INTEGRATED CARE HUB

CRYSTAL METH, OPIATES, OVERDOSE AND HOUSING IN KINGSTON, ONTARIO

2021 Rapid Assessment and Response
Community Needs Assessment

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Author's Note:

Amanda, Justine and Ashley have been serving people who use substances and experience homelessness for over a decade, and their commitment to continuous learning fuelled this project. Their combined knowledge from the field was invaluable to asking the right questions, and showing our community what they see and feel: the hurts, frustrations, grief and small victories they experience every day, dedicated to caring for our most marginalized citizens. This report is born out of passion, from each and every one of its contributors, who generously gave their unique knowledge and talents to its birthing.

Community Partner Consultation:

Addiction Mental Health Services , KFL&A
City of Kingston
Detox Centre
Home Base Housing
Kingston Health Sciences Centre
United Way KFL&A

Providence Care
Kingston Youth Shelter
Kingston Police
Public Health - KFL&A
Sexual Assault Centre

A special thank you goes to the 32 people at the ICH who shared their knowledge, expertise, life experience and time. Since then, we would like to acknowledge that 3 of these generous people are now deceased. Your voices live on in this document. Rest in Peace.

CONTENT & TRIGGER WARNING

This report makes every attempt to stay true to the voices of the people interviewed, people who use substances and may be experiencing homelessness. All have experienced traumatic experiences, which they may have talked about.

Content can involve experiences about substance use and overdose, losing friends and family to drug overdose, homelessness, physical, emotional and sexual assault, intimate partner violence, relationship and family breakdown, involvement in crime, survival sex work, tense interactions with police, first responders, social service and health care workers.

Some readers, especially those less familiar with the lives of people who are 'street-involved', might be upset by the content.

For people who have experienced similar traumas, have loved ones who use substances, and/or have lost loved ones to drug overdose, we caution that some of the content might be triggering.

For immediate or additional support, please see the below resources:

Addiction Mental Health Services, KFL&A
Crisis Line - (613) 544-4229

Ontario Mental Health Helpline
1-866-531-2600

Resolve Counselling
(613) 549-7850

Big White Wall
https://togetherall.com/en-ca/

Moms Stop The Harm
https://www.momsstoptheharm.com/

Members of Canadian Armed Forces Assistance Program
1-800-268-7708

Canadian Armed Forces members, families, and Veterans Line
1-800-866-4546

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DEDICATION AND ACKNOWLEDGEMENTS

This work is dedicated to the many cis and trans youth, men, women, non-binary and two-spirit people who were lost to the Shadow Epidemic of drug poisoning. Also to the sisters, brothers, siblings, spouses, partners, mothers, fathers, aunts, uncles, cousins, and other significant persons who wished that their loved ones could have come home to them. There are too many to name. Rest in Peace.

"How can you not see that these are beautiful people?"
- Jimmy

Land Acknowledgement

As a group of people who identify as settlers and of Indigenous ancestry, we acknowledge that the Integrated Care Hub is situated on the territory known locally as Katarokwi, the traditional land of the Anishinaabek and Haudenosaunee. This territory is included in the Dish With One Spoon Wampum Belt Covenant, an agreement between the Iroquois Confederacy and the Confederacy of the Ojibwe and Allied Nations to peaceably share and care for the resources around the Great Lakes. The Kingston Indigenous community continues to reflect the area's Anishinaabek and Haudenosaunee roots. There is also a significant Métis community as well as First Peoples from other Nations across Turtle Island present here today. We honour and thank the Ancestors of this land for the many gifts we receive. This needs assessment was conducted in the spirit of hoping to improve the lives of all who suffer from challenges with mental health, substance use, and homelessness, while recognizing that Indigenous persons are overrepresented in this group of people. Centuries of systemic racism and Canadian government policies have led to serious health and social inequities for Indigenous Peoples.

FOREWORD

People in our community are dying from drug poisoning at alarming rates. This needs assessment is driven by the necessity to look deeply into the causes for this catastrophe. It requires an open mind to acknowledge that all is not well, but more so, an open heart to listen, truly listen, to the people being harmed in our community, and acknowledge that we, as service providers, may indeed be causing harm even though we have the best of intentions. This type of reflexivity is never easy. The lives of the people served at the ICH are very complex, and the COVID-19 pandemic reveals how our care systems struggle to deal with their needs within multiple intersecting crises: public health, accidental overdoses due to drug poisoning, and growing homelessness. This work has occurred at a pivotal time when the need for specialized care for our most vulnerable and marginalized citizens, is paramount. The findings reported are not to lay blame at anyone's feet, but rather, to acknowledge that we can all do better, which starts with listening to the people we serve.

Philosophically, this report is about values: justice-doing, speaking truth to power, and amplifying the voices of people who are afforded little consultation by authorities, policy makers, or society in general. We hope it will be validating to the experiences of the individuals in our community who use substances and/or are experiencing homelessness. Chronicling their experiences provides insight around the complexities and challenges that the people we serve are faced with every day. We hope our work will come alive on paper, and further inspire the work being done within all community organizations that serve people who use substances.

The global health pandemic saw massive mobilization at every level of government, with solutions emerging rapidly to save people's lives. Decisions were made in consultation with experts. When we sought solutions and clarification in our work, we too consulted with the experts by reaching out to those who use the ICH – people who use substances – to inform our work. As a management team having done this work for over a decade, it was an opportunity to dig into what we might have missed or what has changed, and to reflect on how we may need to do things differently moving forward. Through these difficult conversations, we saw and felt the shame people live with and experience daily. It was difficult to witness... we cannot imagine what it truly feels like to carry.

This report seeks to build capacity, compassion and community across sectors that serve people who use substances, designed to provide a deeper understanding of the thoughts, feelings and needs of people who use substances in our community, people, as will be shown, who also experience cognitive, mental health and physical health challenges. The report is a call to action, something for us to 'shout from the rooftops'. We hope more people will start to shout with us.

Ashley O'Brien, Amanda Rogers, and Justine McIsaac

1. EXECUTIVE SUMMARY

Kingston, Ontario is experiencing a drug poisoning crisis and a homelessness crisis during a global pandemic. In such dangerous times, it is not wise to make assumptions based on pre-COVID knowledge. The people who frequent the Integrated Care Hub (ICH) – its stakeholders – know best what they are experiencing and what they need. A rapid needs assessment about people who frequent the ICH and use crystal meth and/or opiates was undertaken, and this detailed report generated. The information gathered is designed to guide the development of effective responses and drug policy to support people who use crystal meth and opiates, and prevent overdose. It also provides a wealth of information and suggestions from those interviewed on how the health and social service sectors can improve service delivery.

The pandemic exposed how important stable housing is to health, but the overdose epidemic worsened, and continues to rob people of their lives every day, people 'who have people that care about them'. This report provides a window into the lives of people who use substances, survivors of intergenerational trauma, unmet mental health needs, ongoing stress and trauma related to the overdose epidemic, and pervasive stigma. Yet these resilient people maintain hope for a better life and provide practical suggestions on how to help them to help themselves.

The ICH needs assessment involved consultations with 32 stakeholders who have used/use crystal meth and/or opioids. Challenges to social, health, criminal justice and education systems have been identified, many beyond the scope snd operations of the ICH. Six major assumptions on how to better the lives of people who frequent the ICH are articulated, providing a 'spirit of moving forward':

1. Health and social justice for all citizens of KFL & A is the shared goal we are collectively striving for as service providers, friends and family members, neighbours, and society at large.

2. Stigma and discrimination exists in society at large and in our institutions that has caused harm.

3. People served at the ICH have very complex conditions – cognitive, mental health and substance use challenges – what we refer to as 'tri-diagnosis'.

4. People who use substances have a specialized community of their own but long for a 'second chance' to reintegrate into employment and reconnect with their families

5. An integrated care model could be the key to their healing.

6. There is a lack of decent, safe, affordable housing in Kingston, particularly for individuals living in low-income, and/or dealing with physical, cognitive, mental health and/or substance use challenges.

Four populations worthy of special consideration and further inquiry are identified:

WOMEN UNDER THIRTY	INDIGENOUS PEOPLE	VETERANS	PEOPLE WITH CHRONIC PAIN AND/OR PHYSICAL DISABILITIES

Six broad areas of recommendations on how we can do better are outlined:

ANTI-STIGMA TRAINING AND AWARENESS	HOUSING AND INCOME SUPPORTS	HEALING CENTRED ENGAGEMENT AND WELLNESS SERVICES AND PROGRAMMING
HARM REDUCTION, DECRIMINALIZATION, AND IN-PATIENT REHABILITATION	PREVENTION OF MORAL INJURY	LIFE SKILLS TRAINING, EMPLOYMENT, AND MEANINGFUL ACTIVITIES

It is hoped that the recommendations contained in this report inform collaborative problem solving and program design across sectors to better our current provision of supports to people who use substances by addressing systemic challenges. The staff and management at the ICH cannot accomplish this alone and seek a commitment from all health care and social service agencies within the Kingston Frontenac Lennox & Addington (KFL&A) Region – housing, policing, hospital and community services – to work together to address these recommendations as outlined in section 10.7 of the appendices.

2. INTRODUCTION

The Integrated Care Hub (ICH) – which the people we serve often refer to as 'The Hub' – is a community of people that receive and provide support in caring for people who use substances and/or are homeless. The ICH provides a drop-in, a food program, a rest zone, connections to community supports, harm reduction services, and Consumption and Treatment Services (CTS).

The ICH was created by three front-line harm reduction advocates working in the Kingston community for over a decade via Street Health Centre and HIV/AIDS Regional Services. They are Justine McIsaac, Coordinator of Consumption and Treatment Services; Amanda Rogers, Manager of Harm Reduction Services; and Ashley O'Brien, Manager of the Integrated Care Hub. This was in response to three intersections of crisis within the KFL&A region: the global COVID-19 pandemic, a complex housing crisis, and a fatal drug poisoning crisis.

2.1. COVID-19 CREATES NEW CHALLENGES TO SERVING PEOPLE EXPERIENCING HOMELESSNESS

In March of 2019, the City of Kingston was faced with adopting the Canada-wide lockdown and social distancing public health measures to stem the spread of COVID-19. This resulted in many health and social service agencies not being able to provide support at regular capacity. Many organizations were not seeing people in person. Drop-ins, support groups, food programs and other places people were used to gathering had to shut their doors – even public libraries were closed. Shelter capacity was reduced, and tensions, uncertainty and feelings of displacement were, and continue to be high among the people in our community experiencing homelessness. So, while shelters needed to reduce their capacity to maintain social distancing protocols, doing so further isolated and failed to meet the needs of those who use substances.

IN A DRUG POISONING CRISIS, IT IS SAFEST TO BE TOGETHER, BUT IN A GLOBAL HEALTH PANDEMIC, IT IS SAFEST TO BE APART.

During the first few months of lockdown, homelessness became "visible" in Kingston as a homeless encampment at Belle Park emerged that supported up to 50 individuals. This is also when stigma and discrimination from neighbours and community members who were upset about the homeless encampment became more amplified through the media and social media. However, big and beautiful actions of empathy and solidarity from the KFL&A community were also witnessed, as people rallied to provide support to the residents of Belle Park. Divisions on what to do about the situation were palpable.

The needs of people who use substances are often misunderstood to begin with, and adding the stressors of the pandemic during a drug poisoning and housing crisis solidified the need to provide a unique service geared to meet the needs of those who experience chronic homelessness and use substances.

As Harm Reduction Advocates, the founders of the ICH did not previously have experience in providing shelter or housing services, but they did have experience working alongside people who had historically been under-served by this sector and had witnessed people fail to access and maintain shelter or housing time and again.

2.2. DRUG POISONING CRISIS

The Drug Poisoning Crisis means that people who are using substances are dying tragically and at a terrifying rate due to a toxic drug supply with no respite from criminalization, demonization and stigmatization.

In the weeks following the state of emergency declaration as the COVID-19 pandemic and the drug poisoning crisis intersected, the number of opioid-related deaths increased quickly. In Ontario, there was a 38.2% increase in opioid-related deaths in the first 15 weeks of the COVID-19 pandemic (695 deaths; average of 46 deaths weekly) compared to the 15 weeks immediately prior (503 deaths; average of 34 deaths weekly) according to Public Health Ontario (2020).

Figure 1: Preliminary Patterns in Circumstances Surrounding Opioid-Related Deaths in Ontario during the COVID-19 Pandemic (per 100,000)
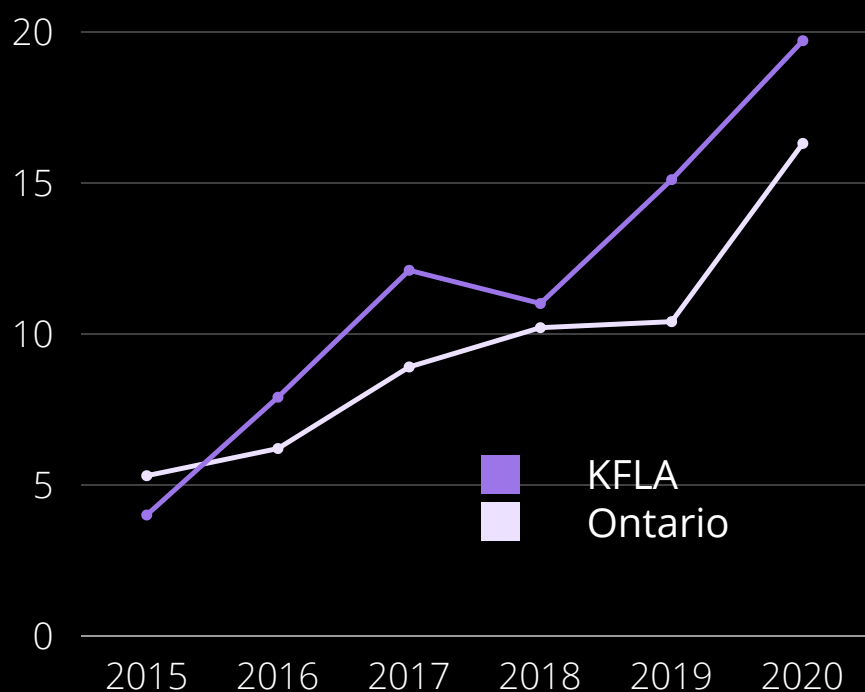
According to the Interactive Opioid Tool by Public Health Ontario, KFL&A experiences a higher than provincial average rate of opioid-related deaths.

In December 2020, the ICH responded to and reversed 70 overdoses on property and in January 2021, the Consumption and Treatment Service (CTS) responded to more overdoses than all of 2018 and 2019 combined. We have termed the overdose crisis "the Shadow Pandemic" because it is hidden, but insidious and deadly. The ICH has proven itself to be a life-saving program based on the number of overdoses responded to and reversed.

2.3. HOUSING NEEDS

The housing situation in Kingston is a longstanding and complicated issue. The City of Kingston is currently seven years into its 10-year homelessness plan. As stated in the City of Kingston's 2018 Housing and Homelessness Report, "In 2018, the Kingston Census Metropolitan Area was reported to have a vacancy rate of 0.6%, a slight drop from 0.7% in 2017." This is well below the national average vacancy rate for 2018, which was 2.4% (Statistics Research Department, 2021). Kingston's vacancy rate has since risen to meet the provincial average in 2020, however the cost of rent has also continued to climb in the same time period according to the Canadian Mortgage and Housing Corporation (CMHA, 2021).

According to the CMHA (2021), average monthly rent in 2020 was $871.00 for a bachelor apartment and $1,145.00 for a one-bedroom unit. The rates for Ontario Works and the Ontario Disability Support Program for a single person with no children however, provides $733.00 and $1,150.00 per month respectively, with $390.00 and $497.00 allotted for rent.

The majority of funding for addressing housing and homelessness comes from the City of Kingston or from the United Way KFL&A, which is the distributor of Reaching Home funding for the region. The City of Kingston functions as the Built for Zero lead in this community, meaning that they administer the By Name List and the Homeless Individuals and Families Information System (HIFIS). The majority of housing and homeless statistics are pulled from the By Name List, which offers real-time data, updated by workers at organizations throughout the city. Additional data is collected by the KFL&A United Way who coordinate the bi-annual, national Point-In-Time (PiT) Homeless Count that collects numerical and basic demographic information on individuals and families experiencing homelessness, providing a snapshot of the homelessness situation in urban Kingston at the time of the count.

According to the By Name List, as of June 17, 2021, there are 190 people actively experiencing homelessness in the City of Kingston. Of those, 155 (82%) are chronically homeless, with an additional 14 people (7%) approaching chronicity. As defined by Built for Zero Canada and the Canadian Alliance to End Homelessness, chronic homelessness is when an individual has been experiencing homelessness for a cumulative total of at least 180 days of the past 12 months, or for three or more unique episodes over the past three years. The 2021 Urban Kingston Point in Time Count revealed a higher number of people experiencing homelessness compared to 2018, statistics that are comparable to those of the By-Name List.

The ICH tracks their homelessness statistics through the use of a program entry form, which asks people to self-identify if they are experiencing homelessness. Of the 245 people who had completed the form from October 31, 2020 to June 17, 2021, 207 people (84.5%) indicated that they did not currently have housing. Of those, 105 (42.9%) were not already counted as actively homeless on the City of Kingston's By Name List nor in the HIFIS. Many of these individuals have since been added to the system, and are currently counted on the By Name List. The same form also asks people if they want to access the ICH's rest zone (76.7% of them indicate that they are), and if they are interested in an intake. Of the 105 people who were not shown on the By Name List or in HIFIS, 29 people (27.6%) indicated that they were not interested in an intake, including the opportunity to be connected to housing supports.

> **THE SYSTEMS PEOPLE ARE CONNECTED WITH STILL EXIST WITHIN THAT SAME FRAMEWORK THAT FAILED TO ENGAGE THEM IN THE FIRST PLACE.**

It is challenging to draw conclusions from this data. It is accepted within the housing and homelessness service sector that the people who access shelters or are sleeping rough only represent one segment of the total population experiencing homelessness. Individuals who are couch surfing, sleeping in cars, bouncing between motels or otherwise precariously housed – referred to as hidden homelessness – are often not, and perhaps do not want to be engaged with housing and homelessness services through any traditional channels. The 105 individuals who were not yet on the By Name List or in the HIFIS can offer a glimpse into the number of people experiencing hidden homelessness in the Kingston community.

This high number of people who are unconnected to services could further indicate a pattern in the way that people engage with housing and homelessness services. Coming to the ICH may be the first entry people have into a shelter, and they may not stay around for long. There is a large degree of transience within Kingston's homelessness community due to the city's central location between Toronto, Montreal and Ottawa. This could also point to a juxtaposition in how people define themselves: contrasting the population that does not have stable, appropriate housing but does not stay within the shelter system either, against those that are entrenched within those services. While both groups may be labeled as 'homeless' through systemic definitions, it is possible that they do not see themselves as such, and therefore may approach accessing services in a different way if they do need help with housing per se.

The ICH occupies a unique position in the local community, with one foot in the housing world, and one foot out of it, so it draws in people who may not have been counted otherwise. This population of under-served people could suggest a need to change the way in which the system finds people who are experiencing homelessness, reaching them directly through other supports rather than directly or via referrals through the shelter and housing system. However, beyond counting people, the impact of such direct connection is limited as the systems people are connected with still exist within the same framework that failed to engage them in the first place.

2.4. STIGMA AND THE OTHERING OF PEOPLE WHO USE SUBSTANCES

As the pandemic wore on and Kingston's homelessness issue became more visible, it also became more publicized, and seemingly divided. The significant public pressure to move the homeless encampment out of Belle Park led to the creation of the ICH in a temporary location at Artillery Park and an eventual move to Montreal Street in fall of 2020. However, the existence of the ICH was, and continues to be, a highly political issue within the Kingston community. Staff have received death threats against the patrons of the ICH and there are regular taunts from people driving by, using hurtful words like "Junkie, Loser, Dirt Bag, Crackhead, Garbage, Animal", and unsympathetic advice like "Just don't do drugs" and "Why don't you get a job." Meanwhile the press makes the homeless population visible through negative encounters, further "reinforcing their 'outsider' status" (Rahman & Abdulkader, 2020, p. 3).

As readers delve deeper into this report, they will see how the stigma becomes internalized by this community of very vulnerable people, further eroding their self-esteem and leading to excessive rates of social disadvantages and health problems. Systemic discrimination is further stigmatizing, such that people experiencing homelessness are socially isolated, losing connection with their families and friends, which can lead to losing hope. Rahman and Abdulkader (2020) conducted an exploratory study of rough sleepers in Birmingham, England, and concluded that people experiencing homelessness are "subjected to permanent stigmatization" (p. 1) because societal expectations of how a life should be lived can rarely be achieved because the "structural conditions of [their] lived reality make this impossible" (p. 2).

Sadly, the many myths, stigma and lack of understanding about people experiencing homelessness, particularly those who use substances, is not unique to Kingston. It is embedded in Canadian society and other Commonwealth countries and leads to the marginalization of people who use substances.

Kobayashi (2020) argues that today's racialized and Indigenous communities, which are over-represented in homeless populations, are still adversely affected by discrimination and colonial practices like labour market segmentation linked to patterns of poverty. Stigma against homelessness is linked to the cultural belief that people experiencing homelessness choose to live the lives they do (Rahman & Abdulkader, 2020, p.3). The pandemic and on-going economic disruptions have pushed many people to the brink of insolvency. Perhaps seeing people experiencing homelessness in Kingston who were clustered in very public ways has provided a mirror to the vulnerabilities many of us face in an uncertain world.

2.5. TRAUMA, ACES AND SYSTEMIC VIOLENCE

In order to know how to meet someone's needs, we need to understand how their needs were not met to begin with or were disrupted along the way. Many people experiencing chronic homelessness have experienced complex and chronic trauma histories that most often result in self-defeating patterns of behaviour (Battaglia et al., 2019; Maté, 2008; Nazarov et al., 2018). Furthermore, intersections based on people's social standing complicate these material concerns. Women and/or people who are a part of BIPOC (Black, Indigenous, and other People of Color) and/or 2SLGBTQ+ (Two-Spirit, lesbian, gay, bisexual, transgender, queer/questioning) communities, experience significant intersectional oppression as well. Homelessness itself, and discrimination against people with mental health and substance use challenges, are also social justice issues that have been exacerbated by the closing of services due to COVID-19 social distancing protocols.

THE THREE FACES OF OPPRESSION

INDIVIDUAL
(Stereotype, Microaggression, prejudice)

GROUP
(Discrimination, phobias, bias)

SYSTEMIC
(Discrimination, isms, violence)
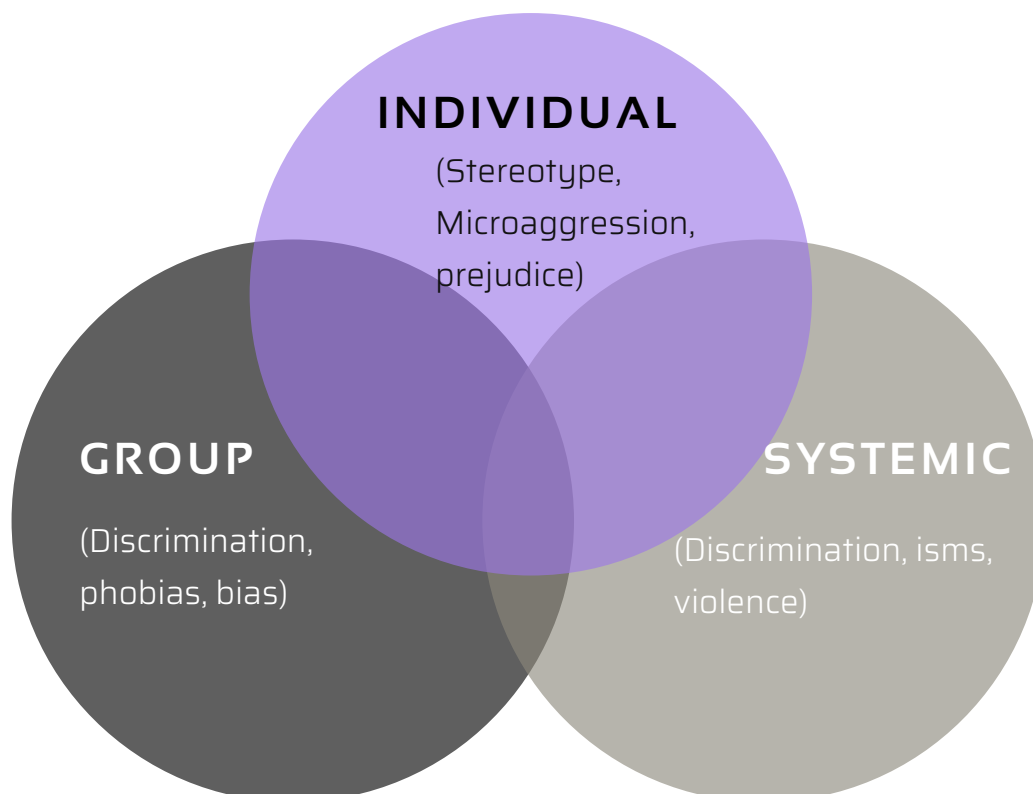
One only has to look to Maslow's Hierarchy of Needs to see how these structural barriers impede people's potential – people who are citizens of KFL&A. People can only become fully self-actualized if other basic needs are met. To stay healthy, people need food, exercise, rest, clean water and air to breathe. These are physiological needs – what our bodies and brains need to work well.

We need to be safe from the elements, from danger (by predators or people), and therefore need secure housing in safe neighbourhoods. To achieve this, we need steady employment or a livable universal basic income to pay for shelter and the resources needed to maintain a healthy household. We also need to know that we are safe from harm, that police and other first responders will help us if we are in need. We need to know that we are safe from people who might wish to rob or harm us.

While our bodies are healthy and safe, we also need to feel love and belonging from our families and friends. If we feel we do not belong – are alone or lonely – our mental health suffers.
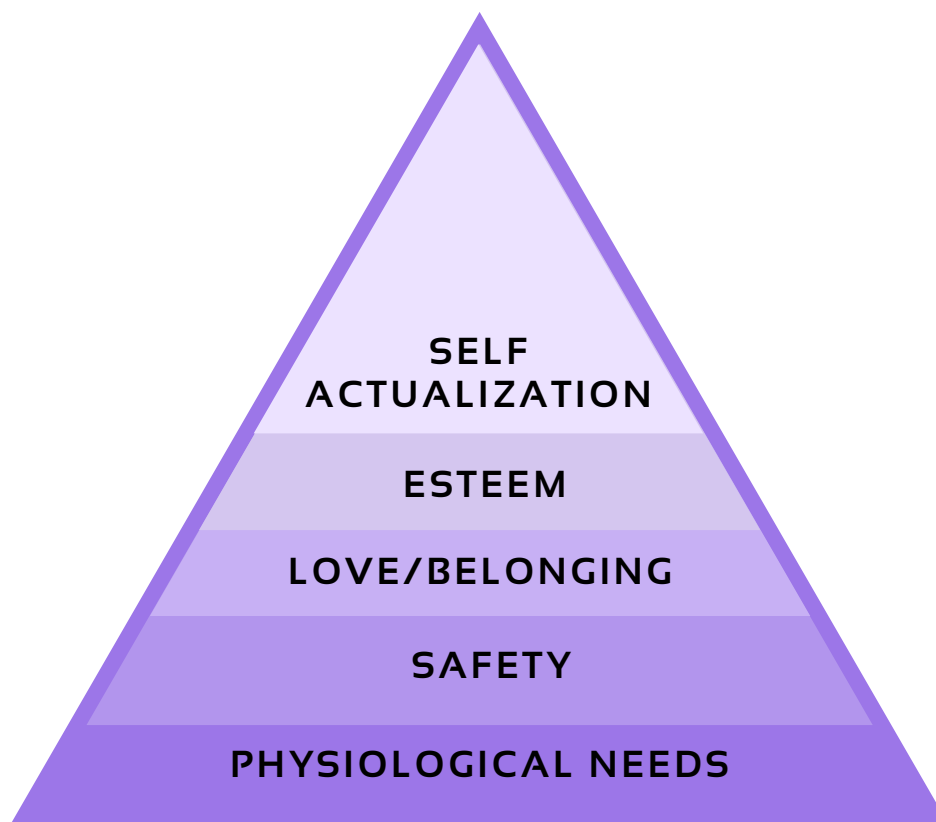
FIGURE 2: MASLOW'S HIERARCHY OF NEEDS (1954)

People who have complex, concurrent disorders (mental health and substance use) often experience chronic homelessness. People who use substances are often disconnected from familial relationships, suffer with low self-esteem, have little self-worth, live in a state of toxic stress, experience food insecurity, likely have higher rates of traumatic brain injuries, live with cognitive disabilities, and are often seen as non-productive and thus, not-valued members of our community.

If a human being's basic needs are met, they are going to behave in predictable ways. We also know that if a person's basic needs are not met, they are going to behave in different, but still predictable ways. So, it is not our behaviour that defines our nature, it is our needs that define our nature. A person's behaviour reflects the degree to which those needs are met or they are not met (Maté, 2008).

2.6. PROBLEMATIZING PATHOLOGY AND DIAGNOSIS

There exists some confusion around the term 'dual-diagnosis', with different definitions being presented. The Centre for Addiction and Mental Health (CAMH) notes that in Canada, dual diagnosis "refers to the combination of a developmental disability and mental health problem" (Lunsky & Weiss, 2012, p. 1). Interestingly, the Diagnostic and Statistical Manual of Mental Disorders (DSM) IV describes a person as having dual diagnosis "when he or she has two or more diagnosed mental disorders with at least one of these disorders being either [Intellectual Disability] or

"Beneath every behaviour there is a feeling. And beneath each feeling is a need. And when we meet that need rather than focus on the behaviour, we begin to deal with the cause not the symptom."
—Ashleigh Warner

Autistic Disorder" (Burge & Williams, 2012, p. 5). The American Addiction Centres define dual-diagnosis as "when a person meets the criteria for a substance use disorder and is diagnosed with one or more additional mental health disorders… Any one of the disorders can arise first and evoke the emergence of the others" (Kelley, 2021, n.p.), which is similar to CAMH's definition of 'concurrent disorder': "Concurrent disorders are co-occurring addiction and mental health problems. No one symptom or group of symptoms is common to all concurrent disorders" (CAMH, 2021, n.p.).

Language is important because in order to find effective solutions to an issue, it must be clearly defined. This needs assessment provided additional insight into the challenges faced by the people we serve. An inclusion criterion for this needs assessment was to have lived or living experience of using crystal meth and/or opioids. Thus all of the participants have had challenges with substance use. The evidence shows that 93 percent of participants self-reported having received multiple formal mental health diagnoses over their lifetime. The evidence also suggests high prevalence of cognitive challenges dating back to school age, as 56% percent of participants self-reported believing they may have a learning disability, and another 25% have ADHD that affected their success in school. Ninety percent also reported having suffered significant head trauma at some point in their lives (often multiple occurrences). It is interesting to note that a survey of Southeastern social, health and developmental disabilities service providers was conducted in 2012 that highlighted a need for better integration of services and education for people with substance use challenges and cognitive/intellectual disability (Burge & Williams, 2012). The evidence in this report suggests that people who frequent the ICH are likely to suffer a 'tri-diagnosis' of cognitive, mental health and substance use challenges, which is important to consider in developing wellness programming for them and training for service providers.
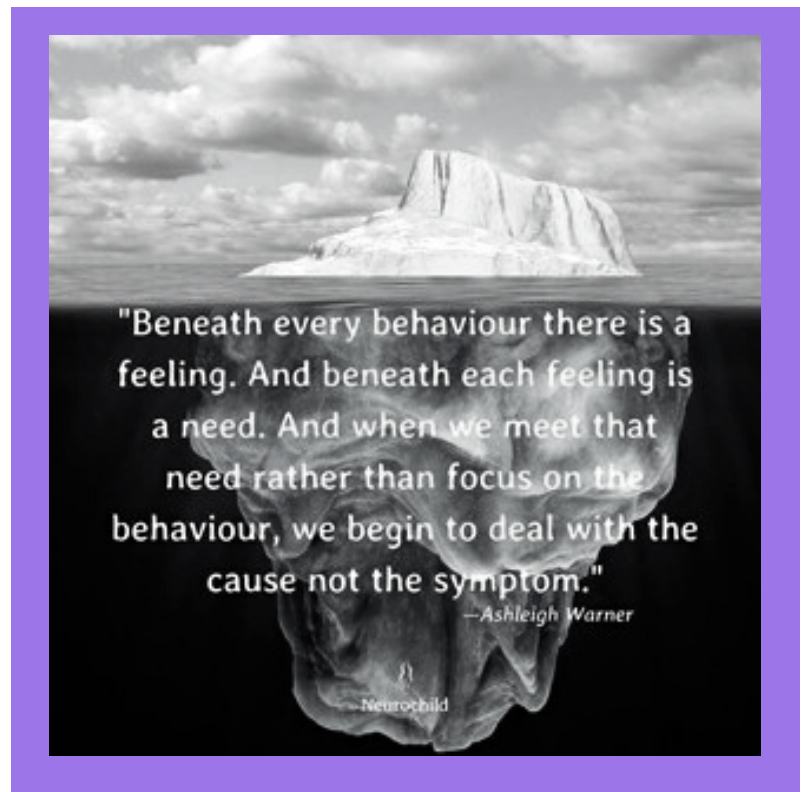
3. RATIONALE AND GOALS OF THE NEEDS ASSESSMENT

Kingston, Ontario is experiencing a drug poisoning crisis and a homelessness crisis during a global pandemic. In such dangerous times, it is not wise to make assumptions based on our pre-COVID knowledge. At the ICH, we believe that the people who frequent the ICH – our stakeholders – know best what they are experiencing, and what they need. A rapid needs assessment about people who frequent the ICH and use crystal meth and/or opiates was undertaken, and this report generated. The information gathered will guide the development of effective responses and drug policy to support people who use crystal meth and opiates and prevent overdose.

This report is designed to be a 'living' document – that is, there are more questions left to be answered, and more importantly, all community service providers who are mandated to provide support to people who experience homelessness (who also use substances) must be mobilized to learn from what the stakeholders have said, find solutions, and ensure that our most marginalized citizens feel social justice has been served. They have suffered far too long.

"IN ORDER TO EMPATHIZE WITH SOMEONE'S EXPERIENCE YOU MUST BE WILLING TO BELIEVE THEM AS THEY SEE IT AND NOT HOW YOU IMAGINE THEIR EXPERIENCE TO BE"

-BRENÉ BROWN

4. METHODOLOGY

A needs assessment about people who frequent the ICH and use crystal meth and/or opiates was undertaken.

Purpose

Participants were told that their input would help ICH management and staff better understand the needs and experiences of people who are using substances in Kingston. Furthermore, the information collected would be disseminated to community organizations to better understand the experiences of people using substances and help improve community support and response efforts.

Potential Risks

Participants were informed about potential risks: talking about past experiences, substance use, and overdose may be challenging, and that they might experience difficult emotions during, and after the interview. Interviewers, who all had trauma-informed care training, checked in with participants before beginning the interview, throughout the interview, and at the end of the interview. Participants were told they could be connected to immediate and long-term counseling supports if they felt they needed on-going support. Their well-being was/is of the utmost importance to staff at the ICH.

Confidentiality and Anonymity

The identity of participants will remain completely confidential. All questionnaires are kept separate from consent forms and will not be linked to participants in any way. Questionnaires have been stored in a locked cabinet and will be destroyed once analysis is complete. Responses by participants are attributed to their self-declared age and gender to preserve anonymity.

Inclusion Criteria

To qualify, participants had to be 18 years of age or older, frequented the ICH, and had used or were using crystal meth and/or opiates.

Methods

Ms. Candice Christmas, a doctoral candidate in health policy and equity and an expert in health systems navigation, was hired to help develop the needs assessment methodology. ICH management developed an interview guide, as well as an information and informed consent sheet. One-to-two-hour semi-structured interviews were conducted by ICH managers, Team Leads and the Program Coordinator between February 1st and April 14th, 2021. It was decided that interviewers would take notes into a hard copy interview guide because audiotaping participants may have created a barrier to their participation. While there was some risk of participant bias because they were talking with workers who provide them services, we believe this was outweighed by the positive relationships participants had with ICH staff and the richness of data that was likely to be produced because the interviewers were trusted by many of the participants.

Compensation

Participants were paid a stipend of $40.00 at the beginning of the interview for sharing their knowledge, expertise, life experience and time. Participants were informed that if they chose not to continue to participate at any point in the interview or preferred to skip questions that they did not feel comfortable answering, they would still be paid the $40.00 stipend for their willingness to participate. Furthermore, their decision to end the interview would not impact their services or care provided at the ICH.

Data Analysis

The consultant transcribed the interview data from hard copy interview guides and then analyzed the data using a gender-based lens, with Descriptive Thematic Analysis and descriptive statistics (measures of frequency, tendency, variation).

Triangulation

A draft report of the data was provided to ICH management to ensure that the data captured through the interviews was contextually sound.

Recommendations for policy and programming were derived from the views of the interviewed stakeholders, then reviewed by the consultant and enhanced with some evidence-based practice from the literature.

Recommendations have since been triangulated by both ICH management, as well as community partners within the same process, to ensure that the voices of participants are presented in the report draft with the highest possible fidelity, without political filtering.

5. FINDINGS AND STAKEHOLDER INTERVIEWS

32

Thirty-two individuals aged 18 and over who frequented the ICH and had used crystal meth and/or opioids participated in semi-structured interviews that lasted from one to two hours in length.

5.1. DEMOGRAPHICS

There were 8 demographic questions: age of participants; self-identified gender and ethnicity; Indigenous heritage; level of education completed and whether the participants believed that they could have a learning disability; whether participants were currently working, hoped to be working and what might be preventing them from doing so; and whether participants had ever been in jail and whether substance use impacted their charges.

One limitation of the needs assessment is a smaller female sample of 11 as compared to 21 males. This speaks to the difficulty of reaching women, especially those under 30 who use substances, a hidden population who may be living with their dealers, and/or involved in trafficking or survival sex work.

Figure 3: Age of Participants

Figure 3: Age of Participants

Legend: Females, Males

Age groups: 18-24, 25-29, 30-39, 40-54, 55-64

X-axis: 0, 2.5, 5, 7.5, 10
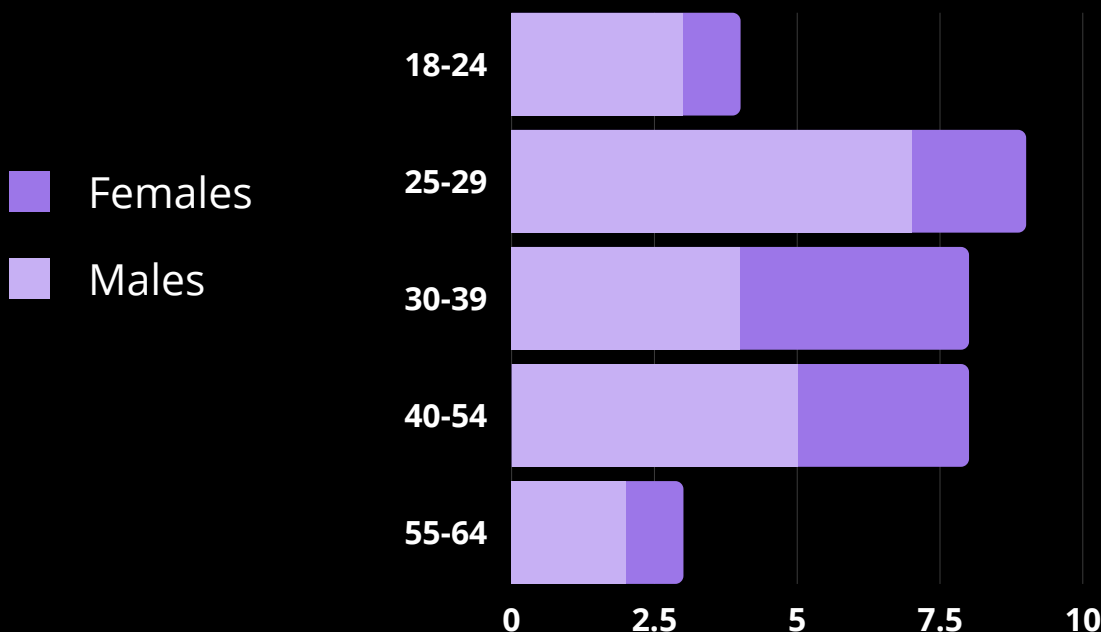
In terms of self identified ethnicity, 48 percent of males and 36 percent of females were Caucasian; 33 percent of males had mixed Indigenous ancestry as did 33 percent of females; 19 percent of males and 18 percent of females were Indigenous, and one female self-identified as being of mixed African decent.

FIGURE 4: SELF-IDENTIFIED ETHNICITY & INDIGENEITY

MALES

48%
CAUCASIAN

33%
MIXED INDIGENOUS

19%
INDIGENOUS

FEMALES

36%
CAUCASIAN

36%
MIXED INDIGENOUS

18%
INDIGENOUS

1
MIXED AFRICAN
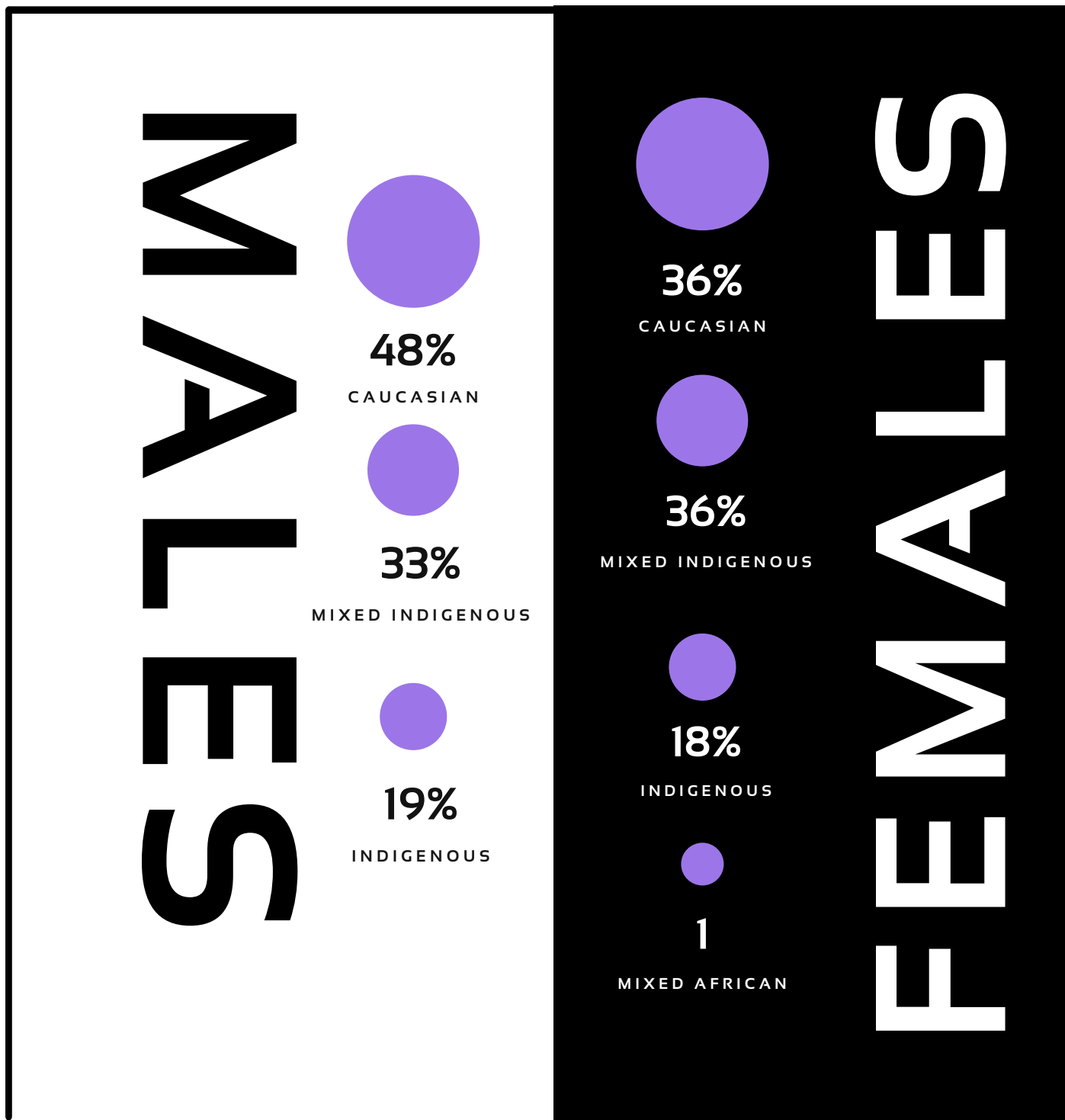
This figure highlights an over-representation of Indigenous people in the KFL&A homeless population.

Fifty-two percent of males completed high school, while only one female did (half of the females had dropped out by grade 10). Reasons for females dropping out ranged from not fitting in at school, not being engaged as a hands-on learner, getting pregnant, being homeless, having to work to support the household, caregiving for a parent, and being sexually assaulted and having to deal with the trauma.

52%
of males completed high school
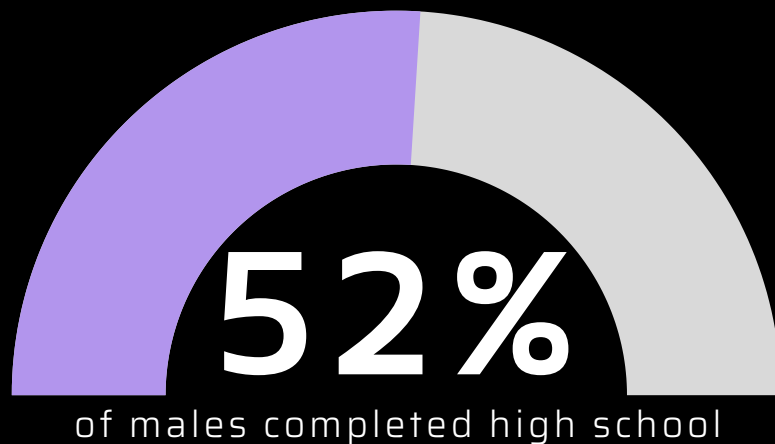
In the sample, males left education much later than females, with 52% having graduated high school and 19% going on to post-secondary. For those who left school, sudden stressful life events led to poor mental health and substance use that compromised their ability to continue. The study did not query in what form educational completion took place. We could hypothesize that given higher rates of incarceration of males who were using substances, they may have completed their education while institutionalized.

FIGURE 5: LEVEL OF EDUCATION COMPLETED BY GENDER

Males

Females

Grade 7 · Grade 8 · Grade 9 · Grade 10 · Grade 11 · Grade 12 · HS Diploma · Post-sec · Post Complete · Graduate
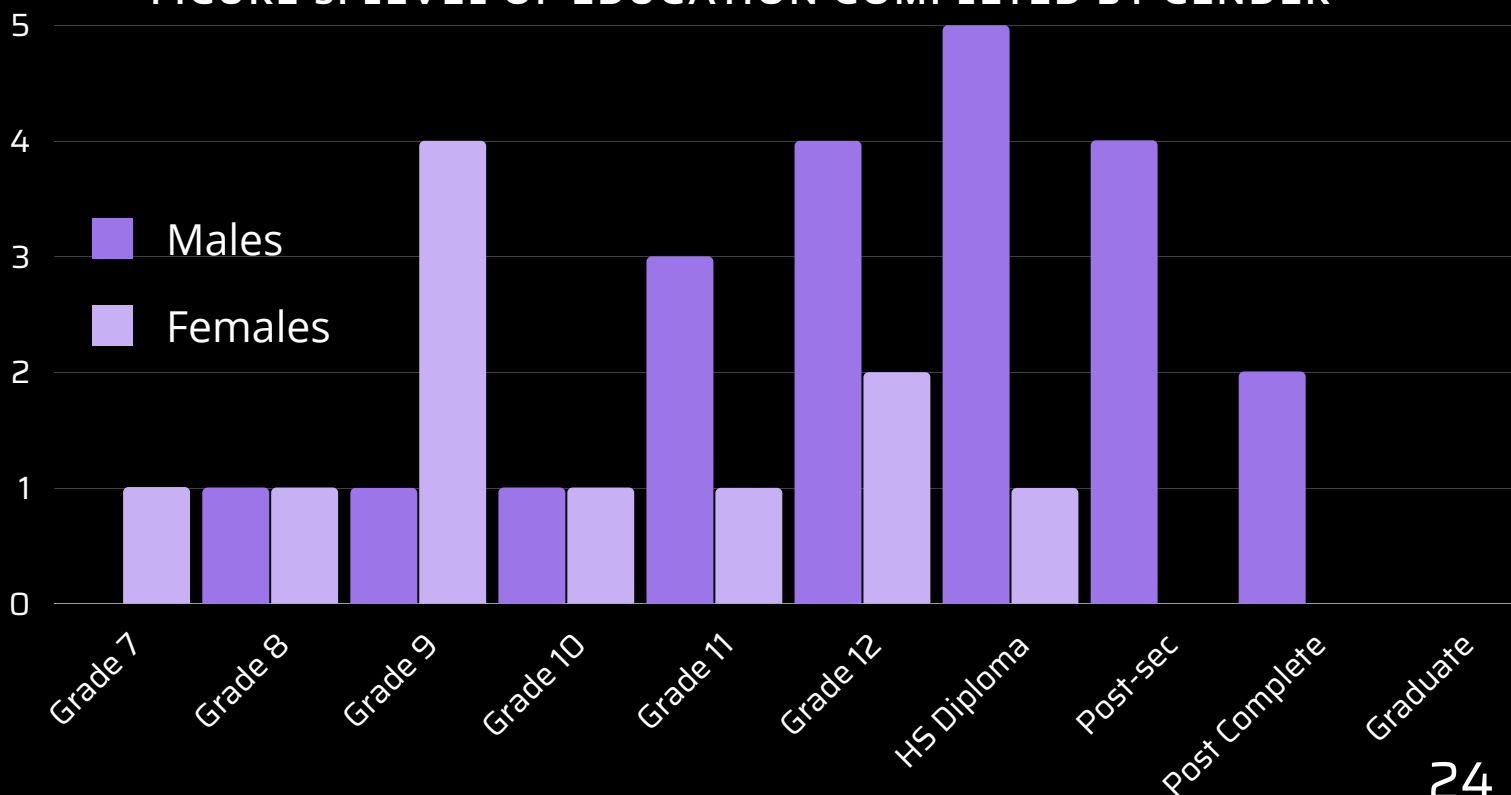
From a developmental health lens, two questions were asked of participants. The first was whether there was anything that had prevented them from continuing on with their education. Mental health challenges were identified as a barrier to education by 22% of respondents, and involvement with drugs and crime by 15%. The second question asked if participants believed they may have had a learning disability that made it (or would make it) hard for them to learn in a typical classroom. 56% of participants cited believing they could have a learning disability that impaired their schooling, with gendered effects (64% being female).

56% REPORTED BELIEVING THEY HAD A LEARNING DISABILITY THAT IMPAIRED THEIR SCHOOLING

FIGURE 6: REASONS FOR NOT COMPLETING HIGH SCHOOL
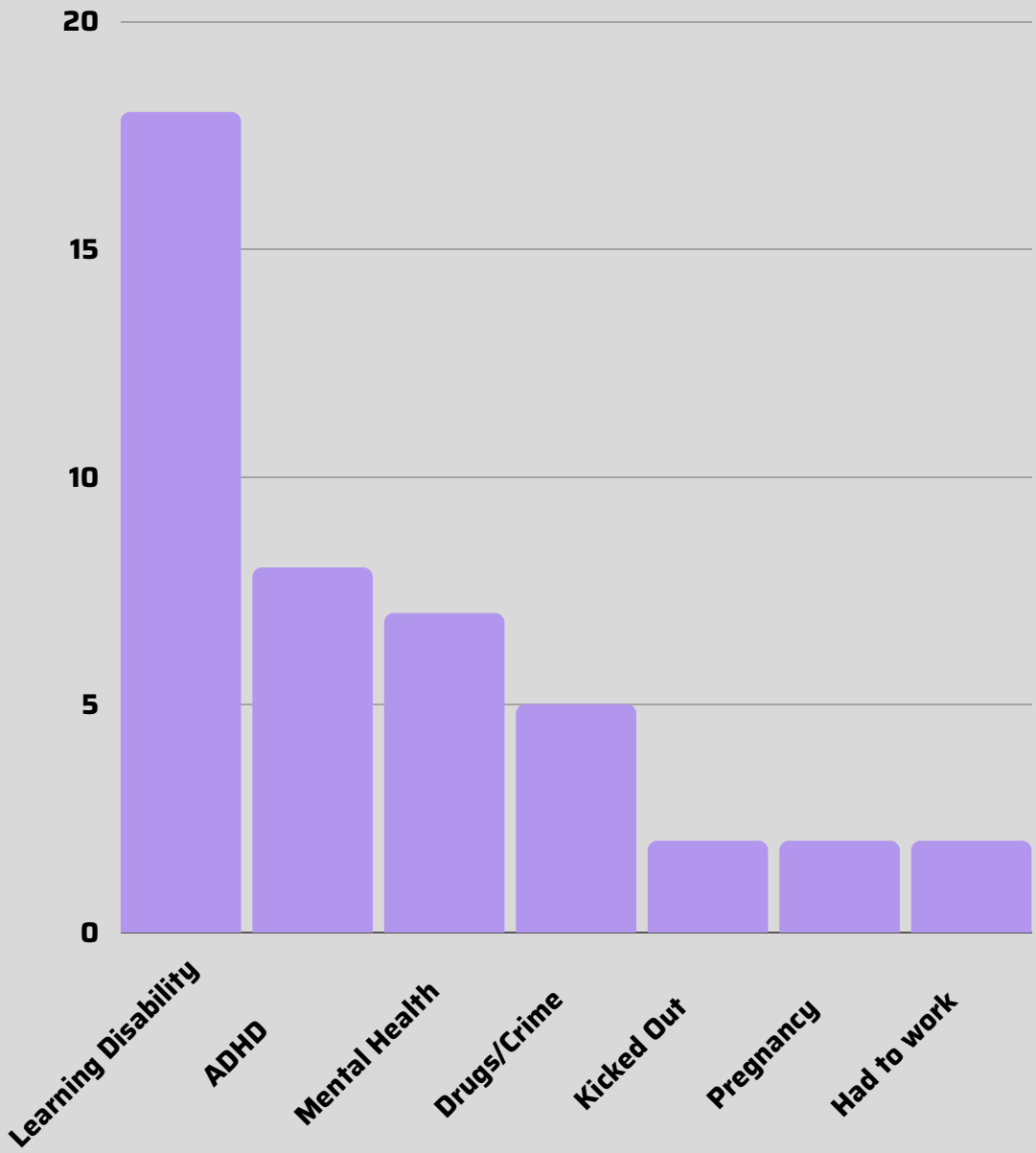
5.2. HEALTH AND WELLNESS

There were 10 questions about participants' health and wellness: food security and quality of nutrition; whether participants had a family doctor or who they saw when unwell; how many times participants had been to the hospital in the past year and for what; whether participants had experienced violence or injury that resulted in significant head trauma, whether they had sought out treatment, and post-event symptoms; self-rated mental health and any medical diagnoses; whether participants ever had children in their life; and how they rated their relationship with family.

5.2.1 FOOD SECURITY

Participants were asked whether they go hungry, and if so, how often.

- 12 indicated they have gone hungry

- 11 indicated they do not go hungry

- 5 do not go hungry now because of being at the ICH but have in the past

- One indicated they were currently doing well, but is a habitually strange eater

- One indicated it depends on individual choices: sometimes fasts or hunger strikes, sometimes due to lack of available food

- One indicated he can never eat enough, is always hungry

- One Indigenous participant indicated he has gone hungry, but that is because he did not like the food that was being served (which warrants further investigation as to whether Indigenous style meals would possibly be more suitable)

"SOME DAYS I EAT, SOME DAYS I DON'T."

"FOOD IS THE EASIEST THING TO GET."

"IT'S PRETTY EASY TO GET FOOD IN THIS TOWN. IT MAY NOT BE GOOD FOOD, BUT YOU CAN GET FOOD."

"THE STRUGGLE IS NOT WANTING TO EAT WHILE DOING DRUGS."

"THERE ARE LOTS OF PLACES TO EAT, IF I DON'T EAT IT'S MY CHOICE."

"I GO HUNGRY ALL THE TIME, UNLESS I'M IN JAIL."

5

PEOPLE REPORT NOT GOING HUNGRY NOW BECAUSE OF BEING AT THE ICH

PARTICIPANTS WERE ASKED WHETHER THEY EAT FRUITS AND VEGETABLES, AND HOW OFTEN...

"EVERY DAY AT THE HUB."

"COUPLE TIMES A DAY, I LOVE FRUIT!"

"I TRY TO EAT AT LEAST ONE MEAL A DAY AND HOPE THAT THERE IS SOMETHING HEALTHY IN IT."

70%
RESPONDED "DAILY"

"I TRY TO EVERY DAY BUT DON'T WHEN ON THE STREET AND NOT AT THE SHELTER."

The remaining 30% of responses indicated varying amounts:

"Very rarely but starting to eat more."

"Sometimes."

"Depends."

"More vegetables before, more fruit now."

"Not too much fruit, but like veggies."

"Not too often, harder to get than cheaper foods."

5.2.2. HEAD TRAUMA

An extraordinary finding was that 90% of males and 91% of females had self-reported having experienced some form of significant head trauma at some point in their lives, which for most involved multiple events. Almost two thirds of participants reported they did not seek treatment (62% of males and 64% of females) unless help was called for them. Post-event symptoms appeared to be more severe for females, though a loss of coordination and trouble sleeping could be confounded with substance use.

91%
OF FEMALES

90%
OF MALES

SELF-REPORTED SIGNIFICANT HEAD TRAUMA
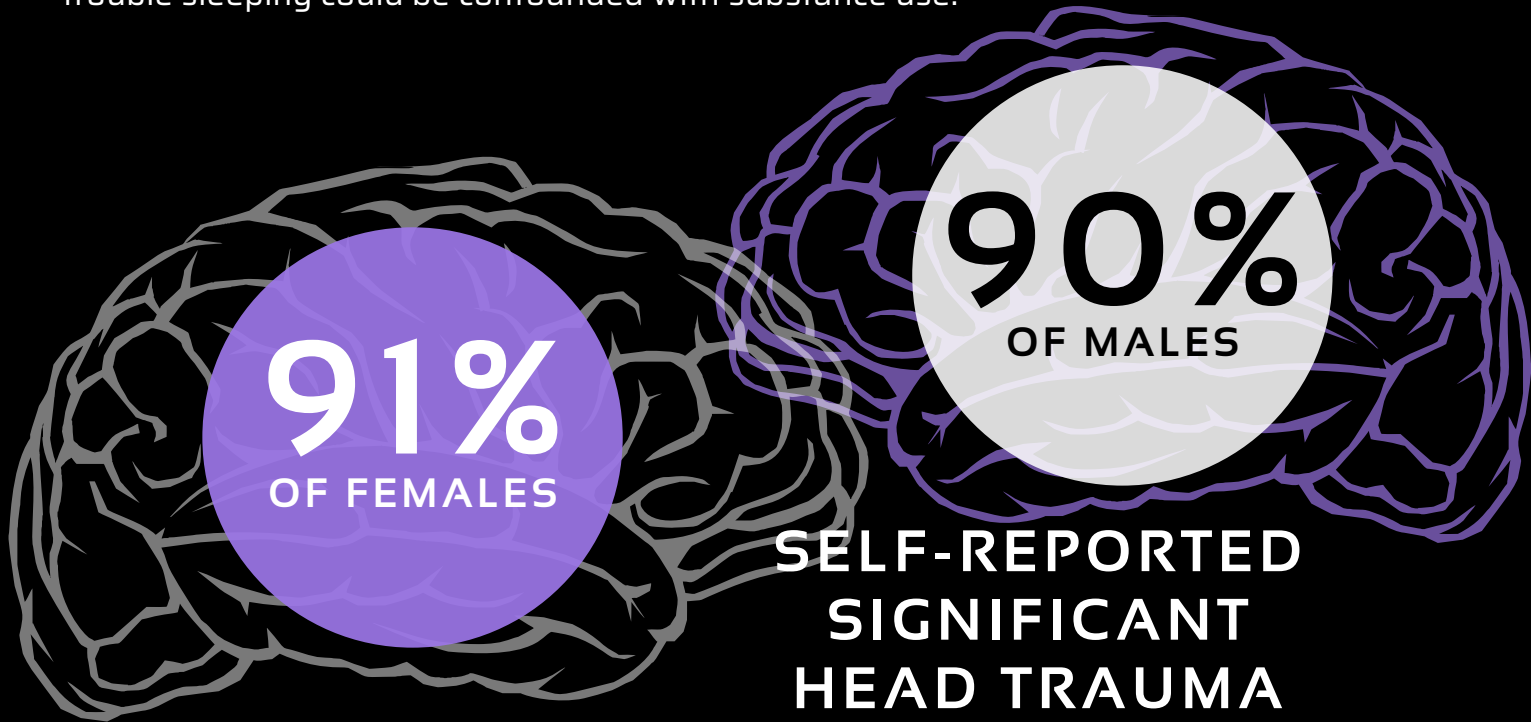
FIGURE 7: SELF-REPORTED SYMPTOMS AFTER SUSTAINING SIGNIFICANT HEAD INJURY
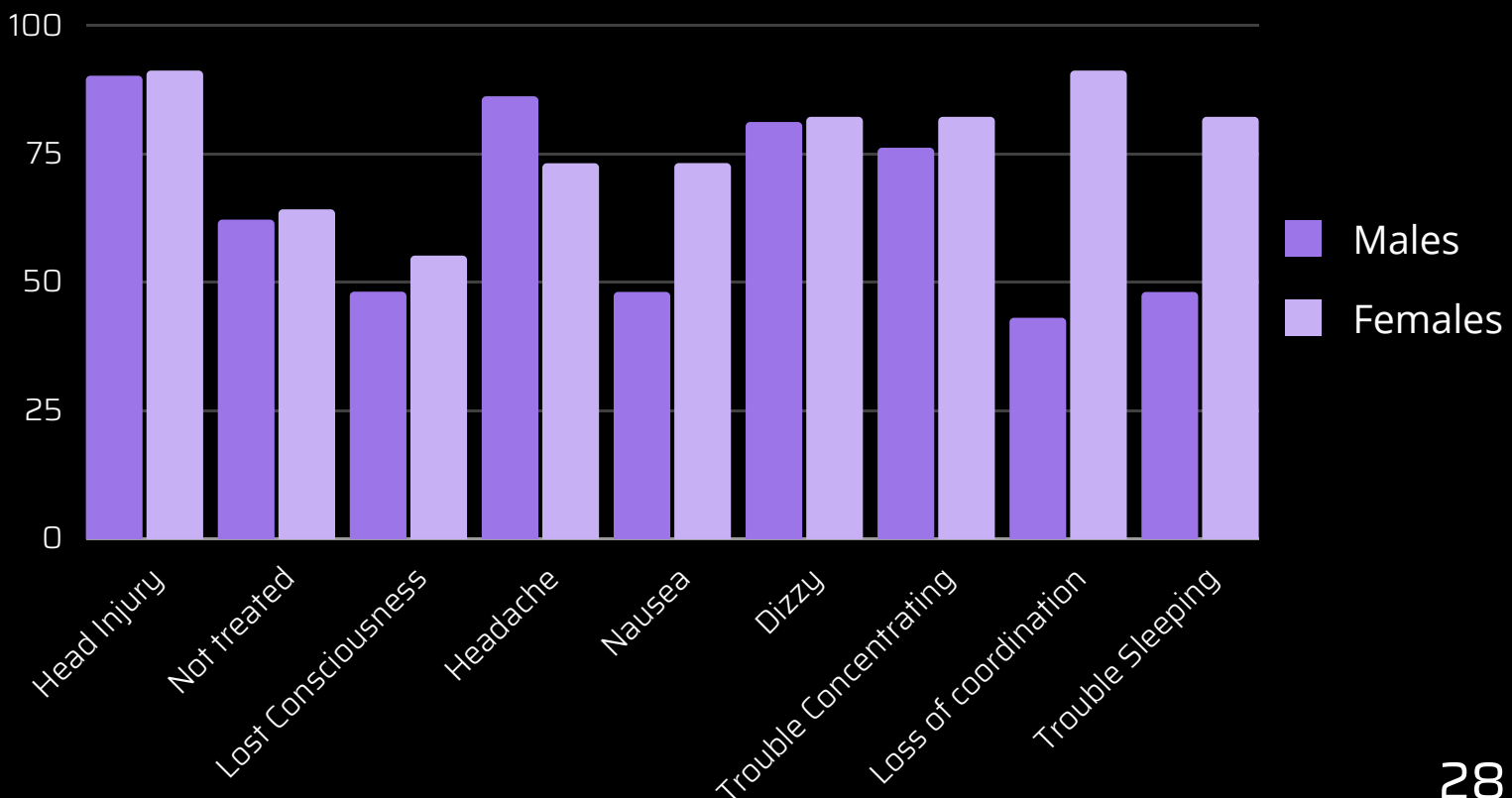
5.2.3. MENTAL HEALTH

FIGURE 8: SELF-RATED MENTAL HEALTH AT THE TIME OF INTERVIEW
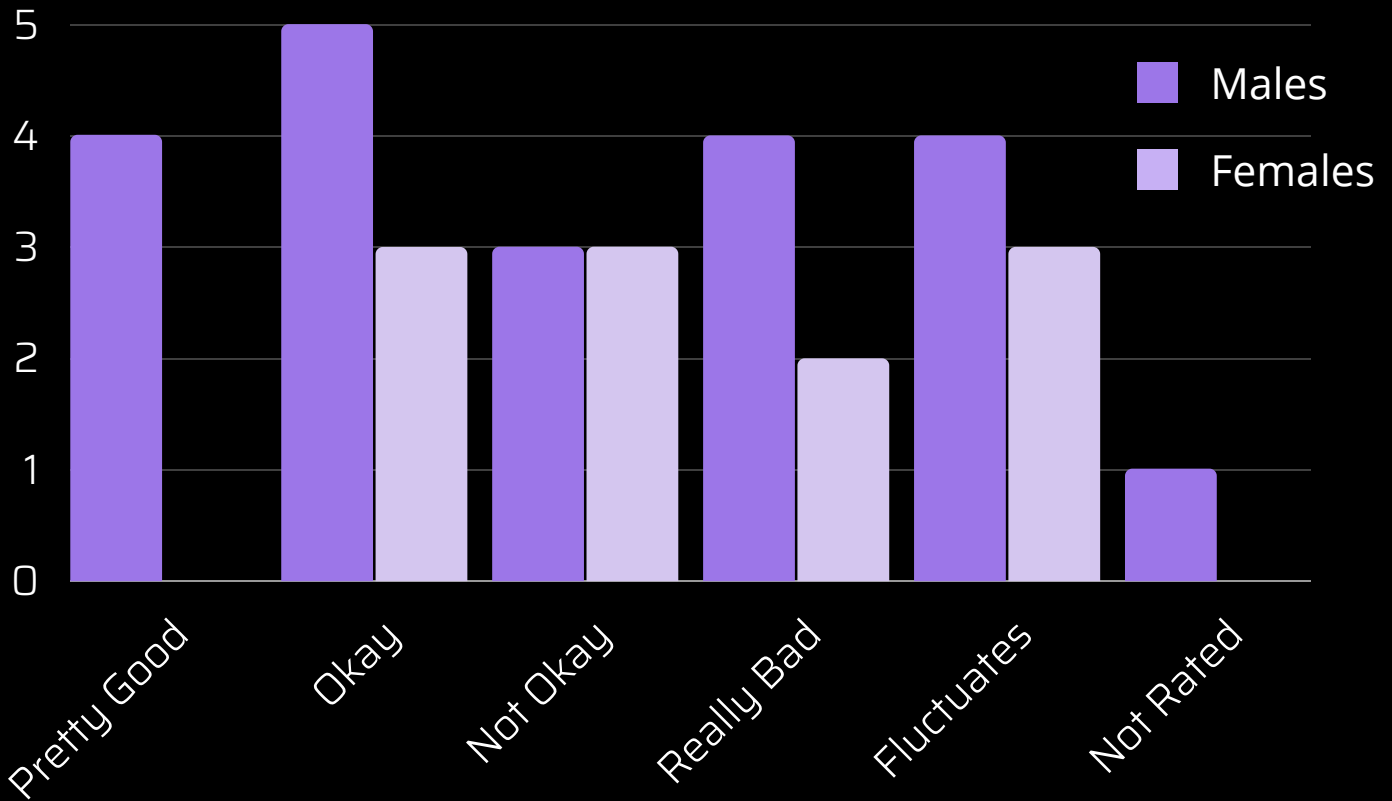
Mental health and trauma have been, and continue to be, significant barriers to wellness in the ICH community.

In total, 95% of males and 91% of females self-reported having had multiple formal mental health diagnoses over their lifetimes.

One female and one male indicated having been diagnosed with fetal alcohol syndrome. One male indicated being diagnosed with psychosis, and another with socio-psychopathic tendencies. One female indicated being diagnosed with dissociative disorder and one with fragmentation disorder. Two males and one female could not recall their diagnoses, and one male indicated he did not have a mental health diagnosis.

Interestingly, when participants were asked if there were any other mental health conditions they believed they were affected by, an additional 32% of males thought they suffered from depression and another 26% of males believed they suffered from anxiety, bringing their self-reported rates closer to that of females. It could be that side-effects from using combinations of opioids, stimulants and depressants may be presenting like depression and anxiety in men. However, it could also be that men's socialization that leads to less help-seeking and reporting of their feelings could influence lower diagnosis of depression in males (Addis, 2008). More research is needed to better understand these testimonials. One participant described himself as "a broken person that can be fixed."

FIGURE 9: MENTAL HEALTH DIAGNOSES RECEIVED BY PARTICIPANTS (HISTORIC)
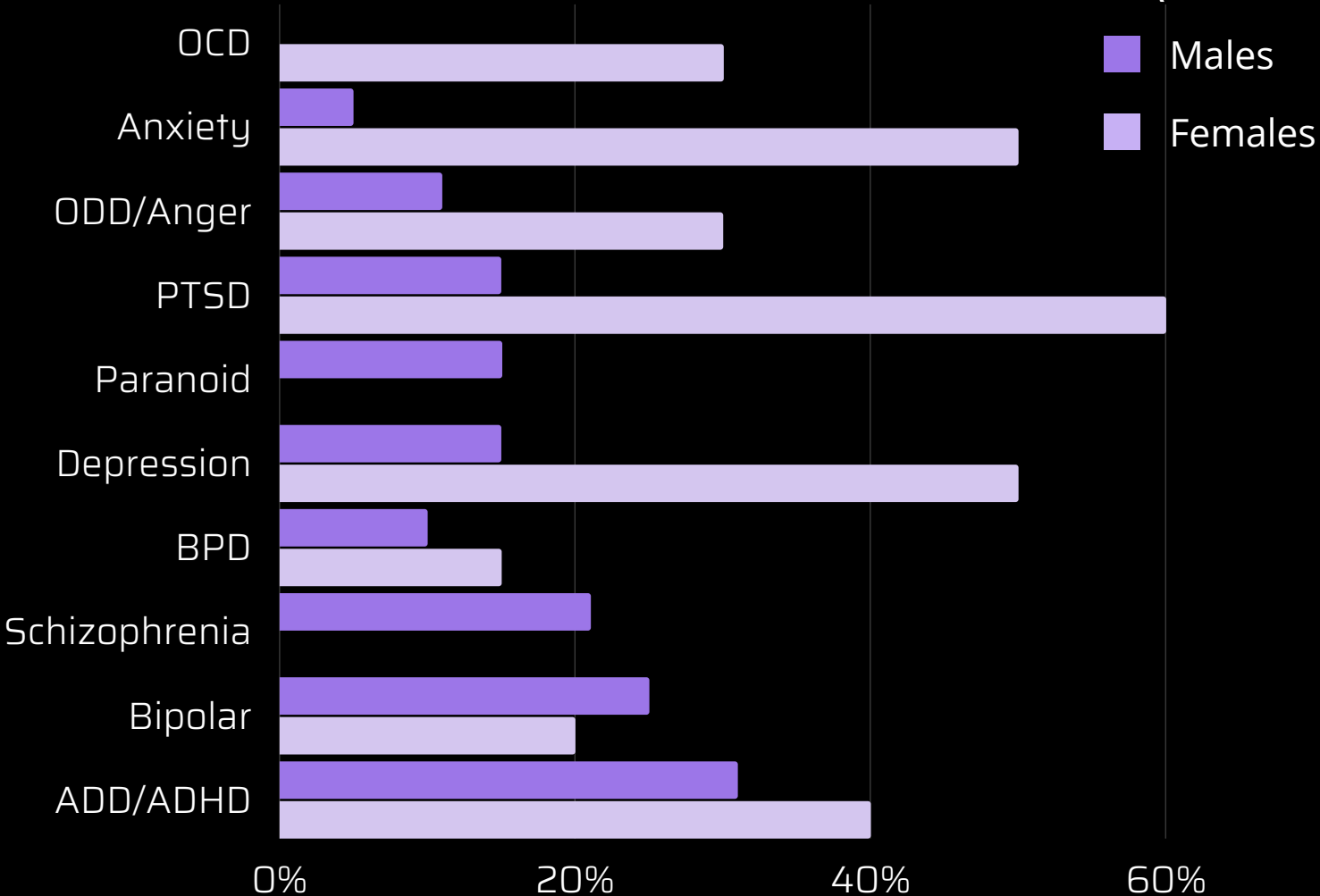
The 60% incidence of PTSD in females, even with the lower sample size, seems significant, and warrants further research as to why, given that people with PSTD are 4 times more likely to have substance use issues than those without PTSD (Kelley, 2021).

5.2.4. INTERGENERATIONAL TRAUMA

Seven participants reported having lost a parent or close loved one by age 20 and another five had no parents surviving. This was an important theme because it indicated intergenerational trauma. In most cases, the loved ones in question were lost to mental health and substance use challenges. In some cases, families were split up by Family and Children's Services (FACS).

Many people experiencing homelessness with mental health and/or substance use challenges lose custody of their children. With sensitivity to the loss and shame people experience in regards to FACS apprehensions, the question was asked whether they had "had children in their lives". Eight of 11 females (73%) indicated they had, and 15 of 21 males (71%).

FIGURE 10: QUALITY OF FAMILY RELATIONSHIPS RATED AT THE TIME OF INTERVIEW
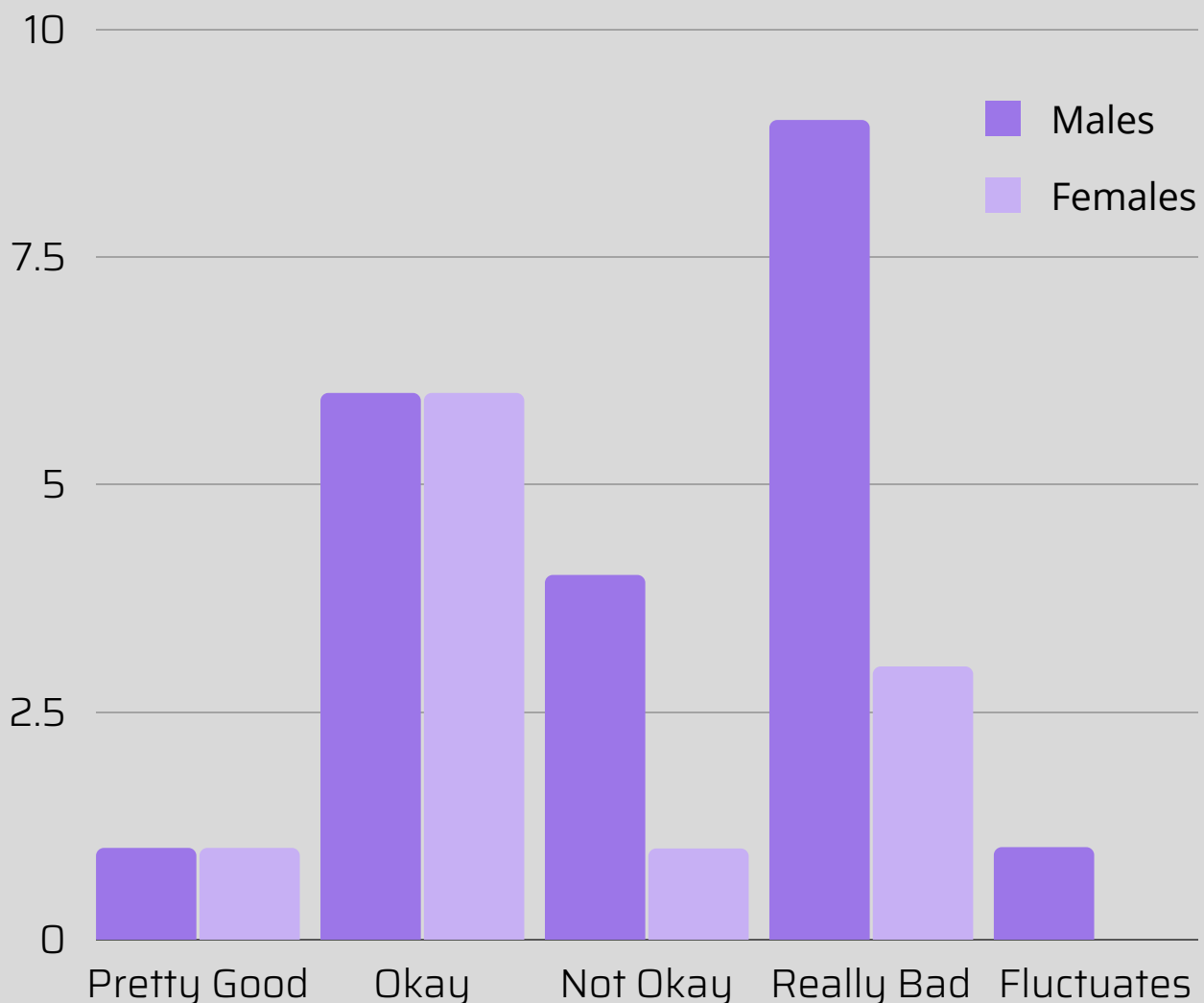
5.2.5. HEALTHCARE SERVICES USED

Six males cited having had negative experiences in the health care sector and another three avoid care altogether. A female said she has a family doctor "but they don't care about me." A male reported that he "fired [his] mean family doctor and go[es] to Street Health." Another male who uses Street Health and Hotel Dieu Hospital [urgent care] said he had not sought out any medical treatment for about 10 years, and that he does not generally trust or feel safe with hospital visits and stays. Another male without a family physician said he goes to the hospital "but then they tell me I'm crazy and to leave."

In the past year, males made an average of 3.7 trips to hospital, females 4.9. Of a total of 134 trips to hospital, mental health issues accounted for 38 trips, overdose 22, physical issues 18, and infections 8 (and another 2 for endocarditis).

"I GO TO THE HOSPITAL BUT WILL AVOID IT UNLESS I'M DYING"

INDIVIDUALS WHO HAVE A FAMILY DOCTOR:

24%
MALES

45%
FEMALES
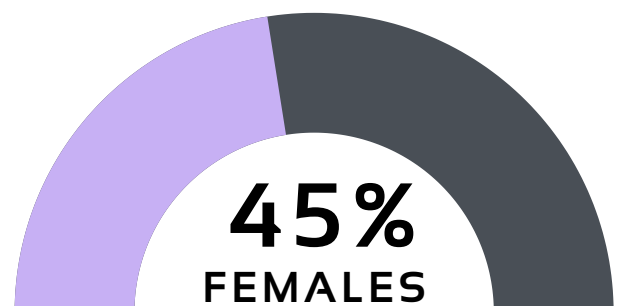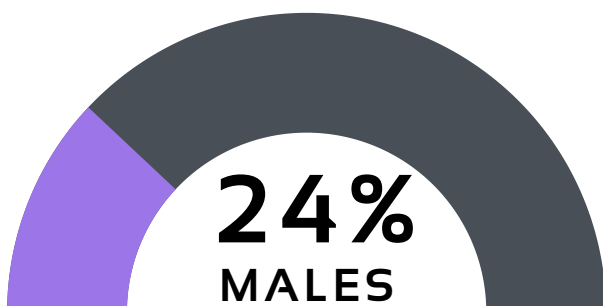
FIGURE 11: TRIPS TO HOSPITAL IN THE PAST YEAR AND REASONS WHY

Other
7.5%

Assault
1.5%

10 trips

Mental Health
28.4%

62 trips
- Misc 20
- Infections 8
- Migraines 5
- Medications 5
- Broken bones 5
- Heart 4
- Open wounds 4
- 'Very sick' 3
- Endocarditis 2
- Cyst 2
- Burn 2
- Hernia 2

38 trips

22 trips

Physical Issues
46.3%
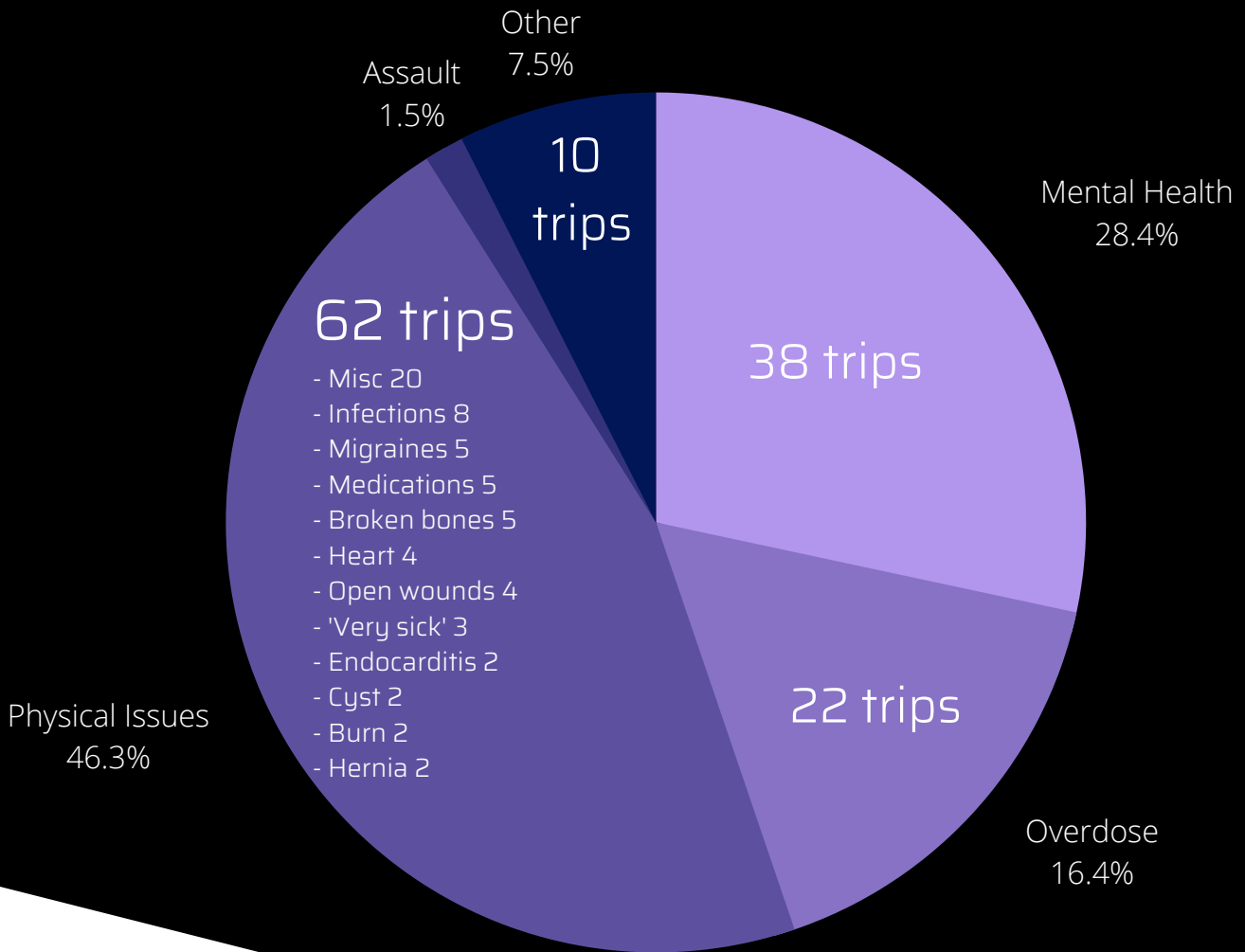
Overdose
16.4%

FIGURE 12: HEALTH SERVICES USED

Males

Females

| | Family Doctor | Street Health | Hospital | Avoids |
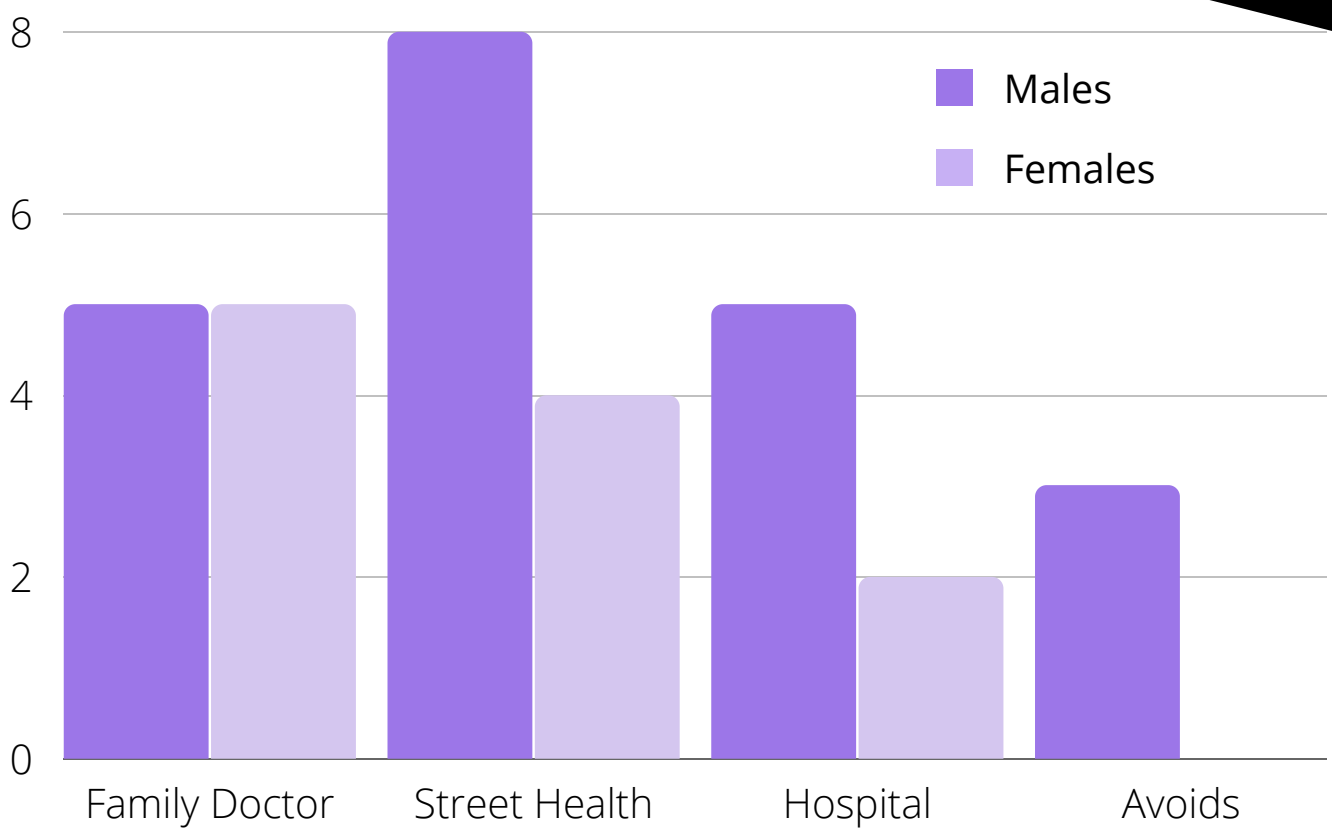
5.3. SUBSTANCE USE

Questions about substance use included when participants started using substances and the impact it had had on their lives; what types of substances they used and links to overdose; what substances they used daily, how they are using, how much and why; their experiences with overdose (acquaintances, people close to them, if they had experienced overdose); and their opinions around safe supply and the decriminalization of illicit substances for personal use. They were also asked what they wished the Kingston community would know about them.

5.3.1. START OF SUBSTANCE USE AND IMPACT

The following data, presented by self-identified gender, explores the age that participants reported starting to use substances (on average females at 14 years of age and males at 13), and how using substances has impacted their lives to date. In too many cases, it robbed people of their childhood.

"LET'S JUST SAY I WISH I COULD GO BACK TO BEING A CHILD."

FEMALES STARTED USING SUBSTANCES AT...

AGE 11

"My kids are gone, my family worries about me, sisters don't look up to me... I should probably have a job, be a normal person."

"I've lost everything, but I don't believe it's because of the drugs. It's because of the PTSD and the stigma that society has placed on drug use. I'm not just a drug addict, I'm a person and I've had a hard life. I don't have family and I'm virtually alone... everyone I love is gone."

AGE 12

"If you had my life, you would know why I use dope."

"It has forever changed me, it's hard to know if I will ever be 'normal' or get over the experiences I've had."

AGE 14

"It altered my life big time... stole my focus, time, goals, confidence, motivation."

AGE 15

"I never thought I'd be doing drugs all the time or that all my friends and family would be dying around me. It's a lot of emotional damage."

AGE 20

"Let's just say we wouldn't be talking right now."

AGE 22

"My dad was a huge drug dealer back in the day and it's taught me a lot. You learn from it. Life would have been better if my dad wasn't a drug dealer, if my mom was alive... She would have kept him in line."

35

MALES STARTED USING SUBSTANCES AT...

AGE 4

"It's been hard – I lost my whole family and business."

"Police raids and contact, it is all dangerous, lots of risks."

"It's ruined many relationships, it's ruined my career, distanced me from my family. I've lost housing. It's led me to criminal activity. It's destroyed my life! I feel like a forty-year-old loser."

"I use drugs for what I need them for, like a medicine wheel, it keeps me calm."

AGE 8

AGE 9

"It impacted every part of my life."

"It's my norm."

"It's destroyed me, but it's all I know."

"It's been life changing but reaffirming... but I won't be able to run away from it... me facing it will help others."

"It has made [life] the worst, there have been some moments of relief, but it truly is the pits of hell."

AGE 11/12

"It has changed everything – every little part."

"It's the love of my life, and the deepest hate and pain of my life."

"I am destroyed and not sure if I can ever be okay. I am a slave."

AGE 13

AGE 14

"It's impacted me negatively from deaths, losing people I get too close to, not having ID, don't talk to parents or have parents, hazards like dirty needles, stealing, gossip, fights, money problems… but it's impacted me positively by meeting new people, building community to keep people safe."

"Using got me through challenging times. There are negative consequences, but in general it helped me with some traumatic memories. It has NOT made me forget my trauma, but it helps to cope."

"Bad – I have no family left, I'm not allowed in their house because they think I'm going to steal for drugs."

"To be honest, I would not be where I am… I would have committed suicide by now without substances."

"It hasn't been great, it always takes time to do anything and I don't like that."

"It's had a big impact. My family won't talk to me, I have money issues, I've lost a lot of things, a loss of opportunity."

"It's been difficult."

AGE 15/16

5.3.2. SUBSTANCES USED AND LINKS TO OVERDOSE

The evidence around substances used and links to overdose is significant. People who use crystal meth on a daily basis reported needing to use another substance to help them sleep, typically marijuana or opioids. Daily users of fentanyl also used meth "to get things done" - give them energy and motivation.

- The 32 people interviewed overdosed a combined total of 205 times.
- People using crystal meth daily and marijuana to sleep overdosed 17 times.
- People using a combination of crystal meth daily and opioids to sleep, or binging on them, overdosed 56 times.
- People using fentanyl daily and crystal meth to 'get things done' overdosed 132 times.

While the prevalence of crystal meth as first drug of choice for daily use (44%) is only slightly higher than that of fentanyl (37.5%), the risk of overdose is almost double, and fentanyl is tainting the crystal meth supply.

FIGURE 13: NUMBER OF OVERDOSES BY SUBSTANCES USED TOGETHER
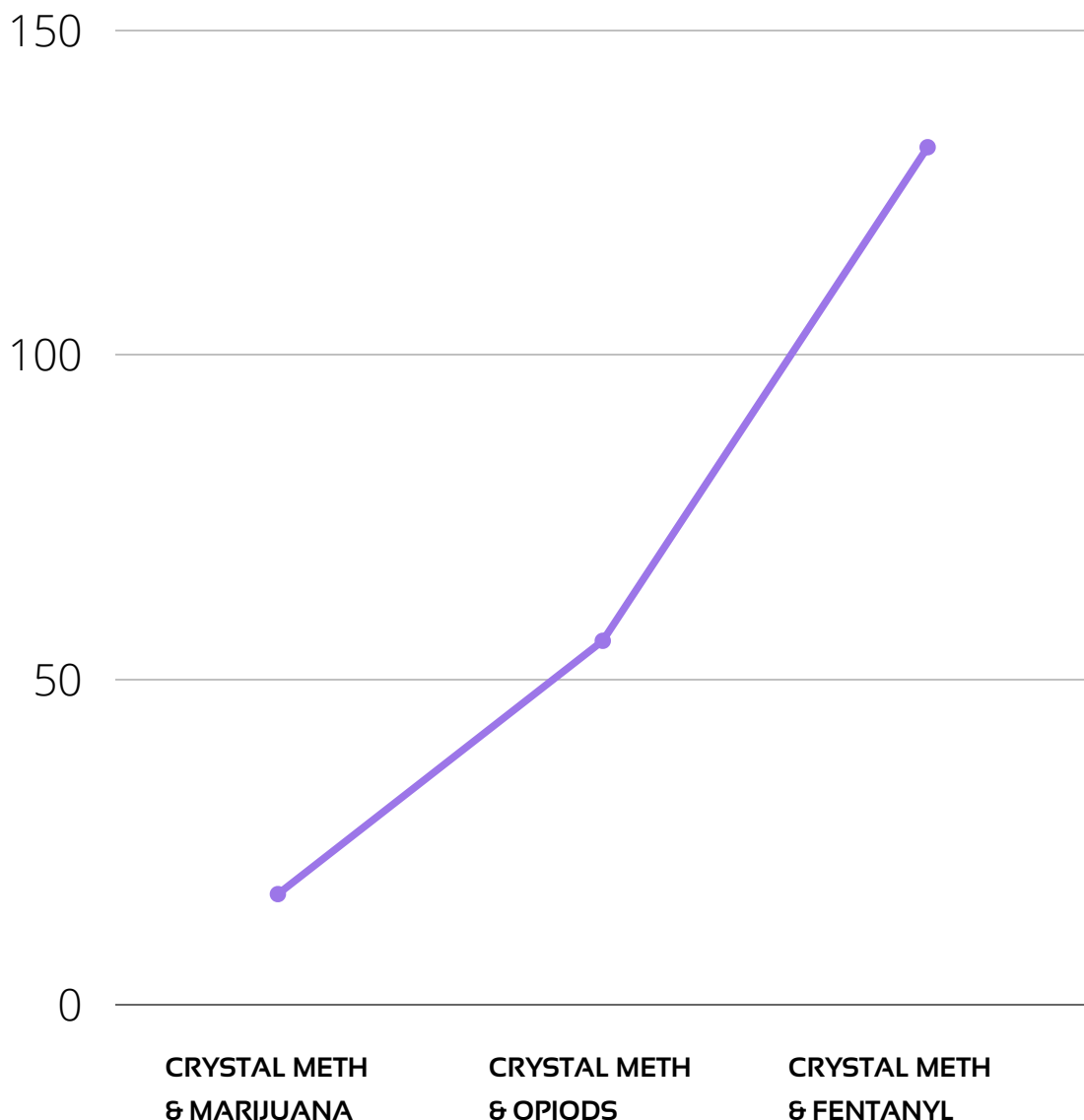
TABLE 1: SUBSTANCES USED DAILY AND LINKS TO OVERDOSE

Gender & Age	1st Daily Use	Other Daily Use	# OD's
F 18 - 24	Meth	Marijuana	No answer
F 30 - 40	Meth		1
F 40 - 54	Meth	Marijuana	1
F 40 - 54	Meth	Fentanyl	No answer
M 18 - 24	Meth	Marijuana	Multiple
M 18 - 24	Meth	Fentanyl	15
M 25 - 29	Meth	Marijuana	No
M 25 - 29	Meth	Fentanyl	8
M 25 - 29	Meth	Marijuana	2
M 25 - 29	Meth	Fentanyl (weekly	5
M 30 - 39	Meth	Percs (weekly)	9
M 40 - 54	Meth	Marijuana (to sleep)	8
M 40 - 54	Meth	Marijuana	No
M 55 - 64	Meth	Morphine	4
F 25 - 30	Fentanyl	Meth	Almost
F 30 - 40	Fentanyl	Meth	6
F 30 - 40	Fentanyl	Meth	5
F 40 - 54	Fentanyl	Meth	9
M 18 - 24	Fentanyl	Meth	17
M 25 - 29	Fentanyl	Meth (weekly)	10
M 25 - 29	Fentanyl	Meth	12
M 30 - 39	Fentanyl	Meth (2-3x week)	2
M 30 - 39	Fentanyl	Meth	10
M 40 - 54	Fentanyl	Meth	2
M 40 - 54	Fentanyl	Meth	50
M 40 - 54	Fentanyl	Meth	9
F 55 - 64	Alcohol	Meth (weekly)	2
M 25 - 29	Alcohol, pot	Meth & Opiates (binge)	15
F 30 - 40	Narcan nasal	Meth	3

THE 32 PEOPLE INTERVIEWED OVERDOSED A COMBINED TOTAL OF 205 TIMES (3 HAD NOT EXPERIENCED OVERDOSE THEMSELVES, SO THE AVERAGE IS 7 TIMES PER PERSON).

5.4. KNOWLEDGE ABOUT SAFER SUBSTANCE USE

Given the shadow pandemic of drug poisoning happening in the region, the needs assessment sought to identify ways in which lives could be saved. The following section explores what participants know in regards to protecting themselves from overdose, like using Consumption and Treatment Services (CTS).

When asked to rate their knowledge about preventing overdose:

Five males said they knew a little about it, three females said they knew something about it, while 14 males and 6 females said they know a lot about it. This evidence suggests that more concrete education around overdose prevention is needed.

"I LEARNED A LITTLE FROM MY PARENTS, SOME FROM OTHERS TALKING ABOUT IT, A LOT FROM PROFESSIONALS."

"MY BODY LETS ME KNOW."

40

FIGURE 14: LEVEL OF FEAR ABOUT OVERDOSING

Really worried
22.6%

Not worried
41.9%

Fairly worried
16.1%

A little worried
19.4%
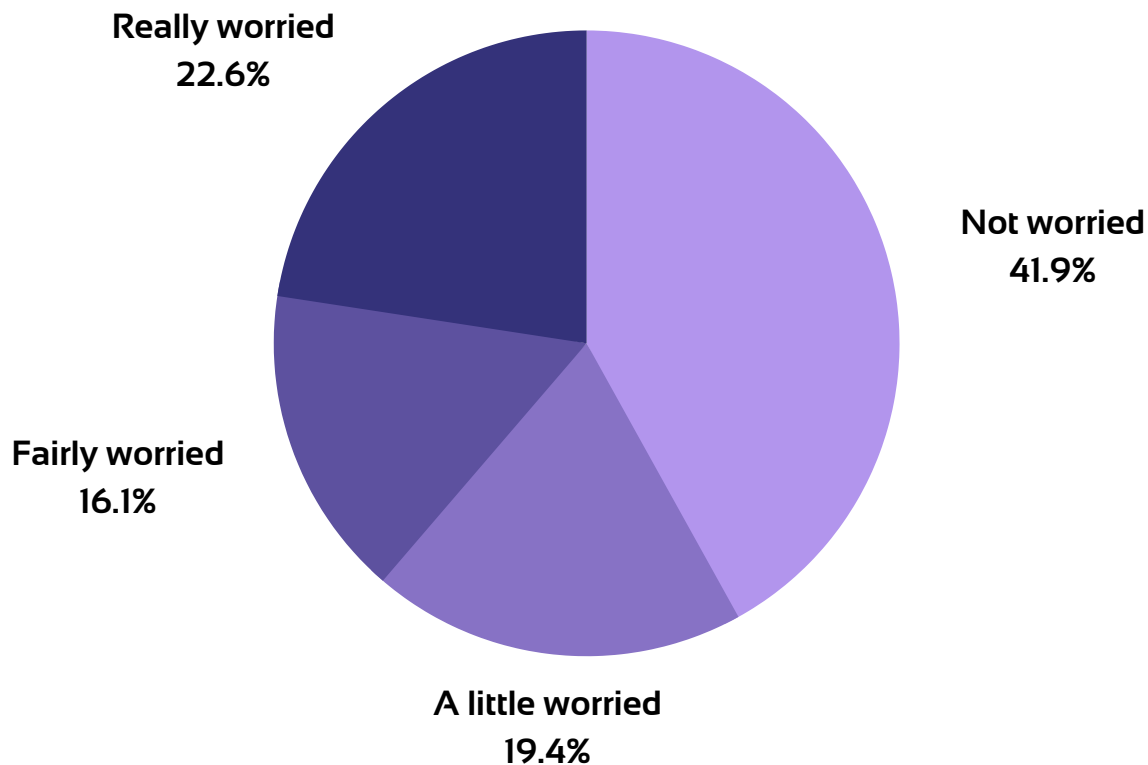
Eleven males and two females indicated they were not worried about overdosing: "You gotta block it out"; use adrenaline; "It's a way of life'; "Would god forgive?"; "When using you don't really think about it"; "Can't even do it [OD] on purpose"; one male indicated he doesn't believe he can overdose from crystal alone unless it is laced; one female indicated she has a high tolerance.

Three males indicated they were a little worried, one mostly about his brother, and another who said he tries "not to be, so it doesn't mess with my high". Three females indicated they were a little worried, but "You have to block it out." One female indicated she was fairly worried: "I try to use with people I trust, not alone", as were 4 males, one with a low tolerance. Three females and four males were really scared of overdosing: "I don't want to die!" A male participant who had been revived numerous times by ICH staff described them "as "heroes, my angels." A female said: "I'm not afraid of losing my friends at The Hub" because staff are on the lookout and are trained to deal with overdose.

"I DON'T WANT TO DIE!"

THE ICH STAFF WHO HAVE REVIVED ME "ARE HEROES, MY ANGELS."

"IT IS A WAY OF LIFE."

"I'M NOT AFRAID OF LOSING MY FRIENDS AT THE HUB."

Stakeholders indicated the following:

- Two females and six males said it didn't change how they use (one because he couldn't remember overdosing, one said he won't let it, and two said "that's the game"); one said it made his substance use worse (to deal with the stress).

- 15 said it did change how they use (only use with trusted people; don't smoke it or let anyone load it; try to use with people around; try to be more cautious; stay away from Fen and only use pills; uses a little less; doesn't inject anymore; try not to share pipes; always test it now; it does for a bit but then I get sloppy again)

- One said "probably, but I try to block it out" while another said he isn't sure because "when it happens it happens".

62% of respondents indicated that overdosing changed the way they use substances

5.4.1. EXPERIENCES WITH OVERDOSE

The following section explores how many people (acquaintances and people close to them) stakeholders knew who had overdosed, whether they had experienced an overdose themselves and how their overdose had impacted them emotionally. On average, males indicated they knew of 50 people who had overdosed, females an average of 57. Males had lost an average of 18 people close to them to death by overdose, females an average of 20. Males overdosed an average of 10 times each in the past year, and females an average of 2.8 times. Of these, 36% had been revived by friends and partners, 23% by ICH staff, 19% by CTS staff (who are also considered to be ICH staff because CTS are onsite), 13% by emergency responders, 6% by strangers, and only one person had been resuscitated in hospital. This indicates that it is the community itself that is responding to overdose an incredibly traumatic phenomenon that leaves them in constant worry.

It is also important to note that CTS staff are likely to be included in the ICH staff count reported of those responding to overdoses, for a total of 42% responses reported.
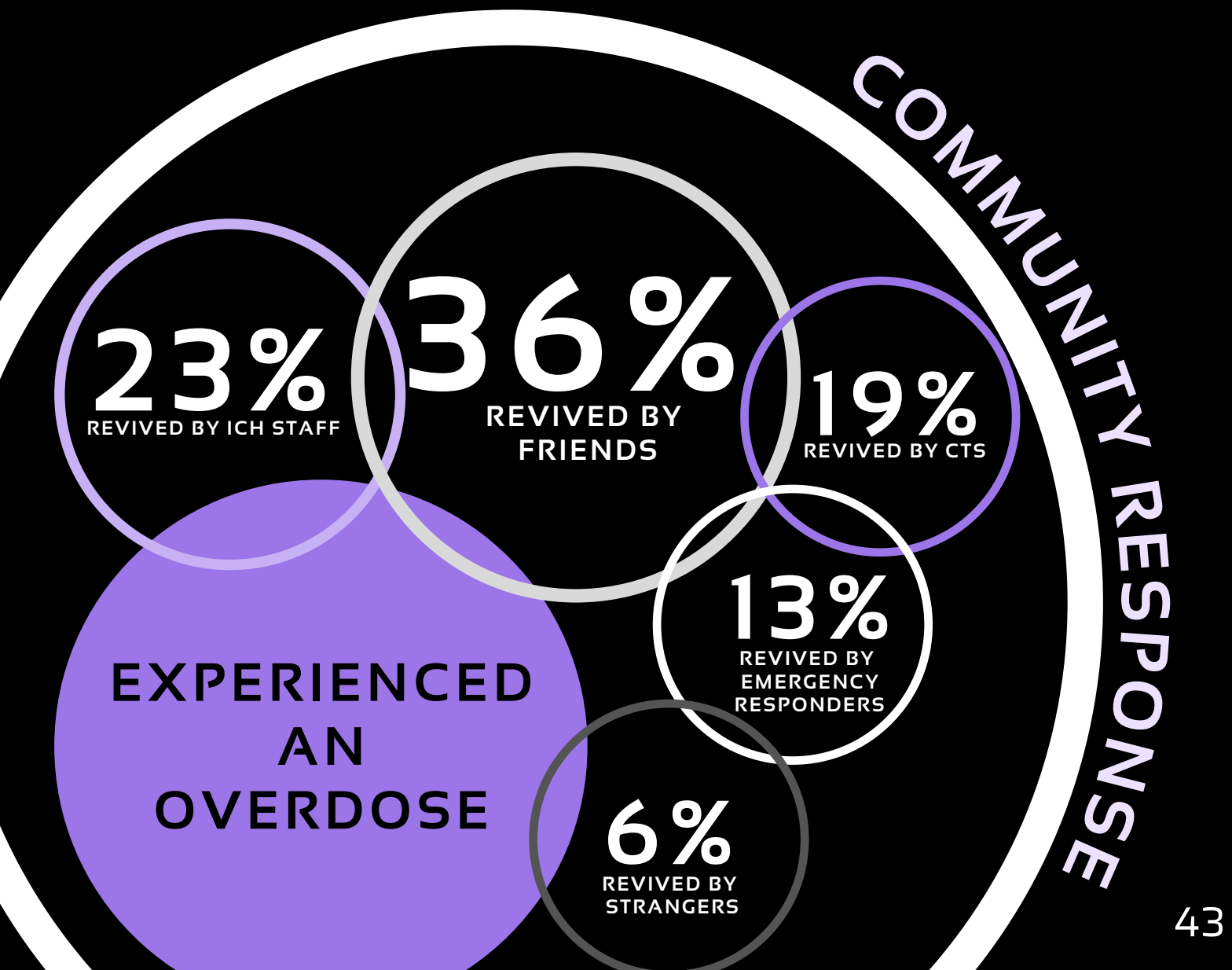
COMMUNITY RESPONSE

23%
REVIVED BY ICH STAFF

36%
REVIVED BY FRIENDS

19%
REVIVED BY CTS

13%
REVIVED BY EMERGENCY RESPONDERS

EXPERIENCED AN OVERDOSE

6%
REVIVED BY STRANGERS

- Four males said their overdose had not impacted them emotionally and one female said: "No, I never really knew I was OD-ing."
- One male said: "It didn't – I am already numb."
- Another male said his overdose did not impact him emotionally (because he couldn't recall waking up), but seeing his girlfriend and friends overdose did.
- Others expressed their emotional distress as follows: "Yes, and physically"; "A lot"; "When I came out of it, I was really upset, crying, a little sad"; "The loss of people really has"; "It's been very hard"; "I'm quiet and keep to myself, always thinking"; "I feel lost and I don't like to think about it"; "I felt bad that I upset others"; one respondent reported that it was a really terrible thing to do but made him see that others know life can go on; "I was pretty upset"; "I felt lucky to still be around"; "I came back crying"; "it made me an emotional wreck"; another respondent reported that it was horrible, he resents the person he suspects spiked his dope; felt betrayed, was unsure if it was given on purpose.

"People judge. I've heard it myself: 'It's just another Junkie, what's the big deal really?' But I didn't choose to be a Junkie, and I don't refer to myself as that."

- One young man in his twenties reported knowing hundreds of people who have overdosed, but six [were] very important people – "it has made me not want to get close to people, it's too painful."
- "Seeing so many overdoses changed my outlook on life, it's made me realize how fragile people are, but also how resilient as well." (30-something Male)
- A middle-aged male said that his fifty plus overdoses have left him "raw and sad…"

  - "Ya, I want to live, but [overdosing] has reminded me how shit my life is, and I guess I question if it is worth living… I hurt deeply every time I find out someone has used fentanyl because they basically punched their ticket to die. It's the saddest, fucked-up thing in the world. That's why I always try to help. I want people to live, but I will only be able to do that until one day I finally do die of an overdose."

- A middle-aged man who overdosed twice said "it's so sad it hurts, I feel like a failure, but I don't want to die!"

44

- One male said not really, one female said no, two males said no, and one male said: "No, I don't care about life". One male said he didn't think so as he was becoming slightly careless again and in general he feels the same way about life.
- Two females and one male said it had changed their outlook, while another male said: "Yes, but I don't want to share that[why]". One male said: "A little, but can't say how." Two females said yes because they wanted to see their kids: "Ya it really has – I want to see my brother and kids one day." Three females expressed gratitude and a new found awareness: "I'm thankful just to be alive"; "I live my days like they are my last. If I think something I say it"; and "I realized that I don't want to die, not everyone gets that opportunity."
- Nine males also had revelations about living: "Yes, definitely"; "I do know I don't want to die yet"; "It makes me think there is more to life than dope"; "It made me more aware that I am in relatively good health, but am also more understanding about how a small group can overdose or want to commit suicide"; "Yes, I realized I like living"; "I was given energy and brought back to life, I breathed to bring back my soul."

"I wish I never started doing it! I wish I took the time to deal with my life and emotions. I wish some past experiences hadn't gone the way they did and then I wouldn't be in this place right now."

"It's so sad it hurts, I feel like a failure, but I don't want to die!"

"We need more awareness, people should not turn their backs on us because of it, it affects a small portion of people, but awareness could be a positive thing."

"It's scary, I wouldn't wish it on anyone, you have to know what you are doing when you respond [to an overdose]."

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5.4.2. SAFE SUPPLY

The evidence indicates that safe supply would save lives and reduce visits to hospital. As one respondent described what safe supply could do:

"[SAFE SUPPLY] WOULD CHANGE MY LIFE. I COULD BE PRODUCTIVE, NOT CHASE DOPE, NOT DIE… JUST LIVE LIFE!"

Almost all participants felt that a safe supply program would save lives, but also allow them to be more productive by not having the constant worry about overdose, or the quest to get substances to not fall ill.

- "It would make me take on more [responsibilities]."

- "I wouldn't die, I wouldn't ever get ripped off, I could function every day no matter what."

- "Save money and not worry about overdose; it would be a lot better."

- "It would change things dramatically, I wouldn't have to do crime to support the habit, I would be able to get a job."

- "I was on safe supply in BC and it was life-changing."

- "It would make life way better, fear would be gone completely, and the game of 'chase' would be over."

- "I wouldn't be worried about people fucking up my shit because of an old debt or something. I wouldn't have to always be looking over my back".

- "It would be huge"; "More people would be alive."

- "I would not go dope sick, but I really love fentanyl, so that's a problem – nothing compares to the feeling it gives you".

- "It would be better, safer, and not having to worry about a clean use, worry about additives."

5.4.3. DECRIMINALIZATION

The interviewers discussed whether participants had gone to jail, whether they believed their substance use impacted their charges, and what they thought about the decriminalization of all illicit substances for personal use. Ninety percent of males had been incarcerated, of which 57% indicated charges were drug related (38% had been arrested for petty theft to support their addiction). For females, 73% had been incarcerated and 64% indicated charges were drug related.

Early incarceration due to drug use dramatically changed peoples' lives. When discussing the prospect of decriminalization of street drugs for personal use, a middle-aged man said: "That's how it all started… I don't think I would be in the situation I am if this [decriminalization] had always been a thing." A middle-aged female said: "The first time I ever went to jail was because of drugs – I was young and it fucked me up."

Most participants supported decriminalization because it would save people from having to engage in petty crimes to support their addictions, being further traumatized in jail, and it would de-stigmatize substance use:

- "Yes!… it's like a promise saying: 'You will live, you will not go to jail, you are okay, there is nothing wrong with you'."
- "It's not complicated – everyone would be better off."
- "I would not have to be out stealing shit in the middle of the night."
- "There would be less worry, less criminal charges, but you would still have to be careful having drugs in a house with kids."

FIGURE 15: RATES OF INCARCERATION

Bar chart legend: Drug-Related Charges; Other Charges. Y-axis: 0 to 100. Categories: Males, Females.
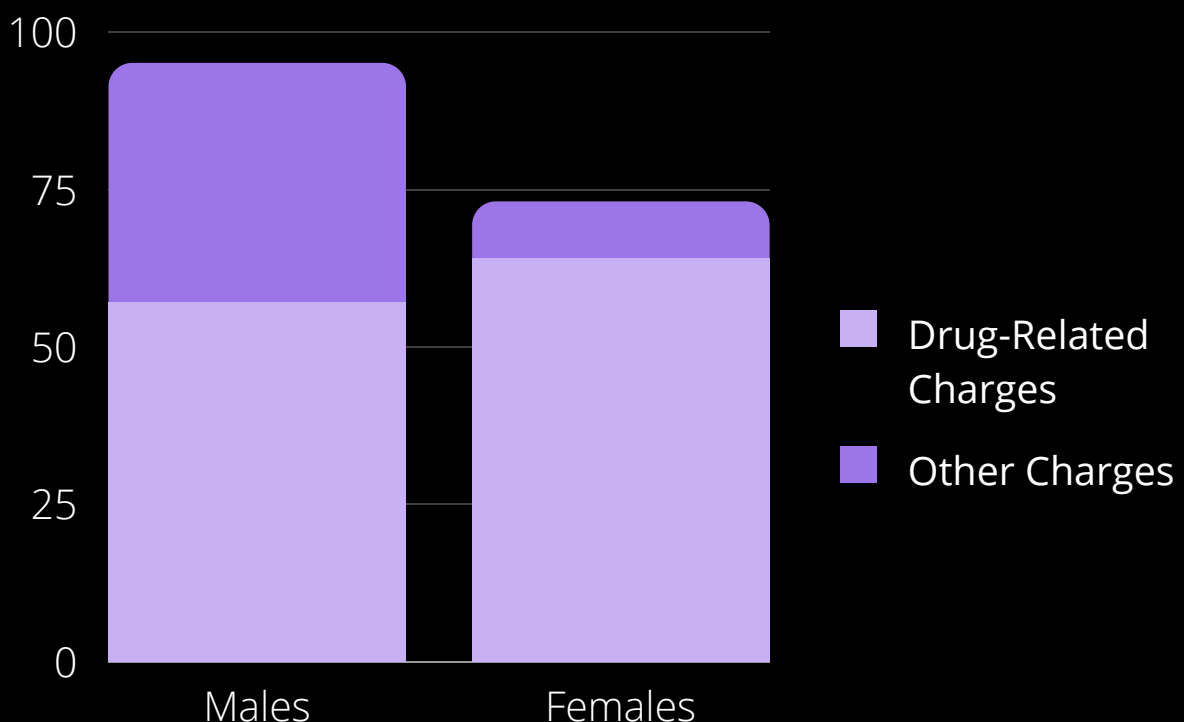
5.5. MESSAGES TO COMMUNITY

Participants were asked what they thought the Kingston community should know about people who use substances. Responses have been grouped thematically.

WE ARE *PEOPLE*, WITH PEOPLE WHO CARE ABOUT US...

- "We are just like anybody else... just because we have a drug habit doesn't mean we are not people... we have family and people who care about us."

- "I am someone's mother – would you treat your mother that way?"

- "We have family."

- "[We] are still people."

- "I am a good person, I have done real things in my life (ran a business), I have kids and I am a grandfather."

"WE HAVE FEELINGS, DON'T MAKE US FEEL WORSE THAN WE ALREADY DO..."

- "We are all people and although we are using to numb, we still feel and hear more than we let on. It takes a thousand 'Atta boy's' to get rid of just one 'You aren't good enough'."

- "My feelings get hurt. I know how people look at me."

- "I just want to see the stigma lifted! People think we are dirt balls, and it is sickening"

"DON'T JUDGE US WITHOUT KNOWING WHAT WE HAVE EXPERIENCED..."

- "Be kind, don't judge me! I have done nothing to you, this is my life, I'm not hurting you."

- "I never thought I'd be doing drugs all the time or that all my friends and family would be dying around me. It's a lot of emotional damage."

- "Don't judge us – don't read a book by its cover. We may use drugs and choose to hurt ourselves, but we didn't choose IT. Don't treat us like scum because we really are not any different than anyone else, just a little more fucked up."

"WE ARE PEOPLE IN PAIN... DON'T EXCLUDE US."

- "We are not all bad people; we are good people, just in a lot of pain, we are humans"; "We are not bad people"; "We are people too!"

- "I wish they knew us as people – we are good people in pain."

- "We carry pain! And I never wanted to cause harm to anyone but myself."

- "There is a deep reason why they are using, there is something there that causes them to use. It could be anything, something small or something major."

- "I have never really had stable housing, not since foster care... I feel like I am a bad person, so karma is the only stability I have."

- "Doing all of the drugs and stuff, it fucks with us. Having our friends OD and die fucks with us even more. If I could tell you one thing... be patient and just remember, imagine the worst moment you've ever had in your life and it is in your head on repeat, every day. That's what our life is and it's why we do drugs. Our stories are all different, but they aren't too far apart.

- "[Fentanyl], it's almost like god's hug, every day."

- "We are not all shitty people. We use dope because of shit people can't see. I'm a human. I'm a part of society. I should be included. Why can't I be included? What's wrong with me? I'm not a bad person. We are all on a journey."

These quotes illustrate the contradictions and complexities of emotions experienced by people who use substances, from the pain that they feel – physical, emotional, and spiritual, and the only way they know how to deal with it – to the deep shame and exclusion that they feel because of stigma and othering.

"WE ARE LOOKING FOR HELP TO HELP OURSELVES..."

- "We are not all shady... There are some really amazing people. We just need a hand up, not a hand out!"

- "Tell the hospital not to shun the users."

- "Never look down on anyone unless you are helping them up."

ENGAGE WITH US, WE MIGHT NOT BE THAT DIFFERENT AFTER ALL...

- "Listen, learn... who knows, you might actually like me. Just a reminder, you are one shitty day away from being me."

- "Everyone has an addiction."

- "It doesn't matter who you are, [other] substances can be used in your life. It can affect you physically, mentally, and spiritually."

- "We are still people, just having a different struggle. Let's see where this [conversation] goes and go from there. There is lots to be learned, and I am still learning."

- "Take the time to get to know us, like The Hub staff"; "Talk to me"; "Come check in on me more"; "Having a social gathering, meeting your neighbours."

- "These are the best fucking people I know, seriously, you're missing out."

This last quote from a young adult male who also described the impact of substances as enslaving in the interview, shows how, within the ICH community, there is an understanding that people are people, and are not defined by their substance use. Stigmatising terms like 'junkie' show how many people in society fail to understand that people who use substances are traumatised, unwell, marginalized, and ostracized. They have their own gifts and talents to offer, if we included them.

ADVICE TO PEOPLE WHO USE SUBSTANCES RECREATIONALLY...

- Be safe – use with other people, not alone.

- Be cautious about how much you use.

- "It's very traumatizing, it changed my life. I hope people never have to experience that ever."

5.6. WHAT PARTICIPANTS WISH FOR

Participants were asked what they would like but cannot afford. Interestingly, not all of the answers were material in nature. The replies from participants provided insight into their humanity, their generosity, and what they missed most in life. It also shows how many participants see benefit in some form of communal living with friends or loved ones. This should be taken into consideration when planning for housing people who use substances.

"To be able to pay last month's rent."

"Phone, data plan."

"A car – I would never stop driving… freedom!!! Never being stuck somewhere."

"Be able to take my girlfriend on a date. Take her to get her nails done and feel pretty again. She doesn't feel like a woman, or pretty. I try to tell her everyday, but she's really depressed, and I'm scared for her."

"This is a tough question because it has been a long time since I shopped for myself: clothing, shoes, hats, travel, a vehicle."

A place to live, get my girlfriend whatever she wants and needs, just basic things.

"Better clothes, money for laundry, buy a rooming house for people."

"Homes for many people, being able to support my habits without committing crimes, basic needs (a belt, boots), groceries, peace of mind, dental work, meds, I just want to be able to support myself."

"A car, get my license back."

"New shoes, and I want to buy my mom a Mother's Day gift, it's been many years."

"My child."

Go on vacation, eat better food, just buy things I need, the basics.

"Get a house for me, my brothers and my mother, to always have groceries, to help my family… everybody deserves to be treated the same way."

"My daughter to not struggle. Pay my fines off. Buy a farm."

"Money can't buy this, but my kids' forgiveness."

"To go back to Nova Scotia, to the ocean."

"Walk, dance, and my own land."

"A home"

I WISH FOR...

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5.7. HOUSING, EMPLOYMENT, AND WELLNESS

There were five questions specifically related to housing: Whether participants felt they had received appropriate support or help while experiencing homelessness; what would help them get out of homelessness; what participants thought shelters could do better; what kind of housing did participants think would work best for them; and if they were to run their own shelter, what did participants think that would look-like (grouped with what shelters could do better in the analysis and data presentation). References to other shelters other than the ICH (The Hub) were anonymized in the data presentation.

The ICH is a low-barrier shelter service offered in KFL&A, specifically designed for people with 'tri-diagnoses' – mental health, cognitive and substance use challenges. To reiterate from the methodology, though not a bias per se, this was a rapid needs assessment for the ICH and it did not endeavour to interview people using other shelter services. Thus the data may appear ICH-centric. However, interested readers can consult the Marshall and colleagues (2021) report on homelessness and services across the KFL&A region for comparison.

It is important to note that housing, employment, substance use, mental health, physical health, and pain management are all interrelated in the lives of the respondents. They were also asked whether they were working, wanted to return to work, and if so, what were the barriers to returning to work.

5.7.1. EXPERIENCES AROUND SUPPORTS FOR PEOPLE EXPERIENCING HOMELESSNESS

Participants were asked about the supports they had received while homeless. Nine stakeholders cited having received supports not specific to the ICH:

- "A roof over my head and food"
- "They assisted me in finding support"
- "Meals and a heater for the cabin"
- "Yes, when I was housed, a long time ago"
- "When I was successfully reached out to and had appointments with staff"

A male indicated that starting April 1st, 2021, he has found a place through assistance (having waited 6+ months), has made good connections with workers, and felt supported by mental health workers. A male said navigating the shelter system has been a learning experience, but it was better than risking his life (e.g., to the cold). One male indicated "in the shelter system I have met a lot of cool people and my partner."

One female indicated having had issues with staff communications, and they were not so helpful with finding her housing. She added that at the ICH, she felt staff were helpful and genuine. Ten other stakeholders indicated they had received quality support at the ICH, but not prior from the homelessness system in general. One said: "The only spot I feel like I have kinda got support was from The Hub. You are all so nice to me." Another said: "I have learned about community resources at The Hub, but I did not feel well supported with other places I have looked for help."

A female participant said she had not received consistent supports: "Not all the time. Shelters use my behaviour problems against me. [One staffer] says I'm a horrible person and they don't even know me. They banned me for no reason." Another female said: "My housing worker didn't work for me. They kept telling me my [poor] place of living was because of my addiction". A male said: "There is [one place] that is awful. What they feed you is not okay. The staff pick who they like and people aren't treated the same there. They play favourites." Another male said: "At [one place] I didn't even last one night, they are fucking assholes. I would sleep on the street before ever going back and have." One male said: "For the most part, but not one place though, they are just mean there". Another male said: "I've stayed at all of them but haven't always had support. One place the staff are just rude." One male hasn't stayed at other shelters except the ICH. A middle-aged male said: "I have been homeless for six years so someone isn't doing their job." A young adult said:

"I feel supported by [Hub] staff, but the government is the problem – the 'high ups' need to step up."

5.7.2. EXPERIENCES AT THE INTEGRATED CARE HUB

Participants were asked about their experiences at the Integrated Care Hub. It was emphasized that their answers would not affect the services they received, and managers were very open to suggestions. The underpinning philosophy at the ICH is inclusion and engagement, which was validated in the participants' responses.

- "At The Hub you try to find out both sides of the situation before making a decision on what to do." (30-something female)

- "I feel like you guys [at The Hub] try really hard. We need to work with you guys more." (Middle-aged female)

- "That we are doing a really, really good job here at The Hub. Our hearts are involved in this and we are really appreciative." (Middle-aged female)

- "We are equal at The Hub, and I feel that. I have my own space, the staff help me a lot, I love The Hub – it's my family." (20-something male)

- [To the ICH staff interviewer] "Thank you for making me feel loved." (30-something male)

5.7.3. ADVICE FOR IMPROVING SHELTER SERVICES

Stakeholders were asked about what could be improved with the Kingston shelter system, including the ICH, and what ideas they had if they were to run a shelter. One young adult noted that "Even in shelters, there is so much stigma still. Break down those barriers. Look at everyone as being different and may need different things. I would accommodate all different needs, have more things to do, and maybe run a clinic right out of the shelter." A 20-something male was quite specific, and clearly had given the issue a lot of thought:

> "My ideal shelter would be a place that you can go for a very short period of time because there is a guarantee you will be housed in a very short period of time…. [and that housing would be] something that is mine, but I also don't want to be alone. I want to share housing with people who are like me. I want a place where I have rights, and I know what those rights are."

STABILITY: SLEEP, NUTRITION AND HYGIENE

- Would add shower limits; need more showers.

- Seven participants stressed the importance of good food supply.

- Satisfy basic needs.

- Offer stability.

- Home cooked meals.

- Better beds.

- Two participants suggested having their own rooms and another that partners could use more privacy.

- My shelter would look like a hotel, an apartment building.

- Try to give people access to the things they want, and optimistic views.

- Where everyone is accommodated, always have somewhere to sleep, where staff would be so kind to everyone and good food!

- Increase capacity with an outside shelter to provide coverage all year round. I like The Hub a lot but give couples more freedom like showering, but The Hub does a lot like letting couples sleep together.

- Be able to keep animals.

OUTDOOR AMENITIES

- A smoke hut and shelter from the elements.

GETTING THE BASICS: CLOTHES, CELLPHONES, ID, BIKES & SAFE STORAGE

- Offer semi-permanent residency, because carrying stuff around is hard.

- Access to clothes because people are selling clothes from donation bins to buy dope.

- Create a points system to be able to buy things from a thrift store.

- A safe place for bike storage and repairs.

PERSONAL SPACE

- "Everyone to have their own personal space, a quiet spot, a place without someone looking over your shoulder. If there was a quiet space people could deal with their mental health."

- "More privacy, especially for sleeping, understanding of where the people are in their lives, why they are there, especially mental health issues."

- Better communication between the staff, consistency, check how staff use their authority (it should be used to help).

- Change the training: it's not a prison, give people freedom.

- Nicer staff at some of the places. Friendly staff like at The Hub.

- Be understanding that everyone is different, staff that are understanding.

- Would be careful to hire staff with lived experience.

CREATING A WELCOMING, CARING ATMOSPHERE

- "…be comforting, help people feel accepted."

- "Kind of like The Hub but be able to let everyone in and make everyone to feel as comfortable and at home as possible."

- "It would look like a family. It takes a village and we have to work together, and we are in it together."

CHECK-INS AND SUPPORTS

- Talk to us, spend time with each individual, find out if everything is okay, provide extra safety.

- Two participants stressed the need for more groups and support programs.

- Dealing with people's mental health issues better.

- "I would run a shelter like a detox, cater to individual needs, be able to socialize."

- "A house to advance people in their surroundings, smaller groups so people can get to know each other."

- "Case managers being nicer and more supportive; more peer support; housing workers being less judgemental."

- "Less issues: Interview people in regards to their mental health and categorize people to live together. Some people get picked on. There's a lot of bullying and thefts".

DEALING WITH CONFLICTS, STEALING AND DRUGS

- Deal with thefts – there are a lot of thefts in shelters.

- "Try to figure out how to curb the stealing and interact with us more to find out what's really going on."

- After a certain hour stop the arguing and fights (clients must be better to staff).

- Take theft seriously, don't turn a blind eye because it's a real problem and creates distrust between peers when they steal from each other – find ways to prevent it.

- Not picking sides when people are fighting. Not kicking people out because they have a meth pipe.

- Be more strict on how things are being resolved.

- There are lots of conflicts with people – try to make each day better, without worries, people knowing they are looked after, feel protected and safe.

- Less drugs around.

- More strict on everything, like selling dope – "take it outside".

MORE THINGS TO DO

- More resources for people, more things to do so we don't just think about dope.

- "More things to keep busy – that always makes me feel good."

- My shelter would be "a nice little pad with cool furniture and a pool table. I would take in as many people as I could. It would look like The Hub."

- Maybe a theme park with lots of things to do.

ENGAGING STAKEHOLDERS IN TRAINING AND WORK

- "Take the time to find out what people are good at and have them help at the shelter, not just a short-term stay."

- "More jobs."

- "I would like to work at the ICH more, to support myself and the place that helps me."

- "There is no community, no skills being offered. The shelter system keeps us down and punishes people for being un-well. Everything can be done better. Be kind. Stop judging."

EDUCATION AND OUTREACH

- Involving the community more in understanding and helping vulnerable people. Embrace one another.

5.7.4. STAKEHOLDERS WANT TO WORK

Almost all of the participants wanted to get back to work, but there were significant barriers: unstable housing, lack of official identification, health challenges, substance use, physical ailments, and caring responsibilities. One male experiencing homelessness in his late fifties who was on ODSP said he would like to retire. Another often thinks about returning to work but spent too much on lunch and travel. He currently has children with family members and wants to see them so "it's not a good time" to start work. He is also "hard into drugs."

The other 19 of 21 males indicated they were not working but would like to be, citing a number of barriers. Two males indicated that COVID layoffs were keeping them from working, and they are now homeless and having to carry their belongings everywhere. One would like to get a business going but his phone, ID, and SIN Card were stolen. One did not have his drivers license anymore. Eight cited not having stable housing as a barrier to working: "No one wants to hire someone that is homeless and can't take care of themselves." Eight cited their substance use as being a barrier to working: "Being an irresponsible person who chooses to use drugs over having a real life." Three cited their mental health issues as a barrier; one, physical health; one male's girlfriend has a lot of health problems and he has to take care of her, another male cited other responsibilities; one can only do office work due to previous injuries and he has not found that kind of work. One would like to be working in construction and demolition, but finding the right job has been a barrier, another would like to be working as a mechanic. Another would like to be working as a mason/artist, but he is not housed, life is in chaos, he has no money and is going through a rough patch. Another male approaching retirement age would like to be a healing/wellness worker, but he suffers from back pain and his age is a barrier to being hired.

Nine of 11 females indicated they were not working but would like to be. Six cited not having stable housing as a barrier to working; 5 cited health issues as barriers (i.e., physical disabilities, chronic pain, kidney related issues, needing to be on medication and mental health); one said using substances was a barrier to working, one wanted to pursue education to do a trade; one was undecided if she would like to return to work; and one indicated she doesn't have the patience to work, her head space isn't right for it.

5.7.5. WHAT STAKEHOLDERS NEED TO SECURE HOUSING

Stakeholders were asked what would help them out of homelessness, and what kind of housing they felt would be best for them.

A 20-something male noted how much more challenging life had become for homeless people since the pandemic was declared, leading to lock downs and service cutbacks. He wanted: "A house that I can afford, a good support network, funding going to the right places, things being made more accessible even during COVID. COVID has put us on the back burner again… it has doubly fucked us up."

Three participants felt a job, getting back to work, and having money was key to getting out of homelessness.

"I JUST NEED SOMEONE TO GIVE ME A CHANCE"

Several people wanted a second chance: three said: "Someone to give me a chance." Another said: "A stable, clean place. I used to own a business. I want that back. It was my life." Another wanted "a name change. [Kingston Police Department] KDP smeared my name and set me up. Landlords google my name and I can't find a place. My children have been humiliated by how I have been portrayed online because of the KPD."

Many stakeholders highlighted how they needed social and professional supports, as well as housing, including transitional supports: "Having a place to stay, like at The Hub, and then help with somewhere to go after." Five were looking for not only additional supports, but "people that care": a good [social] worker, a housing worker to help with interviews, "treating my mental health and substance use issues, and feeling comfortable." Five participants suggested how housing and social/professional supports could be blended with the creation of more places or spaces for community living; "subsidized housing with support from someone to help me adjust and help with my substance use"; "more choices without wait lists"; "something different, where you have no worries, you know everybody is looked after, feel protected and safe"; "to be in an apartment and independent, but also supportive staff."

Stakeholders described how difficult it was to find decent housing while on social assistance. Six spoke to how rising market rents were making living on Ontario Works or the Ontario Disability Support Program even more impossible. One said he needed "more money because housing costs are too high, even in 'assisted' housing"; another "could only afford $1200 max or less". One hoped for a one-bedroom apartment with rent geared to income, another was willing to settle for any kind of housing, but it was important "to be in a good location so I can get around." One lamented that "Everyone wants references, financial statements. Welfare is not enough to get a place with my addiction. I can't afford housing. I could build a cabin or a tiny home to stay in and stay warm all winter." A young man struggled with the idea of trying to better his life because he felt set up for failure: "I feel it's me. I just do not feel motivated, and the lack of affordable housing."

"I NEED MORE MONEY BECAUSE HOUSING COSTS ARE TOO HIGH, EVEN IN 'ASSISTED' HOUSING"

Ten others explained how difficult it was to find affordable housing and **continue to use substances**. They hoped to find affordable places with "good landlords that don't judge"; "Being able to pay rent and still be able to use"; "the basics, and no threat of losing my home because I use substances"; being able to afford a place, good references; comfortable in an apartment complex; an apartment; a motel; "anything other than a box." One participant grew up in foster homes and so was used to unstable and unpredictable housing and was not picky (a partner would be nice but no preference as to style of housing). Another hoped for a "nice place with no more than one roommate, close to a grocery store." Another hoped for accessible housing to accommodate physical disabilities. Another hoped to find a place "that accepts people with a criminal record: it doesn't have to be a nice place, but not a slum." Several participants described being in housing so sub-standard they preferred to sleep rough than with bugs, vermin, mildew and rot.

Others had struggled with conflicts with roommates and were looking to live independently. "Not having roommates screw me over on paying bills, calling police on me. I work, I'm tidy and neat, I respect my spaces." "I am independent, so just my house with a door and I'm happy"; independent housing (notes he has not been well-served by the housing department – no follow up); a small apartment setting with a balcony, internet, and phone; a one-bedroom apartment in a rural area.

Four stakeholders valued reconnecting with family, but their housing would have to accommodate visits. One said having her kids back in her life would act as motivation to do well. Another would like to have a place so his daughter could be with him. Two felt they needed a two-bedroom place: "A one bedroom would be okay, but I have three sons so a two bedroom would be nice so my kids could visit me."

5.7.6. OTHER PRACTICAL SUGGESTIONS FROM STAKEHOLDERS

Stakeholders were asked what else would help them to become well. The responses have been grouped thematically.

TO THE GENERAL PUBLIC

- "How about allowing a person to do what they need to do. Don't get angry with them, anger isn't helping, it just makes things worse."

- "Don't beat on a dead horse."

- "We are good people. Mind your business."

- "Become a bit more knowledgeable about [people who use substances]"; "Maybe just take some time and research it, ask friends and family if it needs to be clarified"; "Have better knowledge about when people are going to commit suicide or overdose."

HOUSING, TREATMENT, LIFE SKILLS AND OPPORTUNITY

- A male in his twenties said he would like to be working at the ICH, has enjoyed opportunities he has had to work through the community support program, but is afraid of his addiction – the desire to quit but the fear of being sick. He believes, with the right opportunity for work, he could quit using.

- "Rather than extremely long prison sentences, people should be given re-integration programs. Programs for treatment instead of sentences [that are] repeatable." (30-something female)

- "I've been denied at three treatment centres and if you told me there was a spot tomorrow I wouldn't go. But if there was an opportunity to work, or any other opportunity to better my life, I'd take it." (30 something female)

- "Give us a chance. Just give us an opportunity. Some will succeed and some may not." (20-something male)

- "I just need the basics, and no threat of losing my home because I use substances. I could be a good Super – I'm handy!" (Middle-aged man)

- We should support each other, forming a community or organization, learning programs like technology, learning, living, giving people a fresh start. (20- something male)

- "Housing… affordable housing – not renting a room from a slumlord that's not fit to live in. You leave and come home, and your door is kicked in. I can't live like that or have my girlfriend in a place like that or a family in a place like that. If I could find housing before my child is born then I know I could keep our child." (30-something Male)

HARM REDUCTION

- A place for people to safely smoke fentanyl.

- More safe injection sites and support them.

"CHANGE THE SYSTEM COMPLETELY, IT'S NOT WORKING. IT'S OBVIOUS, YOU'RE WASTING YOUR TIME WHILE PEOPLE DIE!"

THE SHELTER SYSTEM AND COMMUNITY SUPPORTS

- "Provide more support"; "More counsellors, easier ways to get us what we need, and maybe just be there until we want to get out of it"; "Be there – for normal human interaction – cause sometimes we could use some people who care a bit more and can cope better with the challenges of helping the community. Some people take on too much emotion, or close off completely and become robotic."

- "There is no community, no skills being offered. The shelter system keeps us down and punishes people for being un-well. Everything can be done better. Be kind. Stop judging." (20 something male)

- "The shelter system could involve the community more in understanding and helping vulnerable people. Embrace one another." (Middle-aged female)

5.8. REFLECTIONS FROM THE INTERVIEWERS

We care deeply about the people we serve at the ICH. Each is special and has unique gifts to offer the world. They are people we have come to know and love; people we believe most would love, if they took a chance to get to know them - their stories - their pain - their hearts. The people we serve are capable of so much more than others may believe, and their substance use is not a personal or moral failure, it is a product of pain and systemic marginalization. It is why we are so pained by the lack of dignity, empathy and understanding afforded to people who use substances, which has been highlighted since opening the ICH. Many have been unforgiving and stigmatizing to the people we serve and the staff that support them. We can no longer ignore that community stigma plays a massive role in many of their lack of "successes".

As Managers at the ICH, we recognize the power and privilege that we hold, having the power to grant and deny access to shelter and basic needs support. Stakeholders often live in fear of having shelter access and supports restricted. We were very conscious of this power in the interview process and realized our roles within the organization could result in potential bias when conducting and completing interviews. Our goal was to co-create services and supports from a place of solidarity with the people we serve with positive intent and purpose.

During the interviews, we shared tears and moments of deep vulnerability and connection. It was a humbling experience. What stakeholders disclosed has validated what we as front-line workers have been told for so long: What we are doing as a community isn't working. If we want the people we serve to do better, we need to do better. We have the resources, but we need collective will and reflexivity at both an organizational and individual service provider level. The tallest order of all is to recognize the people we serve as deserving of respect and dignity as fellow human beings, living with the odds against them, and truly acknowledging that they are doing the best they can. Perhaps, it is time we truly recognize that as a society, we are responsible for the systemic and structural conditions that perpetuate suffering in regards to substance use and homelessness.

Our initial focus for the needs assessment was on the impact of overdose, but that is such a multilayered topic. Since the beginning of the 'war on drugs', we have continued to criminalize, demonize and stigmatize people who use substances. We can learn from the mistakes we have made. In 2012, policy makers delisted Oxycontin, which was a safer pharmaceutical grade opiate than Fentanyl. People now play Russian Roulette with their lives with a toxic drug supply. It is a systems failure at multiple levels, and people are being robbed of their lives and their loved ones. We are allowing people to be poisoned and it's nothing less than a catastrophe.

Staff at The ICH are now the **first** first-responders in the drug poisoning crisis. If we had access to a safe supply program, we could reduce significant suffering to the people we serve and the staff that serve them by dramatically reducing the number of overdoses, preventing fatalities, and offering a substitution therapy that would provide people the opportunity to rebuild meaningful lives. This would also decrease incidents of acquired brain injuries, decrease vicarious trauma, decrease costs on 'the system' and ultimately, acknowledge what the research already shows - people are going to use because they are in pain. Until we can truly provide people an opportunity to ease their emotional and spiritual pain, we need to stop blaming people for easing it themselves, possibly the only way they know how. Offering safe supply is not **enabling** anyone. Rather, we are currently withholding a life-saving alternative.

Staff are lifesaving on a daily basis, experiencing constant stress and loss, which contributes to chronic stress, PTSD and moral injury. This calls for the addition of self-care and counselling for ICH staff in these traumatic roles, in the same way that we provide supports to first responders.

We believe we can learn a great deal about the drug poisoning crisis, safe supply and decriminalization by studying the prohibition of alcohol. Temperance workers closed bars and taverns and believed that alcohol was an obstacle to economic success, to social cohesion and to moral and religious impurity. As people turned to bootleg moonshine and unsanctioned speakeasies, prohibition-related crime increased and many people lost their lives. Criminalizing substances has never reduced substance use. It only exacerbates violence, crime, and harm to those most marginalized and suffering.

Shortly after we finished conducting the interviews, we presented to the KFL&A Board of Health to support a motion from the Community Drug Strategy to support decriminalization. It was passed unanimously. We are in a system where substance use often leads to jail, institutionalization, or death. It's time we acknowledge substance use as a serious health and disability rights issue. If someone is using substances to the degree of significant self-harm and not able to care for themselves, we need to care for them all the more. We believe the people we serve are facing challenges that are complex and multi-sectored, requiring specialized care geared to meet the needs of brain injuries, cognitive exceptionalities, chronic physical illnesses, deep emotional and spiritual disconnection, housing, poverty, and inter-genenerational trauma. We believe as a community we need to develop a specialized, holistic, healing-centered engagement model, which we know will take time. If we continue to listen and learn from the experts – substance users, and the literature – we will get there, but in order to move towards change, we need to mobilize a shift towards compassion.

In the meantime, could you imagine if every housing worker, addiction worker, mental health worker, police officer, paramedic and clinician that came in contact with someone we serve believed in them? Maybe the people we serve would start to believe in the possibility of a different future too.

In solidarity,

Ashley O'Brien, Amanda Rogers, Justine McIsaac

6. RECOMMENDATIONS FOR POLICY AND PROGRAM DELIVERY

This section was first developed by the research consultant to reflect what was heard from stakeholders in the interviews – those who frequent, stay, and work at the ICH. Based on their suggestions, the literature was then explored to find examples of best practice related to policy, program delivery, and practical ways to help these citizens on their healing journeys, recognizing that each person's road will be different based on their experiences. Also, many of the services needed, like better access to health and mental health care, require the support of community partners who will be integral to moving plans forward in developing a healing-centred care model along with ICH management for this marginalized population.

Before delving into possible solutions, we consider what we are up against: that the incessant shadow epidemic of drug overdose preceded the COVID-19 pandemic and will continue long after if we do not act in a concerted way. Second, that all the stakeholders at the ICH are suffering from pain – physical, emotional and/or spiritual due to a history of trauma in their lives, calling for an integrated bio-psycho-social-spiritual approach to their well-being. We also introduce the concept of Moral Injury as a condition different from PTSD that may be experienced by our stakeholders, but also by the workers serving them. We suggest a central ethos of healing-centred engagement for health justice is needed to unite all of us who work with marginalized people. We also recognize that more training is needed for those who work with people who use substances, as well as supports for workers who may be suffering from burnout, PTSD and/or moral injury due to their exposures to extremely difficult circumstances and conditions. Finally, the issue of stigma, and the discrimination that people experiencing tri-diagnosis and/or homelessness is also addressed as a significant philosophical issue that underpins any efforts to achieving social justice for our most marginalized citizens.

We suggest that a central ethos of healing-centred engagement for health justice is needed to unite all of us who work with marginalized people.

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6.1. CONTEXT: THE INCESSANT SHADOW EPIDEMIC

When more than one public health emergencies interact to negative effect, a 'syndemic' occurs (Maier & Hume, 2021). In Vancouver, as in KFL&A, the COVID-19 pandemic was exacerbated by an already pre-existing affordable housing shortage leading to increasing homelessness, and a drug poising crisis due to tainted supply chains. Overall, Ontario experienced a 38.2% increase in opioid-related deaths in the first 15 weeks of the pandemic (695 deaths; average of 46 deaths weekly) compared to the 15 weeks immediately prior (Public Health Ontario, 2020). In KFL&A, there was one COVID-19 death (Moore, 2021). In many ways, death by overdose has been eclipsed by COVID-19 in the media and imagination of the general public, but it remains a stark reality for people who use substances, experiencing homeless ness or not.

In a recent presentation entitled "The Coroner and Opioid Epidemic: Speaking for the dead to protect the living", Dr. Kieran Moore (2021), former Medical Officer of Health (MOE) for KFL&A Public Health, and now the MOE for the Province of Ontario, reported that deaths by overdose have increased progressively over the past 20 years, and are now two to three times higher than rates for traffic accidents. Speaking about the aged 25 to 44 cohort, over 30 of whom have died of opioid poisoning in Kingston in the past year, he said: "These are our most young and vital members of society, but people are dying alone, mostly in their homes... of what are arguably completely preventable deaths." He spoke to the grief and shame experienced by family members losing a loved one to overdose, and the need to address stigma by 'hearing the stories' of those who use substances, learning, and supporting their families.

Dr. Moore indicated that not all substance users are homeless, though that is a stereotype that continues to marginalize very vulnerable people and leads to 'NIMBYism'[1] in areas where safe consumption sites are located, like the ICH.

IN ONTARIO, THERE WAS A

38.2%

INCREASE IN OPIOID-RELATED DEATHS IN THE FIRST 15 WEEKS OF THE COVID-19 PANDEMIC

69

1 NIMBY is an acronym for Not In My Back Yard, a sentiment or movement by residents of a particular neighbourhood if they perceive something or someone is a threat to them.

Dr. Gabor Maté, a retired physician who worked in Vancouver's East Side with homeless substance users for two decades, links substance use with trying to escape the pain of unresolved trauma. He also theorizes that the substance use epidemic is a social phenomena arising from a transition to hyper-capitalism over the past twenty years. People derive a sense of meaning through creativity and contributing to the well-being of others. In modern society, communal goals are subjugated by the accumulation of wealth and mass production and consumption. For many people, this leads to an "existential vacuum, the feeling of emptiness engendered when we place a supreme value on selfish attainments" (Maté, 2008, p. 391). One of Maté's patients said: "For me, being a drug addict, the deep down need to escape was almost into a more realistic place than the insanity that we see, the chaos that we see around us."

The evidence in this report indicates that unresolved trauma is linked to substance use. The Shadow Epidemic of drug overdose has arisen due to an increase in tri-diagnosis of human beings who are unable to access the supports they need, and four decades of failed punitive drug policies. It has been eclipsed by efforts to contain COVID-19 even though it has been outpacing morbidity and mortality for years.

"FOR ME, BEING A DRUG ADDICT, THE DEEP DOWN NEED TO ESCAPE WAS ALMOST INTO A MORE REALISTIC PLACE THAN THE INSANITY THAT WE SEE, THE CHAOS THAT WE SEE AROUND US."

- Patient of Dr. Gabor Maté

McGuire (2021) concludes:

"ALL I'M ASKING FOR IS EQUITY... THAT MY SON'S LIFE AND THE LIVES OF OTHER SMART, SENSITIVE PEOPLE WHO USE SUBSTANCES BE CONSIDERED WITH THE SAME WEIGHT AS THOSE WE ARE CURRENTLY PROTECTING FROM COVID-19. EVEN WHEN THEIR ILLNESS MUTATES AND PROVES UNCOOPERATIVE" (P.3).

That would require a central ethos and commitment to healing people with tri-diagnosis. Programs need to align with a more person-centred philosophy and a holistic, integrated approach to healing – physical, mental, emotional, and spiritual. Services need to be more relationship-focused and trauma-informed, asking not what is wrong with a person, but rather, what has happened to them. Significant investments are needed, and structural changes, not just to healthcare delivery, but also to the judicial, public safety, education, housing and social service sectors.

6.2. BIO-PSYCHO-SOCIAL-SPIRITUAL APPROACH: PAIN, TRAUMA AND MORAL INJURY

The theme of pain is weaved throughout the interviews. Seven participants described how they were not bad people, but people carrying a lot of pain. Substance use gave them some form of relief, until they were troubled by the pain and 'sickness' of withdrawal. Pain could be physical, emotional or spiritual. Six participants (5 females and one male) stated that chronic physical pain was a barrier to them being able to find employment in anything other than a 'desk job'. Shame and exclusion due to stigma and othering compounded their emotional pain.
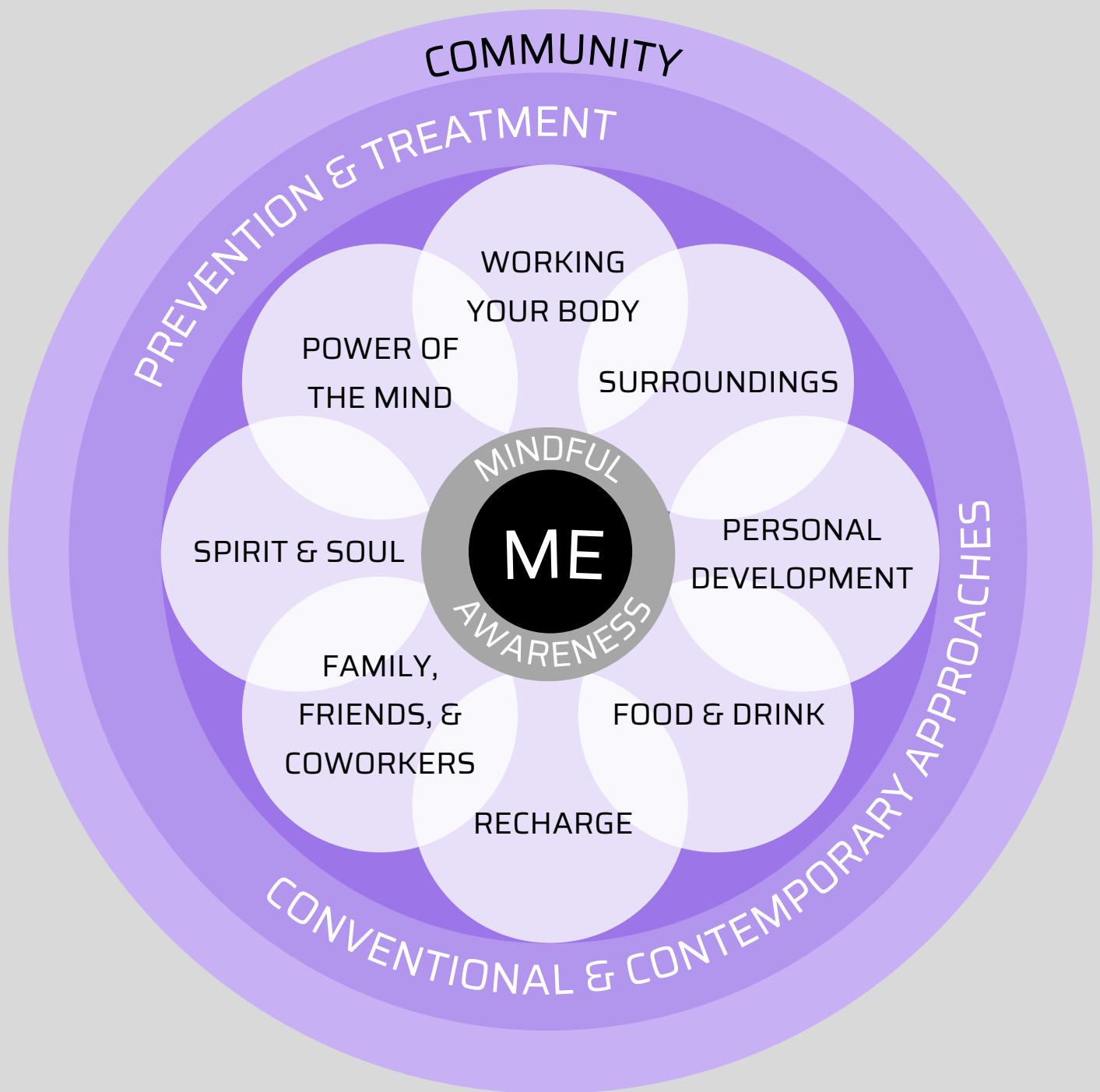
Particularly in the area of Veterans health research, there is a growing body of evidence that demonstrates how exposure to trauma and related diagnoses of PTSD compounds the risk of suffering from chronic physical pain, and that people with PTSD experience greater pain, disability and affective distress than with either condition on its own (Scioli-Salter et al., 2015). There are also neurobiological factors that may contribute to the co-prevalence of mild traumatic brain injury with chronic pain and cognitive, mood and motor dysfunction (Grandhi et al., 2017). Ninety percent of interviewees self-reported having suffered a significant head injury. When discussing persistent symptoms associated with head trauma, 86 percent of males and 73 percent of females self-reported suffering from frequent headaches. One female recalled having been to the emergency department five times in the past year to deal with migraines. Furthermore, 16 percent of males and 60 percent of females self-reported having received a formal diagnosis of PTSD at some point in their lives. Like Veterans, the concept of pain for this group, particularly females, is multi-faceted, involving synergistic interactions between "emotional distress and physiological threat, including pain" (Scioli-Salter et al., 2015, p. 363).

Given the complexity of pain for people who use substances, approaches to Veterans' health in the United States and more recently in Canada, involve bio-psycho-social-spiritual 'Whole Health' paradigms that include complementary and integrative health approaches (Taylor et al., 2019). Whole Health is described as an approach to care that empowers and equips people to take charge of their health and well-being and live their life to the fullest (Taylor et al., 2019). A Circle of Health diagram that follows captures the Whole Health approach to any chronic condition. It is person-centred, emphasizing mindful awareness and eight bio-psycho-social-spiritual domains that impact healthy self-care. The Circle of Health helps Veterans to express what they hope to achieve in bettering their relationships with friends, family, and co-workers. Also, many resources have been transferred online that make it easier to bring loved ones into the circle of care.

... the concept of pain for this group... is multi-faceted, involving synergistic interactions between "emotional distress and physiological threat, including pain."

FIGURE 16: CIRCLE OF HEALTH MODEL
Live Whole Health, US Veterans Affairs (https://www.va.gov/wholehealth/)

COMMUNITY

PREVENTION & TREATMENT

WORKING YOUR BODY

POWER OF THE MIND

SURROUNDINGS

MINDFUL

ME

AWARENESS

SPIRIT & SOUL

PERSONAL DEVELOPMENT

FAMILY, FRIENDS, & COWORKERS

FOOD & DRINK

RECHARGE

CONVENTIONAL & CONTEMPORARY APPROACHES

HOW MIGHT THESE BE INTERCONNECTED?

HOW MIGHT THESE EFFECT YOUR HEALTH?

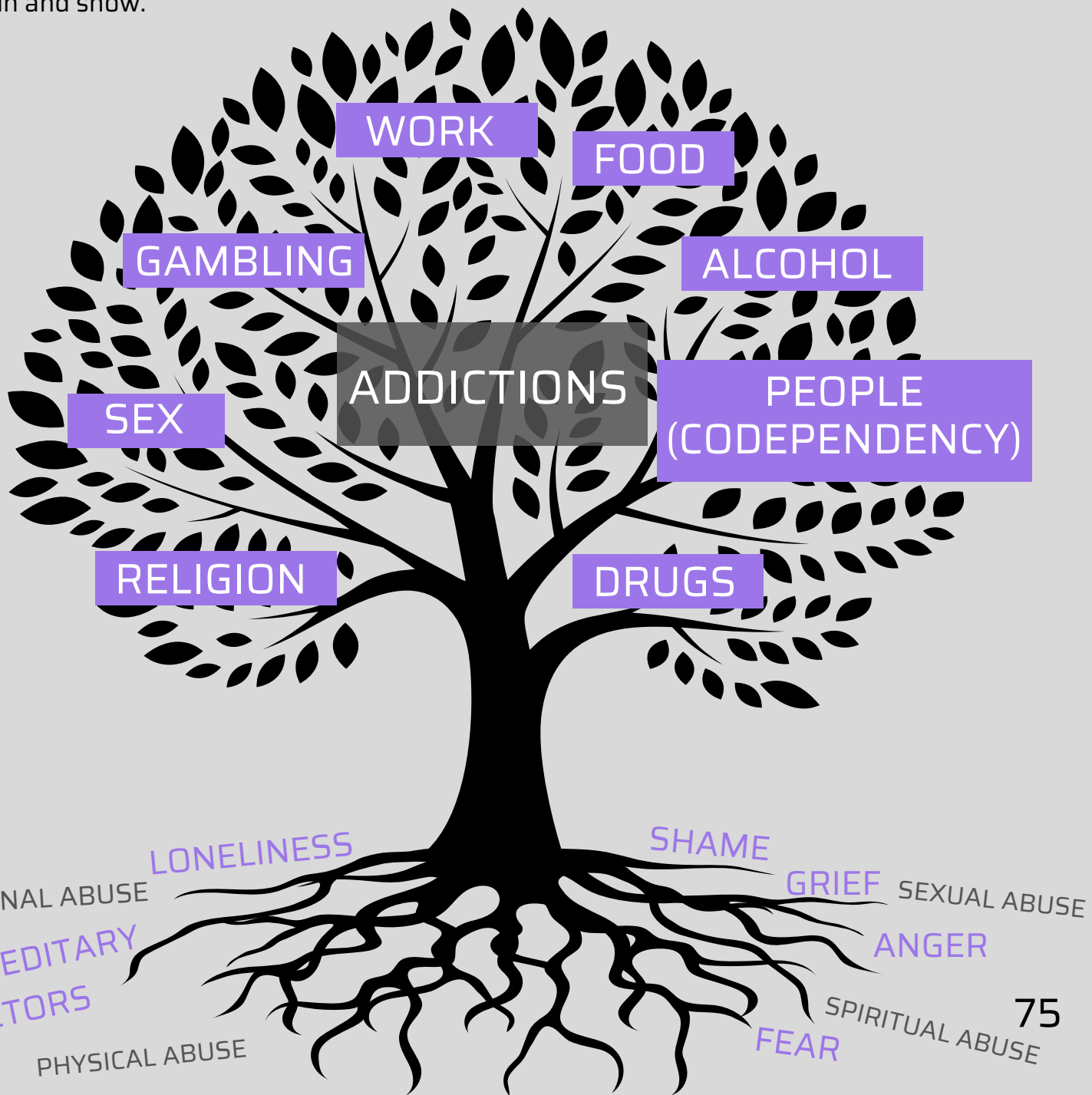WHAT ARE YOUR STRENGTHS?

WHERE ARE YOU?

WHERE WOULD YOU LIKE TO BE?

73

As was presented in section 4 (the data section) people who frequent the ICH often suffer from tri-diagnosis – cognitive, mental health and substance use issues. Luteijn and colleagues (2020) highlight how people with mild intellectual disability or borderline intellectual functioning are at risk of developing mental health problems, including PTSD, and substance use disorder (p. 1), what they describe as 'triple psychopathology.' In a review of 32 studies that discussed the treatment of either PTSD or substance use disorder (SUD) in people with mild cognitive disability, none integrated treatment for all three, and only 9.4 percent mentioned co-morbidity of PTSD and SUD, which can be explained as a reciprocal relationship. PTSD influences the stress responses that may lead a person to "use substances to alleviate negative effect, [while] substance use may exacerbate PTSD symptoms, creating a self-perpetuating and reciprocal cycle" (Luteijn et al., 2020, p. 2). Their findings also suggest that an integrated approach to treatment of both PTSD and SUD concurrently is needed because "treating SUD first – without addressing PTSD – increases the risk of relapse in substance use" (p. 2). Complex mental health needs of people with tri-diagnosis requires addiction medicine, psychiatry and disability care professionals to join forces to close this treatment gap (p. 10).

We believe that a bio-psycho-social-spiritual 'Whole Health' paradigm that includes complementary and integrative health approaches (Taylor et al., 2019) would be ideal to develop customized healing plans for our stakeholders at the ICH suffering from tri-diagnosis, which is impacting their physical, cognitive, mental, emotional and spiritual health. Our community health and mental health care providers could draw on the expertise of researchers working with the Queen's University based Canadian Institute for Military and Veterans Health Research to see how this model, developed by the US Veterans Affairs service, could be transferrable to the ICH population. Indigenous healing modalities should also be considered in program development, given that people of Indigenous ancestry are overrepresented in the people served by the ICH.

PSYCHOLOGICAL SPIRITUAL

BIOLOGICAL SOCIOLOGICAL
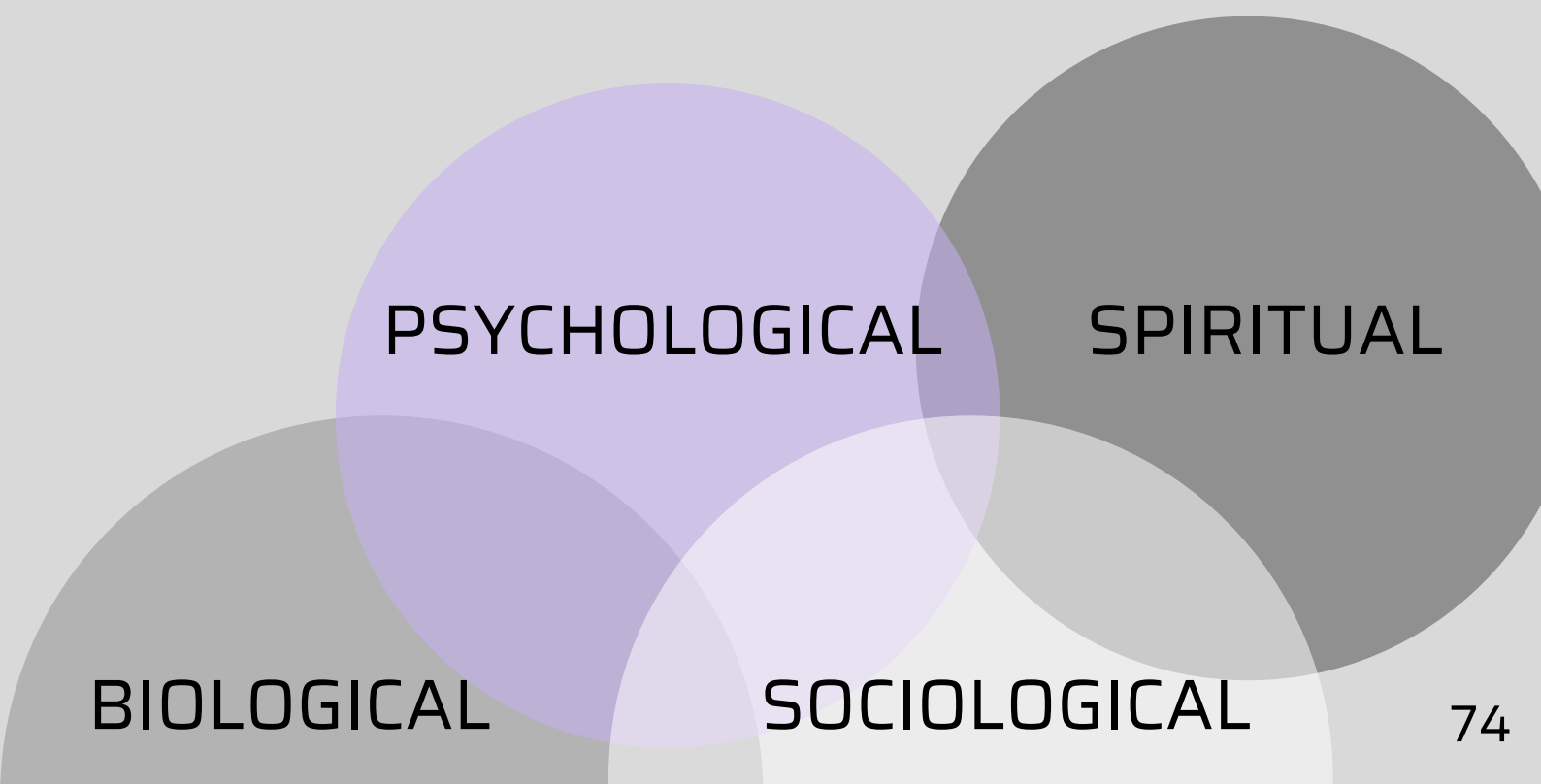
Another new area of research associated with PTSD is called Moral Injury. Dr. Anthony Nazarov (2020), a Canadian expert, described moral injury as a form of psychological difficulty, an interpersonal crisis, or a spiritual wound resulting from learning about, bearing witness to, failing to prevent, being a victim of or perpetrating any event that transgresses one's subjective moral standards or deeply held personal beliefs. It can also result from the betrayal of justice by a person in authority. Currently, moral injury is often studied as a sub-set of symptoms associated with PTSD. It is not a mental health diagnosis. However, standard symptom and outcome measures for PTSD do not capture all symptoms associated with moral injury, and not all cases of moral injury meet the DSM-IV criteria around psychological trauma to warrant a PTSD diagnosis (Nazarov et al., 2018). There is also research that suggests adverse childhood experiences (ACEs) impact susceptibility to moral injury in adulthood (Battaglia et al., 2019). The population interviewed at the ICH expressed having long histories of exposure to trauma. Furthermore, the almost daily exposure to stigma and discrimination constitute potentially morally injurious events. So too might their experiences with frequent service interruptions in the shelter system that left them with nowhere to go in the rain and snow.

WORK

FOOD

GAMBLING

ALCOHOL

ADDICTIONS

SEX

PEOPLE (CODEPENDENCY)

RELIGION

DRUGS

LONELINESS

SHAME

EMOTIONAL ABUSE

GRIEF

SEXUAL ABUSE

HEREDITARY FACTORS

ANGER

SPIRITUAL ABUSE

PHYSICAL ABUSE

FEAR

For workers serving those with tri-diagnosis and/or those who are experiencing homelessness, there are multiple systems level challenges, like service interruptions in shelter services, that could cause potentially morally injurious events when there is nothing the worker can do for the client who is at risk of harm. Similarly, this includes trying to get help for clients who need mental health and addictions supports, but who face long waits or service exclusions.

Finally, knowing that a safe supply program would save lives, but faces so much societal stigma, is another area that might lead to morally injurious events experienced by ICH staff and management. These events can lead to "profound feelings of shame and guilt, and alterations in cognition (e.g., 'I am a failure' and 'colleagues don't care about me or the people we serve'), as well as maladaptive coping responses (e.g., substance misuse, social withdrawal, or self-destructive acts)" (Williamson et al., 2021, p. 453). As will be discussed, a training program to prevent morally injurious events from happening to ICH staff, management, and our stakeholders is under development. The impact of moral injury on personnel who serve marginalized populations who face systemic social injustice should also become an area of research, as it has been for health care workers during COVID-19.

It has been established that trauma is linked to challenges with mental health and substance use, with personal and environmental complexities. Trying to get different professions and sectors to work together on complex problem solving is challenging. Each comes with their own unique professional training and language, associations and colleges, philosophies and goals.

Health justice involves understanding health inequality, inequity and injustice through the maldistribution, misrecognition, and misrepresentations that shape social programs (Borras, 2020) in order to make systems and programs more inclusive for those who are marginalized. A commitment to health justice for people with tri-diagnosis could inspire and sustain action through collective purpose (Hassell & Hewitt, 2018).

However, what is the objective — reform, rehabilitation, recovery? Each of those terms is laden with professional criterion, which may or may not be synchronous across disciplines, or match up with the needs of the person requiring assistance. In particular, sobriety is not always the objective of people who use substances.

PEOPLE DON'T NEED TO BE SOBER AND DRUG FREE TO DESERVE FOOD, SHELTER, AND KINDNESS.

Jaiswal and colleagues (2020) describe a recovery approach as both a process and an outcome, a personal transformative journey beyond measurable clinical outcomes, a vision or guiding philosophy for policy and decision-makers whose qualities include being holistic, non-linear, and strengths-based. "The recovery approach challenges previously held beliefs regarding treatment and prognosis, allowing for a more individualized, holistic approach that respects personal definitions of recovery" (Jaiswal et al., 2020, p. 2). Mental health policies, system guidelines and plans now use the language of personal recovery, "an individualized, ongoing and non-linear journey towards living a life of personal meaning and value irrespective of whether symptoms of mental illness persist or not" (Hancock et al., 2018, p. 1). Hancock questions the utility and relevance of personal recovery discourses for people living with severe mental health challenges given the diversity and complexity of their experiences. Non-linear journey or not, recovery is a noun, the return to a 'normal' state, an objective, or an end point. Healing, meanwhile, can be a noun or an adjective, and is a term that expresses a continuum, with peaks and valleys, not a destination like abstinence, for example. Abundant evidence exists that community integration supports are needed to prevent individual relapses of mental health and substance use challenges and resulting homelessness (Ginwight, 2018; Maté, 2008; McQuaid et al., 2018), supports that may 'end' once the 'patient' has been housed and/or recovered.

NON TRAUMA INFORMED

People need fixing first
Operate from the dominant culture
Right/Wrong
"You're crazy"
Compliance/Obedience
Need-to-know basis for info
Presenting issue
Us vs them
Fear based
People make bad choices
Behaviour viewed as problem
What's wrong with you?
Blame/Shame
Goal is to do things
People are bad
Research and evidence focus

People need safety first
Cultural humility
Multiple viewpoints
"It makes sense"
Empowerment/collaboration
Transparency/Predictability
Whole person and history
We're all in this together
Empathy based
People who feel unsafe do unsafe things
Behaviour viewed as solution
What happened to you?
Respect
Goal is to connect
People are doing the best they can
Values lived experience

TRAUMA INFORMED

SOMETIMES PEOPLE WILL HEAR YOU BETTER IF YOU SPEAK FROM A VOICE OF COMPASSION INSTEAD OF AUTHORITY.

THEY LONG TO BE UNDERSTOOD MORE THAN TO BE LECTURED.

Dodinsky, 2021

Rather, Ginwright (2018) advocates that every sector adopts a Healing-Centred Engagement approach to helping people with tri-diagnosis – cognitive, mental health and substance use challenges who may or may not be experiencing homelessness. A healing-centred approach differs from a recovery or trauma-informed approach in that it highlights the ways in which trauma are experienced collectively, not just as individual isolated experiences that define a person well after the event.

Healing involves more than the healthcare system: also culture, spirituality, civic action and community (Ginwright, 2018, p. 3). This involves a community approach that is cross-sectoral (government, not-for-profit and charitable) and multi-disciplinary (public health, social services and housing, 'psy'-professions, emergency medicine, primary care, social work, public safety, judiciary, the media, and education at all levels).

Healing is a personal transformative journey that may have similarities between people, but will be unique to each individual. We need to engage with them to understand this. Freire (2000) states that "We must realize that [peoples'] view of the world ... reflect their situation in the world" and that "If the structure does not permit dialogue, the structure must be changed."

The ethos that underpins Healing Centered Engagement is the call for dialogical action, to engage with the person who needs help as to what those needs might be. It empowers them, contributing to health justice.

6.4. BIG "P" POLICY

People who have tri-diagnosis are often chronically homeless, with "complex support needs, spanning multiple sectors that do not traditionally work together" (Lamanna et al., 2019, p. 96). Despite the over-representation and impact of intellectual disabilities in homeless populations (12% to 34% of homeless persons, compared with 1% to 3% of the general population), they have received little attention (Lamanna et al., 2019). Add to this mental health and substance use challenges, people with tri-diagnosis are most often disconnected from familial relationships, suffer with low self-esteem, have little self-worth, live in a state of toxic stress, experience food insecurity, likely have higher rates of traumatic brain injuries, live with cognitive disabilities, and are often seen as non-productive and thus, not-valued members of our community (Burge & Williams, 2012; Clouston, 2018; Hancock et al., 2018; Jaiswal et al., 2020; Luteijn et al., 2020).

However, inter-generational trauma is highly structural in nature, and requires significant attention from policy actions in multiple sectors: healthcare, mental health care, public safety, judicial, housing and social supports, and education.

6.4.1. THE HOMELESSNESS SYSTEM

The homelessness 'system' requires major structural changes, given more than half of respondents reported issues with poor conditions and nutrition, service interruptions, and perceived discrimination by staff. As one participant said: "The 'high ups' need to step up."

People with tri-diagnosis – cognitive, mental health and substance use challenges cannot be excluded from homeless services and housing, but they too often are. This has been evidenced in our study, but also in the Marshall and colleagues (2021) Kingston Transition from Homelessness Project recently published (see recommendation # 1, p. 55). Many of the experiences of people served by the ICH, and policy and program recommendations, are similar between this report and theirs, so there is a substantial body of evidence collected within the Kingston community dealing with tri-diagnosis and/or experiencing homelessness. The ICH has been able to identify large numbers of individuals experiencing homelessness who are not represented in any formal statistics gathered by the City of Kingston or other agencies for a few different reasons:

- The ICH's service is low-barrier, accessible and trauma-informed (Marshall et al., 2021, recommendation #2, page 56);
- The ICH's service is geared person-centred, to meet the needs of substance users (Marshall et al., 2021, recommendation #4, page 56);
- The ICH has created space for a pre-existing community – having places to find 'your people' (Marshall et al., 2021);
- The people the ICH serves feel like the staff care because they do; and
- The ICH is simply providing a service that people in the community desperately need (Marshall et al., 2021, recommendation #4, page 56, and #8, page 58).

Many ICH participants see benefit in some form of communal living with friends or loved ones. After being at the ICH and achieving some biopsychosocial stability, a second stage housing option for people in active substance use is needed, geared to meet their needs and to keep them safe from dying of fatal overdoses in their apartments (Moore, 2021). This should be taken into consideration when planning for housing people who use substances. It should also include scaffolded supports for people along their healing journey, ideally available on-site in a 'hub' model of housing and care (Marshall et al., 2021, recommendation #9, page 59).

"THE 'HIGH UPS' NEED TO STEP UP."

6.4.2. INCOME SUPPORTS AND HOUSING

It is clear from the ICH needs assessment and the Marshall and colleagues report (2021, recommendation #1, p. 55) that income supports and housing are inextricably linked to homelessness and on-going poverty in the KFL&A region. Income support legislation is a provincial jurisdiction, while housing interfaces with all three levels of government – federal, provincial and municipal. The federal provision of emergency income support for people facing layoffs due to COVID-19 was benchmarked at $2,000 a month (taxable, providing individuals had earned a minimum of $5,000 in the previous year through employment or self-employment). That was dropped to $900 bi-weekly with taxation at source. Meanwhile, people collecting Ontario Works (social welfare) and the Ontario Disability Supplement (ODSP) were not provided a top up. Neither were seniors on a fixed income. The prices of groceries have gone up during the pandemic due to disruptions in supply chain and scarcity of resources (Douwe van der Ploeg, 2020). This situation is inequitable for people on social assistance and/or a fixed income and suggests that people who are unable to work for whatever reason, are treated differently.

Meanwhile the housing market in Kingston has heated up as more people from urban centres are looking to relocate given the remote nature of work that will likely persist after the pandemic is controlled (Re/Max, 2020). While new construction of rental housing has increased vacancy rates in Kingston over the past two years, the cost of rent has been increasing as well. From 2018 to 2020 the average rent in Kingston rose by 9.8 percent, with the mean rental rate for a bachelor apartment at $871 per month (Marshall et al., 2021, p. 13). This is out of the reach of many individuals living on social assistance in the City of Kingston. Participants at the ICH indicated that social housing waitlists are long. As a last resort, they are forced to share housing with strangers, causing conflict and disruptions. Also, the conditions within 'affordable housing' properties were substandard to public health guidelines. Participants reported issues with safety, air quality (mold and ventilation), heating and cooling, and infestations of vermin and insects.

PARTICIPANTS STRONGLY STATED THE NEED FOR AFFORDABLE, SAFE, HEALTHY, DECENT HOUSING FOR LOWER INCOME PERSONS AND FAMILIES.

As market rents climb, people in precarious employment in the service sector (aggravated by COVID-19 lockdowns), on social assistance and/or fixed incomes, are forced to live in shared accommodation with strangers. Furthermore, without stricter enforcement of public health standards with landlords, many people will continue to find themselves without a roof over their heads, sometimes by choice because their housing situation is intolerable. Rent controls are needed or a plethora of rent-geared to income public housing needs to be built.

SOME BELIEVE THAT PEOPLE ON SOCIAL ASSISTANCE ARE TAKING ADVANTAGE OF THE SYSTEM, WHEN THE REALITY IS, THE SYSTEM PROVIDES NO ADVANTAGES TO EXPLOIT.

The pandemic has also highlighted the need for more capacity: private spaces and individual rooms within the shelter and low-income housing system to ensure people can self-isolate. It would be naïve to think that COVID-19 is the last cataclysmic public health issue we will have to deal with given increasing climate change (Leal-Filho et al., 2020).

Nutrition is also key to homeostasis, as is access to medications. People who have been 'housed' without realistic income supports, will continue to choose between paying the rent, paying the utilities, eating well, filling their prescriptions, accessing therapy or any related activities that could provide joy in their lives.

6.4.3. MEDICAL CARE

Given the high rates of self-reported significant head trauma amongst people who use substances, it is likely that brain injury is a significant health issue in this population. A recent American study of 21 guests at a low-barrier homeless shelter suggests that traumatic brain injury (TBI), defined as a blow or jolt to the head or a penetrating head injury that disrupts the normal function of the brain, is 2.5 to 5 times greater for people experiencing homelessness, "and that risk is 10 times greater for moderate to severe TBIs" mainly due to homeless people being at greater risk of physical of sexual assault (Ang & Wasserman, 2021, p. 2). This is further linked to high rates of cognitive dysfunction like issues with memory, impulse control and goal setting, "which may exacerbate the challenges of matriculating from service programs into housing (p. 2).

Given the complexities associated with head trauma, mood disorder and chronic pain syndromes (Grandhi et al., 2017), housing will not be enough. They need significant medical and psychological care. Furthermore, there is evidence of association between greater pain severity and people who use substances who are unable to access addiction treatment (Voon et al., 2020). However, two thirds of stakeholders have felt stigmatized accessing health care and are not seeking care in situations very dangerous to their health. This stigma is congruent with the findings of the study by Purkey and colleagues (2020) on the experiences of people using emergency services at Kingston hospitals. Training for emergency department leadership, physicians, triage nurses and registration personnel around trauma and violence informed care was identified as an intervention to better care for a subset of vulnerable patients. Furthermore, they acknowledged a participant bias toward medical and emotional stability at the time of the interviews, such that the results "likely under-represent some of the challenges faced by the most vulnerable (and thus the most emotionally dysregulated) patients when they seek care in the ED" (Purkey et al., 2020, p. 8).
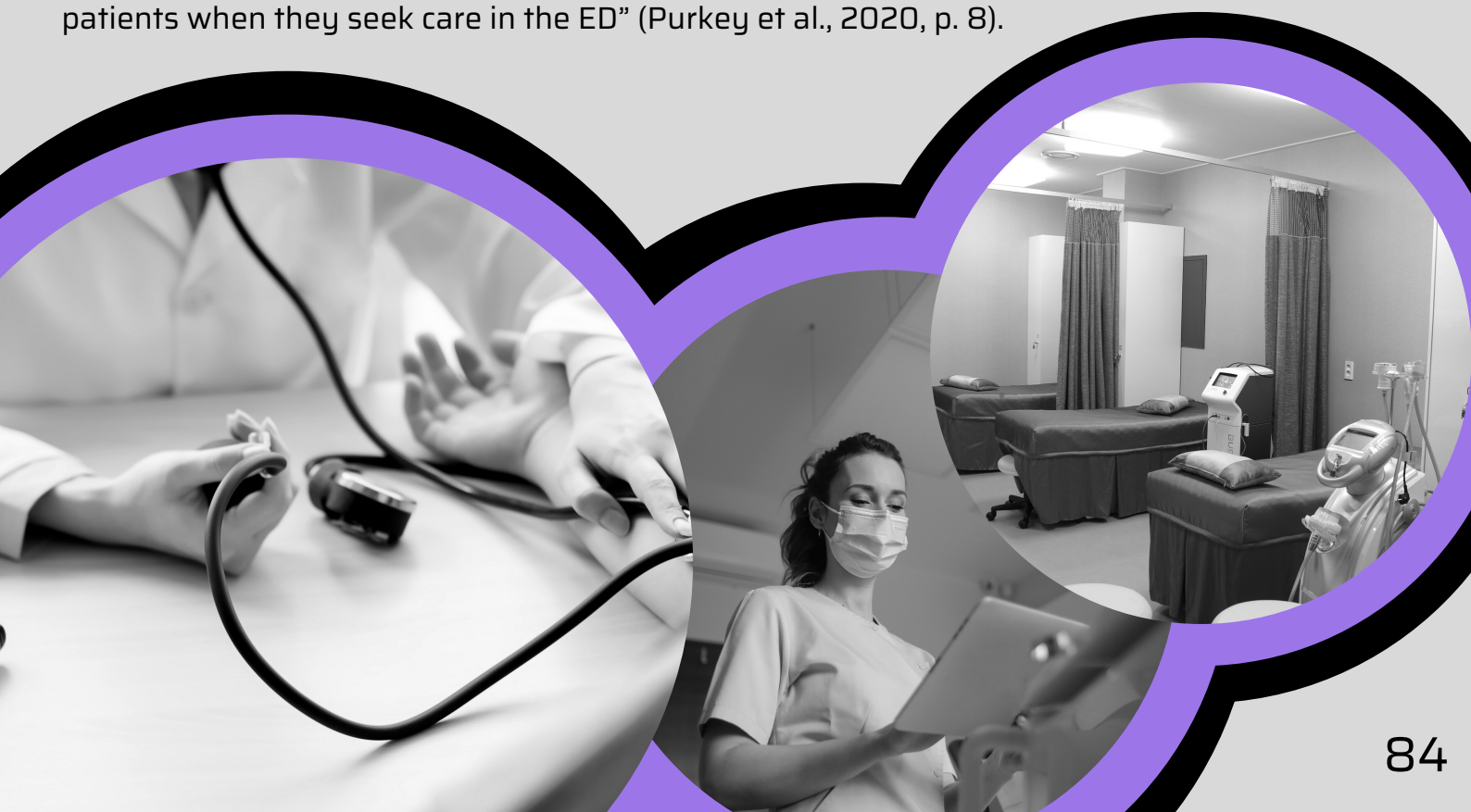
Burge and Williams (2012) conducted a survey about the experiences and views of clinicians and staff members of mental health and social services agencies and hospitals in Southeastern Ontario working with clients with intellectual disabilities, dual diagnosis (and mental illness) or substance misuse issues. The Survey on Substance Misuse and Persons with Intellectual Disability in Southeastern Ontario was designed to determine the size of the population and scope of the issues, satisfaction with existing clinical treatment services for people who use substances, and the "relative need for and nature of services that may be developed to address this clinical issue" (p.5). It was determined that 8 percent of the population had substance use issues, but services were lacking for those with intellectual disabilities. Thus, the call for

> government regulators from both ministries along with program planners, administrators and clinicians, to engage in eliminating such serious programmatic gaps... [and provide] cross-sectoral training to ensure available or newly developed services adequately meet the service needs of those with intellectual disability (Burge & Williams, 2012, p. 19).

While the use of substances is a global public health concern, accessing treatment in Canada proves exceedingly difficult for youth, people of lower income, and those entrenched in street life and vulnerable to violence (Hancock et al., 2018; McQuaid et al., 2018; Prangnell et al., 2016). We need to consider how best to deliver quality medical care to people who use substances that is culturally sensitive, and violence and trauma informed.

6.4.4. ONGOING PSYCHOLOGICAL AND SOCIAL SUPPORTS

Patrons at the ICH will need continued psychological and social supports as well as housing (Hancock et al., 2018; Marshall et al., 2021). This is particularly true for people who inject substances because they are less likely to access the addiction treatment services they need because of binge substance use, severity of addiction, and vulnerability to violence (Prangnell et al., 2016). The evidence suggests that even for those people who are able to access addictions treatments, once they return to their lives, those in isolation are much more likely to relapse again because no one will just give them a chance to have purpose in life. Thus, a high prevalence of moral injury may be experienced by people who use substances, but there is no research specific to those who are experiencing homelessness and use substances.

6.4.5. DECRIMINALIZATION AND SAFE SUPPLY

Maier and Hume (2021) contend that the thousands of lives lost to death by overdose and now higher levels of drug toxicity are due to a long-standing lack of political action and failed policy measures like "a lack of welfare and treatment services to the criminalization of drug use and resulting stigmatization" (p. 2). They suggest that decriminalizing the possession of illicit drugs for personal use "contributes to reducing stigma and associated barriers to accessing supports" (p. 4) and access to a safe, regulated supply of product will save lives (p.5).

In this needs assessment, 90 percent of males interviewed had been incarcerated, of which 57 percent indicated charges were drug related. For females, 73 percent had been incarcerated and 64 percent indicated charges were drug related. It was clear from their testimonies that early incarceration due to drug use had dramatically changed their lives.
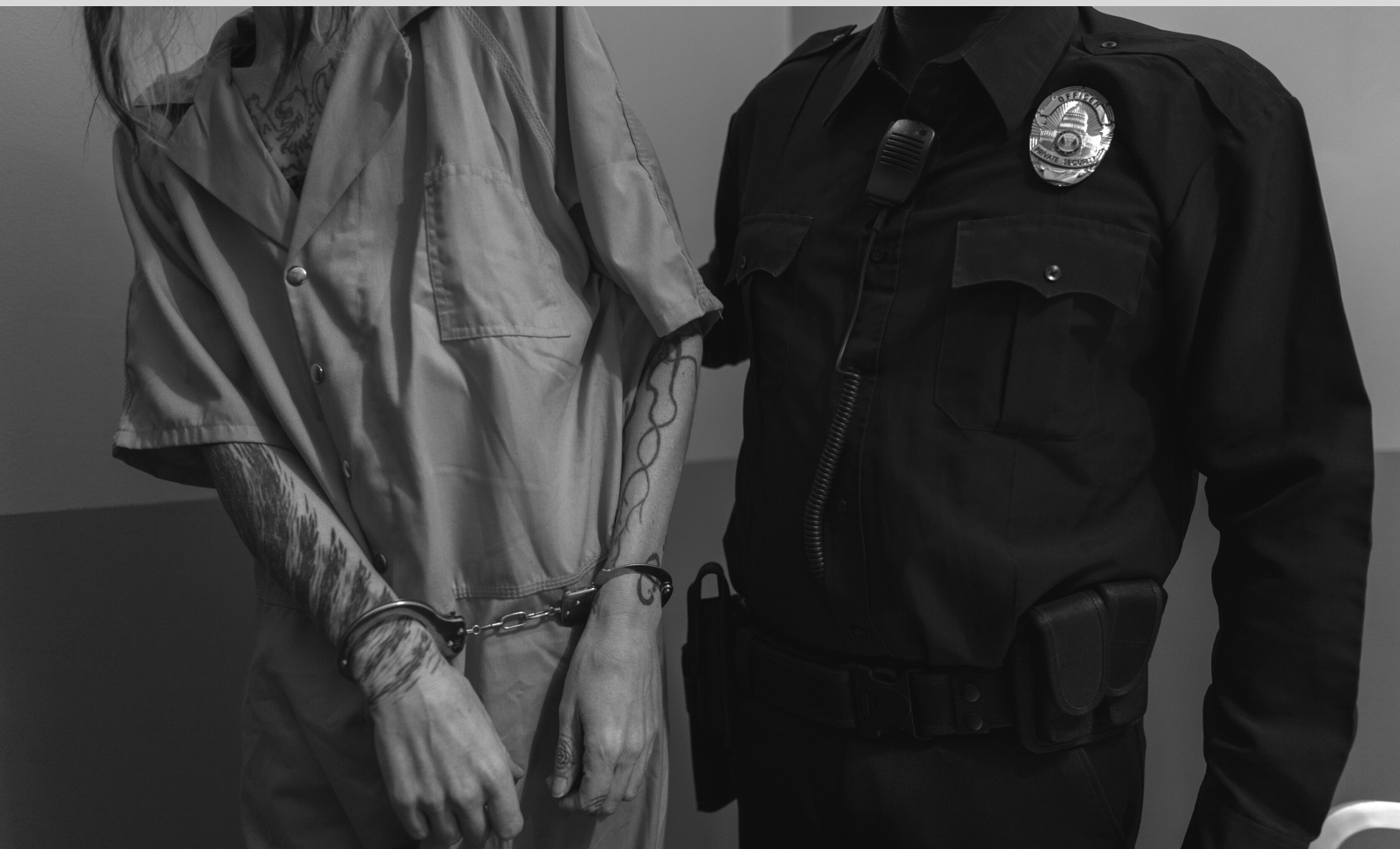
To explore how key Canadian experts view drug law, and debates about law, policy and reform, Seear and colleagues (2021) recently interviewed senior drug use-related policy makers, service providers, advocates and lawyers based in British Columbia and Ontario. This included how these experts deal with criminalisation of drugs, their attempts to navigate, subvert or change the law, and that "contrary to popular perception, people who consume drugs have human rights: ...drug users are humans too" (p. 5).

They recognize how the complex issue of substance use intersects with social determinants of health and the responsibilities of Government with respect to disabilities (Seear et al., 2021, p.6). A human rights approach acts as a counterpoint to a punitive criminal justice approach to substance use. A lawyer lamented:

> the whole criminal justice system is entirely flawed. Like, I think the human rights law is sort of where it's at, by recognising [substance use] as a disability that needs to be accommodated. But criminal law is just punishing people for their disability basically and not looking at it in terms of treatment and rehabilitation, but in terms of punishment and protection of society (p. 6)

The authors conclude that prohibition is not helping the opioid epidemic or keeping citizens safe from the dangers of substance use. The experts support decriminalization of substances for personal use but recognize that this will be a "complicated and messy" process whereby simplistic approaches can sometimes make matters worse. However, "they point to the incontrovertible dynamics of change. Here lies optimism, and the value in thinking about multiple dimensions of change and action" (Seear et al., 2021, p.8).

Meanwhile, an Australian study sought to better understand why the opinions of people who use substances are largely absent from discussions about current drug prohibition laws and potential alternative models of legislation (Greer & Ritter, 2019). While there was no consensus on a preferred model by people who use substances, it was agreed that "public opinion would need to adjust for reform to succeed [and] the views of the affected community are vital to any drug law reform campaign" (p. 1). Participants also showed an affinity toward a medical/prescription approach to drug regulation, which was not dissimilar to the findings of our needs assessment that overwhelmingly called for a regulated safe supply program.

The evidence from this needs assessment around substances used and links to overdose is significant. While the prevalence of crystal meth as first substance of choice for daily use (44%) is only slightly higher than that of fentanyl (37.5%), the risk of overdose on fentanyl is almost double, and fentanyl is tainting the crystal meth supply. The range of participants who had experienced an overdose themselves was never (3 people) to over 50 times (1). From this it would appear that if people who use opioids could be treated for their physical pain through substitutive pharmacotherapy, and people who use crystal meth had access to clean product and medical marijuana for sleeping, the rates of overdose could be dramatically reduced. The evidence indicates that safe supply would save lives and expensive visits to hospital, as well costs to the healthcare and judicial systems in general. Though it will alleviate the tremendous stress of fear of overdose, it will not, however, address their psychological and spiritual pain.

6.5. HEALING-CENTRED ENGAGEMENT AND WRAP-AROUND CARE

As previously discussed, the evidence from this needs assessment suggests that people who frequent the ICH are likely to suffer the 'tri-diagnosis' of cognitive, mental health and substance use challenges, which is important to consider in developing programming for them and training for service providers. The typical first care approach to such complex conditions is to provide substance use and addiction counselling and treatment services (Luteijn et al., 2020; McQuaid et al., 2018). However, in the case of coexisting PTSD (including potential moral injury) and substance use challenges, an integrated healing approach is called for because trying to deal with the substance use first can lead to relapse given the underlying physical, psychological and spiritual pain not addressed.

We believe that language matters in transitioning away from siloed forms of care (medical, psychiatric, substance treatment, rehabilitation), and ensuring that the context of people's lives is understood because it impacts their healing journey. For example, while McQuaid and colleagues (2018) cite long delays for accessing substance use and addiction treatment, as well as these services being cost-prohibitive, not having stable housing or a robust social support network were significant contributors to relapse. Conversely, better outcomes in relation to alcohol and drug use, employment, and self-efficacy were associated with longer stays in supportive housing. They identify a need for "long-term recovery outcome monitoring, particularly as addiction is a chronic disease and like other chronic diseases, relapse is part of the ongoing journey of wellbeing" (McQuaid et al., 2018, p. 9). While the language of recovery is now widely used, Jaiswal and colleagues (2020) caution that "In the absence of a pragmatic understanding of recovery, the practical applications may be limited based on the attitude and knowledge of the individual service provider" (p. 2) ... and the term could be used to simply re-label traditional siloed forms of care. Hence,

> # WE PREFER THE TERM 'HEALING JOURNEY' TO DESCRIBE "THE UPS AND DOWNS OF LIVING WELL" EXPERIENCED BY PEOPLE IN EARLY MENTAL HEALTH AND SUBSTANCE USE RECOVERY
>
> (Hancock et al., 2018).

Moving forward, we believe that we need to shift mental health service delivery to an integrated, wrap-around healing-centred model geared to meet the unique needs of the people we serve. People who have a traumatized sense of self turn to substances to soothe their pain. They are in a constant state of survival to keep the pain at bay, which negatively impacts their nervous systems. Participants talk about their fear of getting 'sick' (withdrawal and the return of pain). The same can be said for people experiencing homelessness, who live day to day not knowing where their next meal will come from or whether they have a safe place to sleep at night. Moving from a perpetual state of surviving to thriving is a complex journey. Thinking back to Maslow's hierarchy, it means the basics to reach a state of homeostasis: good nutrition and sleep, exercise, but also, a personal sense of safety and of not being alone. This first step to healing involves stabilization. It is important to note that stabilization does not necessarily infer abstinence, a criterion for admission to many rehabilitation programs. Once a person is stabilized, they are then fit to start the difficult work on trauma, self-esteem and a sense of purpose, dealing with the past to open doors to a future of wellness. It is unrealistic to believe that people can take this on without being stabilized first, which, as articulated earlier, involves supports, not just housing. Most should also be receiving medical care to determine and address the effects of trauma to the head, for example, and nutrition care to stabilize mood.

STEP 1- ICH STABILIZATION

- SHELTER
- HEALTHY FOOD
- HARM REDUCTION
- MEANINGFUL ENGAGEMENT

STEP 2- SUPPORTED COMMUNAL LIVING

SCAFFOLDED SUPPORTS

- PERSONAL SPACE
- WELLNESS PROGRAMS
- COMMUNITY & SOCIALIZING
- MEANINGFUL ACTIVITIES
- PEER SUPPORT
- HARM REDUCTION

STEP 3- INDEPENDENT LIVING

CHECK-INS, LINKAGES

- EMPLOYMENT
- WELLNESS PROGRAMS
- MEANINGFUL ACTIVITIES
- MENTORING
- HARM REDUCTION

Hancock and colleagues (2018) emphasize that stability and security is foundational for people with tri-diagnosis to draw on their own strengths and move forward, "when material needs, including housing, [are] addressed, and an individual [is] able to connect with a supportive network of workers, carers, friends and family" (p. 1). There is a need for increased supports that engage people in meaningful activity and support life skills. Effective community integration supports are needed to prevent ongoing homelessness, including scaffolding supports throughout the personal transformative journey: stabilize, engage, do the work, circle back.

This means we believe we need to shift away from cognitive-oriented therapies as a first response. Instead, our goal should be getting people who use substances to a level of stabilization where they can think beyond daily - or hourly - survival. We can help them achieve stabilization through occupational therapy principles and a healing-centred engagement approach based on fostering relationships, participation, and sense of meaning.

INTEGRATED CARE HUB

Drop-in

Rest Zone

Consumption & Treatment Services

Engagement/ Employment

Integrated Care

RELATIONSHIPS

SENSE OF MEANING

KEYS TO HEALING

PARTICIPATION

HEALTHY HABITS

Nutrition
Harm Reduction
Sleep
Hygiene
Body Movement
Mindfulness
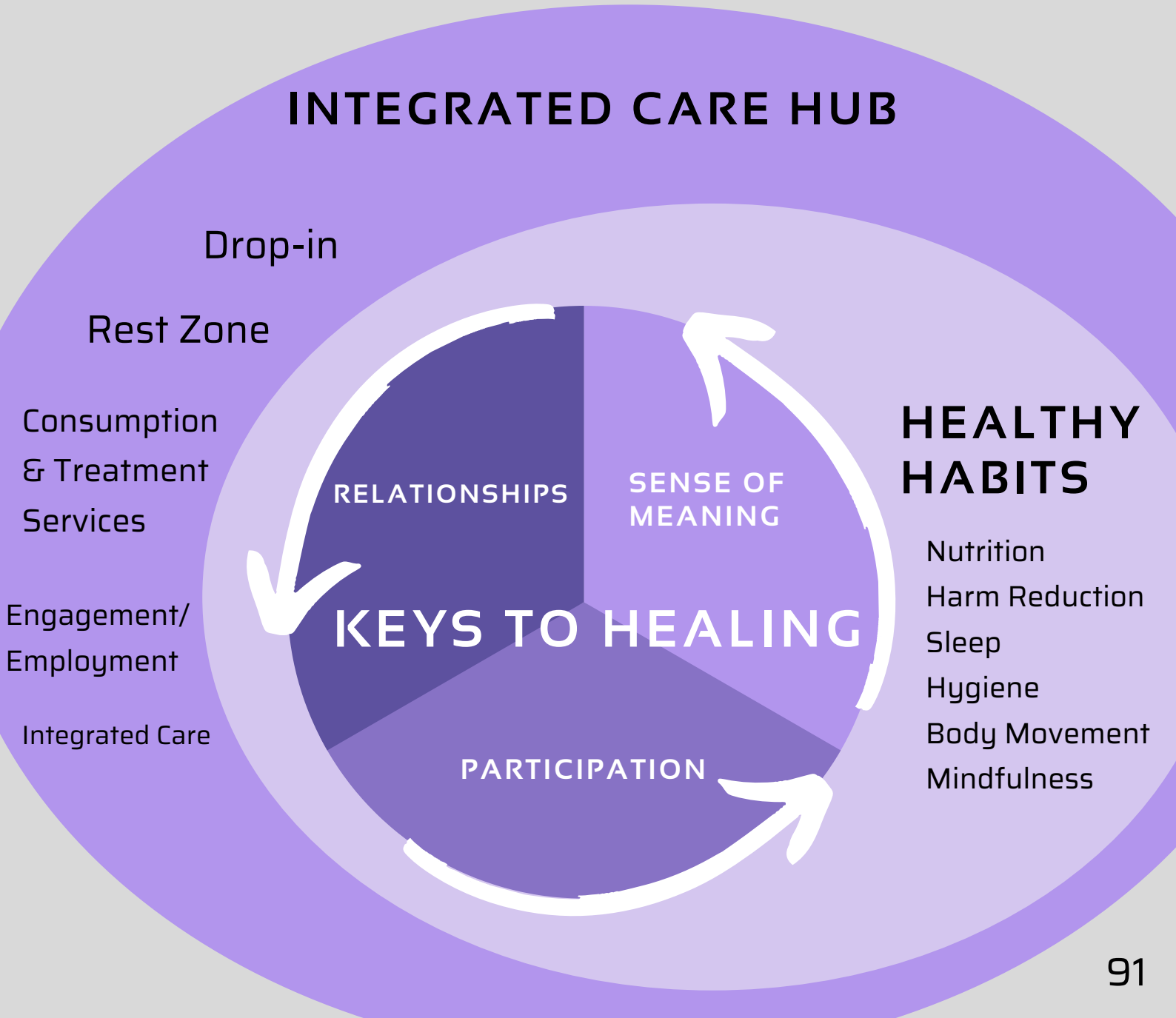
Both occupational therapy and healing-centred approaches are deeply committed to optimizing people's potential, hope and optimism about the future. This involves maintaining and enhancing social connections and community that can be cultivated through the environment; the forming of identity beyond that of "patient" and the professional dyad; the importance of relationships; empowerment; and finding a sense of meaning and purpose in life (Jaiswal et al., 2020). Healing-centered engagement or HCE (Ginwright, 2018) highlights the transitions and/or movement from a life focused on illness and disability to one focused on action and participation. HCE is strengths-based, strives to build empathy with people, and encourages people to dream, to imagine what could be. Thus, critical research and evaluation of the concept of recovery itself "may reinforce the need for substantive restructuring of systems that claim to promote recovery, expanding the focus from the individual to consider cooperative, collective, and systems-level approaches" to healing (Jaiswal et al., 2020, p. 10). In their scoping review of sixty sources around existing evidence on recovery-oriented practice for people dealing with severe mental illness, Jaiswal and colleagues (2020) mapped three major elements that contribute to recovery: relationships, sense of meaning and participation (p. 1). These elements were also echoed by responses received by stakeholders at the ICH.
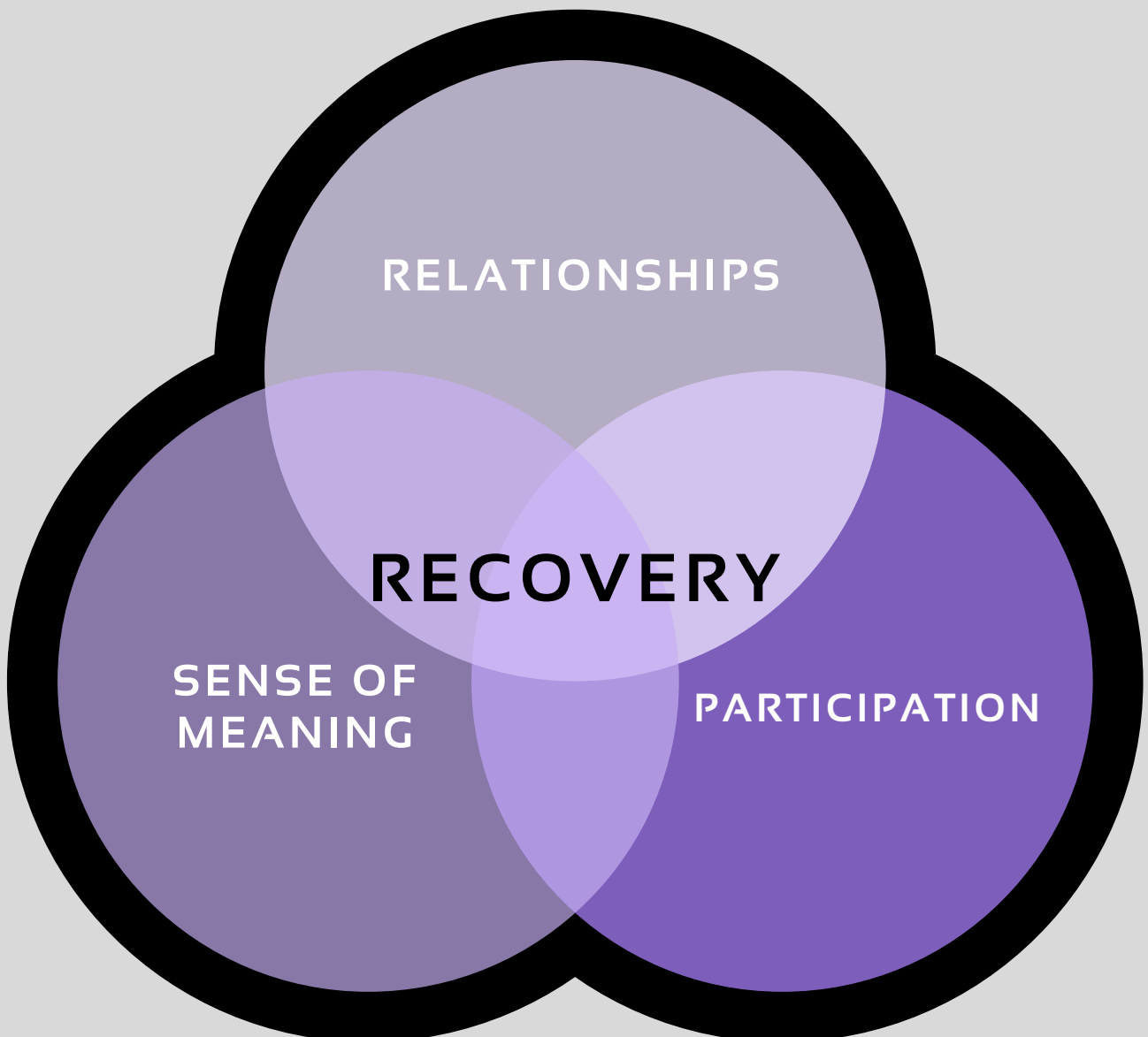
6.5.1. RELATIONSHIPS AND CONNECTION

Stakeholders at the ICH expressed how relationships and connections were important to their well-being, but that their life on the streets had resulted in them being alienated from many important relationships. For example, they wished to find ways to reconnect with family and other significant others. Their peers had become their new community, their 'people'. They knew their wellness depended not just on their own resilience and resourcefulness, but on the broader community (e.g., 'it takes a village'). Their wellness also related to re-establishing a sense of place, which many identified as the ICH ('somewhere to go' where there is 'family'). People were also at different 'places' on the healing continuum. Many insisted that they did not want to be alone but longed to have a personal space of their own.

Relationships and connections have therapeutic value, and should be based on fostering equality, acceptance, empathy, respect, compassion, connection, collaboration, safety, and confidence in people with tri-diagnosis. At the ICH, programming could be created to facilitate opportunities to interact and reconnect stakeholders with family and friends (though some preferred support from friends and others because of the perceived notion that family acted out of obligation). Secure attachments are important to reinforce incremental progress on their healing journey.

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6.5.2. FINDING MEANING AND BELONGING

As to the broader community that includes ICH staff, there are many ways to foster meaningful, inclusive relationships that will help stakeholders recover 'coherence' and reduce isolation. This helps stakeholders to make meaning and reconnect with a sense of self that instils hope, belonging, security, acceptance, and connection, "a feeling that one is a part of a stigma-free community as a mechanism of recovery" (Jaiswal et al., 2020, p. 8). Stakeholders are looking for authenticity, and workers who 'really care' about them. Storytelling in a group setting can provide a safe environment for meaning making, "building self-efficacy, self-acceptance, and reducing self-stigma… critical recovery mechanism[s] that involved helping individuals gain skills and feel more capable of, and confident in, acting independently and participating in society" (Jaiswal et al., 2020, p. 8). Participating in the running of group recovery programs, and developing shared goals, assisted with fostering personal agency, self-creation, self-repair, hope and optimism, integration, and spirituality as "a personal quest for a sense of purpose and meaning of life" (Jaiswal et al., 2020, p. 8).

6.5.3. PARTICIPATION AND MEANINGFUL ACTIVITY

Several stakeholders were looking for more 'things to do' and suggested "Find[ing] out what people are good at." This could potentially inform therapeutic activities. Arts, crafts, dance, drumming, building and other therapeutic modalities enhance a sense of pride in one's capabilities to 'create'. Self-efficacy can be enhanced by involving stakeholders in life skills training and activities like cooking or doing their income tax. Mentoring and training programs in technology and mechanics were suggested as desirable activities by participants. People who frequent the ICH are resilient and have lived through a great deal. They are interested in employment opportunities around peer support and giving back to their community. They want to integrate into community, and the theme of "Give us a chance" was very pervasive in the interviews. Jaiswal and colleagues (2020) see participation in meaningful activity as the third key piece to the healing journey. This can relate to roles in productive work (e.g., employment, volunteering, parenthood, self-care) to alleviate boredom, increase social interaction and feelings of inclusion.

Meanwhile, stigma, financial constraints and psychiatric hospitalization were identified as barriers to recovery. People with tri-diagnosis must be empowered to take agency through an "active and critical attitude" toward the concept of illness and the attitudes of service providers, because "autonomous action [will help] them to become independent citizens rather than subjects of a paternalistic mental health care system" (Jaiswal et al., 2020, p. 9).

6.5.4. CONTEXTS WORTHY OF SPECIAL CONSIDERATION

In developing a healing-centred engagement model of care for people with tri-diagnosis, there are several populations with unique environmental contexts that require additional dialogue around needs and historic service gaps. These include:

- People who self-identify as Indigenous, which are over-represented in the KFL&A population experiencing homelessness, are subject to a history of intergenerational trauma and poverty, are repeatedly exposed to potentially morally injurious events due to systemic racism and lateral violence, are often forbidden from practicing their own spiritual healing rituals or cannot access culturally appropriate and safe programming.

- Veterans, who may have a history of trauma, PTSD, exposure to potentially morally injurious events, and concerns over help-seeking as potentially stigmatizing within their own professional culture.

- People who are physically disabled and/or suffering from chronic pain, because mental health and substance use challenges will exacerbate their chronic conditions, creating negative feedback loops that may keep them from participating in the formal labour force indefinitely, but they still wish to be contributing members of society.

These three groups will all benefit from a healing-centred engagement model of care, but nuances will be required based on the special needs they identify.

6.6. PROGRAMS AND SERVICES

Jaiswal and colleagues' (2020) scoping review that identified three essential elements that contribute to the recovery of people with severe mental illness, applies a functional lens with a focus on the practical application of knowledge to better support evidence-informed care (p. 9). This is the same strategy that led to the undertaking of this needs assessment with stakeholders at the ICH. We have learned that programs to support people with tri-diagnosis need to align with a more person-centred philosophy; services need to be more relationship-focused and violence and trauma-informed; increased supports are needed that engage people in meaningful activity and support life skills; and effective community integration supports are needed to prevent ongoing homelessness. These findings are echoed by Marshall and colleagues (2021) community consultations on transitions from homelessness in KFL&A.

We hope to work with community services providers in healthcare, mental health care, addictions treatment, rehabilitation and care of persons with developmental disabilities, housing, employment, social services, and education at multiple levels, to flesh out a healing-centred engagement care model for people with tri-diagnosis over their healing journey. This work must recognize that people with tri-diagnosis begin their healing journey in the thick of daily survival and ongoing crisis management, which makes it difficult for them to see beyond the immediate.

In order to be successful, our collaborations must be underpinned by anti-oppression approaches using an intersectional lens to ensure the needs of varying identities are understood (i.e., gender, sexual identity, race, Indigeneity, socio-economic status, [dis] ability, age/transitions, Veterans, etc). Management at the ICH has begun to map out seven speciality care pillars related to serving people with tri-diagnosis, but further development is required with community partners.

Figure 17: ICH'S Specialty Services

INTEGRATED CARE HUB

Cultural Safety · Engagement/Employment · Nutrition · Wellness · Stabilization · Trauma & Violence Informed Care · Harm Reduction

Engagement: Connection - Belonging - Participation
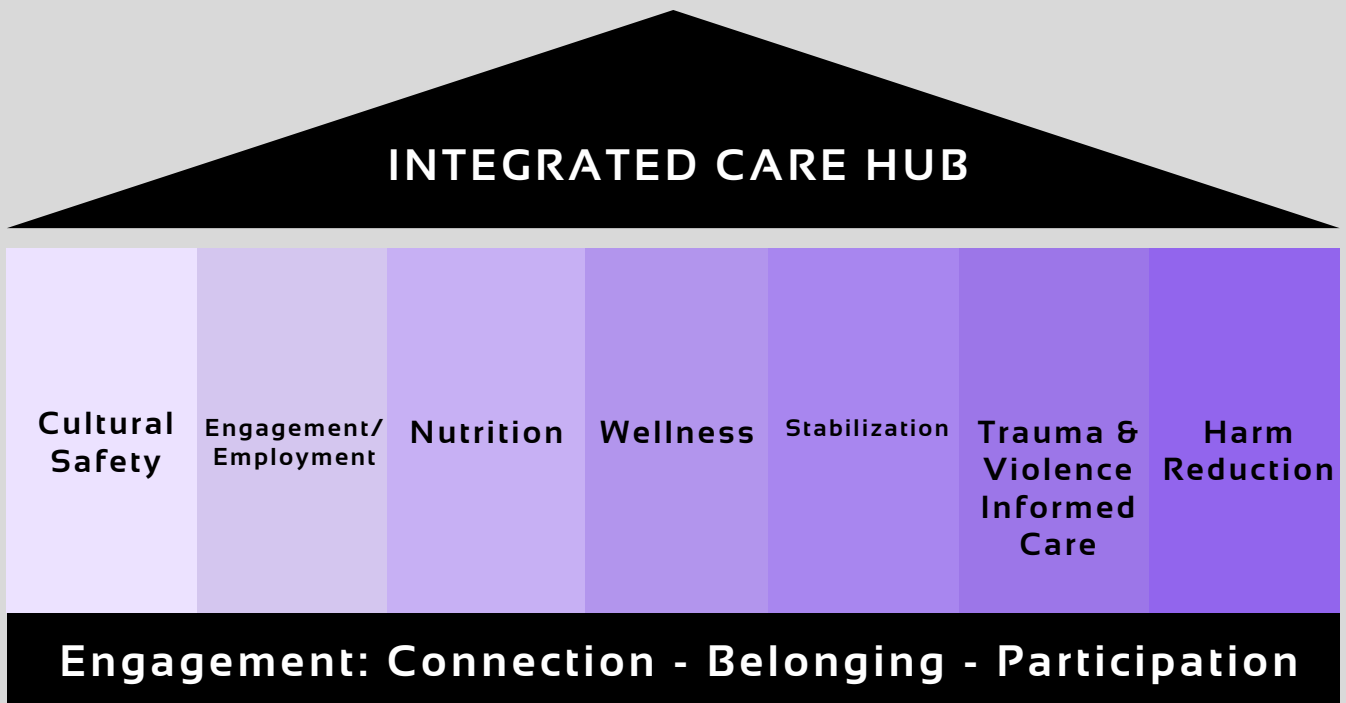
6.6.1. SLEEP, NUTRITION AND HYGIENE

Proper sleep and nutrition are linked to stability of mood and behaviour, particularly for populations who use substances like opioids (Chavez & Rigg, 2020) which can lead to metabolic changes that result in weight loss, constipation, inadequate food intake and unhealthy eating patterns (p. 699). As reported by participants, sleep disruption is a significant issue, particularly for people who use crystal meth and can be awake for several days at a time. The substance also acts as an appetite suppressant.

There are several former chefs on the ICH's staff who make meals and barbeque once a week to build community, but additional infrastructure and resources are needed to fully implement the nutrition strategy and life-skills programming. It was encouraging from the interview data to see how people who frequent the ICH are now enjoying fruits and vegetables on a daily basis.

6.6.2. HARM REDUCTION

Stakeholders at the ICH called for expanded Consumption and Treatment Services (CTS) within the city, but also a supervised place to 'smoke' at The Hub. Support by participants for Safe Supply was unanimous, and the majority supported Decriminalization. These 'Big P' policy issues are discussed in section 6.3.5.

Harm reduction alone in community mental health settings will not be sufficient to move people forward on their healing journeys, but it will help ensure they are not dying of drug poisoning. Mancini and Linhorst (2010) call for stepped healing care plans that also include supportive housing and employment, medication to reduce psychiatric symptoms and substance use behaviours, wellness self-management strategies, and social skills training (p. 142). They emphasize that given the multidimensional nature of the recovery process and the complexity of associated needs and challenges faced by people with tri-diagnosis, harm reduction has its place in recovery, and that both abstinence-only and harm reduction approaches are effective in different ways, depending on the person seeking recovery, and how they define it. Practitioners and program developers are encouraged to "draw on the full range of evidence-based approaches available that are designed to assist people in their recovery journeys" (Mancini and Linhorst, 2010, p. 142).

6.6.3. WELLNESS

Only 24 percent of males and 45 percent of females indicated having a family doctor. Another 38 percent of males and 36 percent of females reported using Street Health services. Furthermore, six males cited having had negative experiences in the health care sector and another three avoid care altogether. It was suggested by one participant that there be a medical clinic on site at the ICH.

Having primary care available on-site would allow for the quick and on-going treatment of issues that frequently trouble people who use substances like infections, cysts, and endocarditis that require safe administration of antibiotics. Pain management is also an issue cited by five participants suffering with chronic physical disabilities. Frequent incidences of head trauma and broken bones could be assessed for referral.

Three participants who are further along on their road to recovery wished there were 'less drugs' at the ICH. In KFLA, there is a lack of in-patient drug rehabilitation programming. While that is out of the scope of ICH's mandate, it is a significant consideration for regional health care service planning.

6.6.4. LIFE SKILLS TRAINING

Several participants indicated that life skills training was an unmet need. Life skills training should be a part of a broader rehabilitation strategy as an outcome, not just one on one occasional didactic training. In developing such programming, planners should keep in mind that people who use substances deal with learning, cognitive and physical disability, which tends to increase with the length of time that they continue to use substances. However, participant seemed keen to learn (re-learn) how to manage a household and their personal and financial affairs.

While the ICH does not have the infrastructure to include a food preparation skills program, this would be an excellent addition to life skills training that could perhaps be provided by a community partner.

6.6.5. EMPLOYMENT AND MEANINGFUL ACTIVITY

When asked if participants believed they may have had a learning disability that made it, or would make it, hard for them to learn in a typical classroom, 56% percent of participants cited believing they had a learning disability that impaired their schooling, an important consideration in program planning. Staving off drug dealing initiation by street-involved persons requires a constellation of innovative interventions like supportive housing, low threshold employment programs, and addiction treatment programming (Hepburn et al., 2016). Ti and colleagues (2014) echo the need for low-threshold employment opportunities for people who use substances but who are trying to stop, because their income-generating opportunities have been previously linked to street-involved practices like survival sex work, panhandling and dealing drugs (p. 58). They also call for supportive housing, evidence-based approaches that reduce harm, and legal reforms regarding drug use (p. 62). Richardson and colleagues (2010) list the following barriers to people who use substances being able to secure legal employment: unstable housing, recent incarceration, survival sex trade involvement, public injecting, daily injecting of substances, HIV and HCV positive status, aboriginal ethnicity, and older age. Though the vast majority of stakeholders at the ICH indicated they would like to return to work, they cited many of these barriers, as well as physical pain management, as problematic to returning to work.

The ICH's Community Support Program allowed for the hiring of people with lived or living experience to act as peer supports, paid employment, engagement and participation in ICH operations, including working alongside staff to serve peers accessing services. It served to help people who use substances make connections, to earn money, and provided a sense of purpose. Miler and colleagues (2020) support efforts to involve people with lived experience in peer support for those dealing with mental health and substance use challenges, concluding that "peers should be respected, valued, supported, and compensated for their work which is often profoundly challenging" (p. 1). Guidelines around five themes relating to challenges experienced by peer supports and risks they face that can be mitigated by host and collaborating services include: vulnerability, authenticity, boundaries, stigma, and lack of recognition. This literature should be consulted should the Community Supports program be reinstated at the ICH.

One participant suggested surveying people who frequent the ICH as to what they like to do and what they are good at. Indeed, there is opportunity to develop a Social Entrepreneurship program at the ICH that could provide people with 'something to do' but also, perhaps, ways to earn a living. For example, one participant said he was a mechanic and liked to fix things, another said he wished there was a bike repair shop. Art-based therapy programs might generate works of art that could be sold via an on-line market. There could also be mentoring opportunities for KFL&A residents who might enjoy sharing their expertise. For example, there could be spa services brought to people who frequent the ICH. The idea is fundamentally being mindful that people who use substances face significant barriers to formal employment, but they are not without skills and talents that could be cultivated to better their wellness and provide revenue streams, notwithstanding that as peers, they 'get' what it is like to live with mental health and substance use challenges.

6.6.6. REWARDING SUCCESS AS A STRENGTHS-BASED STRATEGY

One participant suggested earning rewards through a points system (for items other than basics like clothes and food that should be provided as a basic need). Such a program might provide additional privileges to people staying at the ICH who are not working, but who could help out in other ways. Section 5.4. outlines what participants wished they could obtain if they had money. Local businesses could donate passes and services, while the ICH could provide them with a donation receipt (e.g., spa services, movie passes, etc.).

6.7. OTHER SUPPORTS

There are other supports needed to ensure the creation of successful healing-centred engagement care programs for people with tri-diagnosis. First and foremost, we need to address the stigma around homelessness, mental health and substance use challenges. This is a societal phenomenon underpinned by religious mores around morality, and social values around utility and contribution to society. This stigma has been further exacerbated by neoliberal values around individualism, hyper-competition and consumerism. Such values seep into institutions and curricula, leading to stigmatization, exclusion, and marginalization of people with tri-diagnosis.

These systemic and societal forces can lead to moral injury to the people who are victimized, but also those who are working to help them. Baum and colleagues (2020) emphasize that a "shift in norms is required to stress equity and the right to health" (p. 1). Fundamentally, how society values people with tri-diagnosis will influence policymakers who represent their constituents.

6.7.1. ANTI-STIGMA AND AWARENESS

The evidence as reported from stakeholders of the ICH and what staff have witnessed speaks to the terrible stigma that people who use substances and who may also be experiencing homelessness are subject to on a daily basis.

ICH management plans to work with a community-wide anti-stigma group to develop an awareness campaign. The section that follows outlines meta-themes from the needs assessment that reflect the voices of those who frequent the ICH when asked the question 'what people in the KFL&A community should know about them'.

We hope to use these themes to enhance the "Support, Not Stigma" t-shirt campaign and reinvest proceeds into wellness supports for staff at the ICH.

"THE OPPOSITE OF ADDICTION IS CONNECTION"

- Johann Hari

6.7.2. TRAINING FOR SERVICE PROVIDERS, FRONT LINE RESPONDERS, AND DECISION-MAKERS

The systemic and societal forces that lead to stigma against people who are experiencing homelessness and/or use substances can also creep into the systems and services designed to protect these marginalized populations.

We advocate for the creation of training programs for all service providers, front line responders, and decision-makers who provide supports to people with tri-diagnosis. This starts with training around compassion, and we continue to work on identifying an affordable compassion training program that can be provided across KFL&A.

We hope to work with community providers on a longer-term strategy to develop and launch an anti-oppression curriculum to address systemic and lateral violence based on trauma and violence-informed approaches, and ways to recognize and prevent morally injurious situations.

Larson (2008) urges schools of medicine, nursing and social work to include anti-oppression theory and practice in curricula, and that social workers in particular "engage in anti-stigma and antidiscrimination education regarding mental health in the community in general and also within specific relevant groups" (p. 49). Interestingly, while physicians and nurses see the value of human rights and social justice work, it has been reported that "other disciplines actually deferred this activity to social workers" (p. 52).

While there has been a shift in professional discourse and policy rhetoric towards more socially inclusive, holistic, patient/client-, and recovery-oriented approaches to mental health care, neoliberal policy and service reforms on professional practice and conceptualizations of mental illness have led to what Moth (2018) terms 'biomedical residualism' whereby "organizational processes increasingly recast service users as individual consumers 'responsibilized' to manage their own risk or [be] subject to increasingly coercive measures when perceived to have failed to do so" (p. 133). Where the emphasis was once on supportive care and welfare, neoliberal policy agendas have "reconfigured welfare services so that their policing and social control functions are more prominent" including social housing, which is now short-term based on conditions rather than on stabilization with long-term tenancy (Moth, 2018, p. 145).

The demands for risk management and accountability have led to the exclusion of more person-centred and holistic approaches, replaced by brief assessments of biological signs and symptoms, and subsequent prescribing and monitoring of psychotropic medication, what is coined as 'sleep, mood and meds' (p. 146). These organizational constraints have had the "effect of dehumanizing the service user", and widespread feelings of anger and fear by professionals "with some considering leaving the mental health professions" (p. 147).

Holley and colleagues (2012) contend that the stigma associated with mental health challenges is conceptualized differently from discrimination and prejudice based on gender, race and other forms of difference. They suggest that people with mental illnesses and their allies can change oppressive structures and processes through a critical anti-oppressive paradigm that focuses on power dynamics (p. 51). Clouston (2018) emphasizes that the values of learners and would-be professionals are "Subjective and affective, [requiring] the learning environment to not only promote critical thinking and the development of professional competencies, but to facilitate personal growth and change within students at cognitive, emotional and spiritual levels" (p. 4), but this must also be supported at wider structural levels.

Finally, Paolo Freire's seminal work entitled "Pedagogy of the Oppressed" could be required reading for anyone working with marginalized populations. His Theory of Dialogical Action starts with engaging people in dialogue about what they need to make their lives better. It is foundational to empowering them.

"People with mental illnesses and their allies can change oppressive structures and processes through a **critical anti-oppressive paradigm** that focuses on power dynamics (Holley et al., 2012).

"If it is in speaking their word that people, by naming the world, transform it, dialogue imposes itself as the way by which they achieve significance as human beings" (Freire, 2000, p. 88).

The experience of those who interviewed the stakeholders at the ICH speaks to the power of dialogical action and engaging those we serve in the process of better understanding their needs.

6.7.3. WELLNESS SUPPORTS FOR WORKERS

While not an explicit consideration of the needs assessment, we are concerned about ICH staff burnout, exposure to morally injurious events, and eventual development of moral injury and/or PTSD that would be debilitating to staff's ability to function in their challenging caring roles. Wilson and Richardson (2020) advocate that healing-centred collective care also requires caring about the carers. Healing-centred engagement involves looking at care from a political perspective as well as a clinical one, moving away "from better coping with the environmental conditions that cause pain (resilience) to an analysis of the oppressive structures, systems, and practices that are the root causes of pain" (p. 80). This is difficult work and requires a collective effort. Supports for workers should be built into programming.

The statistics for overdose in the ICH community are staggering, and staff are acting as first first-responders on an almost daily basis. They are also supporting the survivors who are witnessing the overdose of friends and family members. Stakeholders said the following about frequent overdose and drug poisoning:

- "We need more awareness, people should not turn their backs on us because of it, it effects a small portion of people, but awareness could be a positive thing."
- "It's so sad it hurts, I feel like a failure, but I don't want to die!"
- "It's scary, I wouldn't wish it on anyone, you have to know what you are doing when you respond [to an overdose]."

We need to think about supports needed for those who frequent the ICH to address the emotional impacts of living with the threat of overdose daily and witnessing so many friends and family suffer and die. We also need to be thinking about the emotional toll this is taking on ICH staff, who are actively involved in reviving people who are overdosing. They may also be suffering from moral injury in their knowledge that a safe supply program would stem the tide of overdoses in this community.

As mentioned, the ICH will participate in a region-wide anti-stigma campaign, selling t-shirts that promote ICH social justice messaging. We hope that revenues can fund staff solidarity check-ins on a monthly basis that also include education workshops. It is critical that our workers be well in the work.

7. LIMITATIONS AND FUTURE STUDY

One of the limitations of the ICH needs assessment was the under-representation of women under 30 who use substances. This is often a hidden population who may be living with their dealers, and/or involved in trafficking or survival sex work. Further research into why they do not use the shelter system is needed, and what their experiences are so we can develop programs to serve them too.

The 60% incidence of PTSD in females, even with the lower sample size, seems significant, and warrants further research as to why and what additional supports they may require.

Ninety five percent of males and 91 percent of females indicated having had multiple mental health diagnoses, however, an additional 32% of males thought they suffered from depression and another 26% of males believed they suffered from anxiety, bringing their rates closer to those reported by females. This also warrants investigation into how homelessness and substance use impact the mental health of males over time.

The study did not ask participants to identify whether they were Veterans. Knowing the scope of Veterans experiencing homelessness would help inform program development.

While the study asked participants whether they had been to jail previously, it did not ask what type of incarceration and how long it had been since the participant was released. Given KFLA's significant prison population, it would be helpful to better understand how many ICH patrons come from other areas but were released into the Kingston community from provincial or federal correctional institutions.

A study on the needs of people with developmental disabilities who use substances was conducted in our region in 2012. Ang & Wasserman (2021) suggest we better understand the prevalence, causes and effects of traumatic brain injury on people experiencing homelessness, particularly those in low-barrier shelters, who then experience cognitive disability as a result. We should revisit this research in light of the prevalence of tri-diagnosis of people who frequent the ICH, but also to develop "cross-sectoral training to ensure available or newly developed services adequately meet the needs of those with intellectual disability (Burge & Williams, 2012, p. 19).

The impact of moral injury on personnel who serve marginalized populations who face systemic social injustice should be researched to better develop supports to avoid burnout and mental health challenges with staff. We believe this will also contribute to better care of the people we serve across all sectors.

The nature of a rapid needs assessment does not enjoy the luxury of in-depth thematic analysis of the data that a formal research project would. Nor did it seek to interview people using shelters other than the ICH, but for readers seeking comparative data, the Marshall and colleagues (2021) study on homelessness in KFL&A provides this. Thus, the analysis presented in this report is not exhaustive of the experiences and opinions of all people experiencing homelessness who use substances in the Kingston area (like the young female cohort mentioned above). Despite the short turnaround time from the completion of the 32 interviews to a full draft of this report, we are reasonably confident we achieved good saturation of the themes. A comparison of the analysis with the recent report on homelessness by Marshall and colleagues (2021) shows further congruity.

8. NEXT STEPS

Like the Marshall and colleagues report (2021), we also hope to engage in informed community conversations to collectively problem-solve how we can best serve people with tri-diagnosis, and/or experiencing homelessness through their healing journey. As one respondent said: "It takes a Village."

We envision working with community partners to develop a fully integrated whole person healing-centered approach specific to the stakeholders served at the ICH, people with tri-diagnosis – cognitive, mental health and substance use challenges who may or may not be homeless. This will be based on a healing-centred engagement model that includes employment and opportunities to contribute and reintegrate into family and community. With health justice as the ultimate aim, an ethos of dialogical action will enable anti-oppression approaches across the various sectors that serve these marginalized populations.

We need time to develop new pathways to care for people with tri-diagnosis and specialized assessment, and to better understand what kind of human resources and training is needed to serve them best.

With the help of community health and social service partners, it is hoped that the work at the ICH can serve as a formal pilot project, so new care pathways can be explored with community partners, empirical evidence around the effectiveness of the integrated care model can be collected, to lead to the development of a best practice model that could be used in other jurisdictions through sharing our experiences.

We hope to engage community partners across the KFL&A region to support an on-going, multi-media, anti-stigma campaign, to build empathy for people with tri-diagnosis, that their plight is not one of individual failure, but that our systems have not been able to meet their needs, an issue we are attempting to address using the advice from our stakeholders at the ICH, and emerging best practices in medicine, science and social science.

The ICH evolved out of the COVID-19 pandemic, and we believe we have an opportunity to develop a healing-centred engagement model of care for people suffering from tri-diagnosis that will be a best-practice model we can share with the rest of Canada, and indeed beyond. With political will, we can make this a legacy that the KFL&A community can be proud of.

9. CONCLUSION

The Shadow Epidemic of overdose will not disappear after the COVID-19 pandemic is brought under control. We need to build compassion in the sector, but also across Canadian society. We must address the stigma and intergenerational trauma that is perpetuated through moral injury and making people feel less than human, people who are already in terrible emotional and physical pain. This will lead to a reduction in chronic homelessness, which, in turn, leads to significantly reduced costs to our healthcare, criminal justice, and social welfare systems. One cannot put a price on the social costs of not acting to help people who use substances, because they are someone's mother, daughter, grandfather, brother…

Caring for our most marginalized citizens in KFL & A, those with tri-diagnosis who may also be experiencing homelessness, is a matter of social justice. It cannot be an abstraction. It is complicated. It is political, but also a moral imperative.

It is about building people up through community, not hiding them away. The ICH is providing a service that people desperately need. Hope is the turning point that must quickly be followed by the willingness to act. That is what the ICH provides! Homelessness is structural and the stigma against people who use substances is systemic. As a society, we have a shared accountability for the wellness of all of our citizens. We believe that our integrated healing-centred care approach will lead to greater rates of recovery from mental health and substance use issues, and in many cases, break cycles of inter-generational poverty and trauma.

A commitment to health justice and healing-centred engagement with our most marginalized citizens, along with the intellects and hearts of our healers and helpers, can lead to a new paradigm that will save lives, and tax dollars.

10. APPENDICES

10.1. LIST OF FIGURES AND TABLES

10.2. REFERENCES

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10.3. INTERVIEW GUIDE AND QUESTIONS

Crystal Meth, Opiates, Overdose and Housing in Kingston, Ontario
Integrated Care Hub
Rapid Assessment and Response - Community Needs Assessment

Unique Identifier: _____--_____/_____--_____
(interviewee initials – today's date/month – Manager's initials)

INTERVIEW GUIDE and QUESTIONS

Demographics

1. How old are you? (circle one)   18-24   25-29   30-39

40-54   55-64   65+

2. How do you identify your gender?

3. How do you identify your ethnicity? (e.g. French Canadian, Chinese, Jamaican)

4. Do you have Indigenous heritage?
(e.g. Haudenosaunee, Mohawk, Anishinaabe, Algonquin, Ojibwe, Metis, Inuit, etc.)

5. a) What level of education have you completed? (e.g., high school, college, etc.)

   b) Is there anything that prevented you from continuing with your education? (explain)

6. Do you believe you may have a learning disability that made it, or would make it hard for you to learn in a typical classroom? (circle one)   Yes No

7. Are you currently working? (circle one) Yes No

   a) [If no...] Would you like to be working at some point?

      a-i) [If yes to above...] What is preventing you from working right now?

8. Have you ever been in jail? (circle one) Yes No

   a) [If yes...] Do you believe that substance use impacted you receiving charges?

Health & Wellness

9. Are there times when you aren't getting enough to eat? That you go hungry?

10. Do you eat vegetables and fruit? (e.g., every day, a couple of times a week, rarely)

11. Do you have a family doctor? Who do you see when you are unwell?

12. How many times have you been to the hospital in the past year? What for?

13. Have you ever experienced any violence or injury that resulted in your head being harmed by a hard blow? Y / N

    a) If yes, did you experience any of the following symptoms after? (circle all that apply)

        Loss of consciousness – Headache - Nausea – Dizzy –

        Trouble concentrating - Loss of coordination - Trouble sleeping

    b) Did you see a doctor after the injury? Yes   No (circle one – take notes)

14. How would you rate your mental health? (circle one – take notes)

        Pretty good   Okay   Not okay   Really bad

15. Have you been given a mental health diagnosis by a Doctor? (describe)

16. What [other] mental health diagnoses do you believe you have? (describe)

17. Have you ever had children in your life?   Yes   No

18. How is your relationship with your family? (circle one – take notes)

        Pretty good   Okay   Not okay   Really bad

Substance Use

19. How old were you when you first used a substance? _____

20. Which substances do you currently use? List all substances (check all that apply)

21. How often do you use?
     Daily   -   A few times a week   -   A few times a month   -   Once a month

22. How much would you need to use per day to feel well?

23. How often do you ingest substances?
     All of the time   -   Some of the time   -   Rarely - Never

24. How often do you snort substances?
     All of the time   -   Some of the time   -   Rarely - Never

25. How often do you smoke substances?
     All of the time   -   Some of the time   -   Rarely - Never

26. How often do you inject substances?
     All of the time   -   Some of the time   -   Rarely - Never

     a) Education moment - Do you ever use the Consumption and Treatment Service or
     .   CTS – do you know what that is (if not, explain)? Yes No

     b) If no, why not?

     c) If you had access to opioid replacement therapy such as methadone, suboxone or
     .   kadian through the Consumption and Treatment Service or CTS, would you access
     it? .   (circle one) Yes   No   Unsure

27. How does your substance use impact your sleep?

Tick what applies	Sleep	Qualifier / describe
	I sleep a lot. *Skip question 28*	
	My sleep is fine. *Skip question 28*	
	I stay awake for long periods of time. …How long do you normally stay awake while you are using?	*Go to question 28*

Substance Use

28. If you stay awake for long periods of time, have you ever experienced any of the
. following symptoms as a result of your substance use? (Check all that apply)

Tick what applies	Symptoms	Notes
	Auditory Hallucinations - Hearing voices	
	Visual Hallucinations - Seeing something that isn't there	
	Paranoia	
	Not being able to sleep	
	Disorganized speech – like switching topics erratically	

Knowledge About Safer Substance Use

29. How would you rate your knowledge of overdose? (circle one)

     I know a little   I know some   I know a lot

30. How many people have you known that have overdosed?

31. Have you lost anyone to overdose? (circle one)   Yes   No

.   a) ...[If yes] How many people have you lost to overdose? _____

32. How worried are you that you might overdose? (circle one)

  Not at all   I'm a little worried   I'm fairly worried   It really scares me

33. Have you ever overdosed? (circle one)   Yes   No (if no, skip to question 35)

.   a) [If yes...] How many times? _____

.   b) Did your overdose experience change how you use substances?

.   c) How did your overdose affect you emotionally?

.   d) Did your overdose change your outlook on life?

.   e) Is there anything else you would like to share in regards to what your
.   experience was when you overdosed?

Knowledge About Safer Substance Use

34. Have you ever responded to an overdose and given naloxone?   Yes   No

35. Do you ever carry naloxone? (Circle one)

   All of the time   Most of the time   Some of the time   Rarely   Never

36. When you use, what types of things do you do to prevent overdose?

37. Do you know what a Safe Supply Program is? (If yes, have them describe…
.   If no, state that a Safe Supply Program would dispense a prescription grade   .
opiate to people so they do not have to buy street-level drugs that may be   .
contaminated with other additives such as fentanyl or etizolam).

.   a) If you had access to a Safe Supply Program, how do you think it would change
.   your day to day life?

Housing & Wellness

There are currently 4 programs that provide overnight shelter accommodation in the city
of Kingston. The Kingston Youth Shelter, In From The Cold, The Integrated Care Hub and
the Overflow Shelter.

38. Out of all 4 shelters in the city of Kingston, how many have you stayed at while being
homeless?

39. Do you feel like you have received appropriate support or help while being homeless?

40. What would help you get out of homelessness?

41. Living in a shared shelter setting has many challenges, what can shelters do better?

42. Thinking about next steps in your life, what kind of housing do you think would work
best for you?

43. If you were to run your own shelter for people experiencing homelessness, what would that look-like?

44. What kind of things do you wish you could do or afford but you can't?

45. Do you know about the movement to decriminalize possession of illicit substances for personal use? What that means?
.   (If yes, have them describe…
.   If no, state that it is a shift in dealing with people who use narcotics. Instead of
.   punishing them through the criminal-justice system, it recognizes that addiction
.   is a condition that should be addressed through the healthcare system. Drug
.   traffickers would still be pursued, but getting caught with small amounts of
.   'hard drugs' for personal use would not involve arrest or prosecution. Locking up
.   drug users and slapping them with criminal records that made it difficult to find
.   housing and jobs isn't working… it's leading to more overdoses and people not
.   getting the wellness supports they need.

         a) Living in a shared shelter setting has many challenges, what can shelters do
.   better?

46. How would you describe the impact that using substances has had on your life?

47. What do you want people to know about people who use substances?

48. What is one thing our community could do to support you and other people who use
.   substances?

Thank you so much for taking the time to talk with me.
Before we end the formal interview…

… Is there anything else you think we should know?

10.4. INFORMATION AND INFORMED CONSENT FORM

Crystal Meth, Opiates, Overdose and Housing in Kingston, Ontario
Integrated Care Hub
HIV/AIDS Regional Services & Street Health Centre
Rapid Assessment and Response - Community Needs Assessment
<u>Letter of Information and Consent Form to Participate in an Interview</u>

The Integrated Care Hub – aka **The Hub** – is a community of people that receive and provide support in caring for people who use substances and/or are homeless. The Hub provides a drop-in, a food program, a rest zone, connections to community supports, harm reduction services, and Consumption and Treatment Services.

Kingston, Ontario is experiencing a drug poisoning crisis during a global pandemic. The **objective** of these interviews is to compile a **needs assessment** about people who frequent The Hub and use crystal meth and/or opiates.

The information we gather together will **guide** the development of **effective responses** and **drug policy** to support people who use crystal meth and opiates and prevent overdose.

To qualify, a participant must be 18 years of age or older, uses crystal meth and/or opiates, and has frequented the Integrated Care Hub.

Benefits of participation
You'll be helping us better understand the needs and experiences of people who are using substances in Kingston. The information collected here will inform community organizations to better understand the experiences of people using substances and help improve community support and response efforts.

Risks of participation
Talking about past experiences, substance use, and overdose may be challenging. There is the risk you may experience difficult emotions during, and after the interview. As the person interviewing you, I will check in before you begin the interview, throughout the interview, and at the end of the interview, to ensure support is provided to you as needed. If necessary, I can connect you to immediate and long-term counseling supports, so you continue to feel supported. Your well-being is of the utmost importance to us at The Hub.

How will this information be gathered and used?

Information will be gathered by three people who work at The Integrated Care Hub: Justine McIsaac, Coordinator of Consumption and Treatment Services; Amanda Rogers, Manager of Harm Reduction Services; and Ashley O'Brien, Manager of The Hub. Information will be used to identify themes and provide insight into the experiences of people who use substances. This report will inform community response efforts.
What you need to know!

- Interviews are expected to be 1 to 2 hours long, however, your interview could take a shorter or longer amount of time. It's up to you.

- You will be paid $40.00 for sharing your knowledge, expertise, life experience and time. The $40.00 will be given to you at the beginning of the interview.

- You'll be asked questions about your age, gender, ethnicity, community experiences, substance use, overdose, and have an opportunity to tell people what you want them to know about people that use substances, and what to do to support them.

- You can decide not to participate at any point in the interview. You can choose to skip questions you are not comfortable answering. You will still be paid $40.00 for your willingness to participate and your decision to end the interview will not impact your services or care provided by The Integrated Care Hub.

- Your identity will remain completely confidential. All questionnaires are kept separate from consent forms and will not be linked to you in any way. Questionnaires will be stored in a locked cabinet and destroyed once analysis is complete.

INFORMED CONSENT

I have read, or have had read to me, the information that is included on this letter of information and consent form: (circle one)

<div align="center">Yes   No</div>

You agree we can interview you for this needs assessment: (circle one) Yes No

Name of person sharing (print)	
Signature of person sharing	
Name of person receiving	
Signature of person receiving	
Date (DD/MM/YYYY & time)	

10.5. LETTER TO KINGSTON CITY COUNCIL

Policy Brief Submitted to City Council, City of Kingston
March 2, 2021
From the Integrated Care Hub - Kingston

BACKGROUND

In March of 2019, the City of Kingston adopted the Canada-wide lockdown and social distancing public health measures to stem the spread of COVID-19. This resulted in many health and social service agencies not being able to provide support at regular capacity, nor see people in person. Some services moved to online platforms, but not all of our citizens have internet access. Drop-ins, support groups, food programs and other places where people used to congregate had to shut their doors, even public libraries with free internet access were closed. Shelter capacity was reduced, leading to tensions, uncertainty, and feelings of displacement among our homeless population, which continue. While shelters needed to reduce their capacity to maintain social distancing protocols, doing so further isolated, and failed to meet the needs of those who use substances. In a drug-poisoning crisis, it is safest to be together, but in a global pandemic, it is safest to be apart.

PURPOSE

The needs of substance users are often misunderstood to begin with, but the social distancing measures associated with curbing the pandemic hammered home the urgent need to provide a unique service geared to help those who experience chronic homelessness and use substances. The Integrated Care Hub (ICH) addresses three intersections of crisis within our community: the global COVID-19 pandemic, a complex housing crisis, and a fatal drug-poisoning crisis. It was created by and is managed by three experienced front-line harm reduction advocates from the Street Health Centre and HIV/AIDS Regional Services. With public health officials concerned that the rise of variants to the COVID-19 virus may lead to further surges and subsequent lockdowns, it is essential that the ICH remain open to serve the needs of Kingston's most marginalized citizens.

PROBLEM-SOLVING

The Drug Poisoning Crisis means that people who are using substances are dying tragically and at a terrifying rate due to a toxic drug supply with no respite from criminalization, demonization and stigmatization. From the Opiate Mortality Surveillance Report (June/19):

- 73.6% of fatal overdoses occurred among people living in a private dwelling and 9.8% occurred among people experiencing homelessness.
- Nearly half (48.6%) of deceased persons were alone at the time of incident.

We need to be intentional and informed in creating supportive housing programs for people who use substances to ensure proper Overdose Prevention Supports are in place. The number of opioid-related deaths increased quickly in the weeks following the state of emergency declaration. Overall, there was a 38.2 % increase in opioid-related deaths in the first 15 weeks of the COVID-19 pandemic. According to the Interactive Opioid Tool by Public Health Ontario, KFL&A experiences a 21.5 % higher rate than provincial average of opioid-related deaths. The ICH has proven itself to be a life-saving program based on the number of overdoses responded to and reversed. In December 2020, the ICH responded to and reversed 70 overdoses on property. In January 2021, the Consumption and Treatment Service responded to more overdoses than all of 2018 and 2019 combined. In the City of Kingston's housing and homelessness system, there are currently 191 people experiencing homelessness: 154 are experiencing chronic homelessness and 18 will become chronic in the next 60 days (meaning they will have been homeless for over 6 months). The ICH served 213 unique individuals since moving to 661 Montreal Street and 121 of those people were not previously counted in the City's formal homelessness statistics. That means our homeless population is likely closer to 300 individuals.

The ICH has been able to identify large numbers of homeless individuals who are not represented in any formal statistics gathered by the city or other agencies for a few different reasons:
- Our service is low-barrier, accessible and trauma-informed.
- Our service is geared to meet the needs of substance users.
- We have created space for a pre-existing community.
- The people we serve feel like we care, because we do.
- We are providing a service that people in our community desperately need.

RECOMMENDATIONS

1. Systemic changes are needed;
2. Programs need to align with a more person-centred philosophy;
3. Services need to be more relationship-focused and trauma-informed;
4. There is a need for increased supports that engage people in meaningful activity and support life skills; and
5. Effective community integration supports are needed to prevent ongoing homelessness.

We believe that our integrated care approach will lead to greater rates of recovery from mental health and substance use challenges. It will in many cases break cycles of inter-generational poverty and trauma. This will lead to a reduction in chronic homelessness in our community, which, in turn, leads to significantly reduced costs to our health care, criminal justice, and social welfare systems. One cannot put a price on the social costs of not acting to help people who use substances, our most marginalized citizens because they are someone's mother, daughter, grandfather, brother... We need more time to explore new care pathways with community partners; gain empirical evidence around the effectiveness of the integrated care model; and develop a best practice model that could be used in other jurisdictions, sharing our experiences. The ICH evolved out of the pandemic, but we have an opportunity to make this a legacy that our community can be proud of.

10.6. POLICY BRIEF TO THE BOARD OF PUBLIC HEALTH

Policy Brief Submitted to the KFL&A Public Health Board
April 26, 2021
From the Integrated Care Hub - Kingston

BACKGROUND

In March of 2019, the City of Kingston adopted the Canada-wide lockdown and social distancing public health measures to stem the spread of COVID-19, resulting in many health and social service agencies not being able to provide support at regular capacity, or see people in person. Some services moved to online platforms, but many of our citizens have no internet access. Drop-ins, support groups, food programs, and other places where people used to congregate had to shut their doors, even public libraries with free internet access were closed. Shelter capacity was reduced, leading to tensions, uncertainty, and feelings of displacement among our homeless population, which continue. While shelters need to reduce their capacity to maintain social distancing protocols, doing so further isolates, and fails to meet the needs of those who use substances. In a drug-poisoning crisis, it is safest to be together, but in a global pandemic, it is safest to be apart.

The needs of substance users are often misunderstood, but social distancing measures hammered home the urgent need to provide help to those who experience chronic homelessness and use substances. The Integrated Care Hub (ICH) addresses three intersections of crisis: the COVID-19 pandemic, a complex housing crisis, and a drug-poisoning crisis. It was created by and is managed by three experienced front-line harm reduction advocates from the Street Health Centre and HIV/AIDS Regional Services. As the rise of variants to the COVID-19 virus have led to further surges and subsequent lockdowns, it is essential that the ICH remain open to serve the needs of Kingston's most marginalized citizens.

PROBLEM-SOLVING

The drug-poisoning crisis means that people who are using substances are dying tragically and at a terrifying rate due to a toxic drug supply with no respite from criminalization, demonization and stigmatization. From the Opiate Mortality Surveillance Report (June, 2019), 73.6 percent of fatal overdoses occurred among people living in a private dwelling and 9.8 percent occurred among people experiencing homelessness. Nearly half (48.6%) of deceased persons were alone at the time of incident. The number of opioid-related deaths increased quickly after the state of emergency declaration. Overall, there was a 38.2 percent increase in opioid-related deaths in the first 15 weeks of the pandemic.

According to Public Health Ontario's Interactive Opioid Tool, KFL&A experiences a 21.5 percent higher rate than provincial average of opioid-related deaths. The ICH has proven to be a life-saving program based on the number of overdoses responded to and reversed. In December 2020, the ICH responded to and reversed 70 overdoses on property. In January 2021, the Consumption and Treatment Service (CTS) responded to more overdoses than all of 2018 and 2019 combined.

ICH Residents

In order to know how to meet someone's needs, we need to understand how their needs were not met to begin with or were disrupted along the way. It is well known that many people experiencing chronic homelessness have experienced complex and chronic trauma histories that most often result in self-defeating patterns of behaviour. For example, we know that people who have an Adverse Childhood Experience Score of 4+, are 1,000 times more likely to inject substances. It is also important to acknowledge that people are experiencing significant systemic and structural violence within our community. The fact that people on income assistance like Ontario Works and ODSP are not able to access housing due to unrealistic rental rates is one example of systemic and structural violence. We also know that people who are a part of BIPOC, and 2SLGBTQ+ communities and women, experience significant intersectional oppression as well.

People who have complex, concurrent disorders (mental health and substance use) are often chronically homeless, disconnected from familial relationships, suffer with low self-esteem and little self-worth, live in a state of toxic stress, experience food insecurity, likely have higher rates of traumatic brain injuries, live with cognitive disabilities, and are often seen as non-productive and thus, not valued by our community. If a human being's basic needs are met, they are going to behave in predictable ways. We also know that if a person's basic needs are not met, they are going to behave in different, but predictable ways. "It is not our behaviour that defines our nature, it's our needs that define our nature. The behaviour reflects the degree to which those needs are met or they are not met" (Gabor Mate, 2008).

When governments make difficult decisions, like shutting down the economy in order to curb the spread of COVID-19, they consult with experts: epidemiologists, respirologists, health systems managers, etc. Our residents at the ICH are the experts about their lives, and what they need to stay alive, and hopefully one day, claim back their old lives. They all have memories of what life was like before they were homeless. The ICH has just completed a rapid needs assessment about people who frequent The Hub and use crystal meth and/or opiates. We hope above all, that the information gathered will guide the development of effective responses and drug policy to support people who use crystal meth and opiates and prevent overdose. A full report will be available before the end of May, 2021. What follows is a sample.

FINDINGS

<u>Demographics</u>
32 individuals aged 18 and over participated in one-hour semi-structured interviews conducted by ICH managers, team leads and the program coordinator (Feb 1- April 14, 2021). One of the limitations is a smaller female sample of 11 as compared to 21 males. This is evidence of the difficulty in reaching women under 30 who use substances, a hidden population often living with their dealers and/or involved in trafficking or survival sex work. In terms of self identified ethnicity, 47 percent of males were Caucasian and 36 percent of females; 33 percent of males had mixed Indigenous ancestry and 33 percent of females; 19 percent of males and 18 percent of females were Indigenous, and one female self-identified as being of mixed African decent. This highlights the over representation of Indigenous people in the homeless population. Fifty-two percent of males completed high school, while only one female did (half had dropped out by grade 10). From a developmental health lens, 56 percent of participants cited having a learning disability that impaired their schooling.

Mental health and trauma have been, and continue to be significant barriers to wellness in the ICH community. Ninety five percent of males and 91 percent of females indicated having had multiple mental health diagnoses over the life course. Five of 11 females lost a parent or closed loved one by age twenty, one male lost his grandmother and father in the same year and he dropped out of college, one male lost his mother to overdose at the age of 18, and 3 males have not spoken to their family members in over 20 years.

Only 24 percent of males and 45 percent of females indicated having a family doctor. Six males cited having had negative experiences in the health care sector and another three avoid care altogether. In the past year, males made an average of 3.7 trips to hospital, females 4.9. Of a total of 134 trips to hospital, mental health issues accounted for 38 trips, overdose 22, physical issues 18, and infections 8 (plus another 2 for endocarditis).

The evidence indicates that safe supply would save lives and visits to hospital. On average, males indicated they knew of 50 people who had overdosed, females an average of 57. Males had lost an average of 18 people close to them to death by overdose, females an average of 20. An average of 10 males had overdosed in the past year, and 2.8 females. Of these, 53 percent had been revived by friends, 34 percent by ICH staff, 28 percent by CTS staff, 19 percent by emergency responders, 9 percent by strangers, and only one person had been resuscitated in hospital. This indicates that it is the community itself that is responding to overdose, an incredibly traumatic phenomenon that leaves them in constant worry. As one respondent described what safe supply could do: ""It would change my life. I could be productive, not chase dope, not die... just live life!" Staff at the ICH and CTS are also lifesaving, which calls for the addition of self-care and counselling for them in these traumatic roles, in the same way that we provide supports to first responders.

Of significance is the evidence around substances used and links to overdose. People using crystal meth daily (and marijuana to sleep) overdosed 17 times. People using a combination of crystal meth and opioids (to sleep) daily, or binging on them, overdosed 59 times. People using Fentanyl daily (and crystal meth to 'get things done') overdosed 134 times. While the prevalence of crystal meth as first drug of choice for daily use (44%) is only slightly higher than that of Fentanyl (37.5%), the risk of overdose is almost double, and Fentanyl is tainting the crystal meth supply. If people who use substances could be treated for their physical and mental pain through pharmacology, and crystal users having access to clean product and marijuana for sleeping, rates of overdose would be dramatically reduced.

Ninety percent of males had been incarcerated, of which 57 percent indicated charges were drug related. For females, 73 percent had been incarcerated and 64 percent indicated charges were drug related. Early incarceration due to drug use dramatically changed people's lives. When discussing the prospect of decriminalization of street drugs for personal use, a middle-aged man said: "I don't think I would be in the situation I am in, if this [decriminalization] had always been a thing." A forty-ish female said" "The first time I ever went to jail was because of drugs. I was young and it messed me up."

The following is a sample of what respondents said when asked what they wanted the KFL&A community to know:
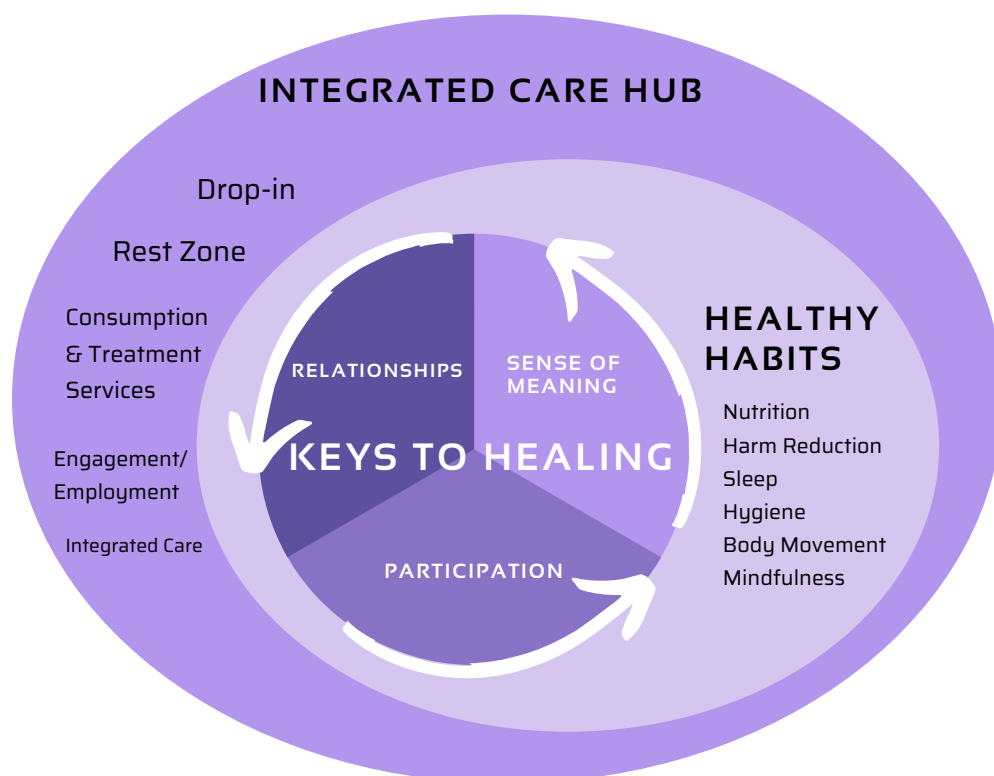
- "Housing… affordable housing – not renting a room from a slumlord that's not fit to live in. You leave and come home and your door is kicked in. I can't live like that or have my girlfriend in a place like that or a family in a place like that. If I could find housing before my child is born then I know I could keep our child" (30-ish Male).
- "Listen, learn… who knows, you might actually like me. Just a reminder, you are one shitty day away from being me" (20-ish Male).
- We should support each other, forming a community or organization, learning programs like technology, learning, living, giving people a fresh start (20ish Male).
- "I just want to see the stigma lifted! People think we are dirt balls and it's sickening" (30ish Male).
- Know that we need personal boundaries [a room], where we can own our own space, because we are always under attack" (30ish Male).
- "We are not all shady. There are some really amazing people. We just need a hand up, not a hand out!" (30ish Female).
- "… really help people, don't just pass by and act like we aren't real people. I'm a real person, I have feelings, real feelings, and they hurt" (30ish Female).
- "The shelter system could involve the community more in understanding and helping vulnerable people. Embrace one another" (middle-aged woman).

"We are doing a really, really good job here at The Hub. Our hearts are involved in this and we are really appreciative" (middle-aged female).

We need to be intentional and informed in creating supportive housing programs for people who use substances to ensure proper Overdose Prevention Supports are in place. Moving forward, we need to shift mental health service delivery to an integrated, wrap-around recovery care model geared to meet the unique needs of the people we serve. This means we believe we need to shift away from cognitive-oriented therapies as a first response. Instead, our goal should be getting people who use substances to a level of stabilization where they can think beyond daily - or hourly - survival. We can help them achieve stabilization through occupational therapy principles, good nutrition, and a mental health recovery approach that highlights the transitions from a life focused on illness and disability to one focused on action and participation.

The ICH has created a Nutrition Strategy to support stabilization based on gut microbiome health research and the positive effects that gut microbiome can have on mental health outcomes. Food is foundational to health and can significantly improve the brains and bodies of the people we serve. Teaching people how and what to eat is life-skills programming that can be used as a harm reduction tool to mitigate side-effects of chronic substance use and stress on the body and brain.

INTEGRATED CARE HUB

Drop-in

Rest Zone

Consumption & Treatment Services

Engagement/ Employment

Integrated Care

RELATIONSHIPS

SENSE OF MEANING

KEYS TO HEALING

PARTICIPATION

HEALTHY HABITS

Nutrition
Harm Reduction
Sleep
Hygiene
Body Movement
Mindfulness

RECOMMENDATIONS

1. More private spaces (e.g., couples), capacity, individual rooms;
2. On-site primary care & referrals;
   - Infections, cysts, endocarditis
   - Pain management
   - Address head trauma, broken bones
3. Systemic changes are needed;
   - Safe Supply
   - Decriminalization
4. Programs need to align with a more person-centred philosophy;
5. Services need to be more relationship-focused and violence & trauma-informed;
6. Increased supports that engage people in meaningful activity and support life skills; and
7. Effective community integration supports are needed to prevent ongoing homelessness.

We envision working with community partners to develop a fully integrated mental health recovery approach specific to the people we serve at the ICH: people with cognitive disabilities, brain injury, complex mental health and substance use issues. This recovery model includes meaningful engagement/employment opportunities using an anti-oppression approach with a nutrition strategy created to address substance use and mental health side effects.

We need time to develop new pathways to care for this population, specialized assessments, and to better understand what kind of human resources and training is needed to serve them best. We hope our work at the ICH can serve as a formal pilot project, so we can explore new care pathways with community partners; gain empirical evidence around the effectiveness of the integrated care model; and develop a best practice model that could be used in other jurisdictions, sharing our experiences.

We believe that our integrated care approach will lead to greater rates of recovery from mental health and substance use issues, and break cycles of inter-generational poverty and trauma. This will lead to a reduction in chronic homelessness in our community, which, in turn, leads to significantly reduced costs to our health care, criminal justice, and social welfare systems. One cannot put a price on the social costs of not acting to help people who use substances, our most marginalized citizens, because they are someone's mother, daughter, grandfather, brother. Their lot in life is greatly impacted by the structures in place. To counter this systemic marginalization, there must be a shared accountability for wellness. The Hub evolved out of the pandemic, and we think we have an opportunity to make this a legacy that our community can be proud of.

10.7. SYNOPSIS OF RECOMMENDATIONS

Kingston, Ontario is experiencing a drug poisoning crisis and a homelessness crisis during a global pandemic. In such dangerous times, it is not wise to make assumptions based on our pre-COVID knowledge. We believe that the people who frequent the Integrated Care Hub (ICH) – our stakeholders – know best what they are experiencing and what they need. A rapid needs assessment about people who frequent the ICH and use crystal meth and/or opiates was undertaken, and a detailed report generated. The information gathered will guide the development of effective responses and drug policy to support people who use crystal meth and opiates, and prevent overdose. It provides a wealth of information and suggestions from the stakeholders interviewed.

This document serves as a synopsis of new assumptions gleaned from the needs assessment, and proposes some recommendations to begin addressing them. We heard our stakeholders, and we now have some new ideas about how to help them to help themselves. This synopsis provides a start to mapping how community members and organizations can contribute to health and social justice for people who use substances in KFL&A. We hope to achieve a commitment from all health care and service agencies within the KFL & A Region – housing, policing, hospital and community services – to work together to address these recommendations.

Before we attempt to modify programming and operations, it is imperative that we first agree on an ethos that will guide our work, reflect on our positionality and privilege, and take an ethical stance around collective values and the six assumptions that arise from them, which are listed below.

Assumption #1 – Health and Social Justice for all citizens of KFL & A is the goal we are collectively striving for as service providers, friend and family members, neighbours, and society at large. The COVID-19 pandemic exposed how important stable housing is to health, but the overdose epidemic worsened, and continues to rob people of their lives every day, people 'who have people that care about them'. The Shadow Epidemic is incessant.

Implications
- People who are homeless and/or use substances are valued as much as other citizens, recognizing that their challenges are not just the result of individual choices, but of environmental and societal forces as well.
- People who are homeless and/or use substances are worthy of respect for their resilience and agency despite living in very challenging circumstances.

- We recognize that stakeholders at the ICH are the experts about their own lives and should be engaged in dialogue on the development of policy and of programming, and their evaluation.
- The tax dollars spent on policing, judicial and corrections have not curbed substance use, associated street crime, and the human suffering it entails. There must be a better way.

Assumption #2 – That stigma against people who are homeless and/or use substances is often perpetrated in most aspects of society (policy makers, health and social service providers, friend and family members, neighbours, and society at large). Though difficult to do, it is important that we acknowledge this within ourselves, and the harm that has been done in our institutions and communities, knowing we can do better by being accepting of what we have heard from stakeholders of the ICH.

Implications
- We must engage in self-reflection as to how our biases impact the lives of people who are homeless and/or use substances, as well as the organizations we work for and/or are affiliated with in an effort to identify and address stigma in all of its forms.
- Group discussions about moral injury and anti-oppressive approaches could start some of these challenging conversations in a way that is safe and constructive, and provides a common de-stigmatizing language, because language matters.
- We need to build empathy for people who use substances, that their plight is not one of individual failure, but that our systems have not been able to meet their needs and individual contexts, an issue we are attempting to address using the advice from our stakeholders at the ICH, and emerging best practices in science, medicine, and social science.
- Language is important: words like disorder, illness, and issues are individualizing and stigmatizing. We use the word challenges.
- We need to provide specialized training to front-line staff, managers and decisions makers around reflexivity, anti-oppression approaches and the prevention of moral injury.
- People who serve marginalized populations are often subject to potentially morally injurious events when they witness stigma or cannot get the help that people need because of policies and service restrictions, for example. They too need supports for their mental, emotional and spiritual well-being, similarly to First Responders.

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Implications
- We must engage in self-reflection as to how our biases impact the lives of people who are homeless and/or use substances, as well as the organizations we work for and/or are affiliated with in an effort to identify and address stigma in all of its forms.
- Group discussions about moral injury and anti-oppressive approaches could start some of these challenging conversations in a way that is safe and constructive, and provides a common de-stigmatizing language, because language matters.
- We need to build empathy for people who use substances, that their plight is not one of individual failure, but that our systems have not been able to meet their needs and individual contexts, an issue we are attempting to address using the advice from our stakeholders at the ICH, and emerging best practices in science, medicine, and social science.
- Language is important: words like disorder, illness, and issues are individualizing and stigmatizing. We use the word challenges.
- We need to provide specialized training to front-line staff, managers and decisions makers around reflexivity, anti-oppression approaches and the prevention of moral injury.
- People who serve marginalized populations are often subject to potentially morally injurious events when they witness stigma or cannot get the help that people need because of policies and service restrictions, for example. They too need supports for their mental, emotional and spiritual well-being, similarly to First Responders.

Assumption #3 – Many of those served at the ICH are people with complex conditions – cognitive, mental health and substance use challenges – who may or may not be homeless (e.g., they could be couch surfing or surviving outside of the homeless shelter system, but their housing is not stable). We refer to these complex conditions as "tri-diagnosis." [2]

2 See http://www.community-networks.ca/wp-content/uploads/2015/11/survey-report-oct-15v.pdf

Implications

- There are significant chronic health challenges as well as mental health and addictions challenges that need to be addressed. Head injury, infections, chronic pain and PTSD (especially females) are pervasive within this population, and inter-related.

- A linear model of recovery and associated health outcomes is not practical for this population who lack stability in their lives (housing, employment, mood, caring relationships, etc.), where day-to-day survival is what drives them. They need to first experience a feeling of stability and safety ("consistency and predictability across time" – Vikki Reynolds) before they can begin the difficult work of dealing with the roots of their addiction (ACES, intergenerational trauma, etc.).

- A fully integrated whole person healing-centered approach specific to stakeholders we serve that addresses the many steps they will take (and likely re-take) on their healing journeys.

- Housing and meaningful engagement/employment are ultimately involved within the healing journey to wellness and independence but must be low barrier at the outset given the prevalence of cognitive and mental health challenges within the population of people who are experiencing homelessness and/or who use substances.

- For people who are experiencing homelessness and/or who use substances, sobriety should not be the first goal to recovery. Most of the ICH stakeholders interviewed indicated they would continue to use substances even when housed. Thus harm reduction practices must be an on-going feature in wellness programming for this population. Most indicated that a safe supply program would allow them to integrate back into employment without the constant fear of overdose, or having to engage in street crime for income.

- There are significant structural barriers to realizing a healing centred engagement approach to wellness (which takes time) that need to be identified and addressed, given the siloed nature of government funded services and the precarious funding of not-for-profits.

Assumption #4 – The people served at the ICH are often disconnected from their biological family and the people they knew before they became street-involved. This is either forcibly because those relationships deteriorated under the strain of living with someone with mental health and addictions challenges, or by choice as the person afflicted attempts to shield their loved ones from the pain and afflictions they suffer. Additionally, intergenerational trauma is often a source of pain. Rather, their social support net often consists of people in similar situations as they are – people in day-to-day survival mode – who nonetheless look out for each other, especially as it pertains to the threat of overdose.

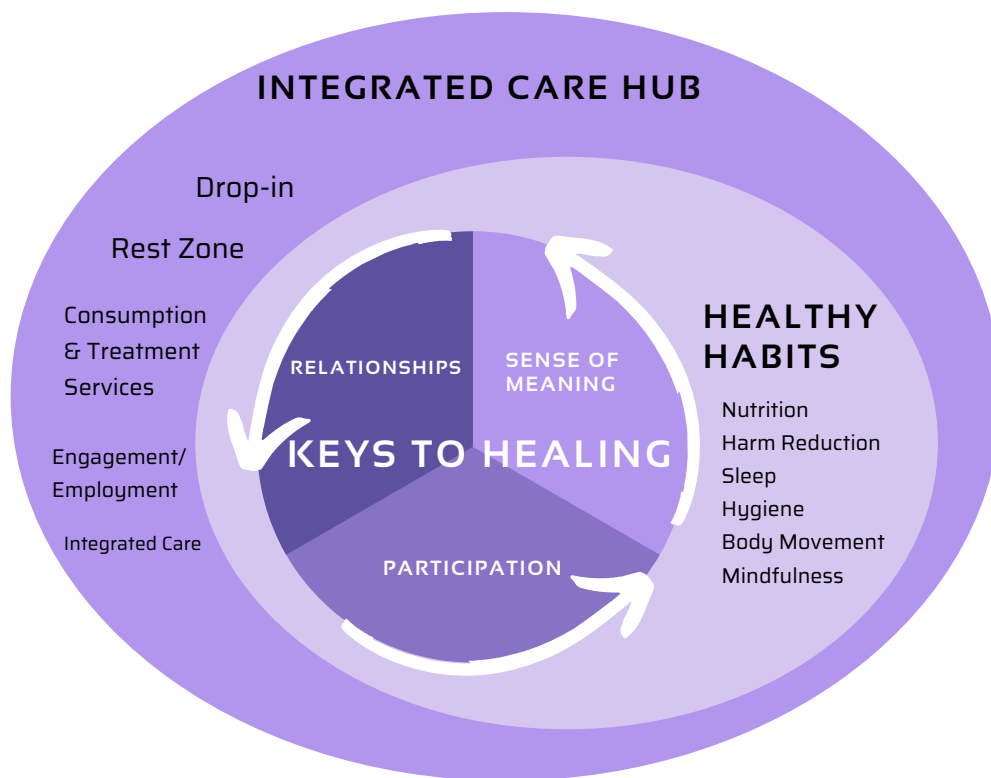| STEP 1- ICH STABILIZATION	STEP 2- SUPPORTED COMMUNAL LIVING SCAFFOLDED SUPPORTS	STEP 3- INDEPENDENT LIVING CHECK-INS, LINKAGES
• SHELTER • FOOD • HARM REDUCTION • MEANINGFUL ENGAGEMENT	• PERSONAL SPACE • WELLNESS PROGRAMS • COMMUNITY & SOCIALIZING • MEANINGFUL ACTIVITIES • PEER SUPPORT • HARM REDUCTION	• EMPLOYMENT • WELLNESS PROGRAMS • MEANINGFUL ACTIVITIES • MENTORING • HARM REDUCTION

Implications

- In the initial stages of the healing journey, people need their community at the ICH.
- Later, the healing centred engagement model should provide opportunities for people to contribute and reintegrate into family and community before being expected to live independently, as many need to redevelop a social safety net, and rebuild their identity and self-confidence.

Assumption #5 – The people served at the ICH want to work, to contribute to society, to reconnect with their children, and remember a life before using substances and/or homelessness. Almost all are looking for a second chance, what they describe as "a hand up, not a hand out". However, survival on the streets has had a significant impact on their cognitive, physical and mental health. One participant suggested if we knew what they were good at, and what they liked, we could develop customized programming to help them build on their gifts.

Implications

- We need time to develop new pathways to care for people with tri-diagnosis and specialized assessment.
- We need to better understand what kind of human resources and training are needed to serve them best.
- We need to explore ways to engage ICH stakeholders in social entrepreneurship and trades.

INTEGRATED CARE HUB

Drop-in

Rest Zone

Consumption & Treatment Services

Engagement/ Employment

Integrated Care

RELATIONSHIPS

SENSE OF MEANING

KEYS TO HEALING

PARTICIPATION

HEALTHY HABITS

Nutrition
Harm Reduction
Sleep
Hygiene
Body Movement
Mindfulness

With the help of community health and social service partners, is hoped that the work at the Integrated Care Hub can serve as a formal pilot project, so new care pathways can be explored with community partners, empirical evidence around the effectiveness of the integrated care model can be collected, to lead to the development of a best practice model that could be used in other jurisdictions through sharing our experiences.

Assumption #6 – There is a lack of decent, safe, affordable housing in Kingston, particularly for individuals living in low-income, and/or dealing with physical, cognitive, mental health and/or substance use challenges.

Implications

- Like the Marshall and colleagues "Beyond Surviving" report (2021) on homelessness in Kingston, similar issues and subsequent recommendations are raised by the ICH's needs assessment. We support the 9 recommendations of the Marshall and colleagues report, adding two more (see the Housing and Supports section on page 7).

What follows is a synopsis of recommendations based on the results of the rapid needs assessment.

#1. ANTI-STIGMA TRAINING AND AWARENESS STRATEGY

How we value people with tri-diagnosis seeps into institutions and curricula, leading to stigmatization, exclusion, and marginalization.

Recommendations:

1.1 Use the testimonies of ICH stakeholders to inform an anti-stigma strategy across the KFL&A region
- Partner with the Community Drug Strategy's Stigma Subcommittee
- Articulate how prohibition policy and practice is not helping the overdose epidemic or keeping citizens safe from the dangers of substance use

1.2 Building compassion on the front line: quick resources that organizations can provide to their managers and staff, in hospitals and community
- The Best Explanation of Addiction I've Ever Heard – Dr. Gabor Maté – Bing video
- Johann Hari: Everything you think you know about addiction is wrong | TED Talk
- Nadine Burke Harris: How childhood trauma affects health across a lifetime | TED Talk

1.3. Develop a long-term strategy for curriculum and training based on anti-oppression
.   theories and dialogical action
- A coordinated commitment by all social service organizations to commit to not tolerating discrimination against people who use substances. This includes a commitment by leadership for education/training to build compassion for people with mental health and substance use challenges who may or may not be experiencing homelessness
- Resource: Pedagogy of the Oppressed, a short book by educator, Paolo Freire, 1970 https://envs.ucsc.edu/internships/internship-readings/freire-pedagogy-of-the-oppressed.pdf

#2. HARM REDUCTION, DECRIMINALIZATION AND IN-PATIENT REHABILITATION

Harm reduction alone in community mental health settings will not be sufficient to move people forward on their healing journeys, but it will help ensure they are not dying of drug poisoning.

Recommendations:

   2.1. Increase access to CTS

   2.2. Healing journey: provide both abstinence-only and harm reduction approaches

   2.3. Publicly funded in-patient rehabilitation and stabilization

   2.4. Decriminalization of substances for personal use (build on the support received from
.   the Board of Public Health and Municipalities of KFL&A)

   2.5. Safe-supply pilot at the ICH (crystal meth, fentanyl, medical marijuana) using a
.   medical/prescription approach to drug regulation

#3. PREVENTING MORAL INJURY (UNREPAIRED SHAME)

Moral injury is described as a from of psychological difficulty, an interpersonal crisis, or a spiritual wound resulting from learning about, bearing witness to, failing to prevent, being a victim of or perpetrating any event that transgresses one's subjective moral standards or deeply held personal beliefs. It can also result from the betrayal of justice by a person of authority (Nazarov, 2020). The risk of experiencing morally injurious events by stakeholders is related to stigma, service interruptions, street life, and trying to take care of their community during the housing/drug poisoning/COVID-19 crisis. For workers and management serving them, morally injurious events are related to reversing and witnessing overdoses, and not being able to get people the help they need. Moral injury is an injury of the heart and/or soul when the mind is unable to find meaning around situations of injustice. It can involve feelings of guilt, shame, and anger, which can also lead to shaming and blaming behaviours as a defense mechanism.

Recommendations:

   3.1. Anti-stigma training and awareness

   3.2. Check-ins around potentially morally injurious events

   3.3. Grief counseling for the ICH community, staff and management

   3.4. Counseling for front line workers around exposure to morally injurious events and
.   the debilitating effects of burnout

- Resources:
  - Nazarov, A. (2020). "What is moral Injury? An Overview." 2020 CIMVHR Symposium Series - Unpacking Moral Injury: Current Understanding, Gaps, and Future Directions, October 29, sourced from https://symposium-series.cimvhr.ca/en/2020/moral-injury
  - Understanding Moral Injury on the front lines of a pandemic: https://youtu.be/AybMPLVbtvg
  - Moral Stress Amongst Healthcare Workers during COVID-19: A Guide to Moral Injury, sourced from https://www.moralinjuryguide.ca/wp-content/uploads/2020/07/Moral-Injury-Guide.pdf
  - Brené Brown, Listening to Shame and Daring Greatly: https://youtu.be/psN1DORYYVO
  - The Zone of Fabulousness, Vikki Reynolds: https://www.youtube.com/watch?v=XLmxb2sc_Nc

#4. HEALING CENTRED ENGAGEMENT (HCE), WELLNESS SERVICES AND PROGRAMMING

People who frequent the ICH are likely to suffer the 'tri-diagnosis' of cognitive, mental health and substance use challenges. Their psychological trauma also manifests physically. Typically, the first care approach to such complex conditions is cognitive: to provide substance use and addiction counselling and treatment services. That needs to change (Luteijn et al., 2020 [3] ; McQuaid et al., 2018) [4] . Moving from a perpetual state of surviving to thriving is a complex journey, requiring addiction medicine, psychiatry, occupational therapy and disability care professionals to join forces, also culture, spirituality, civic action and community.

Recommendations:

4.1. Nutrition Strategy - The ICH needs stable funding for the implementation of its Nutrition Strategy to support stabilization based on gut microbiome health research and positive effects on mental health outcomes.
- Resource: Impact of Gut Health for Mental Health and Relapse Prevention https://www.youtube.com/watch?v=VJLR1uzEXq8

3   https://www.semanticscholar.org/paper/Post-traumatic-stress-disorder-and-substance-use-in-Luteijn-VanDerNagel/62bfb335deb3fc4caa7e30251b2fff546913f2fd

4   https://www.semanticscholar.org/paper/Examining-Barriers-as-Risk-Factors-for-Relapse%3A-A-McQuaid-Jesseman/eff492ffd3d8debf2143d5feb9edc59535d432de

4.2. Expanding medical care and on-site primary care: permit quick and on-going treatment of infections, cysts, and endocarditis that require safe administration of antibiotics; pain management for people with physical disabilities; pathways for head trauma; broken bones assessed for referral.

- Resource: Comprehensive Person-Centred Pain Management: Common Themes and the Way Forward: https://symposium-series.cimvhr.ca/video/chronic-pain.mp4

4.3. Integrated Care within a bio-psycho-social-spiritual community-based approach (Jaiswal et L, 2020 [5]; McQuaid et al., 2018) emphasizing belonging and enhancing social connections, including reconciliation-based family programming.

- Resource: The New Paradigm: Healing Centered Engagement (Ginwight, 2020), https://youtu.be/MKUNtOUQuFM

4.4. Occupational therapy and the development of personalized care plans through dialogical action, building up people's potential, hope and optimism about the future.

- Resource: Canadian Association of Occupational Therapists' 2019 Conference on Addressing Addiction, https://caot.ca/document/6886/PIF%20Report_Addressing%20Addiction_2019.pdf

4.5. Novel therapies for dealing with trauma 'wounds':
- Somatic therapies for healing trauma wounds
  - Resource: Healing Trauma by Peter Levine: Resolving the Trapped Fight/Flight/Freeze Response, https://youtu.be/twMSB8yuZbw
- Eye movement desensitization and re-imagination (EMDR)
  - Resource: What is EMDR Therapy? https://youtu.be/1IPsBPH2M1U

4.6. Implement Indigenous-led healing modalities, and recognition that settler colonialist systems are at the root of the disproportionate social, health and well-being challenges experienced by Indigenous Peoples on and off Reserves.

- Resources:
  - Blending Aboriginal and Western Healing Methods to Treat Intergeneratinoal trauma with Substance Use Disorder in Aboriginal Peoples who Live in Northeastern Ontario - https://harmreductionjournal.biomedcentral.com/track/pdf/10.1186/s12954-015-0046-1.pdf
  - Engaging Indigenous People who use Substances - https://rnao.ca/bpg/courses/engaging-indigenous-people-who-use-substances
  - Indigenous Peoples and COVID-19 - https://www.canada.ca/en/public-health/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/from-risk-resilience-equity-approach-covid-19/indigenous-peoples-covid-19-report.html

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5 https://www.semanticscholar.org/paper/Essential-Elements-That-Contribute-to-the-Recovery-Jaiswal-Carmichael/9c064f3eae44fea2b1902eb0259fc8bc49045c88

#5. LIFE SKILLS TRAINING, EMPLOYMENT AND MEANINGFUL ACTIVITY

Staving off drug dealing, theft, as well as lowering the risk of involvement in trafficking or survival sex work requires a constellation of innovative interventions.

Recommendations:

5.1. Low-threshold employment opportunities for people who use substances (learning, cognitive and physical disabilities can negatively impact employability).

5.2. ICH's Community Support Program (CSP) - hiring of people with lived or living experience to act as peer supports: formal paid employment, engagement, and participation in decision-making activities like program planning and problem-solving.

5.3. Social Entrepreneurship.

5.4. Life skills training, mentoring, peer programming.

5.5. Meaningful Activity – creative and therapeutic modalities.

#6. HOUSING AND INCOME SUPPORTS

Addressing an unmet need in our community, the ICH provides a supervised environment for people who use substances and/or may be experiencing homelessness who may otherwise congregate in encampments, without the safety measures of Consumption and Treatment Services, crisis and overdose intervention, and security patrols of the area in which these people now congregate around the ICH.

Recommendations:

6.1. For emergency shelters, more private rooms are needed: capacity for physical isolating (infectious disease control), privacy for couples, ability to lock away belongings to reduce theft.

6.2. Sustainable support for the ICH to continue services that are low-barrier, accessible and trauma-informed that serve a pre-existing community with cognitive, behavioural, mental health and/or substance use challenges (Marshall et al., 2021, recommendation #2, #4, & #8).

6.3. Also needed is a second stage housing option for people in active substance use that allows for communal living with the privacy of personal space as well as the ability to access on-site wrap-around supports based on the individual goals of a person's healing journey.

6.4. Overdose prevention needs to be prioritized in the development and delivery of care programming.

6.5. Income supports that are equitable: Participants strongly stated the need for affordable, safe, healthy, decent housing for lower income persons and families. This situation is inequitable for people on social assistance and/or a fixed income whereby people who are unable to work for whatever reason, are treated differently (Marshall et al., 2021, recommendation #9).

POPULATIONS REQUIRING SPECIAL CONSIDERATION

The following populations have unique needs, and further consultation with them is required to better understand how to serve them.

1. Outreach to women under 30 who use substances who are under-represented in the needs assessment, and may be subject to trauma, violence, involvement in trafficking or survival sex work
2. People who self-identify as Indigenous are over-represented in the needs assessment, are subject to a history of intergenerational trauma and poverty, are repeatedly exposed to potentially morally injurious events due to systemic racism and lateral violence, are often forbidden from practicing their own spiritual healing rituals or cannot access culturally appropriate and safe programming.
3. Veterans, who may have a history of trauma, PTSD, exposure to potentially morally injurious events, and concerns over help-seeking as potentially stigmatizing within their professional culture.
4. People who are physically disabled and/or suffering from chronic pain: Mental health and substance use challenges will exacerbate their chronic conditions, creating negative feedback loops that may keep them from participating in the formal labour force indefinitely, but they still wish to be contributing members of society. Chronic pain may limit the employment they can engage in.

CONCLUSION

The ICH needs assessment involved consultations with 32 stakeholders who have used/use crystal meth and/or opioids. Challenges to social, health, criminal justice and education systems have been identified, many beyond the scope of the ICH. Five major assumptions on how to better the lives of these people are articulated, providing a 'spirit of moving forward' that acknowledges health and social justice for all; that stigma and discrimination exists in our institutions that has caused harm; that the people served at the Hub have very complex conditions referred to as tri-diagnosis; that people who use substances have a specialized community of their own but long for a 'second chance' to reintegrate into employment and reconnect with their families; and that an integrated care model could be the key to their healing. Four populations worthy of special consideration and further inquiry are identified: women under thirty, Indigenous people, Veterans, and people with chronic pain and/or physical disabilities. Six broad areas of recommendations on how we can do better are outlined: anti-stigma training and awareness; harm reduction, decriminalization, and in-patient rehabilitation; prevention of moral injury; healing centred engagement and wellness services and programming; life skills training, employment, and meaningful activities; and housing and income supports. We hope the recommendations contained in this synopsis inform collaborative problem solving and program design across sectors to better our current provision of supports to people who use substances by addressing systemic challenges. The staff and management at the Integrated Care Hub cannot accomplish this alone. We hope to achieve a commitment from all health care and service agencies within the KFL & A Region – housing, policing, hospital and community services – to work together to address these recommendations.