Ontario Association of Interval & Transition Houses

HARM REDUCTION NEEDS ASSESSMENT ONTARIO VAW SHELTERS

Submitted to the Ministry of Children, Community & Social Services (MCCSS)

June 30th, 2022

Background

Needs Assessment

With funds provided by the Ministry of Children, Community & Social Services (MCCSS), the Ontario Association of Interval and Transition Houses (OAITH) was tasked with conducting a Harm Reduction Needs Assessment as part of our project deliverable for 2021-2022. Over a span of 12 years OAITH has developed a range of learning tools and events relating to harm reduction for shelters across Ontario. These include training courses, resource documents, videos, in person training days and a provincial conference. Further to this, OAITH has partnered with Lakehead University to support research studies focusing specifically on harm reduction practice in VAW shelter settings.

In 2020 as VAW shelters amended and adapted to many changes related to COVID 19, they were faced not only with adapting services to meet the needs of survivors of gender-based violence, but they were also faced with a growing opioid crisis driven by a toxic drug supply. While shelters remained open, member organizations began reporting that mental health and addiction services and other services were closing or significantly reducing services, programs and contacts with service users. This led to insurmountable pressures being put onto VAW shelters services and in some cases this has led to deaths occurring in shelters. Shelters have reported increases in the number of survivors entering shelters that use substances and have reported drug toxicity as a challenge to successfully utilizing naloxone. In order to address these impacts, shelters have identified harm reduction practices as a critical component of VAW work at this time (Trudell et al., 2021).

Building upon previous work, OAITH designed the needs assessment questions around the harm reduction framework continuum as a tool to assess current practices being used by participating shelters (See Appendix). While the tool has been in developmental stages it hasn't been utilized publicly. Using the tool as a framing for some of the questions in the needs assessment will also allow us to make amendments needed to the tool due to the fast changing landscape of substance use service provision

Varying indicators within the continuum were utilized as questions within the needs assessment, and the practices associated with each level were included as possible responses to the question. Survey participants were asked to select the statement that best described their practices related to a certain area of harm reduction implementation. A word

document of the questions contained within the needs assessment has also been provided at the end of this report for reference.

Additional questions were developed to assess the impact of the opioid crisis and toxic drug supply, training needs, gaps in policy development, existing community connections, successes and challenges when working with survivors of gender-based violence who use substances.

Developing a Harm Reduction Framework

In 2016 with funds provided by the MCCSS, and in partnership with Dr. Angela Hovey and Dr. Susan Scott from Lakehead University, OAITH began developing a harm reduction framework continuum for Violence Against Women (VAW) Shelters in Ontario. Two studies were conducted with OAITH members to inform the development of this continuum, including: Understanding the landscape of substance use management practices in domestic violence shelters across Ontario and All women welcome: Exploring residents' experiences with harm reduction at an emergency shelter, as well as information that was collected during a Harm Reduction Conference held with OAITH members in 2018.

The framework has been developed as a continuum of practices and provides 4 different levels of harm reduction implementation as it relates to 5 different areas of work within shelter, including: policies, procedures, and operations, facilities, staffing and training, on-site supportive services and community connections. The creation of this framework will assist in guiding the implementation of harm reduction practices within shelters and the use of levels will ensure that shelters can incorporate practices that will best meet the specific needs of the communities in which they are serving.

Included below are the definitions of each harm reduction level. A draft copy of this framework has also been included at the end of this report as a reference (Appendix).

Definitions of Levels of Harm Reduction Practice:

Level 1

Uses strategies that restrict active use of substances during a shelter stay. Non-use policies may be required in order to accommodate cultural considerations or provide a substance-free setting for women who have this preference. If unable

to accommodate a woman for reasons related to substance use, shelter must provide a safe alternative service option (i.e., making a referral).

Level 2

Uses strategies characterized by basic harm reduction principles that acknowledge the use of substances and their potential risks and harms without actively accommodating or actively supporting safer use. Strategies of this nature allow more women to access shelter service while maintaining a non-use shelter environment.

Level 3

Uses passive and some active strategies such as proactive discussion around substance use and accommodation of safer use, without actively supporting safer use. These strategies work to reduce the stigma associated with substance use and support increased access to substance use services in the community (e.g., safe consumption site).

Level 4

Uses active strategies of acceptance, accommodation, and support of safer use. Strategies are inclusive of all women regardless of their substance use, allowing for the most universal access to shelter. Substance use is destigmatized and barriers to active use are removed where possible.

Limitations:

It is important to note that there are a number of limitations to this needs assessment. Although harm reduction can be applied to a wide range of behaviours/ practices, for the purpose of this needs assessment the shelters were asked to report on harm reduction practices/procedures related to substance use. Other harm reduction practices may be present in VAW shelters in Ontario but not necessarily captured in this needs assessment.

Additionally, due to the format of this needs assessment respondents were required to select the statement that best describes practices related to a number of harm reduction indicators. The variation in how harm reduction practices are implemented may have been challenging for some respondents to locate their practices within the continuum, and may have also led to some confusion for respondents, which appeared to result in several respondents skipping questions. These skipped questions also reduced the number of respondents that could be included in any analysis using the overall

harm reduction continuum scores. Additionally, as the majority of questions were multiple choice there was limited opportunity for respondents to provide any context to their selected responses.

It is also important to note that at the time of this study, VAW shelters in Ontario are continuing to face many impacts related to the global Covid-19 pandemic (Hancock, 2021). Throughout the pandemic, there have been additional challenges and barriers related to implementing harm reduction practices within shelter due to staffing impacts and shortages, public health movement restrictions and closures of community based substance use programming. The barriers have been compounded by an increasingly toxic drug supply which has increased the risk for accidental drug poisonings and overdose among those who use substances. (Canadian Institute for Health Information, 2021). This harm reduction continuum and needs assessment, however, do not take into account the impacts of the pandemic on the implementation of harm reduction practices within shelter. Ongoing assessment and evaluation of the VAW sector's implementation of harm reduction practices will be imperative to understand how harm reduction may be implemented when shelters and survivors are not experiencing additional barriers related to the current pandemic. It is important to note that within the context of the pandemic, there has been a notable change in the experiences of those who use substances and indications of an increasingly toxic drug supply. Preliminary data from Public Health Ontario has indicated an increase among emergency room visits, hospitalizations and deaths related to opioids and an increase in the number of deaths related to fentanyl (Public Health Ontario, 2020).

This needs assessment was only made available to OAITH member organizations and does not include the experiences of non-member VAW shelters in Ontario. While there was a wide range of shelter respondents from all across Ontario with varying sizes and community needs, there may have been differences in the experiences of non-member VAW shelters in relation to the implementation of harm reduction measures that were not captured within this needs assessment.

Language/Terminology:

In the following report, substance-related deaths and non-fatal overdoses will be referred to as drug poisonings. Drug poisonings can occur when an individual has taken enough of or a combination of substances that could result in illness or death and are oftentimes accidental (Alberta Health Services, 2020). The language used to describe substance use and harm reduction practices is important, as previous research has indicated that using morally centered language when discussing substance use and harm reduction can impact service provider attitudes and can also increase barriers for service for people who use substances. Not only does the language of overdose place the onus on the individual and

suggest that the individual has knowingly consumed too much of a substance but it also does not accurately describe the current situation in Canada (Interior Health, 2022 & Collins et. al. 2018). The term drug poisonings better describe substance-related deaths as poisonings that are the result of the unregulated and increasingly toxic drug supply within Canada (City of Vancouver, 2019).

Survey Respondents

As the harm reduction continuum has been created based on the practices implemented within shelter settings, the survey was sent only to organizations that were operating a shelter/residential program, to a total of 69 shelter organizations. Member organizations that provide only transitional housing and community-based organizations to survivors, such as counselling support or legal advocacy, were not included within this needs assessment. Additionally, this survey was sent only to OAITH member shelters and as a result was not available to non-OAITH member violence against women (VAW) shelters in Ontario. A total of 43 survey responses were received and were reviewed to ensure completion. A total of 8 surveys were omitted from the survey, as these surveys were not completed beyond the initial demographic questions. A total of 35 survey responses were included in the analysis. The response rate for this survey was 50.7% (35/69). Survey respondents were anonymous and were not required to identify their organizations within the survey or any personal information about the staff member who completed the survey.

MCCSS Region

The survey was disseminated among OAITH member organizations and included shelters from each MCCSS region within Ontario. Each MCCSS region was included within the final survey analysis. Of the 35 responses included within the analysis, 4 responding shelters were from the Toronto region (11.4%) and 5 responding shelters were from the Central Region (14.3%). The North and East regions each had 8 respondents (22.9%) and there were 10 respondents from shelters in the West region (28.6%).

Community Size

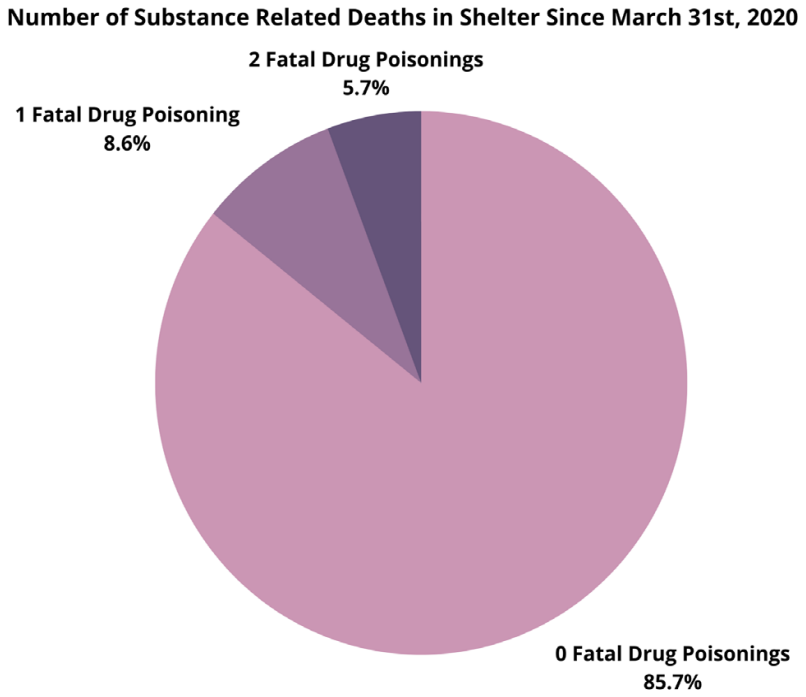
The majority of respondents (42.9% or 15) were located in a suburban area which included a mix of both rural and urban areas. Respondents also commonly indicated that they were located in a rural and/or northern community accounting for 37.1% (or 13) of the respondents. One-fifth of the respondents (20% or 7) indicated that their organization operated within an urban community.

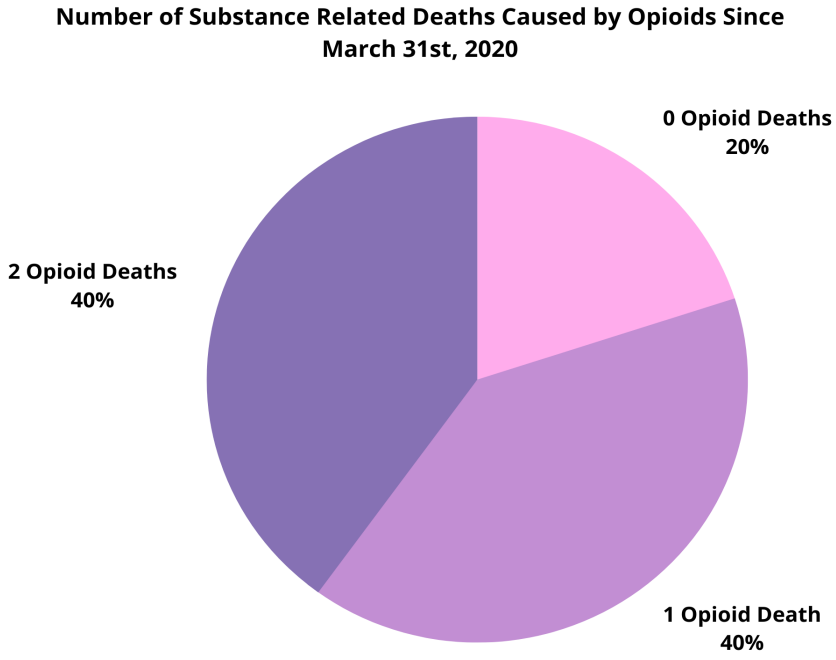
Shelter Size

Just over one third of respondents (40% or 14) indicated that their shelter was small and had 15 beds or less within their shelter. Over 30% of respondents (31.4% or 11) indicated that they had a medium sized shelter that had between 16 and 25 beds. A total of 10 survey respondents (28.6%) indicated that their shelter was large and had more than 25 beds within their organization.

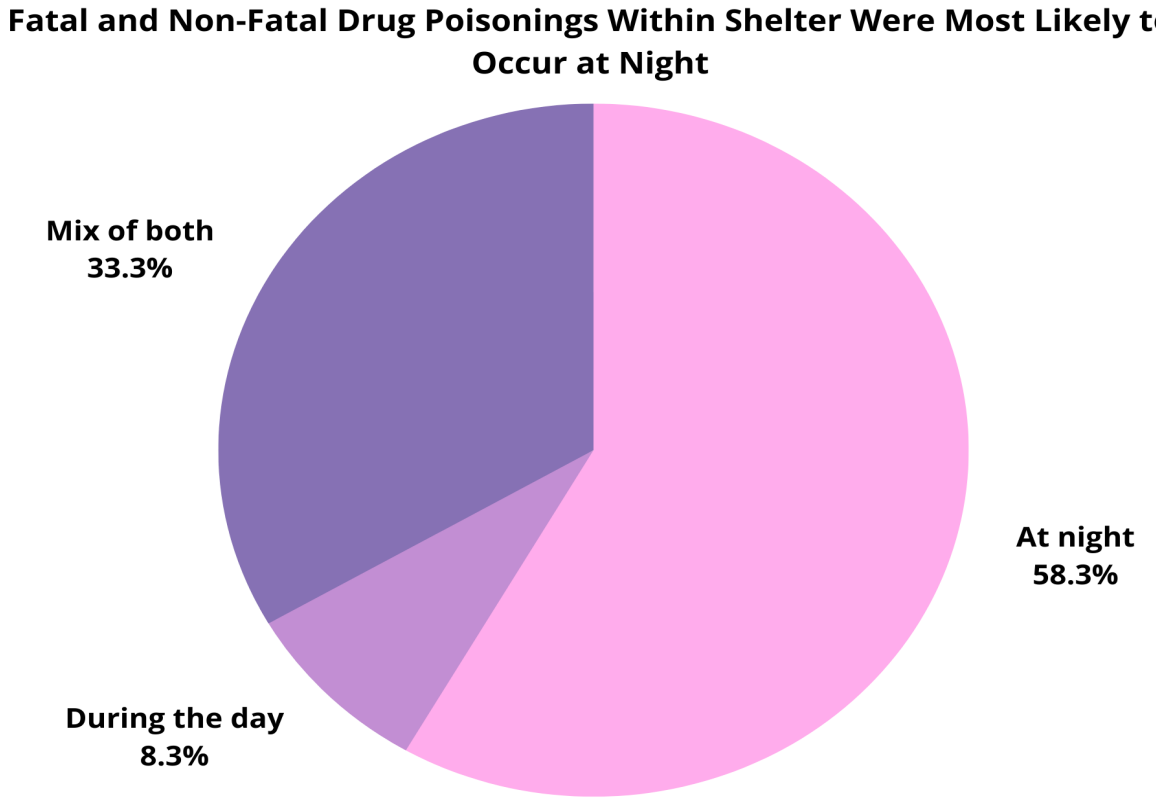
Responses from the survey have been collected from 35 different shelters that are operating within varying communities, with varying resources and who are serving a wide range of survivors with differing needs. While there are many unique differences among the shelters included in this needs assessment, the overall findings will be able to demonstrate general, preliminary findings about the current implementation of harm reduction practices among VAW shelters in Ontario.

Drug Poisonings Among Shelter Residents and Non-Residential Clients





When asked how many fatal drug poisonings have occurred within shelter since March 31, 2020, the majority of survey respondents (85.7%) reported that there have been zero fatal drug poisonings within their shelter during this time period. While the majority of p i ip in VAW Shelters have not experienced fatal drug poisonings on site, 8.6% of respondents indicated that there had been one on-site fatal drug poisoning within this timeframe and 5.7% of survey respondents reported two on-site fatal drug poisonings within this period. In total, 14.3% (or five respondents) of survey respondents indicated that there had been at least one on-site fatal drug poisoning in the previous two years. Of those five shelters who reported at least one on-site fatal drug poisoning in the past two years, 80% indicated that these drugs poisonings were caused by opioids, with 40% indicating one on-site drug poisoning was caused by opioids and 40% indicating that there had been two opioid related drug poisonings on-site in this time period.

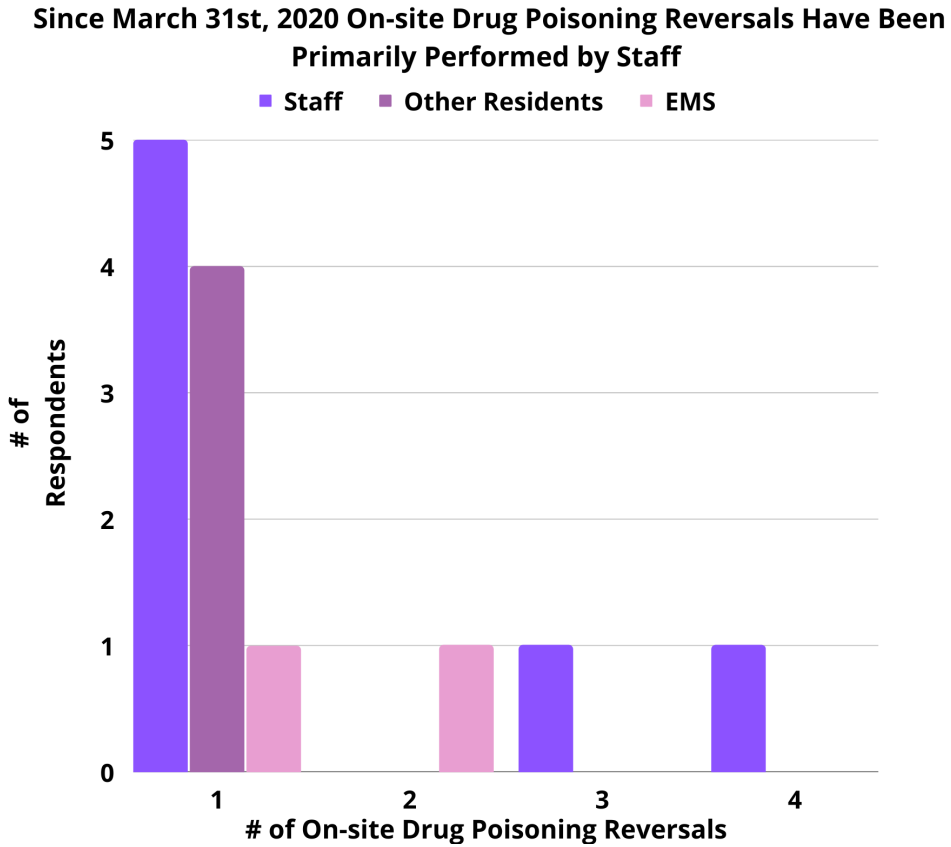


When asked what time of day drug poisonings were most likely to occur within shelter, 58.3% of respondents reported at night and 33.3% of respondents reported that drug poisonings occurred both during the day and at night. Only 8.3% of respondents indicated that drug poisonings had occurred during the day. One of the respondents that indicated their shelter was not double-staffed 24 hours a day, also identified that they were a large shelter (more than 25 beds) and was located in a suburban area. This respondent also identified that on-site drug poisonings were occurring at night. As the majority of survey respondents also indicated that they are experiencing drug poisonings at night, a time in which many VAW shelters are single-staffed, it would be beneficial to increase staffing levels during the night to ensure staff are able to respond to an emergency within shelter, such as a drug poisoning.

When asked if there had been any drug poisoning reversals on-site since March 31st, 2020, 34.3% of respondents indicated that there had been at least one drug poisoning reversal on-site within this time frame, while 65.7% of respondents indicated there had not been any drug poisoning reversals on-site. Previous research has highlighted a number of factors that contribute to high rates of substance use among survivors of gender-based violence. Survivors may have been coerced into using substances by an abusive partner, they may have used prior and they may use substances to cope with the psychological and emotional impacts of gender-based violence (Hovey & Scott, 2019; Ogden et.al., 2022). While we do not have the actual rates of survivors in shelters who do use substances, the link between substance use and experiences of gender-based violence would suggest that shelters are likely supporting a number of women that use substances at any given time.

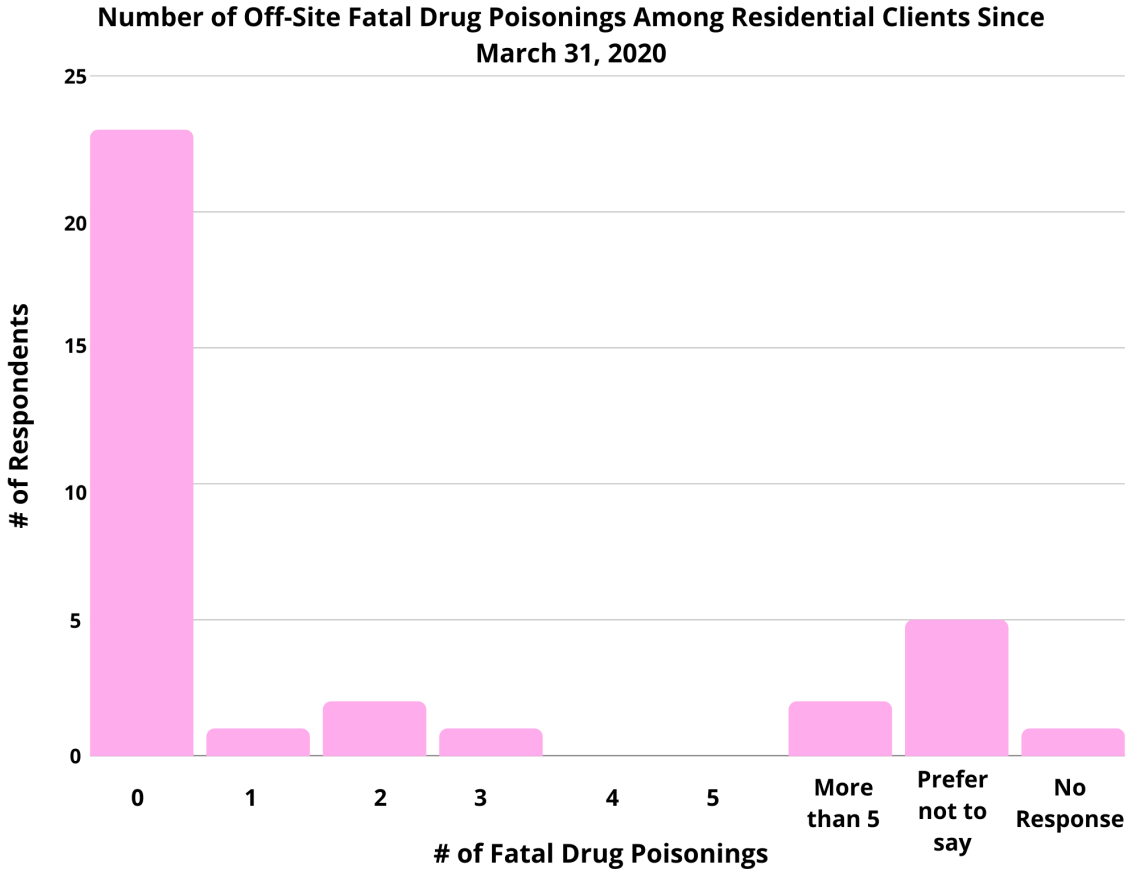
The majority of those reversals were performed by staff, however several respondents also reported drug poisonings on-site had been reversed by emergency medical services (EMS) and also by other residents. Most respondents indicated that one drug poisoning reversal had occurred in shelter since March 31st, 2020 which were primarily reversed by staff and other residents. However a couple of respondents also reported that as many as four drug poisonings have been reversed on-site during this time period, highlighting both the importance of accessible naloxone and naloxone training for staff and the traumatic impact on staff who may be required to perform multiple drug poisoning reversals while working in shelter. Due to the associated trauma that can occur for staff, it is also important that staff can access supports following a traumatic incident such as a drug poisoning reversal or death, which may include debriefing and access to clinical supports as well as ongoing monitorin and/or leaves of absence (Trudell et al., 2021). This data also suggests that it will be imperative to ensure that naloxone kits are easily accessible within shelter and/or provided to residents to ensure it is readily available in the event of a drug poisoning. It may be beneficial for shelters to also consider what supports will be

available for residents, including any residents who may have actively participated in the drug poisoning reversal, to address the emotional impact resulting from witnessing and/or reversing a drug poisoning.



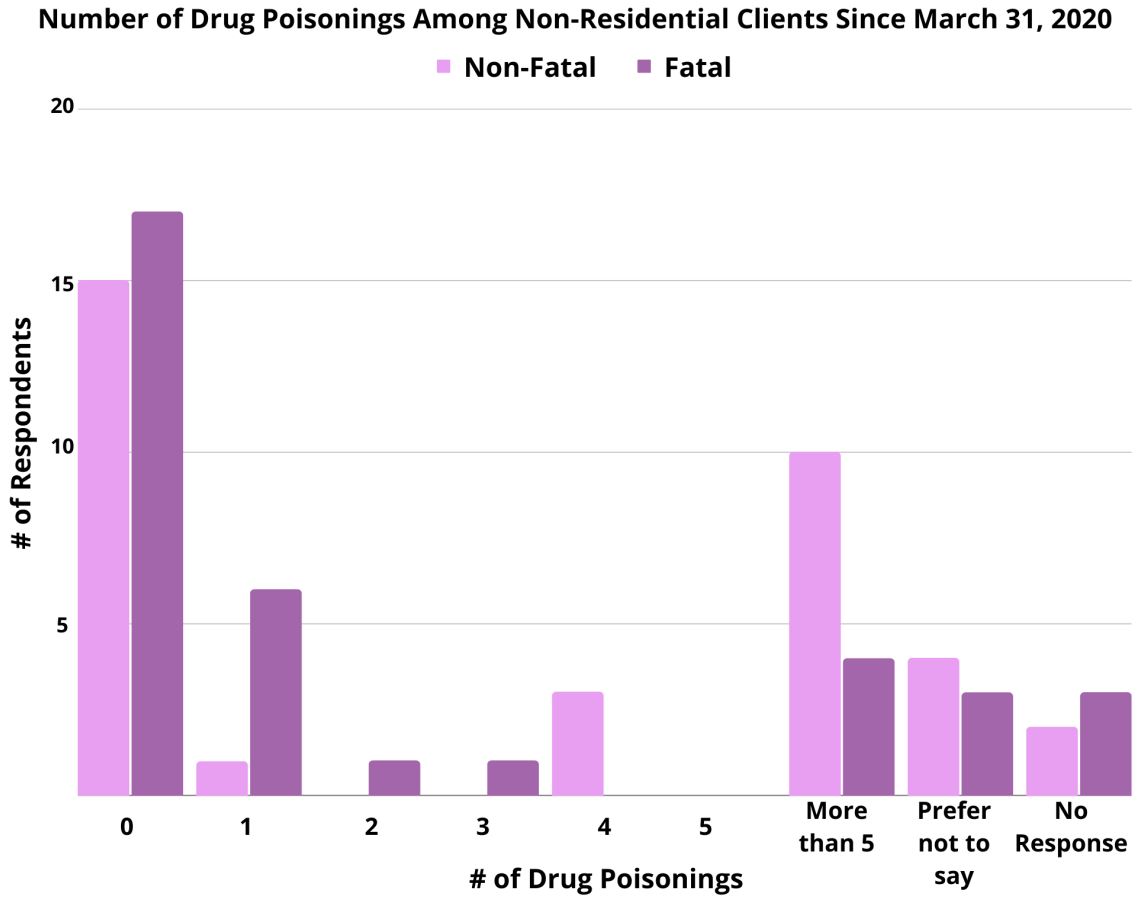
In addition to on-site fatal drug poisonings, respondents were also asked to report on the number of off-site fatal drug poisonings among residential clients. The majority of respondents (23/35) indicated that they were not aware of any fatal drug poisonings among residential clients that had occurred offsite. However, there were four respondents that reported that there had been between one to three fatal drug poisonings among residential clients that had occurred off-site. Additionally, two respondents reported that there were more than five fatal drug poisonings that had occurred off-site. A total of six respondents selected prefer not to say, or skipped this question. The number of fatal drug poisonings that are occurring offsite highlights a need for greater access for residents to harm reduction supplies such as naloxone and safe-use kits to improve safety outcomes for residents who are using off-site. It would also be beneficial to provide ongoing

safety planning for residents that considers risk reduction strategies associated with using and education on how residents can mitigate those risks when using off-site. While the majority of respondents indicated there were zero off-site fatal drug poisonings among residential clients, 17.1% of all survey respondents indicated there had been at least one off-site fatal drug poisoning among residential clients. Access to greater resources and education and programming related to harm reduction for residents may help to reduce the number of preventable deaths occurring among shelter residents.



Responding shelters were also asked to report on the number of drug poisonings among non-residential clients (those who access outreach programs but don't reside in the shelter) since March 31st, 2020, if this information was available. The majority of respondents indicated there were zero fatal and non-fatal drug poisonings that they were aware of among non-residential clients. Several respondents did not provide an answer to this question or selected "prefer not to say". There were several respondents, however, that indicated they were aware of both fatal and non-fatal drug poisonings

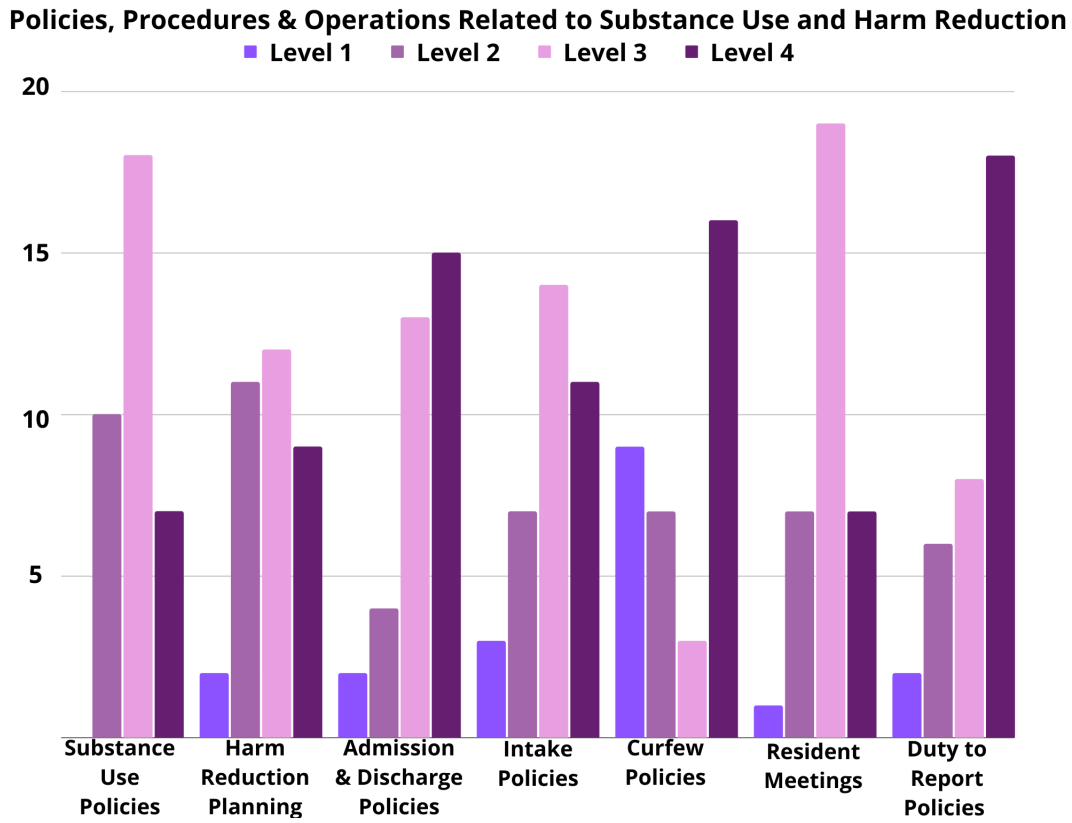
among non-residential clients. Notably, six respondents indicated that they were aware of one fatal drug poisoning among their non-residential clients. In addition, ten respondents reported that they were aware of more than five non-fatal drug poisonings, while four respondents stated they were aware of more than five fatal drug poisonings among outreach clients. It is important to note that this category may include a wide range of responses, and it will be beneficial for further research to collect further data and examine the possibility of supporting non-residential clients who use substances with harm reduction practices and support on an outreach basis.



Policies, Procedures and Operations

Within the needs assessment there were seven questions included that examined shelters' policies, procedures and operations related to substance use and harm reduction. These questions examined policies on substance use, admission and discharge, intake, curfews and as well as their duty to report policies. Respondents were also asked to describe practices related to harm reduction planning within their organization and the incorporation of harm reduction discussion at resident meetings.

Responding shelters were most likely to report practices that aligned with Level 3 and Level 4 of the harm reduction continuum suggesting that policies have been developed among VAW shelters in Ontario to ensure residents who use substances can safely access shelter services.



In particular, when asked to describe their policies regarding substance use, no responding shelter indicated that their shelter had a written policy that required non-use among shelter residents. This aligns with updated MCSS VAW Emergency Shelter Standards, which state that “the shelter will have a policy and procedure that outlines how they will provide support to women who use substances” and that “the written policy and procedure will outline how the shelter will respond to women who are in possession of substances and or use substances on shelter premises" (MCSS, 2015 p.14). Ten respondents indicated that their policies ensure that survivors who use substances are not excluded from services, which corresponds to Level 2 practices outlined in the continuum. Respondents most commonly indicated that their policies went beyond ensuring services were accessible and actually defined harm reduction and mandated the use of harm reduction practices within shelter (Level 3) as a part of their policy on substance use. Additionally, more than five respondents noted that their policies on substance use aligned with Level 4 of the continuum and outlined harm reduction programming, access to safe supplies and external partnerships related to harm reduction.

Shelters were also asked to describe their policies and practices for resident intake. Respondents most commonly identified practices that aligned with Level 3 and Level 4 of the continuum. Level 3 practices were the most common responses and included clearly identifying type and level of substance use among residents, outlining the harm reduction practices and providing safety planning related to substance use. Eleven respondents highlighted practices that aligned with Level 4 practices on the continuum, including regular meetings and check-ins with residents regarding any substance use related needs they may have. These practices are important in mitigating the risk of harm for residents who use but also in reducing stigma surrounding substance use as this can be a barrier to accessing support and services related to substance use (National Harm Reduction Coalition, 2021).

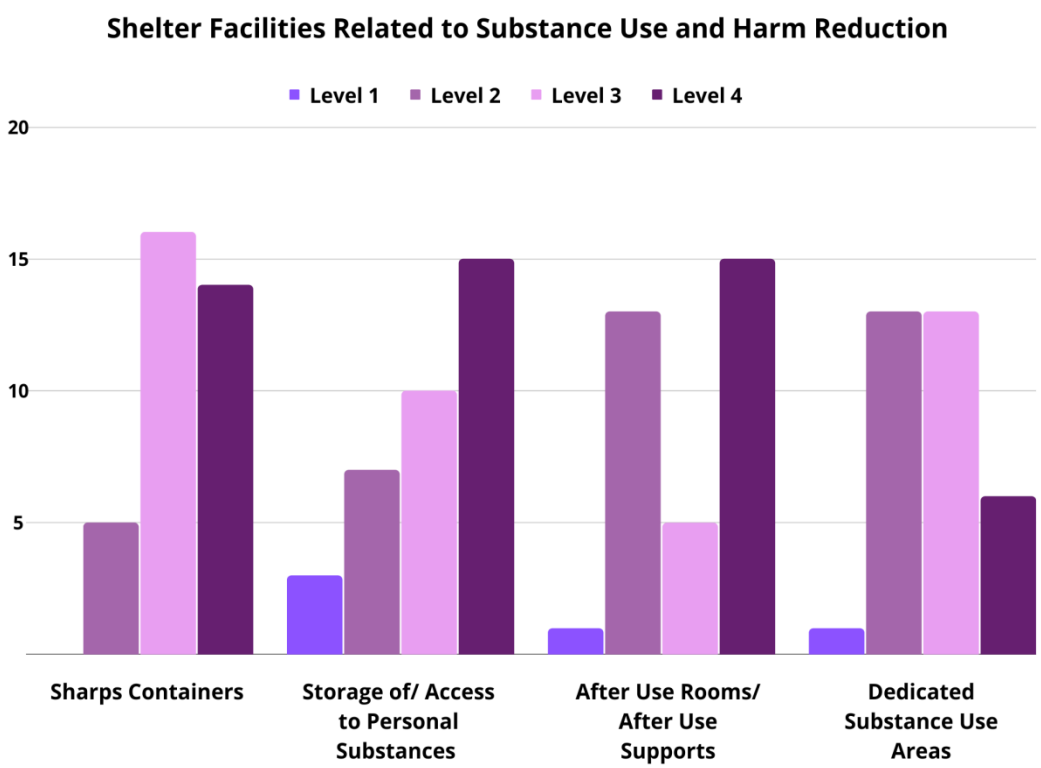
When describing their policies related to staff’s duty to report, the majority of responses aligned with Level 4 on the harm reduction continuum. Most respondents indicated that residents are clear regarding staff’s duty to report as it relates to parental substance use and that staff may assist with safe use to mitigate the need to report. Respondents less commonly identified Level 3 practices and Level 2 practices, which included informing residents regarding the duty to report and the circumstances surrounding this duty (Level 3) and that staff and residents may not be clear on the duty to report as it relates to parental use (Level 2). Additionally, a couple of respondents identified Level 1 practices and reported that the duty to report may be understood as children of those who use substances are automatically at risk and circumstances to report are unclear. Although the majority of respondents have reported that staff are clear on the duty to report as it

relates to parental substance use, eight respondents indicated that this duty may or may not be clear or may be conflated to automatically assume risk. This highlights the need for increased partnerships with Children's Aid Societies (CAS) and additional training regarding this duty and risk mitigation strategies to increase safety for survivors who use substances and their children. In the community connections section of the needs assessment few survey respondents indicated that they have partnerships with CAS that actively discuss harm reduction practices or risk mitigation. This reinforces the need to expand these partnerships to ensure that shelters can work collaboratively with their local CAS to increase safety for survivors and their children.

Facilities

The needs assessment examined VAW shelters facilities as it relates to harm reduction practices and procedures. Respondents were asked four questions regarding the provision of sharps containers, storage of substances on-site, after-use supports and the availability of designated substance use areas within shelter. Based on the results, very few shelters reported practices and/or procedures that aligned with Level 1 of the harm reduction continuum. The majority of respondents however reported Level 3 and Level 4 practices related to their shelters facilities.

When asked to describe access to sharp facilities within shelters, all respondents identified practices aligning with levels two, three and four. No respondents indicated Level 1 practices, which provided sharps containers for medical use only. A few respondents indicated that sharps containers are only accessible in or near staff areas. The majority of respondents however indicated that accessible sharps containers were either provided on-site (Level 3) or within resident rooms and accompanied by clear rules regarding the safe disposal of paraphernalia (Level 4). It will be important that shelters continue to provide accessible sharps containers for residents to ensure the safe disposal of substance use supplies for other residents within shelters.



When asked to describe how residents can store and access personal substances on-site the majority of respondents reported that there was private, unsearched space provided for the secure storage of personal items on-site, which could include personal substances (Level 4). Ten respondents identified practices that aligned with Level 3 of the harm reduction continuum, which included the provision of storage, on-site or in private rooms, for legal substances. Respondents less commonly reported that they provided a space for storage of legal substances accessible by residents or via staff, e.g. provision of fridge space for methadone (Level 2) or that there was only a storage of prescribed medications allowed on-site (Level 1). It may be helpful for shelters who are currently operating at Level 1 or Level 2 to learn from other shelters who are currently allowing storage of personal items and substances on-site and to learn how they have mitigated risks with these practices.

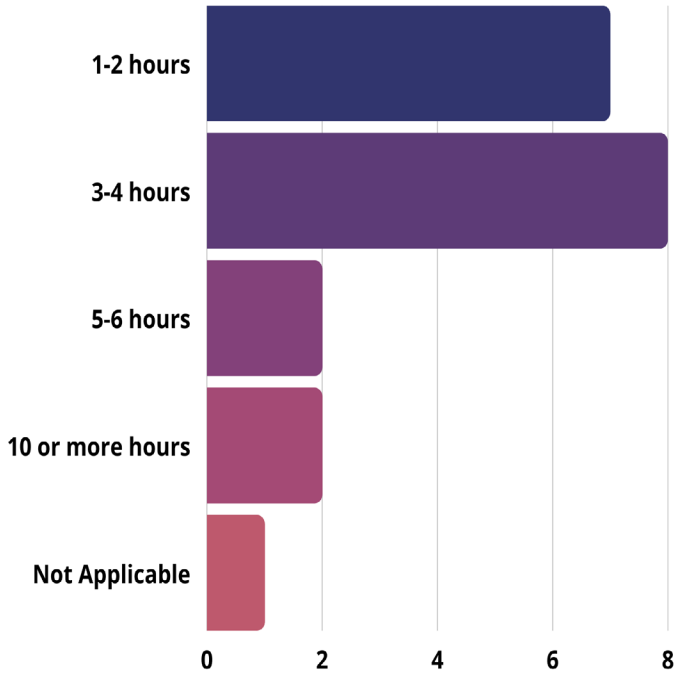
Respondents were also asked to describe the types of after-use supports and/or facilities that were provided to residents. Respondents most commonly reported that there is supervision provided to monitor residents who return to shelter intoxicated available in an after-use room or in the residents private room (Level 4) or that residents are not discharged but may or may not receive staff support or be referred to withdrawal management services (Level 2). As recommended in this report, the creation of private rooms within shelters and increased staffing capacity will be able to assist shelters in providing more in-depth after-use monitoring and support for residents.

The needs assessment also examined the availability of designated substance use areas within shelter facilities. The majority of respondents indicated that there were dedicated areas for smoking/vaping tobacco and medicinal marijuana (Level 2) or that there were designated areas for smoking, including recreational marijuana use (Level 3). The next most common response was categorized as a Level 4 practice and indicated that there was a designated area for use of any legal substances, for example residents can consume alcohol on-site. One respondent indicated that smoking areas were provided for tobacco use only (Level 1). These practices may provide safe areas for residents to use on-site and it also reduces the level of control and restriction against legal substances that residents must face. In doing so, it provides residents with increase autonomy and choice over their decisions, aligning with a feminist and trauma-informed framework and ensures that shelter policies do not replicate controlling and/or oppressive practices with their organizations (Alexander, 2013).

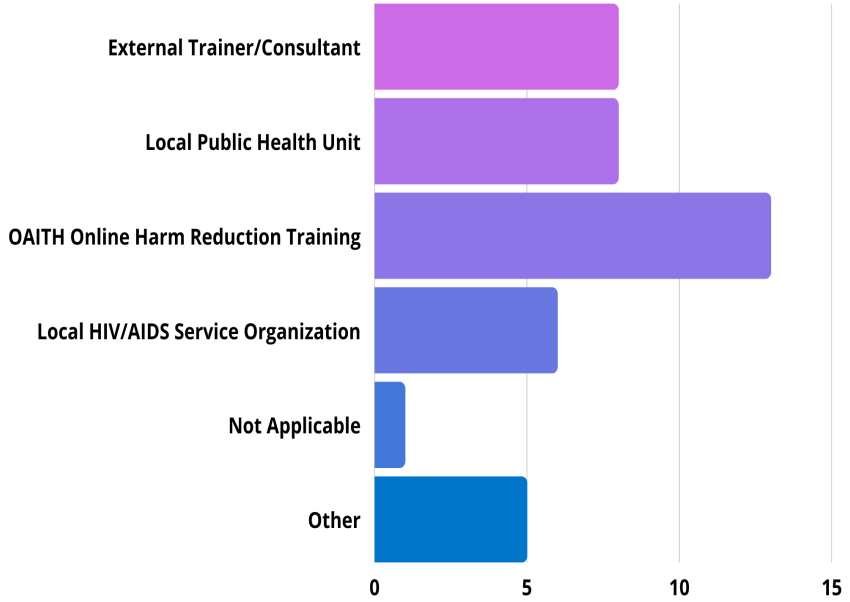
Staffing and Training

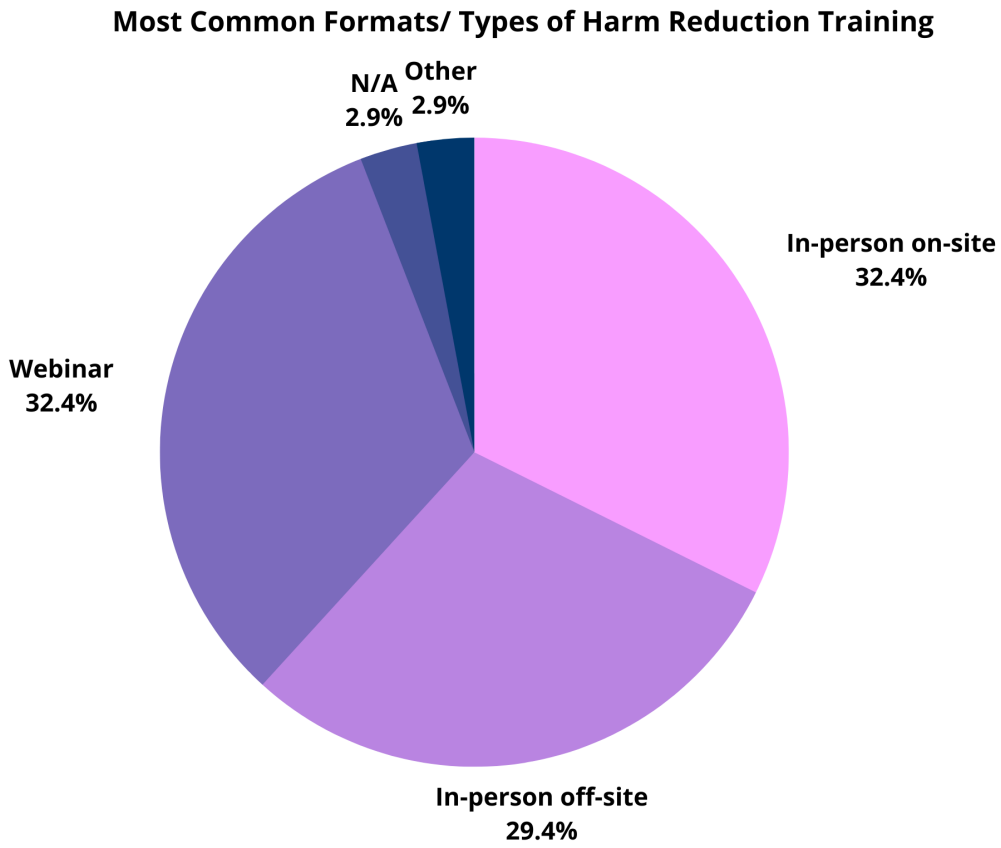
When asked about the length of harm reduction training offered to staff, the majority of respondents indicated that staff received between 1-4 hours of training through their organization. Only a few respondents indicated that their staff receives more than 5 hours of harm reduction training. The most common source of training that was accessed was the OAITH online harm reduction training but several respondents also indicated their organization received training from their local public health, from external consultants and through a local HIV/AIDS service organization. Respondents also reported that they are accessing this training in a variety of formats, including webinar and in person training occurring both on-site and off-site. Other external training was provided by local pharmacies as well as through partnership with St. John's Ambulance. As the majority of respondents are providing their staff with access to OAITH's online harm reduction training, it would be beneficial to update and expand the existing training to provide more in-depth and practical training for VAW front-line staff but also for shelter management and leadership.

Number of Hours of Harm Reduction Training Provided to Staff

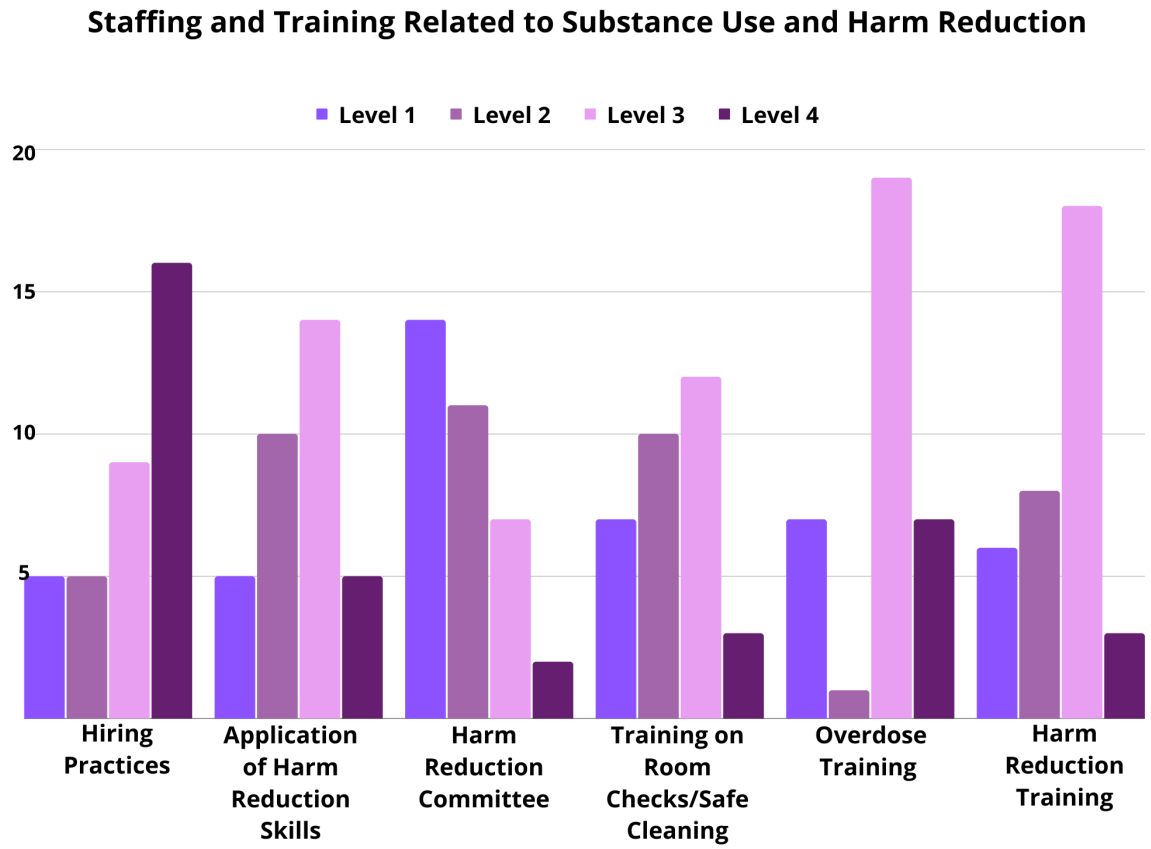


Most Common Sources of Harm Reduction Training





Within the needs assessment, respondents were asked a total of six questions regarding staffing and training practices within their organization. Among four of those indicators related to harm reduction training and the application of these skills, the most common responses corresponded with a Level 3 on the harm reduction continuum. In addition, hiring practices within shelter was most commonly ranked as a Level 4 while access to an internal harm reduction committee was ranked lower, with the most common responses corresponding with a Level 1.



When asked about shelter hiring practices, most respondents reported that they included questions about safer substance use practices and harm reduction when interviewing new staff. These skills are beneficial for staff working in shelter and therefore an asset for new staff to have before they begin working in shelter. It is important to note, however, that shelters operate within a unique congregate setting and it would be beneficial to ensure that all VAW shelter staff can access practical training related to the implementation of harm reduction practices within shelter that has a gendered-trauma informed lens and understands the unique settings in which shelters operate.

When asked about how harm reduction skills are applied by staff within the shelter, respondents most commonly indicated that core competencies related to harm reduction are incorporated with on-going staff supervision meetings. Research on the VAW sector has noted that knowledge and skills related to working with individuals who use substances and implementing harm reduction practice are critical for VAW shelter staff to have (Scott et. al., 2022). Respondents also

often reported that core knowledge and skills related to harm reduction are required in job postings. Only a few respondents indicated that staff are supported in making referrals to other shelters/ services for survivors who use substances (Level 1) or that staff are encouraged to participate in on-going collaborative research or further training related to harm reduction practices (Level 4). It may be beneficial to provide access to more collaborative, community-based harm reduction research projects for shelter staff to collaborate with other shelters and services providers to better understand the unique needs of the populations they are serving.

When asked about their organization's harm reduction committee, the majority of respondents indicated that they do not currently have a harm reduction committee or plans to develop this type of committee within their organization. This may in part be due to the lack of allocated resources that have been provided to shelters related to harm reduction. Dedicated staffing positions and funds to support this type of development may help shelter organizations better facilitate this type of committee within their organization. The creation of these types of committees may also provide staff with more opportunities to collaborate with other staff and local organizations who support individuals that use substances. It may also be beneficial to examine the benefits of supporting the sector with a reinstated provincial harm-reduction committee to drive future research and resource development for the sector.

The creation of harm reduction committees are not only important for increasing staffing capacity but can also provide guidance on future programming and policy development within shelters. It is important to include the voices and experiences of those with lived experience in discussions about harm reduction practices to ensure that programming and policies can effectively meet the needs of those accessing services and do not unintentionally exclude or harm certain vulnerable populations. Previous research has supported this need and has found that the inclusion of people with lived-experience in the decision making processes can improve services, reduce risk associated with substance use and can improve health outcomes (Belle-Isle, 2014).

When asked to describe the type of overdose training that is provided to shelter staff, respondents most commonly indicated that staff are trained to administer naloxone if they find a resident experiencing a drug poisoning. While it is incredibly important for staff to be trained on the administration of naloxone to be able to reverse a drug poisoning on-site if needed, this current level of training is more responsive to drug poisonings than it is proactively working to prevent drug poisonings. More support within shelters such as increased staffing and/or designated harm reduction staff may be beneficial in increasing staff's capacity to assess, monitor and respond to residents who are presently affected by their use. Previous research among VAW shelter residents highlighted the need for more monitoring by staffing to not only

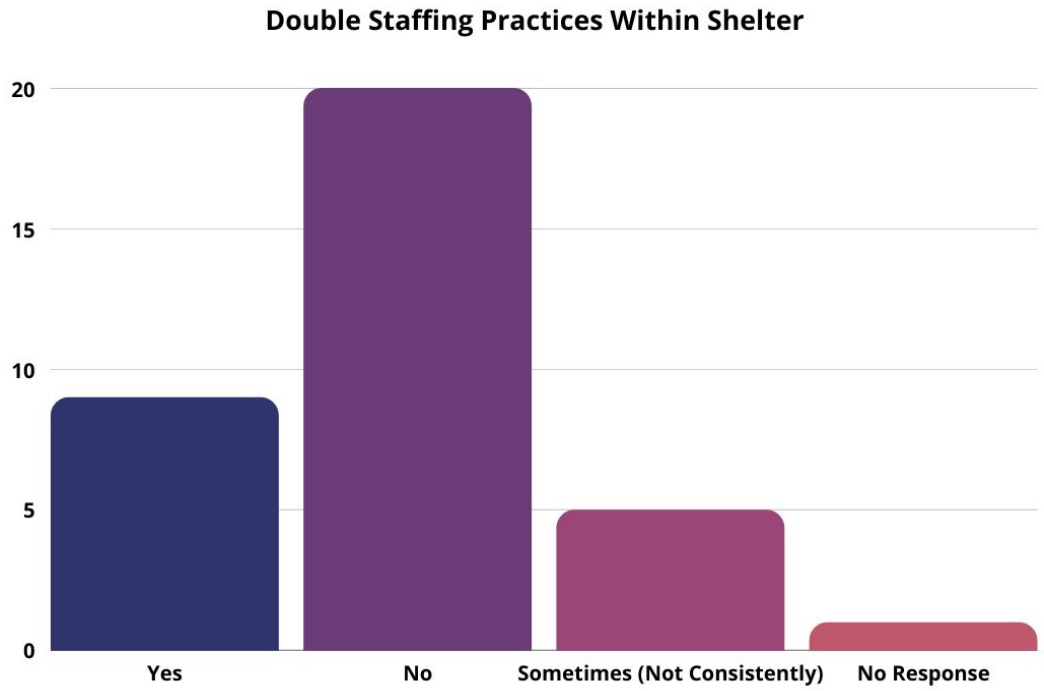
prevent or respond to drug poisonings but also to respond to any behavioural issues, or other emergencies occurring in shelter, as this would increase safety for all residents within shelter (Hovey & Scott, 2019). This will be important in responding to drug-poisonings and reducing the chance of a fatal drug poisoning within the shelter and it will also support the overall feelings and/or perceptions of safety in the shelter among all residents, regardless of substance use.

On-Site Supportive Services

Double Staffing Practices Within Shelter

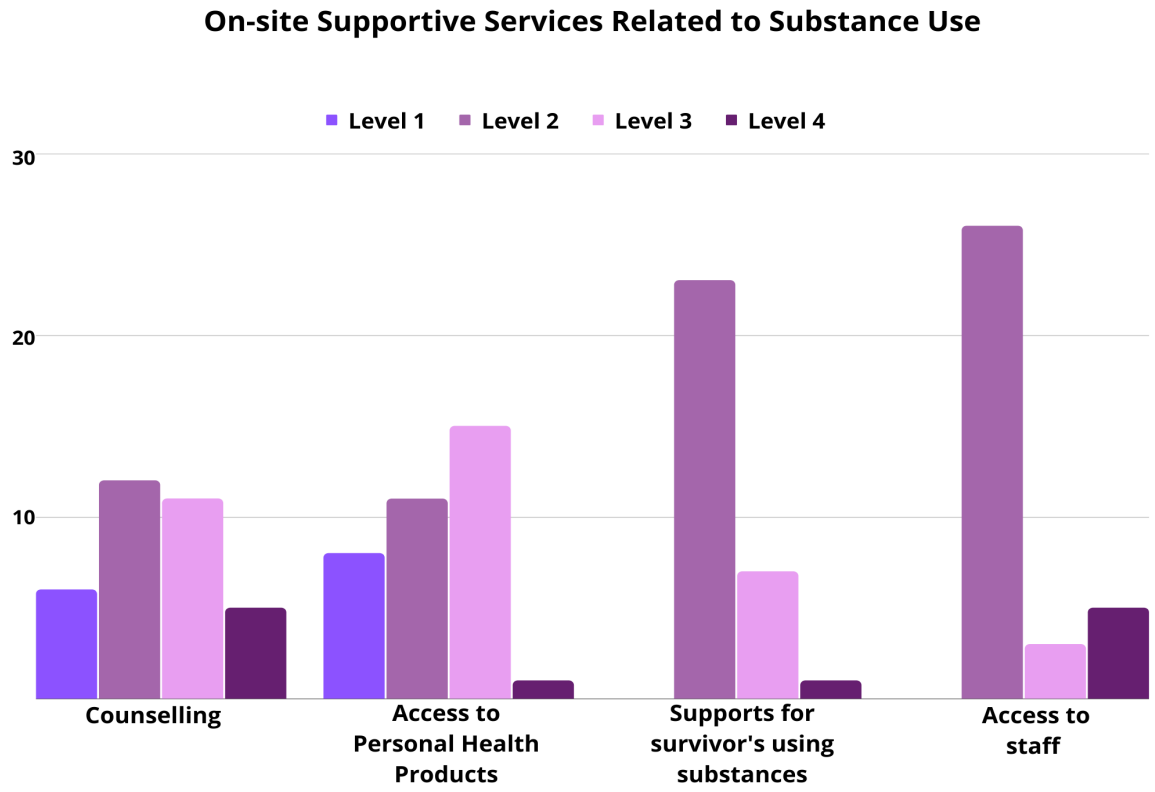
Within the needs assessment, shelters were asked to indicate if their shelter is double-staffed. Shelters were able to select one of the following options: yes, no or sometimes (not consistently). The majority of respondents (57.1% or 20/35) indicated that their shelter is not double staffed. Only 25.7% (9/35) of responding shelters reported that their shelter was double staffed and 14.3% of respondents indicated that their shelter was double staffed sometimes, but not consistently. One respondent (2.8%) skipped this question and provided no response. Previous research has noted that increased staffing will allow for better monitoring and will improve safety outcomes for all residents within shelters (Hovey & Scott, 2019), which would be especially true for the night time, as many Ontario VAW shelters are single-staffed at this time.

Of the responding shelters that indicated they have implemented double staffing, the majority were from suburban areas (66.7% or 6/9). Two shelters that indicated they were double staffed (22.2%) were from a rural area and only one shelter (11.1%) indicated they were in an urban area. None of the responding shelters that identified having double staffing practices were located in the Toronto region. Respondents were most commonly from the Central and West regions, each accounting for 33.3% of shelters with double staffing practices. One of the responding shelters (11.1%) was from the North region and two responding shelters (22.2%) were from the East region. The majority of responding shelters that are double staffed were large shelters (55.6% or 5/9) and have more than 25 beds within their shelter. Small shelters with 15 beds or less and medium sized shelters with between 16 and 25 beds each accounted for 22.2% of respondents that operate with double staffing.



A lack of staff resources may create challenges for staff responding to emergencies within the shelter. On-site crises, such as an onsite drug poisoning reversals or deaths, require immediate response and attention from staff. Inadequate staffing levels may result in delayed response times to on-site emergencies and it may also hinders staff's ability to support the other residents in the shelter during these emergency situations. Previous research among shelter staff reported single-staffing as a perceived challenge or barrier to implementing harm reduction practices within shelter and shelter staff noted that this hindered their ability to fully support survivors with harm reduction practices (Hovey et al, 2019).

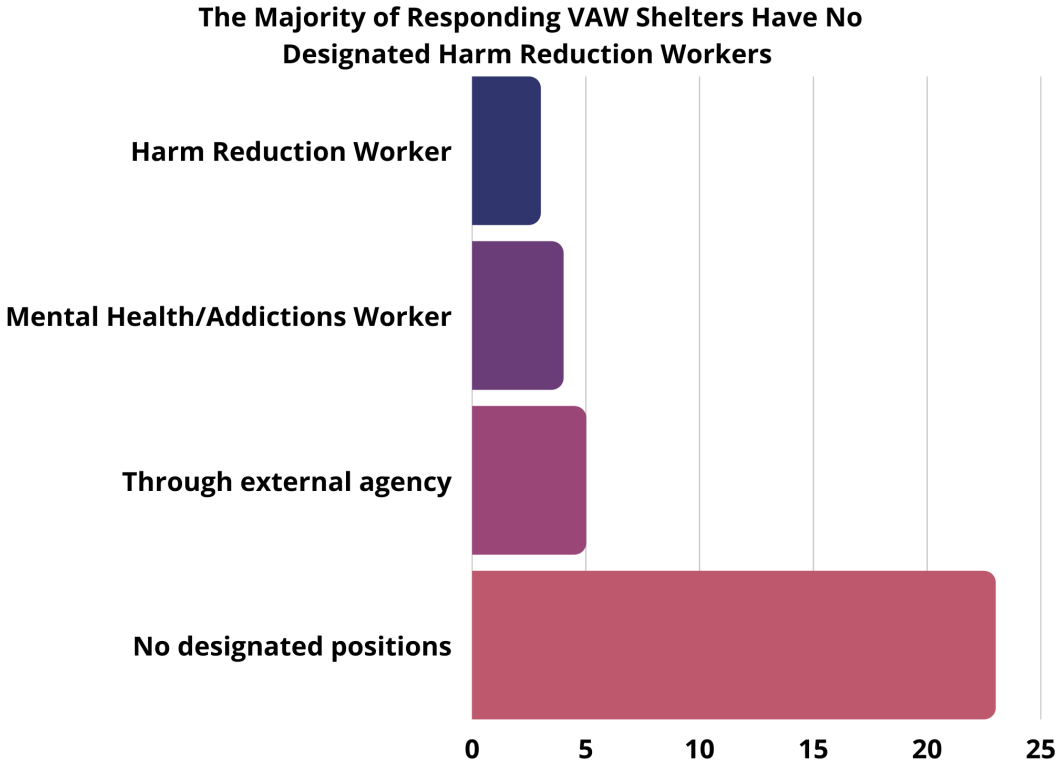
In addition, without adequate staffing organizations may be limited in the types of support that can be provided to residents within the shelter. This is clearly illustrated through the analysis of on-site supportive services within the shelters included below. A total of four questions were included within this section of the needs assessment, examining practices related to substance use counselling, access to personal health products, supports for survivor's use (e.g. transportation, childcare) and access to staff within the shelter. In all indicators, with the exception of access to health products, the most common responses corresponded with Level 2 harm reduction practices on the harm reduction continuum.



When asked what counselling services related to substance use were provided, respondents most commonly indicated that they facilitate temporary transfers to off-site settings for withdrawal management and/or arranged off-site substance use counselling for residents. Similarly, when asked what services are provided to support survivors' substance use, respondents most commonly indicated that they provided transportation to other services providing supports regarding substance use. This highlights the lack of on-site support within shelters that is provided to survivors that use substances. Additionally, when asked to describe residents' access to staff related to substance use, the majority of respondents indicated that the residents have an "open door" to access workers to discuss substance use. The lack of staff outreach or planning related to substance use may also be related to low staffing capacity within shelters.

Survey respondents were also asked if they have designated harm reduction workers on site. As can be seen in the graph below, the majority of respondents (65.7% or 23/35) indicated that they do not have a designated harm reduction worker

within their organization. Without a designated harm reduction worker on-site, the added responsibilities related to the implementation of harm reduction must be delegated to shelter staff who are already tasked with supporting survivors through trauma, ensuring resident safety and assisting survivors with system advocacy and navigation. The lack of staffing capacity and lack of designated staffing positions within shelters, as noted above, may impact a shelters capacity and ability to be able to offer on-site substance related services within shelters. OAITH has made requests and recommendations to MCCSS and to the Associate Ministry of Mental Health & Addictions in the past for additional staffing and specifically designated programming within VAW Shelters. Notably this was brought forth in the Shelter Realities Report (2016).

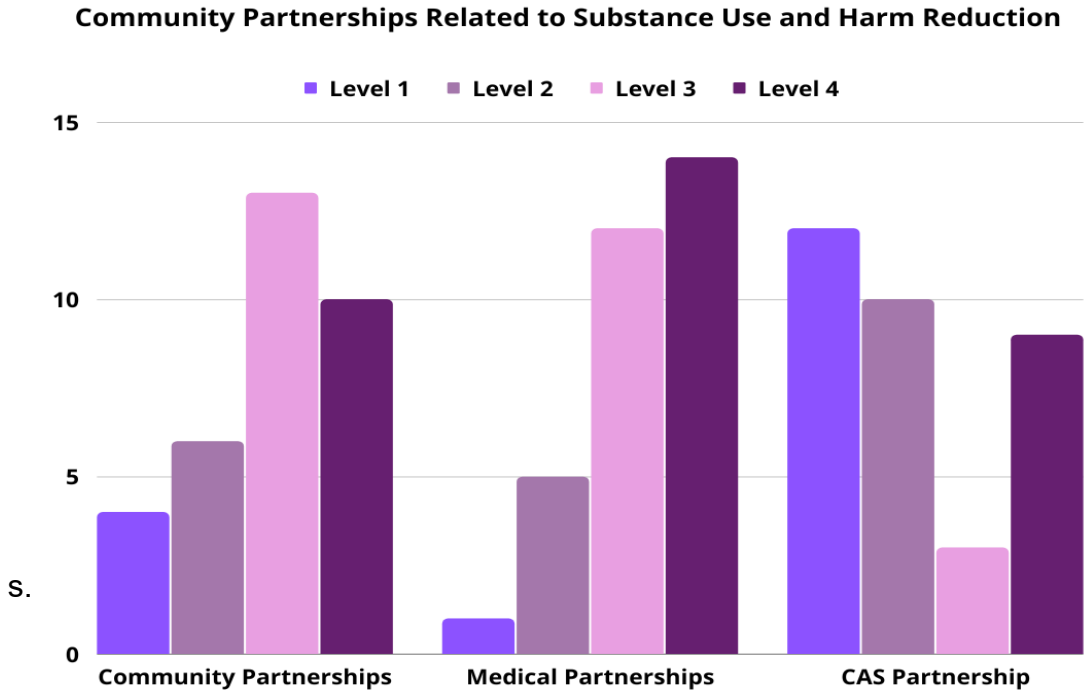


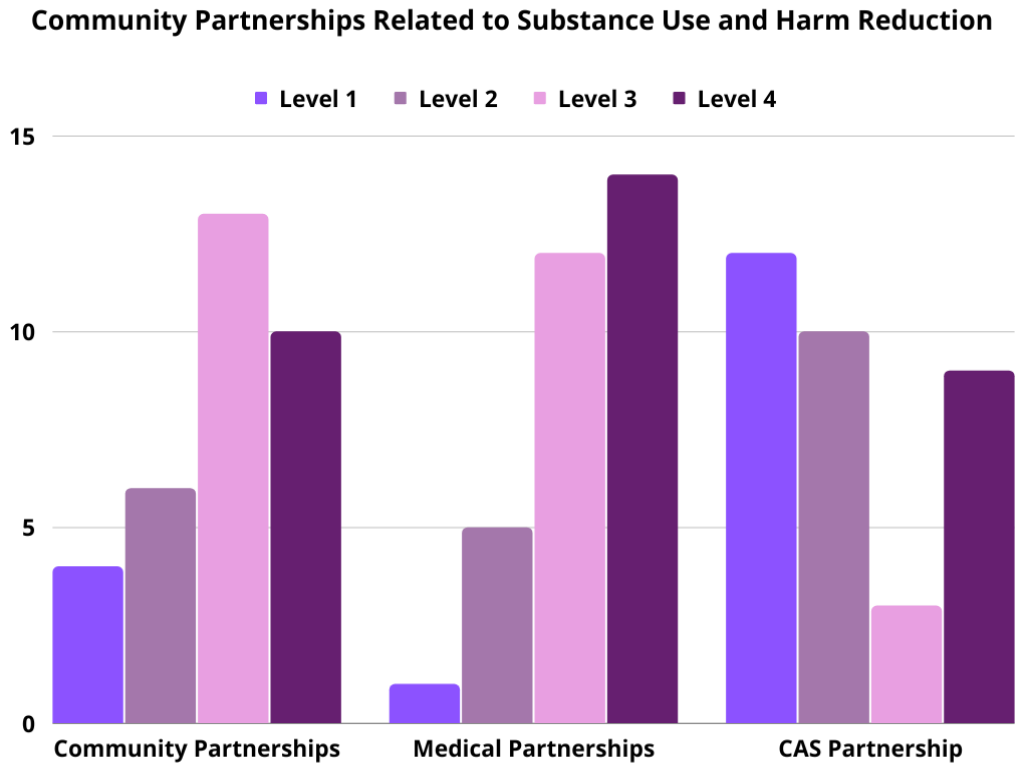
Community Connections

Respondents were all asked to describe their community connections related to harm reduction, including community partnerships, medical partnerships and their partnership with Children's Aid Societies (CAS). When asked to describe the shelter's medical partnerships the majority of responses corresponded with Level 4 and Level 3 practices included in the

continuum. Respondents were most likely to indicate that staff engaged in active discussion regarding safe use and support residents with appointments and access to supplies and testing. Many respondents also identified that their shelter works collaboratively with their local pharmacy and/or public health to facilitate needle exchange, access to HIV, STI/STD testing and access to naloxone. Shelter respondents were least likely to identify practices that corresponded with Level 1 of the continuum, such as referrals to medically-based abstinence services.

When describing the shelter's community partnerships, responses most commonly identified Level 3 and Level 4 practices. This includes community-based partnerships to offer on-site counselling and harm reduction training (Level 3) and active participation in community-based harm reduction committees and strategic discussion regarding substance use in the community (Level 4). Respondents less commonly identified partnerships with community-based abstinence programs (Level 1) and partnerships with community based substance use services (Level 2). This highlights that the majority of responding shelters have been working to increase their internal capacity through community-based partnerships as opposed to connecting with community partners to enhance referrals to other programs. Staffing and resources to be able to maintain these partnerships will ensure that knowledge can continue to be shared through these partnerships and shelters can continue to increase their internal capacity to be able to better support residents that use substance.





When asked to describe the shelter relationship with CAS as it relates to harm reduction practices the majority of respondents identified practices that aligned with Level 1 and Level 2 of the harm reduction continuum. Respondents most commonly reported that their partnership with CAS did not involve any discussion regarding harm reduction (Level 1) or that some staff may engage in harm reduction discussion with some CAS workers on a case-by-case basis (Level 2). Very few respondents indicated that they are beginning to have these discussions with CAS partners (Level 3) but nine shelters did indicate that they have ongoing and productive relationships with CAS as it relates to ensuring the safety of children and harm reduction practices (Level 4). There is quite a variation in the responses that were provided but as the majority of respondents reported practices aligning with Level 1 and Level 2 of the continuum this may be an area of future partnerships and training that could be expanded on. It will be important to ensure that shelters continue to actively work with partners, such as CAS, to reduce the risk of assumptions and misconceptions on the role of parenting as it relates to substance use. Previous recommendations coming from the Report of the Motherisk Commission, identified the need to address harmful misconceptions about parental substance use through ongoing training for CAS staff and increased partnerships (Beaman, 2018). Shelter partnership with CAS can work to address these myths and misconceptions and can work collaboratively to better support survivors and their children.

Challenges Associated With Implementing Harm Reduction Practices Within Shelter

When asked to describe any associated challenges with implementing harm reduction practices within shelter, respondents identified three key themes. The first theme that was identified was staff resistance to the implementation of harm reduction principles and practices within shelter. Ten respondents attributed challenges with implementing harm reduction practices to staff perceptions, hesitation, fear and anxiety. Respondents noted a lack of consensus and direction regarding harm reduction in the sector contributed to some of this hesitation and indicated that fear regarding drug poisonings and associated liability led to increased fear and anxiety regarding this implementation. A few respondents also noted challenges related to the perceived hesitation from other stakeholders, including funders, referral agencies and board members regarding the implementation of harm reduction practices.

Eleven survey respondents also cited impacts on other residents as a challenge to implementing harm reduction practices within shelter. Some respondents highlighted concerns from other residents within shelter who did not use substances and noted that this could be triggering for other residents due to past trauma and/or past substance use. Six respondents also noted that concerns about children's safety within shelter created challenges and barriers to the implementation of harm reduction practices. One respondent described the concerns about the safety of children within shelter when dangerous behaviour is associated with use "the biggest challenge is keeping children residing in shelter safe when folks who use substances exhibit risky behaviors i.e. leaving sharps in public spaces, leaving substances out in spaces where children can access." Previous research examining resident attitudes towards harm reduction implementation has also noted that concerns for the safety and comfort of other residents and children staying in shelter are an important consideration to have in the operational planning related to harm reduction. Participants in that study provided recommendations for the separation of spaces within shelter to increase safety for other residents and their children (Hovey & Scott, 2019). These fears and concerns continue to be present among shelter staff and residents today. The provision of private and secure storage, such as lockers and safes, is a practice that is currently being implemented by at least fifteen VAW shelters in Ontario and may be beneficial in addressing potential risks and preventing accidental consumption or injury related to substances in shelter.

The Covid-19 pandemic was also noted as a barrier to implementing harm reduction practices within shelter over the past 2 years. Throughout the pandemic, VAW shelters in Ontario have faced staffing shortages as a result of several factors including staff burnout, high rates of turnover and low wages within the sector (Maki, 2019). Covid-19 related challenges were identified by 9 respondents within the survey. Respondents indicated the staffing shortage has made it more

challenging to implement harm reduction practices as staff capacity was reduced and staff were tasked with additional pandemic related responsibilities. Additionally, respondents noted due to the high rates of turnover among staff it was increasingly challenging to find staff with experience in harm reduction or to train new staff. Respondents also reported challenges in supporting this model within a single staffed model and with limited resources. One respondent noted the additional challenges that were faced by rural communities throughout the pandemic as it related to accessing resources and substance related services or medical professionals.

Benefits and Successes of Implementing a Harm Reduction Approach Within Shelters

When asked what was the biggest benefit of implementing harm reduction practices within shelter, 10 respondents noted that harm reduction within the shelter led to improved outcomes for both staff and residents. This model allowed shelter staff to build rapport and trust among residents and improved safety for residents in shelter. One respondent described the impacts on resident safety stating that residents “know they can have the conversations and safety plans will be created and they can return to shelter - no matter what - they are then safe.” One respondent also noted that this has created an authentic space within their shelter for people who use substances and has led to a decrease in the number of drug poisonings in shelter. The reduction in drug poisonings was also seen as a benefit for staff as it reduced the feelings of burnout and fear, associated with responding to drug poisonings. Six respondents also noted that utilizing a harm reduction approach allowed staff to better meet the needs of survivors within shelter and has ensured that services remain inclusive and accessible to those experiencing increased vulnerabilities.

In order to successfully implement a harm reduction approach within shelter, survey respondents identified three key themes. At least eight respondents indicated that staffing and training were critical for successfully implementing this approach within shelters. Some respondents also noted that training on naloxone use and crisis intervention improved safety outcomes for residents and decreased the level of fear and burnout among staff. Additionally, access to resources was also identified as a critical component of harm reduction practices by four survey respondents. Respondents noted that access to medical supplies such as naloxone as well as items for personal storage such as fridges, safes and lockers were necessary in order to safely implement a harm reduction approach. Lastly, three respondents reported that partnerships were an important component of harm reduction as it allows for increased sharing of information and assists with service referrals. One respondent reported that their organization was connecting with another shelter’s executive

director which allowed them to gain a sense of direction and greater awareness regarding harm reduction and substance use within shelter.

Statistical Analysis

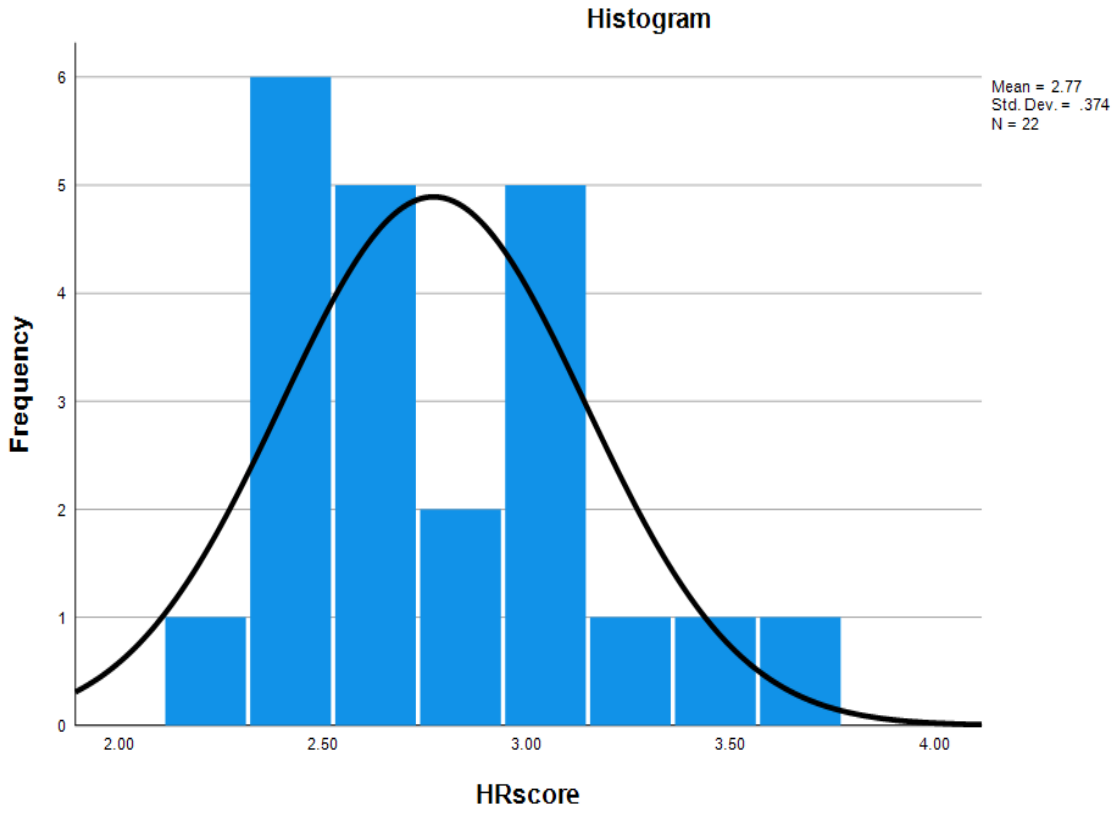
Based on the data from the needs assessment, Dr. Angela Hovey and Dr. Susan Scott performed a statistical analysis to determine if there were any significant differences among the different shelters and their level of implementation of harm reduction practices. The following summary provides an overview of this analysis and their results. It is important to note that the biggest limitation of this analysis is that due to the number of missing or skipped responses, there were only 22 entries that had fully completed all questions in the needs assessment related to the harm reduction continuum that were ultimately included in the statistical analysis performed by Dr. Hovey and Dr. Scott. The 22 survey responses included responses from all MCCSS regions, however, only one survey from Toronto was able to be included in the statistical analysis.

Statistics

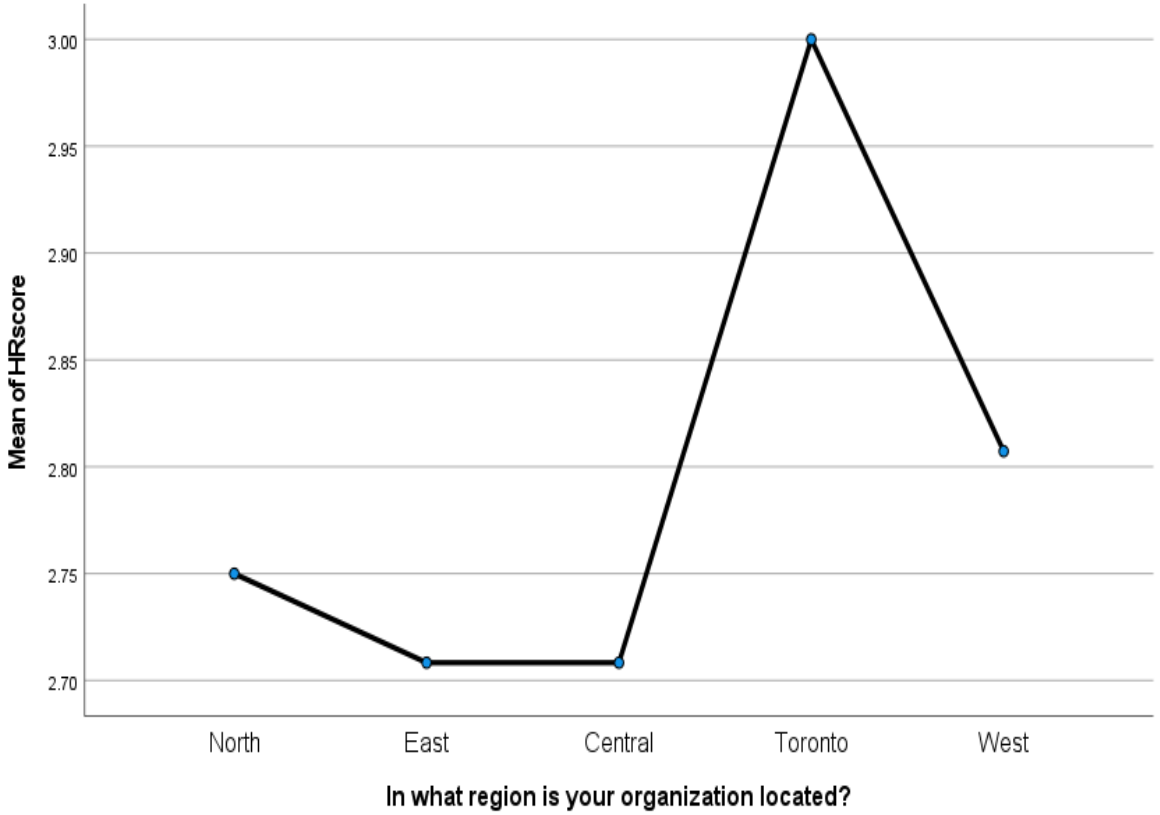
The Harm Reduction score for each respondent was calculated by creating a total mean score from the 24 survey questions based on the Harm Reduction Framework items. The responses were situated on a scale representing Levels 1 to 4 (the level definitions can be found within the report background). These scores were then used for analysis to determine any differences between shelters when compared by geographical region, size of shelter, rural/suburban/urban areas, and whether or not the shelter experienced any drug poisoning reversals.

The mean score, or the average score, among the 22 responding shelters included in the statistical analysis was 2.77 or a Level 2 on the harm reduction continuum. Mean scores ranged from a minimum of 2.21 to a maximum score of 3.71. While there are limitations to this analysis, the mean score provides preliminary information regarding how VAW shelters in Ontario might be currently situated within the harm reduction continuum. Further research would be beneficial to accurately situate all VAW shelters in Ontario on this continuum and to further explore additional factors that may impact a shelter's level of implementation of harm reduction practices. The histogram below illustrates the distribution of the Harm Reduction scores.

Geographical Region

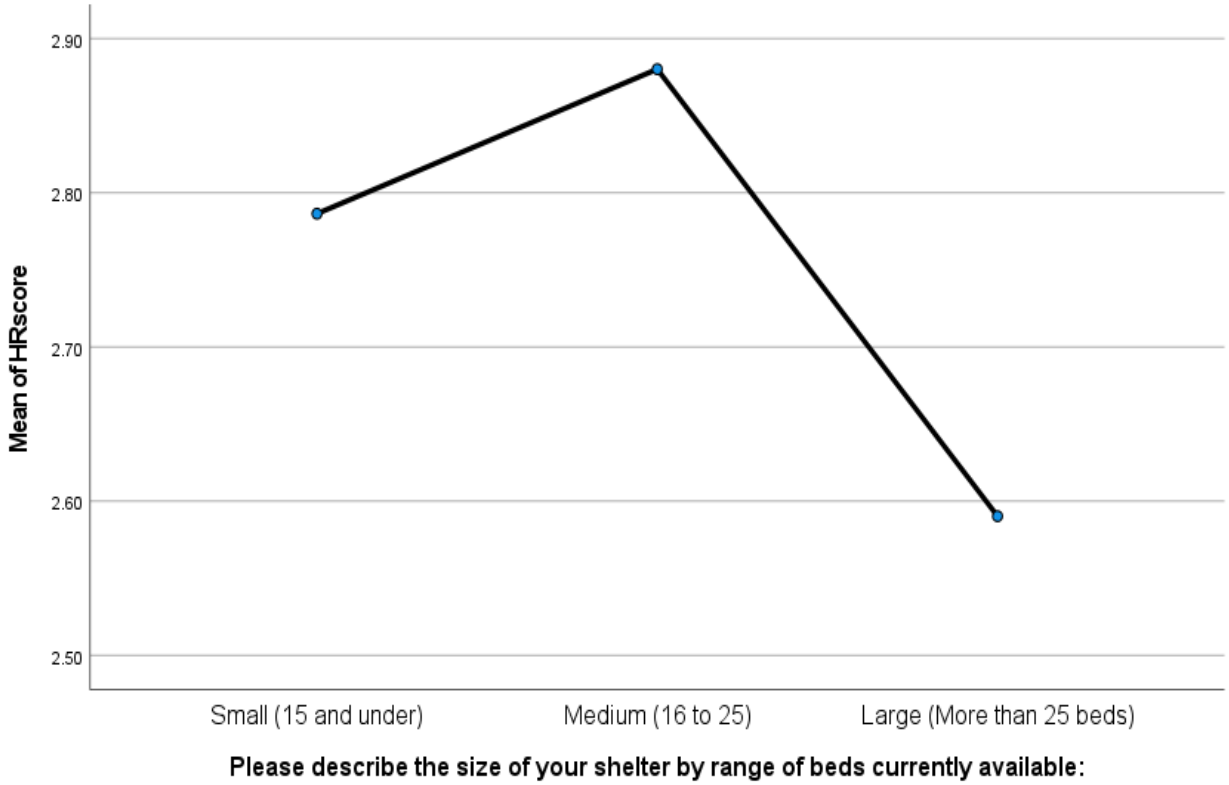


The Harm Reduction scores were then used to test for any regional variation among shelter respondents based on the MCCSS region in which the shelter was located. A one-way ANOVA was conducted to determine any differences in Harm Reduction scores and the five geographic regions (North, East, Central, Toronto, West). No differences were found [$F(4, 17) = 0.14$, *ns*].



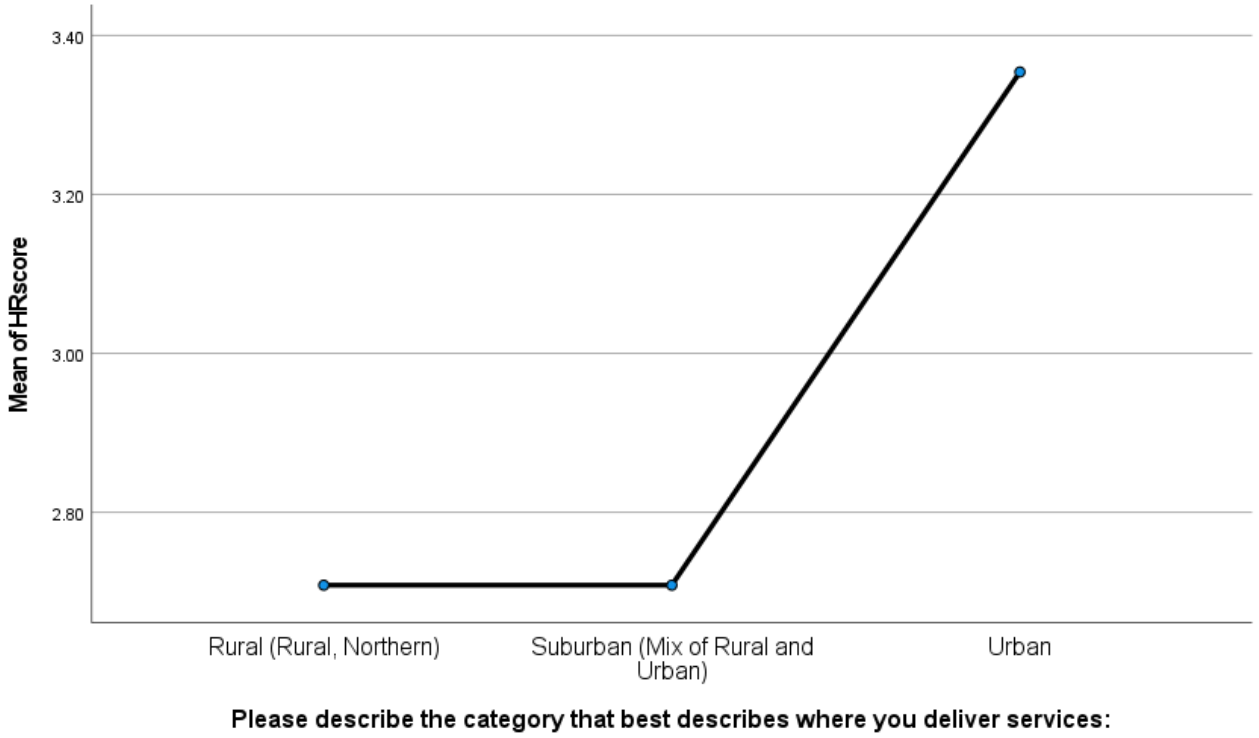
Size of Shelter

A one-way ANOVA was conducted to determine any differences in Harm Reduction scores and the size of the shelter. The shelter size was based on the number of beds in a shelter; therefore, small = 15 and under, medium = 16 to 25, and large = more than 25 beds. No differences were found [$F(2, 19) = 1.05$, *ns*].



Location of Shelter (Urban, Suburban, Rural)

A one-way ANOVA was conducted to determine any differences in Harm Reduction scores and the shelter service area: Urban, Suburban, or Rural. Although the Urban score appears proportionally higher than both Suburban and Rural, no significant differences were found [$F(2, 19) = 3.31$, $p = .058$].



Drug Poisoning Reversals

T-Test

Harm Reduction scores were also used to identify any differences among shelters that had indicated there had been a drug poisoning reversal on site since March 31st, 2020 versus those who reported no reversals had occurred on-site. An Independent *t*-test was conducted to compare the 8 shelters that reported drug poisonings reversed on-site since March 31, 2020 to the 14 shelters that reported no drug poisoning reversals since then. Despite the fact that shelters with drug poisoning reversals had higher Harm Reduction scores (M = 2.97, SD = .41) than those without (M = 2.65, SD = .31), there were no significant differences between these two groups [$t(20) = 2.06$, $p = .053$].

Recommendations

Staffing

Through the creation of the Ministry of Community and Social Services VAW Emergency Shelter Standards, shelters were required to create policies and procedures to ensure that all women, including those who use substances, can access support and programming within the shelter (Ministry of Community and Social Services, 2015). Many VAW shelters in Ontario are single-staffed throughout the night, however, a time when the majority of respondents reported drug poisonings had occurred in their shelter. It is imperative that Ontario VAW shelters receive funding to increase the number of staff in shelters at night to ensure the shelter can quickly respond to emergencies within the shelter, such as a drug poisoning and ensure the safety of all residents in the shelter.

Designated Staffing Positions

Currently shelter staff are tasked with implementing harm reduction practices, ensuring resident safety and supporting the needs of both residents who use substances and those who do not use substances. Furthermore, shelters have been faced with increasing rates of substance use and drug poisonings among residents and supporting residents with increasingly complex needs. In order to successfully support survivors and ensure residents' safety, it will be imperative that shelters receive sustainable funding to support the provision of a designated harm reduction worker within shelters.

Harm Reduction Training

Respondents noted that training was essential in helping staff understand the connections between substance use and trauma, allowing them to better respond to survivors' needs. As many respondents indicated their organization accesses training through the OAITH training portal it would be beneficial for this training to be updated to reflect the current drug poisoning crisis and expanded to provide more practical training for new and existing front-line staff in VAW shelters.

Organizational Leadership

Currently training is provided to OAITH member organizations frontline staff through the OAITH Training Portal. It would be beneficial for this training to be expanded to include training for organizational leadership including executive directors and board members as this training can provide direction for the expansion of harm reduction frameworks within a VAW shelter setting.

Naloxone Training

As reported by The Public Health Agency of Canada, in the first year of the pandemic opioid toxicity deaths (referred to as "drug poisonings" in this report) increased by 96% compared to the previous year (Public Health Agency of Canada, 2022). Training on drug poisoning reversals and deaths has been noted by survey respondents as a key component to implementing harm reduction practices within shelters, reducing staff burnout and saving lives. It is therefore essential that all VAW shelter staff receive training on the use of naloxone and that all shelters have barrier-free access to naloxone kits for staff and resident use.

Resource Development

While OAITH has created a harm reduction framework for VAW shelters, we would also recommend the creation of additional resources that will support shelters with the practical implementation of the harm reduction framework and practices within shelter.

Creation of Private Bedrooms Within Shelter

In response to the Covid-19 pandemic, recent research has examined existing shelters models and have recommended the creation of private bedrooms for residents and an increase in the number of bathrooms with no shelter (McLean & Wathen, 2020). These changes not only reduce the risk of virus transmission but can also increase privacy and a sense of dignity among residents in shelter (Nellies, 2022). It is recommended that Ontario VAW shelters receive funding for small scale infrastructure upgrades/renovations to implement these changes and that all newly constructed VAW shelters are designed to provide private rooms for all residents.

Supporting Survivors Outside of Shelter

As identified in the examination of drug poisonings among shelter clients, there have been several off-site non-fatal and fatal drug poisonings among residential clients and non-residential clients, suggesting the need for increased safety planning around use and greater access to safe use supplies. It is recommended that shelters receive the resources (e.g. staffing, funding, infrastructure) to be able to expand harm reduction practices and services to ensure services and safe supplies can be accessed by both residential and non-residential shelter clients to improve safety outcomes for all those accessing services within VAW shelters.

Research

It is recommended that further research is conducted among VAW shelters in Ontario to accurately situate all Ontario VAW shelters on this continuum. This research will provide a more complete analysis of the implementation of harm reduction practices in shelters and can identify further areas of need within VAW shelters. Research can also examine the implementation of harm reduction practices with non-residential clients that are also accessing shelter services on an outreach basis.

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Appendix A

Harm Reduction Needs Assessment Questions

1. In what region is your organization located?

North
East
Central
Toronto
West

2. Please describe the category that best describes where you deliver services:

Rural (Rural, Northern)
Suburban (Mix of Rural and Urban)
Urban

3. Please describe the size of your shelter by range of beds currently available:

Small (15 and under)
Medium (16 to 25)
Large (More than 25 beds)

4. Is your shelter double staffed 24 hours per day?

Yes
No
Sometimes but it's not consistent

5. Please identify what LHIN your organization delivers services in. (Select all that apply if your services are in more than one catchment area)

Central East LHIN
Central LHIN
Central West LHIN
Champlain LHIN
Erie St. Clair LHIN
Hamilton Niagara Haldimand Brant LHIN
Mississauga Halton LHIN
North East LHIN
North Simcoe Muskoka LHIN
North West LHIN
South East LHIN
South West LHIN
Toronto Central LHIN
Waterloo Wellington LHIN
Prefer not to answer

6. How many substance use related deaths have occurred **in shelter** since March 31st, 2020?

0
1
2
3
4
5
More than 5

Prefer not to answer

7. Of the substance use related deaths that have occurred in shelter since March 31st, 2020 how many have been caused by opioids?

0
1
2
3
4
5
More than 5
Prefer not to answer

8. Have there been any overdoses reversed on-site since March 31st 2020?

Yes
No
Prefer Not To Answer

On-site Overdoses

9. In total, how many overdoses have been reversed onsite since March 31st 2020?

0
1
2
3
4

5
More than 5
Prefer not to answer

On-site Overdose Reversals

10. Of the total number of overdose reversals, how many were reversed by:

Staff
Other Residents
Emergency Medical services (e.g. paramedic, firefighter, police)

11. If you've experienced overdose deaths and/or reversals have these generally occurred:

At night
During the day
Mix of both

Off-site Overdoses & Non-Residential Clients

12. How many substance use related deaths of residential clients have occurred **off-site** since March 31st, 2020?

0
1
2
3
4
5
More than 5

Prefer not to answer

13. How many non fatal overdoses in total have occurred that you're aware of for non residential clients (ie community, outreach clients) since March 31st, 2020?

0
1
2
3
4
5
More than 5
Prefer not to answer

14. How many overdose deaths have occurred that you're aware of for non residential clients, since March 31st, 2020:

0
1
2
3
4
5
More than 5
Prefer not to answer

Policies, Procedures and Operations

15. Select the statement that best describes your organization's policies on substance use:

Written policies require non-use of substances. Residents must abstain from using substances to access services and this may include some prescribed medications (i.e. methadone, suboxone)
Written policies ensure survivors using substances are not excluded from accessing shelter's services
Written policies define the concept of harm reduction and mandate the use of harm reduction approaches in shelter
Written policies inform designated harm reduction programming for residents to access safe use supplies, harm reduction workers and partnerships with harm reduction organizations

16. Select the statement that best describes your organization's operational planning as it relates to harm reduction:

Planning ensures the maintenance of a non-use shelter environment and does not knowingly allow for any use during shelter stay, including off-site
Planning maintains a non-use shelter environment that allows residents to use off-site with staff knowledge
Planning for harm reduction implementation (e.g. internal harm reduction committee made up of staff from all levels, management, frontline, outreach etc.)
Planning focuses on expansion of implemented harm reduction approaches, such as creating safe use areas in the shelter for legal substances. Peer to Peer Programs are offered and those who are on the continuum of substance use are on harm reduction committees.

17. Select the statement that best describes your organization's admission and discharge policies as they relate to substance use:

Survivors referred to safe alternative to accommodate if any substance use identified as an issue or unable to remain abstinent during stay - may include use of abstinence contracts
Survivors who present to shelter seeking services or returning from outings while visibly intoxicated are referred to other substance use services until detoxed. Clear no tolerance rules of unsafe conduct and behaviours related to substance use (e.g., leaving used needles out, selling or exchanging drugs)
Survivors who are visibly intoxicated when seeking support or returning from outings are admitted and accommodated within shelter. Clear guideline and consequences for substance use related discharges

Flexible rules include escalating consequences for use of illegal substances on-site or unsafe conduct and behaviour related to substance use to minimize substance use related discharges (i.e. discussion, warnings and "postponement periods")

18. Select the statement that best describes what questions are asked at intake in regard to substance use:

Intake does not inquire about substance use or used to screen for substance use
Staff may or may not ask survivors at intake about their use of substances. Residents are encouraged to discuss substance use in order to refer to support services and create a safety plan
Staff assess survivors at intake for their level and type of substance use needs to create a safety plan. Residents are provided with a clear outline of the harm reduction approach at intake
Staff routinely meet with the resident to discuss their substance use related needs to facilitate ongoing safe use of substances

19. Select the statement that best describes your organization's resident curfew policy:

Curfews require residents to return to the shelter on a nightly basis
Residents are permitted to sign out for overnights if they have used or are planning to use substances
Curfew time allows for return to shelter following closing of bars
No curfews are set

20. Select the statement that best describes how substance use is discussed at residents' meetings:

Meetings may include review of non-use policies
Meetings may address and review no tolerance rules regarding unsafe conduct and behaviours related to substance use
Meetings may address shelter issues related to substance use through facilitated discussion. Use of informal education approaches by staff to reduce stigma and review harm reduction approaches

Meetings may be used to formally educate residents about substance use and harm reduction, including information about overdose and lethal drug poisoning

21. Select the statement that best represents the staffs' and residents' understanding of your organization's policy around duty to report as it relates to substance use:

Duty to report parental substance use may be conflated to mean children are considered automatically at risk when substances are used; circumstances under which to report about substance use may be misunderstood
Staff and residents may not be clear about duty to report in relation to parental substance use; circumstances of reporting are related directly to children at risk by parent's use
Residents are actively informed that staff have a duty to report; circumstances of reporting regarding parental substance use are related directly to children at risk by parent's use and safety strategies discussed have not been followed
Staff and residents have a clear understanding of duty to report and how it relates to parental substance use; staff may assist with specific strategies to support safe parental use of substances to mitigate the need to report

Facilities

22. Select the statement that best represents how your organization provides for sharps containers within your shelter:

Sharps container for medical purposes only (e.g., disposal of insulin needles/containers) in staff office
Sharps/disposables containers near or in staff only areas
Accessible sharps/ disposables containers are available on-site
Accessible sharp containers are available and may be provided in rooms; Clear protocols provided for disposal of any substance use paraphernalia

23. Select the statement that best describes how residents can store and access personal substances:

Prescription medication stored in staff only areas (no unprescribed substances allowed)
Space for storage of legal substances on-site (i.e., provision fridge space for methadone); accessible to resident and/or via staff
Secure storage of legal substances in rooms or on-site; accessible to residents
Space for private, unsearched, secure storage of personal items on-site, which may include substance use related items

24. Select the statement that best represents how your organization supports residents after they have used substances:

No space for residents who have used substances; referred to withdrawal management
May or may not have an “after substance use” room; residents are not discharged for use; staff may provide some support or refer to withdrawal management
Provision of a supervised “after substance use” room to support and monitor residents who return to the shelter intoxicated
Supervision available to monitor residents who return to the shelter intoxicated in “safe after substance use” room or in their own room

25. Select the statement that best represents your organization's designated substance use areas:

Designated areas for smoking/vaping tobacco products only
Designated areas for smoking/vaping tobacco products and for smoking medical marijuana
Designated smoking areas including recreational marijuana
Designated area(s) for use of any legal substance (i.e., allow residents to drink on-site)

Designated Consumption Site

26. Is there a designated area to consume edible marijuana products?

No
Yes (please specify)

Staffing and Training

27. Select the statement that best describes how harm reduction practices and knowledge are considered in your hiring practices:

Harm reduction knowledge and practices are not included in job descriptions
Job descriptions require naloxone and first aid certification and training
Training and knowledge about safer substance use practices and harm reduction
Staffing interviews include questions about safer substance use practices and harm reduction

28. Select the statement that best describes what harm reduction skills are applied by employees within your organization:

Staff supported in making appropriate referrals for survivors requiring alternative shelter due to substance use
Core knowledge and skills of harm reduction are required in job postings
Harm reduction core competencies are integrated with supervision meetings
Staff are encouraged to undertake individual and group research projects and inter-collegial training

29. Select the statement that best describes your organization's harm reduction committee:

No harm reduction committee or plans for this type of committee
Early stage discussions and planning for harm reduction training and program needs
Internal harm reduction committee consisting of all staff levels for planning and implementing training and program needs
Harm reduction committee includes resident representatives, staff may also be involved in harm reduction initiatives with community-based partners

30. Do you have any designated harm reduction workers in your organization?

Yes, we have our own Harm Reduction Worker
Yes, we have our own Mental Health and Addictions Worker
Yes, we have an external agency who provides these supports
No, we do not have any internal or external positions designated for harm reduction

31. Select the statement that best describes the type of training that is provided to staff as it relates to safe cleaning and/or room checks:

Staff are trained to complete safe room and personal property (e.g., bags, suitcases) checks, accounting for possible presence of sharps, substances, and paraphernalia on an as needed basis
Staff are trained to complete safe room checks only, accounting for possible presence of sharps, substances, and paraphernalia. Personal items are not checked.
Staff are trained to complete safe room checks, accounting for possible presence of sharps, substances, and paraphernalia between discharges and new admissions to room
Staff are trained to respond to room checks in relation to critical incidents involving substance use deaths or near deaths that occur in shelter

32. Select the statement that best describes what overdose training is provided by your organization to staff:

Overdose training may be part of required first aid training
Staff are trained to recognize the signs of risk of overdose and call for help
Staff are trained to administer naloxone if they find a resident experiencing a drug poisoning or overdose
Staff are required to be trained to assess, monitor and respond to residents who they know are presently affected by their use - this includes administering naloxone for drug poisonings and overdose

33. Select the statement that best describes the harm reduction training that your organization provides to staff:

Minimal training provided in use of non-judgmental language use or safer substance use

Staff are trained in use of respectful, non-judgemental language around substance use; Some staff may receive training on safer substance use practices
All staff receive ongoing in-house training on harm reduction and safer substance use practices; trained to address behaviours rather than substance use.
All staff receive comprehensive ongoing, specialist training on safer substance use and overdose prevention practices; Broad application of harm reduction theory (including safer sex, self harm, HIV/AIDS, Hep C prevention)

Staff Training

34. What type of harm reduction training do shelter staff receive? Select all that apply.

Webinar
Web-based modules
In-person off-site
In-person on-site
Other (please specify)
Not Applicable (Harm reduction training is not provided)

35. Who provides harm reduction training to staff in your organization? Select all that apply.

Local Public Health Unit
OAITH Online Harm Reduction Training
Local HIV/AIDS Service Organization
External Trainer/Consultant
Other (please specify)
Not Applicable (Harm reduction training is not provided)

36. Approximately, how many hours of harm reduction training does each staff receive?

1-2 hours
3-4 hours
5-6 hours
7-9 hours
10 or more hours
Not Applicable (Harm reduction training is not provided)

37. How many staff onsite have received training to administer naloxone?

On-site Supportive Services

38. Select the statement that best describes your organization's counselling services related to substance use:

Facilitate transfer to substance treatment or other shelter settings that accomodate substance use needs
Facilitate temporary transfer to safe setting that can support withdrawal management process followed by return to shelter; off-site substance use counselling made available
On-site substance use counselling provided by community partner
Designated agency funded on-site substance use counsellor. Testing for substance use related health concerns provided periodically on-site. Agency has a harm reduction outreach program.

39. Select the statement that best describes what personal health products are available in shelter:

Availability, distribution of brochures regarding safer substance use, local substance use services and programs
Distribution of health-related products such as condoms, dental dams and razors
Distribution of safety kits specific to substance use (e.g. safe injection and safe inhalation kits; naloxone kits)
Needle exchange programs on-site accessible to community

40. Select the statement that best describes what services are provided by your organization to support survivors' use:

Transportation and childcare provided for abstinence-based services (e.g. AA Meetings)
Transportation provided for residents to attend appointments with other service providers regarding substance use
Childcare is provided for residents needing to attend substance related services, meetings or appointments
Childcare is provided for residents while they are using

41. Please describe how accessible staff are within shelter for substance use discussions:

Residents supported by staff abstinence-based discussions
Residents have “open door” to access shelter workers on an ongoing basis to discuss substance use
Substance use and safety are integrated into life skills and/or safety planning programming within the shelter; on-site peer support (ie peer support from current/former drug users) is facilitated
Staff provides strategies for safe use off-site

Community Connections

42. Please describe any community partnerships that your organization has as it relates to harm reduction practices:

Referrals to abstinence-based self-help (e.g. 12 step) or substance use treatment programs
Community partnerships for substance use services or programs that prioritizes shelter referrals
Shelter has community partners to support ongoing harm reduction training (e.g public health) and on-site counselling
Shelter advocates for community substance use strategies and is engaged in relevant community based harm reduction committees, task forces, etc.

43. Please describe any medical partnerships that your organization has as it relates to harm reduction practices:

Medically-based supports for abstinence (e.g., Antabuse)
Shelter referrals to doctors who specialize in medical cannabis use or methadone, or suboxone. Shelter collaborates with pharmacies for substance use information, methadone

Shelter works collaboratively with pharmacies and public health for access to naloxone, needle exchange and access to HIV, STI/STD testing
Shelter supports active discussion about safe use supplies to accommodate safe use. Workers accommodate by supporting residents with appointments, as requested, to access supplies and testing to reduce barriers and improve health outcomes

44. Please describe your partnership with CAS as it relates to harm reduction practices:

Relationship with CAS does not include harm reduction discussions
Some shelter workers begin to introduce harm reduction approaches to some individual CAS workers when they attend the shelter
Begin to have formal meetings to discuss harm reduction between shelter and CAS agency
Shelter has ongoing, productive partnership with CAS to provide protection for children while respecting harm reduction objectives

45. Does your organization participate in any harm reduction/ substance use committees/ networks in your local community?

No
Yes (please specify)

Harm Reduction Challenges & Successes

What has been the biggest challenge to addressing residents' substance use and/or implementing harm reduction practices within your organization?

What has been the biggest success to addressing residents' substance use and/or implementing harm reduction practices within your organization?

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Appendix B

Draft Harm Reduction and Substance Use Practice Strategies Continuum

Harm Reduction and Substance Use Practice Strategies Continuum

Concepts to consider in development of continuum:

- Importance of the gradualism (consider developing a thoughtful approach to change vs. ripping the band-aid off) and situational context; need to build upon the strengths and purpose of the organization – not suggest striving for Level 4 as best practice for a particular shelter or the women they serve.
- Relationship and connection are central to harm reduction
- Harm reduction focuses on keeping people alive, keeping people safe, and promoting health; Should there be an organizational goal of facilitating opportunities for "improvement" (for lack of a better way of capturing this concept)?
    - What does this mean in harm reduction? Having conversations, encouraging steps towards improving safety, quality of life, improving health
    - Does not mean: imposing treatment goals; not working with a person based on where they are at; not taking action where action is needed; not having rules or guidelines where needed to ensure safety; not striving to ensure good health (physical and mental) for all within a setting
    - Focus must include collective group (shelter as a community and communal living) and individual residents

Sources informing continuum:

1) Survey project findings - Name of Study: *Developing the landscape of substance use practices in VAW shelters across Ontario*/Survey distribution: June 2017; Published article: Hovey, A., Roberts, C., Scott, S., & Chambers, L. (2020). Understanding the landscape of substance use management practices in domestic violence shelters across Ontario. *Journal of Family Violence, 35*(2), 191-201. https://doi.org/10.1007/s10896-019-00056-0
2) Qualitative data from shelter interviews - Name of Study: *Shelter access for all women: Creating a harm reduction framework*/Interviews: January – February, 2018; February – March, 2020
3) Conference discussion notes - Name of Conference: *Current Practice to Future Directions: Harm Reduction in VAW Shelters*/Date: May 15-16, 2018

4) Qualitative study data – Published article Hovey, A., & Scott, S. (2019). All women welcome: Exploring residents' experiences with harm reduction at an emergency shelter. *Partner Abuse, 10*(4), 409-427. doi:10.1891/1946-6560.10.4.409

Definitions of Levels of Harm Reduction Practice:

Level 1

Uses strategies that restrict active use of substances during a shelter stay. Non-use policies may be required in order to accommodate cultural considerations or provide a substance-free setting for women who have this preference. If unable to accommodate a woman for reasons related to substance use, shelter must provide a safe alternative service option (i.e., making a referral).

Level 2

Uses strategies characterized by basic harm reduction principles that acknowledge the use of substances and their potential risks and harms without actively accommodating or actively supporting safer use. Strategies of this nature allow more women to access shelter service while maintaining a non-use shelter environment.

Level 3

Uses passive and some active strategies such as proactive discussion around substance use and accommodation of safer use, without actively supporting safer use. These strategies work to reduce the stigma associated with substance use and support increased access to substance use services in the community (e.g., safe consumption site).

Level 4

Uses active strategies of acceptance, accommodation, and support of safer use. Strategies are inclusive of all women regardless of their substance use, allowing for the most universal access to shelter. Substance use is destigmatized and barriers to active use are removed where possible.

Major Topics:

1) Policies, Procedures, and Operations
2) Facilities
3) Staffing and Training
4) On-site Supportive Services
5) Community Connections

Continuum of Harm Reduction and Substance Use Practices				
Topic	**Level 1**	**Level 2**	**Level 3**	**Level 4**
Level Description	**Restrict active use during shelter stay, including for accommodation of cultural considerations. Provide safe alternative for women arriving under the influence.**	**Basic harm reduction principles used. Do not actively support safe use. Shelter services can be accessed if under the influence.**	**Mainly passive with some active strategies. Accommodation of safer use. Reduces stigma of use. Increases access to shelter services.**	**Active strategies to support and accommodate safer use. Most inclusive. Use is destigmatized. Barriers to active use are removed where possible.**
Policies, Procedures, and Operations				
General Substance Use	Written policies require non-use of substances; Residents must abstain from using substances to access services and this may include some prescribed medications (i.e., methadone, suboxone)	Written policies ensure women using substances are not excluded from accessing shelter's services	Written policies define the concept of harm reduction and mandate the use of harm reduction approaches in the shelter	Written policies inform designated harm reduction programming for residents to access safe use supplies, harm reduction workers and partnerships with harm reduction organizations
Operational Planning	Planning ensures the maintenance of a non-use shelter environment and does not knowingly allow for any use during shelter stay, including off-site	Planning maintains a non-use shelter environment that allows residents to use off-site with staff knowledge	Planning for harm reduction implementation (e.g., internal harm reduction committee made up of staff from all levels - management, frontline, outreach etc.)	Planning focuses on improvement and is committed to expansion of implemented harm reduction approaches; Residents may participate on harm reduction committee
Applying	Staff ensure women who	Staff uphold principles in	Staff consistently uphold	Staff consistently uphold

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Harm Reduction Principles	present with substance use needs are referred to safe alternative shelter services	their communication with residents regarding substance use	principles in their work with residents regarding substance use	principles in their work regarding substance use and other areas (e.g., sex work, child welfare)
Medications	May not allow use of some prescribed medications (i.e., methadone, medical marijuana) on-site; Staff store all prescription medication	Prescribed medications (i.e., methadone, medical marijuana) are allowed on-site; Staff may store but do not dispense prescription medication	Prescribed medications are the responsibility of the resident but may require alternative storage options for medications that require refrigeration	Prescribed medications are the full responsibility of the resident with each room having a lock box to store medications
Admission and Discharge	Women referred to safe alternative to accommodate if any substance use identified as an issue or unable to remain abstinent during stay - may include use of abstinence contracts	Women who present to shelter seeking services or returning from outings while visibly intoxicated are referred to other substance use services until detoxed; Clear no tolerance rules of unsafe conduct and behaviour related to	Women who are visibly intoxicated when seeking support or returning from outings are admitted and accommodated within shelter; Clear guidelines and consequences for substance use related discharges	Flexible rules include escalating consequences for use of illegal substances on-site or unsafe conduct and behaviour related to substance use to minimize substance use related discharges (i.e., discussion,

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		substance use (e.g., leaving used needles out, selling or exchanging drugs)		warnings, and "postponement periods")
Intake: Ask About Use	Intake does not inquire about substance use or used to screen for substance use	Staff may or may not ask women at intake about their use of substances; Residents are encouraged to discuss substance use in order to refer to support services and create a safety plan	Staff assess women at intake for their level and type of substance use needs to create a safety plan; Residents are provided with a clear outline of the harm reduction approach at intake	Staff routinely meet with the resident to discuss their level and type of substance use to facilitate ongoing collaborative safety and behaviour management planning
Curfews	Curfews require residents to return to the shelter on a nightly basis	Residents are permitted to sign out for overnights if they have used or are planning to use substances	Curfew time allows for return to shelter following closing of bars	No curfews are set
Residents' Meetings	Meetings may include review of non-use policies	Meetings may address and review no tolerance rules regarding unsafe conduct and behaviours related to	Meetings address shelter issues related to substance use through facilitated discussion; use of informal	Meetings may be used to formally educate residents about substance use and harm reduction, including

Continuum of Harm Reduction and Substance Use Practices				
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		substance use	education approaches by staff to reduce stigma and review harm reduction approaches	information about overdose and lethal drug poisoning
Duty to Report to CAS	Duty to report parental substance use may be conflated to mean children are considered automatically at risk when substances are used; circumstances under which to report about substance use may be misunderstood	Staff and residents may not be clear about duty to report in relation to parental substance use; circumstances of reporting are related directly to children at risk by parent's use	Residents are actively informed that staff have a duty to report; circumstances of reporting regarding parental substance use are related directly to children at risk by parent's use and safety strategies discussed have not been followed	Staff and residents have a clear understanding of duty to report and how it relates to parental substance use; staff may assist with specific strategies to support safe parental use of substances to mitigate the need to report
Facilities				
Sharps Containers	Sharps containers for medical purposes only (e.g., disposal of insulin needles/containers) in	Sharps/disposables containers near or in staff only areas	Accessible sharps/disposables containers are available on-site	Accessible sharps/disposables containers are available and may be provided in rooms; Clear protocols

Continuum of Harm Reduction and Substance Use Practices				
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	staff office			provided for disposal of any substance use paraphernalia
Access to Personal Substances	Prescription medication stored in staff only areas	Space for storage of legal substances on-site (e.g., provision fridge space for methadone carries, personal lockers in entrance area to shelter); accessible to resident and/or via staff	Secure storage of legal substances in rooms or on-site; accessible to residents	Space for private, unsearched, secure storage of personal items on-site, which may include substance use related items
On-site Substance Use Areas	Designated areas for smoking cigarettes and tobacco vaping only	Designated areas for smoking and vaping tobacco products, and for smoking medical marijuana	Designated smoking areas including recreational marijuana	Designated area(s) for use of any legal substances (i.e., allow women to drink on-site)
After Substance Use Room	No space for residents who have used substances; referred to withdrawal management	May or may not have an "after substance use" room; residents are not discharged for use; staff	Provision of a supervised "safe after substance use" room to contain and monitor residents who	Supervision available to monitor residents who return to the shelter intoxicated in "safe after

Continuum of Harm Reduction and Substance Use Practices				
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		may provide some support or refer to withdrawal management	return to the shelter intoxicated	substance use" room or in their own room
Safety in Facility	Standard safety equipment for building security	Elevated safety equipment such as portable emergency call buttons are provided to staff	Room allocation considerations on an individual basis for using and non-using clients	Room allocations/physical layout provide for separation of using and non-using clients
Staffing and Training				
Training: Harm Reduction	Minimal training provided in use of non-judgmental language with substance use or safer substance use	Staff are trained in use of respectful, non-judgmental language around substance use; Some staff may receive training on safer substance use practices	All staff receive ongoing in-house training on harm reduction and safer substance use practices; trained to address behaviours rather than substance use	All staff receive comprehensive ongoing, specialist training on safer substance use and overdose prevention practices; Broad application of harm reduction theory (e.g., safer sex, self harm, HIV/AIDS, Hep C prevention)

Continuum of Harm Reduction and Substance Use Practices				
Topic	**Level 1**	**Level 2**	**Level 3**	**Level 4**
Level Description	**Restrict active use during shelter stay, including for accommodation of cultural considerations. Provide safe alternative for women arriving under the influence.**	**Basic harm reduction principles used. Do not actively support safe use. Shelter services can be accessed if under the influence.**	**Mainly passive with some active strategies. Accommodation of safer use. Reduces stigma of use. Increases access to shelter services.**	**Active strategies to support and accommodate safer use. Most inclusive. Use is destigmatized. Barriers to active use are removed where possible.**
Training: Trauma Informed	Trauma-informed training provided	Trauma-informed training provided separately from harm reduction related training	Management and staff have ongoing, open dialogue and training about agency policies related to harm reduction and trauma-informed practices	Trauma-informed training is integrated with harm reduction training at all levels of the organization
Training: Overdose	Overdose training may be part of required first aid training	Staff are trained to recognize signs of risk of overdose and call for help	Staff are trained to administer naloxone if they find a resident who is experiencing a drug poisoning or overdose	Staff required to be trained to assess, monitor and respond to residents who they know are presently affected by their use. This includes administering naloxone for drug poisonings and overdose
Training: Safe Cleaning and/or Room Checks	Staff are trained to complete safe room and personal property (e.g., bags, suitcases) checks, accounting for possible	Staff are trained to complete safe room checks only, accounting for possible presence of sharps, substances, and	Staff are trained to complete safe room checks, accounting for possible presence of sharps, substances, and	Staff are trained to respond to room checks in relation to critical incidents involving substance use deaths or

Continuum of Harm Reduction and Substance Use Practices				
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	presence of sharps, substances, and paraphernalia on an as needed basis	paraphernalia. Personal items are not checked.	paraphernalia between discharges and new admissions to room	near deaths that occur in shelter
Harm Reduction Committee	No harm reduction committee or plans for this type of committee	Early stage discussions and planning for harm reduction training and program needs	Internal harm reduction committee consisting of all staff levels for planning and implementing training and program needs	Harm reduction committee includes resident representatives; staff may be involved in harm reduction initiatives with community-based partners
Employee Skills	Staff supported in making appropriate referrals for women requiring alternative shelter due to substance use	Core knowledge and skills of harm reduction are required in job postings	Harm reduction core competencies are integrated with supervision meetings	Staff are encouraged to undertake individual and group research projects and inter-collegial training
Harm Reduction Informed	Harm reduction knowledge and practices are not included in job	Job descriptions require naloxone and first aid certification and training	Training and knowledge about safer substance use practices and harm	Staffing interviews include questions about safer substance use practices

Continuum of Harm Reduction and Substance Use Practices				
Topic	**Level 1**	**Level 2**	**Level 3**	**Level 4**
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Hiring	descriptions		reduction	and harm reduction
On-site Supportive Services				
Substance Use Counselling	Facilitate transfer to substance treatment or other shelter settings that accommodate substance use needs	Facilitate temporary transfer to safe setting that can support detox process followed by return to shelter; off-site substance use counselling made available	On-site substance use counselling provided by community partner	Designated agency funded on-site substance use counsellor; Testing for substance use related health concerns provided periodically on-site; Agency has a harm reduction outreach program
Health-oriented Products	Availability, distribution of brochures regarding safer substance use, local substance use services and programs	Distribution of health-related products such as condoms, dental dams, and razors	Distribution of safety kits specific to substance use (e.g., safe injection and safe inhalation kits; Naloxone kits)	Needle exchange program on-site accessible to community

Continuum of Harm Reduction and Substance Use Practices				
Topic	**Level 1**	**Level 2**	**Level 3**	**Level 4**
Level Description	**Restrict active use during shelter stay, including for accommodation of cultural considerations. Provide safe alternative for women arriving under the influence.**	**Basic harm reduction principles used. Do not actively support safe use. Shelter services can be accessed if under the influence.**	**Mainly passive with some active strategies. Accommodation of safer use. Reduces stigma of use. Increases access to shelter services.**	**Active strategies to support and accommodate safer use. Most inclusive. Use is destigmatized. Barriers to active use are removed where possible.**
Services Supporting Women's Use	Transportation and childcare provided for abstinence-based services (e.g., AA meetings)	Transportation provided for residents to attend appointments with other service providers regarding substance use	Childcare is provided for residents needing to attend substance related services, meetings or appointments	Childcare is provided for residents while they are using
Accessibility of Staff for Substance Use Discussions	Residents supported by staff in abstinence-based discussions	Residents have "open door" access to shelter workers on an ongoing basis to discuss substance use	Substance use and safety are integrated into life skills and/or safety planning programming within the shelter; On-site peer support is facilitated	Staff provide strategies for safe use off-site
Community Connections				
Partnerships	Referrals to abstinence-based self-help (e.g., 12-Step) or substance use treatment programs	Community partnerships for substance use services or programs that prioritizes shelter referrals	Shelter has community partners to support ongoing harm reduction training (e.g., public health) and on-site counselling	Shelter advocates for community substance use strategies, and is engaged in relevant community-based harm reduction committees, task forces etc.

Continuum of Harm Reduction and Substance Use Practices				
Topic	**Level 1**	**Level 2**	**Level 3**	**Level 4**
Level Description	**Restrict active use during shelter stay, including for accommodation of cultural considerations. Provide safe alternative for women arriving under the influence.**	**Basic harm reduction principles used. Do not actively support safe use. Shelter services can be accessed if under the influence.**	**Mainly passive with some active strategies. Accommodation of safer use. Reduces stigma of use. Increases access to shelter services.**	**Active strategies to support and accommodate safer use. Most inclusive. Use is destigmatized. Barriers to active use are removed where possible.**
Medical/ Pharmacies	Medically-based supports for abstinence (e.g., Antabuse)	Shelter referrals to doctors who specialize in medical cannabis use or methadone or suboxone; Shelter collaborates with pharmacies for substance use information, methadone	Shelter works collaboratively with pharmacies and public health for access to naloxone, needle exchange and access to HIV, STI/STD Testing	Shelter supports active discussion about safe use supplies to accommodate safe use. Workers accommodate by supporting residents with appointments, as requested, to access supplies and testing to reduce barriers and improve health outcomes
CAS	Relationship with CAS does not include harm reduction discussions	Some shelter workers begin to introduce harm reduction approaches to some individual CAS workers when they attend the shelter	Begin to have formal meetings to discuss harm reduction between shelter and CAS agency	Shelter has ongoing, productive partnership via agreements with CAS to provide protection for children while respecting harm reduction objectives