"Safe, More Dignified, Based on My Humanity"

What We Heard:

Report on engagement with people who have lived and living experience with substance use regarding an Overdose Prevention Site

Chief Public Health Office
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Executive Summary

BACKGROUND

In Canada and Prince Edward Island (PEI), illicit drug toxicity poisonings (overdoses) are on the rise. The Department of Health and Wellness (DHW) has a mandate to establish a safer consumption service in the form of an Overdose Prevention Site (OPS).[1] The following *What We Heard* report presents the findings of engagement with people who have lived and living experience with substance use regarding an OPS.

PURPOSE AND RESEARCH QUESTION

Engagement with people who have lived and living experience is at the heart of harm reduction. To that end, a survey was administered to answer the following question: "What type of service model (and other requirements) for an Overdose Prevention Site will meet the needs of people who have lived and living experience with substance use?"

RESEARCH APPROACH AND METHODOLOGY

The survey was developed through QuestionPro and was completed online and in-person. DHW and community partners worked together to recruit participants and administer the survey. Participants were provided a $10 gift card as reimbursement for their time and expertise. Quantitative data were analyzed using QuestionPro™ and Excel™, while qualitative data were thematically analyzed using Nvivo™.

KEY FINDINGS

A total of 55 participants completed the survey. When similar OPS engagement was implemented in Moncton – a city with twice the population of Charlottetown – 70 responses were collected. Using this as a benchmark, the 55 responses collected in Charlottetown is an encouraging response.

- **Gender**: 38 participants (70%)[2] self-identified as men, pointing to the needs of this demographic but also the need to ensure that underrepresented groups are able to access services at an OPS.
- **Age**: 33 participants (61%)[3] self-identified as between the ages of 30 and 49.
- **Demand for an OPS**: 48 participants (87%) stated that they would go to an OPS if one was available.
- **Reasons for going to an OPS**: The most frequently cited reasons for going to an OPS were for safety (“so I don’t die”) and due to risk of overdose (“dangerous now due to fentanyl”).
- **Frequency of visits to an OPS**: 29 participants (53%) stated that they would go to an OPS once per day or more than once per day.
- **Reported locations of substance use**: All 55 participants (100%) self-reported substance use in a public space during the last 6 months. This clearly demonstrates the need for a safer, designated space for supervised consumption.
- **Hours of operation**: The vast majority of participants suggested that an OPS should be open 7 days per week.
- **General location**: Consistent with OPS facilities across Canada, participants stated that the OPS should be in a central area, within a short walking distance of services they currently access.

[1] An OPS is a federally approved service that provides a safer, supervised environment for people to consume pre-obtained substances, and receive medical assistance from trained staff should a person experience an overdose

[2] As one participant skipped this question, 70% represents 38 of 54 participants.

[3] As one participant skipped this question, 61% represents 33 of 54 participants.

- **Additional services**: In addition to services already provided at an OPS, participants shared that an OPS could connect them to medical, housing, and addictions and mental health services.
- **Modes of consumption**: Intravenous (injection) and inhalation (smoking) were the most frequently reported modes of consuming substances, representing 72% of responses.
- **Substances consumed**: A combination of opioids (i.e., hydromorphone/Dilaudid) and stimulants (i.e., crystal meth) were the most frequently reported substances consumed – though this varied depending on the mode of consumption.
- **Experience with overdose**: Of the 13 participants who reported experiencing a drug-related overdose in the past 6 months, 9 of 13 reported that they did not seek medical attention, and 6 of 13 reported that naloxone was used in response.

Overall, findings from this engagement support the need for an OPS as a safer, designated space for supervised consumption and other supports. Findings from engagement will help ensure that the OPS meets the needs of its clients/participants.

Sommaire

CONTEXTE

Au Canada et à l'Île-du-Prince-Édouard (Î.-P.-É.), les intoxications aux drogues illicites (surdoses) sont à la hausse. Le ministère de la Santé et du Mieux-être (le ministère) a le mandat de mettre en place un service de consommation plus sûr sous la forme d'un site de prévention des surdoses (SPS)[4]. Le rapport suivant sur ce que nous avons entendu présente les conclusions d'une mobilisation des personnes ayant une expérience vécue passée ou actuelle liée de consommation de substances concernant un SPS.

OBJECTIF ET QUESTION DE RECHERCHE

La mobilisation des personnes qui ont une expérience vécue passée ou actuelle est au cœur de la réduction des méfaits. À cette fin, un sondage a été administré pour répondre à la question suivante : « Quel type de modèle de service (et autres exigences) pour un site de prévention des surdoses répondra aux besoins des personnes ayant une expérience vécue passée ou actuelle de consommation de substances? »

APPROCHE ET MÉTHODOLOGIE DE RECHERCHE

Le sondage a été élaboré à l'aide de QuestionPro[MC] et a été rempli en ligne et en personne. Le ministère et les partenaires communautaires ont collaboré pour recruter des participants et administrer le sondage. Les participants ont reçu une carte-cadeau de 10 $ pour les compenser pour leur temps et leur expertise. Les données quantitatives ont été analysées à l'aide de QuestionPro[MC] et d'Excel[MC], tandis que les données qualitatives ont fait l'objet d'une analyse thématique au moyen du logiciel Nvivo[MC].

PRINCIPAUX CONSTATS

Un total de 55 participants ont rempli le sondage. Lorsqu'une activité de mobilisation semblable concernant les SPS a été mise en œuvre à Moncton – une ville comptant le double de la population de Charlottetown – 70 réponses ont été recueillies. En se basant sur ces données comme point de repère, les 55 réponses recueillies à Charlottetown constituent une réponse encourageante.

- **Sexe** : 38 participants (70 %) s'identifiaient comme des hommes, ce qui montre les besoins de ce groupe démographique, mais aussi la nécessité de veiller à ce que les groupes sous-représentés soient en mesure d'accéder aux services d'un SPS.
- **Âge** : 33 participants (61 %) ont indiqué qu'ils avaient entre 30 et 49 ans.
- **Demande pour un SPS** : 48 participants (87 %) ont indiqué qu'ils fréquenteraient un SPS si ce service était disponible.
- **Raisons pour aller à un SPS** : Les raisons les plus fréquemment citées pour aller à un SPS concernaient la sécurité (« pour que je ne meure pas ») et le risque de surdose (« c'est dangereux maintenant en raison du fentanyl »).
- **Fréquence des visites à un SPS** : 29 participants (53 %) ont indiqué qu'ils iraient à un SPS une fois par jour ou plus d'une fois par jour.
- **Endroits mentionnés pour la consommation de substances** : Tous les 55 participants (100 %) ont indiqué avoir consommé des substances dans un lieu public pendant les six derniers mois. Cela

[4] Un SPS est service approuvé par le fédéral qui fournit un environnement plus sûr et encadré permettant aux gens de consommer des substances qu'ils ont obtenues et de recevoir une aide médicale de la part de membres du personnel formés s'ils se retrouvent en surdose.

montre clairement le besoin d'un endroit désigné et plus sécuritaire pour la consommation supervisée.

- **Heures d'ouverture** : La grande majorité des participants ont suggéré que le SPS soit ouvert 7 jours sur 7.
- **Emplacement général** : Comme pour les autres SPS au Canada, les participants ont indiqué que le SPS devrait être dans un lieu central, à une courte distance de marche des services qu'ils fréquentent actuellement.
- **Services additionnels** : En plus des services déjà fournis à un SPS, les participants ont mentionné qu'un SPS pourrait les mettre en relation entre autres avec les services médicaux, de logement ainsi que de toxicomanie et de santé mentale.
- **Modes de consommation** : La consommation par intraveineuse (injection) et par inhalation (fumer) était les modes les plus fréquents de consommation de substances, représentant 72 % des réponses.
- **Substances consommées** : Les opioïdes (c.-à-d., hydromorphone/dilaudide) et les stimulants (c.-à-d., méthamphétamine en cristaux) étaient les substances consommées les plus mentionnées – même si cela variait selon le mode de consommation.
- **Expérience de surdose** : Parmi les 13 participants qui ont indiqué avoir vécu une surdose liée à la consommation de drogues au cours des 6 derniers mois, 9 sur 13 ont indiqué qu'ils n'avaient pas demandé d'aide médicale, et 6 sur 13 ont indiqué avoir utilisé la naloxone comme traitement.

Globalement, les constats découlant de cette initiative de mobilisation confirment le besoin d'un SPS comme espace désigné et plus sécuritaire pour la consommation supervisée et l'obtention d'autres soutiens. Les conclusions tirées de cette initiative de mobilisation aideront à s'assurer que le SPS réponde aux besoins de ses clients / participants.

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Abbreviations

CPHO: Chief Public Health Office

DHW: Department of Health and Wellness

OPS: Overdose Prevention Site

SCS: Supervised Consumption Site

UPHNS: Urgent Public Health Need Site

Introduction

Background

In Canada and Prince Edward Island (PEI), illicit drug toxicity poisonings (overdoses) are on the rise. This is driven largely by fentanyl and fentanyl analogues, which have made the illicit drug supply increasingly toxic. According to Health Canada, during the first year of the COVID-19 pandemic there was a 96% increase in apparent opioid-related deaths in Canada compared to the previous year.[5] PEI has also seen an increase in opioid-related overdoses and deaths over the same period of time.[6] Harm reduction[7] interventions have been proven to save lives and promote both public health and public safety.

The following *What We Heard* report presents the findings of engagement with people who have lived and living experience with substance use regarding an Overdose Prevention Site (OPS). An OPS is a federally approved service that provides a safer, supervised environment for people to consume pre-obtained substances, and receive medical assistance from trained staff should a person experience an overdose. OPS, and related harm reduction services, provide the following benefits (Kennedy et al., 2017):

- Prevent drug-related overdoses and deaths;
- Prevent bacterial, viral, and other infections (i.e., HIV, hepatitis C, endocarditis, cellulitis, etc.);
- Connect people to treatment and other supports (i.e., medical, housing, income, etc.);
- Improve public order, reduce public substance use, and reduce discarded needles in public spaces; and
- Cost savings (i.e., reduced health spending by preventing illness and hospital admissions).

Most importantly, an OPS and related harm reduction services help people live with greater dignity and respect for their human rights.

An OPS is made possible through Health Canada's *Subsection 56(1) Class Exemption in Relation to Urgent Public Health Need Sites (UPHNS) in PEI*. Under this exemption, the Minister of Health and Wellness can establish an UPHNS, and can identify a "designated person" to act as operator of the UPHNS.[8] An UPHNS can be used to establish an OPS, a drug checking service, or both services. An OPS allows for effectively the same scope of services as a Supervised Consumption Site (SCS). An OPS is preferred as it allows for greater flexibility on staffing and service delivery, and the fact that PEI currently has in place the required exemption from Health Canada – making it a more timely, flexible option.

More information can be found at the Government of PEI's Harm Reduction Services and Supports webpage.

[5] Health Canada. (2022). Opioid and Stimulant-Related Harms in Canada. Available at: https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants/

[6] Government of PEI, Department of Health and Wellness. (2022). Preventing Opioid-Related Overdoses: https://www.princeedwardisland.ca/en/information/health-and-wellness/preventing-opioid-related-overdoses

[7] Harm reduction is any policy, program or service that helps a person or community reduce harms related to substance use without necessarily requiring a decrease in substance use. Prevention, treatment, and harm reduction all work together to help build healthy and safe communities.

[8] Health Canada. (2022). Subsection 56(1) Class Exemption in Relation to Urgent Public Health Needs Sites in Prince Edward Island.

Purpose

Lived and living experience engagement is at the heart of harm reduction. It is essential that people with lived and living experience with substance use can participate meaningfully in the development of harm reduction services and supports such as an OPS.

To that end, a survey was administered to answer the following research question: "What type of service model (and other requirements) for an Overdose Prevention Site will meet the needs of people who have lived and living experience with substance use?"

Public Policy

The Department of Health and Wellness (DHW) has a mandate to establish a safer consumption service in the form of an OPS.[9] In March 2022, the Harm Reduction Coordinator was hired to implement this mandate. To support this work, the Harm Reduction Coordinator formed the Community Harm Reduction Steering Committee, and started engagement with people who have lived and living experience with substance use. Findings from engagement activities are summarized in this report.

Research Approach and Methodology

Survey Design

The OPS lived and living experience engagement survey was developed through QuestionPro™, an online survey software. The survey included both quantitative questions (closed-ended, check all that apply, rank order) and qualitative questions (open-ended). Question were based in-part on similar surveys from other jurisdictions as they developed their own OPS or SCS. Responses were anonymous, though participants had the option of self-identifying. See Appendix A for survey questions.

Survey Administration and Recruitment of Participants

The OPS survey was distributed, administered, and returned in both online and in paper format. The survey was promoted by sharing URL links and social media posts with stakeholders, and through posters displayed at service hubs like the Community Outreach Center, P.E.E.R.S Alliance, the Native Council of PEI, the Queen Street Recovery Clinic, and Health PEI Public Health (Charlottetown Needle Exchange Program site and the Hepatitis C Treatment Program site). The poster included information on the survey, a link and QR code to the survey, and contact information (see Appendix B).

To support accessibility, participants had the option of completing the survey online, or in-person with support of a survey administrator. Survey administrators included the Harm Reduction Coordinator, and the agencies listed in the previous paragraph.

Consistent with the harm reduction principle of meaningful lived and living experience engagement, participants were provided a $10 gift card as reimbursement for their time in completing the survey. Participants who completed the survey in-person were provided with a gift card upon completing the survey. Participants who completed the survey online were given the option of providing any of the

[9] Government of Prince Edward Island. (2021). Prince Edward Island Budget Address. Available at: https://www.princeedwardisland.ca/sites/default/files/publications/budget_address_2021.pdf

following forms of contact information so that they could receive an e-gift card: email, phone number, or mailing address.

The survey was launched on May 17, 2022 and analysis began on September 1, 2022.

Survey Sample

Eligible participants were those who self-identified as a person who has consumed street-source (illicit) substances/drugs in the last 6 months. Due to the stigma faced by people who use drugs, a randomized sample – with a population that is well-defined and where participants are randomly selected – was not considered feasible. As a result, the survey's sample is non-probabilistic.

A combination of voluntary sampling, convenience sampling and snowball sampling were used to identify survey participants (Edwards, Thomas, Rosenfeld & Booth-Kewley, 1997). This combination of sampling methods proved effective in recruiting people from a population that experiences high levels of marginalization, and is therefore harder to reach. For example, when similar OPS engagement was implemented in Moncton – a city with twice the population of Charlottetown – 70 responses were collected. Using this as a benchmark, the 55 responses collected in Charlottetown is encouraging.

Data Analysis

Data collected through quantitative survey questions were analyzed using QuestionPro's™ built-in analytics. Data collected through qualitative (open-ended) survey questions were thematically analyzed using the Nvivo™ application.

In practice, thematic analysis means that qualitative data was reviewed as a whole, and then codes were assigned to specific responses. Codes were then organized into themes, which serve as the basis for key findings identified in the qualitative data (Braun & Clarke, 2012). See Figure 1 for a visual description of this process.

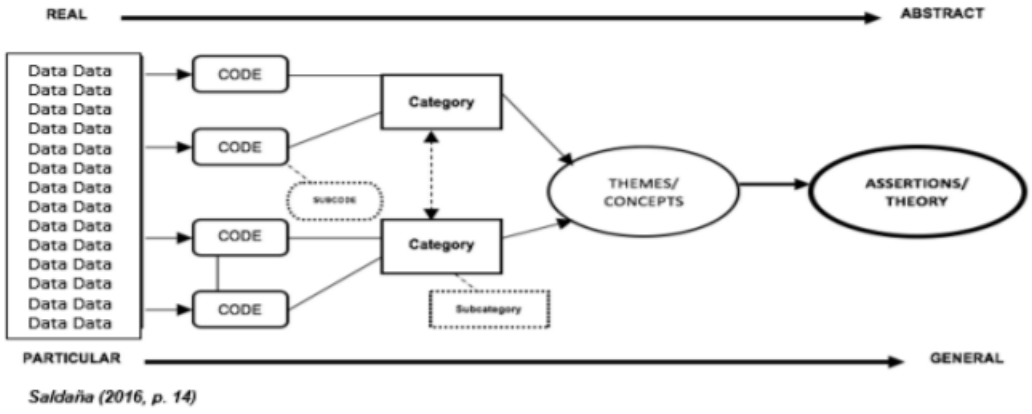

Figure 1. Thematic analysis process

Limitations and Delimitations

One limitation of this survey is related to the sampling method. As noted, people with lived and living experience with substance use often experience significant stigma and marginalization. As a result, it is difficult to "define" this population's exact numbers – let alone reach people to participate in surveys.

While this means that findings should not be considered statistically representative of the entire population of people who have lived and living experience with substance use, the methods chosen were appropriate to the context and produced valuable findings.

With regards to delimitations — choices made which set boundaries for research — survey data selected for analysis was collected between May 17, 2022 and September 1, 2022. However, the number of responses received is considered appropriate for the population engaged. Further, when analyzing the data collected, clear themes emerge in the survey's findings. This suggests that the data collected reached the point of "saturation" and that it is unlikely that entirely new findings would have emerged by waiting for more responses before analyzing the data.

Results

From May 17, 2022 and September 1, 2022, a total of 64 survey responses were collected. However, the survey's first question screened participants for eligibility: "Have you consumed street source substances / drugs in the last 6 months?"

A total of 55 respondents answered "yes" to this question, meaning their responses were included for analysis. Respondents who completed the survey in-person and answered "no" to the screening question were still able to complete the survey, share their feedback and receive a gift card as reimbursement.

Participant Demographics

To protect the anonymity of participants, demographic questions were kept to a minimum. Participants were, however, asked to select their current gender identity and their approximate age.

As shown in figure 2, when **asked to select their current gender identity**, 38 participants (70%) self-identified as men, 13 participants (24%) self-identified as women, and 3 participants (6%) self-identified as non-binary / gender diverse.[10] While these findings are consistent with client/participant demographics at other OPS, it is important to ensure that under-represented groups – such as women, gender diverse people, Indigenous people, and people of colour – are able to access services at an OPS.

[10] The total number of responses is 54 due to the fact that 1 participant skipped this question.

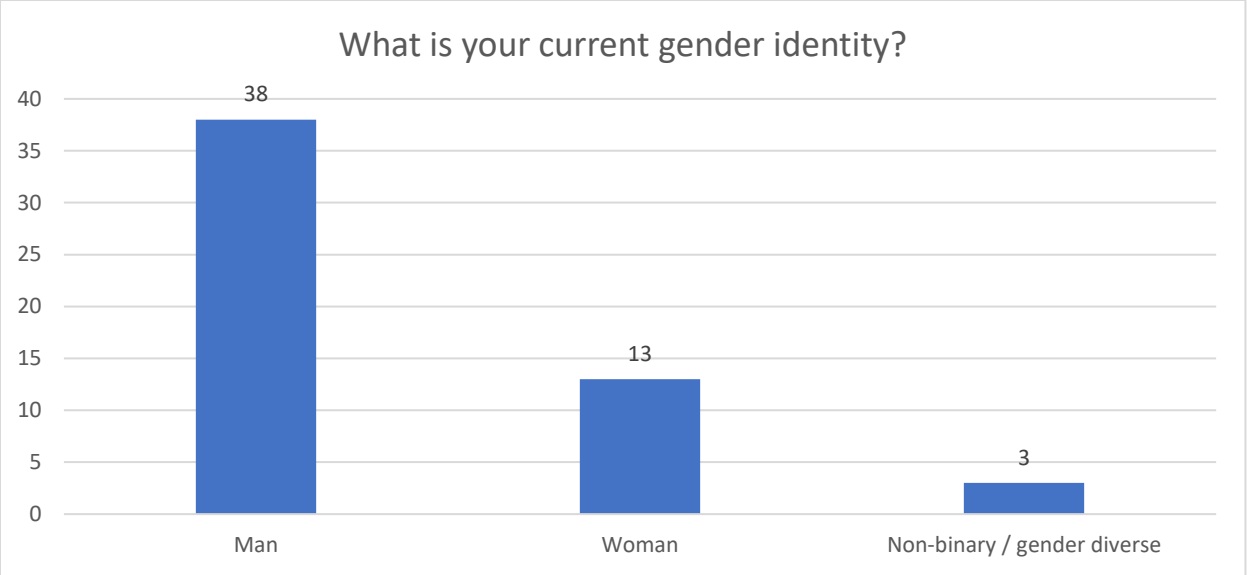

Figure 2. Gender identity of participants.

Participants were also asked to identify their age based on 6 possible age ranges. Figure 3 shows that 0 respondents (0%) identified as age 19 and under, 7 respondents (13%) identified as between ages 20-29, 20 respondents (37%) identified as between ages 30-39, 13 respondents (24%) identified as between ages 40-49, another 13 respondents (24%) identified as between ages 50-59, and 1 respondents (2%) identified as age 60+.[11] With 33 participants (61%) between the ages of 30 and 49, this is consistent with New Brunswick's results from the "Tracks" survey of people who inject drugs – which found that 61.5% of respondents were between the age 30 and 49 (Pacquette & Warren, 2020).

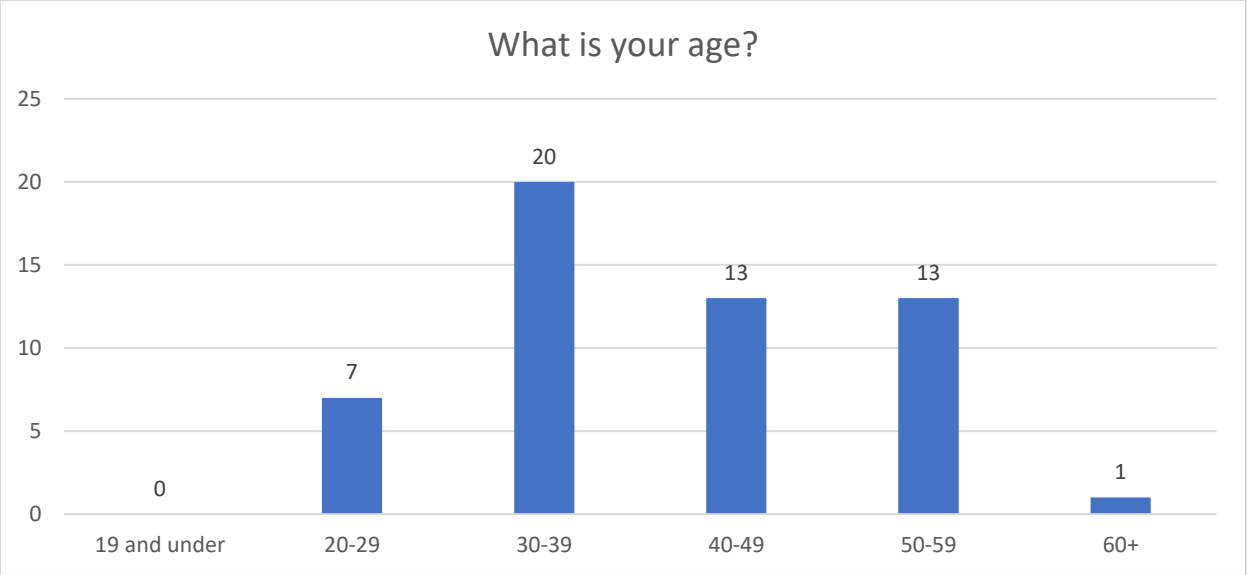

Figure 3. Age of participants.

[11] The total number of responses is 54 due to the fact that 1 participant skipped this question.

Assessing the Need for an Overdose Prevention Site

Participants were asked a series of questions to assess the need for an OPS, including demand for an OPS, reasons for going to (or not going to) an OPS, and the general areas where participants currently consume substances.

Participants where asked if they would go to an OPS if one was available. As per figure 4, a total of 48 respondents (87%) responded "yes" while 7 respondents (13%) reported "no."

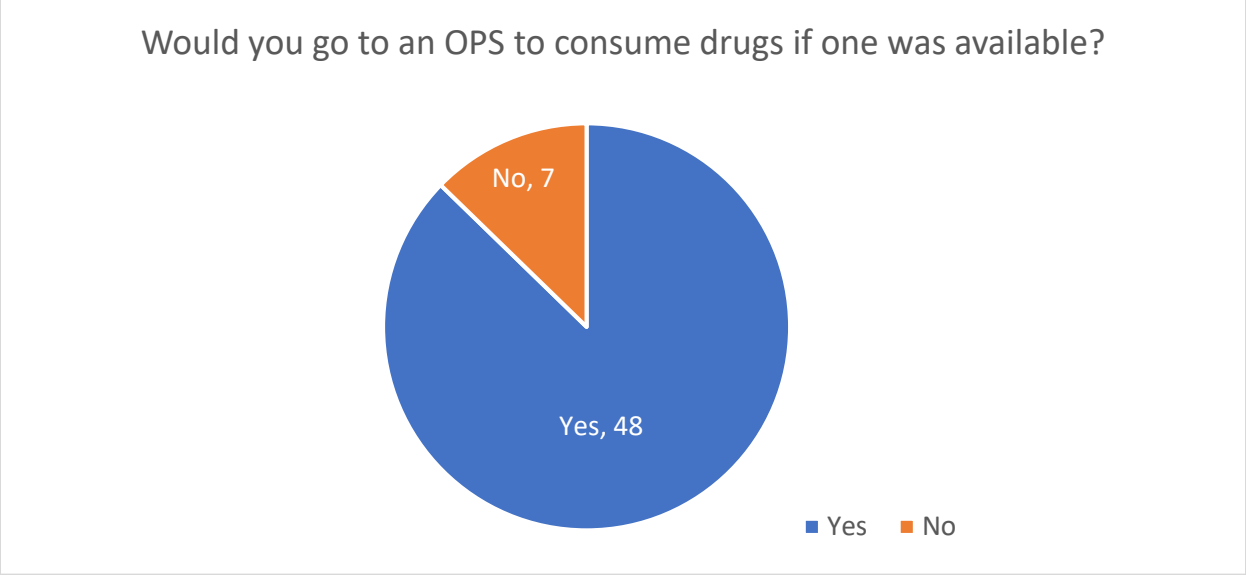

Figure 4. Participants' responses to whether or not they would go to an OPS.

In a follow-up question, **participants were asked why they would (or would not) attend an OPS**, and could provide multiple reasons. Responses were analyzed using thematic analysis, and the following themes were identified (see figure 5). Examples of responses from these themes are provided below.[12]

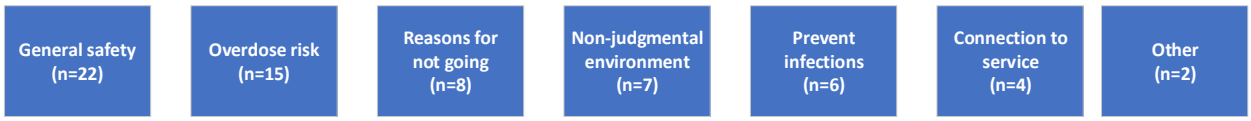

Figure 5. Themes from participants on why they would (or would not) go to an OPS.

GENERAL SAFETY:
Twenty-two (22) participants referred to general safety in describing why they would go to an OPS.

- "Safety, so I don't die."
- "I'll feel safer at an OPS."
- "It would be practical and safe."

[12] Participants often provided multiple reasons for why they would go to an OPS. As a result, the number of responses coded will be more than the number of participants.

OVERDOSE RISK:
Fifteen (15) participants cited overdose risk as a reason for going to an OPS.

- "Using substances is dangerous now due to the rise of fentanyl."
- "There's staff there to save lives in case of overdose."
- "To prevent overdoses when not aware of what is in the unregulated substance."

REASONS FOR NOT GOING:
Eight (8) participants provided reasons for which they would not go to an OPS.

- "It is something I do by myself."
- "The substances I use are not strong enough to lead to an overdose so I might not use it. But I think the existence of OPS is important for the community."
- "Concern - for fear of being arrested when leaving the site."

It is important to note that most of these participants may still benefit from an OPS. For example, using substances alone is a key risk factor for overdose death, and can be addressed through supervised consumption. Also, given the increasing toxicity of the illicit drug supply, it is very difficult to know the potency of an illicit substance. Further, it is important to reassure participants that Health Canada's UPHNS exemption applies to them at an OPS, and to work collaboratively with police services to ensure that participants have access to an OPS. Overall, participants who reported that they would not go to an OPS still reported that they support the establishment of an OPS.

NON-JUDGMENTAL ENVIRONMENT:
Seven (7) participants referred to the importance of a non-judgmental environment when explaining why they would go to an OPS. Participants made references to the need for a stigma-free environment, to be familiar with those providing services, and that confidentiality is important.

- "It's more safe, more dignified, based on my humanity and what I'm going through right now, away from the public, in a safer familiar circle and space. Away from the stigma that follows."
- "People who I know [providing] services."
- "Yes - confidentiality."

PREVENT INFECTIONS:
Six (6) participants cited the importance of preventing infections, such as Hepatitis C and HIV, by having access to sterile needles and other safer use equipment.

- "Safer supplies available. Clean water for rigs…"
- "Safer use supplies."
- "Cleanliness."

CONNECTION TO SERVICES AND SUPPORTS:
Four (4) participants explained that connection to other services and supports would encourage them to go to an OPS.

- "Other services like addictions treatment or referral are important."
- "Medical support would be available."
- "Get a boost [nutritional supplement] maybe."

Participants were also asked to rank order the most important factors in their decision to use an OPS, and were provided with 5 options, including the ability to write-in an "other" option. Analysis of results was based on a weighted average, with higher rankings (i.e., 1) weighted more heavily than lower rankings (i.e., 5). These findings should be interpreted with caution due to survey completion challenges when the survey was completed on-paper and not online. See figure 6 for details.

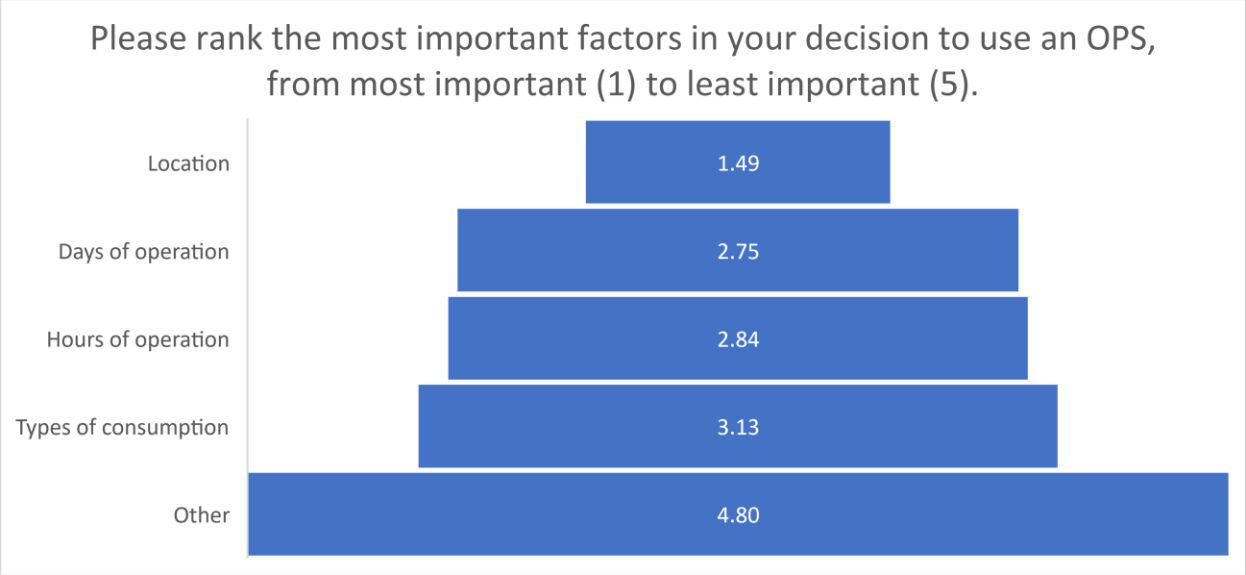

Figure 6. Ranking of factors in participants' decision to use an OPS.

Examples of "other" factors that would influence participants' decision to go to an OPS.

- "Way to check or test drugs."
- "Food, snacks."
- "No police, nice staff."

Reference to police reflect the complicated relationship that people who use illicit substances can have with police services, due in part to the criminalization of illicit substances. It is important to note that Health Canada's UPHNS exemption allows people to use pre-obtained illicit substances at an OPS (UPHNS). Having a mutual understanding of this exemption will support effective engagement with police services, and will ensure that an OPS is accessible to participants.

Participants were asked how often they would use an OPS. It is important to note that, depending on the half-life of a substance (duration of its effect), a person may use a given substance several times per day in order to prevent withdrawal. Determining how often participants would use an OPS provides for a more accurate representation of demand for services, as it allows for an estimate of daily visits, and not just the number of unique clients/participants.

As shown in figure 7, the most common response from participants was more than once a day, which is consistent with OPS in other jurisdictions across Canada. Notably, more than half of participants (29 total or 53%) reported that they would use an OPS once per day or more than once per day, with another 19 participants (35%) reporting that they would use an OPS once per week to a few times per week.

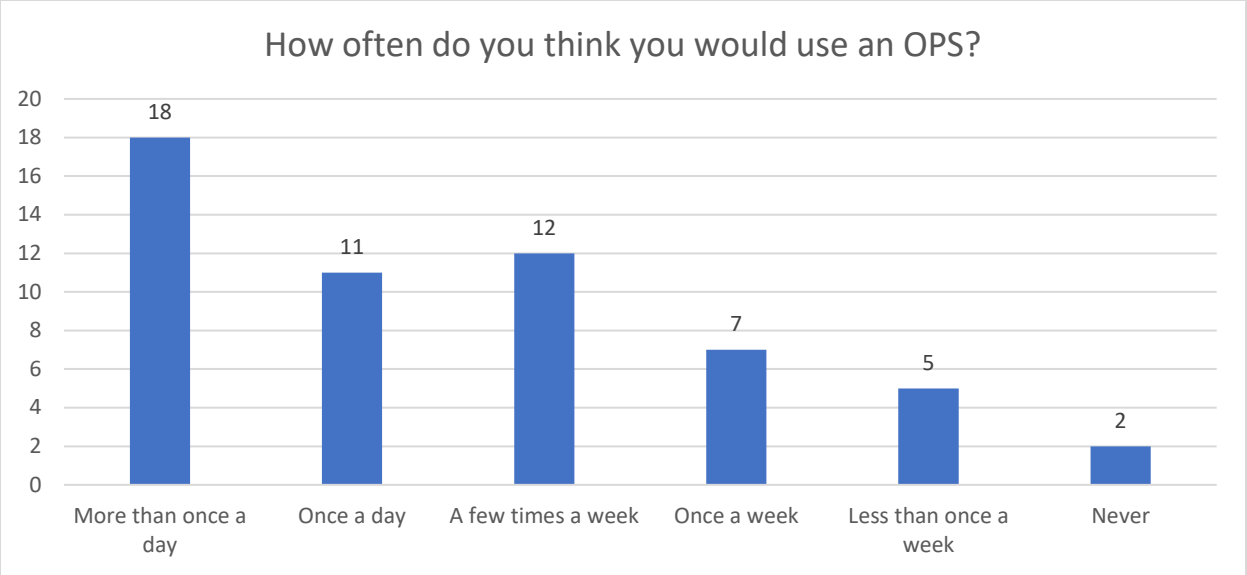

Figure 7. Anticipated frequency of participant OPS visits.

In a "check all that apply" question, **participants were asked to select where (generally) they had consumed substances in the last 6 months**. The purpose of this questions was to assess the need for a safer, private space for supervised consumption. Peer-reviewed scientific research has demonstrated that supervised consumption, such as an OPS, is effective in reducing riskier public substance use by moving it to a safer, private and supervised setting (Portier et al., 2014).

As shown below in figure 8, all 55 participants (100%) reported substance use in a public place in the last 6 months (i.e., street, park, washroom, or other public place). This clearly demonstrates that there is a need for a safer, private space for supervised consumption. This need can be met through an OPS, with benefits for both public health and public safety.

Finally, it should be noted that respondents who reported consuming substances in other settings – such as family or friend's place, a vehicle, or their own dwelling – may also benefit from access to an OPS, especially if they are using alone.

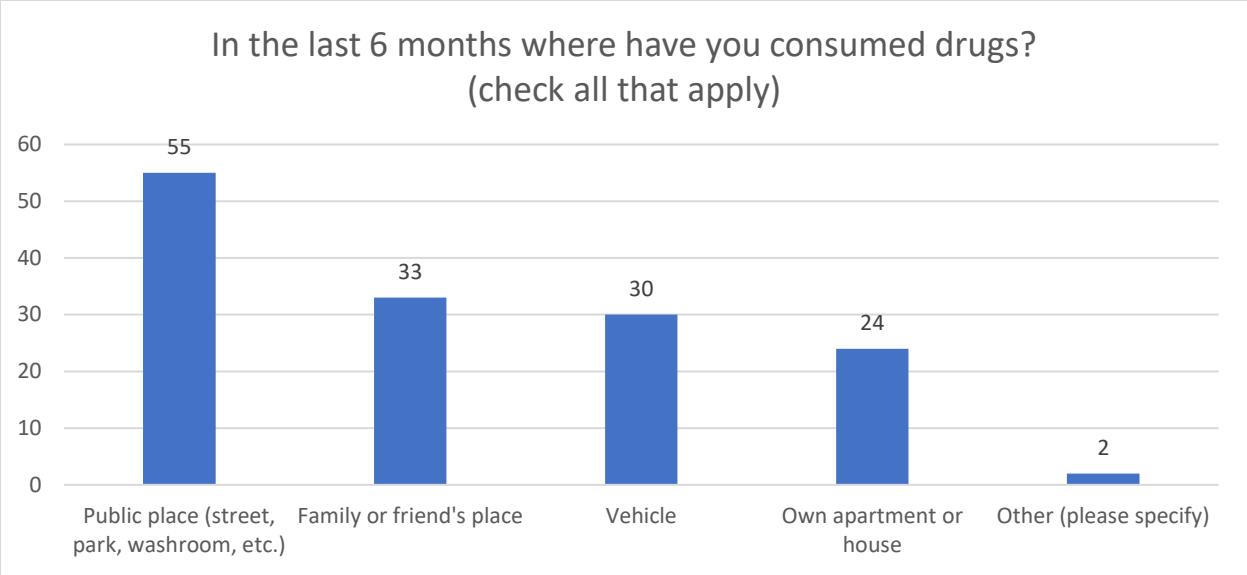

Figure 8. General locations of substance use reported by participants.

Participant Feedback on Overdose Prevention Site Operations

Participants were asked a series of questions to collect feedback on OPS operations. This important feedback increases the likelihood that services provided will meet client/participant needs.

When **asked to provide feedback on which days of the week an OPS should be open (check all that apply)**, the vast majority of participants selected all days of the week (see figure 9). These findings are not surprising, as daily substance use can be a reality. There are many reasons for this, including a need to prevent withdrawal symptoms which can be debilitating.

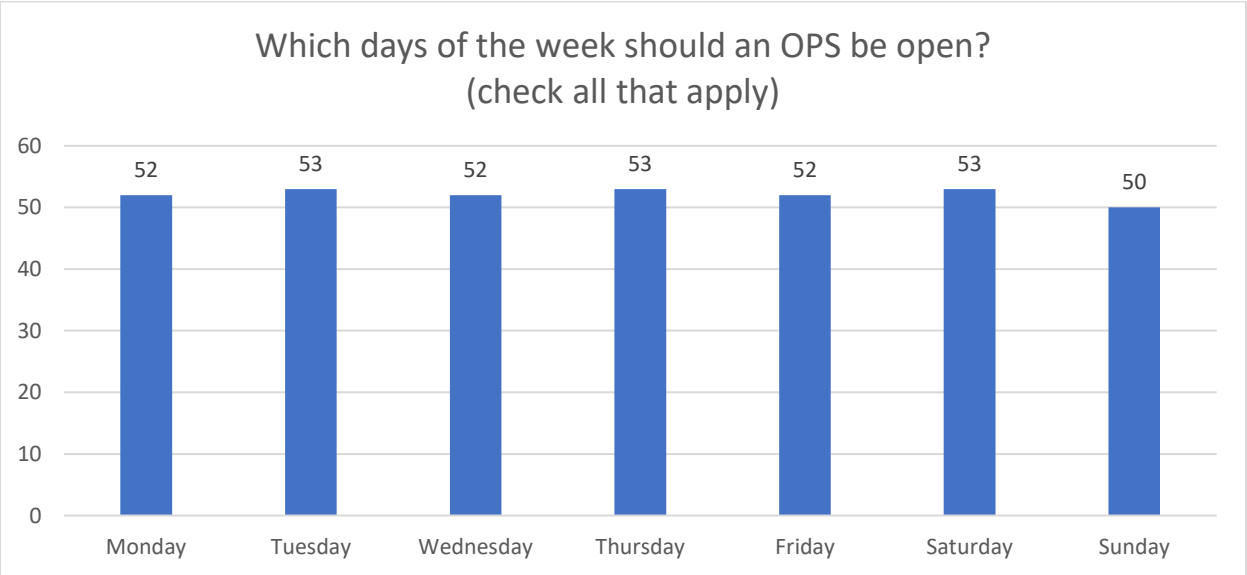

Figure 9. Participant feedback on preferred days in which an OPS should be open.

Participants were asked to provide feedback on preferred hours of operation for an OPS. Participants were provided a range of options and could also "write-in" other hours of operation not listed. Options written-in were then coded and are reflected in figure 10. The most frequently provided response was "24/7." While very few OPS (or SCS) in Canada are open 24/7 – including those in large metropolitan centers – remote (phone-based) overdose prevention services like the National Overdose Response Service (NORS)[13] and the Brave App[14] offer 24/7 access to supervised consumption even when an OPS is closed overnight.

Beyond this, there was considerable variation in responses to this question. Overall, it is apparent that an OPS should not open too early, and that hours of operation should be coordinated with other service providers.

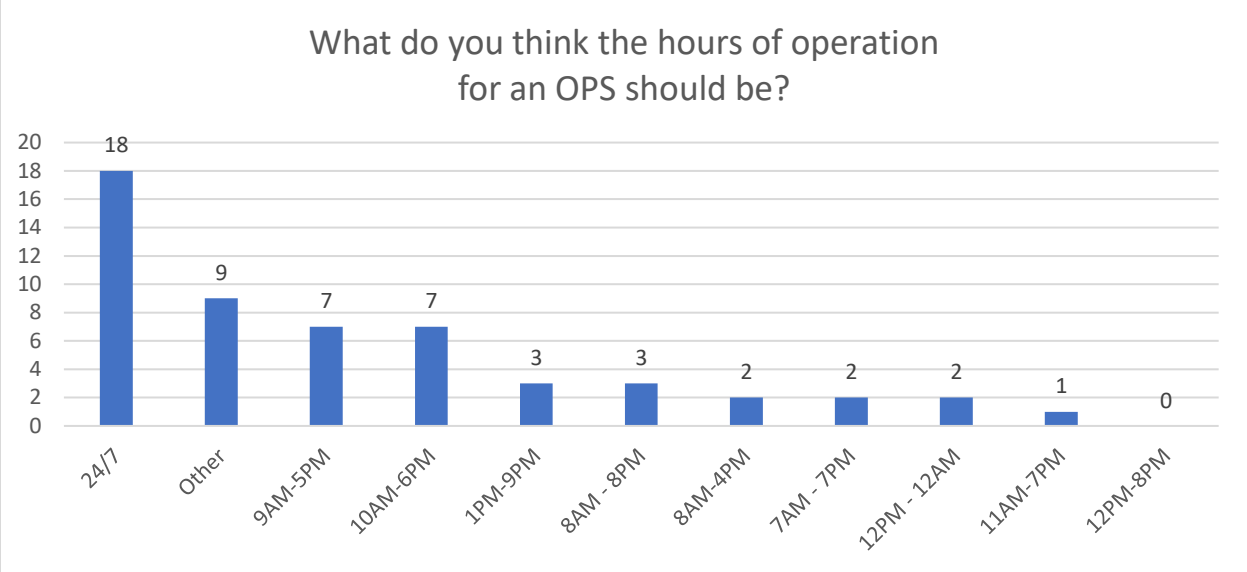

Figure 10. Participant feedback on preferred hours of operation.

Participants were also asked to provide general suggestions on a location for an OPS in the Charlottetown area. The purpose of this question was to identify strategic areas that will be easily accessible to clients/participants, and to focus the search for an OPS location. Based on a jurisdictional scan of similar engagement reports from across Canada, it is well understood that an OPS must be within a short walking distance of its clients/participants and service providers who work with them (i.e., within 20 minutes on-foot). If an OPS is too far away then participants will be more likely to consume substances alone, which significantly increases their risk of dying from a drug-related overdose.

Participant responses were analyzed using thematic analysis, and organized into themes.[15] These findings, displayed in figure 11, give an indication of a geographical area that would be accessible to clients/participants. Consistent with OPS across Canada, this area is in a central location and is a short

[13] NORS: https://www.nors.ca/about
[14] Brave App: https://www.brave.coop/app
[15] Note that the number of suggestions provide is greater than the number of participants due to the fact that many participants provided more than 1 suggestion.

walking distance from important services like shelters, the Community Outreach Center, the Queen Street Recovery Clinic, the Soup Kitchen, Food Bank and others.

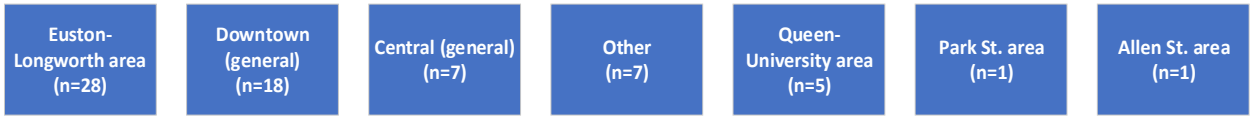

Figure 11. Themes from participant feedback on OPS location.

It is important to note that, when providing feedback on an OPS location, some participants expressed concern that they may face stigma when trying to access an OPS:

- "There are many stereotypes…"
- "It would be hard for folks to use [the] OPS with increased judgement from the community."

As with other jurisdictions across Canada, it will be important to balance community engagement with the need to offer life-saving services to people at an OPS.

Participants were asked what other services should be at an OPS. This is in addition to services typically provided at an OPS, including: supervised consumption, overdose response (as required), drug checking, distribution and safe disposal of harm reduction supplies, as well as engagement and referral to external services. The purpose of this question was to understand the scope of services that OPS clients/participants are seeking. Responses to this open-ended question were analyzed using thematic analysis, and organized into themes. Examples of responses from these themes are provided further below.[16]

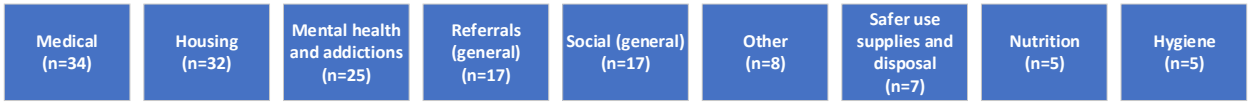

Figure 12. Participant feedback on other services or referrals that should be connected to the OPS.

MEDICAL:

Thirty-four (34) participants made references to accessing medical services, either by referral from the OPS or by meeting with a heath care provider at the OPS.

- "Referrals to methadone clinic [opioid replacement therapy]."
- "Bloodwork [for sexually transmitted and bloodborne infections]."
- "Nurses."

HOUSING:

Thirty-two (32) participants made references to accessing housing services, either by referral from the OPS or by meeting with a housing-related service provider at the OPS.

- "Housing referrals."
- "Referrals to low-barrier housing."
- "Housing info and referrals."

[16] Participants often provided multiple reasons for why they would go to an OPS. As a result, the number of responses coded will be more than the number of participants.

MENTAL HEALTH AND ADDICTIONS:
Twenty-five (25) participants made references to accessing mental health and addiction services, either by referral from the OPS or by meeting with a mental health and/or addictions service provider at the OPS.

- "Mental health and addictions counselling."
- "Referrals to addictions and mental health treatment."
- "Notices or info about group sessions (anonymous meetings, etc.)."

REFERRALS (GENERAL):
Seventeen (17) participants made general references to the importance of being referred to services from the OPS. Harm reduction services like an OPS are often successful in improving client/participant connection to much-needed services and supports.

- "Referrals."

SOCIAL (GENERAL):
Seventeen (17) participants made general references to accessing social services, either by referral from the OPS or by meeting with a social service provider at the OPS.

- "Social services."

OTHER:
Eight (8) participants made references to other services that they would like to access.

- "Connected to Outreach Center because they offer lots of services."
- "Someone smart to show us…ways to inject or smoke more safer [to reduce harms]."
- "Financial management support."

SAFER USE SUPPLIES AND SAFE DISPOSAL:
Seven (7) participants made references to accessing safer use supplies and safe disposal of used supplies – services that will be offered at the OPS.

- "Service to pick up sharps."
- "Safer [use] supplies."
- "Narcan (naloxone)."

NUTRITION:
Five (5) participants made references to the importance of being able to meet their nutritional needs, in-part through the OPS.

- "Food."
- "Snacks and coffee."
- "Boost."

HYGIENE:
Five (5) participants made references to being able to tend to their personal hygiene.

- "Personal hygiene"
- "Clothes."
- "Bathrooms."

Reported Modes of Consumption and Substances Consumed

Participants were asked to identify their most common mode of consumption, or way that they consume substances. Options included: Inject (intravenous), smoke (inhalation), snort (intranasal), swallow (oral), and other. This helps inform the development of a service delivery model for the OPS. Many participants entered more than one mode of consumption, meaning that the number of responses is greater than the number of participants.

As shown in figure 13, inhalation/smoking (28 participants) and intravenous/injection (27 participants) where the most frequently reported modes of consumption. Other modes of consumption were less frequently reported, including intranasal/snort (11 participants), oral/swallow (7 participants), and other (3 participants). These results demonstrate that polysubstance use (consuming more than one type of substance) should be anticipated in operating the OPS. These results also reflect trends in consumption where people may consume depressants like opioids through injection, while consuming stimulants through smoking – though this is not always the case.

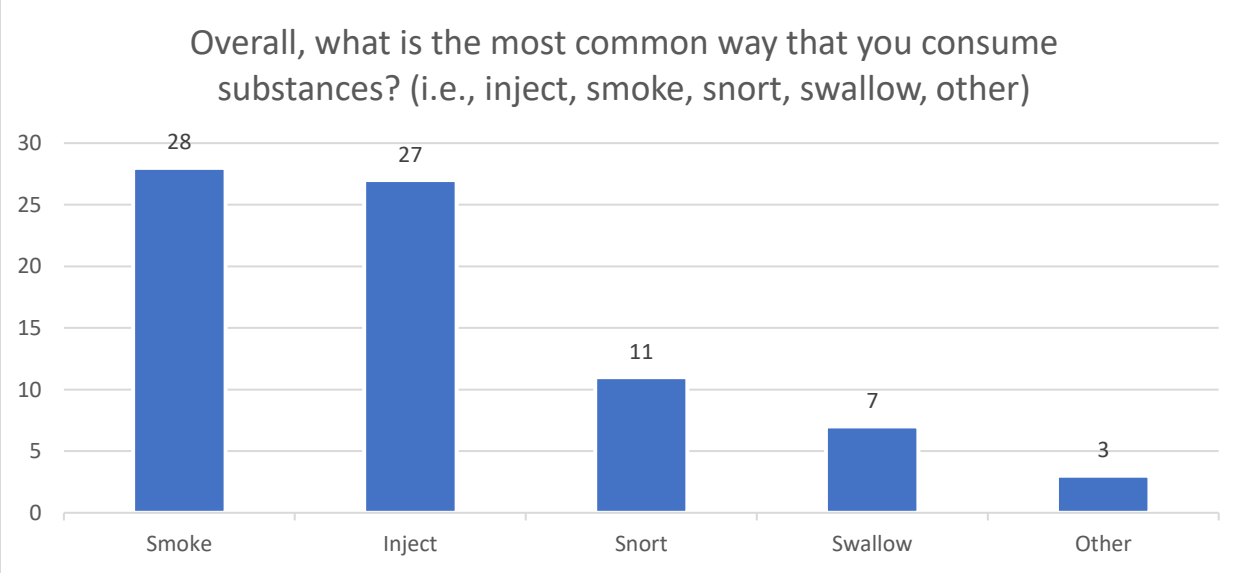

Figure 13. Modes of consumption as reported by participants.

Participants were asked a series of "check all that apply" questions on which substances they have consumed in the last 6 months for each mode of consumption. The purpose of this question was to have a baseline understanding of substances that participants are currently consuming. It is important to keep in mind some important caveats when interpreting these findings. First, while participants may have a general sense of what substances they are consuming, the illicit drug supply is unregulated – meaning that

it is impossible to be certain of what exactly a person is consuming. Second, the illicit drug supply changes frequently, meaning that future illicit supply may be very different from the current illicit supply.

When asked which substances they had **injected (intravenous)** in the last 6 months, participants reported a combination of depressants (mostly opioids) and stimulants. The five most frequently reported substances were: crystal meth (27 participants), hydromorphone/Dilaudid (26 participants), cocaine (20 participants), methylphenidate/Ritalin (19 participants), and fentanyl (17 participants). See figure 14 for details.

In light of overdoses linked to fentanyl and fentanyl analogues, it should be noted that in some cases fentanyl is consumed deliberately. There are several reasons for this. For example, the unregulated nature of the illicit drug supply means that fentanyl may be all that is available in the illicit supply at a given point in time. Other factors include increasing levels of tolerance to opioids, and efforts to prevent debilitating withdrawal symptoms ("dope sick"). Moving forward it will be important to monitor the presence of fentanyl and its analogues in the illicit drug supply through the OPS and drug checking services.

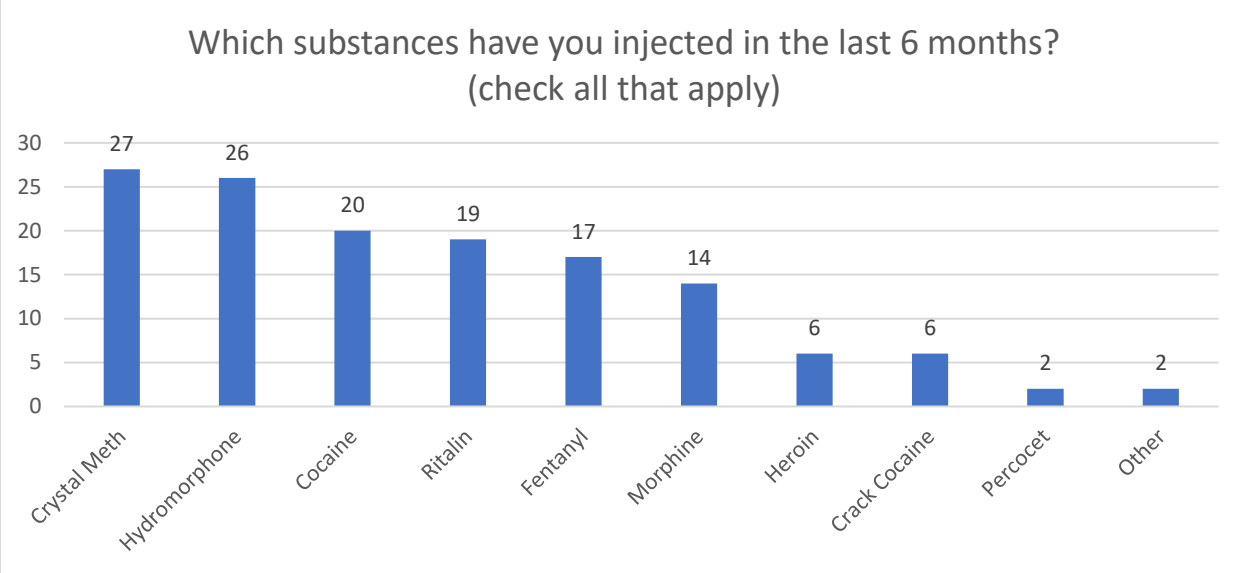

Figure 14. Substances injected in the last 6 months as reported by participants.

When asked which substances they had **smoked (inhalation)** in the last 6 months, participants reported mostly stimulants, along with some other substances. The five most frequently reported substances were: crystal meth (43 participants), cannabis (38 participants), cocaine (20 participants), crack cocaine (20 participants), and fentanyl (14 participants). See figure 15 for details.

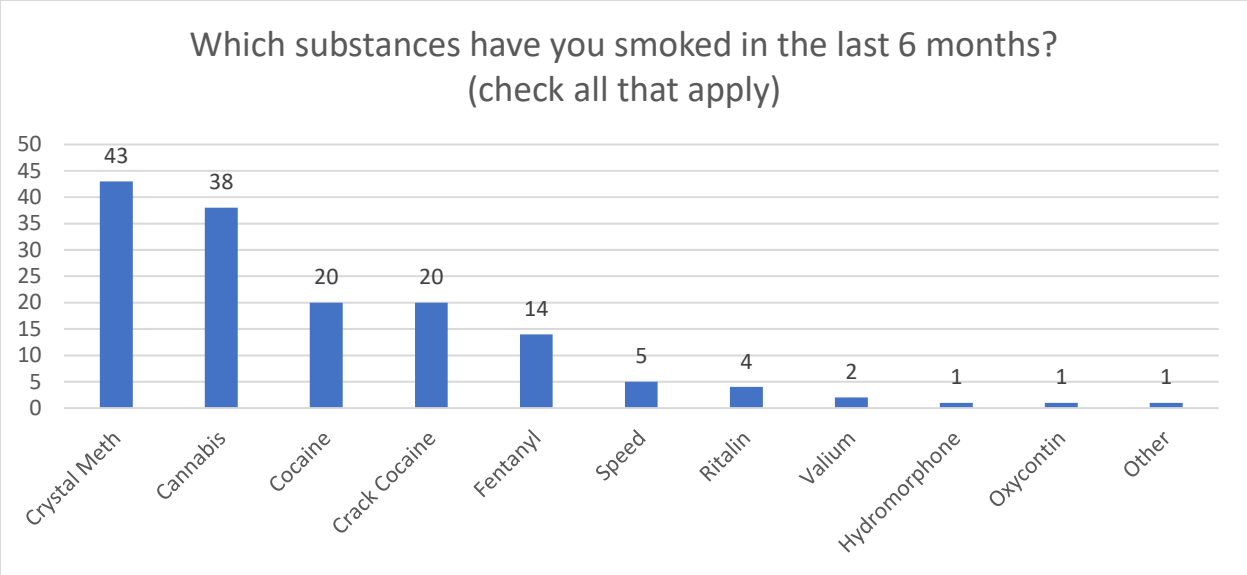

Figure 15. Substances smoked in the last 6 months as reported by participants.

When asked which substances they had **snorted (intranasal) or swallowed (oral)** in the last 6 months, participants reported a combination of stimulants and depressants, with stimulants appearing more frequently. The five most frequently reported substances were: cocaine (22 participants), speed (20 participants), crystal meth (19 participants), methylphenidate/Ritalin (14 participants), and benzodiazepines (13 participants). See figure 16 for details.

The presence of benzodiazepines in the illicit drug supply should also be monitored through the OPS and drug checking services. Benzodiazepines are another depressant that – when used in combination with opioids – can increase the risk of overdose. Further, while naloxone (Narcan) can reverse an overdose due to opioids, it cannot do the same for benzodiazepines.

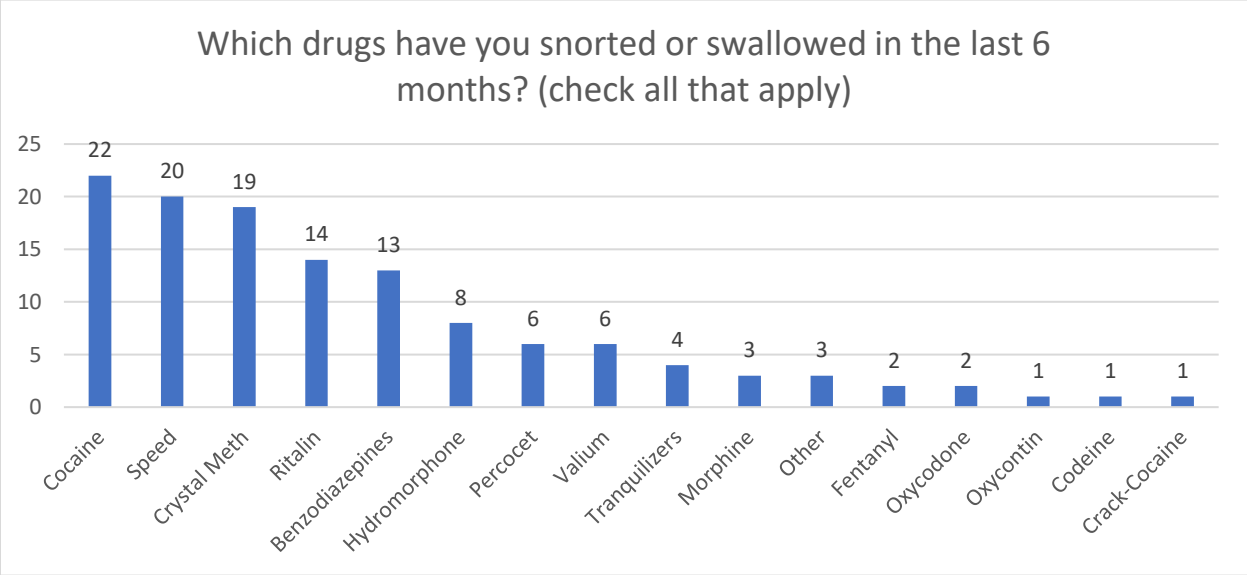

Figure 16. Substances snorted or swallowed in the last 6 months as reported by participants.

Participant Experiences with Drug-Related Overdoses

Participants were asked a series of questions on their experiences (if any) with drug-related overdoses. Findings from these questions will help inform overdose response policy and procedures at the OPS.

When participants were asked if they had overdosed from drugs in the last 6 months, 42 participants (76%) answered “no” and 13 participants (24%) answered “yes.”

Of the 13 participants who answered “yes,” 9 participants (69%) reported that they did not seek medical attention, while 4 participants (31%) reported that they did seek medical attention. Having access to an OPS may increase the probability that a person would seek medical attention following an overdose, as OPS staff could facilitate access to medical attention. See figure 17 for details.

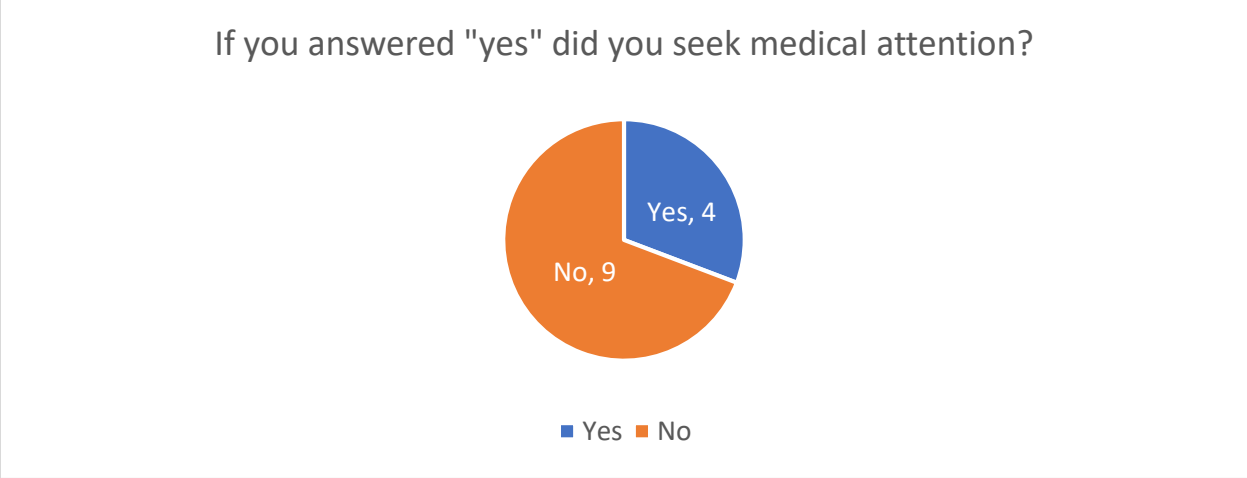

Figure 17. Participants who reported seeking medical attention following an overdose.

These same 13 participants were also asked if naloxone was administered to revive them following an overdose. Six (6) participants reported “yes,” 4 participants reported “no,” and 1 participant reported “unsure.” Having access to an OPS would mean that naloxone can be administered should an overdose occur. See figure 18 for details.

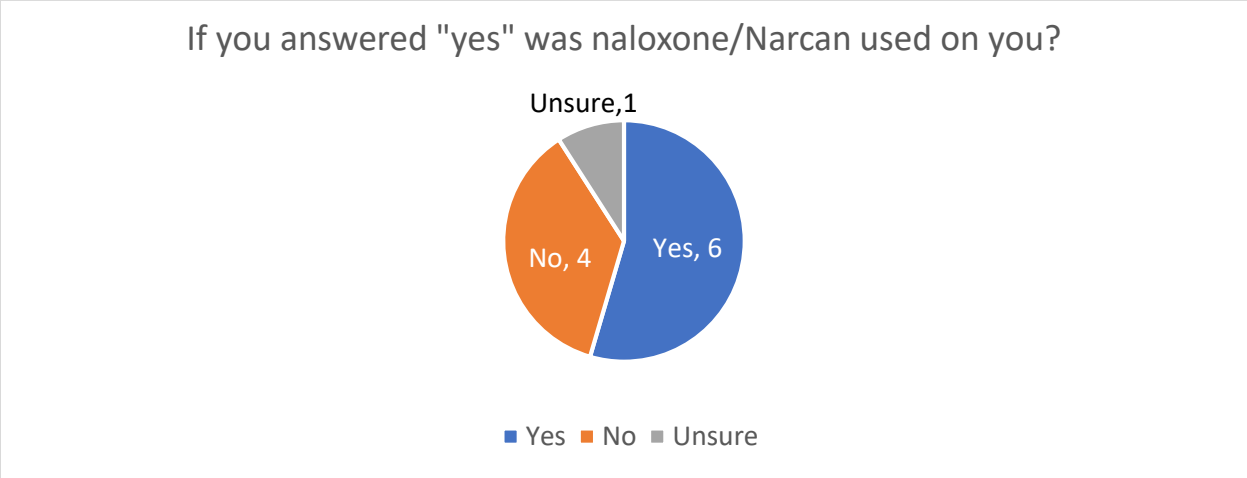

Figure 18. Participants who reported that naloxone was used following an overdose.

Other Participant Feedback

At the end of the survey, participants were asked if they had any other feedback to provide. Some participants provided additional feedback. Examples are provided below.

- "Staff need to be friendly and non-judgmental."
- "Staff should know what they are doing (people who are knowledgeable, people who support BIPOC individuals, drug awareness, substance use awareness)."
- "People need information on bad batches and toxic drugs."
- "Yeah have more than one [OPS]."

Conclusion

This *What We Heard* report has presented findings from engagement with people who have lived and living experience with substance use regarding an OPS. Findings from this engagement support the need for an OPS – a safer, designated space for supervised consumption and other supports. Findings from this engagement will also help ensure that the OPS meets the needs of its clients/participants. Engagement with people who have lived and living experience with substance use will continue following the implementation of the OPS.

> *"It's more safe, more dignified, based on my humanity and what I'm going through right now, away from the public, in a safer familiar circle and space. Away from the stigma that follows."*
> *– Survey Participant.*

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Appendix A: Survey Questions

1. Have you consumed street source substances / drugs in the last 6 months?

Yes
No

2. What is your current gender identity?

Man	Woman	Non-binary / gender diverse	Other gender identity (please specify)

3. What is your age?

19 and under	20-29	30-39
40-49	50-59	60+

4. Would you go to an Overdose Prevention Site to consume drugs if one was available?

Yes
No

5. Please explain why you would or would not go to an Overdose Prevention Site.

6. How often do you think you would use an Overdose Prevention Site?

More than once a day	Once a day	A few times a week
Once a week	Less than once a week	Never

7. Please rank the most important factors in your decision to use an Overdose Prevention Site, from most important (1) to least important (5).

Location	Days of operation	Hours of operation	Types of consumption	Other

8. If you selected "other" what other factors would be important in your decision to use an Overdose Prevention Site?

9. Where would be a good location for an Overdose Prevention Site in the Charlottetown area?

10. Which days of the week should an Overdose Prevention Site be open? Check all that apply.

Monday	Tuesday	Wednesday	Thursday
Friday	Saturday	Sunday	-

11. What do you think the hours of operation for an Overdose Prevention Site should be?

8AM – 4PM	9AM – 5PM	10AM – 6PM	11AM – 7PM
12PM – 8PM	1PM – 9AM	Other (please specify)	-

12. Overall, what is the most common way that you consume drugs? (i.e., inject, smoke, snort, swallow, other).

13. Which drugs have you injected in the last 6 months? Check all that apply.

Heroin	Hydromorphone (Dilaudid)	Morphine	Fentanyl	Percocet
Cocaine	Crystal meth	Crack cocaine	Methylphenidate (Ritalin)	Other (please specify)
N/A	-	-	-	-

14. Which drugs have you smoked in the last 6 months? Check all that apply.

Cocaine	Crystal meth	Crack cocaine	Cannabis	Hydromorphone (Dilaudid)
Morphine	Percocet	Fentanyl	Methylphenidate (Ritalin)	Speed
Oxycontin	Oxycodone	Valium	Codeine	Tranquilizers
Other (please specify)	N/A	-	-	-

15. Which drugs have you snorted or swallowed in the last 6 months? Check all that apply.

Cocaine	Crystal meth	Hydromorphone (Dilaudid)	Morphine	Percocet
Fentanyl	Methylphenidate (Ritalin)	Speed	Oxycontin	Oxycodone
Valium	Codeine	Tranquilizers	Benzodiazepines	Crack cocaine
Other (please specify)	N/A	-	-	-

16. In the last 6 months, where have you consumed drugs? Check all that apply.

Public place	Family or friend's place	Vehicle	Own apartment or house	Other (please specify)

17. What other services should be at an Overdose Prevention Site (i.e., referrals, medical, social, housing, etc.)?

18. Have you overdosed from drugs use in the last 6 months?

Yes
No

19. If you answered "yes" did you seek medical attention?

Yes
No

20. If you answered "yes" was naloxone/Narcan used on you?

Yes	No
Unsure	N/A

21. Do you have any other comments or suggestions for an Overdose Prevention Site?

Appendix B: Promotional Poster


Prince
Edward
Island
CANADA