm reduction programs (85). These models exist on a continuum that ranges from a very low threshold peer participation model to a more structured employment development model. This allows service users (who are interested and able) to move along the continuum, learning additional skills and taking on greater responsibilities. Many harm reduction workers currently employed began their careers in this way. Low threshold participation and employment models offer ways of expanding harm reduction services while also imparting benefits to the workers themselves, such as increased skills and income.

Actions:

For agencies already offering harm reduction programs and services:

1) Continue to provide resources and support the expansion of the harm reduction work force.

- Additional harm reduction workers are needed to scale-up programs and services, with a particular focus on staffing after-hours programs and locating workers in spaces where people gather to use drugs. Agencies need to be adequately staffed so that they are not sharing one worker between multiple locations.
- While funding from the TC LHIN in 2017 allowed agencies to begin to address the need for harm reduction program expansion, this need will continue to increase due to the overdose crisis. Existing funding should be extended, and increased to meet high levels of continuing need.
- Fund and support the development of participation and employment opportunities for people who use drugs. All workers require adequate compensation for their labour.

2) Continue to support programs as they develop innovative ways to expand hours of operations and service delivery.

- Programs that provide services directly into the spaces where people gather to use drugs are particularly necessary and need to continue to be scaled-up, including:
  - Satellite Sites
  - Mobile services/delivery of equipment
  - Vending machines for equipment
  - Outreach programs

3) Ensure that organizations working on harm reduction within the prison system are supported, and that harm reduction programs for people who are leaving the prison system and use drugs are developed and supported.

For community agencies that work with people who use drugs but offer minimal or no harm reduction services:

4) Provide financial and human resource support to partner agencies to develop harm reduction programming and policies. The Harm Reduction Lead within the LHIN sub-region *(recommendation 2)* would be well-placed to assist agencies with the integration of harm reduction philosophy and principles.

- Agencies require sufficient training on harm reduction philosophy and programming;
- Support agencies to develop necessary organizational and programmatic policies that are consistent with a harm reduction philosophy. For example, agencies must have policies that;
- Reflect a low-threshold approach to working with clients and a commitment to working with people who demonstrate challenging behaviours;
- Require staff training in conflict de-escalation;
- Permit people who use drugs or alcohol to access services when intoxicated;
- Restrict barring or exclusion from programs to rare and extreme situations.

5) Support communication and partnerships between allied organizations.

- The Harm Reduction Lead *(recommendation 2)* would be a key resource to support allied organizations, allowing them to continue to focus on their mandates while also offering additional services and information to their service users who use drugs.

Recommendation 5:

Scale-up overdose prevention sites & supervised consumption services

AT A GLANCE:

THE CHALLENGE:

- Recent data on overdose prevalence and geographic distribution in the TC LHIN supports the need to rapidly scale-up overdose prevention sites (OPS) and supervised consumption services (SCS);
- There is an urgent need for OPS services within drop-ins, shelters & in housing complexes (both privately-owned and in Toronto Community Housing Corporation (TCHC) building) where drug use is present; implementation of OPS in these locations should be supported and scaled-up.

THE SOLUTION:

- Encourage organizations who are providing services for people who use drugs to immediately apply for permission to open overdose prevention sites (OPS). This includes harm reduction programs, shelters, housing providers, and drop-ins. Supervised consumption services (SCS), where supervision of injection drug use is offered alongside supervision for people who smoke and/or inhale drugs, are also necessary;
- Provide funding and support for the agencies that have already opened OPS or supervised injection sites (SIS) to expand their programs to include supervised consumption services, where supervision of open smoking/inhalation is offered for drugs like heroin, fentanyl, crack and crystal meth, which also present an overdose risk;
- Ensure that operating hours of OPS and SCS reflect levels of greatest need within the community, not hours of greatest convenience for the organization.

Background:

It was recently announced that there were 1,053 deaths from overdose in Ontario from January-October 2017, a 52% increase over the same period in 2016 (1). These numbers suggest that Ontario's total number of deaths for 2017 will not be far behind BC, where they saw 1,436 deaths from overdose in 2017 (86). The overdose crisis shows no signs of abating, and urgent measures are necessary to address this crisis.

In addition to the appearance of illicitly-produced fentanyl in the illicit drug supply, there are many factors that contribute to the risk of overdose. Criminalization of drug use leaves people reliant on purchasing substances of unknown quality and potency from the illicit market. Criminalization also forces people to hide their substance use, as fear of exposure and arrest force people who use drugs in public spaces (e.g., alley ways) to inject their drugs quickly or all at once (87). In this way, homelessness intersects with criminalization to further exacerbate the risk of overdose (88). Additionally, fear of police and experiences of discrimination from health providers can discourage people to call for assistance, even in emergency situations such as overdoses (48,89). Women and Indigenous community members, particularly those who are street-involved, are at high risk of overdose and are particularly affected by intersection forms of marginalization that make them more vulnerable.

Overdose prevention sites (OPS), supervised injection sites (SIS), and supervised consumption services (SCS) offer safe places for people to use pre-obtained drugs under the supervision of trained staff. In the Canadian context, SIS and SCS require approval from Health Canada to operate, which can be a complicated process. Overdose prevention sites are a more recent innovation, introduced in British Columbia in December 2016 by the provincial government in response to the magnitude of the overdose crisis there. OPS are incredibly similar to SIS/SCS, and offer monitoring of injection drug use and intervention in case of overdose, in addition to being a low-threshold method of building relationships with a marginalized group of people who inject drugs (90). The major difference between these services is that while SIS/SCS require federal approval from Health Canada to operate, three provinces (BC, Alberta, and Ontario) now offer a provincial-level exemption to allow for OPS to open without seeking federal exemption, an attempt to speed up access to these essential services (91).

Currently, in the TC LHIN there are 4 federally exempted supervised injection sites operating at: Toronto Public Health's The Works; South Riverdale Community Health Centre's keepSIX; Fred Victor Centre; and at the Queen West location of Parkdale Queen West Community Health

Centre. Additionally, there is one unsanctioned OPS that has been operating in Moss Park since August 2017 by a group of volunteers from the Toronto Overdose Prevention Society, and one sanctioned OPS that has been approved at St. Stephen's Community Health Centre but is not yet open. Recently released data on the neighbourhoods with the highest number of calls to Toronto Paramedic Service for suspected overdose for the 6-month period from August 2017 to January 2018 (92,93) show that the Moss Park area had the highest number of overdose calls in the City of Toronto. This data also demonstrates a continued need for new OPS and SCS in neighbourhoods throughout the TC LHIN area.

What we heard from respondents:

Need for Overdose Prevention Sites & Supervised Consumption Services

Respondents from across the city saw an urgent need for OPS or SCS, and hoped that more organizations, including their own, would move forward to open additional sites soon.

> "We really need a site here. The thing about *(neighbourhood)* is that people don't move from here. They don't go to other parts of the city. Even to *(harm reduction program),* it's not that far, they won't go. So, it has to be here. We need a safe injection site here." (Service user)

However, respondents from several agencies expressed that there is still resistance among the management in some organizations to opening OPS/SCS:

> "I would also like to see some management just moving a little bit faster around a lot of the things that we've been trying to promote. Which is the overdose prevention site. It's our major gap." (Service user)

And some respondents expressed that they thought management of certain organizations were concerned about community disapproval of an OPS/SCS:

> "I think *(management)* fears a lot of the community. Because they get a lot of calls from community people. A lot of NIMBY. And it's like 'What are you doing over there? Your clientele is right on the lawn. They're passed out; they're puking; they're peeing.' So, they gotta hear from all the houses around here." (Service provider)

Respondents, particularly service users, also highlighted the need for OPS inside of shelters:

> "Better yet, let's get sites inside the shelters. I remember (laugh) at *(shelter name)* I used to use their washroom all the time. So, have a room inside the shelter to use safe. I mean, I think we're pushing that. We just gotta get harm reduction into the shelters." (Service user)

And finally, respondents spoke about the need for OPS inside of the buildings where people who use drugs reside, particularly within Toronto Community Housing Corporation (TCHC) buildings:

> "Respondent 1: We need overdose prevention sites in TCHC buildings. I think it's a perfect idea. Overdose prevention rooms.
>
> Respondent 2: And it's not like they don't have the space to do it. They do. It could actually be monitored and run by a professional.
>
> Respondent 1: God forbid, like I've had so many overdoses in my apartment. And not – like, I was able to bring them back, but if anyone would've died in my apartment –
>
> Respondent 2: –You would've been screwed.
>
> Respondent 1: And living with that. Who wants to live with that? Right?" (Service user)

Need for supervised smoking and inhalation spaces

Respondents said that to further prevent overdoses, the current options must be expanded to include supervised smoking and inhalation. They pointed out that people also smoke heroin and fentanyl, which puts them at risk of overdose. There have also been a small number of cases in which other drugs (notably crack cocaine and/or cocaine) have been contaminated with fentanyl, leading to overdose:

> "The goal is that safe injection sites turn into safe consumption sites, because I've been hearing a lot of people smoking and then dropping on the floor, you know what I mean? Because it's getting into everything. So I think that it should be not just a safe injection site, it should be a safe consumption site." (Service provider)

Respondents framed the addition of supervised smoking and inhalation services as a health equity issue. They argued that offering supervised consumption services only for injection but not for smoking/inhalation risked reinforcing stigmatizing perceptions of different types of people who use drugs and different types of drugs.

> "Not providing spaces for smoking too just reinforces that horrible drug hierarchy that most people have in their head. That, you know, if you're a teenage pot smoker, you're at the pinnacle. If you're an injection drug user that's shooting opiates, you're at the bottom." (Service provider)

Additional evidence from the literature:

A key evidence-based intervention for addressing the risk of morbidity and mortality from overdose is supervised injection sites (SIS) (12,13,94). There is an extensive body of evidence from around the world that SIS are effective at reducing overdose mortality, but that they also reduce transmission of bloodborne diseases such as HIV, hepatitis B and C, and improve the health of people who inject drugs by connecting them to low-threshold healthcare and social services, including treatment programs while being cost-effective (95-98). As mentioned above, OPS function in a manner very similar to SIS.

Supervised consumption services (SCS) offer spaces for both injection and inhalation/smoking to people who use drugs. SCS are important for several reasons. First, they have the potential to reach a population of people who use drugs that are still underserved within the response to substance use (99). Additionally, both heroin and fentanyl can be and are smoked by people who use drugs, leaving them at risk of overdose from this method of consumption. Finally, there have been case reports of overdose clusters where people who were using what appeared to be crack cocaine or powdered cocaine and who were otherwise opiate-naïve, subsequently overdosed on fentanyl (100,101). Target drug testing done by Health Canada reveals fairly low levels of fentanyl contamination in cocaine and crystal methamphetamine samples overall (and no cannabis samples testing positive for fentanyl), and so while the magnitude of this phenomenon should not be overstated, it is nonetheless a risk (3). There have been anecdotal case reports of fentanyl overdose following consumption of crack cocaine in Toronto as recently as February 2018.

Organizations that deliver harm reduction services to people who use drugs should immediately consider opening OPS to provide access to this life-saving service in the midst of a crisis situation. The scale of the overdose crisis in the TC LHIN area is severe, and the geographical information provided by Toronto Public Health's Overdose Information System can be used to help decide on ideal locations for OPS/SCS scale-up (92).

In addition to organizations providing dedicated harm reduction services to people who use drugs, target locations for OPS and SCS include shelters, supportive housing, and housing complexes where large numbers of people who use drugs live. Coroner's reports from Ontario show that 61% of people dying of overdose are found in a private residence (93). There are many reasons to believe that scaling up the opening of OPS within shelters and housing targeted at people who use drugs has promise in reducing overdose deaths (90,102). Several OPS within housing environments have already been implemented in BC, including in supportive housing and in homeless shelters (90). Ensuring that OPS are easily available in the environments where people who use drugs find themselves is key to intervening in the overdose crisis. Other low-threshold options that are being experimented with during the overdose crisis that could be piloted include peer witnessing, and formalized check-ins via phone or text with a harm reduction worker or peer.

Actions:

1) **Support the immediate scale-up of overdose prevention sites and supervise consumption sites.**

    - Funding that was provided by the TC LHIN in late 2017 was used to support the operations of the OPS in Moss Park by providing funding for human resources in partner organizations that were then dedicated to supporting the OPS, and other overdose prevention efforts. Due to the continuing increase in overdose rates, this funding must be maintained and expanded to address the magnitude of the overdose crisis, and its concentration in the geographical area served by the TC LHIN.

    - Encourage and provide support to organizations that are providing harm reduction services that do not currently have an OPS, SIS or SCS to immediately apply for permission to open one.

    - Organizations applying to open an OPS/SIS should investigate adding supervised smoking/inhalation services to their supervised injection services.

    - Encourage and provide support those organizations who are already operating an OPS/SIS to expand services to include supervised smoking/inhalation services.

    - While many organizations will match OPS hours with agency opening hours during roll out period, hours should quickly scale-up to reflect hours of greatest need as identified by the community.

2) **Support organizations that provide dedicated services to women and/or Indigenous populations to open an OPS immediately.**

3) **Encourage and support organizations that provide shelter and housing to people who use drugs to open an OPS/SCS immediately to address the high levels of overdose happening in shelters and housing complexes.**

    - This includes the Toronto Community Housing Corporation (TCHC), who provide large amounts of housing in the City of Toronto.

4) **Ensure that organizations have access to sufficient funding for infrastructure improvements to provide adequate space for OPS/SCS**

    - This includes ensuring support and resources are available for renovations to existing buildings, expansions, rental of additional locations for service delivery, or temporary units such as trailers.

5) **Ensure that OPS/SCS are sufficiently staffed by well-trained harm reduction teams that include people who use drugs and who reflect the communities that are being served, for example, women or Indigenous populations.**

    - Ensure that staff have the necessary supports and resources for a healthy work environment.

Recommendation 6:

Support the implementation of low-threshold managed opioid programs, managed stimulant programs, and managed alcohol programs

AT A GLANCE:

THE CHALLENGE:

- Contamination of the drug supply with fentanyl has led to an alarming increase in opioid-related overdoses. There is an urgent need to respond to this crisis by implementing new methods of opioid prescribing in low-threshold, community-based settings, and addressing current barriers faced by those who wish to access managed opioid programs but cannot.
- There are few treatment options for people who use stimulants.
- People who drink alcohol and suffer negative consequences from their alcohol use are not well-integrated into harm reduction programs. This is particularly the case for people who drink non-potable or non-beverage forms of alcohol (e.g. hand sanitizer, mouthwash, etc.).

THE SOLUTION:

- Facilitate and support the establishment of managed opioid programs. Proposed models for the implementation of managed opioid programs include:
  - Programs that provide both injectable and oral opioids, adapted from programs currently operating in Vancouver that provide both diacetylmorphine (heroin) and hydromorphone *(Dilaudid)* (103-105);
  - New, low-threshold models such as vending machines that dispense oral hydromorphone, such as the program in development in BC (20);
  - Piloting low-threshold programs that prescribe and dispense oral hydromorphone in community settings.
- Explore the potential of managed stimulant programs as an option for reaching people who use stimulants, and offering them treatment and care (106).
- Explore the scale-up of managed alcohol programs to address the needs of a group that is very marginalized, in need of support, and isolated from health services.
- Ensure that people who use substances are key voices in the development and implementation of these programs to ensure that they are low-threshold and responsive to community needs.

Background:

Given the current contamination of the illicit drug supply, there is an urgent and critical need for a safe and regulated source of opioids. Traditional opiate agonist treatment programs use methadone and buprenorphine-naloxone *(Suboxone),* and recently published Canadian guidelines recommend buprenorphine-naloxone *(Suboxone)* as a first-line treatment for opioid use disorder, with methadone cited as an alternative treatment (59). While these treatment options are well-established, there is a substantial group of people who use opioids for whom these programs are not effective, and potential barriers to accessing these programs, including an insufficient number of prescribers, locations and hours of operation, and restrictive policies (e.g., those that require abstinence of all drugs) may interfere with access to or retention in treatment (107-110). Given these issues and the increasing rates of opioid-related overdose, there is a need to implement new methods of opioid prescribing in low-threshold, community-based settings (20). Managed opioid programs, where people are prescribed diacetylmorphine (heroin) or hydromorphone *(Dilaudid)* aim to provide a safer alternative to the illicit drug supply for people who use opiates, hold promise in increasing the options for people who use opioids.

There are very few treatment options for people who use stimulants (such as cocaine, crack cocaine and crystal methamphetamine). The research on managed stimulant programs is not as robust as the research on managed opioid programs or managed alcohol programs (106), however people who use stimulants need an alternative to being reliant on an illicit drug supply and subject to the structural vulnerabilities and criminalization that accompany this.

Similarly, people who experience health and social harms related to their drinking (particularly those who drink non-potable alcohols) face many barriers to services and care across the health and social service sectors. Harm reduction has not traditionally offered programs to people who drink alcohol, partly due to the foundations of harm reduction programming in addressing the health consequences of injection drug use, and then later expanding to provide support, equipment, and education for people who inhale/smoke illicit drugs. As such, people who use alcohol have often been on the fringes of harm reduction programs, and would benefit from being able to access the supports offered within harm reduction programs, specifically from managed alcohol programs.

What we heard from respondents

Need for managed opiate programs

Respondents in all groups advocated for the rapid scale-up of low-threshold managed opioid programs as a method to ensure that people who are dependent on opioids have access to a pharmaceutical supply of opioids of known quality and dose.

> "We need regulated, safe drugs. Non-toxic. People aren't going blind from drinking, because there's labels on your alcohol." (Service provider)

Respondents reported that methadone and buprenorphine-naloxone programs are available, but that more options are crucial because those treatment options do not work for everyone.

> "Suboxone and methadone doesn't work for everybody, okay? And they're pushing it on people, and that's not right.." (Service user)

Service providers are interested in scaling up their ability to offer methadone and buprenorphine on demand, as well as offering oral hydromorphone. Some respondents recognized the potential for agencies to be leaders and innovators by offering low-threshold managed opioid programs:

> "It would be great for CHCs to be some of the forefront leaders, to start prescribing heroin and hydromorphs to drug users. To take that risk." (Service provider)

Respondents worried about the potential to scale-up managed opioid programs that use diacetylmorphine because they rely on extensive infrastructure, including the need to import the medication from abroad. They voiced a preference for prescribing oral hydromorphone because it is inexpensive, health care providers have extensive experience with it, and it is readily available in pharmacies. Respondents voiced two concerns about the implementation of scaled-up hydromorphone prescribing. First, respondents were worried that it would be difficult to find prescribers to implement these programs. Second, they feared that hesitation around how to operationalize these programs would delay their implementation.

> "The quickest way to scale it up *(managed opioid programs using hydromorphone)* would be for physicians to do it. Although, a lot of people don't have physicians, a lot of physicians don't want to work with this population. We are going to need a lot of different options." (Key informant)

> "How do we multiply that *(prescription hydromorphone)* and scale it up a bit? Like, we need actual real leadership from agencies and coordination among EDs to mobilize for that on a city level." (Service provider)

Need for managed stimulant programs

Respondents noted that crystal methamphetamine use in Toronto seems to be increasing, and crack cocaine use continues to be substantial in Toronto. They cited an on-going need for low-threshold services for this population, and they expressed interest in managed stimulant programs to expand the options available to people who use stimulants:

> "I want to be able to get MDMA and methamphetamines from my doctor. You're getting what you're asking for. You're getting good drugs. No more getting dirty drugs on the street" (Service user)

Need for managed alcohol programs

Respondents highlighted the health harms and social isolation that they see among people who solely consume alcohol, particularly non-beverage or non-potable alcohols, and especially among people experiencing intersecting vulnerabilities such as street-involvement, homelessness, race, and experiences of colonialism. Respondents highlighted both the health and social harms that alcohol was causing to people, and the lack of services for marginalized people who drink alcohol:

> "And to add to that, one of them is barred from liquor stores, so they had to go to the dollar store and buy Listerine and that's all they can afford. So, you're on Listerine and the health effects of drinking Listerine constantly." (Service provider)

Service providers brought up the need to integrate programs and services for people who drink alcohol into harm reduction programs:

> "I think it's really important for us to name alcohol, and non-beverage alcohol as needing harm reduction services as well. That sometimes gets left out, and that's why there's so many folks that are actually not coming to our harm reduction programs, because they don't see themselves in that. It's like 'I'm not a drug user. Right? I'm a drinker.'" (Service provider)

Additional evidence from the literature

Managed Opioid Programs

Increasing rates of opioid-related overdose have led to calls for the implementation of new methods of opioid prescribing in low-threshold, community-based settings (20). Managed opioid programs provide pharmaceutical medications, such as diacetylmorphine *(heroin)* or hydromorphone *(Dilaudid),* to people who are currently dependent on illicit opioids. In managed opioid programs, pharmaceutical opioids are prescribed by a health care provider to people who are dependent on illicit opioids. This provides a safer alternative to the illicit drug supply. Participation in managed opioid programs are often restricted to people who have been dependent on opioids for many years, and who have repeatedly attempted and not succeeded at achieving stability on traditional opioid replacement programs using methadone and buprenorphine-naloxone *(Suboxone).* Diacetylmorphine and injectable hydromorphone provide alternative options for treatment for those people who have not responded well to these other forms of opioid treatment and/or who continue to use illicit opioids while engaged in treatment (104,105).

One form of managed opioid program is heroin assisted treatment (HAT). HAT programs provide people with a dose of diacetylmorphine *(heroin)* to be consumed under the supervision of medical professionals. HAT programs have long been used in Europe and demonstrate strong results (111-113). A study conducted in Canada (NAOMI) involved participants in Montreal and Vancouver who were randomized to receive either heroin assisted treatment or methadone maintenance treatment. Participants in both groups reduced the number of days where they used illicit opioids, however the group receiving HAT reduced their use more significantly than the group receiving methadone (105). And while both groups showed improvements in their health and social functioning, the HAT group showed significantly greater improvements in their medical and psychiatric status, economic status, employment situation, and family and social relations compared to the group receiving methadone (105). These results correspond to studies in England, Spain, Germany, Switzerland, and the Netherlands, all of which found HAT to be more effective than methadone. These Canadian and European studies further demonstrate many positive benefits of HAT, including dramatic reductions in illicit drug use and needle sharing, reduced risk of acquiring HIV, hepatitis B and C, improved housing and employment stability, and dramatic reductions in criminal activities (105,111-114).

A recent Vancouver-based study examined whether injectable hydromorphone was an effective and acceptable alternative to diacetylmorphine (heroin) prescription for managed opioid programs. Injectable hydromorphone was found to be non-inferior to diacetylmorphine; additionally, retention in treatment was high (over 80%) and there were fewer side effects among people receiving hydromorphone (104). The study authors conclude that hydromorphone is a suitable alternative to diacetylmorphine prescription, particularly in jurisdictions where diacetylmorphine is not easily available (104). Guidelines are now available in BC for both forms of managed opioid programs that use injectable opioids (115,116). A model for managed opioid programs using injectable opioids has been in place now for some time at the Crosstown Clinic in Vancouver (20,116), with recent scale-ups in other venues in the Downtown Eastside of Vancouver.

There are several models of managed opioid program available, each with different infrastructure requirements and potential to be scaled-up. Importantly, low-threshold programs are required to meet the needs of the widest group possible and achieve health equity for people who are dependent on opioids. Key to the implementation of low-threshold opioid prescribing is to centralize the needs of people who are opioid dependant and in need of a safe supply of opioids. Pharmacotherapy for opioid dependence has often been driven by provider convenience and fear of diversion, rather than by a reflection on what works best for patients in need of opioid replacement options (110).

Managed Stimulant Programs

Research evidence for substitution treatment for stimulants is currently not as strong as that for opioid substitution treatment, and requires further research (106). Existing treatment options almost exclusively focus on abstinence-based approaches, and operate on appointment-based schedules that can be difficult for people to comply with. Further, many may not offer counselling and social supports appropriate to the situations of people who use stimulants (117,118). Withdrawal management and subsequent treatment programs for people who use stimulants is over-capacity in Toronto, and difficult to access (57). The integration of a harm reduction approach in managed stimulant programs makes it an appealing alternative to many of the existing treatment options for stimulant use.

Managed Alcohol Programs

Managed alcohol programs (MAPs) work with people who consume alcohol, most generally those who are dependent on alcohol and suffer severe health and social harms from their alcohol use (119). These programs administer a prescribed dose of alcohol at regular intervals, and are located within shelters, supportive housing programs and, less commonly, drop-in centres (119). MAPs have been offered within some shelters and supportive housing programs for many years, mainly beginning as small pilot programs for a population experiencing high levels of harms from their alcohol use (120). However, there is an emerging evidence base from Canadian MAPs that demonstrates that offering housing combined with a stable, regular dose of alcohol can improve several health and social indicators, such as the reduction of the number of emergency department visits and encounters with police (121,122, 123). Further research suggests that MAPs can also be effective at stabilizing housing status, and, for people who are in a MAP for longer than two months, reducing the amount they drink on a daily basis (123). Some programs prioritize family and cultural reconnection, which, when implemented with support from Indigenous community members, can provide an environment that is consistent with Indigenous principles of healing and principles of harm reduction (119).

Actions:

1) Facilitate and support the implementation of managed opioid programs using injectable prescription opioids.

- Clinical trials in Vancouver demonstrate that diacetylmorphine and injectable hydromorphone can safely and effectively be used in managed opioid programs. Prioritize injectable hydromorphone over diacetylmorphine to avoid the need to import diacetylmorphine.
- Support the rapid scale-up of pilot programs using injectable hydromorphone for eligible patients within hospital settings (including those with Rapid Access Addiction Medicine clinics).
- Hospital settings with on-site pharmacies and existing addiction medicine programs (for example, in Toronto: CAMH, St. Michael's Hospital, Women's College Hospital, St. Joseph's Healthcare) are well placed to pilot managed opioid programs using injectable hydromorphone because they have the necessary infrastructure already in place, including:
  - Pharmacies with expertise in compounding (necessary for injectable hydromorphone);
  - Clinical infrastructure, including space for administration, and staff to dispense medications and observe its administration. Managed opioid programs that use injectable opioids require observed administration, several times a day. Co-locating these programs with supervised consumption services may be one option.
- Support the addition of high dose (50 & 100mg/ml) injectable hydromorphone to the Ontario Drug Benefit formulary for use in managed opioid programs.

2) Facilitate and support the implementation of managed opioid programs using oral hydromorphone.

- Explore a low-threshold program that involves the prescription of oral hydromorphone in community-based settings. This option should be offered in addition to, and not in lieu of, injectable hydromorphone options to accommodate diverse needs.
- Oral hydromorphone could be prescribed by clinicians within community health centres, and dispensed daily at local pharmacies.
- Such a program could be modeled after the Toronto Community Hepatitis C program, in which a clinical program spans across multiple community health centres:
  - There is good potential for quick scale-up in community settings such as community health centres with well-established harm reduction programs and medical providers familiar with people who use drugs for this model;
  - In this model, a team of support staff (harm reduction workers, social workers, specialized nurses) could move between community health centres to support the program in different locations;
  - Each CHC would ensure that one prescriber (MD or NP) was available to cover the clinic in their location;
  - This model effectively mobilizes a population health approach, reduces administrative costs, and ensures access to the service in several locations.

3) Provide support for organizations who wish to partner with a research study on a vending machine dispensing model for managed opioid programs.

- Health Canada has approved a study of the use of vending machines for oral hydromorphone dispensing in Vancouver (20);
- Community health centres with harm reduction programs that include supervised consumption services should explore the possibility of partnering on this study and becoming Toronto sites in this research project;
- By locating this program within organizations that already offer supervised consumption services and medical care (such as South Riverdale CHC, Parkdale Queen West CHC, and Toronto Public Health's The Works), on-site prescribers could enrol suitable patients, and supervised consumption services are available to provide wrap-around care;
- This model has the potential to effectively reach a population at high risk of overdose.

4) **Facilitate and support the implementation of low-threshold programs for stimulant use.**

- Enhance support for low-threshold programs that engage people who use stimulants (particularly crack cocaine and crystal methamphetamine).
- Explore the development of a managed stimulant program to offer a safer alternative to leaving people who use stimulants reliant on the illicit drug supply.

5) **Facilitate and support the implementation of managed alcohol programs.**

- Invest in the expansion of managed alcohol programs within low-threshold shelters and housing programs;
- Harm reduction programs should draw on the experience of existing MAPs to learn how to implement managed alcohol programs in harm reduction program settings. This would open doors to greater services and care for a group that is very marginalized and in need of support.

6) **Ensure that people who use opioids, stimulants and alcohol are key voices in the development and implementation of managed programs.**

- It is necessary to ensure participation by people who use the substances concerned, to ensure that the programs that are developed are responsive to community needs, and not dominated by overly medicalized models of service delivery.

Recommendation 7:

Scale-up integrated case management and medical service provision within harm reduction programs for people who use drugs and have multiple, complex health and social needs

AT A GLANCE:

THE CHALLENGE:

- There is a strong need for integrated case management for people who use drugs and have multiple, complex health and social needs, such as homelessness, poverty, and who have mental and physical health challenges.
- There is a need for specialized support as people attempt to access housing, income support programs, adequate food, and medical and social services.
- People experiencing multiple complex health and social needs overwhelmingly perceive discrimination and report negative experiences when trying to access health and social services.
- There is a lack of primary medical care, as well as a lack of specialized medical care for people who use drugs and have multiple, complex health and social needs.
- There is a lack of capacity and expertise to properly address the situation of people who use drugs and experience mental health crisis within community settings.

THE SOLUTION:

- Existing harm reduction programs need coordinated case management staff dedicated to addressing the holistic needs of their clients.
  - Support the scale-up of system navigation support to services users, including one-on-one accompaniment to help people access specialized housing, medical and social services.
- Support the delivery of training in and scale-up of trauma-informed care for people who use drugs.
- Scale-up delivery of medical services directly within the harm reduction programs to offer a method of improving access to care and improving health equity.
  - This includes programs providing anonymous HIV and hepatitis C testing, and service corridors to appropriate HIV and hepatitis C treatment programs, where needed.
  - Anonymity must be maintained for harm reduction service users who desire it, and confidentiality of medical information must be ensured in any scale-up of the provision of medical services within harm reduction programs.

Background:

While there is much diversity within the population of people who use drugs, there is a small but visible minority who struggle with multiple physical health, mental health, and social needs such as homelessness and extreme poverty. This group is over-represented among the clientele of harm reduction programs due to the low-threshold entry point to services offered by these programs, and the commitment to meet service users where they are at.

There is extensive research documenting the very poor health outcomes of people who experience multiple complex health and social needs such as homelessness, drug use, history of trauma or abuse, and experiencing mental health challenges. For example, the rate of premature mortality is 2-5x higher amongst people who are experiencing homelessness compared to the general population, and the use of illicit drugs may increase this risk (124). Additionally, people who are homeless experience higher rates of infectious diseases, of chronic diseases, and show higher rates of traumatic brain injuries (125).

Research has documented the difficulties that people experiencing homelessness, drug use and mental illness face when accessing healthcare services, and the negative attitudes and experiences of discrimination they face is a key barrier to healthcare access (126,127). In particular, people who use drugs frequently report that their status as a 'drug user' affects the quality of health care that they receive (127). This is a major health equity issue.

What we heard from respondents:

Need for comprehensive, wrap-around services and care within harm reduction programs

Respondents in this consultation highlighted the need for comprehensive, wrap-around services for people within harm reduction programs, that include not only access to harm reduction equipment and education, but access to support for a wide variety of health and social needs:

> "It needs to be full service. You can come in and get your harm reduction supplies, but where is the counselling? Where's – you know what I mean? The injection site, for when you need to get high. Everything needs to be brought together. Say somebody who has mental health issues, also, with addiction, you come into this facility, you'll get your help with your supplies, but where's the help for the people that need it, mentally? Right? Physically? Right? I mean, yeah, we have access for some people, for wheelchairs and stuff, but it's still, it's so hard to get in and out of this facility, even in a wheelchair." (Service user)

Case management

There is a need for on-site, immediate access to case management services. This need was most forcefully expressed by front-line harm reduction service providers, as well as by clinicians providing medical care to this population:

> "I think most of the clients that we work with, at the community health centre, in other words, like, seriously marginalized drug users, I think every single one of them can really benefit from case management, people advocating for them around everything related to the social determinants of health, whether it's like 'Yeah, I want to go get my meds at the pharmacy', to having an interview with a prospective landlord, or talk to an OW worker and actually get the money that I deserve, like, everything. Cause these are, my clients are people who are absolutely unable to navigate anything remotely complex, generally speaking. And they suffer for it, all the time." (Service provider)

Support needs to be mobile. Respondents suggested models of mobile support such as service navigation or peer navigator models that can help people to access services within the community or to attend appointments:

> "We need capacity for escorts, to take people to appointments in the community. Some kind of service navigation role. Because when we get them appointments, we need to make sure that people can get there." (Key informant)

Rapid, low-threshold access to primary medical care

There is a need to expand access to rapid, low-threshold medical care, in the spaces where this population is already located:

> "Wait lists don't work. Appointments two weeks from now don't work. I need to be able to access services now, not weeks from now – especially because they have so many needs. The people we work with – they are homeless, they use drugs, they often have mental health concerns. They are so transient." (Key informant)

> "We don't have an issue to connect them to our in-house doctor. We don't have an issue getting them to see psychiatrists here. But we haven't had a psychiatrist in *X* months. Our doctor comes a few hours a week. We need a full-time NP *(nurse practitioner),* on site. But we don't have funding for that." (Key informant)

Providing primary care within community health centres that offer harm reduction services is an effective model. However, in practice, there needs to be a recognition of the specialized nature of the care provided by nurse practitioners or family doctors in these models, to account for the complexity of the cases they are seeing. The current rostering system in place may not adequately reflect the highly specialized nature of the care they are providing.

> "Identify staff who work with people who use drugs, give support to them. We have different folks on different teams that are good: doctors, counsellors, nurses, and everything else. Their schedules tend to get overwhelmed, they get burned out, they can't do more. They're under pressure to see more clients, so we said remove the agency expectations of panel

size – the expectation that you have to see this many patients in the course of a week. Remove this from some of the docs who take on most of our harm reduction clients who have very complex care needs. They have the same, see the same amount of clients as the other doc next door to them. And they need to just remove some of these unrealistic expectations. Cause there's so few of them, and they're treated as very generic GPs." (Service provider)

Need for low-threshold services that address mental health needs among people who use drugs

Respondents perceived a lack of low-threshold services that address and can accommodate the needs of people who use drugs and who struggle with mental health challenges. This population often ends up in harm reduction programs because these are the only low-threshold services available:

"Mental health is incredibly stigmatized. There is not a lot of support. If you are going to the 1st floor of *(CHC with large harm reduction program)* to get harm reduction supplies, there are not a lot of equivalent places where you can go to try to get some support on your own terms in the mental health sphere, that are demedicalized. There are not as many options to try to feel out what's available without feeling like you are going to lose control. And even to get case management. There are all these criteria and wait lists, and it's all so siloed. You have to make all these referrals to mental health workers, and you get referred this worker who you don't know, you have no time to get to know. People need time, to trust, to build trust, and we don't have that in the system right now." (Key informant)

A particular challenge relayed by respondents is to be able to provide an adequate response to people in crisis who use drugs and who experience mental health challenges. They felt that the community-level options need to be expanded:

"We see so many people here that are in distress and want to reach out, but the options are super limited. It's like Emerg? Not good. Like a *(named crisis centre).* But for people who are still using drugs, and that is low barrier enough that it could accommodate people that use drugs." (Key informant)

"We need to be able to access services that support us. If I have a person, who is chaotic, who is a danger to themselves, the only option is the hospital. And two days later, they get released, with no follow up. Their medical situation hasn't changed. Their mental health situation hasn't changed." (Key informant)

Additional evidence from the literature:

The literature suggests that the provision of case management to people who use drugs, particularly people who use drugs and/or have mental health challenges and are experiencing homelessness, has positive effects on quality of life and access to specific health services (128). A more recent systematic review further demonstrates that case management can improve health outcomes for different groups of people, including people who use drugs and people with mental health challenges (125). Studies of case management within supportive housing, including Housing First models, have also found it generally effective for people who use drugs (129,130). These studies all offer strong support for service models that provide comprehensive case management, regardless of the exact nature of the population or the setting in which it is delivered.

However, there is also research which suggests benefits of tailoring primary health care services to the population (e.g., to people who use substances, or to people experiencing homelessness), including models that employ outreach and street-based nursing (125). A recent report on homelessness from the City of Toronto also recommends providing health care services directly in the shelter system, to improve access to care (131).

A particularly good model has been developed in Toronto for providing comprehensive services and supports for people who use drugs and are living with hepatitis C, by the Toronto Community Hep C program (132). In this model - which shows positive outcomes for hepatitis C treatment adherence and completion - teams of primary health care providers, specialists in hepatitis C treatment, case managers and workers with lived experience provide holistic, wrap-around care for a population of people who often continue to use drugs (132,133). This model is appealing because it provides comprehensive services directly within the agencies that are already providing harm reduction programs, allowing for trust to be built rapidly between people who use drugs and service providers. This program could be utilized as a model to expand service delivery to people who use drugs and have other complex care needs.

Actions:

1) **Ensure the provision of comprehensive services and support, including dedicated case management and primary medical care, within harm reduction programs and in other programs where people who use drugs and have complex needs receive services.**

    - Models where teams of primary health care providers, specialists, case managers and workers with lived experience provide holistic, wrap-around care for specific populations should be supported and expanded.

    - In partnership with CHCs, the TC LHIN should investigate alternative methods of rostering patients and/or panel size expectations to accommodate the realities of providing care to an extremely complex group of patients.

    - Organizations must ensure that case managers and primary care providers are trained in harm reduction, and in the provision of trauma-informed care.

        – Anonymity must be maintained for harm reduction service users who desire it, and confidentiality of medical information must be ensured in any scale-up of the provision of medical services within harm reduction programs.

2) **Explore the delivery of low-threshold, de-medicalized mental health services and supports for people who use drugs and have concomitant mental health challenges.**

    - The number of beds in crisis centres available for people who are using drugs and experiencing mental health crisis needs to be increased.

    - There is a lack of services that have the expertise or infrastructure to accommodate people who use substances and are experiencing physical or mental health crises. The integration of a harm reduction approach and programming (including OPS/SCS) within hospitals, shelters and crisis centres would help to reduce patients leaving against medical advice while in need of continuing health support.

3) **Provide system navigation support to services users when necessary, including one-on-one accompaniment to help people access specialized housing, medical and social services, including psychiatric care.**

    - The experience of people who use drugs, with training and support, can be mobilized to provide system navigation support.

Recommendation 8:

Focus on building harm reduction agencies

AT A GLANCE:

THE CHALLENGE:

- There is often a disconnect between the philosophy in place within harm reduction programs, and the larger agencies in which these programs are located.
- Harm reduction programs may provide compassionate and comprehensive support to people who use drugs and work to ensure their meaningful involvement, while other agency programs refuse services to people who use drugs or engage in stigmatizing behaviours towards them.

THE SOLUTION:

- Develop the capacity of agencies to deliver services grounded in harm reduction across all programs and at all levels.
- Increase the capacity of harm reduction programs to respond to needs of people who use drugs and the overdose crisis.
- Expand harm reduction philosophy and integrate harm reduction approaches into other programs and at all levels of the organization, and ensure it is well-integrated across all encounters and consistently reflected in policies across the organization.

Background:

Despite the somewhat uneasy relationship that historically existed between harm reduction and institutional health and social services, harm reduction programs are often located within community health centres, which are often medicalized and clinical environments. In many cases, there is a disjuncture in philosophy and service approach between the harm reduction program, and the programs of the wider agency. Specifically, the non-judgmental, low-threshold approach to working with service users present in harm reduction programs may not be reflected in wider agency policies and practices. Harm reduction programs, like the population that they serve, are often marginalized within agencies. There may be little connection or continuity between harm reduction programs and other agency services. Other agency staff may have little understanding of drug use and harm reduction. As such, the difficulty that many people who use drugs have accessing health and social services may continue to exist even within agencies that provide harm reduction programs alongside a wide range of services.

What we heard from respondents:

Respondents working within agencies with harm reduction programs expressed their concerns that the harm reduction approach and philosophy were not integrated at all levels of the agency. They worried that they were harm reduction *programs,* within larger health and social service-providing agencies. Respondents wanted to discuss ways that their agencies could move from being an agency that offers harm reduction programs to being a 'harm reduction agency', where harm reduction approaches and principles were actively integrated into all aspects of agency functioning, including in policy, training, and service provision.

> "How do we re-operationalize harm reduction so that it is a part of clinical; it's not an option. It's a part of dental; it's a part of the administrative staff that comes in; that your harm reduction workers can talk honestly and start advocating why their clients need the services of these agency hubs." (Service provider)

Service provider respondents shared their reluctance to make referrals for harm reduction service users to other agency programs because they could not be confident that people who use drugs would have a positive experience with other agency staff:

> "This is more of an agency one, but it's not just for our agency but all agencies. So one is that places being more careful about taking on the language stating what the agency beliefs and values are. So saying we are a harm reduction agency, but then not having to do much to back that up besides say 'oh, we give out kits so we're a harm reduction agency'. So, if you're going to be a harm reduction agency you have to have all staff on board with harm reduction. You can't have someone who goes to the doctor and they don't get all their meds because they smoked a joint, but you give out kits through harm reduction. And what I'd really like to see for the agency is that I can feel confident that I can refer to any staff member in the building and that I know they're going to be treated well, regardless. And that's not what we have, so. It's difficult as harm reduction staff to work in an agency." (Service provider)

Respondents described a need for the development of organizational policies that reinforce the status of organizations as harm reduction agencies, that specifically prohibit discrimination by health care providers towards clients based on drug use, sex work, or street-involvement:

> "Non-judgmental, accessible harm reduction healthcare and health facilities, like, actual policies that must be enforced, so that people cannot discriminate against those who use drugs or engage in sex work, or are street involved, this type of thing. So, it shouldn't be that someone has to look for a harm reduction friendly facility or a harm reduction friendly doctor. It should be that everybody is practicing that and suspending their personal judgement, and hopefully, changing their personal judgement." (Service provider)

Actions:

1) **Ensure that the organization's mission, values, and strategic planning are aligned with a harm reduction philosophy. This includes:**

   - A focus on diversity, inclusion, and the meaningful participation of people with lived experience of drug use in policy and program design and service delivery.
   - Providing client-centered care, drawing on principles from a restorative justice approach and recognizing the social determinants of health.

2) **Foster the development of organizational policies that are consistent with and reflective of a harm reduction philosophy. This includes:**

   - Policies regarding clients' access to services, i.e., limiting the use of service restrictions (also known as barring) for extreme situations;
   - Policies regarding intoxication or drug consumption onsite (particularly important for agencies that do not have OPS/SCS);
   - Policies that support a low-threshold approach to working with people who use drugs.

3) **Ensuring that all programs within an agency (not simply harm reduction programs) are implementing harm reduction philosophies and frameworks. This includes:**

   - Providing comprehensive harm reduction and anti-discrimination training for all staff, whether or not they work with harm reduction service users. This includes support and administrative staff, not just frontline workers *(see recommendation #9).*
   - Giving consideration to the messaging being relayed to service users within agency settings. An example of a sign that might be found in a clinical program that is not aligned with harm reduction philosophy is one that states: "Opioids and benzos will not be prescribed by doctors".
   - Exploring how clinical programs can develop innovative approaches (such as managed opioid programs) to meeting the needs of people who use opioids and other drugs, and reducing their reliance on an unsafe illicit drug market.

Recommendation 9:

Build the capacity of the harm reduction workforce through training and support

AT A GLANCE:

THE CHALLENGE:

- Organizations adding harm reduction programs (such as OPS/SCS) require intensive specialized training; in addition to harm reduction training, training is required in restorative justice, working with women, working with people engaged in sex work, working with racialized groups, and working with Indigenous community members.
- Managers, administrators, clinical staff, and support staff often lack training and background in harm reduction.
- There is a heavy reliance on established harm reduction programs to train and support nascent programs, or other programs within the same agency, without any funding or resources to do so. This demand exists on top of their regular workload.
- Emotional and psychological support for front line workers is an urgent need, particularly as they cope with grief and trauma related to the multiple losses resulting from the overdose epidemic. The few resources that do exist are not equally accessible to all workers.
- There is a lack of support that is tailored to the needs of people with lived experience of drug use who are also front-line workers and service providers.

THE SOLUTION:

- Increase training capacity and support that is specialized for the harm reduction workforce.
  - Establish a province wide training program;
  - Conduct an environmental scan of existing training programs, modules, and manuals;
  - Ensure specialized training for working with women, Indigenous, racialized and trans- communities is available;
  - Include specialized training in restorative justice, trauma, anti-oppression, and social determinants of health.
- In organizations offering harm reduction programs, mandate general harm reduction training for all agency workers, including managers, administrators, support staff, and clinical staff.
- Establish and support mentorship for executive and management level staff and board members from colleagues at agencies with harm reduction expertise.
- Develop targeted support (including paid leaves) for front-line workers to address grief and loss in the face of the overdose epidemic and to prevent staff burn-out, including paid sick time for peer workers or others working on a casual basis.

Background:

Need for training

There are insufficient specialized training opportunities for the harm reduction workforce. Although there are several 'basic harm reduction' training programs (e.g., Harm Reduction 101), these are not always up-to-date with the latest knowledge and practices, such as those required for scaling up harm reduction programs and services necessary to run an OPS/SCS. Organizations who are looking for training in harm reduction often turn to those agencies with established harm reduction programs that are known within the community for their expertise. These agencies have been providing training and support to nascent programs across the province of Ontario (and occasionally beyond the province) with little to no resources, and in addition to their regular workloads.

Organizations, including ones with established harm reduction programs, are often ill-equipped to provide culturally-appropriate services to women or members of Indigenous, racialized, or trans-communities. Lack of understanding of the needs of these communities can result in inappropriate care and discourage people from these communities from seeking services. Additionally, many of the policies and responses to people who demonstrate difficult behaviours are based on a reactive and sometimes punitive approach (e.g., barring from services). Training is needed in new approaches to handle difficult behaviours in order for agencies to provide low-threshold services.

An additional difficulty is that managers and executive administrators may lack a background and training in harm reduction, and find themselves responsible for harm reduction programs or called upon to offer harm reduction services. This group needs specialized training and support, particularly the mentorship of colleagues who do have this expertise.

Support for grief and loss from the overdose epidemic

Frontline workers have experienced numerous and repeated losses over the course of the overdose epidemic. Due to the ongoing overdose crisis that has taken the lives of partners, friends, family, colleagues, and service users, many workers are now dealing with grief and experiencing symptoms of trauma. As community leaders and supporters, frontline workers have been present from the beginning of this epidemic, and continue to be present while they navigate loss and its impacts. They have been tasked with scaling up the harm reduction response to the epidemic, while also struggling with grief, trauma, and loss. Grief and trauma hurt the ability of frontline workers to be effective in their work. It also undermines worker retention and continuity of care.

The conditions of work further compound the stress experienced by frontline workers coping with crisis. They are often carrying heavy caseloads that involve complex needs in an under-funded, under-resourced work environment. Many frontline workers are being asked to work on contracts without benefits, and those who have been hired for their lived experience often still rely on social assistance as primary source of income. Part-time and casual staff may not have benefits to cover mental and physical health services or to provide sick leave. If workers are not formally employed, they may not be eligible to access resources set up for employees. But even more generally, there are very few opportunities for support for loss, grief, and trauma.

What we heard from respondents:

Need for specialized training

There was a worry expressed from respondents that many agencies purported to be 'harm reduction' or low threshold, without having the appropriate training or policies in place, and without having harm reduction as part of a cohesive service model throughout the agency:

> "And, I think it's a buzzword and it's kind of, harm reduction and low threshold have become combined. You know what I mean? And I feel like there's been a neglect right now, around addiction, homelessness, mental health and even the shelters. You know what I mean? It's like, 'Seriously? You'll bar someone from coming in, because if you're drinking or using drugs, you can't enter a shelter system right now.' So, there needs to be an understanding of what that really means, to be low threshold." (Service provider)

There was also a clear need for support for programs looking to scale-up harm reduction capacity:

> "We really need capacity building for agencies in housing and mental health. There are a lot of requests from agencies to develop training for harm reduction in these sectors right now." (Key informant)

Some respondents also noted a gap at the management level, in terms of their background and support for harm reduction programming:

> "Where I find there's a gap, where we're not supported? That's at the upper management level. I think that there's, I don't know if it's a lack of training or if people have really, really strong skill sets, and checked every other box in the interview, but people don't seem to understand this client base. And they don't seem to have compassion for street involved people, homeless people, people who use drugs, people who do sex work." (Service provider)

Respondents expressed a desire to learn new approaches to working with people with difficult behaviours other than restricting services and involving police:

> "Working in the social work field and offering services to people, I've had guys twice my size tell me they're going to fucking kill me. I didn't take it as that. You know, they're having a tough time. You need to be able to be empathetic, and realize that this person, there's stuff going on. So how can we better help them, versus cast them off or push them away or call the police. Not just, 'You're barred. Get out.'" (Service provider)

"Involving the police is just not an option with this population. The level of trauma they have already experiencing from being brutalized. It just can't be the go-to, the last resort. We need other options." (Service provider)

Support for grief and loss

Many people addressed the urgent need to acknowledge the grief, trauma, and loss that frontline workers are experiencing and to provide them with resources and support to manage these burdens:

"We need support for people in grief, everyone is traumatized." (Service provider)

"I would add, we need adequate support for trauma and grief. Everyone, like, service users, service providers, like, just general support in that. Because that's not happening." (Service provider)

Additional evidence from the literature:

Restorative justice training for low-threshold services

Training in restorative justice provides necessary tools for ensuring that agencies are able to offer low-threshold services to people who use drugs and who may have behaviours that are difficult to manage. Organizations frequently respond to problematic behaviours in reactive and punitive ways, such as by limiting or restricting access to services. This runs counter to a harm reduction approach, which seeks to work with people to reduce risks of drug-related harm without penalizing them (134). Restorative justice offers a different approach to working with people, by attempting to maintain their engagement in services to protect their well-being (134,135) and focusing on people, relationships and accountability, rather than punishment (135). It is an approach that is attentive to power dynamics and human needs, not just organizational needs (136). It is a cooperative process that involves participation and consensus, with the aim of strengthening relationships and community in order to prevent further harm (135). Community-based restorative justice/harm reduction projects, where people who use drugs and had involvement with the criminal justice system were trained as restorative justice facilitators, and work to reduce conflict and develop community solutions to disruption exists and should be replicated (134).

Supporting frontline workers experiencing grief and loss

Addressing grief, trauma, and loss in the workplace involves developing healthy work environments, and fostering a 'grief-aware community' within the workplace. Care should be taken to ensure workers have appropriate workloads, effective supervision, and appropriate debriefing (137). Agencies should have policies in place for dealing with grief and loss, and resources readily available for their workers. Opportunities for group support and rituals should be provided, as they can reaffirm a sense of connectedness and alleviate some of the distress associated with grief and trauma (137). Workplace unions can also be an organizational factor that contributes to reducing workplace distress (138). The provision of health benefits and paid leave options are necessary for workers engagement in therapeutic activities to support their recovery (139).

Advocacy work offers an important intervention for people experiencing grief and trauma. Research shows that engaging in systems-level advocacy can offer hope to frontline workers, help them connect with others who share their values and concerns, and to feel empowered to make broader change (139). However, fear of losing their jobs may prevent workers from participating in advocacy work, and organizations may be reluctant to engage in advocacy or support the advocacy efforts of their workers for fear of losing funding. This can further contribute to frontline workers' burnout and workplace distress. Advocacy can be a powerful means to addressing the systemic and structural barriers to health and well-being, and promoting health equity.

Actions:

1) Ensure that all staff within agencies receive training on harm reduction.

- All staff, regardless of position type or whether their position is within a harm reduction program, must receive harm reduction training.

2) Establish and support a province wide training program on harm reduction.

- This program could be modeled after similar existing ones, such as OHSUTP (Ontario HIV and Substance Use Training Program) and the Women's HIV/AIDS Initiative;
- Conduct an environmental scan of existing training programs and resources that can be drawn upon;
- Develop a series of training modules that provide up-to-date, consistent information about effective harm reduction practices and programs;
- Develop specialized training for providing services to specific populations such as women, people who work in the sex trade, the trans community, racialized communities, and the Indigenous community;
- Develop training in restorative justice, trauma-informed service provision, and the social determinants of health.

3) Ensure that management-level staff receive harm reduction training adequate to their role and the positions they supervise.

- Support inter-agency mentorship between managers at similar levels to build capacity and facilitate the exchange of expertise across organizations.

4) Support the development of targeted grief and loss-related supports for people who use drugs and harm reduction service providers on the front-lines of the overdose crisis.

5) Foster safe, healthy workplaces that are also 'grief-aware' communities.

- Ensure organizations have policies in place for grief, loss, and traumatic events, and that frontline workers have access to a wide range of resources and services to support them with grief, trauma, and loss. This includes access to one-on-one counselling, paid leave and health benefits.
- Ensure the provision of specialized supports to workers with lived experience.
- Provide support and resources to existing community agencies and groups who are engaged in supportive programs for frontline workers, such as the Toronto Harm Reduction Alliance, the Frontline Workers Support Group, and the AIDS Bereavement and Resiliency Program of Ontario.

Recommendation 10:

Support calls for rapid change in drug policy

AT A GLANCE:

THE CHALLENGE:

- Canada's drug policy is based on an approach that criminalizes both illicit drugs and the people who use them.
  - This approach has been linked to negative health and social outcomes for people who use drugs.
- The current overdose crisis is rooted in this prohibitionist drug policy.
  - Lack of regulation of the drug supply leaves it open to contamination.
  - People who use drugs cannot be certain of the quality and strength of illicit drugs, making them vulnerable to overdose.
- Criminalization creates significant barriers for people who use drugs to health and social services, housing, income, and employment, and further marginalizes individuals.
- Criminalization disproportionately affects members of marginalized communities, such as Indigenous populations, women, and racialized populations, and is a key driver to health disparities faced by these communities.

THE SOLUTION:

- Support calls for drug policy reform. There is strong and growing consensus at the national and international level about the health and social benefits of decriminalizing currently illicit drugs. Strong advocacy is required to push Canada's approach to drugs away from criminalization, and towards one that is evidence-based and premised on drug use as a health and social issue, rather than a criminal one.
- Support advocacy for the exploration of potential models for the legalization and regulation of currently illicit drugs to address the current contamination of the drug supply.

Background:

In the early 20th century, governments around the world for the first-time enacted laws prohibiting drug use, and punishing those who used drugs. During this period, Canada enacted the 1908 Opium Act, which was based on racist ideas regarding drug use by certain racial groups, and prohibited the use of opium without a medical prescription (23). Several pieces of drug control legislation were introduced in the subsequent years. With each new legislative act, the list of banned or "illicit" substances increased, as did the powers given to enforcement authorities. This culminated with the enactment in 1997 of the current Controlled Drugs and Substances Act (CDSA), which guides current drug enforcement efforts in Canada.

In developing these laws, decisions around the legal status of specific drugs were not evidence-based. In fact, attempts to evaluate the harm stemming from the use of psycho-active substances consistently finds that the health and social harms from the use of *legal* psychoactive substances (like alcohol and tobacco) rank as high or higher than many of the currently illicit drugs (140,141).

Not only is Canada's current prohibitionist approach not evidence based, there is mounting evidence of the ineffectiveness of such approaches to drug policy (43,142). Prohibitionist approaches focus on the criminalization of both drug possession by people who use drugs, and on the cultivation, production and distribution of illicit substances. Decades of evidence suggests that increasing the criminal sanctions associated with drug use has failed to affect usage rates or improve the health of people who use drugs (143,144). Instead, recent evidence demonstrates that the criminalization of drug use is directly responsible for increasing the harms associated with drug use. For example, studies show that criminalization increases the risk of HIV among people who inject drugs (45) and their risk of overdose, and contributes to people being denied access to necessary medical treatments, housing and other social services (145).

There is also increasing evidence that the over-reliance on the criminal justice system to attempt to address drug issues further exacerbates health inequities and impedes efforts to address some of the issues underlying problematic drug uses patterns, including mental health, colonialism, and histories of trauma. An expanding body of literature in the US documents the disproportionate effects of criminalization of drug use on racialized populations, particularly on African-American people (146,147). Less recognized is that these patterns of over-representation of racialized minority groups for drug offences are also present in Canada. In the Canadian context, Indigenous people, particularly Indigenous

women, are disproportionately represented in the criminal justice system for drug-related offences (148). This has prompted organizations and agencies across the spectrum of health and social services to advocate for the exploration of alternatives to the current system of criminalization, and for evidence-based and public health approaches to drug use (145,149).

What we heard from respondents:

In this consultation, respondents described the LHINs as having an important role to play in advancing policies that promote the health and well-being of the population. This includes providing support for policies that are evidence-based, and promote health equity and public health goals, and pointing out when existing laws and policies are not aligned with the goals of improving the health of the population. Respondents saw decriminalization and harm reduction as central to an evidence-based, comprehensive public health approach to drugs in Canada, and aligned with the goals and values of LHINs:

> "I'd like to see activism, especially around decriminalization, being supported as a part of our job, but also as a priority of our agencies." (Service provider)

> "I like the thought of LHINs advocating for harm reduction politically, cause if they're saying to us, harm reduction's super important! Tell us why you think harm reduction's super important, cause obviously you do! But why not turning that around to the politics? And what I think is most interesting around that is if politics change, can we get a guarantee that the LHINs will continue to pursue harm reduction? Cause we're in a medium-lucky space right now, both locally, provincially and federally, but that can change really fast. And it'd be nice to have support, as a middle-ground of support." (Service provider)

Respondents frequently referred to Portugal's lengthy experience with drug decriminalization (150). Additionally, many respondents felt that while decriminalization is an urgently needed first step, it does not go far enough. They felt that some form of legalization model was necessary, in which government regulation of drug markets would replace the current illicit markets.

> "Decriminalize drugs. I think it'll save overdoses because that's how people overdose too. You're buying off somebody; it's crap, and you don't know what you're doing, and then you're going to go get some real shit, that's like 'Oh my god.' And then, you know what? It causes problems. Then you drop. So, decriminalize drugs." (Service user)

> "Decriminalization and regulation for drugs that are currently illegal, because people don't know how much fentanyl is in their fentanyl or morphine in their morphine." (Service provider)

Respondents emphasized the role that decriminalization of drug use would have in addressing other systems that marginalize and produce health inequalities among people who use drugs, such as the ongoing impacts of colonization or the experiences of people who use drugs with the child welfare system:

> "Globally, looking at some countries that have managed to decriminalize, across the board. And we have to change the laws and policies to have that be applied broadly, we think. So that's one of the barriers, would be, changing the laws. So current laws and attitudes that are existing at the moment. Drug laws are federal, and so we need national support for those things to change. And there are other national issues that are directly impacted by drug laws, like colonization, child welfare systems, housing systems, poverty, overall." (Service user)

However, respondents also identified concerns that powerful interest groups, such as those in the criminal justice sectors, would be resistant to changing the status quo:

> "Okay. So, barriers to this, we have, obviously, you know, whole empires are built upon drug prohibition. People earn their fucking salaries locking up and harassing and brutalizing street-based low level drug dealers and users. Obviously, dismantling drug war capitalism is going to be a big one." (Service provider)

Respondents also noted that framing drug use as a medical issue was not sufficient, and there was a need to explore a human rights approach to drug use:

> "We're in the process of reframing drug use from a criminal issue to a medical issue. But we need to push it away from that, to a human rights issue" (Service provider)

Additional evidence from the literature:

Within the drug policy community, consensus is emerging that the decriminalization of drug possession is necessary to address the health and social issues that are attributed to drug use (142). This consensus is the product of a substantial body of research that finds many of the negative effects of drug use are either caused or enhanced by the criminalization of drug use (145). Support for decriminalization is further bolstered by research coming out of Portugal. In 2001, Portugal decriminalized the possession of small amounts of drugs for personal use. While the impacts of this measure are somewhat contested, it is generally agreed that this reform has lead to reduced rates of HIV transmission and overdose, and improved access to harm reduction and treatment, without any concomitant increases in drug usage rates (150,151).

The issue of decriminalization and regulation of currently illicit drugs is timely given that Canada is in the process of changing the legal status of cannabis. In the case of cannabis, the federal government decided to bypass the decriminalization of personal possession and use of cannabis, move directly to the legalization of the possession of cannabis, and the regulation of its production, distribution and sale throughout government or government-affiliated outlets. This move is justified by the fact that harms of criminalizing cannabis vastly outweigh the harms associated with the use of the drug itself (152).

Actions:

1) **TC-LHIN should support health and social service organizations, particularly those that provide harm reduction programs and services for people who use, that advocate for evidence-based change to current drug policies and are calling for decriminalization and regulation.**

    - At first glance, the recommendation for Local Health Integration Networks to support advocacy for drug policy reform may not seem to be within the purview of a health authority. However, organizations and agencies across the spectrum of health and social services are advocating for alternatives to the current system of criminalizing the possession of small amounts of drugs for personal use. For example, the recent Overdose Action Plan from Toronto Public Health called for initiating community conversations on what a public health approach to drug policy might look like.

    - Further, the Toronto Central LHIN's Strategic Plan 2015-2018 recognizes the need to "reorient the health system to take into consideration the broader social determinants of health" and to partner with organizations "to work towards addressing the full range of factors that impact health" (153). Supporting advocacy for drug policy reform is consistent with this commitment.

2) **TC-LHIN should provide support for using strong evidence and best practices to build policy and to inform changes to drug laws, including emphasizing that policies and laws should promote health equity and human rights.**

    - TC-LHIN could recognize and provide support for policies that support the human rights of people who use drugs, and for evidence-based policies that are likely to have strong positive impacts on the health of people who use drugs, including those that remove the threat of criminal justice involvement for people who use drugs. This includes working to end police accompaniment of paramedics on overdose calls, which dissuades people who use drugs from calling 911 for assistance.

    - TC-LHIN should support and promote the voice and perspectives of people who use drugs within drug policy debates.

    - Organizations across the health and social service sector have called for drug policy reform that is evidence-based and aligned with the health and social needs of people who use drugs. Such organizations include: the Canadian Public Health Association, the Centre for Addiction and Mental Health, the Health Officers Council of British Columbia, the Canadian Association of Social Workers, the Canadian Drug Policy Coalition, American Public Health Association, the Global Commission on Drug Policy, and the World Health Organization. Most recently, the current Mayor of Vancouver called upon the federal government to decriminalize the possession of all drugs for personal use on March 9th, 2018.

Recommendation 11:

Address stigma and discrimination against people who use drugs

AT A GLANCE:

THE CHALLENGE:

- People who use drugs consistently report difficult and stigmatizing experiences when attempting to access health care and social services. Primary healthcare services within CHCs that offer harm reduction services are not immune to these attitudes.
- Stigma and discrimination cannot be untied from the social determinants of health; drug use intersects with poverty, racialization and experience of colonialism to result in increased stigma for certain groups of people who use drugs when compared to others.
- Stigma and discrimination are barriers to accessing care, and as such, increase the harms associated with drug use, including the risk of health harms and premature mortality.

THE SOLUTION:

- Develop and scale-up measures to reduce stigma and discrimination against people who use drugs within the healthcare sector, including training for health and social service providers.
- Provide agencies with the necessary resources and support to develop organizational and program policies that are aligned with a harm reduction philosophy.
- Using a large scale public education campaign, promote evidence-informed messages to combat the prevalence of unfounded and harmful myths around drug use, people who use drugs, and drug treatment.

Background:

Stigma and discrimination towards people who use drugs is closely tied to the illicit nature of drug use. However, it is amplified by social factors such as poverty, belonging to a racialized group, homelessness or being precariously housed, having a history of trauma, and the ongoing impacts of colonization. People who use drugs are treated very differently based on their social positions, and the social perceptions surrounding the drug they are using. For example, there is a certain prestige around cocaine use among rich, white people that stands in stark contrast to the moral panic around crack cocaine use among racialized minorities, despite the pharmacological similarities between the two drugs. The discrimination and stigmatization of people who use drugs creates barriers to accessing health and social services, housing, employment, and income security.

A significant concern is the persistence of stigma and discrimination against people who use drugs in healthcare and social service settings. This issue is well-documented in the literature, and was also frequently voiced by respondents in the consultations. This is a clear health equity issue, as it not only results in people who use drugs receiving substandard healthcare and social services, but also serves to dissuade them from seeking necessary care (127,154).

Although agencies voice a commitment to equity, diversity, and anti-oppression, insufficient training and lack of policy development for peer programs and workers with lived experience may permit discrimination and stigmatization to flourish in the workplace, despite best intentions. Peer workers and harm reduction workers who use drugs report feeling mistrusted and marginalized by policies that limit their access to spaces (e.g., not being given a key to their workplace), classify them in ways that limit their wages and opportunities for advancement, and exclude them from staff events, such as parties, professional training, meetings, and support groups (155). Managers recognize the need for clear, aligned policies and training but report having insufficient time or resources to do this essential work.

What we heard from respondents:

Respondents discussed the prevalence of stigma they encounter when interacting with service providers:

> "I think hospitals and doctors need to be more, like, accepting and not so stigmatizing. They think that because we're addicts, our pain's not real. Whereas, in reality, our tolerance is probably higher, so we actually need more than the average person. But they think we're just drug seeking. If I needed drugs, I'm not going to the hospital anyway. You know what I mean?" (Service user)

> "I find with doctors they're very judgmental. We need them to work from a harm reduction point of view, as opposed to people who are telling you what to do and giving you judgement and telling you this, that, right?" (Service user)

Respondents related experiences of stigmatization and discrimination even when interacting with service providers in sectors that frequently work with people who use drugs, and even in contexts that profess to use harm reduction approaches:

> "There is a lot of stigma that needs to be addressed. Honestly, a lot of service providers who say they do harm reduction don't know what harm reduction is, or how to do it properly." (Key informant)

Some respondents spoke of the distinctions made between different types of drugs, and different types of people who use drugs:

> "People make a big distinction between their, like, weekend cocaine habit, and people who use heroin, or are injection drug users, or people who use crystal, like, this type of thing. And it's bizarre. People have so much misinformation and they're so misguided. I feel like there's a need for a broader educational base that is not scare tactics." (Service provider)

Respondents offered ideas about how to address stigma and discrimination:

> "Radical inclusion is the underlying philosophy around a lot of restorative and transformative justice. That could look like training and policy in organizations, access to complaints processes and different ways of support. And making sure it is client, drug user, and sex worker driven. So this actually looks at ways of involvement, because we also talked about people *(who use drugs)* could be on boards, on advisory committees, on other operational committees, participating in evaluation processes and also on staff teams." (Service provider)

Other respondents also mentioned the need for broad-based educational campaigns on drug use to help combat stigma:

> "We need non-judgmental, non-prohibitionist educational campaigns and resources, with all of the knowledge and all of the information. So not just what the possible cons of drug use are but what the pros are, of drug use and all of the different reasons people use drugs and all of them being presented as equally valid, whether it's for pain relief or pleasure or boredom, or whatever." (Service provider)

Additional evidence from the literature:

Numerous effective interventions to combat stigma and discrimination have been designed and implemented within health, mental health, and drug treatment domains; however, the political will and resources to support and scale-up these interventions is needed (156). Effective anti-stigma and discrimination efforts must target individual, environmental, and policy levels (156,157). Additionally, one of the key measures for reducing stigma and discrimination against people who use drugs is drug policy reform (such as decriminalization).

Training is essential for all people employed in an agency, including volunteers, support staff, administrators, management, and service providers (156). Training should also be available for medical and social/community workers, students, and first responders (157). People who use drugs should be involved in the design and delivery of the training program. They should be well-trained and well-paid to deliver the training. At the environmental level, there is evidence for small to moderate positive impacts of both mass media campaigns and interventions in terms of stigma-related knowledge, attitudes, and intended behaviour (158).

Social marketing, mass media, and education campaigns must be supported with policy changes and human rights legislation (159). The lack of policies or specific guidelines for working with people who use drugs (both as clients and as colleagues) can reinforce discriminatory behaviour (156). Policies need to be reworked to reflect a harm reduction philosophy and to make sure that organizational policies do not conflict with program goals or agency values. It is essential that people who use drugs participate in the development of policies across the system.

Actions:

1) **Ensure that training to reduce discrimination and stigma against people who use drugs is provided for all health and social service providers.**

   - Require mandatory anti-stigma training for all providers in health and social service settings, including executive and management-level administrators, human resource personnel, and administrative and custodial staff.
   - Anti-oppression training is already a standard component of most workplace training programs. Specific training related to the stigmatization and discrimination of people who use drugs must be added and required for all employees.
   - Involve people who use drugs in the design and delivery of training.

2) **Ensure that supports are in place to help organizations in multiple sectors (shelter, housing, mental health, drop-in programs) become more accessible to people using drugs.**

   - Provide the necessary resources and support to assist agencies to develop organizational and program policies that are aligned with a harm reduction philosophy. The Harm Reduction Lead would be well-placed to assist with this work.
   - Policies are needed for peer programs and to support workers with lived experience, to help them succeed in the workplace and promote equity and inclusion throughout the organization.
   - People who use drugs should be involved in the development of policies across all levels of the system, and could help offer programmatic insights into how organizations can better meet their needs.

3) **Support the development of broad-based drug education campaigns to reduce stigma**

   - Partner with organizations to allow for the development and dissemination of evidence-based anti-stigma campaigns that are informed by the experiences of people who use drugs.
   - Partner with organizations engaged in anti-stigma, anti-discrimination, and anti-oppression work. Build on existing and past projects and their products (e.g., digital stories, speakers bureaus).
   - Recognize the links between criminalization and the ongoing stigmatization of drug use. The decriminalization of drugs and people who use drugs may contribute to reduced stigmatization and discrimination of people who use drugs.

Recommendation 12:

Support measures to increase access to housing and adequate income for people who use drugs

AT A GLANCE:

THE CHALLENGE:

- In Toronto, there is a dire need for emergency housing (particularly shelter beds) and long term, low-cost housing.
- There are a lack of shelters in Toronto that work from a harm reduction approach, making it difficult for people who use drugs to access the shelter system.
- The rates that recipients of Ontario Works (OW) and the Ontario Disability Support Program (ODSP) receive are extremely low, and undermine the ability of people who receive these forms of income support to adequately ensure their health.
- The links between homelessness, poverty, and negative health impacts are very clear.

THE SOLUTION:

- Support efforts to draw attention to the links between poverty, homelessness and precarious housing, and negative health outcomes.
- Support the development of partnerships within the TC LHIN between agencies with a strong harm reduction focus, and shelters and housing providers. This will allow for emphasis on the importance of harm reduction approaches to housing, and for scaling-up the opening of OPS within shelter and housing *(see recommendation 5).*
- Support efforts to open more shelter beds in the TC LHIN area, and to increase the availability of and access to low cost housing.
- Support calls for an increase in the rates for Ontario Works and the Ontario Disability Support Program.

Background:

The winter of 2017/2018 in Toronto was a cold and difficult winter, where an extended period of extreme cold exposed the long-neglect of the housing and shelter system, with shelters over-capacity, and warming centres completely deficient at meeting the needs of those experiencing homelessness (131,160). Data from the City of Toronto for the winter of 2017/2018 shows a 30% increase in the average number of people accessing shelter beds compared to the previous winter, and these numbers do not include record numbers of people accessing the emergency warming centres that were opened over the winter (131). Furthermore, the state of the warming centres and 24-hour winter respite centres was revealed to be far below the minimum shelter standards set by both the City of Toronto and the United Nations recommendations in an evaluation conducted just this year (160).

Although this consultation centered around harm reduction and substance use, respondents consistently reported that it is increasingly difficult for people who use drugs to find housing, particularly for those who are homeless or with histories of street-involvement. Service provider respondents also highlighted that they having difficulty assisting this population to remain housed, and are seeing increased rates of evictions. With historically low vacancy rates for rental units in Toronto, it is not surprising that people who use drugs, have histories of street-involvement, and are on social assistance are finding it difficult to find housing. The City's own housing department notes that increased demand on its shelter services are "driven by the decrease in housing affordability, loss of low-end of market rental stock to real estate development pressures, low incomes, and stagnant social assistance rates" (131). The inability to access shelter increases the harms associated with drug use and undermines people's capacity to ensure their own safety (125).

Shelters and housing services are also relevant to a discussion of harm reduction and substance use. Historically, there has been difficulty in integrating harm reduction approaches and models into shelters and housing in Toronto (contrary to some other jurisdictions like Vancouver, whose main supportive and social housing providers are agencies with a solid foundation in harm reduction). Many shelters and housing providers will not allow people who are actively using drugs or alcohol to use their services, or housing is made contingent on abstinence from drug or alcohol use (128,129). This is particularly true of Toronto Community Housing Corporation (TCHC), the largest housing provider in the city. Making housing contingent on abstinence is a difficult requirement for people who use drugs, is contrary to social equity principles, and is not justified by research (129,161). Access to stable shelter and housing is a necessary precondition for guaranteeing the safety and survival of people who use drugs, and mitigating the harms of drug use.

What we heard from respondents:

Respondents tied the overdose crisis to the gradual erosion of social assistance rates and lack of affordable housing and shelter for people who use drugs. They also cited housing as the starting point for beginning to build a basis for stability:

> "We need something around housing, a big-level advocacy for housing. It's not just an overdose crisis, it's like, a poverty crisis and housing crisis. But in addition to that, better, safer temporary shelters because not everybody actually wants housing, and that should also be okay." (Service provider)

Respondents highlighted the insufficiency of social assistance rates, and how they are not enough to allow for a healthy standard of living:

> "A basic income, whether you're working or not, whether you're on OW or ODSP, right, the money they ask you to survive on in a month is not nearly enough. It's crazy." (Service user)

> "Why am I subjected to having to go to a food bank, when you could give me a little extra money, and I could actually, through autonomy and self determination, purchase my food, without it being handled by god knows who, and everything, right?" (Service user)

Respondents pointed out the lack of harm reduction within the shelter and housing sectors, and the need for it:

> "What I'd like to see is like a home, you know, where we can place homeless people, addicts, you know, where they can use openly within that home. You know?" (Indigenous service user group)

> "We have to take it as a given that people will use, even in shelters. And we have to stop kicking them out for that. The only way to engage them is to provide non-judgmental services where they are at. In terms of reducing harm, that is key. And there are just not enough shelters doing this." (Key informant)

Respondents saw the potential for LHINs to promote the implementation of harm reduction approaches in shelters and housing:

> "When it comes to shelters, there's a lot of safety concerns and just not enough of them, and not enough that are harm reduction-based, which is not cool." (Service provider)

> "There is a real opportunity for cross-learning needing, for trying to engage in cross-learning. For creating partnerships with more experienced organization, to help to encourage this" (Key informant)

Additional evidence from the literature:

Addressing the lack of shelter space and the need for low cost housing for people who use drugs is crucial from a health equity and population health approach. The literature shows extremely negative health outcomes for people who are homeless, from vastly increased mortality, to increased rates of infectious and chronic diseases (162-164).

There is a high need for harm reduction shelters, that provide people who use drugs with services and support without requiring them to stop using drugs or alcohol (118). Evidence supports the integration of medical and mental health services into these shelters as a first step towards addressing the health needs of people experiencing homelessness *(see recommendation 7)* (125,128). The overdose crisis has put a spotlight on the potential of housing providers and shelters as partners in addressing the risks of overdose amongst their service users by integrating overdose prevention sites into their locations (i.e., shelters, warming centres, 24-hour respites, etc.) *(see recommendation 5)* (90).

Housing First is an approach in which housing is provided to people who are homeless without first requiring that they undertake treatment or achieve abstinence. The evidence for this approach shows that it is effective in reducing homelessness, emergency room visits, and hospitalizations for participants (130). Some research suggests that a Housing First model with people who use drugs may require additional supportive services to help ensure successful integration (129). In this consultation, respondents also stated that a Housing First model required additional supports for youth. To address the overdose crisis, overdose prevention sites have recently been integrated into housing environments in Vancouver, and this model should be rapidly implemented in Toronto as well (90).

Actions:

1) **Support TC LHIN funded supportive housing services in the development of harm reduction-based policies and guidelines, that can serve as a model for other shelters and housing service providers (such as the TCHC).**

   - Implement best practice recommendations to ensure that access to services is low-threshold, including the removal of requirements for abstinence and policies that bar or evict people for drug or alcohol use.
   - Ensure that staff are trained in restorative justice approaches to working with people who have problematic behaviours *(see recommendation 8)*.

2) **Provide support to shelters and housing service providers to rapidly implement overdose prevention sites to address the overdose crisis *(in line with recommendation 10).***

3) **Support calls to raise social assistance rates for both Ontario Works and the Ontario Disability Support Program.**

4) **Support advocacy for more harm reduction shelter beds to be opened in the TC LHIN area.**

5) **Support efforts to increase availability of low cost and low threshold housing.**

Appendix 1:

Essential Elements in a Harm Reduction & Substance Use Continuum of Care

Philosophical approach

- Provide low-barrier, low-threshold access points for people who use drugs
- Ensure the perspectives and needs of people who use drugs are central to the service model
- Respect the choices and self-determination of people who use drugs
- Employ differential models that meet the needs of priority populations: women, racialized populations, Indigenous people, people who are street-involved, people who are engaged in sex work, people who are homeless or precariously housed
- Address drug policies both organizationally and in society that criminalize drug use and contribute to stigma and discrimination towards people who use drugs
- Commit to confidentiality and anonymity for service users
- Advocate for adequate shelter for people who are use drugs and are experiencing homelessness; adequate, low cost housing; and access to adequate income support programs

Programs and services

- Distribution of sterile injection equipment
- Distribution of smoking/inhalation equipment (for crack cocaine; crystal methamphetamine; heroin, fentanyl and other opioids)
- Variety of outreach models (outreach, Satellites Sites, mobile services, distribution within housing/shelters/drop-ins)
- Naloxone distribution and training (both intramuscular and intranasal)
- Overdose prevention sites/supervised consumption services, including access to supervised smoking/inhalation services
- Drug testing
- Easy access to health care providers (primary care, foot and wound care, STBBI testing and treatment, etc.)
- Easy access to case management
- Access to system navigation support and accompaniment
- Referrals to evidence-based treatment programs, including opioid agonist treatment (when appropriate and when requested)

Human resources

- Ensure that harm reduction programs are properly staffed and resourced
- Ensure that the time taken to provide healthcare services to people who use drugs and have complex needs is accurately reflected in the panel size expectations for health service providers
- Ensure that people with lived experienced of substance use are prioritized as workers
- Ensure that key populations (women, Indigenous people, members of racialized groups) are represented among program staff and management

Infrastructure and support

- Provide training, support and capacity-building for staff
- Ensure the availability of sufficient and appropriate physical space for programmatic needs
- Ensure space is accessible to people who use drugs, including: being on the ground floor; space in proximity to entrance or with separate entrance; having clear signage; not having to have doors unlocked or to be buzzed into spaces by reception
- Offer flexible models for service provision – for example, partnerships with other organizations to establish storefronts for provision of harm reduction services, and/or OPS/SCS
- LHIN: providing a capacity-building and support role

Appendix 2:

Most Urgent Need in Harm Reduction Right Now

In the final question of the consultation, respondents were asked to write out their answer to "Right now, what is the most urgent need in harm reduction and substance use". Key informants were asked to answer the same question verbally. The responses are tabulated here, and organized by recommendation number.

Most Urgent Need in Harm Reduction Right Now	Number of times
Recommendation 10	
Decriminalization	17
Regulation/legalization	6
De-carceration	1
No cops on overdose calls	1
Recommendation 5	
More OPS/SIS	17
Safe inhalation sites	2
Indigenous workers at SIS	1
Recommendation 6	
Safe, non-toxic drug supply	10
Prescription heroin – doctor prescribed opiates	5
Prescription stimulants	2
Prescription alcohol/more services for people who use alcohol	2
Recommendation 8	
Non-judgmental, inclusive approaches to people who use drugs	8
Listen & learn from drug users, nothing about us without us	5
Comprehensive harm reduction strategy in agencies - consistent harm reduction values across agency	4
Resources to implement harm reduction in agencies	2
Take risks, be leaders, support your harm reduction frontline staff	1
Recommendation 12	
Affordable housing	8
Harm reduction shelters	2
Hot meals	2
Recommendation 4	
Access to and training on Naloxone	6
Harm reduction programs open more hours/ open 24/7	4
Low-threshold access	2
Recommendation 11	
Education on drugs for society – education to reduce stigma	6
Stop stigmatizing, start educating	4

Most Urgent Need in Harm Reduction Right Now	Number of times
Recommendation 1	
More funding to hire staff	4
More permanent funding/less project funding	3
Space to expand harm reduction services/a second building	3
Living wage for PWUD/people with lived experience	2
Recommendation 7	
Harm reduction-based case management, immediate access to resources that meet service user's needs	4
Nurse/doctor on site in harm reduction programs	4
Harm reduction services are holistic and integrated	1
Recommendation 9	
Education for staff on harm reduction & stigma	3
Support for grief, "everyone is traumatized"	2
Non-punitive approaches, restorative justice approaches	2
Recommendation 3	
Drug user resource centre	4
Indigenous healing centre that is focused on harm reduction	2

* Some respondents wrote more than 1 urgent need

Appendix 3:

Additional Quotes from Respondents

Strength 1: Supportive and welcoming staff in harm reduction programs

"One of the strengths here is the support. We're definitely supported." (Service user)

"It's very supportive here. Well, the harm reduction staff are very supportive." (Service user)

"Some of the staff -- and the peers, are *(organization)* biggest strength." (Service provider)

"For me, the -- like everyone else -- it's the staff. I really, truly believe *(organization)* does get more for their dollar [laughter] in many of their staff. They are quite lucky, cause a lot of the people who do work in the harm reduction field, to me, could be working at other places, right?" (Service provider)

"I think a strength is definitely the people working at the health centre. I think a lot of the staff are the best." (Service provider)

"Everyone seems hyper-skilled and connected and like, very strong bonds with folks who access services. So I'd say that's definitely the main thing I've noticed." (Service provider)

"There are so many people here so willing to help you, it's incredible. They strive to help you. Like, it's not like other places where you've got to ask for it, they come to you here. It's awesome." (Service user)

Strength 2: Staff create spaces that are safe and accessible for people who use drugs

"I would say that a strength is that the staff are really compassionate, caring, and have good life experience." (Service provider)

"One of the strengths that they have is that they have a very open, like they have a non-judgmental attitude here that when you come and you get a kit, you can just get a kit, you know what I mean? They don't question the using aspect of things, you know what I mean?" (Service user)

"They're very caring. It's all around services to people of all walks of life, no race, no colour, no religion." (Service user)

"It's very supportive. Well, the harm reduction staff are very supportive. There's other staff that are not very supportive, and very judgmental." (Service user)

Strength 3: Integration of people with lived experience into teams of service providers

"As far as strengths at *(organization),* everyone has already mentioned about the staff and the peer workers here. Couldn't ask for better people to work with, compassion-wise. And it's nice to have peers here, taking on more roles, and bigger roles. I think it makes an important statement." (Service provider)

Strength 4: Positive effects on access to harm reduction equipment and supports

"A strength, we have a lot of experience and knowledge about harm reduction here." (Service provider)

"A strength is information. All the information they provide, on diseases, on how to stay safe." (Service user)

Strength 5: Positive impacts on social determinants of health for people who use drugs

"I think one of the strengths, I do agree, again, that our staff is very passionate. Like, we are very committed to the work. Very innovative and always trying to really meet the needs and the gaps that we have in the community." (Service provider)

"There's a lot of shared social relationships and organizational history and education that's shared across sites and between staff members and community members." (Service provider)

"As a couple people said, the team, some people are new to the team, but I feel like I've got to know them enough, or have a good feeling that we have a lot of good fighters here." (Service provider)

Recommendation 1: Increase and stabilize funding for harm reduction programs and services

Insufficient and unstable funding is the primary weakness:

"It means, you know, full funding, not annual funding, piece-meal funding, it means funding that can sustain multiple locations. It can sustain staff from, you know, beg, borrowing and stealing to get a minimum wage." (Service provider)

"Having worked for many, many - twenty years - in an organization that had almost no money, everybody else got funded, and we never got funded. And we were doing, like the harm reduction work on the ground, and in the prisons, and that was really painful a lot of the time." (Service provider)

Lack of physical space and infrastructure necessary to provide harm reduction services:

"Having a suitable space is a really important piece of getting it right." (Service provider)

"They *(front desk staff)* are not harm reduction workers. In the absence of *(HR worker),* because he goes to three different places, he's overstretched. But if there was a room, you know, that had privacy. You know? And *(harm reduction worker)* can actually demonstrate, show you how to use it, especially with people that are OD'ing and stuff, even that prevention. So, if there were an office, people feel comfortable and you can give them a whole lecture, 'This is how to do it'." (Service user)

Reliance on un- or under-paid peer workers to perform instrumental program tasks:

"People with lived experience need living wages. Period." (Service provider)

"When you pay somebody a reasonable wage, you're telling them, through your actions that you actually care and that their experience is valid, and worthwhile and it makes them uniquely qualified." (Service provider)

The challenge to provide sufficient services outside of the downtown core:

"It's such a stereotype, that the suburbs are more conservative. But we have a lot of immigrants, both first and second generation in our area. Many of them never really encountered drug use until their kids got to high school. When we try to develop harm reduction programming, it's hard to get it funded, because there is a knee-jerk reaction to anything that might be considered to be encouraging drug use." (Service Provider)

"One challenge is just the large area that we're trying to serve, and you know, physically being able to get to all the places where we need to see people." (Service Provider)

Recommendation 3: Fund and support the opening of a Resource Centre for People who use Drugs

"We need more people with lived experience hired and put into leadership positions" (Service provider)

Recommendation 4: Continue to build and enhance access to baseline harm reduction services

Increasing access to harm reduction equipment, programs and education is necessary:

"There was a van that used to go by, a couple of years ago, that had the soups, clothing, socks, supplies, harm reduction equipment. Jackets for the winter, and a nurse. We need that again." (Service user)

"They can make a coke machine, right? We just push the button and you can have your supplies come out. A vending machine, a twenty-four-hour vending machine, for kits" (Service user)

"We need people that just, you know, come around in the community, and you can call this number and say 'Hey, are you around? Do you have a kit?' You know what I mean? That would be great to have, you know?" (Service user)

Recommendation 5: Scale-up overdose prevention sites & supervised consumption services

Need for Overdose Prevention Sites & Supervised Consumption Services

"We need an injection room here. They already have one, at the Works, Toronto Public Health, have an injection site already there. We need one here. And it needs to be 24 hours, right? I think it should be 24 hours instead of just certain hours during the day. They're good, clean." (Service user)

"These things (OPS) need to be put in place so that people can access it, and people need to come out from underground, cause they're finding dead bodies. And they find the person died from an overdose." (Service user)

Resistance from management to opening OPS/SCS

"Respondent 1: We need an OPS. Bring that trailer from Moss Park to our parking lot.

Respondent 2: Oh my god. Please.

Respondent 1: And we also have a really big lawn. We could put it there, it's a perfect place.

Facilitator: So what would be the barriers in terms of putting a trailer, for an overdose prevention site, into the parking lot?

Respondent 2: Upstairs *(management)*. Yes, they're going to be upset about it.

Respondent 1: Um, we will lose our jobs.

Respondent 2: Yeah, they don't want to see it. They have blinders on." (Service providers)

Need for supervised smoking and inhalation spaces

"It does have to be a certain type of space, but I think should be a space for people to feel safe to do their smokeable drugs." (Service user)

"I think having programs set up for one group but not the other, like that just reinforces like, junkies hating crackheads and meth users hating junkies." (Service provider)

Recommendation 6: Support the implementation of low-threshold managed opioid programs, managed stimulant programs, and managed alcohol programs

Need for managed opiate programs

> "I feel like we should be doing same day starts for, like, methadone and suboxone in this building, and prescribing Dilaudid in this building" (Service provider)

> "I'm going through it right now. I'm on a drug that works for me. Now, she *(doctor)* wants to taper me down, and taper me off, and put me on Suboxone. It won't work. Suboxone is not good for my heart. It keeps you awake. I can't do it. And she's not listening to me. So now I gotta go out there and find another doctor, before I run out of my stuff that I've been on for the past seven, eight years." (Service user)

Need for managed stimulant programs

> "I'd like to see more options for funded substitution therapies. Amphetamine prescriptions for folks who use crystal -- all voluntary, not coerced." (Service provider)

Need for managed alcohol programs

> "I'd like to see that *(managed alcohol programs)* integrated more into harm reduction. I feel it's something that, I mean, there's very good reasons for it right now, why injection drug use has a priority. But you know, I find inhalation is sort of secondary to injection and then alcohol kind of falls off the radar." (Service provider)

> "It's a part of the holistic issue. The guys that sit out in the park, in front of *(name)* community health centre, that site, you know, are constantly barraged by the police and constantly harassed. And they only drink. And why are they harassed so much? And that would be true also for our Indigenous population, that tends to sit out in front of this site." (Service provider)

Recommendation 7: Scale-up integrated case management and medical service provision within harm reduction programs for people who use drugs and have multiple, complex health and social needs

Case management

> "I want them to be able to come in and get an immediate need that they have met. I want to be able to pick up the phone to somebody who knows what's going on. Like, it might be like a case manager or something like that, because I intake people all the time. And like I know have seven problems, two of which I can deal with. The other five, I have no clue. And I knew last week, but now that's program's closed. Somebody I can call and say 'I need this.' It can be a systems navigator, or whatever you call those kinds of people. Like, somebody, 'Here are my problems.' And even if they can't fix it, they can get me to a place that's relevant." (Service provider)

Need for system navigators:

> "Isn't it important in harm reduction that we always employ or use peers, not only supports, but how about something called a peer navigator, somebody who's already been through all of this, to help navigate people coming in, experiencing this for the first time, be it pursuit for housing, or safe use practice and what harm reduction is." (Service user)

Rapid, low-threshold access to primary medical care

> "The *(provision of primary care in shelters)* model is great for getting people care in shelters or drop-ins. But there is no long-term responsibility for ongoing healthcare needs. They still don't have a family doc." (Key informant)

> "And then folks who work specifically with folks with histories of street involvement and substance use, don't see as many people because it's often complex care for folks who don't access because they get treated like shit when they walk through the door, usually. So there needs to be a better way of justifying how we're using taxpayer's money without reducing people to statistics and numbers and building the trust so we're not constantly surveilling people and documenting them. And the programs and workers themselves." (Service provider)

Need for low-threshold services that address mental health among people who use drugs

> "The quick fix doesn't work. The current psychiatric system doesn't work for this group. This is a group that needs time to build trust. We have a better chance of engaging them in community setting than in hospitals. But if we are going to engage them in community services, we need to have the time, to let them get to know us, on their terms." (Key informant)

Recommendation 8: Focus on building harm reduction agencies

> "They should have a lot of upper management that have actually experienced our lives. You know what I mean?" (Service user)

> "I think it goes back to the idea of like, what it means to identify yourself as a harm reduction agency. If you are not hiring people that do identify as people who use drugs and you're not supporting people to identify as people use drugs, you are not a harm reduction agency and you need to stop using that word." (Service provider)

Recommendation 9: Build the capacity of the harm reduction workforce through training & support

Need for restorative justice approaches

> "We need to be low barrier to bring people into their care decisions. I mean, it's ridiculous that swearing is what excludes people from help." (Service provider)

Need for training and support for harm reduction at the management level:

> "The disconnect is what I see. Like once again, there's nobody at the top that has any experience with homelessness, mental health or drug, people that use drugs. So, how can they understand it? How can there be even a voice? It's just all of them talking, with their ignorance, about how 'We need to get rid of these people, because we don't like the way they behave.' It's so weird. 'How can we stop this?' Because it makes the workplace inconvenient." (Service provider)

Recommendation 10: Support advocacy for rapid change in drug policy

The need for decriminalization:

> "And how about stop throwing people in jail for ridiculous things. Like, small amounts of something, what does it take to say, 'Be on your way.' You know? Like, I can understand if the person has a bag with a scale and a pound of this. You know, okay, I can't even understand but that's the way the system is. But, I hear some people, what they go away for, it's absolutely ridiculous. It's like the cops hunt them down. You know? Like 'There he is.' And they stop him and they search him, and there he goes, off to jail, just cause the cops know him." (Service user)

> "I feel like decriminalization doesn't need to be talked about. Because it's just sort of like, everyone thinks, 'Yeah, we should just decriminalize it.' I don't think there's going to be much disagreement on it. It's like, 'Decriminalize it all; make it all safe.' In order to make it safe, you must decriminalize it. I don't see anybody having much of a differing of opinion." (Service provider)

> "We've got this model, which is to decriminalize, like, Amsterdam or Portugal. So there'd be no jails, no cops, no legal issues around drug use. Drugs would be safe and good, like when you pick up from the medical weed centre. So, you go somewhere, and you say, 'This is what I want.' And like a dispensary where it's quality and quantity." (Service user)

Decriminalization as part of a comprehensive drug strategy:

> "I wanted to talk about like, how Portugal has decriminalized drugs. So, we already have that. But what they also do is they give – instead of jailing those people that they would previously criminalize, now those people are getting help. So, whatever that looks like, whether they're rehabilitated or they have a harm reduction program going on. We need to model our drug laws around that, around the fact that it's a health problem, it's not a crime problem. It's a health problem." (Key informant)

> "When we look at comprehensive strategy, we look at, everywhere from education, prevention, support, all the way up to and including the decriminalization of substances." (Service provider)

Recommendation 11: Address stigma and discrimination against people who use drugs

> "And that we're kind of setting up, like, this is the gold star, so if other CHCs are going to go in, you have to do it like, this way is the definition of harm reduction. And how you treat community members meaningfully, and not, you know, fobs that are timed or you can't use the kitchen, or we don't want peers in the staff bathroom or, you know? Continued dehumanizing things." (Service provider)

> "Stigma makes for a lack of allied doctors and prescribers. If we can't even find someone in favour of harm reduction at *(CHC known for being HR-friendly),* like, where are they?" (Service provider)

> "They *(doctors)* should all take a one on one, not just one course, maybe like a year. You know what I mean? Put them in, come on the street with us. Go to an injection site. You know? Do a couple of shifts there. See what it's really like, because they're all book smart. They aren't, you know, they don't walk the walk. And until, you know, you're out on the street and you see what's going on, you really don't have a clue. So I think they need to, you know, spend some time on the street. They need to spend some time with people. The people that are there helping, they know, they help them because they've got pictures of them in books and stuff, but they have no clue. Some of them. I'm not saying all of them. Not all of them are like that." (Service user)

Recommendation 12: Support measures to increase access to housing and adequate income for people who use drugs

> "Well, in my scenario, it would be first on a need to need basis, you provide them the opportunities to build a foundation for themselves, as a first step. So, to me, that looks like assuring or guaranteeing some sort of stabilized housing, then you can work on other stuff. Like being homeless and, always in, you're always being challenged. Right? How do you relax and take stock and regroup? How do you reenergize, right? Very difficult." (Service user)

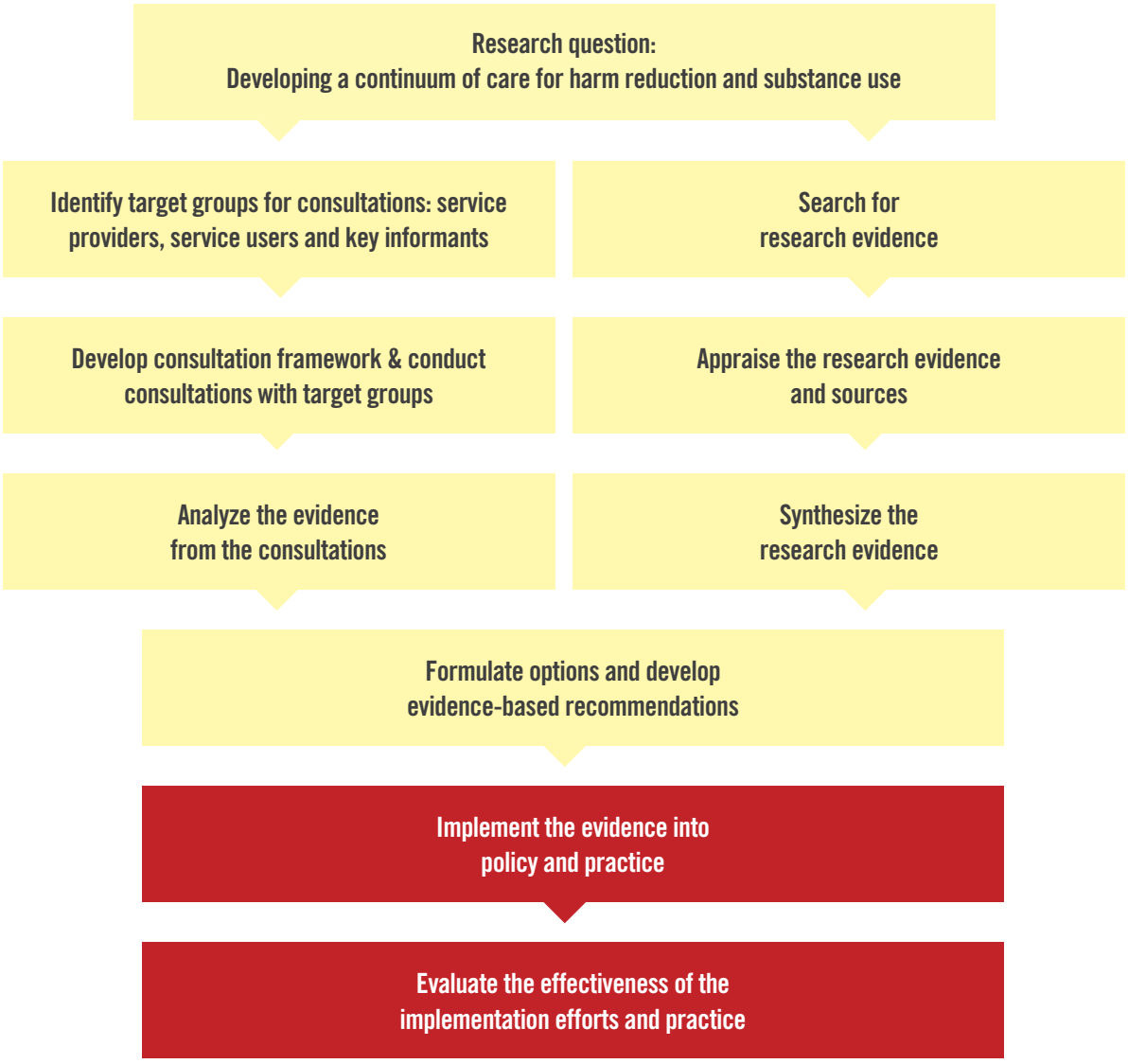
> "When I look at a comprehensive harm reduction strategy, and that includes harm reduction housing. It includes a whole array of areas in which we have seen the dismantling of our social infrastructure or a social safety net, through a whole Neo-Liberal agency. I mean, so when you look at that, like, what do we mean? So, when you look at comprehensive, it needs to be very inclusive, all the way up to and including housing for long term senior users who are now in the last stages of their life, so that we don't have to run around the city, trying to get TESS to pay for funerals, right? So, that's what I mean, like, when I look at a comprehensive strategy." (Service provider)

Appendix 4:

Detailed overview of the research methodology

Research Framework

A research framework was developed to guide the data collection and analysis, and to frame the writing of the recommendations. The research framework is summarized in the diagram below, and illustrates the stages of the research process. The boxes in yellow highlight the elements that were undertaken in the development of this report; the boxes in red represent the next steps, to ensure that the recommendations made achieve their maximum effect.



** Adapted from: Evidence-informed policy-making: Stages in the process. Geneva: World Health Organization.*

Data collection

Three phases of data collection occurred during the consultations for this report. Overall, a participatory approach guided the data collection and informed the types of data collected. Throughout this process, the advisory panel was consulted at each major stage in the development of the research process and consultation plan. The main priority in the consultation process was to ensure that the perspectives of people who use drugs and access harm reduction services (service users) were centralized. Additionally, service providers involved in the delivery of front-line harm reduction services were prioritized for engagement. These two groups were specifically prioritized in order to draw upon the first-hand, experiential knowledge and expertise that they possess, and have this reflected this in the recommendations. Care was taken to design a research process and consultation group format that would be participatory. While the consultation groups loosely followed a focus group format, a series of 5 activities were used in each group to incite participation from all group members. The activities were designed specifically for this consultation, both to illicit the desired information on harm reduction programming, but also to ensure that all individuals would participate and no single voice would dominate.

Data collection included 3 phases, summarized below:

1) **Program information – December 2017:**

Survey on program offerings

- A short survey was distributed to 5 community health centres;
- Collected information on current harm reduction program offerings
- Enquired about program planning, program expansion currently underway, and medium-long term programming priorities.

2) **Consultations with 108 harm reduction service users and service providers – January & February 2018:**

Consultations with people who use drugs (7 consultation groups in locations around the City);

- Targeted in-person consultation with small groups of people who use drugs, who are also users the harm reduction programs;
- Activity-based focus group, focused on brainstorming an 'ideal' model for a harm reduction continuum of care.

Consultations with front line harm reduction workers (5 consultation groups, one in each CHC)

- Site visit to each of the CHCs harm reduction programs;
- Targeted discussion with people involved in the harm reduction program, including front-line staff and workers with lived experience of substance use (peer workers);
- Activity-based focus group, focused on brainstorming an 'ideal' model for a harm reduction continuum of care.

Consultation with Indigenous community members (1 consultation group)

- Consultation with Indigenous community members who use harm reduction services;
- Consultation developed in partnership with and co-facilitated by an elder who is an Indigenous community member.

Meeting with Executive Directors and key team members (1 consultation group)

- Targeted consultation to discuss strengths, gaps and needs in the service continuum for harm reduction and substance use;
- Focus on the varying environments and contexts that exist in different areas of the Toronto Central LHIN;
- Discussion of the priorities for any future investments in this area.

3) **Key informant interviews with 17 community partners – February & March 2018:**

- One-on-one in person or telephone meetings;
- Key community partners were nominated by harm reduction programs and ED advisory leads;
- Key informants were also chosen to ensure that a variety of different sectors and geographic areas of the TC LHIN were represented.

In the first phase, a short survey was distributed to harm reduction programs in five community health centres in the Toronto Central LHIN (one in each sub-region). Harm reduction program managers in each community health centre completed the survey.

In the second phase, consultation groups were organized. Each of the participating community health centres assisted the author in organizing consultation groups, and in recruiting service users and service providers involved in the harm reduction program. The focus groups were co-facilitated by two facilitators. The groups with service users were co-facilitated by a peer researcher, who had previously been trained in facilitation and had experience working on several research projects, and the focus group with Indigenous community members was co-facilitated by an Indigenous community member with extensive research experience, who also provided advice for adapting the facilitation guide and format to reflect Indigenous teachings.

The consultation groups were held in January and February 2018. A total of 14 consultation groups were held with:

1) People who use drugs and access harm reduction services (service users) (7 groups);
2) Front-line harm reduction service providers (5 groups);
3) Indigenous community members who access harm reduction services (1 group).
4) Executive team members and key program managers from each of the 5 community health centres (1 group).

The consultation groups lasted approximately 2 hours, and were run in a focus group style with two facilitators. The focus groups were structured to contain several activities and discussion segments. The activities were specifically designed to: 1) 'warm-up' participants to the topic under discussion; 2) elicit the strengths and gaps in the current harm reduction programming; 3) brainstorm an 'ideal' model for harm reduction services and care; 4) rank and operationalize some of the key ideas of the ideal model; and 5) identify the most 'urgent need' in harm reduction right now.

In the third phase, key informant interviews were used to supplement the data collected in the consultation groups. Key informants were recruited in two ways. First, each of the 5 community health centres was asked to nominate their 5 top partners in the community. Based on these nominations and feedback from the ED advisory group, a list was compiled for key informant interviews. The author also compiled a list of key organizations within each LHIN sub-region to ensure that a variety of different sectors were represented. The final choice of interviewees was made by the author, in order to ensure balance in different sectors and from across the geographical area of the Toronto Central LHIN. The key informant interviews used similar questions to those asked in the consultation groups. They were conducted by phone or in person, and lasted anywhere from 30 minutes-1.5 hours.

Consultation questions

Facilitated activities and discussions were held during the consultation groups and key informant interviews. The following questions guided the discussion:

- What are the current strengths in the service continuum for harm reduction and substance use?
- What are the current weaknesses or gaps in the service continuum for harm reduction and substance use?
- In an ideal world, what would an ideal model of wrap-around services and care for harm reduction for people who use drugs look like?
- How would you operationalize the models in the previous question?
- Right now, what is the most urgent need in the area of harm reduction and substance use?

Agencies represented

Respondents for consultations (both service providers and service users) and key informants were drawn from organizations working in: healthcare and public health (including healthcare and social service providers in both community health centres and hospital settings); agencies working with the corrections system; community organizations addressing mental health and homelessness; and shelters and community housing providers.

Analysis & Synthesis

With the consent of respondents, the consultation groups and key informant interviews were audio-recorded and transcribed. Iterative and thematic analytic methods were used to identify key themes that emerged in the discussions in the consultation groups and key informant interviews (165). Once initial themes were identified, they were compared (between the different consultation groups) to identify consistent themes. The qualitative methods used in this report have been used by the author in previous research studies (34,166).

The research evidence was synthesized simultaneous with the analysis of the themes emerging from the consultations to allow for the evidence to inform the development of the recommendations. Major themes were condensed into categories that corresponded to major areas of service provision, agency and organizational functioning and issues, and structural factors at the macro-environmental level. These categories were further condensed in consultation with the research evidence, and form the basis of the recommendations that were developed. A preliminary version of the recommendations was provided to all members of the advisory panel members for comment. Feedback was used to structure the final version of the recommendations in the report.

List of agencies represented in the consultation groups and key informant interviews include:

- All Saints Church-Community Centre
- Eva's Initiatives
- Inner City Family Health Team
- LAMP Community Health Centre
- Parkdale Queen West Community Health Centre
- Parkdale Activity-Recreation Centre (PARC)
- Regent Park Community Health Centre
- Sistering
- South Riverdale Community Health Centre
- Street Health
- St. Stephen's Community House
- Toronto Public Health
- Toronto Urban Health Fund (Toronto Public Health)
- St. Michael's Hospital
- Unison Health & Community Services
- Woodgreen

Appendix 5:

Resource List

Drug policy and systems-level advocacy

Drug policy:

Boyd, S. Drug use, arrests, policing, and imprisonment in Canada and BC, 2015–2016. 2018.
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Canada's Drug Futures Forum. Canada's Drug Futures Forum: Summary of proceedings and final recommendations. April 4-5 2017.
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Available from: http://pqwchc.org/wp-content/uploads/Story-Gleaners-presentation-how-current-Canadian-drug-policy-affects-the-health-of-people-who-use-drugs-2011.pdf

Toronto Public Health. Toronto Overdose Action Plan. Toronto: Toronto Public Health. 2017.
Available from: https://www.toronto.ca/wp-content/uploads/2017/08/968f-Toronto-Overdose-Action-Plan.pdf

Social determinants of health:

Health Nexus and Ontario Chronic Disease Prevention Alliance. Primer to Action: Social Determinants of Health, Toronto:
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National Collaborating Centre for Determinants of Health. Integrating Social Determinants of Health and Health Equity into Canadian Public Health Practice: Environmental Scan 2010. Antigonish, NS: National Collaborating Centre for Determinants of Health, St. Francis Xavier University; 2011.
Available from: http://nccdh.ca/images/uploads/comments/Environ_Report_EN_150604.pdf

Stigma, discrimination and substance use:

Khenti, A, Sapag, JC, Bobbili, S. Ending stigma starts with you: Preventing mental illness and substance use related stigma and promoting recovery oriented practices in primary health care, Final report. Toronto: Centre for Addiction and Mental Health; 2016.
Available from: http://pqwchc.org/wp-content/uploads/Ending-Stigma-Starts-With-You-Final-Report-2016.pdf

Regent Park Community Health Centre and Street Health. Our Harm Reduction Stories: Working towards healthier outcomes. Toronto: Regent Park Community Health Centre; 2013. Available from: https://www.youtube.com/watch?v=_VcMIS9dXo0

Toronto Drug Strategy Implementation Panel. Stigma, discrimination, and substance use. Toronto: City of Toronto; 2010.
Available from: https://www.toronto.ca/wp-content/uploads/2018/01/93e2-stigmadiscrim_rep_2010_aoda.pdf

Involving people who use drugs

Balian, R and White, C. Harm reduction at work: A guide for organizations employing people who use drugs. New York: Open Society Foundations. Available from: https://www.opensocietyfoundations.org/reports/harm-reduction-work

Belle-Isle, L, Pauly, B, Benoit, C, Hall, B, Lacroix, K, LeBlanc, S, Sproule, R, Cater, J, Johnson, M, & Dupuis, G. From One Ally to Another: Practice Guidelines to Better Include People who Use Drugs at your Decision-making Tables. CARBC Bulletin #14, Victoria, British Columbia: University of Victoria; 2016. Available from: https://www.uvic.ca/research/centres/cisur/assets/docs/bulletin-14-from-one-ally-to-another.pdf

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Toronto Harm Reduction Task Force. Information guide for peer workers and agencies [Internet]. 2nd ed. Toronto ON: Toronto Harm Reduction Task Force; 2013. Available from: http://www.canadianharmreduction.com/sites/default/files/PEERGUIDE2013.pdf

Harm reduction programs and services

Best practice recommendations for harm reduction programs

Strike C, Hopkins S, Watson TM, Gohil H, Leece P, Young S, et al. Best Practice Recommendations for Canadian Harm Reduction Programs that Provide Service to People Who use drugs and are at risk for HIV, HCV, and Other Harms: Part 1. Toronto ON: Working group on Best Practice for Harm Reduction Programs in Canada; 2013. Available from: http://www.catie.ca/sites/default/files/BestPracticeRecommendations_HarmReductionProgramsCanada_Part1_August_15_2013.pdf

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Wrap around service model

Toronto Community Hep C Program. Toronto Community Hep C Program Guide Book. Toronto: South Riverdale Community Health Centre; 2012. Available from: http://www.catie.ca/en/resources/toronto-community-hep-c-program-guide-book

Taking action on the overdose epidemic

Naloxone training

Toward the Heart is part of the BC Centre for Disease Control. They have a website that provides overdose prevention and response materials, including training videos and manuals, and online training programs on how to administer naloxone.
Available from: http://towardtheheart.com/naloxone-training

Overdose prevention and response

BC Centre for Disease Control. BC overdose action exchange II. BCCDC; 2017 August.
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Provincial Health Services Authority. BC overdose prevention services guide. Provincial Health Services Authority; 2017.
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Overdose prevention sites (OPS) and supervised injection sites (SIS)

BC Centre on Substance Use. Supervised consumption services: Operational guidance. BC Centre on Substance Use.
Available from: http://www.bccsu.ca/wp-content/uploads/2017/07/BC-SCS-Operational-Guidance.pdf

Fraser Health. Overdose prevention site manual. Fraser Health; 2017 August.
Available from: http://www.fraserhealth.ca/media/20170908_Fraser_Health_Overdose_Prevention_Site_Manual.pdf

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Working with special populations

Indigenous community experiences with and access to health and social services

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Available from: http://www.wellesleyinstitute.com/wp-content/uploads/2015/02/Summary-First-Peoples-Second-Class-Treatment-Final.pdf

Native Youth Sexual Health Network. Indigenizing harm reduction: Moving beyond the four-pillar model. Visions. 2016;11(4):36-39.
Available from: http://www.heretohelp.bc.ca/visions/indigenous-people-vol11/indigenizing-harm-reduction

Western Aboriginal Harm Reduction Society. Talking circle series: Healthcare experiences of Aboriginal peoples living in the Downtown Eastside. Vancouver: WAHRS; 2017. Available from: http://wahrs.ca/cultural-sharings-in-research/

Well Living House. Niiwin Wendaanimak Four Winds Wellness Program: Evaluation Report. Toronto: Well Living House; 2017

LGBTQ people and harm reduction

Rainbow Health Ontario. Evidence brief: LGBTQ people, drug use, and harm reduction. Toronto: Rainbow Health Ontario; 2015.
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Safer Stroll Outreach Project. Super Hos – Women in the know! A project and resource guide by sex workers. Toronto: Regent Park Community Health Centre. 2008.
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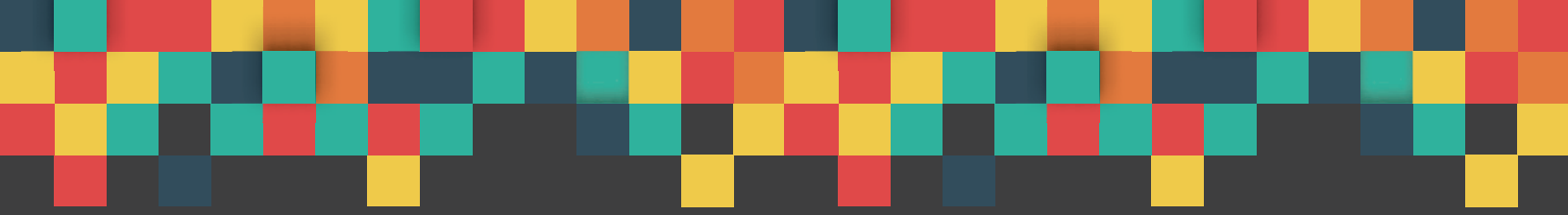


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