Toronto Shelter-Hotel Overdose Preparedness Assessment Project

Final Report and Recommendations
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Completed by the Toronto Shelter-Hotel Overdose Action Task Force

Toronto Shelter-Hotel Overdose Action Task Force:

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Background

As a result of the swift onset of the COVID-19 pandemic in the spring of 2020 and subsequent Ontario Health guidelines for physical distancing in congregate living environments, Toronto's shelter system underwent a sudden and significant transformation. In the early days of the pandemic, the City of Toronto's Shelter, Support and Housing Administration (SSHA) division began directly operating shelter services in hotel and motel settings. As these new sites opened, shelter system clients were assigned to either remain in a traditional, albeit reconfigured congregate setting, or offered a room in a shelter-hotel. By the summer of 2020, community-based shelter operators had also started to operate shelter-hotels, marking a new era for sector service delivery.

With the risk of COVID-19 transmission driving this system-wide pivot, local harm reductionists quickly drew attention to new overdose risks for residents who use drugs in these settings. Shelter operators had been tasked with quickly translating their traditional congregate-living shelter operations to the hotel-setting while upholding dynamic pandemic-driven public health measures. Some operators also found themselves serving new-to-them populations of people experiencing homelessness. Operators faced the challenging task of responding to two co-occurring public health emergencies, with the overdose crisis escalating and exacerbated by the COVID-19 pandemic. This precarious context provoked a focused group of Toronto harm reduction experts with lived, frontline, and management experience to form the Toronto Shelter-Hotel Overdose Action Task Force (Task Force) in August 2020. The Task Force mobilized quickly to partner with the SSHA division and offer an evidence-informed strategy for preventing unnecessary overdoses and overdose fatalities in the new shelter settings. SSHA quickly endorsed the Task Force's request to implement the Toronto Shelter-Hotel Overdose Preparedness Assessment Project (TSHOPAP).

Concurrently to TSHOPAP, the Task Force set out on a longer-term initiative, developing a peer drug use witnessing program demonstration project, the Shelter Hotel Overdose Prevention Project (SHOPP). While SHOPP's development was both imperative to creating a local evidence base to support a low-barrier overdose intervention and informed TSHOPAP's evolution, it is beyond the scope of this report.

Project Summary

TSHOPAP launched in September 2020, introducing a community health model of assessment and intervention to identify and address overdose preparedness in Toronto's pandemic-era shelter-hotel system. The project was intentionally designed to be a collaborative effort of Toronto's shelter and harm reduction sectors, and aimed to provide urgent, direct assistance to the shelter-hotel site operators to develop and implement site-specific overdose mortality prevention plans. The primary goal of TSHOPAP was to immediately contribute to the prevention of further overdose deaths at all shelter-hotel locations. The secondary goal was to enable site operators to build capacity in overdose awareness, prevention and preparedness through knowledge sharing partnerships with local harm reduction programs and experts.

The Task Force behind TSHOPAP aspired to build relationships within the shelter-hotel sector that would support the uptake of robust harm reduction programming within the shelter sector at large. As such, the Task Force employed a harm reduction approach that centred rapport building, mutual learning, and collaborative goal setting. This was a deliberate strategy grounded in public health and humanistic imperatives. The Task Force hoped that the initiative would help create positive working relationships between the shelter and harm reduction sectors. TSHOPAP concluded in mid-December 2020, though the model has been replicated in shelter and housing settings since then.

Project Methodology

Design

The purpose of TSHOPAP and the urgency in which it had to be implemented led the Task Force to adopt a classic community health assessment and planning framework (planning, stakeholder engagement, assessment, prioritization of issues, intervention planning and implementation, and evaluation of process and outcomes) for the project. The Task Force conceptualized an appraisal model, whereby a team of two experienced staff from robust harm reductionist agencies in Toronto (assessment team), visited the site and collaborated with shelter-hotel management, frontline workers and residents who used drugs. Together, the intersectoral team assessed the organization and physical site for overdose preparedness and co-developed a triaged set of recommendations for implementing enhanced overdose awareness, prevention and response practices. Implementation was framed and realized as the shared responsibility of the shelter program and harm reduction assessment team members. All parties were responsible for the intervention planning process, initiated during the site visit. The harm reduction contingent became a direct-line resource to the site team, and accountable for directly providing, referring and/or brokering the applicable resources and supports for the site assessment team. The site team was responsible for implementing the recommendations in a specified timeframe and identifying further needs as they arose after the assessment.

Following each assessment, the harm reduction assessment teams were responsible for documenting and initiating pre-scheduled check-ins with the shelter hotel operators. Within days of the visit, the assessment teams emailed a private Google Drive link to the site teams with their assessment documentation, requesting review for accuracy and completeness. This same shared document was used to record status updates on recommendation implementation at the 1- and 2-week post-assessment email check-ins, and from ad hoc communications or other follow ups. Each assessment concluded 14 days following the site visit; although, connections fostered within the intersectoral assessment team were intended to continue, enabling enhanced harm reduction and overdose preparedness competency within each of the shelter-hotel teams. The assessment process was followed up with surveys for participant site teams and the harm reduction assessors, to evaluate the learnings from, experience, perceived value and translatability of TSHOPAP.

Approach

The assessment process was intentionally crafted to be supportive, educational, and pragmatic. The harm reduction assessors brought empathy for the shelter-hotel operators' incredible task of successful adaptation to their new settings, as well as an appreciation for the opportunities and constraints specific to each site and operating organization. The assessment team approach was conversational yet anchored in a systematic assessment tool that was shared to the site team prior to the visit as an educational tool. Deploying a strengths-based approach, assessors celebrated existing good practices in overdose preparedness. They supported the site teams to identify deficiencies, providing education on evidence-informed and emerging practices in overdose preparedness for consideration. Intervention planning considered the unique challenges and opportunities of each shelter hotel site. Follow-up TSHOPAP activities were similarly designed to encourage, trouble-shoot, and highlight successes. As such, the assessment process was an intervention in and of itself.

The TSHOPAP model and approach were developed by the Task Force through an iterative and consensus-driven process, and solidly founded on harm reduction principles. In addition to the goals of stopping overdose deaths in the hotels and building overdose competencies within the shelter sector, was the desired creation of a model with potential for use in other community service settings. This meant that the learnings from earlier assessments helped fine tune mechanisms for later assessments; thereby, the Task Force's debriefing and decision-making processes became an innate system of continuous quality improvement for the project.

Tools and Materials

The Task Force developed and utilized numerous tools to support TSHOPAP implementation and outcomes: Overdose Preparedness Assessment Tool, Overdose Preparedness Toolkit, and a series of health promotion materials designed for the hotel sites in response to needs identified during assessment visits.

Overdose Preparedness Assessment Tool (Appendix A)
The Overdose Preparedness Assessment Tool was the defining document of TSHOPAP operations. It was crafted by the Task Force and refined following pilot testing with the first two hotel sites. The assessment tool was purpose-built for examining overdose preparedness in Toronto's shelter hotel settings. It drew extensively from the evidence body of best and emerging practices in community-based overdose awareness, prevention and response, while also integrating expectations laid out in the Toronto Shelter Standards (TSS) including the 2018 Harm Reduction Directive, and Harm Reduction Framework (HRF).

The assessment tool is a mixed-format, four-page document consisting of checklists and guided narrative text spaces, covering three focal assessment domains. The tool allows an assessment team to systematically review the shelter hotel operator's organizational policies, protocols, culture, and training as they directly relate to overdose awareness and readiness, and as they contribute to a culture of support for people who use drugs and fidelity to harm reduction principles as laid out in the HRF. The assessment form also provides a comprehensive list of overdose awareness and prevention strategies, serving as benchmarks for existing overdose preparedness interventions and also a menu of options for immediate and longer-term consideration. The final domain outlined in the assessment tool is a review of the shelter-hotel site's physical environment for overdose risk, a space useful for documenting the built-form challenges identified during an assessment team's site tour.

In design and function, the Overdose Preparedness Assessment Tool is a living document. The tool housed the documentation of co-developed site-specific recommendations and well-defined implementation plan for enhancing overdose preparedness. As well, all assessment team members could access the document at any time to provide status updates. During TSHOPAP, each site's specific documentation was accessible only to the Task Force and members of a site's intersectoral assessment team.

Overdose Preparedness Toolkit
Each overdose preparedness assessment was accompanied by a suite of resources thoughtfully curated to support resident safety when using drugs and enhance site staff knowledge of overdose-related service strategies. The toolkit consisted of softcopy resources and where possible, printed materials for immediate application. The *Overdose Preparedness Toolkit* consisted of, but was not limited to:

- The Works' *5 Step Overdose Response* poster (Appendix B)
- *Naloxone Kits Available Here* posters
- *Naloxone Kits Available Here* stickers
- Naloxone Kits (to ensure immediate, adequate access)
- Grenfell Ministries Overdose Prevention Line* promotional flyers
- BeSafe App promotional flyers
- *My Overdose Prevention Plan* client planning resource (Appendix C)
- *Call Us!* posters (promotion of post-drug use wellness checks by staff)
- Overdose responder door hangers (for hotel residents to indicate their skill and availability to respond to overdose)
- Street Health Overdose Prevention Site promotional stickers (for downtown hotels)
- Engaging in Overdose Prevention Conversations (staff resource)
- Contact information/business cards of harm reduction assessors

  * This resource has since been retired as an Ontario overdose prevention service, replaced by the National Overdose Response Service.

While the majority of the toolkit consisted of existing resources from Toronto Public Health or other harm reduction organizations, two of the health promotional materials were developed by the Task Force as a direct response to needs identified in early hotel site assessments. The Task Force quickly developed the *Call Us!* poster to support the quick implementation for one site operator who expressed interest in staff providing on-demand, non-judgmental wellness checks for clients following in-room drug use. The overdose responder door hanger idea was inspired by the hotel setting during an assessment visit as the site operator and harm reduction team discussed possible creative but discreet ideas for residents to self-identify as an overdose responder. The setting elicited the hotel-style door hanger that could be placed on a room door handle whenever the resident was willing to intervene in an overdose with naloxone.

Evaluation

The Task Force used a mixed methods approach to evaluate TSHOPAP processes and outcomes, including project stakeholder experiences. Feedback was sought from shelter-hotel operator staff who took part in the assessment process, as well as the harm reduction assessment team members who led the process for each site. The project's meeting minutes were also reviewed for their narrative value for robustly articulating TSHOPAP's successes, challenges, and pursuant recommendations for overdose preparedness in the shelter system.

Site Operator Survey

Site operators were sent a short Google Forms survey that covered the acceptability of TSHOPAP and its impact on site operators' knowledge, commitment, and actions related to overdose preparedness in their particular settings. It also solicited recommendations for assessment method, process, and tool improvement. Acceptability measures included: perceived benefits of the assessment process and its outcomes, effectiveness of the assessment tool and process, usefulness of print and e-copy resources from the toolkit, and feasibility of overdose preparedness recommendations derived from the assessment. The survey also asked for a self-assessment of changes in overdose preparedness knowledge and awareness of organizational policy and practice implications for overdose prevention, preparedness and response. In closing, survey respondents were asked about the transferability of TSHOPAP model and learnings to other practice settings, and their opinion on the impact of the assessment process on the relationship between shelter and harm reduction sectors.

Harm Reduction Assessment Team Survey

The harm reduction workers who made up the TSHOPAP assessment teams were issued a survey soliciting their reflections on the assessment process and project outcomes. They were asked to describe their perceptions of the project's benefits, both planned and unintended, and the intervention's impact on them, including knowledge development. The assessment team members were also asked to consider the appropriateness of applying the overdose preparedness assessment model to other shelter programs and other social service settings. The survey concluded with an option for assessors to consider the data and experience amassed from their participation in TSHOPAP, to inform recommendations for systemic changes to the shelter system regarding overdose.

Analysis

The Task Force applied a continuous and terminal analysis approach to TSHOPAP. Due to the novel nature of the intervention, ongoing and progressive quality improvement on the assessment process and tool was essential to the project's implementation and success. As such, the Task Force discussed and refined the assessment tool based on assessor feedback in project meetings and through email briefings. The assessment process and toolkit were revised based on the experiential learnings and site operators' emergent needs, particularly in the early phase of project rollout.

To summarize project findings and to develop systemic recommendations arising from TSHOPAP, the Task Force reviewed assessment documentation, both surveys' results, Task Force meeting minutes, and email communications between assessment and site operator teams, for recurring themes and inconsistencies. Employing a basic thematic analysis framework, the Task Force was able to discern the nuances between sites and site operators, and clearly define the systemic challenges for overdose preparedness in the shelter hotel system. In parallel to this analytical

process, the Task Force reviewed the Toronto Shelter Standards (inclusive of the 2018 Harm Reduction Directive update) and Harm Reduction Framework for the purposes of evaluating shelter hotel fidelity to established sector expectations and to ground the project's pursuant system-wide recommendations for improving overdose prevention and preparedness. The recommendations devised from this project were reviewed by both the Task Force and shared with all assessment team members for feedback prior to finalizing.

Overdose Preparedness Assessment Results

Results for this project reflect data collected during the onsite overdose preparedness assessments. Of the 17 shelter-hotel sites identified by the project team and SSHA during the course of TSHOPAP, 16 sites (94%) participated in the assessment process. As part of the project team's commitment to honouring the confidentiality of site-specific recommendations and to support building relationships of trust, the site-specific results and recommendations will not be discussed in this report. Instead, the results presented here represent aggregate trends observed across site assessments, include input on systemic issues from the site operators, and are presented using a thematic framework for clarity.

Openness to Harm Reduction

The majority of sites expressed strong support for the values of harm reduction and had a good understanding of what harm reduction means in practice, beyond simply the distribution of supplies. This openness to harm reduction was evident in the amount of effort already underway toward the goal of overdose prevention and through the multiple ways in which site operators were willing to make immediate adjustments to overdose prevention efforts. Almost universally, this process resulted in positive conversations, acceptable and feasible recommendations, increased knowledge of overdose prevention strategies, and an increased willingness to evaluate existing policies from a harm reduction lens. While it is necessary to note that this openness to harm reduction was not shared by all participating shelter-hotel programs, the openness and support shown by the vast majority of sites can be utilized as a catalyst for further system-wide progress.

Staff Training as a System-Wide Challenge

Across all sites, operators discussed the challenges inherent in getting all client-facing staff appropriately trained in harm reduction philosophies and overdose prevention in a timely and ongoing way. The number of staff required to safely operate the sites often necessitates operators having to rely on staff from employment agencies to fill gaps in the schedule which often results in shifts with frontline service staff who do not have comprehensive knowledge of harm reduction and overdose prevention or response. Site operators also discussed the challenges in ensuring all training is completed and up to date prior to site opening due to the speed at which these sites were developed. Universally, operators acknowledged the importance and necessity of better training for all onsite staff, including security personnel, but felt that they did not have the appropriate resources and structure to ensure that this happens, particularly in the context of high staff turnover. In some cases, operators discussed the stress of having to utilize operating budgets to supplement training for staff from employment agencies and stressed the desire for more regular, sector-wide training opportunities for all onsite staff.

Disconnect between Toronto Shelter Standards and Overdose Prevention Approaches

The shelter-hotel site assessments consistently revealed the challenges faced by site operators in interpreting and following the existing TSS and HRF in the hotel setting, with respect to overdose preparedness and prevention, especially within the COVID-19 context. On several occasions, the assessment teams heard that the physical distancing requirements behind the shelter-hotel model were an obstacle to implementing even basic overdose prevention practices that would otherwise be supported by the TSS. Interventions such as peer or staff witnessed drug use and guest policies that supported these practices were interpreted as being in contravention to pandemic related public health measures. It was evident to the assessment teams that hotel site operators lacked the foundational support and guidance needed to balance their approaches to the two public health crises.

Notably, the HRF was not referenced by site operators or mentioned during the assessments despite its alignment to the intervention. The HRF addresses many of the situations that hotel site operators, staff, and residents brought up during TSHOPAP visits. In particular, the assessments revealed lingering staff resistance to harm reduction across sites, situations of client discharge due to overdose, and difficulties managing competing needs of residents who use

drugs and those who are abstinent. Despite this disconnect, most of the site operators endorsed the importance of a harm reduction approach and overdose preparedness in the new hotel settings.

Location is Important for Overdose Prevention

A central discussion point for many assessors and site operators was the impact of site location on the safety of residents who use drugs. Operators highlighted the challenges inherent in having to encourage residents to travel upwards of 1.5 hours in some cases to a safer use site in order to comply with organizational policies and procedures pertaining to onsite drug use. Several operators discussed the urgent need to have increased harm reduction and overdose prevention services onsite to mitigate overdose fatalities as they acknowledged that travelling to these services is not always feasible or realistic for residents. Location was also discussed as an important predictor of the sense of stability and community connection for shelter-hotel residents. It was reported that residents are community members of the places (typically downtown Toronto) from which they relocated and have existing relationships with workers which became harder to maintain when sites were farther from the downtown core. These relationships and services are often central parts of people's daily routine and help keep folks engaged in health, social, and overdose prevention services. As such, being able to easily maintain these routines is positively correlated to more stability and connection during transition. Operators noted that in sites further from residents' original locations, there was often a difficult transition period marked by increased isolation which, in some cases, increased overdose rates.

Need for Increased Wraparound Supports for People Who Use Drugs at Outset

The desire to integrate fulsome and comprehensive wrap-around supports within the shelter-hotel sites was evident across all onsite assessments. Operators clearly articulated the importance of wraparound supports, particularly but not limited to, overdose prevention supports to prevent fatalities, increase retention of residents, and improve resident experience and satisfaction. In the context of site operations, operators highlighted the scale of work related to running new shelter-hotel sites and raised the difficulties in trying to implement new services or practice changes while simultaneously trying to maintain daily operations. Repeatedly, operators expressed the importance of having system-level guidance and resource support to ensure that wrap around services are in place prior to opening. Operators named onsite injection services, robust naloxone distribution, harm reduction peer support, and peer witnessing as onsite harm reduction and overdose prevention services that would assist in increased overdose preparedness at their site.

Resident Stratification as a Problematic Approach to Overdose Prevention

As discussed throughout the report, site operators were acutely aware of the risk of overdose within the shelter-hotel system. In an attempt to mitigate this risk, several operators discussed their resident stratification approach as an overdose prevention strategy. This approach has resulted in people who use drugs being actively screened out of shelter-hotel beds and kept in congregate settings with less protection from COVID-19 and increased surveillance. In some cases, a spot at the shelter-hotel site was deemed to be a "reward" for good or stable behaviour in the congregate site. While likely well-intentioned as an overdose prevention approach, these risk stratification approaches center drug use as the predominant risk factor, rather than examine the systemic responses to drug use as the driver of risk. People who use drugs are then prevented from accessing shelter-hotel programs where there are increased COVID-19 protection measures and other setting-based benefits. Simultaneously, some sites applying these stratification measures had fewer overdose prevention practices in place due to the perception of the setting's lower risk. This often correlated with a lower degree of preparedness when overdose response is required.

Formalizing Informal Processes as a Means to Progress

Site assessors repeatedly remarked on the significant extent of excellent work being done by staff at the shelter-hotel sites. Throughout the assessment process, site staff and management detailed the ways in which staff work to leverage their harm reduction experience and relationships to find innovative solutions for residents who use drugs. Often, this work requires staff to find and utilize loopholes, take creative approaches to problem solving within institutions, and operate from a shared informal sense of how each specific site works. In many cases, site operators

discussed how that requires a reinterpretation and/or "bending" of the policies and procedures as written. This assessment process found that these approaches are generally wise practices which are reasonable, appropriate, centre site-specific expertise and resident experience, and are in the interest of progressive harm reduction. However, the informal nature of these practices inherently makes them precarious and subject to staff consistency. Formalizing these practices and creative approaches through policy reviews, training, and formal practice changes fosters responsive leadership, staff expertise, and collaborative community-focused ideas in onsite overdose response and harm reduction frameworks.

Project Evaluation Survey Results

Upon completion of the 16 overdose preparedness assessments, the participating shelter-hotel site operators and assessors were sent project evaluation surveys, specific to their respective TSHOPAP roles as described in the Project Methodology section of this report. Response rates for each group were 44% (n=7) and 55% (n=6) respectively.

Site Operator Feedback

Shelter hotel operators were asked to evaluate four aspects of their TSHOPAP experience: the overdose preparedness assessment tool, overdose preparedness resources provided by the Task Force, overdose preparedness recommendations derived from the assessment process, and their perceptions of the project's impact.

Site operators reported that the overdose preparedness assessment tool developed and used in TSHOPAP was acceptable, serving as a useful anchor for the assessment process. Overdose preparedness resources, such as The Works' *5 Step Overdose Response* poster, *My Overdose Prevention Plan* client planning resource and provision of naloxone kits at the time of assessment were overwhelmingly received as supportive interventions for implementing recommendations from the assessments. Having the harm reduction assessment teams offer safer drug use supplies during the onsite visit would have been a welcome addition to the toolkit. With regard to recommendations derived from the overdose assessment process, site operators expressed that they were both acceptable and feasible.

The most significant findings from the site operator survey pertained to their knowledge gains and perceptions of project legacy. Seventy-one percent of respondents felt that their knowledge of overdose preparedness increased as a result of their involvement with TSHOPAP. The reasons expressed were varied which was not surprising, considering the variance in baseline knowledge at the outset of the assessment process across site operators. The vast majority of respondents expressed that TSHOPAP created stronger ties between their organizations and the harm reduction sector which can be reasonably extrapolated to suggest that the project was a net benefit in terms of building bridges and supportive relationships between sectors. All respondents reported that they will likely apply the overdose preparedness recommendations learned in other settings and that they recommend the model for other shelter program settings.

Harm Reduction Assessor Feedback

The harm reduction assessors' survey responses about their perceptions of TSHOPAP's benefits, the personal impacts of their participation in the project and resultant learnings, reflected a general sense of satisfaction with the intervention, yet discouragement about the safety of people who use drugs in Toronto shelter-hotels. Respondents expressed views that TSHOPAP enabled harm reduction workers to offer immediate and practical supports in response to expressed needs related to overdose preparedness at site visits, offered the frontline workers the opportunity to help move some site operators further along in their current approaches through capacity building efforts, and build productive relationships with shelter operators that might not have otherwise occurred. One respondent remarked specifically about feeling that they were able to contribute to positive systemic changes as a result of their participation in TSHOPAP.

The impacts of project participation and learnings expressed through survey responses were less positive. Respondents were overwhelmingly concerned for the safety and wellbeing of people who used drugs at the shelter hotel sites, based on the assessor's exposure to site operations and the lack of harm reduction practices and supports in place. There were two striking survey responses in reference to assessor learnings that are worth particular mention in this report; first, one respondent was particularly concerned about some overtly stigmatizing views and disparaging remarks about people who use drugs shared by site management and staff, in repeated incidents. Another expressed concern about the intent to follow through in reference to agreement to implement but lack of follow through on the overdose preparedness and prevention recommendations. This respondent mentioned the need for system-wide accountability mechanisms, as these were out of scope for the project team and beyond their authority.

While 100% of assessor respondents endorsed the TSHOPAP model for further use in the shelter-hotel setting, they also wanted to see it adopted in traditional shelter programs, housing, and drop-in programs, making specific recommendations for model improvements. One respondent suggested to shorten the assessment tool and others iterated the importance of resident participation, an aspect of the project that was built in but extremely difficult to execute due to the urgency of the task. Prioritizing the participation of residents who use drugs was a key recommendation for future iterations of the overdose preparedness assessment model.

Recommendations for systemic changes to strengthen shelter overdose preparedness were also solicited in the assessor survey. Consistent, mandatory, and robust harm reduction training and a mechanism for ensuring shelter providers provide evidence-based, standardized support for people who use drugs, trended among respondents. Additionally, respondents called for greater, low barrier access to a range of harm reduction and overdose prevention services in the shelter system, in locations that are closer to residents' existing supports. Naturally, there were also calls for more affordable housing in Toronto.

Limitations to Data

This report outlines the results as interpreted by the project team and, as with any project, there are inherent limitations. The primary limitation is present in the collection of data as it proved extremely difficult to organize the inclusion of residents who use drugs in the onsite assessments and due to time constraints of the project, assessments had to move ahead without this inclusion. As a result, the assessments were largely competed with exclusively site staff, most often only management level staff. This inevitably results in significant bias within the data collected which is acknowledged by the project team. To mitigate this limitation, recommendations are also informed by available data pertaining to overdose rates in the shelter system as well as consultation with harm reduction experts in community.

Recommendations

Below is a list of recommendations that the Task Force derived from analysis of the aggregate Overdose Preparedness Assessment results and shelter-hotel operator process evaluation responses. They have been tested against the existing body of best-practice research and community-derived harm reduction expertise. These recommendations are intended to inspire further progress and relentless commitment toward the shared goal of zero overdose deaths within the shelter-hotel system.

1. Create an Overdose Crisis Response Lead position at SSHA to oversee system-wide overdose prevention responses, standardize overdose prevention policies and procedures, and create and monitor rigorous accountability structures. This position should be accountable for ensuring that overdose prevention directives are implemented across the shelter system and embedded within the TSS.

Evident across the results of this project was an overwhelming need for system-level leadership and accountability oversight. Operators expressed challenges interpreting and applying the TSS and HRF and highlighted challenges in adapting formal policies, procedures, and training needs to reflect more progressive and consistent approaches to drug use and overdose prevention. There were also significant variances in policies, approaches, and training requirements across shelter-hotel sites which presents ongoing challenges for residents who use drugs when seeking shelter across an inconsistent system. To address this immediate need, this task force recommends hiring a senior-level position to oversee, and be responsible for, the shelter sector response to the overdose crisis. This leadership position should be the primary person responsible for an overdose response strategy across the shelter system and implement regular accountability structures to ensure consistent and appropriate utilization of the HRF across all sites and within the formal TSS.

2. Immediately scale-up onsite overdose prevention interventions across the shelter-hotel system including overdose prevention sites, peer witnessing projects, spotting programs, and safer supply access.

Site operators and site assessors were clear in their requests to urgently expand the onsite overdose prevention interventions and that is reflected in this task force recommendation. Site operators spoke to the need to have increased onsite safe substance use options that are supported by systems-level policy, resource allocation, and training supports. It is the recommendation of the Task Force that all sites within the shelter-hotel system be prepared to operationalize a plurality of overdose prevention options including but not limited to supervised consumption spaces, peer witnessing programs, spotting programs, and integrated safer supply access in order to appropriately respond to the unique contexts and preferences of each site and its residents. People who use drugs should be integral to the development and implementation of these programs and engaged as experts in order to discern which interventions are most appropriate for each site.

3. Ensure harm reduction and overdose prevention programs and interventions, including the training of all staff onsite, are in place prior to all shelter-hotel openings going forward.

It was clear throughout the assessment process that the transition period into a new site was the most challenging time for both residents and staff. For many residents, moving into a shelter-hotel represents moving into a new neighbourhood and new environment where relationships and trust with staff are not yet developed. This often

translates to a period where isolation, and therefore overdose risk, is more pronounced. Consequently, it is crucial to have strong harm reduction and overdose prevention measures in place at the outset to ensure that residents have access to the types of services that they need to support safer use practices and create welcoming environments for people who use drugs. Having all client-facing staff appropriately trained prior to opening is also imperative to a safer transition period for residents. Operators spoke to the challenge of changing practices and facilitating training while sites were open and requested increased SSHA support to ensure timely, adequate, and system-wide training to support staff capacity building during onboarding. Having these resources and programs in place at baseline and operated by confident, well-trained staff is a significant and important overdose prevention strategy.

4. Improve quality, consistency, and timeliness of shelter sector overdose data (inclusive of race and gender) sharing in order to ensure interventions are rapidly responsive, appropriate, and centre equity.

In order to ensure that system and community responses are evidence-based and adaptable to real-time realties, the Task Force recommends an urgent improvement of data sharing processes for shelter sector overdose incidence and prevalence data. This enhancement should be reasonably actionable in the short term due to the availability of the data through the existing Toronto Overdose Information System, Toronto drug checking services, and the Shelter Management Information System (SMIS). SMIS, as well as other formal and informal information sharing networks, has the functionality to fan out alerts and assist in triggering the deployment of outreach teams, grief-related services and other community-driven responses.

It is also the recommendation of the Task Force that race and gender information are collected and shared to identify important trends and expose where targeted responses may be required. Overdose prevention responses, harm reduction programs, and staff training must all be thoroughly rooted in social justice and intersectional approaches to equity - having strong, transparent, widely available, and timely data is essential to this work.

5. Ensure widespread and fulsome utilization of existing internal and external harm reduction and health expertise and resources (community training, harm reduction supply distribution channels, naloxone ordering systems, peer work models, etc.).

As a result of decades of work and community advocacy, there are numerous community programs focused on harm reduction and overdose prevention across Toronto. The assessment process highlighted the siloed nature of the shelter and harm reduction sectors that, in many cases, resulted in barriers and challenges for shelter operators when trying to access supplies, information, and training. For example, many shelter-hotels reported having a difficult time sourcing enough naloxone to distribute widely to residents. In some cases, this was true even when the operating agency had a contract in place with Toronto Public Health - The Works for another department. As a result of these access challenges, the Task Force recommends that SSHA and site operators, with the support of The Works at TPH, enable widespread access and connection to available harm reduction community resources - especially supply distribution, training, and capacity building supports.

6. Standardize harm reduction and overdose prevention policies, procedures, and onsite tools across the shelter and shelter-hotel system and immediately implement fulsome and rigorous accountability measures to ensure sector-wide consistency in harm reduction and overdose prevention approaches.

Many shelter-hotel residents have, and will likely continue to have, experience with several different shelter sites and operators. As people move through the system, their experience of harm reduction and overdose prevention can vary substantially. This lack of consistency results in confusion, difficulty navigating rules, lack of trust, and increased overdose risk. To address this consistency issue, the Task Force recommends that SSHA leverage the TSS to support system-wide standardization of harm reduction and overdose prevention, response, and training policies as well as regular systematic oversight to ensure consistency in implementation and policy interpretation. It is the recommendation of the Task Force that residents who use drugs should be engaged in this policy development process as leaders, experts, and primary stakeholders. Accountability and funder-level leadership will be central to this system-wide change, and regular and rigorous review of onsite operations will be essential to promote a consistent and harm reduction-driven experience for shelter residents.

7. Utilize the Toronto Shelter-Hotel Overdose Assessment Preparedness Project model at all shelter-hotel, respite, and congregate shelter sites in 2021 as a supportive mechanism to HRF implementation and increase overdose preparedness across the entire shelter system.

In alignment with the project evaluation results, the task force recommends expanding the use of the project model across all shelter-hotel, respite, and congregate shelter sites to address the rates of overdose and overdose deaths across the entire shelter system. The Overdose Preparedness Assessment Tool has been revised and updated to be more widely applicable to various shelter settings and can be utilized to support the implementation of the HRF and overdose preparedness measures. The tool can be further adapted and should be utilized given how it facilitates a truly collaborative model of capacity building and relationship development between the shelter and harm reduction sectors. Due to the urgency of the overdose crisis, it is recommended that all shelter programs, including respite sites, undergo an overdose preparedness assessment in 2021.

Conclusion

TSHOPAP represented well, some very foundational qualities of community-based harm reduction, in particular its evidence-basis, pragmatism and flexibility. The project demonstrated an effective re-imagining of a long-established best practice model of community health assessment, adapting it to meet an emerging community need while grounding the process firmly in a harm reduction approach. It introduced a promising practice to both the shelter and harm reduction sectors and a novel forum for the two to collaborate on a mutually concerning challenge. It is the greatest hope of the Task Force that TSHOPAP prevented overdose deaths in the shelter-hotel system. The Task Force encourages that the precedent setting work of TSHOPAP continue on, in an ever-evolving way, integrated into the conceptualization, design, implementation and evaluation of Toronto shelter services going forward.

Appendices

Appendix A: Overdose Preparedness Assessment Tool

Shelter Harm Reduction and Overdose Preparedness Assessment

Site and Assessment Team Details

Date:

Site Name and Operator:

Site Address:

Assessment Team:

Site Representative(s):

Resident Representative(s):

Harm Reduction Sector Representative(s):

Site Basics:

Number of residents: _____ Number of rooms/units: _____ (or Number of beds: _____)

Gender(s) served (including proportions):

_____

Priority populations (eg. Indigenous, youth, 2+SLGBTQ):

_____

Staff positions on site:

_____

Organizational Policies & Protocols

Organizational policies or protocols include:

☐ A commitment to a harm reduction approach to drug use

☐ The requirement for all client service staff to employ a harm reduction approach to drug use

☐ A commitment to destigmatizing drug use – example:

_____

☐ Non-punitive responses to drug use onsite

☐ Protections from discharge on basis of drug use and/or drug selling (in and of itself)

☐ Clear directive for not engaging CAS on basis of drug use alone (if applicable)

☐ Clear directive for police non-engagement related to drug use alone

☐ A client-led wellness check system that respects client autonomy and privacy (while balancing safety concerns)

☐ An overdose response and naloxone administration directive, covering inside and outside incidents

☐ Other:

_____

Client INITIAL intake protocol includes at minimum, UNIVERSAL orientation to the site's:

☐ Harm reduction policy and programming, including overdose preparation and prevention services

☐ Non-punitive response to drug use on site (primacy of support and care)

☐ Safer drug use supply availability (☐ Supplies are available at intake)

☐ Naloxone availability (☐ Naloxone is offered to all clients at initial intake)

☐ Wellness check protocols

Secondary intake protocol includes supportive discussions about:

☐ Individual overdose preparation/planning

☐ Organizational policies on CAS protocols (if applicable) and police engagement related to drug use

☐ Processes for resident participation in site activities, job or volunteer opportunities

☐ Feedback and complaints mechanism

☐ The role of security staff on site

☐ Emergency contact information (document next of kin)

☐ How to support continued access to services: harm reduction, health care /prescribers, employment, etc.

Notes:

Harm Reduction Operational Requirements

The organization has consistent access to and systems in place to manage:

☐ Safer drug use supply distribution

☐ Naloxone distribution

☐ Biohazardous waste/sharps disposal

☐ Overdose response and naloxone administration (see section below: Overdose Prevention, Preparedness and Response Strategies)

Safer drug use supplies are available to clients:

☐ 24/7 ☐ barrier free (eg. self-serve stations) ☐ through designated residents/peers ☐ through all staff

☐ through visiting service providers

Naloxone is available to clients:

☐ 24/7 ☐ barrier free (eg. self-serve stations) ☐ through designated residents/peers ☐ through all staff

☐ through visiting service providers

The following involvement opportunities are in place for people who use drugs:

☐ Resident harm reduction and/or overdose prevention advisory committee

☐ Paid positions that utilize their drug culture expertise and offer further skill development

☐ Volunteer positions

☐ Consultation about site harm reduction, overdose prevention, and overdose preparedness initiatives

☐ Training and education in harm reduction and overdose response

The following referral pathways for harm reduction care are established:

☐ Local/accessible harm reduction program ☐ OAT prescriber ☐ Safer Supply prescriber

☐ Community Health Centre ☐ Local pharmacy ☐ Other:

Notes:

Overdose Prevention, Preparedness and Response Strategies

Up-to-Date overdose-related policies and procedures specifying:

☐ The established protocol for overdose responses onsite (inside and outside)

☐ Staff expectations for engaging in client-centred overdose prevention and preparedness practices-

- ☐ ongoing collaboration with clients to assess their overdose risk
- ☐ supporting clients to use more safely in their rooms or elsewhere onsite (eg. peer witnessing, request staff to do post-drug use wellness checks, use overdose prevention phone lines or app-based spotting)
- ☐ supporting clients to be trained in overdose prevention, recognition & response and carry naloxone

☐ Frequency of staff overdose refresher training and simulation participation (with tracking mechanism)

☐ Regular and systematic quality assurance checks of all onsite naloxone and related PPE

☐ Directives for frequent and systematic monitoring of communal and secluded locations onsite (including outside)

☐ Requirements for staff debriefing and offering client support following an overdose

☐ Post-overdose incident responsibilities (contacting next of kin in case of death, restocking naloxone and PPE, documentation, overdose reporting, staff care plans)

Routinization of overdose prevention, preparedness and response

☐ Establish overdose prevention and preparedness as a standing item at all site meetings

☐ Ensure shift meetings include reports or discussion about: overdose details from previous shift, identifying clients with increased need for overdose-related support, emerging conditions introducing new or increased overdose risk (eg. potent drug circulation), and staff overdose-related responsibilities.

Physical space assessment

☐ Conduct initial and recurring site safety audits to identify site locations presenting overdose incident risk

☐ Devise harm reduction-orientated strategies for creating safer spaces for drug use (eg. identify locations for quick-access naloxone such as communal bathrooms, meal areas, hallways)

Location	Risk(s) identified	Safety Strategies

Overdose response stations

☐ Create self-serve naloxone stations, that include: naloxone kits, medical gloves in various sizes, disposable surgical masks, hand sanitizer, large posters of overdose response protocol

In-room interventions (hotel room and single unit spaces)

☐ Ensure private client dwellings have operational telephone with room-to-room and external outgoing functionality

☐ Display 911 call directions close to or on phone

☐ Display overdose response protocol poster

☐ Promote overdose prevention services: naloxone, peer witnessing, staff post-drug use wellness checks, National Overdose Response Service, Safer Use Support Line, BeSafe App, onsite/local supervised consumption services

Programmatic interventions (onsite)

☐ Onsite overdose prevention site/supervised consumption service

☐ Peer witnessing program (phone and/or in-person)

☐ Staff witnessing program (phone and/or in-person)

Overdose awareness and education (client trainings, posters, flyers, discussions)

☐ Display overdose response protocol posters in communal spaces

☐ Promote naloxone availability

☐ Display overdose prevention line promotional materials

☐ Promote onsite overdose prevention services

☐ Offer and promote overdose training

Notes:

Staff Training

ALL site staff are trained in:

☐ Expectations for engaging with people who use drugs (respect, non-discrimination, trauma-informed)

☐ Overdose recognition and response (including dispatching back up, and as appropriate, naloxone administration)

☐ Safer sharps handling

In addition to the above, client service staff are trained in:

☐ CPR

☐ Overdose recognition and response skills training/simulation

☐ Overdose prevention and client safety planning

☐ "Harm Reduction 101" (history, philosophy & science, anti-stigma, drugs, drug use, impacts of drug use)

☐ Harm Reduction Supplies, naloxone distribution & best practices

☐ Role expectations related to harm reduction and drug use policies

☐ Organizational harm reduction and overdose related policies and protocols

☐ Trauma-informed care

Notes:

Recommendations

Recommendation	Priority (high, moderate, low)	Responsible Person(s)	Target Implementation Date

Assessment Follow Up Plan (Harm Reduction Representative)

☐ Email assessment documentation to site operator

Date:

☐ Connect with site operator within 1 week of assessment (support, recommendation updates).

Date:
Updates:

☐ Connect with site operator within 2 weeks of assessment (support, recommendation updates).

Date:
Updates:

Assessment Team Reflections

Appendix A: Overdose Risk Audit Procedure

Step	Action	Deliverable
1	Schedule site visit for overdose audit with site operator	• review of goals of audit, participants (including recruitment of site resident), and process
2	Identify site's specific physical space and organizational vulnerabilities to overdose risk and their potential for precipitating overdose death (ie. "risk areas.")	• An inventory of risk areas (including site locations, policies, procedures, staffing, staff skill, etc.)
3	Rank overdose risk areas by priority.	• Prioritized list for action planning
4	Determine overdose risk elimination and control measures.	• A record recommended risk elimination and control measures • Adequacy (acceptable, feasible) of risk elimination and control measures
5	Eliminate the risk or implement risk controls.	• Site operator and Task Force implement controls that functioning appropriately
6	Measure the effectiveness of controls.	• Monitor through follow up to confirm controls continue to function.
7	Make changes to improve continuously.	• Site Operators continuously monitor for improvements.

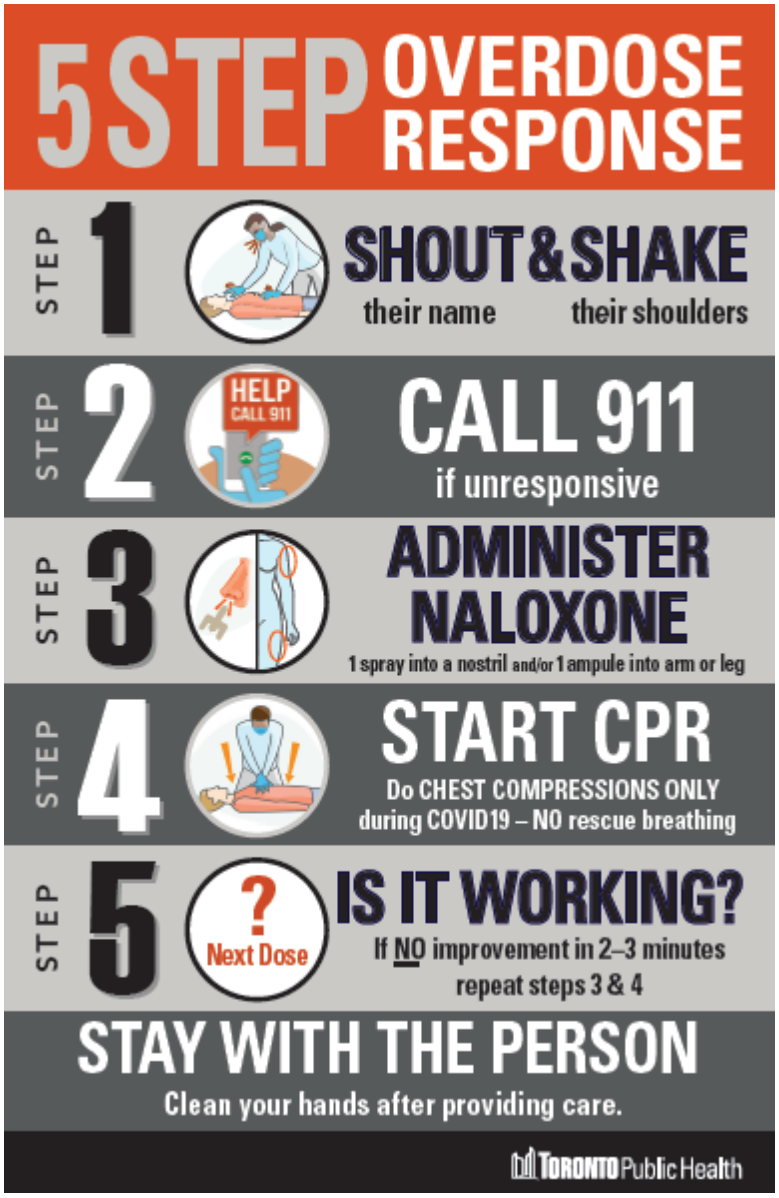
(Adapted from: Canadian Centre for Occupational Health & Safety, Sample Risk Assessment Form)

Appendix B: Good Practices for Assessment Teams

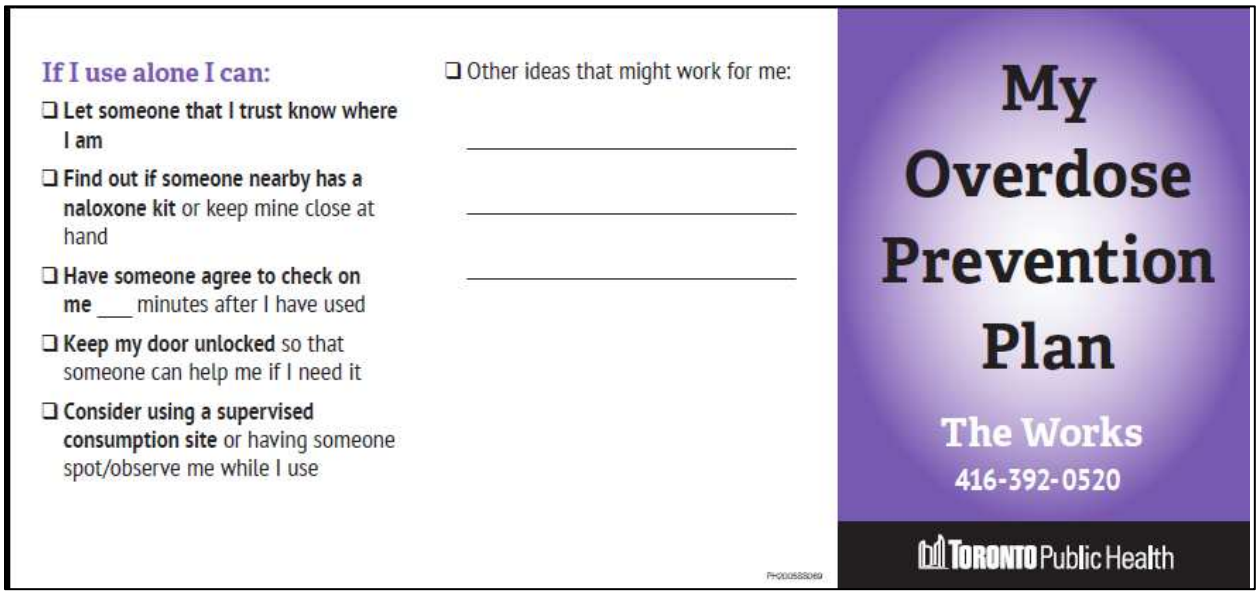
- Review the objectives, process and confidentiality with all participants before starting the audit
- Get an overview of the space layout and resident access areas from the site operator prior to doing a walk-about.
- Take a photos or video during the audit if possible and note the location where it was taken.
- Take notes or use photos and video to document positive features as well as problem areas.
- Keep notes on the improvement ideas generated during the audit to help develop recommendations
- Talk to people you meet during the audit- introduce yourself; tell them what you are doing and ask for their thoughts; consider asking whether they have had any bad experiences, and what changes they'd like to see.
- On the Hotel Overdose Risk Audit Tool, record very accurate details and very specific location information for each location or feature.
- Hold an audit team meeting onsite, immediately following the audit- review the findings and (further) develop recommendations.
- Ensure all recommendations are clear and assigned for accountability and follow up.
- Develop concrete plans for action steps and follow up.

(Adapted from: City of Toronto: Safety Audits webpage)

Appendix B: The Works' 5 Step Overdose Response Poster



Appendix C: *My Overdose Prevention Plan* leaflet



If I use alone I can:

- ❑ **Let someone that I trust know where I am**
- ❑ **Find out if someone nearby has a naloxone kit** or keep mine close at hand
- ❑ **Have someone agree to check on me** ___ minutes after I have used
- ❑ **Keep my door unlocked** so that someone can help me if I need it
- ❑ **Consider using a supervised consumption site** or having someone spot/observe me while I use

❑ Other ideas that might work for me:

_____

_____

_____

My Overdose Prevention Plan

The Works
416-392-0520

Toronto Public Health

My Overdose Prevention Plan

Self-Assessment

1. **What am I using?** Am I using it with other drugs or alcohol?
2. **When is the last time I used?**
3. **How is my overall health?**
4. **Do I use alone or with others around?**

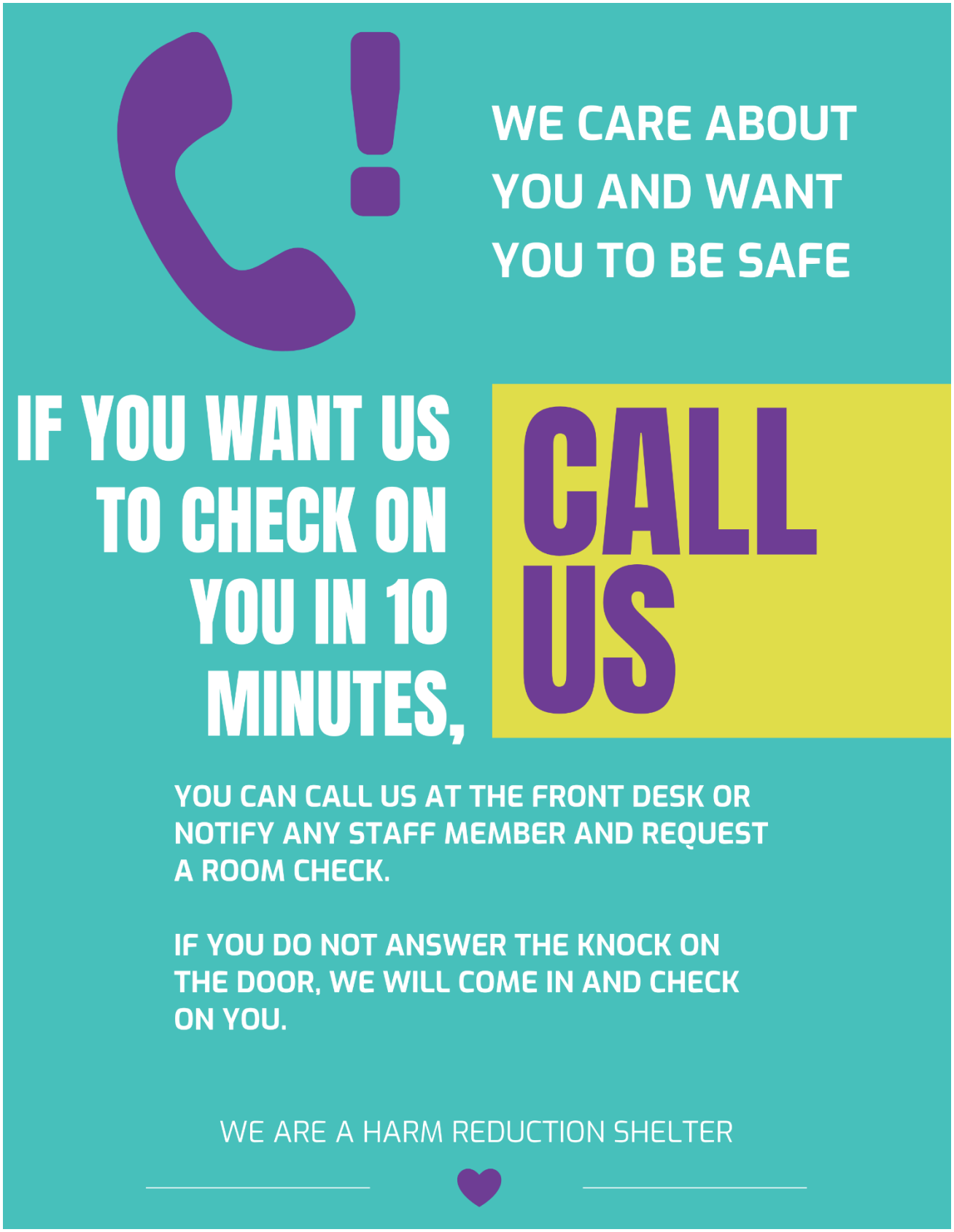
Some things I can do to help keep myself as safe as possible:

- ❑ **If I haven't used for a while** (been sick or in jail/treatment) or I am ill, I can start with a lot less than what I might usually consume
- ❑ **If I have a new dealer or supply**, I can smell it, taste a little, do a small tester shot, or ask others about the quality of the supply
- ❑ **If I usually mix my drugs**, I can try to avoid using different drugs at the same time or use smaller amounts of each
- ❑ **If I use drugs and alcohol together**, I can try to use one at a time or try smaller amounts of each
- ❑ **I can try to use only at a supervised consumption site**

If I usually use with someone else I can:

- ❑ **Talk with them about overdose** before we use and have a response plan
- ❑ **Make sure one of us has been trained to use Naloxone and have a kit on hand**
- ❑ **Use one at a time** so we can help each other if the other person goes down
- ❑ **Make sure to call 911** or at least let a staff know if there is an overdose, so I have back up in case things get worse

Appendix D: *Call Us! Poster*



Appendix E: Overdose Responder *Door Hanger*