Evaluation of the Substance Use Services at a COVID-19 Isolation and Recovery Site in Toronto

A MARCO Report

December 14, 2021

MAP Centre for Urban Health Solutions
UNITY HEALTH TORONTO
UNIVERSITY OF TORONTO

About the MARCO Study

The MARCO project is evaluating how local efforts responding to the COVID-19 pandemic serve people experiencing marginalization, and how these interventions can be improved. Changes in society to control the pandemic have affected everyone, but they place a particularly heavy burden on people who are marginalized.

About this Report

This is a MARCO Evaluation report. This report highlights the key findings from the evaluation of the Substance Use Services at the COVID-19 Isolation and Recovery Site. The views contained in this report do not necessarily express the views of any MARCO community partner, funding agencies, MAP, St. Michael's Hospital, Unity Health Toronto, the University of Toronto, or any other organization with which MARCO authors or project team members may be affiliated.

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Land Acknowledgement

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

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What was evaluated?

In the spring of 2021, we conducted an evaluation of the Substance Use Services offered at one of the COVID-19 Isolation and Recovery Sites (CIRS) in Toronto, Ontario. Three separate sites were open at different points in the pandemic. The sites were set up early in pandemic to provide a COVID-19 isolation space for people experiencing homelessness who were exposed to COVID-19, had symptoms of COVID-19, or were diagnosed with COVID-19. This evaluation explores the Substance Use Services at the site that was open at a hotel in Etobicoke from April 7th, 2020, to June 30th, 2021.

The Substance Use Services offered on-site included:

- Harm reduction education and distribution of harm reduction equipment (including sterile injection equipment, and safer smoking and inhalation equipment)
- Provision of cigarettes and outdoor space for physically-distanced smoking
- A managed alcohol program
- Prescription opioids and/or stimulants as treatment or as an alternative to unregulated drugs that people would buy themselves (opioid agonist treatments, safer opioid supply, stimulant medications)
- Prescription of medications to treat withdrawal from drugs or alcohol
- Services to prevent and respond to overdoses:
  - An on-site overdose prevention site (a room where people can go to use substances - primarily by injection under the supervision of trained staff)
  - In-room witnessing when using substances by staff when clients requested it
  - Telephone or in-person check-ins when using substances when clients requested it
  - Naloxone distribution to staff and clients

What were the key findings?

The COVID-19 pandemic precipitated a novel, integrated suite of residential harm reduction and clinical substance use services for people experiencing homelessness. The extent of the integration of the services offered and their delivery within a residential setting was brought about by the need to facilitate the COVID-19 related isolation for clients, and is unique among community and clinical environments. This integrated model for service delivery in shelter and residential settings kept people healthy and safe during their stay at the site and helped to prevent overdose-related deaths.

> "Honest to God, like everything here has been so amazing … The harm reduction team here is amazing, like they will go above and beyond to make you feel comfortable, like down to a cup of tea, down to snacks, down to, you know. They're just a really good team here … And it was like way better to get here and find out that this is where I was going to be because I didn't know." [CIRS Client]

Key findings from client interviews

Clients spoke positively about their interactions with staff at the site. Clients appreciated the range of on-site services, including harm reduction and clinical services.

Clients highlighted the things that helped them isolate at the site, including having easy access to the managed alcohol program and prescription

Client-centred care was facilitated at the CIRS due to an ability to say 'yes' to client requests

medications for people who use opioids, such as opioid agonist therapy and safer opioid supply. This allowed clients to remain on-site (as they did not have to leave to acquire substances) and manage their substance use without withdrawal and discomfort.

> "If I had withdrawal issues with alcohol or the opioids and they just didn't want to do anything about it, I would have checked myself out. I wouldn't have felt good about it because I'm trying to be responsible. I don't want to spread the COVID. It would have done my best to be careful. But no, I would have to leave to get myself my alcohol and get myself my drugs." [CIRS Client]

When overdose concerns were identified, staff from all teams worked together with the client to create an individualized safety plan. The plan might include using the overdose prevention site, having a staff member stay with the client in their room while they used substances, or frequent telephone or in-person checks.

Many clients felt safer at the site than in other shelter settings because of variety and nature of the substance use services available. Having their own rooms with a private bathroom and a TV gave clients privacy and dignity, and contributed to their positive experience.

Some clients were reluctant to talk about their substance use with staff because of past negative experiences with service providers and healthcare workers.

Key findings from staff interviews

The ability to say 'yes' to client requests more freely allowed stronger client-centered care:

> "I think overall what's worked is that I work with a group of committed professionals and that they come with the objective of meeting the needs of the client, where a client-first shelter, everything we do, we're putting the client first." [Peer worker]

Collaboration between on-site teams fostered a rapid learning and skill-building process around harm reduction.

Primary care providers at the site were able to rapidly become comfortable and skilled at providing opioid agonist therapy and safer opioid supply. This was facilitated by support from the specialist substance use team and the guidance documents on substance use services available to consult on-site.

Provision of an easy-to-access managed alcohol program is feasible and helped facilitate client engagement. This model may be useful to replicate to assist in the expansion of managed alcohol programs in other clinical and shelter settings across Toronto, given the existing gaps in this area.

Staff emphasized the feasibility and value of providing integrated substance use services to people experiencing homelessness in the settings where they were living. However, more funding is needed to support the development and sustainability of integrated clinical and harm reduction programs post-pandemic.

Discharge was a major concern for staff. Staff worried about the lack of stable housing and the lack of integrated and comprehensive substance use services within sheltering options in the community.

Discharge from the CIRS and continuity of care in the community post-discharge was a key source of anxiety for clients and staff members. Lack of housing for clients as well referral challenges and a lack of capacity in both safer opioid supply and managed alcohol programs in the community meant that many clients who were receiving these at the site were discontinued on discharge. Many clients expressed their desire to continue with safer opioid supply (SOS) following discharge, and their impression that they would continue to benefit from SOS in the community, particularly after having been stabilized on it at the CIRS.

> "I feel that's ridiculous, that you've got me on a safe system while I'm here and now you put me out into the into the world and I'm going to be back on using a drug *[fentanyl]* that will probably kill me on day." [CIRS Client]

What are the recommendations moving forward?

While the substance use services at the CIRS were implemented due to the unique challenges brought on by the COVID-19 pandemic, there are many findings from this evaluation that are transferrable and can be used to assist in the development of long-term strategies to address the needs of people experiencing homelessness in the period beyond the COVID-19 pandemic. Our findings highlight an urgent need for wraparound substance use-related supports embedded within shelter and housing options that will persist beyond the context of the COVID-19 pandemic. The substance use services offered at the CIRS provide a model for service delivery within shelters, supportive housing settings, in hospitals and across healthcare sites in the community. Below, our specific recommendations are presented.

Recommendations applicable to clinical, residential and shelter settings

- Intake and discharge were highlighted as moments of major stress for clients. Reducing transfers and providing ongoing and clear communication throughout the process may help to alleviate the intense stress associated with these transitions.
- The need to rapidly develop a CIRS led to a unique mix of harm reduction, clinical and sheltering services being offered to clients. It provided a model for how to deliver a full range of substance use services where people live, in shelter settings and in hospital settings that are feasible and acceptable to clients and staff.
- The overdose crisis and the need to facilitate people staying on-site led to wide uptake of opioid agonist therapies (OAT) and SOS prescribing within the CIRS. This was coupled with the provision of comprehensive harm reduction services including harm reduction equipment distribution, access to an on-site OPS, and in-person and telephone checks from staff when using drugs. An easily accessible managed alcohol program was also available on-site. This allowed clients to remain on-site and manage their substance use without withdrawal and discomfort, and provides a model for broader implementation across the sector.
- Support from people with lived/living experienced of drug use, harm reduction and clinical services allowed for the successful operation of comprehensive substance use programs in the CIRS. Prioritizing the expertise of people with lived/living experience and trained harm reduction workers was crucial in delivering low barrier services.
- Comprehensive training on harm reduction practices and overdose response across all teams - including people with lived/living experience, harm reduction, clinical, and shelter workers - is essential for reducing overdose risk and harmonizing goals within interdisciplinary teams.
- There are limited options and evidence for supporting people who use stimulants and for stimulant prescribing. The needs of clients who use stimulants are frequently overlooked, and further investigation of novel options for support for people who use stimulants (including options for stimulant replacement therapy) is necessary.

- There is a need for supervised smoking spaces to accommodate a wider range of drug consumption preferences.
- Avoiding the separation of close contacts can help reduce overdose risk, as they can monitor each other when using substances while isolating together.

Recommendations for the health and social service sector

Delivery of wraparound substance use services with on-site support from people with lived/living experience, harm reduction and clinical services in the spaces where people live and in homelessness service settings should be prioritized.

- During COVID-19 and beyond, there is an urgent need for embedded, comprehensive substance use services grounded in harm reduction within shelters, supportive housing settings, in hospitals and across healthcare sites in the community.
- Allocation of substantive and stable funding for the delivery of comprehensive substance use services across the homelessness service sector, in shelters, in the spaces people live in community, and in large, well-resourced healthcare sites (e.g. hospitals) should be prioritized.
- There is a need for a sub-acute care space for people experiencing complex, unmet mental and physical health needs alongside substance use, or to stabilize substance use among people experiencing homelessness. A model similar to the CIRS may be effective at meeting this need.

Strong investment in comprehensive, long-term housing solutions is needed. While the provision of well-funded short-term solutions for people experiencing homelessness who needed to isolate due to an infectious disease was necessary to address the COVID-19 pandemic, delivery of integrated, comprehensive services must be prioritized even when people experiencing homelessness do not represent infectious disease risks to the larger community.

Introduction

High rates of drug-related overdose deaths have occurred across Canada, with over 21,000 deaths in Canada from January 1st, 2016 to December 31st, 2020.[1] Amid the overdose crisis, the COVID-19 pandemic emerged, exacerbating already existing health disparities. A state of emergency to address the COVID-19 pandemic was declared on March 17th, 2020, representing the start of public health restrictions including lockdowns, service closures, and directions to stay at home and engage in physical distancing. The introduction of these public health measures led to the temporary closure of some health and social services, creating additional barriers to access.

Harm reduction programs and clinical substance use services were among the services impacted by physical distancing measures. In the months following the state of emergency declaration there was a significant increase in opioid overdose related deaths across Ontario; a 60% increase in opioid overdose-related mortality was reported for 2020, as compared to 2019.[2]

The COVID-19 pandemic and the overdose crisis have also significantly intersected with the lack of affordable housing in the City of Toronto. Given the concern that COVID-19 would spread quickly through congregate settings— including those within the homeless shelter system—there was a strong need to establish spaces for COVID-19 related isolation for people experiencing homelessness and/or who were unsheltered and/or living in the shelter system and/or living in encampments. More details about homelessness and sheltering during the COVID-19 pandemic are available in Appendix 1.

The MARCO Programs

MARCO was started in the early days of the COVID-19 pandemic by academic investigators, community investigators, and partner organizations working directly with people experiencing marginalization. Community investigators included people with lived experiences of marginalization, staff or leaders of community agencies, and people from advocacy organizations. We hosted a publicly available online survey to identify programs for evaluation. We considered a broad range of programs, interventions, and policies; these were not restricted to programs from MARCO partner organizations. A sub-committee of community and academic investigators selected programs based on: the potential for the research findings to have an impact on people experiencing marginalization; the need for the evaluation, the current well-being of the population being served by the program; and the feasibility of completing the evaluation within the available time and resources.

The MARCO programs are:

- COVID-19 Isolation and Recovery Sites for people experiencing homelessness
- Substance Use Services at a COVID-19 Isolation and Recovery Site
- Evaluation of Outreach Supports for People Experiencing Homelessness in Toronto Encampments During COVID-19
- Toronto Developmental Service Alliance's Sector Pandemic Planning Initiative
- Adapting the Violence Against Women Systems Response to the COVID-19 Pandemic

In March 2020, a group of community agencies collaborated with the City of Toronto to begin offering COVID-19 Isolation and Recovery Sites (CIRS). CIRS provided services for people experiencing homelessness who: 1) tested positive for COVID-19; 2) were close contacts of someone who had tested positive; and 3) people who were awaiting COVID-19 test results.[3] These 3 groups of people required isolation under the Toronto Public Health Class order.[4] This report details the results of an evaluation of the comprehensive substance use services offered at the CIRS.

The Population

Early in the pandemic, public health guidelines for self-quarantine at home following a COVID-19 diagnosis or close contact with someone with a COVID-19 diagnosis were quickly developed for housed people. The need for spaces where people experiencing homelessness could isolate was quickly identified as a critical measure for preventing viral spread within the community, particularly in congregate settings like homeless shelters. At the beginning of the pandemic, hospital emergency departments were not permitted to discharge people who were diagnosed with COVID-19 or awaiting test results if they did not have a safe place to isolate. This urgent need for isolation spaces led to the rapid development and opening of the CIRS for people experiencing homelessness.

For the purposes of this report, we define homelessness as: "the situation of an individual, family, or community without stable, safe, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it."[5] In practice, the also CIRS served people meeting the Indigenous definition of homelessness[6], as well as people experiencing homelessness who were living in the shelter system or in encampments, and people who were precariously housed (e.g., couch surfing or living in a boarding house with shared bathrooms and kitchens). Additional definitions are listed in Appendix 2.

There are a variety of shelters are in operation across the City of Toronto for different populations, including families, women and children who have experienced domestic violence, newcomers and refugees to Canada, people experiencing mental health challenges, and people who use substances. All of these varied population groups were accommodated at the CIRS. The need to ensure that harm reduction supports and substance use services were available within the CIRS was identified early in the planning process, to mitigate harms such as withdrawal, overdose, and premature departure from the isolation site prior to the completion of the 10-14 day isolation period, if required.

While a wide variety of services and supports were provided to the clients who stayed at the CIRS, this report will focus specifically on the substance use services (SUS) that were provided at the CIRS to people who use substances, including: alcohol; tobacco; cannabis; stimulants (e.g., crack cocaine, cocaine, crystal methamphetamine); and opioids (including prescribed opioid agonist therapy, safer opioid supply, and unregulated opioids from the street supply).

The Program

While 3 separate CIRS were in operation at different points in the pandemic period, this report focuses on the CIRS program that operated from

A Community-Based Study

MARCO included community-based investigators, many with lived experience, as full partners. The MARCO Community Committee has representatives from 11 community agencies, representing a broad spectrum of organizations. MARCO's steering committee includes both academic and community-based investigators. Each program evaluation team included at least 1 community investigator and hired people with lived experience as peer researchers. Across MARCO, researchers with lived experiences of marginalization were involved in all aspects of the study, from recruitment and interviewing participants to data coding and interpretation.

April 7th, 2020 to June 30th, 2021 at a hotel in Etobicoke. During this time period, there were a total of 2,840 stays at the Etobicoke CIRS, including 1,641 stays among people who were positive for COVID-19 and 1,199 stays among people who were awaiting a COVID test result or were close contacts of someone who had tested positive (with some individuals having more than one stay due to multiple tests or potential exposures) *(personal communication, City of Toronto).* Until June 30, 2021, this CIRS site was designated as an Alternate Care Facility of the University Health Network. The site continues to operate after June 30, 2021 under a modified governance model.

The CIRS operated as a partnership between:

- Parkdale Queen West Community Health Centre
- The Neighbourhood Group
- Inner City Health Associates
- University Health Network
- Shelter Support and Housing Administration, City of Toronto

The substance use services at the CIRS were seen as integral to facilitating the ability of people who use substances to complete a period of isolation for suspected or diagnosed COVID-19 infection. The substance use service was comprised of an interdisciplinary team of professionals, illustrated in Figure 1, including:

- Peer workers
- Harm reduction workers
- Nurses
- Primary care providers (nurse practitioners, family and emergency medicine physicians)
- Substance use physicians

Shelter staff from the Social Service and Housing Administration from the City of Toronto were also on-site at the CIRS to facilitate intake into the site from community partners, manage operations of the physical site and meals, as well as to facilitate discharge planning and referral to the shelter system or other housing options on discharge.

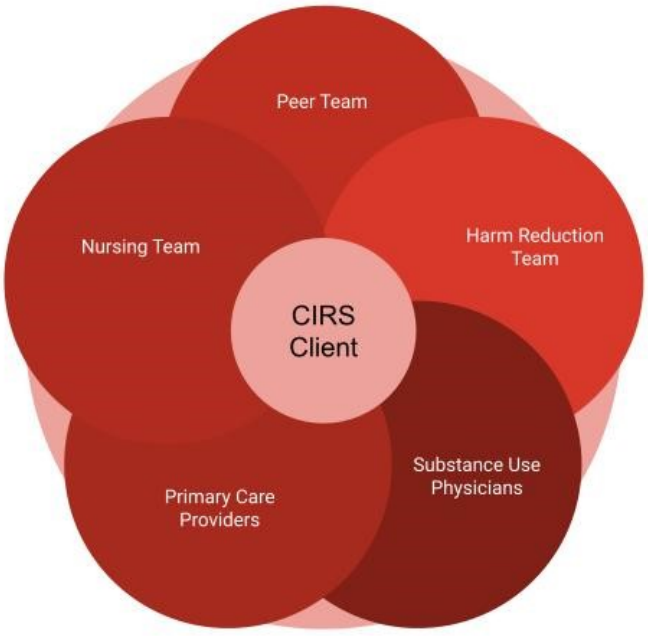


Figure 1. COVID-19 Isolation and Recovery Site Substance Use Care Team Breakdown

Peer team

- On-site 24 hours a day/7 days a week
- Workers with lived experience of marginalization, including mental health, substance use, or homelessness
- Role is to provide a connection point with clients and assist in accessing on-site teams and services
- Frequent interactions with clients such as taking people for breaks outside and providing snacks

Harm reduction team

- On-site 24 hours a day/7 days a week
- Workers with experience in the provision of harm reduction-focused services for people who use drugs
- Initially seconded from community-based harm reduction programs, later drawn from a variety of occupational backgrounds
- Role is to advocate for clients and provide harm reduction and social support
- Implementation of overdose prevention and response services
- Delivery of harm reduction training and supports to all teams

Nursing team

- On-site 24 hours a day/7 days a week
- Responsible for checking in with clients to monitor progression of COVID-19 related symptoms
- Facilitate access to medical care and medical teams on-site

Primary care team

- On-site approximately 8 hours a day & available virtually 24 hours a day/7 days a week
- Nurse practitioners, family and emergency medicine physicians providing general medical care
- Provides on-site and/or virtual medical care
- Monitor COVID-19 related symptoms, manage health issues
- Provides substance use related care and/or facilitates access to substance use physicians

Substance use physicians

- Available virtually 24 hours a day/7 days a week
- Physicians with specialized experience and training in the provision of medications and care for substance use and substance use disorders
- Prescription of medications (OAT & safer supply) for substance use and for the treatment of substance use-related conditions directly to patients
- Provides support and specialist advice by phone to the general medical team (on-site nurses, NPs, and MDs)

Substance use services

The goal of the Substance Use Services (SUS) was to provide comprehensive supports that would meet the needs of people who use substances – including drugs and alcohol — staying in the CIRS, while also facilitating a space where they could meet COVID-19 related care goals. The resulting interdisciplinary substance use services that were offered on site were a novel combination of community-informed harm reduction services and clinical care. Clients were able to receive personalized care with respect to their substance use goals while being connected with wraparound care. Services included:

- Harm reduction education and distribution of harm reduction equipment (including sterile injection equipment, and safer smoking and inhalation equipment)
- Provision of cigarettes and outdoor space for physically-distanced smoking
- A managed alcohol program (MAP)
- Prescription opioids and/or stimulants as treatment or as an alternative to unregulated drugs that people would buy themselves (opioid agonist treatments (OAT), safer opioid supply (SOS), stimulant medications)
- Prescription of medications to treat withdrawal from drugs or alcohol
- Services to prevent and respond to overdoses:
    - An on-site overdose prevention site (a room where people can go to use substances - primarily by injection - under the supervision of trained staff)
    - In-room witnessing when using substances by staff when clients requested it

- Telephone or in-person check-ins when using substances when clients requested it
- Naloxone distribution to staff and clients

Additionally, clients were not penalized, sanctioned, or expelled from the CIRS if they were found in possession of their own supply of unregulated substances (such as street-acquired fentanyl, crack cocaine, cocaine, and crystal methamphetamine) or if they were selling or sharing them amongst themselves, as long as they were respecting infection prevention and control (IPAC) procedures.

Client stay at the CIRS

During their stay at the CIRS, clients were provided with a hotel room consisting of their own bedroom and bathroom, three meals a day, and snacks on request. They were encouraged to notify the peer team if they needed to leave their own room to go outside. Each room had a landline that the client and staff could use. When applicable and following a consent process regarding the risk of spreading COVID-19, clients were welcome to share their room with an intimate partner, support person, or family member(s).

Upon arrival at the CIRS, clients underwent an intake with on-site staff, typically a nurse and a harm reduction worker (Figure 2). At intake, all clients were provided with a menu that details the substance use services available on-site, and were asked to identify their substance use-related needs (Appendix 3). If clients indicated that they had substance-use related needs, the harm reduction team would work with them to plan for how to meet their needs during their stay on-site, including the provision of harm reduction equipment and information regarding the overdose prevention site. If necessary, the client would also be connected with a member of the primary care medical team (physician or nurse practitioner) to discuss medical or pharmaceutical options to support them during their stay.

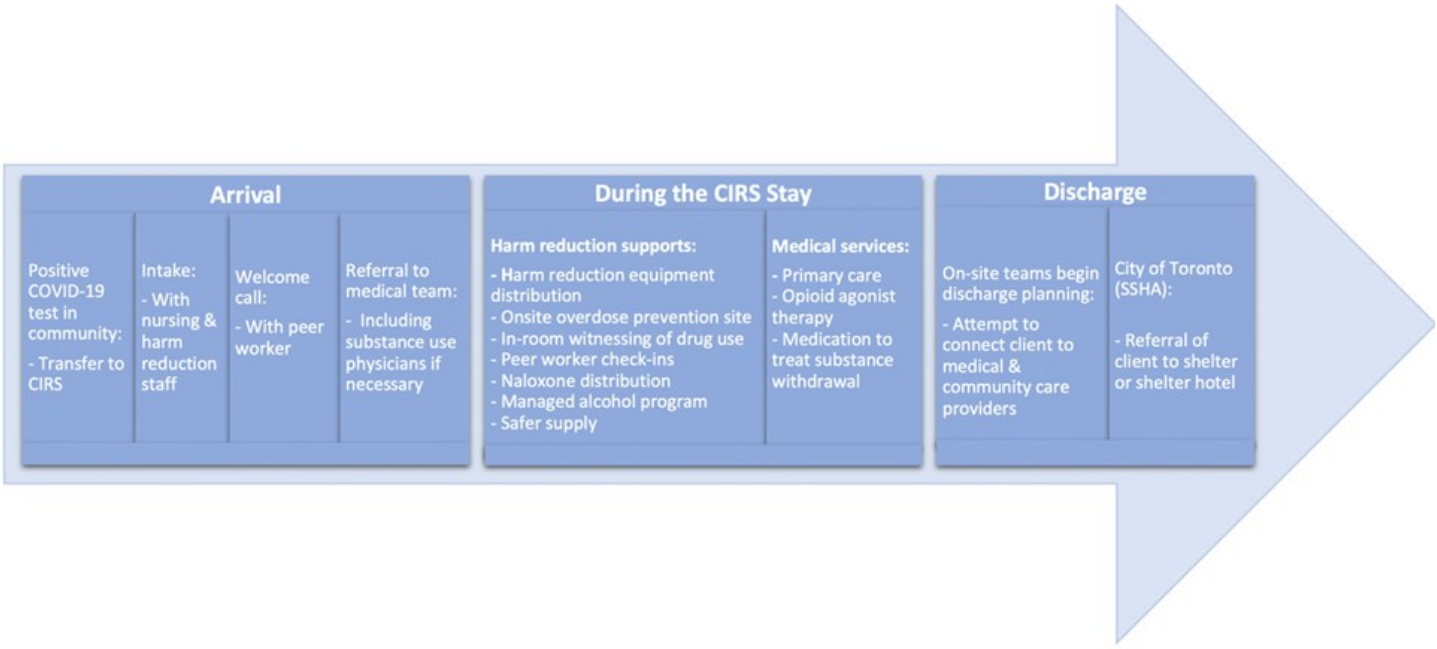


Figure 2: Access pathway for Substance Use Services available to clients at the CIRS

The majority of the supports available on-site were social care and were led by the peer and harm reduction workers. Harm reduction workers staffed the overdose prevention site and were also available to clients to witness drugs use in their rooms if the need arose. Peer workers were responsible for most of the client contacts on-site. This included connecting with all new clients during a welcome call, helping clients get acquainted with the site and the services available, conducting regular wellness checks, snack delivery, informal counselling, and taking clients on outdoor breaks (including for smoking).

Due to the recognition that some clients may not disclose their substance use or their substance use-related needs early in their stay, information about the substance use services available was also provided to clients in their hotel rooms. Peer and harm reduction workers continued to connect with clients when staff suspected that substance use related care might be helpful. Clients would often disclose their substance use related needs to peer and/or harm reduction workers in the days following their arrival on-site, which would then prompt a review of their care plan by the interdisciplinary team in order to ensure a holistic approach, and that they were receiving the substance use services that would best support their needs. Additionally, medical care for substance use could be accessed at any point during a client's stay at the CIRS through a referral from the peer, harm reduction or nursing team. Clinical substance use supports were also available from a team of substance use specialized physicians on call 24 hours a day to facilitate this.

Methods

Qualitative research methods were used to conduct a multi-stakeholder evaluation of the substance use services offered that operated at the CIRS at a Etobicoke hotel from April 9th, 2020 to June 30th, 2021.

Sampling and Recruitment

Our research team recruited 25 clients from the CIRS in April and May 2021 to complete in-depth, semi-structured qualitative interviews. During the months of April and May 2021, Toronto was in the midst of the 3rd wave of COVID-19, with lockdowns in effect and very severe outbreaks of COVID-19 within homeless shelter settings across the city. Due to this, the CIRS was frequently at or near capacity during this period.

All participants (n=13) who provided data on their source of income identified Ontario Works or Ontario Disability Support Program as their major source of income.

Table 1: Participant demographics - CIRS Clients

Characteristic	N (Total=25)
Racial/Ethnic Identity	
Indigenous	10
Black or Person of Colour	3
White	12
Gender	
Women	7
Men	16
Transgender, gender-fluid, gender non-	2

We also recruited 25 staff from the CIRS to complete in-depth, semi-structured qualitative interviews. All staff interviews took place in June and July 2021. A purposive sampling strategy was used to recruit 5 site staff from each of the 5 teams involved in the provision of substance use services: 1) peer workers; 2) harm reduction workers; 3) nurses; 4) primary care providers (nurse practitioners, family physicians and emergency physicians); and 5) substance use physicians. More detail on the methods used in this evaluation can be found in Appendix 4.

Due to small sample sizes in some categories, participants who self-identified as Black, Indigenous or a Person of Colour (BIPOC) were grouped together to ensure confidentiality and prevent potential inadvertent identification.

Table 2: Participant demographics - CIRS Staff

Characteristic	N (Total =- 25)
Gender	
Women	16
Men	7
Transgender, gender-fluid, gender non-conforming, or non-binary	2
Racial/Ethnic Identity	
White	15
BIPOC	10
Staff Team	
Peer worker	5
Harm reduction worker	5
Nurse	5
Primary care provider (Nurse practitioner, general	5
Substance use physician	5

Results

Findings from Client Interviews

Transition from Community to the CIRS

For a majority of clients, the process of getting tested for COVID-19 and transitioning to the CIRS was difficult and stressful. Clients described receiving little information about the testing process or what to expect in case of a positive result. Clients staying at physical distancing shelter sites at the time of their test described feeling "frazzled" and overwhelmed as they were rushed by shelter staff to provide contact tracing information and to leave the shelter upon testing positive for COVID-19. Some clients found having a support person, such as a partner, to be helpful during this process.

> "The staff was banging on my door, telling me that I was COVID positive and that anybody who had been in my room that night, I needed to trace back. So I emailed. I texted. I had four friends in my room. So all four of those people, and then the staff were like yelling at me in the hall. It was just such a bad experience. And then all of a sudden at like 8 o'clock that night, they were like, 'you're going to this hotel, the bus is here right now.' And I was like, 'what the…?' I wasn't packed or nothing. And they were threatening to call the police. And it was just really, really, really traumatic… I was so frazzled. Like, just the way that they did it, it was just so abrupt and it made me feel so unhuman." [CIRS Client]

Clients spoke of experiencing and witnessing stigma and discrimination from shelter staff following a COVID-19 diagnosis. Witnessing negative experiences can lead clients to delay seeking testing in order to avoid discrimination, or to avoid health or social services in the future due to fears of experiencing stigma or discrimination.

> "People probably don't want to get tested or come forward because of what they're seeing going on in the hotels. When the infection is pinpointed, people are made to look like they're being, you know, like they're so bad. Right? And you can't do it like that, because people are going to hide out. They're going to not tell nobody because they don't want to be discriminated or pulled out in front of everybody like that or alienated, you know what I mean?" [CIRS Client]

In addition to discrimination, clients reported not having their symptoms taken seriously by healthcare staff. Some clients were met with accusations of 'drug seeking' from hospital staff and clinicians when seeking out COVID-19 testing at a hospital.

> "When I went to *[name of hospital]* the first day, I said I'm feeling some symptoms. And they didn't want to take the swab tests…so they put me out. So they sent me to the *[name of shelter].* So I was there for just two hours. And then the shelter sent me to *[second hospital].* Then I got tested. Then I got tested positive … It seems like, it seems like they thought I was going through withdrawal but I wasn't going through no withdrawal … They thought I was going through withdrawal, that I wanted something and they didn't trust me". [CIRS Client]

Intake Process at CIRS and "Menu" of Services

While some clients had prior knowledge of the services available at the CIRS (e.g., from hearing from others or having stayed at the CIRS previously), most did not know what to expect. Upon arrival at the

CIRS, clients completed an intake with a nurse and a harm reduction worker and were presented with a written 'menu' of substance use related services. Clients found the menu to be a helpful format for learning about the services.

However, a number of factors negatively impacted the intake process. First, the testing and referral process was stressful for many. Some clients reported feeling unwell during this process (e.g., due to COVID-19 symptoms). Clients explained that this made it difficult for them to absorb all the information presented, and to discuss their needs at the time of intake.

> "I was out of it because of the overdose. So, like, even during that day, I don't remember it too much because of the overdose. It was a lot … But you guys were very helpful here." [CIRS Client]

Second, as part of the intake process took place in the lobby, some clients were reluctant to discuss their substance use related needs due to lack of privacy. Additionally, being able to have a support person at the CIRS allowed some clients to better advocate for their needs.

> "Yeah. It's like a very social thing out front, like with the people all there and stuff and like some people like that. But I'm like really introvert. Right? So, like, it took me a long time to come out of my shell. So like things that may have should have been said to the nurse, didn't get said. You know, and if I didn't have *[my partner]* to go: "Hey, make sure you tell them that you don't you can't eat this and you don't do that … " You know, like if I didn't have him, pushing me because he had already experienced it, it probably would have taken a long time to get those things implicated." [CIRS Client]

The CIRS provided information about available services on-site in multiple ways: at intake with the menu, in client's rooms on arrival, and during check -in calls with peers early in their stay. Data from this evaluation highlights the importance of having a variety of sources of information for clients on the substance use services available on-site, at multiple points during a client's stay, to reinforce information about available services and provide openings for clients to discuss their needs with staff members.

Summary of feedback from client interviews

The transition to the CIRS was a stressful moment for clients. Attention to the following points may help to improve client experience:

- Provide clients more time to prepare for their transfer to the CIRS and more information about the CIRS.
- Ensure more privacy at intake to facilitate client comfort in disclosing and discussing their substance use related needs.
- Reinforce information about services available at the CIRS at different points in their stay as clients may not be able to take in all the information presented at the time of intake.

Impact of staying at the CIRS on Substance Use

Overall, clients reported using less at the CIRS due to a combination of factors, including a change in environment, not having access to drugs from the unregulated market, feeling unwell due to COVID symptoms, a decrease in tolerance, and having access to OAT and SOS. While some clients were able to purchase unregulated drugs during their stay at the CIRS, the location of the CIRS away from downtown Toronto separated clients from familiar communities and made it difficult for many clients to purchase drugs from their usual sources. Additionally, loss of income during clients' isolation at the CIRS further restricted clients' ability to purchase drugs.

> Interviewer: "Then in terms of the use of fentanyl or crystal, did you feel like this, the pattern of consumption increased, decreased? Is it about the same quantity that you used to have?"
>
> Client: "No, it definitely decreased, probably by like 50 percent or more. "

Interviewer: “OK. Is that because you started on the safer supply program?”

Client: “Well that, and location and the fact that I have COVID, I can't access my resources financially.” [CIRS Client]

Some clients spoke about bringing drugs to the CIRS in anticipation of challenges accessing their regular supply of drugs once at the CIRS, and to mitigate possible withdrawal.

> “I knew when they made the phone call to me to come back, I made a point of not coming back before I secured some drugs for at least the first twenty-four hours. So that *[withdrawal]* would not happen until I knew what was going on, you know what I mean?” [CIRS Client]

A number of clients emphasized that they wanted to complete their isolation and not leave the CIRS to purchase drugs as it could put others in the community at risk.

> “I'm not the type of person that's going to go and infect people for my drug, you know, but it put me in a really tight place.” [CIRS Client]

Clients expressed concern about the risk of transmitting COVID-19 to members of their community and were willing to isolate in order to reduce the risks of COVID-19 to others. The provision of comprehensive substance use services at the CIRS was a key factor in supporting clients to complete their COVID-19 related isolation periods and help them to keep others in their communities safe, particularly for those who were living in congregate settings like shelters.

Access to Substance Use Services at the CIRS

Ensuring clients had access to a range of substance use services on-site was critical to enabling clients to look after their health and complete their isolation at the CIRS. Both the primary care medical team (available for on-site and virtual consultations) and the specialized substance use physicians (available to support primary care providers and for virtual consultations with clients) at the CIRS offered several medication options for people who used substances to initiate treatment, prevent and/or treat withdrawal, and facilitate the ability of clients to isolate on-site. This included safer opioid supply (SOS) with prescribed hydromorphone tablets (frequently referred to by the brand name Dilaudid in interviews), opioid agonist therapy (OAT) with methadone, buprenorphine, and slow-release oral morphine (frequently referred to by the brand name Kadian in interviews), medications and supports for people using stimulants, and medications to treat alcohol withdrawal, as well as a managed alcohol program (MAP).

> “If I had withdrawal issues with alcohol or the opioids and they just didn't want to do anything about it, I would have checked myself out. I wouldn't have felt good about it because I'm trying to be responsible. I don't want to spread the COVID. It would have done my best to be careful. But no, I would have to leave to get myself my alcohol and get myself my drugs.” [CIRS Client]

The provision of comprehensive medication options allowed clients to remain on-site to complete their isolation and recovery periods (as they did not have to leave to acquire substances), and to manage their substance use without withdrawal and discomfort.

Opioid Agonist Therapy (OAT) and Safer Opioid Supply (SOS)

Overall, clients expressed they were satisfied with the OAT and SOS programs at the CIRS. The provision of OAT and SOS allowed clients to complete their isolation without experiencing opioid withdrawal and discomfort. For clients who were prescribed OAT before arriving at the CIRS, continuation of OAT was mostly seamless.

> “When I got here, they asked me what substance issues I used… So I told them that I was on methadone but I was also using a certain amount of fentanyl and basically they gave methadone right away. I had to wait a day

Access to comprehensive substance use services including a managed alcohol program & medications like opioid agonist treatment & safer supply helped clients isolate on-site

for the Dilaudid because the Dilaudid makes up for fentanyl. But I've got no issues. I think the treatment here has been amazing." [CIRS Client]

Among clients receiving SOS, most did not have a prescription for SOS before arriving at the CIRS, though some clients expressed they had been interested previously.

"Yeah, I used a lot for the first two days I was here, then I had a consultation with the nurse practitioner. They put me on Kadian and I had a couple Dilaudids because I was worried just in case the Kadian didn't work. But it turned out that it worked OK for me… So I'm not gonna use anymore, like as far as I'm here with the Kadian." [CIRS Client]

Clients also provided feedback on drawbacks of the OAT and SOS programs. First, some clients reported wait times of up to a day for a consultation with a physician upon CIRS admission and irregularities in dispensing times, leading to withdrawal symptoms.

"Because my medications are not yet being dispensed at the same time every day, there's like a lag in between. So like a couple hours here, a couple hours there. But those couple hours are pretty bad." [CIRS Client]

Second, the quantity of SOS prescribed did not always meet clients' needs, which led some clients to supplement their SOS prescriptions with drugs from other sources.

"If it wasn't for me bringing my own dillies *[Dilaudid tablets],* my own stuff to sleep in, and my own pain medication, it would have been really hard. But I had stuff on me, so I just did it all myself through the experience. They gave me a bed to sleep in and that's about it. Couple of dillies, they gave me like four a day but that's not enough." [CIRS Client]

Some clients noted that they did not learn about the SOS program until later during their stay or until after they began OAT. Due to prior negative experiences with healthcare practitioners, some clients were reluctant to express their needs despite wanting to try SOS.

"I haven't really brought it up with the nurse. I figured, like, I don't know if I want to bring it up with the nurse because maybe they'd just be like, 'While you're here, you're on the methadone.' So why even bother? I'm not sure how that conversation would go." [CIRS Client]

Managed Alcohol Program (MAP)

Overall, the feedback on MAP at CIRS was very positive. Clients reported that MAP was easy and fast to access, and that having a MAP program on-site helped facilitate their isolation. Without MAP, clients felt they would be pushed to leave the CIRS to purchase alcohol, which they did not wish to do as it may put the community at risk. Clients were also able to receive anti-craving medications to reduce their alcohol consumption while on-site if they desired.

"So, she said that if I need alcohol, they will supply me 70 percent of what I normally drink. And then they said that that's a maximum of five beers. So, you know, that's been going well … I'm also on an anti-craving medication. So that's kind of helping as well, too." [CIRS Client]

One of the drawbacks of the program that was identified by clients was a lack of options for

different types of alcohol, as only beer and wine were available.

> "I don't drink that much that I have withdrawal, but it helps with the pain from my stomach cancer. So that's why I drink specifically vodka." [CIRS Client]

Stimulants

One major drawback of the substance use services available on-site was the lack of treatment options for stimulants.

> "They said not to worry about having to put anything together for my substance use, that they would provide everything and I'd be taken care of … But there's nothing to do with cocaine, nothing to do with the meth and I don't do opioids so … They have cigarettes, that's good." [CIRS Client]

While the lack of stimulant replacement therapy options has been identified in the substance use research and clinical literature,[7] the need to facilitate the isolation of people during the COVID-19 pandemic led some COVID-19 related guidelines to recommend stimulant replacement.[8] Some clinicians on-site did attempt stimulant prescribing, which will be discussed in the staff interview results section.

Summary of feedback from clients on substance use services

- Overall, most clients using opioids prior to coming to the CIRS reported that receiving a continuation of their existing OAT or SOS prescription, or a new prescription was a relatively smooth process. Immediate consultations with a substance use physician upon admission and more regular delivery of medications to reduce withdrawal symptoms for clients were identified as areas for improvement.
- Clients accessing MAP reported that the program was easy to access; more options for different alcohol types would have been appreciated.
- While there were some attempts at ensuring that stimulant replacement therapy was available for clients on-site, this did not translate into widespread access for clients.

Harm Reduction Equipment Distribution

Overall, clients reported high levels of satisfaction with and access to harm reduction equipment on-site, including injection equipment (sterile needles and syringes, cookers, filters, and sterile water) and safer smoking and inhalation equipment (crack stems and crystal meth pipes).

> Interviewer: "How quickly were you able to access what you needed? Was it quick enough?"
>
> Client: "Yeah, I just like when I called for a needle kit, they were here within five minutes or less. Same with the pipe, they were here right away." [CIRS Client]

Some clients reported experiencing wait times after requesting materials; some clients also recommended including more needles in the injection kits to avoid having to request the kits as frequently.

> "When you get this equipment, they only give like two needles in a kit. I think they should give a little bit more than that, the needles in particular, because, like, I might use two or even three needles at one time, Right? So, I find that to be a little on the low side. I think they should provide a few more like four or five needs in each kit." [CIRS Client]

Summary of feedback from clients on harm reduction equipment distribution

- Ensure more timely delivery of sterile injection and safer smoking equipment upon request and include more needles in each kit.

Overdose Risk and Response at the CIRS

Clients reported using drugs in their room—both alone or with a partner—and sharing with other clients at the CIRS.

> "We shared with each other because we have a little bit limited funds and not much. So we would pick up and just share with each other to help us and our addictions." [CIRS Client]

Many clients reported feeling safer at the CIRS than in other settings, such as physical distancing shelter sites, due to the availability of a range of overdose response options (e.g., telephone check-ins, overdose prevention site) and substance use services at the CIRS. Specifically, clients felt the availability of SOS reduced their risk of overdose.

> "There's no need for that because two Dilaudids is nowhere near as much as one point of fentanyl. Two Dilaudids is maybe a quarter point. So I could do a point of fentanyl and not OD so I'm not going to OD on two Dilaudids. I've only got one OD in my life and that was last summer. And that was because I did way more than I should of. The good thing about Dilaudids is, you're not going to get a hot dose - it's going to be standardized, it's going to be the same. My two Dilaudids I do today will be the same Dilaudid I do tomorrow, so overdosing is not an issue." [CIRS Client]

However, some clients also spoke about feeling at higher risk of overdose death as a result of having to isolate alone or due to separation from a close contact. One client recommended ensuring close contacts are not separated while at the CIRS.

> "Much higher risk here because you're isolating everybody. So they're by themselves, there's no one with them. So if they drop, they drop…I have a boyfriend. But they took me here. They left him there and they didn't even test him. So obviously he's positive. And so they just took me away from my boyfriend and threw me in a room for two weeks by myself. So if I had opioids and brought stuff with me, if I OD'ed, you would find me in the morning dead, there's no one else here." [CIRS Client]

Individual safety plans

When overdose was identified as an area of concern, staff members from all teams worked together with the client to put together an individualized safety plan that may have included using in the on-site OPS, frequent checks by a member of the peer, harm reduction or nursing team, or in-room witnessing. However, some clients preferred not to disclose to staff due to previous negative experiences with service providers and healthcare practitioners.

> "I'd rather have it where nobody knows I'm actually smoking … if they ask then I'll be straight up for it. But if not, then I don't bother advertising or anything like that because it's no one's business. I really care for people's judgments on how they look at people when they are an addict." [CIRS Client]

Overdose Prevention Site (OPS)

Clients were aware the CIRS offered an on-site OPS but none of the clients interviewed for this evaluation reported using the service. Some clients expressed feeling more comfortable using drugs in their rooms, due to consistent check-ins from staff. Other clients declined to use the OPS to avoid stigma.

> "I just I don't like this, you know, like it's not a cool thing to be doing, you know what I mean? Injecting. It's a little bit embarrassing. So I'd rather do it by myself, which is not safe. You know, it's more dangerous, but I don't know. I don't like people to watch. You know, it's not something that I'm proud of." [CIRS Client]

Clients also reported that they experienced nervousness or embarrassment from injecting in front of other people.

> "I get more nervous using around people … It's just easier for me to do, it's needles, I got to find the vein and do all that stuff. So I get nervous and it's hard to do." [CIRS Client]

Clients' decisions to not use the OPS were also linked to a lack of perceived overdose risk due to being a part of the SOS program and receiving a known dose of Dilaudid, which they perceived put them at lower risk of overdose.

> "I have used such services *[OPS]* before… I'm not really concerned about the safety anymore since I've switched to Dilaudids from fentanyl." [CIRS Client]

Some clients also expressed that the COVID-19 symptoms they were experiencing made it difficult for them to use the OPS. Here, the wellness checks and offer of in-room observation of drug use (particularly for those isolating on their own, without a partner or friend) were an important overdose prevention and response tool.

> Interviewer: "Were you offered to use the OPS room?"
>
> Client: "Yeah I was, but I was too sick … I couldn't even move out of my bed."
>
> Interviewer: "And were you offered to get any follow up calls to check in, like a wellness check?"
>
> Client: "Yeah, but my partner was like: 'I'm always here with her. Like if she goes on the nod, I'm always watching her like so …' But that's an awesome, like an awesome thing to have those checking calls, those are an awesome idea. Cause for a lot of people … they say, don't use alone. And like before I met *[my partner],* all I did was use alone." [CIRS Client]

One major drawback of the OPS at the CIRS was the lack of a supervised smoking or inhalation area on-site. There is a general lack of access to supervised smoking or inhalation spaces in Canada, even though there is a particular need for them with increased rates of overdose associated with smoking fentanyl.[2]

> "I used the *[OPS]* at Moss Park just to try it out, like the tent. It was only up for a short period of time, but it was really cool. I liked that they had this outdoor smoking area where you could go and smoke your fentanyl." [CIRS Client]

Telephone and in-person check-ins

For clients who preferred to use in their rooms, check-ins were conducted by telephone or in-person by staff from the peer team several times a day, and especially after providing a client with sterile injection equipment.

> "Almost every time they brought the kits, they told me about the safe injection site, and they ask me what I'm exactly doing, and if they want me to make a call, if they want to call back, I usually say no, but sometimes they call anyways … I think it feels a little bit intrusive to me, but I think it's necessary." [CIRS Client]

CIRS staff worked together with clients to develop individualized wellness plans. However, while clients were understanding of why routine telephone or in-person check-ins were necessary, they found the checks to be intrusive at times.

> Interviewer: "Those wellness checks that you get over the phone or are at your door, do you feel they are intrusive, or do you feel it's a good thing?"
>
> Client: "Fifty-fifty. It's nice to know that you're doing your job, I guess, but at the same time, it kind of kills my buzz." [CIRS Client]

A number of clients indicated they preferred telephone checks over in-person checks as it was less interruptive.

> "If it's just going to be two times, it's OK… But I don't need the harm reduction team to check in on me as much as they did. Once in while I'm totally OK with. Two for today, fine. But I just don't want we get like 20 phone calls a day." [CIRS Client]

Compared to other settings, some clients felt the check-ins were less invasive at the CIRS due to the positive relationships they had developed with the peer workers. Many clients reported that the staff from the peer team at CIRS made them feel very welcome overall.

> "I feel safer here. Yeah, 100% safer. Even with the check-ins…Way, way less invasive here.

The comprehensive substance use services offered at the CIRS resulted in clients expressing that they felt safer in CIRS than in other shelter settings

They make them more welcoming. They actually make you wanna talk to them, you know, as opposed to at the other place where it's like they walk in and it's like it's more about 'What are you up to, what are you doing, who's in your room, what's going on?' You don't feel like they're there for you or for your wellness. They're more there just poking around." [CIRS Client]

Summary of feedback from clients on overdose risk and response

- Fears of facing stigma when accessing the on-site OPS and discomfort injecting in front of other people were reported as reasons for not using the OPS among clients in this evaluation. This underlies the urgent need to address stigma and discrimination against people who use drugs in health and social services more broadly.
- In-room monitoring of drug use and telephone and in-person checks are important additional tools to ensure safety. Telephone check-ins were preferred over in-person check-ins.
- Avoid unnecessary separation of close contacts, as they can monitor each other while isolating together.
- There is a need for supervised smoking and inhalation spaces to accommodate a wider range of drug consumption preferences.

Discharge and Discontinuity of Care

Discharge from the CIRS was a stated source of anxiety for many clients. Most clients expressed that they did not know what to expect following discharge, including a lack of knowledge of where they would be staying within the shelter system after discharge, and which prescriptions they would continue to receive upon discharge.

"The discharge? I guess once I get some more answers, I'll feel a lot better about the discharge, I just wish I could get some more info… Where are they going to take me? What prescriptions are they going to give me? I don't like not knowing what's going on, once I know what's going on, I'll feel a lot better about my discharge." [CIRS Client]

Clients receiving OAT at the CIRS were informed they could expect to continue OAT in the community once discharged. However, due to lack of SOS prescribers in the community and a reluctance of addiction medicine physicians providing OAT to continue prescriptions for SOS clients, many clients were informed that SOS would likely be discontinued upon discharge.

"They said, basically, we'll make sure you get your Dilaudids while you're here, but when you leave, the prescription will not go with you. It ends when I leave here. That's what I was told. So I just assume once I'm on the outside again, I'll take my methadone and I'll buy my fentanyl again." [CIRS Client]

The inability to continue SOS following discharge was highlighted as an issue for all clients receiving it; clients highlighted that they did not want to return to using fentanyl following discharge. Additionally, many clients expressed that they wished to continue receiving SOS following discharge because they thought that they would continue to benefit from SOS in the community, particularly after having been stabilized on SOS at the CIRS.

"I feel that's ridiculous, that you've got me on a safe system while I'm here and now you put me out into the into the world and I'm going to be

back on using a drug *[fentanyl]* that will probably kill me on day." [CIRS Client]

Another major factor in the anxiety many clients expressed around discharge planning was the lack of affordable housing in the City of Toronto, which had led to a rise in encampments during the COVID -19 pandemic. At the time interviews were being conducted for this evaluation in spring of 2021, encampment evictions were being conducted across the city, leading to client uncertainty regarding whether the encampment they had been living in (and their belongings) had been cleared or not.

"I don't even know. I'm not sure. I don't know. I'm not even sure it'll still be there *[encampment they were staying in prior to the CIRS].* The city has been talking about removing those campsites, so I'm not even sure it'll still be there." [CIRS Client]

Clients expressed that they expected their discharge from the CIRS and transition to homeless shelters in the community to be stressful. This was due to the uncertainty regarding which shelter (and which area of the city) they would be placed in, as clients had little say in their post-discharge placements.

"I really don't know, it depends on where I go. It all depends on the environment for me. And what support I have … I'm not really looking forward to it, not right now. That's because I'm not sure if I'm going right back to this same thing I was doing, or am I going to be maybe get some place where I can actually do something?" [CIRS Client]

For some clients, they were being discharged back to shelters or sheltering hotels where they had been staying prior to the CIRS. However, for some of these clients, discharge represented a loss of stability and the intensive supports that had been available and had benefited them during their stay at the CIRS, as these supports are currently not available within the shelter system or the sheltering hotels.

"I like where I am right now. I'm just starting to get my feet on the ground. I don't want to have to change it, I need a moment to just collect myself. And take some time for self-care and get my mental health together and everything together before they start moving me around and back into Scarborough, into the *[sheltering hotel]* there. Cause it's a totally different lifestyle out there." [CIRS Client]

Summary of feedback from clients on discharge

- Discharge was identified by clients as a major source of stress and uncertainty.
- Early discussions around discharge planning and knowing where they would be stayed post-discharge may be helpful to alleviate this.
- A combination of lack of capacity in existing community-based SOS program and lack of clinicians outside of existing SOS programs willing to prescribe SOS to clients who received it at the CIRS was a major issue in discharge planning. This represents a major risk factor for overdose but also a missed opportunity to continue care for patients who were stabilized on SOS during their CIRS stay.

Overall Experience of the CIRS

Overall, clients provided positive feedback regarding their time at the CIRS. Clients spoke positively about their interactions with staff and appreciated the range and quality of substance use and harm reduction services that were provided at the CIRS.

"Honest to God, like everything here has been so amazing…The harm reduction team here is amazing, like they will go above and beyond to make you feel comfortable, like down to a cup of tea, down to snacks, down to, you know. They're just a really good team here… And it was like way better to get here and find out that this is where I was going to be because I didn't know." [CIRS Client]

When asked about experiences of stigma and discrimination at the CIRS, clients often noted that

their experience at the CIRS was better than previous experiences at hospitals and other shelter sites.

> "People were very nice. So the staff are all very nice about it. Much nicer than, say, *[hospital name*]. I didn't like that. I've noticed that. I know my friends and those at *[that hospital]* in particular. So some of my friends and I noticed a lot of that attitude. Negative attitude." [CIRS Client]

Findings from Staff Interviews

Interviews with staff at the COVID isolation and recovery site (CIRS) were conducted with staff from five teams: peer support, harm reduction, nursing, primary care providers, and substance use physicians. We identified five major themes in the staff interviews, which are presented in the first section below. We also present insights into the substance use services and interventions offered to clients from the perspectives of members of each team at the CIRS.

Care model and principles

The ability to say "Yes": Provision of client-centered care

Staff described an unprecedented ability to provide supports and services to clients receiving substance use services at CIRS. Unlike in other community and clinical settings they had experienced, the interdisciplinary staff team was able to readily provide a wide variety of both medical and harm reduction interventions.

> "I think it was it was a good space, it obviously had it's hard moments, and it was a high stress environment at times. It was kind of like a roller coaster because it was very dependent on how many people were coming, how many clients we had on site. But we were always kind of prepared … the good thing about the site is that we have is adaptability. Like we were always ready for whatever came at us. And if things got hard, then everybody would kind of get in together and sort it out." [Harm reduction worker]

The substance use services needed to be comprehensive yet flexible enough to adapt to the wide variety of needs of clients who arrived on-site for their COVID-19 isolation periods.

> "We had very simple scenarios, like people who were fentanyl users but didn't have health complexities, and really just needed a stable script and were good, like easy-peasy people that kind of flowed through the system that way. So they were really like simple to manage on-site. We had people who had massive complexities that had substance use with regards to opioid use, like fentanyl and all the lovely analogs, plus benzos, plus alcohol, who experienced very frequent overdoses in the community. And so being creative around solutions with those folks, like I'm so surprised that not more people died. I know that's morbid, but given who came through the sites where they came from and their level of use with street supply. That's so immense" [Harm reduction worker]

The high level of wraparound substance use supports was possible due to comprehensive staffing of multiple teams both on-site and on-call, including having peer workers, harm reduction workers, and nurses available on-site 24 hours a day, with substance use specialized physicians available on-call 24 hours a day. Staff were able to adjust the degree of care and monitoring clients received based on ongoing consultation with them, where transparency about the wide variety of substance use services available facilitated an environment that promoted openness about people's substance use and related needs.

> "I don't know how many addiction consults I did at 11 o'clock at night to get people on safe supply? It had to be thousands. Even to be able to have that conversation with people to say it's an option, it's here for you and particularly where a client was like, "I didn't bring anything with me …" And I would say, "Well, why don't we arrange an addictions consult so that you don't get dope sick and see how you like it? There's no harm in giving it a try, yeah?" And often it would open the door to them to try it, and there were a few successes where clients left on safe supply and went to hotel programs where it would be continued." [Harm reduction worker]

Importance of Interdisciplinary Teams

The interdisciplinary teams at the SUS were highlighted as an integral aspect of the CIRS environment. Diverse expertise across all staff roles, combined with close collaboration and ongoing communication contributed to an adaptive approach

to promoting client well-being, providing access to substance use services, and preventing overdose. Participants described a team environment that attempted to disrupt traditional hierarchical power structures in clinical environments by centering the expertise of the harm reduction and peer teams.

> "Historically, clinical services were able to erase or exclude harm reduction from the conversation because things had traditionally been so normalized and siloed around how the model, the medical model or the model of care typically unfolded. And then as it came to fruition in the recovery site, it was absolutely impossible to work in silos. Like you could not operate that way, even though there were efforts to remain siloed. So that led to very significant philosophical and practice conflicts that needed to be negotiated over long periods of time … I think that one of the biggest pieces was that the primary goal of the recovery site was to support people in their isolation. And so we had to have a practice and philosophical shift as a whole in order to support a public health goal." [Harm reduction worker]

Participants also emphasized the importance of having access to the different staff teams, as they brought distinctive skillsets that contributed overall to the ability to effectively support client safety.

> "It's not one team can do it all. When we do have clients that are that are identified as high risk, it takes different professions with different expertise to help the client … You need to be able to address the needs at the time and the needs of the clients … It's multifaceted and that's why working with a diverse team helps you address and tackle the issue from different perspectives because it's different issues." [Nursing team member]

Many staff spoke of the ways in which members of all of the teams needed a period of adaptation to the unique model of care that had been established at the CIRS, where the roles of team members within client encounters and in the provision of client services had to be negotiated beyond the roles that many were used to in their previous work environments.

> "And I think that for people that are not used to working in a place with doctors - which is a lot of our team - like a lot of our team, do not work in a health care setting before or if they have, they worked in a health care setting that doesn't typically have physicians in it … because there's this really novel dynamic where a lot of physicians are not used to working with peer workers or harm reduction workers either. And so this new way of how do we actually provide collaborative care and figuring out how we get on the same page before we go into the clinical encounter and come up with a bit of a plan together for like, 'I'll take the lead on this part. You take the lead on this part. Let's figure out what the dynamics of interaction are going to look like'. That's pretty new and I think for an increasing number of practitioners they got to a place where that was working, but has taken a lot of work and I think probably continues to be an ongoing challenge." [Primary care provider]

Tension around harm reduction principles

Despite the overt mandate of the CIRS to centre harm reduction when working with clients around substance use, interviews with staff reflected both covert and overt tensions around harm reduction principles. Covert tensions around harm reduction principles emerged through positive bias towards abstinence from drug use, as well as assumptions that linked reduced drug use with stability and success for clients. Some staff who struggled with harm reduction principles explored these tensions in interviews.

> "You know, I think a lot of people have this idea of what rehabilitation looks like or a success story, and that's all relative. I can see how people within my situation or a similar situation could look at someone experiencing homelessness or experiencing addiction and say like, 'Oh, it would be great if they got clean and got a job and became a functional member of society'. That - to a lot of people - is what 'success' looks like. So understanding that, you

The collaboration between on-site interdisciplinary teams fostered a rapid learning around harm reduction

know, someone who continues to use drugs throughout the rest of their life, that is not a failure, necessarily. So I think my perspective on what success means has definitely changed. And so it doesn't mean that people need to stop using drugs. And that's also a principle of harm reduction. It's like they can continue doing what they're doing, just doing it in a safer way. So, if you want to continue using drugs for the rest of your life, OK, that's your choice. How can we get you just into a better living situation so you're not sleeping rough? You know, things like that? I think that has broadened my perspective." [Nursing team member]

Many staff - particularly clinical staff from nursing and medical teams - highlighted the rapid learning curve they experienced at the CIRS in relation to learning about and employing harm reduction principles in their work.

"I think the site provided a lot of people from the medical and nursing site with lots of challenging cases in terms of understanding how to support one's autonomy and meet them where they're at. Even when, from our perspective, that seemed to be so risky. Like, they're routinely taking risks with their life, and particularly with something that we perceive as really problematic, and so how do we try to meet them where they're at in that case? This was a major source - like personally - a source of discomfort and work, and also for a lot of medical team members. And it was very helpful, I think, in those circumstances, particularly to have the harm reduction team who are really oriented in that philosophy of supporting autonomy to help us work through a lot of that." [Primary care provider]

High stress work environment

Staff interviews captured the stress experienced across all staff roles at the CIRS in relation to substance use, due to the ongoing overdose crisis. Particularly for staff working on-site, the critical situations arising from overdoses contributed to an acutely intense work environment. Despite being rare, experiences with fatal overdoses created feelings of grief and guilt amongst staff, in addition to intimate understandings of the difficulties that clients face within and outside of the CIRS.

"The managerial team takes a lot of initiative in allowing people to have access to resources whenever you go through something as highly impactful as an overdose response. And we have lost clients at the site. So we do have grief circles where we're able to kind of feel those emotions around the loss of the client. But yeah, just finding a self care team that helps you, because it is the kind of work that's very emotional and it takes a toll on you." [Harm reduction worker]

Staff members mentioned that organized forms of support offered after critical incidents like debriefings and healing circles. Staff from the peer and harm reduction team also mentioned offers of support from their managers on-site. While these were viewed as helpful, staff also highlighted how the regular day-to-day challenges of meeting client needs could be very intense. This stress was further exacerbated during periods where there were multiple shelter outbreaks and the CIRS was at full capacity and very busy. Staff members often provided each other with support in these moments.

"I think there was also mutual aid between harm reduction workers. In terms of us

supporting each other … I think it was just organic. We were in the midst of a lockdown, particularly the first lockdown, if you go back to the very first lockdown when we opened the site. There were very few people around outside right there. There was really nothing open. You really were isolated. And so your colleagues became your people. So it just kind of organically grew that, you know, "How are you doing? Anything I can help you with?" Sometimes some of us stayed a little bit after shift just to have that social interaction." [Harm reduction worker]

Further, the effects of the COVID-19 pandemic was a perpetual stressor for staff, in addition to the high intensity work environment of the SUS.

"You know, I think I think the struggle is that we as workers are still dealing with the consequences of a pandemic as well. So obviously it does take a toll on us, because we also have outside lives that are impacted by the virus. And so it's a struggle sometimes because we're in the midst of it. But we're also providing support for our clients." [Peer worker]

Tools that were identified by staff that helped reduce stress related to client substance use on-site included: each worker having naloxone on their person during their shift; having protocols in place and known to staff to guide the response to critical incidents on-site; the use of 'codes' to quickly communicate across teams and ensure back-up during critical incidents; and having a white board in the staff room to convey major priorities for each shift. Teams also highlighted the importance of working together to assist clients with complex care needs.

"If we have a complex client who needed extra care and attention, we divided that extra care and attention among the three teams to make it manageable. So sometimes we had every half hour checks on somebody who had a history of multiple overdoses, we would divide those checkpoints up in terms of nursing, doing a check then peers, and harm reduction." [Harm reduction worker]

The clinical teams highlighted the importance of several tools and resources to support their work, including: having access to a handbook for substance use team members; clinical guidelines for prescribing that were developed by the members of the substance use team from CIRS;[9] and access to an addiction medicine specialist on-call 24 hours a day. They underlined that these were key resources that supported the development of competencies around the provision of clinical substance use services on-site.

Interviewer: :"And have you used that or consulted with the substance use manual that was produced?"

Staff: "Every day, I've got it right here. I have a printout, every day I use it. "

Interviewer: "OK, so I'm guessing then that it's a helpful tool."

Staff: "It is. I would say originally in the beginning when I first started, I was I was using it a lot more just to kind of like confirm and just to kind of like, verify. I also really like to touch base with the addictions on-call docs a lot." [Primary care provider]

Broader lack of resources and support in the sector for people experiencing homelessness

One of the major reflections among staff working with people who used substances at the CIRS was concern about what would happen to clients' substance use following discharge, once they left the CIRS. Providing continuity of care for clients post-discharge proved extremely challenging for staff, for several reasons.

First, discharge from the CIRS frequently happened very quickly and with sparse information regarding the location in community where clients would be discharged to in the community. This left limited time to arrange referrals to community resources that could continue to provide health services or medications that had been prescribed on-site.

Interviewer: "So to make sure that they would continue with medications after their discharge

from the site - were there ever any bumps in the in the road with all of that? Did you hear from any clients who had issues with the process or anything like that?"

Staff: "It is like after they leave, they leave. So we have no information about what happens next…there were a couple of clients who were frequent visitors, at least on a monthly basis. So you already knew them and you were very familiar with that. But there are others that you just never heard about again." [Harm reduction worker]

The lack of appropriate services and funding to address the housing and overdose crises, exacerbated by service closures during the COVID-19 pandemic, as well as widespread stigma towards drug use were all described as urgent, ongoing threats to client health that preoccupied staff.

It was widely recognized by staff that the temporary environment of the CIRS might be providing a reprieve for clients, but that the overall lack of services across the sector did not offer sustained opportunities to support client health and stability following discharge.

"People would say this over and over again at the time of discharge, which always sticks out to me, "You're sending me back to the exact same place that I've kind of come out of". And they are kind of stabilized now after two weeks… that speaks to the lack of community housing, the lack of like, health care can only solve so much. And I think that's probably the biggest piece that I find is we do all of this and then we send people right back to that same space. And that's always kind of disheartening to hear. And you're kind of trying to understand how you can best support and move the needle forward. But like, no amount of, like, medication is going to solve that in my mind." [Primary care provider]

For staff of the CIRS, the lack of continuity of care and difficulty in ensuring follow-up led to moral distress from the uncertainty regarding how clients would fare when they returned to the precarious conditions outside of the CIRS. Staff described being frustrated at having resources available to support people on-site at the CIRS, but then lacking an equally well-resourced system to provide continuity of care once they no longer required COVID-19 related isolation.

The issues around continuity of care were particularly apparent around continuing prescriptions for SOS. While prescribers spoke of being able to refer to addiction medicine physicians in the community to ensure that clients started on OAT could be continued on these medications following discharge, there were difficulties in ensuring continuity of care for people started on SOS at the CIRS. Participants highlighted that this was due to a lack of SOS prescribers in community; both because existing SOS programs were small and lacked capacity to take on the volume of people being discharged from the CIRS, and because there was difficulty in finding addiction medicine physicians or RAAM clinics that would continue SOS for clients who had been initiated and stabilized on it during their stay at the CIRS.

"Often it was a conversation about how when you leave here, the hydromorphone wouldn't be continued. Like there were a few people that we managed to get into programs *[SOS programs in the community].* I took over a small number of people. There's limited numbers of people who are willing to do this *[SOS prescribing]* at this point." [Substance use physician]

Despite the issues around continuity of care for people who started on SOS during their CIRS stay, some staff expressed optimism that the support for capacity building for providers that occurred within the CIRS may translate into more familiarity and capacity across the health system to provide SOS more broadly.

"We see huge issues around continuity of care. But I look at it as the hope and possibility from it, at a systems level…what it added from a systems lens is creating an entire new cohort of providers that have familiarity and comfort in providing *[SOS].* So I think from a systems

The lack of broader resources in the community to support continuity of care following discharge from the CIRS was a major issue and created significant moral distress for staff

perspective, the capacity building element is invaluable. Like you can't put a number on that because what we know is out in the world, there's so many blockades to having providers participate and provide safer supply. And so this really gave an opportunity for learning and teaching and onboarding and normalizing this. And I think it really helped people leave the abstinence focus paradigm around how we treat addictions." [Harm reduction worker]

Summary of feedback on care model and principles

- The unprecedented range of resources that staff could use to support CIRS clients was an effective intervention to promote safety and ensure dignity for clients of the CIRS.
- Many clinical staff experienced a rapid learning curve around the application of harm reduction principles in their work.
- The ongoing overdose crisis combined with the COVID-19 pandemic created a high intensity, stressful work environment for CIRS staff.
- Disrupting the traditional hierarchy of clinical care and integration of the expertise of peer and harm reduction workers benefited both staff and clients at the CIRS.
- The lack of broader resources in the community to support continuity of care following discharge from the CIRS was a major issue and created significant moral distress for staff.
- Lack of housing and lack of prescribers for safer opioid supply in the community meant that clients who were stabilized at the CIRS were discharged into precarious circumstances, putting at risk the gains made during their time on-site.
- Structures that were identified by staff as contributing to and exacerbating the marginalization faced by CIRS clients include: lack of safer opioid supply prescribers; lack of housing due to the affordable housing crisis; the overdose crisis; and medical stigma towards people who use drugs.

Staff Roles

Peer Workers

Members of the peer team were workers with lived experience of marginalization, whose role included being the primary on-site contact point for connecting clients to other teams or on-site services, as well as for social needs (chatting, taking people outside for breaks or to smoke). Peer workers were on-site 24 hours a day, were in frequent contact with clients, and had the highest number of touchpoints with clients among any of the CIRS staff teams. Peer workers would also engage clients in discussions about their substance use, their safety needs, and their general state of mind during their stay at the CIRS.

"So basically peer support workers are front line workers who have lived experiences, whether it's homelessness, mental health issues, addiction, substance use, and basically for the point of contact with clients. So often times when clients arrive at the shelter, they get assessed by nursing and by harm reduction, and then peer support workers take over. We're responsible for regular engagement with clients, anything they need, whether it's snacks, whether it's going outside for smoke breaks. We're basically the point of contact. But more importantly, we're also the ones that build a rapport and relationship with the clients. And I

think that's really important just in terms of collecting information and to overall understand how best to support them, and relaying that information to harm reduction and to nursing that in order for them to put together a better plan for them during their stay." [Peer worker]

As staff with firsthand experience with substance use, mental health concerns, and/or homelessness, peer workers were often clients' main point of contact to access the on-site substance use services, and were often advocates for clients' unmet needs with other staff teams. Other staff teams frequently highlighted the crucial role played by peer workers in connecting with clients, broadening their understanding of harm reduction, and adding an essential element of community-grounded knowledge to the care delivered at the CIRS.

"What makes the site so unique and why many of us just loved working there was the involvement of non-medical team members, and really trying to incorporate a nonmedical model as much as possible…So really, I think the biggest thing was having harm reduction workers, as well as peer support workers, the city of Toronto staff, social workers, just having such a big involvement of the social side of care." [Primary care provider]

While the importance of the peer workers on-site was highlighted by staff across all teams, a small number of staff raised the issue that the peers could have been better utilized on-site.

"Peers were really important in their interactions with people. When you talk to the peers, they're mostly feeling like they're just cigarette running fools. And actually the peers have come to us like, "Thank god I'm not in that job anymore. It's a horrible job". So we really want to refocus the role of the peers, in being supports for people beyond just cigarettes." [Primary care provider]

Harm Reduction Workers

The harm reduction team is one of the first teams that connects with clients upon arrival at the CIRS. These initial interactions with clients involved assessments for substance use, mental health history, and safety plans regarding substance use or suicidality. An essential part of this role involves transparent conversations with clients that hinge on a non-judgmental approach towards clients' substance use.

"So the harm reduction team is that one of the first teams that has interaction with the clients when they first arrive. And then we're responsible for the intake process. We have a list of questions, but obviously, we kind of make it into a conversation, and that way you make the client feel a little bit more comfortable to share. So we would ask the very general questions downstairs because the nursing team, as well as the City of Toronto team, requires some information before we take them up to their room. And then up in the room, they were in a private space and more comfortable space, and we were asking the more private questions in a way. So if they had or if they were using any sort of substance, like where were they going to use it here, or where they're not going to use it and how often they use it, how much they use and what kind of supports they need because they are sitting at an isolation site that's kind of very far away from their usual location of interaction. So we would ask them, what would you need from us then, please? Like, never hesitate to call us at any time." [Harm reduction worker]

The harm reduction team adjusted their approach to supporting clients based on the disclosed frequency of drug use, as well as clients' substance of choice, and the clients' stated preference for monitoring and support during substance use. Harm reduction workers were responsible for working with clients to prevent and manage substance use and overdose on-site. At times, when there were large numbers of people who use drugs on-site at the same time, it could be

challenging work, involving frequent checks on clients in their room.

> "You know, constantly doing wellness checks, room to room to room with my pulse oximeter, checking, bringing their stats back up. Making sure they're OK and then going on to the next client, and then coming. Coming back. And then in the midst of all of that, finding an unwitnessed overdose … one time I counted 22 fentanyl users in the building at once." [Harm reduction worker]

In addition to working with clients around substance use, staff from the harm reduction team also highlighted the frequency with which they were called upon to use their skills in de-escalation and crisis management in their role.

> "We deal with a fair amount of crisis and complexity in our clients. I think my experience in de-escalation and crisis intervention was really helpful at the recovery site, for we had a number of code whites [*person experiencing agitation]* over the time I was there. I responded to a lot of code whites. And de-escalated a lot of clients over the course of the time that I was there." [Harm reduction worker]

Nursing Team

Staff working on the nursing team were involved in conducting the initial health assessment with clients when they arrive on-site, performing daily vital sign checks with clients, helping to develop client care plans, assisting clients access their medications, and liaising with the other staff teams to inform policy and procedures at the CIRS. Nurses provided clinical support at the overdose prevention site and offered concrete clinical assistance to substance use service clients through coaching them on injection practices and injury prevention around substance use.

> "So mainly assessment of client needs, whether that be at intake, identifying that they are on medications and require a daily dispense on-site, so supporting people in isolation to be able to continue to get their prescriptions for things like OAT. Also assessing people for SOS while they're isolating so that they have a safer use while they're admitted, also doing various withdrawal assessments and also supporting with induction of either methadone or Suboxone, both in terms of actually administering the medications as well as follow up assessments. And then communicating with the physicians about those assessments, dosing, prescription refills, things like that as well." [Nursing team member]

As with other staff roles, some nurses came to the CIRS with limited harm reduction experience. This prompted some members of the nursing team to experience a tension between working to support traditional, abstinence-based ideas of health with support for client autonomy around substance use. However, the novel environment of the recovery site, which included the high involvement of the peer and harm reduction teams, facilitated rapid learning around harm reduction principles.

> "Some of the barriers, I think, would be what I described earlier with nursing. Integrating, maintaining safety while also respecting autonomy, I think is a challenge, especially when people are alone in a hotel room, they're away from their supports, they're outside of their normal safety contacts that they have with their peers. And so that's been a challenge … I think another barrier is people who don't come from a harm reduction background, who perhaps are well intentioned but don't necessarily fully understand the scope of harm reduction." [Nursing team member]

Primary Care Providers

The team of primary care providers working at the CIRS included nurse practitioners, family physicians and emergency physicians. They provided general medical care, monitoring COVID-19 related symptoms, ensuring the continuation of prescribed medications, and prescribing new medications while clients were on-site. They also provided substance use related care if they had previous experience doing so, or arranged referrals to the specialist substance use physicians if necessary.

Client consultations also included discussions with clients to clarify substance use goals during their time at the recovery site.

> "My initial role was as the on-site physician at the recovery site. So that would entail a mixture of meeting clients either directly in the clinic room or sometimes even at their hotel room. Other times it would be over the phone. And in terms of the link with substance use, it would be a mixture, again, of directly speaking with the client or also speaking about them with the nurses, whether as it would relate to their use of substances or the concern about withdrawal from a substance." [Primary care provider]

Primary care providers had differing levels of experience and expertise working with people who use substances prior to their work in the CIRS. Some had limited exposure to working with substance use, while others had substantial experience. For those with more limited previous experience, they identified some of the strategies that helped them to improve their skills supporting people who use drugs at the CIRS.

> "So both as my role as one of the physicians learning and then later on as one of the physicians supporting, what we found most helpful was having the manual, we called it the Substance Use Handbook. And that was developed by the addiction medicine docs. And then afterwards, the feedback that was given on how to organize it and how to really add to it was from the physicians in the group. And then in parallel, we had formal education sessions. So at some point I think it was every week and then it became every two weeks. And most of the education sessions … most of the demand was for substance use and addiction medicine. And I think it just became very clear that that's what our clients need. And so let's bring ourselves up to that level." [Primary care provider]

Substance Use Physicians

When implementing the CIRS, there was a recognition that the convergence of the COVID-19 pandemic and the overdose crisis required the provision of enhanced substance use related supports for people who needed to isolate due to a COVID-19 diagnosis. Substance use physicians were recruited to provide on-call support for the teams on-site, able to consult on a range of treatment options that might assist clients in completing their COVID-19 related isolation periods on-site, while also reducing overdose risk.

> "I was really interested to do it. I think none of us really knew how this [*COVID-19 pandemic*] was going to turn out. I think there was a lot of concern early on about overdose, right? Rightfully so, as we've all seen, unfortunately. And so I was interested to be involved. I also thought it was potentially a good opportunity to do some things in a new institutional environment that maybe could allow for some creative prescribing that maybe we aren't able to do elsewhere that I was interested to be involved in." [Substance use physician]

The concern over the need to facilitate the isolation of people who use drugs led to the inclusion of a substance use physician service in the CIRS model, where physicians with expertise in the treatment of substance use provided on-call support to other staff teams within the CIRS.

> "I provide consultancy over the phone as a member of the substance use team for the recovery sites. I've never been to the Covid-positive or recovery site or any other site. So everything is done virtually all over the phone or via [*electronic medical system*] messaging. And so we essentially just receive phone calls and discuss cases with other physicians who are on site. Sometimes we're requested to do direct client interactions, which we do. And so mostly what I do is provide sort of quote unquote
>
> expert opinion around substance use issues." [Substance use physician]

One of the major responsibilities for the substance use team was to provide support to on-site teams (including the general medical team), as well as to develop resources such as a program handbook to

initiate and assist other staff to the substance use prescribing within the CIRS context.

> "So I definitely noticed over time that that the on-site physicians, maybe many of whom who never had any substance use confidence or training before, have become really comfortable with a lot of things. But in the beginning, it was sort of more basic things like, 'This patient is using fentanyl, what do I do?' And it was a lot more going through the full assessment. And now the calls are very much like, 'This person uses six points a day. I want to start them on 30 mg methadone and 8 Dilaudid. Does that sound reasonable?' And almost always now it's just me saying, 'Yeah, that sounds great.' And then sometimes we just have conversations about challenging cases and both agree that this is hard, there is no right answer here. But I think that sounds like a good plan to try and minimize harm and maximize engagement." [Substance use physician]

The combination of having resources available for the primary care team like the substance use manual,[9] which provided clinical guidance for prescribing, and having a dedicated team of substance use specialists available on-call to assess patients or provide consultation for staff members allowed for primary care providers to rapidly increase their skill and confidence in the provision of specialized substance use related care.

Summary of feedback on staff roles

- Peer workers played a crucial role in supporting clients and in the provision of easily accessible care
- Harm reduction staff provided flexible care for clients based on their identified needs and the information they disclosed, and also provided training and support for other staff teams on harm reduction principles
- In addition to providing general nursing care and assessments, nurses provided clinical support at the overdose prevention site and offered concrete clinical assistance to substance use service clients (e.g., on injection technique)
- Primary care providers were involved in the provision of general medical care, COVID-19 monitoring, providing prescriptions, referrals to and consultations with substance use specialists, and management of substance use related care when necessary
- Substance use specialist physicians were recruited to provide on-call support for the teams on-site, able to consult on a range of treatment options that might assist clients in completing their COVID-19 related isolation periods on-site, while also reducing overdose risk.
- The combination of a substance use manual that provides clinical guidance for managing substance use and access to physicians who were specialized in substance use allowed for primary care providers to rapidly become skilled and comfortable providing substance use related care.

Responding to Emergent Challenges of Providing Substance Use Services in the CIRS

Training and Support for Staff

As the CIRS was established quickly to meet an urgent, pandemic-related need, staffing was a challenge. For all teams, it was necessary to find workers with strong experience and training in working with people experiencing homelessness, who were experienced in harm reduction, and who were available to work. This led to high rates of turn-over, and the loss of institutional memory when turn-over would occur.

> "This goes back to the precarious work environment that every team faced. The staffing structure was horrible from the get-go for everybody— like it is not good. It was a big challenge. And because it was precarious work, we ended up with all teams—peers, harm reduction and nursing—with consistent and frequent staff changes. And so it was very, very difficult. And same with the medical directors. We lost like 50 percent, more than 50 percent of our leadership … we would lose so much

institutional memory around really great practices. And we'd always have to start fresh." [Harm reduction worker]

One of the areas that staff highlighted where training and support had a strong positive impact was in supporting clinicians to acquire new skills in prescribing medications for substance use. Both primary care and substance use physicians frequently highlighted the skill acquisition that had occurred in this area due to the support of the on-call substance use service.

"The last time I did one [*a substance use consult*], I was like, wow, everyone really has figured out ways to do this! I mean, it's a different skill set working in these sites compared to longitudinal care, but everyone has really up-skilled to the point that a lot of what we're doing is just agreeing, and providing an opinion sometimes for challenging cases. But often they have come up with a plan already." [Substance use physician]

The high turn-over, as well as the need to onboard staff onto all teams who may have less experience working with populations of people experiencing homelessness or who use drugs meant that significant training was often required. This included the development of training sessions around harm reduction to ensure that all teams were well-versed in this approach to addressing substance use.

"We ended up having a lot of formal and informal trainings around what does harm reduction look like as like a continuum of services and how do we deliver that information? Because I think that, again, they challenged a lot of people's basic knowledge of what they thought harm reduction was and what harm reduction is. So every team experienced significant learnings." [Harm reduction worker]

Addressing Overdose Risk

There were continuous attempts at the CIRS to adapt interventions to reduce the risk of overdose on-site. For example, staff members realized that one commonality in the small number of overdose fatalities that had occurred on-site was that clients had not disclosed their drug use at intake, and overdosed soon after arrival after using drugs they had brought with them.

"So of the cases that I was involved in or involved in the de-brief, only one had disclosed substance use. Another one out of four, I think there has been one subsequent likely overdose death. My understanding is that person but had also not disclosed, but another community member recognized that there might be something going on. But, yeah, that was one where substance use was a known component of the person's situation, but the rest were not. I think that that was by far the most common thing." [Primary care provider]

Staff responded with attempts to adapt service provision on-site by trying new ways of engaging with people early in their stays (such as development of the substance use menu that is provided to clients at intake) to ensure that clients were familiar with the harm reduction interventions that were available.

"I think the big thing really was the menu, you saw the paper form that people could be left with them to fill it in their own time and then could get picked up by someone later. That was a direct response to overdoses in the setting of non-disclosure. I think anyone that used or came from a shelter where there's lots of drugs, the harm reduction team toured a lot of folks through the OPS just to be like, 'Hey, we have this spot'." [Primary care provider]

Use of Evidence in Care

Staff explored the role of evidence in supporting patient populations that use unregulated drugs during interviews. In the context of the ongoing overdose crisis, one of the most contentious areas were staff reflections on the use of evidence underlying SOS prescribing at the CIRS. Here, staff reflected on prescribing SOS to attempt to address overdose risk in a context where there is limited

evidence on SOS effectiveness or impact on patient outcomes due to the newness of SOS as an intervention. Some prescribers described ambivalence towards newer approaches such as SOS even while engaging in SOS prescribing on-site at the CIRS, with uncertainty about its impacts and effectiveness.

> "But it can't just be because there's no evidence for something doesn't mean you can't try it. And that's because you are never going to gather of the evidence unless we actually do it, right? That's number one. Number two, I think that the conflict I have seen is patients who have not changed, among the people who I have followed. There have been a couple who have stopped using fentanyl, but the majority of people have not. I don't know if that's the goal of safer opiate supply. And I'm not convinced as yet because I haven't seen it be super effective for a lot of people. But it doesn't mean that it's not making their lives a little bit better. Maybe they're using less fentanyl. Maybe they're trading their tablets instead of having to participate in crime to get money to support their fentanyl use. So maybe it is reducing harms in other ways. It's just not obvious." [Substance use physician]

In the context of the current overdose crisis, the harms of a volatile unregulated drug supply that is predominantly fentanyl are clear. Other staff members described the importance of also mobilizing existing knowledge based in community expertise to respond effectively to the overdose epidemic.

> "In medicine, the way we are often trained is to say, you're going to do this intervention. You need the evidence base to figure out whether it's beneficial, and then also to make sure there's no harms of your intervention. But it's very focused on the things that you do. And I think the shift in mentality that I've needed to make in myself, and also that I hope we make as a medical community, is the risks and benefits of not intervening. We can't wait for 10 years of studies for prescribing hydromorphone in the midst of the fentanyl crisis, like we do need to act on less stellar evidence, but to continue to look at our patients and talk to them. I mean, they're the experts, right, to hear that feedback from them about what's working and what isn't. And again, just to really focus on stability in people's lives. And if it feels like what we're doing is destabilizing people, we need to pivot very rapidly. And if we feel like it's improving their stability and that's what they tell us, then we have to listen." [Substance use physician]

Members of the clinical and harm reduction teams at the CIRS created a guidance document for SOS prescribing on-site that helped healthcare providers feel more comfortable with this novel approach. It built off of existing Ontario guidance documents that addressed SOS prescribing[10] as well as guidance documents on risk mitigation prescribing to support people who use substances during the pandemic.[8, 11] Several of the team members from the CIRS also collaborated on a guidance document for risk mitigation/SOS prescribing that was heavily informed by the work at the CIRS, which was released by ICHA (the organization providing clinical care at the CIRS).[9]

Summary of feedback on emergent challenges

- High rates of turnover led to a loss of institutional memory and the requirement for significant training
- Harmonizing staff approaches to harm reduction principles and ensuring ongoing training was an ongoing priority
- Staff attempted to quickly innovate and develop new approaches to addressing overdose risk on-site following critical incidents, such as with the development of the substance use menu
- Due to the need to facilitate COVID-19 related isolation, prescribers were willing to prescribe novel interventions such as safer opioid supply and stimulant replacement therapies despite limited evidence available
- Both the immediate risk posed by the crisis of overdose deaths from unregulated fentanyl

and the need to facilitate people staying on-site led to wide uptake of OAT and SOS prescribing within the CIRS

Substance use services on-site at the CIRS

Intake

Similar to how clients described their admission or intake to the CIRS as a stressful moment, after opening the CIRS, staff also realized that steps had to be taken to facilitate the process of disclosure of substance use-related needs once people arrived on-site. Staff were concerned with how to support people with substance use needs such as avoiding withdrawal, while also helping them to facilitate their COVID-19 related isolation on-site. One method that was implemented was the use of the "Substance use menu" (Appendix 3), a paper hand-out that clients were given to complete to help communicate their substance-use related needs to staff. The menu provided a way to list the substance-use related services available on-site, and communicate to clients the harm reduction approach being taken to substance use at the CIRS.

> "The substances menu that was used was implemented later, like a few months later, was largely based on the reflection that we had had some serious gaps in clients who had not disclosed *[their substance use].* So trying to understand, like, how do we make disclosure safer, or feel like if people disclose, they're going to get something that's going to help them." [Primary care provider]

Provision of Opioid Agonist Therapy (OAT)

The provision of OAT at the CIRS was a mainstay of treatment for people who use opioids while they were on-site for their isolation periods, and crucial to prevent withdrawal from opioids while on-site. Provision of adequate treatment (either OAT, SOS, or a combination of both) was also a major tool in reducing the potential harms from unregulated, street-acquired fentanyl on-site, and the associated overdose risk.

> "But I think also the whole pandemic just changed the way all the prescribing happened. It changed the way methadone and morphine and hydromorphone and everything was prescribed … The recovery site has been a really interesting effort. I think substance use treatment and harm reduction has complex goals frequently, and they're hard to tease out sometimes, and they evolve, and they change. And what's been really interesting and was really helpful at the beginning of the creation of the recovery site was the only goal was how do you make people comfortable enough to want to stay in a building that they've never been in for 2 weeks? So I know it was very unique because it was a singular goal … Like, how do you prevent people from feeling that they need to leave and what does that look like?" [Substance use physician]

For clients on OAT prior to arrival at the CIRS, the medical teams on-site would continue the prescription. For people who were not on OAT but reported using opioids on arrival, staff attempted to ensure that clients could quickly access medications (OAT and/or SOS). Clinical staff on-site recognized that for some clients, this might be an avenue for engagement with substance use medications or treatment options on a longer-term basis. Additionally, as reflected in the quote below, the availability of on-site nursing support and the ability to more closely monitor people initiating methadone allowed for rapid titration and less frequent urine drug screening than is commonly practiced in community settings.

The ability to more rapidly reach a therapeutic dose of methadone (alongside the ability to pair methadone with short-acting opioids like hydromorphone) was seen as an advantage for clients who were interested in initiating longer-term treatment.

> "My guess would be about three quarters are interested in something more long term. I'd say the vast majority of people were interested in short acting hydromorphone, like the Dilaudids were kind of the mainstay of therapy they were

interested in. But a lot of those people were interested in a longer acting treatment, like methadone primarily, and were interested in trying to go up on their methadone to a reasonable dose, because that can be quite hard. When I work as a community provider, it's quite hard sometimes to titrate that up to a dose that is comfortable for people and that takes weeks and that's really hard for people to get through. And so the fact that we were able to do that a bit quicker and with supporting people with shorter acting opiates that would help them not have to go through as bad withdrawal was quite, I think, a positive experience for a lot of clients. I'd say about a quarter of people said, 'I want nothing else other than just something to replace the fentanyl' in terms of short acting use, and their plans were to return to fentanyl use once they left the recovery site." [Substance use physician]

For the primary care providers on-site who did not have strong expertise in working with people who use drugs or prescribing medications for substance use prior to working in the CIRS, there was the opportunity to learn new skills due to the support from the specialized substance use physicians. The staff member below both reflects on their new prescribing skills, as well as the differences between prescribing at the CIRS in contrast to in clinical settings in the community.

"Kadian for acute withdrawal, all of this was a new world for me, I'd never prescribed methadone, but I think more importantly, these are clients who actually don't have any intention or desire necessarily to quit, cut down or to start OAT. You are replacing someone's drug dealer and the dynamic is different, OK? And that's how most of our addictions providers a year later are reflecting on this. I think something like, 'Oh, why is this so different than my addiction practice?' It's like no one's coming to you for help. They're coming to you for withdrawal." [Primary care provider]

Safer Opioid Supply (SOS)

In addition to OAT, the provision of SOS on-site ensured that clients had medications that would facilitate their ability to isolate during their stay at the CIRS. Providers identified that offering a safe, regulated supply of substances prevented the harms associated with accessing unregulated drugs (including the volatility in the unregulated opioid supply from fentanyl and other analogues, as well as criminalization). While SOS was seen as a medical intervention that did not have the evidence base of more accepted interventions such as OAT, clinicians weighed the risks and benefits of intervening in a complex situation.

"And I think one of the things in medicine that is quite pervasive is the idea of doing no harm. But we don't often talk about the harm in the things we don't do. And so when, you know the risks of not intervening in the midst of the fentanyl crisis are incredibly high. And so the risk and benefits of all of the things we have done historically in terms of the way we prescribe, methadone restrictions, all of those things. Now, the risks of not doing that are so much higher. And so we do have to have a completely different paradigm in how we approach people." [Substance use physician]

Some staff expressed concern over the lack of access to SOS after discharge, and the potential destabilization clients might experience after their stay at the CIRS ended, with limited options and availability for SOS in the community.

"I felt uncomfortable about starting something that couldn't be continued. And overall I felt it was unfair to people. But I had lots of talks with lots of people about whether it's better to offer it during that [*their stay at the CIRS*] and not be able to continue, than to not offer it at all. I think that probably it was better to be able to at least have it while people were there. And I really wonder what happened to everyone when they left." [Substance use physician]

Similar to OAT, the availability of a specialized substance use team supported clinical teams to

The availability of a specialized substance use team and the development of guidance documents were key aspects in supporting primary care providers to rapidly become comfortable with providing substance use related care

provide SOS at the site. Since prescribing of SOS was still contested - even among clinician at the CIRS - the availability of the substance use manual and guidance document was useful as a tool for achieving consensus and consistency for prescribers on-site.

> "I think as they became more comfortable, and once you've prescribed opiates, safe supply or OAT a few times, it's not difficult. These medications are not unfamiliar medications to a lot of people. So once you've done it a few times, it's very easy to continue prescribing. But I think that those guiding documents are probably quite helpful because we actually had a document that everybody was on board with. They were comfortable referring to it to prescribe medications." [Substance use physician]

Stimulant prescribing

Clinical staff described some attempts at prescribing pharmaceutical stimulants to clients at the CIRS who used unregulated stimulants such as crystal methamphetamine, cocaine or crack cocaine. Prescribers struggled with wanting to mitigate the risks associated with the use of unregulated stimulants with the lack of evidence regarding the effectiveness of stimulant replacement, and were willing to attempt stimulant replacement at the CIRS. However, secondary effects from the stimulants (notably tachycardia, which is rapid heart rate) were noted during vital sign checks.

> "I'm much less comfortable with the stimulant prescribing, so I did some initiation in consultation with other people. And this is like the evidence is not super high … And one of the challenges also with stimulants is we checked people's vital signs every day. And so if people on a lot of stimulants, then their heart rate is really high all the time. And it's not really good to give them more stimulant. Where with opioids, people just get to such a sweet spot physiologically that people could take their opioids and be fine physiologically. If you take a lot of stimulants, you're not fine physiologically, like their heart rate is really high. And so I think oftentimes people got initiated and they were really tachycardic all the time, much like if they were using meth, they were really tachycardic all the time. But then they had this really clear contraindication to increasing their dose … it's hard." [Primary care provider]

The high heart rate noted following stimulant use dissuaded prescribers from increasing doses for clients, despite the recognition that use of unregulated stimulants would cause a similar high heart rate. Most prescribers at the CIRS who attempted to prescribe stimulants to clients found that the benefits for clients were not as clear as with opioid prescribing (which were clearly effective at relieving the symptoms of opioid withdrawal at adequate doses).

> "And whether or not it works for people, some people would say, 'Maybe it helps a bit?' But's very, very different than if people feel like opioids aren't helping, usually we could get to a dose that that would going to help. But it just didn't seem to be nearly as easy *[with stimulants].* And maybe it was like our protocols and our doses were not in the right place. It was just much harder to get to the right place." [Primary care provider]

Overall, several prescribers described a willingness to prescribe pharmaceutical stimulants to reduce use of unregulated stimulants, as they attempted to support people during their time at the site. In particular, they attempted this early in the pandemic response. However, they grappled with the lack of evidence for stimulant replacement therapies and difficulty in judging whether the medications were having a positive benefit for clients. The combination of unclear impact for clients with the secondary effects from the stimulants prescribed led to waning interest in prescribing these medications as time went on at the site.

Managed Alcohol Program (MAP)

The managed alcohol program (MAP) provided alcohol to clients who requested it during their stay at the CIRS in order to facilitate isolation. Control of most prescribing and delivery alcohol shifted from the nursing team to the harm reduction team after several months of experience with the program to support efficiency and client comfort, and to de-medicalize the process of alcohol provision to clients.

> "Now there's a little bit more autonomy on the harm reduction team doing that [*MAP provision*]. And I think it's great because sometimes what would happen in the past is that they would take a really long time to write these MAP orders. So if somebody is going through withdrawal and they weren't getting their alcohol right away, many times the clients would have to leave and go get whatever was available to them or use other substances such as hand sanitizer and stuff like that, because it was also going missing all the time in the hotel. Once we started kind of figuring out that that was happening, then we had to take measures to kind of speed up the process a little bit. To make it easier for the client to get whatever they needed, at the time that they needed it." [Harm reduction worker]

Most clients who used the MAP program were not seeking to adjust their substance use, and the provision of alcohol was seen as an effective strategy to facilitate client isolation on-site, as well as to reduce the harms from consumption of non-beverage alcohols such as hand sanitizer. Prior to the COVID-19 pandemic, there were few options for providing alcohol within shelters or clinical settings such as emergency departments, even though it was recognized that access to services may be difficult for those who frequently use alcohol. This changed due to the need to facilitate on-site isolation of people who drink alcohol at the CIRS.

> "I don't hear much about MAP right now. Look, I think it's just pretty routine and there's nothing eventful about it. And so, like for months now, I really haven't heard anything. But I do think that as a preliminary service, it was huge. It was unheard of to just go to a shelter and get free booze. So I think that that had a really large impact in the first half of the pandemic." [Harm reduction worker]

Within the substance use service, there was also the option of receiving medications to reduce cravings for alcohol, or to prevent alcohol withdrawal if a person wished to attempt to decrease their alcohol consumption, and staff highlighted this as an advantage of this service.

> "I think we tried to stress with the MAP…that if you don't want to stop drinking, and you don't want to go through withdrawal and you'd prefer alcohol to manage your withdrawal and kind of continue with that rather than using benzodiazepines, that's great. And then for people, who truly didn't want to continue with alcohol, like, I would hope that discussion has been had about the other options that we could provide people to help them reach whatever goal they had. I think even with MAP, we encouraged or we discussed the option of medication management. Things that can help reduce cravings. So it wasn't one or the other." [Substance use physician]

Overdose Prevention Site (OPS)

The OPS was established at the CIRS in order to provide a supervised space for clients to use drugs

or medications, where staff would be available to offer education on safer drug use, or to intervene in case of overdose or other medical issues. Staff identified that although most clients preferred to use in their private rooms, many expressed interest in and curiosity about the OPS. Strategies to make the OPS more welcoming were also put in place, including turning on music, developing rapport with clients, and allowing flexibility for where in the OPS clients were permitted to use (e.g., in the bathroom of the OPS).

> "I think for clients who use the OPS site, it works well for them because they're able to use in a comfortable environment and more relaxed environment and we try to do that— not bother the client so much. Because if they use in the OPS room and then they've been monitored, then they go back into their room and we have to constantly be checking because they're using substances … The first 15 minutes they're going to overdose. Then if they've been walking back, then we can kind of monitor them less and they appreciate that." [Nursing team member]

Staff found that a friendly, non-judgmental, non-instructive approach to supporting clients was the most effective way to facilitate future access to the OPS service. Even though OAT and SOS were offered on-site, some clients still chose to use fentanyl, which can carry a high risk of overdose.

> "We had one client who had multiple overdoses on the same day. He had a bad batch of fentanyl, but he was bound and determined that he was going to use that batch of fentanyl. So we put a bed in the OPS and we did ask him to sleep in the OPS. But we respected his decision. And so, certainly his life was saved." [Harm reduction worker]

Though the OPS was available as a resource for injection drug use, the lack of dedicated space for clients to smoke crack cocaine or methamphetamine was a service gap for clients. Additionally, the utilization of the OPS was sometimes felt to be low, with many people choosing not to use in the OPS, opting to use in their rooms instead. While new clients were offered a tour of the OPS and incentives were trialed to attempt to increase use, a spectrum of strategies to reduce the risk of overdose were necessary to address the wide variety of needs on-site.

> "One of the pieces, I think that stressed people out is definitely that, yes, we have an OPS on site, but why use an OPS when you have a really nice room? And so I think that dynamic was really interesting and a good structural analysis around how do we improve OPS systems? Because, again, I think we're working with dated structures to a certain degree. So, how adaptable can we be in this type of setting that respects both client autonomy and provides an intervention more supportive for individuals?" [Harm reduction worker]

Room Checks and Providing Observing/ Spotting in Rooms

The variety of substance use services available at the CIRS allowed staff to creatively support clients' with their substance use. Staff worked with clients to establish safety plans, including whether clients desired a staff member to observe their substance use to prevent accidental overdoses. The peer team was the main staff team monitoring clients during their substance use, and this was found to be an effective strategy to reduce the risk of accidental overdose. Ensuring that all staff carried naloxone with them, taking turns monitoring clients when needed, and having the other staff teams on-call were also factors influencing the success of in-room observation.

> "Harm reduction is mostly responsible for substance use. The only thing we do as peers is a couple of things. Number one, sometimes clients call and ask for kits, needle kits, pipe kits. We provide them with those. But the other thing we do is we are monitoring while they're using. So when we become aware that clients are using, we inform harm reduction and we inform nursing. And as a team, we all ensure that the clients are, number one, safe, but also monitoring their overall well-being while they are using." [Peer worker]

Staff made adaptations to support clients, including in the area of cultural safety. One harm reduction worker described making adjustments to room accommodation and in-room observation to respect the cultural practices of Indigenous clients at the CIRS.

> "Some of the things that we would try to do would be to really align with cultural practices. So we had this period of time where we had a bunch of folks from the Indigenous community come through the site. And we know that communal living is a thing. We know that folks will be safer together that way. And we don't want to play into the whole colonial narrative. So we want to be able to give two sets of adjoining room so y'all can isolate together. But that usually went against what we were instructed around isolation and recovery practices, but they didn't align with community and cultural needs, and so we really tried to be like, 'How can we make this work for everybody in the best way possible?' And in spaces like that, people had had their community to spot them." [Harm reduction worker]

Summary of feedback on substance use services

- A wide continuum of substance use services was necessary at the CIRS to meet the variety of different needs of clients at the site.
- A commitment to easily accessible services and to adapting services after critical incidents or to better meet client needs led to continuous attempts to improve service delivery.
- Both the immediate risk posed by the crisis of overdose deaths from unregulated fentanyl and the need to facilitate people staying on-site led to wide uptake of OAT and SOS prescribing within the CIRS.
- There were small-scale attempts by healthcare providers to prescribe pharmaceutical stimulants as a replacement for unregulated stimulant use. However, it was difficult to judge where the medications were having a positive benefit.
- The experience of offering substance use services at the CIRS during COVID-19 demonstrates that provision of a continuum of low threshold substance use services within residential and clinical environments is possible. The substance use services offered at the CIRS provide a model for service delivery within shelters, supportive housing, in hospitals and across healthcare sites in the community.

Overall Work Environment

Across staff teams, respondents highlighted that the overall work environment of the CIRS was extraordinary in terms of client supports, with strong interdisciplinary collaboration and high levels of embedded harm reduction practices. Regardless of staff background, the stark difference from other healthcare and clinical settings was emphasized by respondents from all staff teams.

> "I'll start with the things that were different just because I think it's what makes the site so unique and why many of us just loved working there. So what was different was the involvement of non-medical team members, and really trying to incorporate a nonmedical model as much as possible, even though that was it was restricted with the hospital designation. So really, I think the biggest thing was having harm reduction workers, as well as peer support workers, the city of Toronto staff, social workers, just having such a big involvement of the social side of care. I think that was the biggest difference that was that I saw." [Primary care provider]

The environment of the CIRS was also intense and stressful given the constant effort to support clients to use substances as safely as possible. However, staff recognized the worth and importance of the substance use services offered—not only in the context of COVID-19—but beyond as well.

> "I think overall what's worked is that I work with a group of committed professionals and that they come with the objective of meeting the needs of the client, where a client-first shelter, everything we do, we're putting the client first." [Peer worker]

Discussion

What we learned

The substance use services at the CIRS were a crucial component of the comprehensive, integrated and low-threshold services aiming to support people experiencing homelessness who required isolation due to COVID-19. Clients described that the COVID-19 testing process, and the intake into the CIRS was very stressful and marked by upheaval. However, once on-site, clients were generally satisfied with their accommodations (particularly having a private room with a bathroom) and with the services offered on-site. In particular, clients highlighted that the availability of OAT, SOS, and MAP were crucial in their ability to isolate on-site. Due to previous negative experiences, some clients felt reluctant to disclose their substance use, especially initially. Nonetheless, clients frequently expressed feeling safer at the CIRS compared to other settings in the community. Clients identified areas for improvement including: receiving more information about the CIRS prior to arrival, reducing the length of wait times for critical services like OAT, SOS, and MAP on-site, easier access to SOS prescribing, and a lack of treatment options for stimulants. Discharge was a great source of anxiety among both clients and staff; continuity of care following discharge, particularly for SOS and MAP, were identified as major issues. The lack of housing and lack of broader resources in the community to support continuity of care following discharge from the CIRS was a major issue, and created moral distress for staff, and significant stress and destabilization for clients.

Staff described having an unprecedented ability to provide a wide array of comprehensive, easily accessible supports and substance use services to clients at the CIRS due to the urgent needs of the COVID-19 pandemic. The interdisciplinary teams including peer workers, harm reduction workers, nurses, and physicians on-site allowed for a mutual learning environment that disrupted the traditionally hierarchical power structures often seen in clinical environments. The CIRS was a high-stress work environment as staff were navigating the complex care needs of those most affected by the co-occurring overdose crisis, homelessness crisis, and COVID-19 pandemic. In addition, some staff members were ambivalent towards harm reduction principles, and there was steep learning curve for many staff members on multiple teams to adapt to the unique work environment at CIRS and the provision of comprehensive, harm reduction-based services. The implementation of training around harm reduction and substance use, as well as the development of tools like the substance use handbook and the availability of a team of physicians specialized in substance use were effective at allowing staff to rapidly learn new skills and develop new competencies in providing care for people who use substances.

While the substance use services at the CIRS were implemented due to the unique challenges brought on by the COVID-19 pandemic, many findings from this evaluation are transferrable beyond the context of the pandemic. The learnings from the provision of these services at the CIRS may be used to assist in the development of long-term strategies the period beyond the COVID-19 pandemic to address the needs of people experiencing homelessness who use substances. The experience of offering substance use services at the CIRS during COVID-19 demonstrates that provision of a continuum of low threshold

substance use services within residential and clinical environments is possible. The substance use services offered at the CIRS provide a model for service delivery within shelters, supportive housing settings, in hospitals and across healthcare sites in the community. Disrupting the traditional hierarchy of clinical care and integrating the expertise of peers and harm reduction workers into interdisciplinary teams benefited both staff and clients at the CIRS. The interdisciplinary team model and the commitment to low threshold services that met clients' substance use needs led to the provision of a continuum of substance use services that is unparalleled.

Recommendations

Recommendations applicable to clinical, residential, and shelter settings

1. Intake and discharge were highlighted as moments of major stress for clients. Reducing transfers and providing ongoing and clear communication throughout the process may help to alleviate the intense stress associated with these transitions.
2. The need to rapidly develop a CIRS led to a unique mix of harm reduction, clinical and sheltering services being offered to clients. It provided a model for how to deliver a full range of substance use services where people live, in shelter settings and in hospital settings that are feasible and acceptable to clients and staff.
3. The overdose crisis and the need to facilitate people staying on-site led to wide uptake of OAT and SOS prescribing within the CIRS. This was coupled with the provision of comprehensive harm reduction services including harm reduction equipment distribution, access to an on-site OPS, and in-person and telephone checks from staff when using drugs. An easily accessible managed alcohol program was also available on-site. This allowed clients to remain on-site and manage their substance use without withdrawal and discomfort, and provides a model for broader implementation across the sector.
4. Support from people with lived/living experienced of drug use, harm reduction and clinical services allowed for the successful operation of comprehensive substance use programs in the CIRS. Prioritizing the expertise of people with lived/living experience and trained harm reduction workers was crucial in delivering low barrier services.
5. Comprehensive training on harm reduction practices and overdose response across all teams— including people with lived/living experience, harm reduction, clinical and shelter workers—is essential for reducing overdose risk and harmonizing goals within interdisciplinary teams.
6. There are limited options and evidence for supporting people who use stimulants and for stimulant prescribing. The needs of clients who use stimulants are frequently overlooked, and further investigation of novel options for support for people who use stimulants (including options for stimulant replacement therapy) is necessary.
7. There is a need for supervised smoking spaces to accommodate a wider range of drug consumption preferences.
8. Avoiding the unnecessary separation of close contacts can help reduce overdose risk, as they can monitor each other when using substances while isolating together.

Recommendations for the health and social service sector

1. Delivery of wraparound substance use services with on-site support from people with lived/living experience, harm reduction and clinical services in the spaces where people live and in homelessness service settings should be prioritized.
2. During COVID-19 and beyond, there is an urgent need for embedded, comprehensive substance use services grounded in harm reduction within shelters, supportive housing settings, in hospitals and across healthcare sites in the community.
3. Allocation of substantive and stable funding for the delivery of comprehensive substance use services

across the homelessness service sector, in shelters and the spaces people live in community, as well as in large, well-resourced healthcare sites (e.g., hospitals) should be prioritized.

4. There is a need for a sub-acute care space for people experiencing complex, unmet mental and physical health needs alongside substance use, or to stabilize substance use among people experiencing homelessness. A model similar to the CIRS may be effective at meeting this need.
5. Strong investment in comprehensive, long-term housing solutions is needed. While the provision of well-funded short-term solutions for people experiencing homelessness who needed to isolate due to an infectious disease was necessary to address the COVID-19 pandemic, delivery of integrated, comprehensive services must be prioritized even when people experiencing homelessness do not represent infectious disease risks to the larger community.

Appendix 1: Homelessness and sheltering situation in Toronto during the COVID-19 Pandemic

As of September 2021, the total population of people experiencing homelessness in Toronto is estimated to be 8,760.[12] Since 2013, this number has increased by 60 percent, due in large part to rising housing costs and chronic underfunding of housing supports and long-term housing options.[13] The housing crisis in Toronto has been exacerbated by the COVID-19 pandemic, leading to increased evictions and precarity for many people. At the same time, Toronto's shelter system is facing a crisis as it is unable to accommodate the number of people experiencing homelessness, leaving many unsheltered. According to administrative data collected by the City of Toronto, the shelter system is over 90 percent full, with 6,820 using the system as of October 17, 2021.[14] As a result, many people requiring and seeking space in the shelter system are denied.

Toronto's shelter system consists of emergency and transitional shelters, 24-hour respite sites and drop-ins, and warming centres during winter months. Additionally, new shelter-hotel sites have been added during the COVID-19 pandemic. Generally, services are categorized into one or more of the following groups: youth; women; men; mixed-gender; and family. Respite sites and drop-ins were designed to be low-barrier services to provide essential supports (e.g., resting space, meals, referrals) to people who may face barriers to access to traditional shelter settings but have become increasingly used as de facto shelters.[13] Many people rely on these 24-hour respite sites and drop-ins for shelter when they are denied access to traditional shelter beds. However, these sites often operate at near full capacity and are unable to accommodate everyone.[13] Warming centres are typically only activated when an Extreme Cold Weather Alert is issued once temperatures drop to minus 15 degrees Celsius. The number of warming centres available varies each year. Respite sites and warming centres are typically located in arenas and tented pop-up structures that offer minimal privacy as clients sleep on cots or mats in a single congregate space. For a number of reasons, including fear of COVID-19 transmission, gender-based violence, poor conditions, lack of privacy, and individual and systemic discrimination, many people experiencing homelessness do not feel safe in congregate settings.[13]

Shelter-hotels are temporary response sites that provide shelter in hotels or motels leased by the City of Toronto. While shelter-hotel programs have been in operation long before the COVID-19 pandemic (largely for families and refugees), they have been rapidly scaled up to facilitate physical distancing and increase capacity in the shelter system during the pandemic.[15] Compared to traditional shelter settings and respite sites, shelter-hotels offer clients private rooms; however, they remain congregate settings where clients are subject to many rules.

Despite being a key part of the City of Toronto's response to the COVID-19 pandemic, many of the shelter-hotels have reported COVID-19 outbreaks. Furthermore, shelter-hotels are frequently ill-prepared to support people who use substances, people living with disabilities, and trans and non-binary people.[13]

Since 2019, the number of deaths in the City of Toronto's shelter system has increased significantly, due in large part to the overdose crisis driven by drug toxicity.[16] In 2020, close to two-thirds of all deaths in the shelter system—and over

half of all deaths among people experiencing homelessness in Toronto—resulted from overdose from drug toxicity.[13] At the same time, non-fatal suspected overdoses have risen from an average of 26 per month in 2018 to 102 in 2021.[17] The number of deaths related to drug toxicity have been further worsened during the COVID-19 pandemic. One likely reason is that physical distancing requirements mean that more people are using drugs alone, a known risk factor for overdose. Other probable reasons for this increase include changes in the drug supply, fluctuations in income leading to inconsistent day-to-day opioid use and loss of tolerance, and disruptions to harm reduction and social services. Additionally, as many of the shelter-hotels are located away from the downtown core and people's familiar neighbourhoods, clients may be forced to find new supplies for drugs. In response to the increase in fatal and non-fatal overdoses, the City of Toronto has implemented some harm reduction services, such as overdose prevention sites (also called "Urgent Public Health Needs Sites"), peer or staff witnessing, and naloxone distribution in a small number of the shelter-hotel sites.[18] However, these services remain under-resourced and sparse.

Outside of the shelter system, many people experiencing homelessness seek refuge in encampments. While encampments existed before the COVID-19 pandemic, most commonly under bridges, in ravines or forested areas of parks, they have become more visible during the pandemic. According to the City of Toronto, there are approximately 200 tents in encampments in parks across the city as of September 5, 2021.[19] Between April 2020 and September 2021, 1,858 people were moved out of encampments and into the shelter system—mostly into shelter-hotels though also into other settings—by the City of Toronto staff. While some encampment residents wanted to move into the shelter system, many did not but were still forcibly evicted and had their belongings destroyed by city workers and police. Many encampment residents want to move into permanent housing but prefer to remain in encampments rather than entering the shelter system for various reasons. However, approximately 8 percent of former encampment residents have received permanent housing while the vast majority of former encampment residents remain outdoors or in the shelter system.[19]

Appendix 2: Glossary

COVID-19 Isolation and Recovery Site (CIRS)

COVID-19 Isolation and Recovery Sites provide a space where people experiencing homelessness who were affected by COVID-19 could isolate. Clients at the site include those who tested positive for COVID-19, had been exposed to someone who tested positive for COVID-19, or had been tested and were awaiting their test results. Clients stayed in private hotel rooms for 10-14 days (if exposed or positive for COVID-19) or until they received a negative COVID-19 test result (if awaiting COVID-19 test results).

Homelessness

While experiences of homelessness vary widely, a broad definition of homelessness provided by the Canadian Definition of Homelessness is "the situation of an individual, family, or community without stable, safe, permanent, appropriate housing, or the immediate prospect means and ability of acquiring it."[5]

Indigenous Homelessness

According to the definition of Indigenous homelessness in Canada[6], Indigenous homelessness "describes First Nations, Métis and Inuit individuals, families or communities lacking stable, permanent, appropriate housing, or the immediate prospect, means or ability to acquire such housing." Due to historical and ongoing settler colonialism and racism, Indigenous people have been dispossessed of their territories, worldviews, ancestors, and governance systems. As such, an Indigenous definition of homelessness goes beyond structures of habitation to account for "individuals, families and communities isolated from their relationships to land, water, place, family, kin, each other, animals, cultures, languages, and identities."[6]

Managed Alcohol Program (MAP)

The managed alcohol program provides clients with a measured amount of alcohol, most commonly beer or wine.

Opioid Agonist Therapy (OAT)

Opioid agonist therapy is a treatment for opioid use disorder that includes the prescription of medications, such as methadone, buprenorphine (frequently referred to by the brand name Suboxone), and slow-release oral morphine (frequently referred to by the brand name Kadian), that reduce cravings and withdrawal for opioids.

Overdose Prevention Site (OPS)

Overdose prevention sites are spaces where people can consume drugs under the supervision of staff trained in overdose response.

Peer

Workers with lived or living experience of marginalization, including mental health challenges, substance use or homelessness

Peer researcher

Peer researchers are people with lived experience in the field of study, and can contribute their knowledge and expertise to the research

Safer Opioid Supply (SOS)

Targeted at people who rely on the unregulated supply of opioids (which in Toronto is predominantly unregulated fentanyl and fentanyl analogues), the safer opioid supply provides clients with prescription opioids, most commonly

hydromorphone (frequently referred to by the brand name Dilaudid) to reduce their overdose risk, and to reduce cravings and withdrawal.

Stimulants

Stimulants are a category of drugs that produces a temporary increase of the central nervous system, including cocaine, crack cocaine, crystal methamphetamine, or prescription stimulants like methylphenidate (Ritalin), dextroamphetamine (Dexedrine).

Substance Use Services (SUS)

A range of specialized substance use services are provided to clients at the CIRS. These services include but are not limited to the distribution of sterile drug use equipment, overdose prevention and response, and specialized prescribing of opioid agonist therapies, safer opioid supply, and medications for withdrawal management.

Appendix 3: Menu of Substance Use Supports at the COVID-19 Recovery and Isolation Site

[redacted]

Name/Initials:
Room #:

Some of the options in this menu require sharing information with the nursing and the doctors. If there is anything you do not want shared, please let us know.

Sometimes a doctor will want to call you directly. Do you have a phone where we could reach you?

Phone #:

[redacted]

Mental health can be impacted by isolation.

We want to support you with your mental health and safety.
Do you have a history of suicidal ideation or self-harm?
If you are experiencing these thoughts and feelings here at the hotel – please let us know.
We will work together on plan for your safety.

[redacted]

What else do you want us to know?

Share anything you think is important for us to know and that will help us support you better during your stay.

Harm Reduction

SUPPORTS AT THE HOTEL

[redacted]

PARKDALE QUEEN WEST Community Health Centre

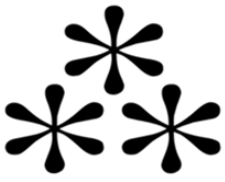
Some people want to keep using alcohol/drugs while at the hotel – that is okay! We want to support you to be safe, we have kits, supplies and an OPS on site.

Some people may want to reduce or stop drinking or using at the hotel. Support with detoxing or reducing use is available here for people who want that

This information will only be shared with the peer, nursing, and harm reduction teams.

What do you use?

- ❑ Cigarettes
- ❑ Alcohol
- ❑ Fentanyl
- ❑ Heroin
- ❑ Crystal Meth/Tina/Ice
- ❑ Dilaudids/Hydromorphone
- ❑ Morphine/Kadian
- ❑ Cocaine/Crack
- ❑ Cannabis/Marijuana
- ❑ Benzos
- ❑ Other:



Harm Reduction Supplies & Services

[redacted]

While staying at the hotel what might you be interested in:

- ❑ Use in the overdose prevention site
- ❑ Someone to stay with me when I use
- ❑ Someone to check on me when I use
- ❑ Rigs & injection equipment
- ❑ Snorting straws
- ❑ Foil
- ❑ Crack pipes/stems
- ❑ Crystal meth pipes/bowls
- ❑ Naloxone/Narcan & OD response training
- ❑ Nicotine patches/ Cigarettes
- ❑ Medication to help with alcohol or drug cravings*
- ❑ Medication for withdrawal*
- ❑ Medication to substitute for street drugs*

*Requires nursing/doctor involvement

How can we help?

While you're here, are you worried about:

- ❑ Alcohol withdrawal
- ❑ Benzo withdrawal
- ❑ Opioid withdrawal

Are you interested in:

- ❑ Methadone
- ❑ Suboxone
- ❑ Other prescription opioids

Are you interested in support with:

- ❑ Cigarette use
- ❑ Alcohol use
- ❑ Drug use

Are you interested in mental health support?

- ❑ Yes
- ❑ No

Note: This was presented to clients as a tri-fold pamphlet

Appendix 4: Research Methods

Qualitative research methods were used to conduct a multi-stakeholder evaluation of the substance use services offered that operated at the CIRS from April 9th, 2020 to June 30th, 2021 at a hotel in Etobicoke. The evaluation proceeded in four steps:

1. A logic model was developed with community stakeholders to inform the study design;
2. 25 qualitative interviews with clients receiving Substance Use Services at the CIRS;
3. 25 qualitative interviews with CIRS staff including peer workers, harm reduction workers, nurses, primary care providers (nurse practitioners, family and emergency medicine physicians), and substance use physicians;
4. The research team used iterative and thematic analytic methods to identify the key themes that emerged in the interviews and synthesize the research findings.

Logic model

The first element of the evaluation was a logic model building session with community stakeholders, which was conducted in October 2020 to inform the study design and creation of interview guides for clients and staff holding various roles in the sites. The final logic model that was developed is illustrated in Figure 3.

Data collection with clients

We recruited 25 staff from the CIRS to complete qualitative interviews. All interviews took place in June and July 2021. While staff did not have to be currently employed or working at the CIRS, they had to have worked frequent shifts for at least one month to be eligible to participate. This was done to ensure that staff members had the depth of experience necessary to comment on the workings of the substance use service. A purposive sampling strategy was used to recruit 5 site staff from each of the 5 teams involved in the provision of substance use services: peer workers, harm reduction workers, nurses, primary care providers (nurse practitioners, family and emergency medicine physicians), and substance use physicians.

As this is a community-based study, community partners from 3 of the 4 main organizations involved were part of the research team and these partnerships were leveraged to identify potential candidates for the staff interviews. An attempt was made to identify candidates with varying perspectives, experiences, and social locations to represent the diversity across their teams. Community partners were asked to contact potential participants and obtain consent to pass on contact information to research staff, who then reached out by email to recruit participants. All staff interviews were completed over the phone or Zoom. All study participants were provided with the study's consent form ahead of the interview by email and provided an opportunity to ask any questions of the study team prior to the interview.

With the consent of participants, all interviews were audio-recorded and transcribed, with any identifying details removed during transcription. Interviews ranged in length from 43 minutes to 94 minutes, with interviews lasting an average of 70 minutes. All participants were offered a $40 honorarium for their participation in the qualitative interview.

Analysis

The full research team – which includes members of the on-site frontline and leadership teams at the

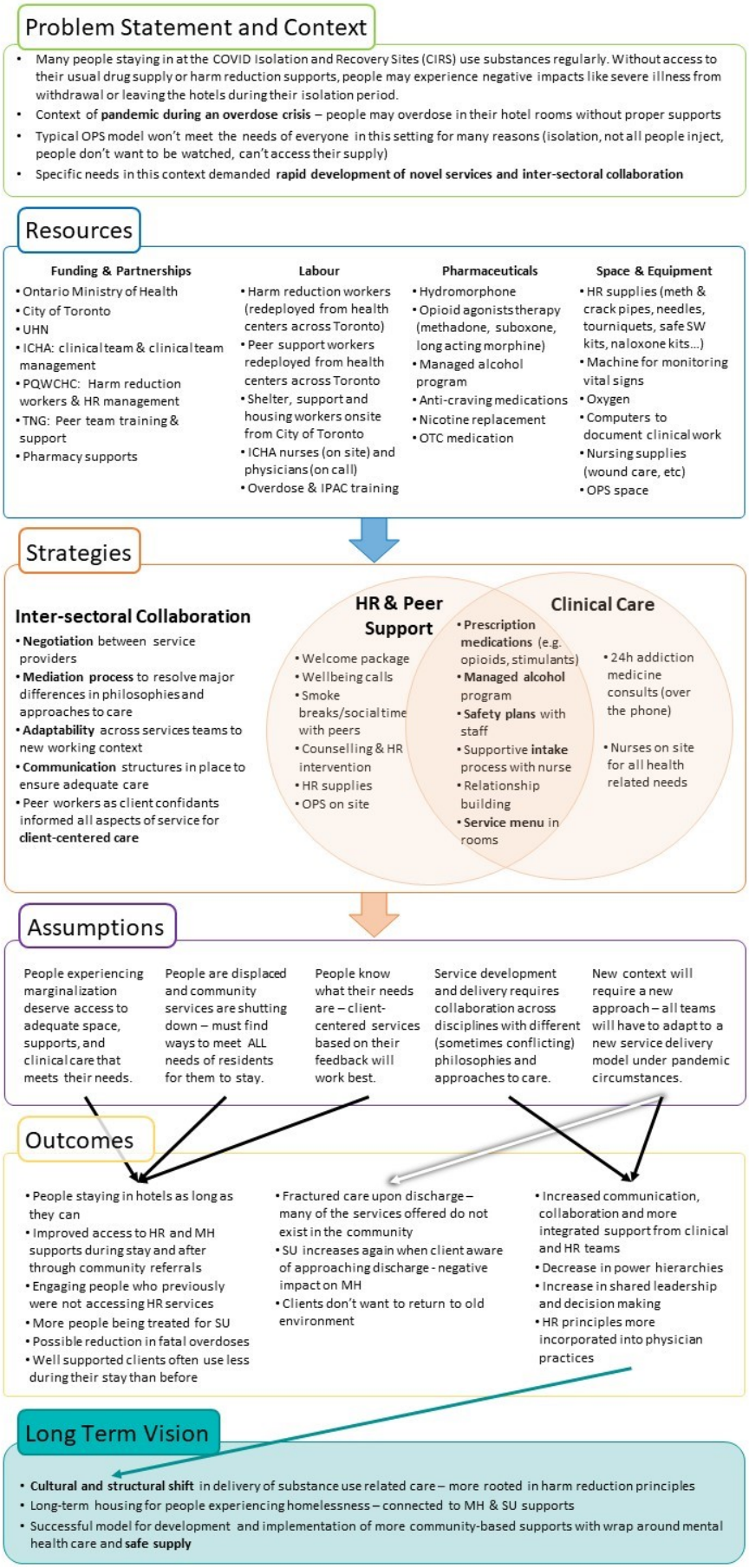


Figure 3. Logic Model

Abbreviations— ICHA: Inner City Health Associates; PQWCHC: Parkdale-Queen-West Community Health Centre; TNG: The Neighbourhood Group; UHN: University Health Network; MH: Mental Health; OPS: Overdose Prevention Site; HR: Harm Reduction; SU: Substance Use

CIRS - provided input into the main thematic areas to focus on during analysis. An analysis team composed of research coordinators, research assistants and one of the project leads (who was not an on-site staff member or involved in directly providing care to clients or supervision to staff) met regularly and were responsible for developing the analytic plan and activities. Analysis team members coded and analysed all transcripts using Dedoose (www.dedoose.com). To maintain confidentiality of the participant responses, community partners on the research team did not have access to audio-recordings or transcripts. Iterative and thematic analytic methods were used to identify key themes that emerged in the interview discussions, with additional themes identified using the program logic model and feedback from the full research team on main areas of analytic interest. Once initial themes were identified, they were compared between the different groups of participants to identify consistent themes. Analysis team members met regularly to talk about the themes being identified and identify the main areas for analytic attention in the final evaluation report. They also regularly presented preliminary results from the coding and analysis to the full research team for comment, feedback, and refinement. Analysis team members were responsible for preparing a first draft of this report, and all research team members were offered an opportunity to review and provide feedback on the draft report.

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