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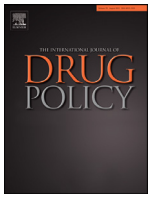

Research Paper

"It's just not the same": Exploring PWUD' perceptions of and experiences with drug policy and SCS services change in a Canadian City

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ABSTRACT

Background and Aims: Shifting political contexts can significantly alter drug policy approaches and available supports for People Who Use Drugs (PWUD). The purpose of this study was to explore how shifts in provincial drug policy approaches, specifically the replacement of a Safe Consumption Site (SCS) with a smaller mobile Overdose Prevention Site (OPS) in Lethbridge, Alberta Canada, impacted PWUD' access to and experiences with harm reduction services.

Methods: We conducted semi-structured interviews with 50 PWUD in the City of Lethbridge, Canada. Through traditional fieldwork, we recruited participants within, and just outside of, downtown Lethbridge. Using a standardized general prompt guide to begin interviews, participants were asked a variety of questions about their experiences with and perceptions of SCS access and changes to SCS provisions. Interviews were audio recorded, then transcribed, coded, and analyzed.

Results: Participants reported regular and frequent access and overall positive experiences with the SCS, despite also noting certain operational barriers (e.g., long wait times). By contrast, participants reported more limited use of the new OPS compared to the SCS because of three main reasons: (1) concerns about location; (2) smoking room elimination; and (3) lack of social space and activities. Overall, changes to SCS provision produced a range of negative consequences for PWUD in Lethbridge. These relate to perceived increases in drug-related harms (e.g., increased overdoses) as well as negative social impacts (e.g., lack of place to meet other people).

Conclusion: Findings from this study provide preliminary indications of the importance of understanding how contextual and locally-specific elements (location, limits on permitted route administration, and social aspects) can work together to facilitate SCS uptake and even overcome traditional SCS barriers. Conversely, the absence of such elements can hinder SCS uptake. Results show that the value of SCS might differ across locations, pointing to the need for further locally-grounded examinations of harm reduction service uptake and experience.

Introduction

Few North American jurisdictions have been unaffected by the recent overdose epidemic. It is no surprise then that in recent years, governments have increasingly recognized harm reduction as a critical component of effective controlled drug and public health policy, with over 100 Supervised Consumption Services (SCS) in operation across 11 countries (National Harm Reduction Coalition, 2022). In Canada, over the past 10 years, the toxic drug supply fueled by low-cost synthetic opiates (e.g., fentanyl) has led to almost 31,000 drug poisoning deaths and is expected to substantially increase without meaningful public health response (Humphreys et al., 2022).

In Canada, sanctioned SCS have been in operation since 2003, and 39 SCS are currently operating (Government of Canada, 2022). Canada's first SCS, located in Vancouver, British Columbia, has been one of the most widely researched in the world, providing foundational evidence of the many health and societal benefits these services provide (Andresen & Boyd, 2010; Boyd, 2013; Pinkerton, 2011; Young & Fairbairn, 2018). Yet, despite this history and the robust evidence surrounding SCS' benefits, Canadian harm reduction proponents have not seen support for SCS come easily. Political resistance—and outright opposition—to SCS have significantly slowed their expansion (see Kerr et al., 2017). Over the last 7 years, however, the overdose epidemic in Canada has propelled Governments to reconsider the benefits of SCS and has hastened their

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long-awaited expansion. Changes in Federal and Provincial Government leadership—specifically, the 2015 elections of Liberal Prime Minister Justin Trudeau (Canada) and New Democratic Party Premier Rachel Notley (NDP, Alberta)—led to initial increased political support and funding for harm reduction initiatives, such as new SCS development, to address the impacts of Canada's toxic drug supply (Wood, 2016).

The Province of Alberta has experienced some of Canada's highest rates of opioid-related deaths and hospitalizations (Belzack & Halverson, 2018; Public Health Agency of Canada, 2021). In Alberta, full political support for SCS was short-lived. While Alberta's NDP Government oversaw the expansion of harm reduction services across the province, the 2019 election of the United Conservative Party (UCP) began to reverse that progress. The UCP Government swiftly shifted controlled drug/public health policy away from evidence-based harm reduction toward a moralistic model of abstinence and treatment (Hudes, 2019). As is often the case, UCP opposition to SCS was based on misconceptions that SCS increase crime and social disorder, encourage drug use, and prevent treatment (Atkinson et al., 2019; Barry et al., 2019; Southwick, 2018). Notably, no existing empirical research has shown that SCS increase crime and drug use or prevent people from stopping drug use (Davidson et al., 2021; Donnelly & Mahoney, 2013; Fitzgerald et al., 2010; Freeman et al., 2005; Potier et al., 2014; Wood et al., 2006). In fact, harm reduction initiatives, specifically SCS, have long been found to increase treatment program uptake and reduce infectious disease transmission, lethal overdose rates, and public drug use (Bayoumi & Zaric, 2008; Dolan, Fry, McDonald, Fitzgerald, & Trautmann, 2000; Jozaghi & Reid, 2015; Kerr et al., 2007; Kennedy et al., 2017; Kerman et al., 2020; Kral & Davidson, 2017; Lambdin et al., 2022; Marshall et al., 2021; Marshall, Milloy, Wood, Montaner, & Kerr, 2011; Milloy & Wood, 2009; Panagiotoglou, 2022; Potier et al., 2014; Tran et al., 2021; Small, Wood, Lloyd-Smith, Tyndall, & Kerr, 2008). Moreover, research in Alberta specifically has found SCS reduced public drug use, drug poisoning deaths, and healthcare costs (Alberta Community Council on HIV 2020; Hansen et al., 2020; Khair et al., 2022; Marshall et al., 2021; Urbanik & Greene, 2021).

Despite the empirical evidence and benefits of SCS, in August 2020, Alberta's then busiest SCS, run by a non-profit organization, in the City of Lethbridge was closed, just two and half years after opening. That same month, it was replaced with an Overdose Prevention Site (OPS), operated by Provincial health authorities. In Canada, OPS and SCS are legally distinguishable, with the latter having significantly greater procedural and practical requirements for permissible operations. For example, SCS require lengthy applications that are individually reviewed and earn a legal exemption to offer a full range of services (e.g., consumption supervision, counselling, and naloxone) from Health Canada. On the other hand, OPS are broadly exempted under the law on the basis that they are *temporary* measures meant to respond to urgent public health needs and do not provide the level of support of SCS.

Through a health equity lens, we examine how changes in policy and service provision impacted PWUD' access to harm reduction services. A health equity framework (HEF) centres itself on recognizing and addressing issues of equity/inequity in health outcomes by focusing on individual and community level agency and fair heath/social services access, and critically, the "multiple spheres of influence" shaping public health outcomes (Peterson et al., 2021). Drawing from Peterson et al. (2021), we employ HEF with a specific focus on two dimensions—"systems of power" and "relationships and networks". Peterson et al. (2021) define "systems of power" to include the "policies, processes, and practices that determine the distribution and access to resources and opportunities needed to be healthy" (p.742). Critically, systems of power refer to both macro (government policy) and meso-level (institutional policy) influences. Institutional policies and practices have the ability to positively shape health outcomes and may even "mitigate the effects of "big" policies" (p. 743), referring to macro policies that have the potential to intensify health inequities. The second sphere of influence, "relationships and networks", refers to the "[…] many connections and support structures made up of family […], friends, romantic partners, and people within cultural communities, neighbourhoods, schools, and workplaces.", and/or health and social service environments. Positive social relationships can serve to protect individuals against harms, while the absence of such networks can contribute to "…stigma, discrimination, or pressure" that exacerbate harms and health inequities (p.743).

In this paper we examine the impact of the closure of the SCS in Lethbridge within the context of macro-level changes in Provincial policy and meso-level institutional (SCS/OPS) practices, illuminating how the availability of harm reduction services has changed PWUD' connection to critical "relationships and networks". In this context, we also draw upon Duff's (2010) conception of the "enabling place" to highlight the full breadth of both health and social benefits harm reduction services can offer to PWUD. Duff (2010) uses the term "enabling place" to describe harm reduction initiatives that, by providing PWUD with critical "social, material, and affective resources", "[…] facilitate a richer or more meaningful experience of place" (p. 338). Our data highlight the critical role of the SCS in offering PWUD with such resources and place. PWUD' perceptions and experiences of the closure of the SCS demonstrate how/why the development of an "enabling place" in SCS/OPS is critical for the full realization of harm reduction goals.

By illuminating how PWUD narrate the consequences of changes in local harm reduction service provision, this paper adds to the existing literature on SCS access and experiences by providing further insight into (a) the contextual factors that facilitate SCS access and uptake; and (b) how contextual elements of harm reduction services can work together to facilitate uptake and even serve to overcome traditional SCS barriers. Documenting how shifts in policy and service provision impact PWUD' access to SCS is paramount for policy, funding decisions, and critically important for real-time service planning. As such, we conclude with policy recommendations meant to inform harm reduction scholars, advocates, Governments, and service providers seeking to improve SCS uptake.

Methods

Context

Lethbridge, a city located in southern Alberta (Canada) with a general population of 101,799 (and a houseless population of 454 based on the most recent data available), has experienced some of the highest rates of opioid-related overdose deaths in Alberta, with the City's Indigenous communities being disproportionately impacted (City of Lethbridge, 2022; Government of Alberta, 2021a,2021b;2022b; Turner, 2018). In Lethbridge, Indigenous persons are over three times more likely to die from opioid drug poisoning than non-Indigenous persons (Government of Alberta and Alberta First Nations Information Governance Centre, 2021a,b). In 2017, to address the province-wide overdose epidemic, the Government of Alberta established the Minister's Opioid Emergency Response Commission (MOERC) which was charged with providing expert, evidence-based policy guidance. Later that year, in its final report to Government, MOERC recommended the opening of 6 SCS, in the cities of Calgary, Edmonton and Lethbridge (Government of Alberta, 2017). These recommendations led to Alberta's first sanctioned SCS opening in 2018 and culminated in the operation of 6 SCS across 4 cities by 2019 (Calgary, Edmonton, Grande Prairie-mobile and Lethbridge) and 1 overdose prevention site (OPS) in Red Deer.

However, the election of the UCP that same year marked a move away from harm reduction with the Government cancelling new SCS and related programs (e.g., injectable opioid agonist treatment) in favour of their preferred 'abstinence' and 'recovery' approach. In 2020, Lethbridge's SCS was closed, influenced in part by a UCP Government commissioned Report that was widely, and justifiably, critiqued for its methodological failures and ill-supported conclusions that SCS increased social disorder/crime and prevented treatment (see

Drug Policy Coalition 2020; Galarneau et al., 2022; Government of Alberta, 2020a; Livingston, 2021). While in operation (February 2018-August 2020) Lethbridge's SCS received considerable attention as the most frequently accessed SCS in the Province and in North America (Yousif, 2019), averaging almost 14,000 monthly visits (Government of Alberta, 2022a). Notably, the SCS provided supervised smoking space which expanded its harm reduction reach by providing a safe place to smoke and access important public health services. However, with this success came challenges and critique from local and Provincial Governments, local businesses, and other community members which ultimately contributed to the site's closure.

The same month the SCS closed, it was replaced with an OPS, a mobile RV unit which remains stationary. Unlike the SCS, the OPS does not provide a safe smoking space, leaving a void in service provision at a time when more people are overdosing via inhalation than injection (Giliauskas, 2022). In comparison to the SCS, the OPS averages about 4200 monthly visits (Government of Alberta, 2022a). While the SCS was located in an easily accessible location in Lethbridge's downtown proper, the OPS is parked further from the core in an industrial area where other social services (e.g., shelter, soup kitchen) are located and where encampments are routinely set up. The area is patrolled by security guards, and police were frequently observed in the area. During fieldwork, we observed police officers forcing people out of encampments and destroying their homes just outside the OPS. See Fig. 1 for additional information on the two sites.

Data collection and analysis

In the Spring of 2022, the authors conducted 50 semi-structured interviews with street-involved PWUD about their perceptions and experiences of SCS service provisions and access following changes in drug policy and consequent changes in SCS service provision in the City (See Fig. 2 for sample characteristics). The interviews ranged in length between 17-59 minutes, with an average length of 35 minutes. Participants were recruited via traditional fieldwork and non-probability snowball sampling, where willing participants shared what we were doing with others and referred them to us. The authors spent considerable time in areas within and surrounding downtown Lethbridge, getting to know people in the area who were street-involved and self-identified as PWUD. Recruitment occurred in two ways 1) the authors approached people hanging around in the downtown, and 2) individuals who were curious who we were, approached us. In both cases, we explained we were researchers, the study's purpose and invited them to be interviewed at their leisure. Interviews were conducted until thematic saturation was reached. To capture the breadth of street-involved PWUD' experiences and perceptions, the researchers did not recruit participants via Lethbridge's SCS or any other organization/agency (see Bourgois, 1998; Fry, 2002; Schäffer, Stöver, & Weichert, 2014; Urbanik, Maier, & Greene, 2022). Eligibility for participation was restricted to people 16+ and to those residing or spending significant time in downtown Lethbridge.

Almost all individuals invited to interview agreed to participate and were compensated $30.00 for their time and knowledge. Of the total sample (N=50), two declined to have their interview audio recorded. In these cases, the interviewer took extensive notes during and after the interview to fully capture their accounts. Prior to the interviews, the researchers explained the consent process and made clear that they could share what they were comfortable with, end the interview at any point, and skip any questions they wanted to, noting that this would not affect their compensation. Interviews were completed in spaces chosen by participants, such as parks, alleyways, parking lots, outside public libraries, and mall food courts. While these spaces were often frequented by participants' friends/others, the researchers did their best to encourage setting up interviews in semi-private locations so interviews could not be overheard (e.g., at the chosen location, such as a park, away from pathways and groups). The interviews began with the authors using a general prompt guide (developed by the authors), and participants were asked a variety of questions about their experiences and perceptions of street life in Lethbridge, including questions about SCS/OPS, safety, victimization, and legal actors (e.g., police). With research assistant assistance, audio recordings were transcribed, and interviews thematically analyzed.

	SCS	OPS
Route Administration permitted	Injection, Oral, Snorting, Smoking	Injection, Oral, Snorting
Injection booths	13	3
Smoking rooms	2	0
Open hours/7 days week	24	20
Appointment necessary	No	No
Medical intervention (drug poisoning)	Yes	Yes
Average quarterly visits*	48,076[1]	Unavailable*
Average unique individual quarterly visits**	380	273
Overdose reversals**	3360	862

Fig. 1. SCS Characteristics by Site.
*Data extracted from COVID-19 Opioid Response Surveillance Report (see Government of Alberta, 2020b).
**Data extracted from the Alberta Substance Use Surveillance System to up to second quarter of 2022 (see Government of Alberta, 2022a).

The researchers applied deductive and inductive thematic analysis to guide the identification of common themes throughout all stages of data collection, exploring new themes until thematic saturation was reached (Charmaz, 2011; Guest et al., 2006; Small, 2009). Guided by Braun and Clarke (2006) and Maxwell (2012), we continuously examined the data at each stage of data analysis, discussing interview data, reading and re-reading interview notes and transcripts to identify initial free codes and used an open-coding process that resulted in the initial identification of 13 organizational themes (e.g., SCS, OPS, victimization, police experiences, drugs) and 29 substantive themes (e.g., SCS/OPS location, SCS/OPS access, drug use location, route administration, street-based violence, police violence), safety, SCS/OPS resources, security). At the final stage of analysis, the authors, following Braun and Clarke's best practices, reread all interview transcripts and notes to ensure that the organizational and substantive themes were representative of the coded

Age	16-29	26.0% (n=13)
	30-49	46.0% (n=23)
	Over 50	16.0% (n=8)
	Missing	12.0% (n=6)
Gender	Woman	50.0% (n=25)
	Man	46.0% (n=23)
	Transgender	4.0% (n=2)
Ethnicity	white	32.0% (n=16)
	Indigenous	68.0% (n=34)
Housing Status	Houseless	100.0% (n=43)
Substance	Meth	6.0% (n=3)
	Meth and Opioids	60.0% (n=30)
	Alcohol and Meth	8.0% (n=4)
	Alcohol	24.0% (n=12)
	Methadone	2.0% (n=1)
Route*	Smoke	41.7% (n=15)
	IV	33.3% (n=12)
	Smoke and IV	25.0% (n=9)
Access SCS	Yes	62.0% (n=31)
	No	34.0% (n=17)
	Missing	4.0% (n=2)
Access OPS	Yes	18.0% (n=9)
	No	78.0% (n=39)
	Missing	4.0% (n=2)

Fig. 2. Sample Characteristics.
*Route (n=36): Excludes 14 cases (alcohol 12, methadone 1, missing, 1).

data, and participant quotes selected to represent these themes accurately reflected the data. The data used in this paper are based on 3 organizational themes (SCS, OPS, drugs) and 6 substantive codes (SCS/OPS location, SCS/OPS resources, SCS/OPS access, drug use location, route administration, safety). All participant names are pseudonyms.

Findings

Participants spoke candidly about their experiences with and views of the SCS and OPS, providing important insight into the impact of policy and service changes on their lives. In general, the SCS' replacement with an OPS was perceived negatively. While most participants reported regular, routine access of the SCS, far fewer reported (routinely) accessing the OPS, often referring to it as "the bus". Those who reported accessing the OPS said they mainly did so for the purpose of obtaining injection supplies:

> *"There's a bunch of people who go to get supplies there, that's about it. Never really been to that one."*
>
> (Trent)

> *"I just go there once and a while to get rigs...Usually, I never go to the bus."*
>
> (Dre)

Those who reported OPS access for consumption reported doing so to reduce the risk of overdosing. Marcus explained: "*If I shoot up, I use the injection site now. I barely ever shoot up now though, but when I do, I go to the bus. Just because it seems that, like. I've overdosed 38 times."* In contrast, participants reported SCS access for a broader range of motivations, including both health and social reasons (see below).

Participants took time to share their views on what they perceived were some of the broader health and social impacts of the SCS closure, which included higher numbers of drug poisoning deaths and unsafe syringe disposal since the closing of the SCS. Reflecting on when the SCS was still in operation, participants often discussed how unsafe syringe disposal in public spaces was reduced: "*There's not gonna be so much needles on the ground and there'll be safety for kids*." (Monica). Grant explained that after the SCS opened: "[The park] *got cleaner. Like needle wise, it got cleaner*." Not surprisingly, participants noted that after the SCS closure public syringe disposal increased: "*There's more needles around"* (Addison), and *"Honestly, I think there's more needles and stuff found outside"* (Alex).

Participants also reported that since the SCS closure they were seeing more people dying from overdose: "*There's too many people dying now*" (Ethan), and *"More people have died, a lot of more people died"* (Adia). These increases were more than just numbers; through tears, Destiny explained "*We lost like over 30 friends since it closed*." All participants reported experiencing the loss of friends and/or family members to drug poisonings, and many participants noted increases in overdoses and deaths in public settings since the SCS closure. To illustrate, Cher explained "*one of the reasons why I didn't like it when they shut down*" is "*I've walked through this park, and I've seen dead people. I've seen people die."* Ben rhetorically asked: "*Who's watching them?*" as he elaborated on the lack of institutions and services that keep local PWUD safe. Participants' accounts are reflected in the significant increase in drug poisoning deaths in Lethbridge since its closure. While the SCS was in operation, an average of 3 people died from opioid drug poisonings monthly, this average has increased to 6 deaths monthly since the SCS closure (Government of Alberta 2022a).

For participants who had previously and routinely accessed SCS, changes in location, services provisions, and social aspects, were the three primary factors influencing their decisions to limit or avoid OPS access. Participants' narratives pointed to three core contextual elements that differentiated SCS from OPS: (1) smoking room access; (2) location; and (3) the provision of social activities/services/space. Importantly, these factors appear to have facilitated SCS uptake, even in the presence of traditional SCS access barriers (e.g., long wait times), and the absence of these elements appeared to limit OPS uptake even when some of those barriers were comparatively lesser than they were at the SCS (e.g., wait times). Many participants reported positive SCS experiences and accessed it regularly. This was particularly true for participants reporting meth and down use via smoking and injection (see Fig. 3).

		SCS Access	No Access	OPS Access	No Access	Total
Substance	Meth	33.4% (n=1)	66.6% (n=2)	0.0% (n=0)	100.0% (n=3)	100.0% (n=3)
	Meth and Opioids	86.7% (n=26)	13.3% (n=4)	30.0% (n=9)	70.0% (n=21)	100.0% (n=30)
	Alcohol and Meth	25.0% (n=1)	75.% (n=3)	0.0% (n=0)	100.0% (n=4)	100.0% (n=4)
Route	Smoke	86.7% (n=13)	13.3% (n=2)	6.7% (n=1)	93.3% (n=14)	100.0% (n=15)
	IV	91.7% (n=11)	8.3% (n=1)	16.7% (n=2)	83.3% (n=10)	100.0% (n=12)
	Smoke and IV	88.9% (n=8)	11.1% (n=1)	55.6% (n=5)	44.4% (n=4)	100.0% (n=9)

Fig. 3. Substance and Route Administration by SCS/OPS Access.

Access to smoking rooms and supplies

Participants frequently reported the OPS restriction on smoking prevented them from access and led them to find alternative locations for consumption: "*You can't smoke in the bus or around the bus. So we just go other places*. (Kris). Even those participants who reported OPS access noted the benefit permitting smoking provided, stating the SCS:

> *"…was way better than this little one. It was a lot bigger, and they got a smoking room."*
>
> (Axel)

> *"… was better…because more people were able to go in and use…and plus they had the down smoking room and then the side smoking room".*
>
> (Terry)

Critically, a number of participants reported preferring the SCS because they did not want to inject "*all the time*": *"I liked the* [SCS] *because you could smoke there, cuz I don't like shooting up all the time"* (Diamond) or had stopped injecting altogether: "*I stopped using needles…So I don't really go in there*" (Danica). The smoking restriction also limited OPS access for participants that wanted to reduce intravenous drug use by smoking instead: "*Cuz I'm trying not to inject. You can only inject on the bus. You obviously can't smoke fentanyl on the bus and stuff, right?*" Similarly, Heath reported: "*I really would rather just smoke…My veins are already kicked in enough, they're pretty bad. I'm a pretty heavy user"*

The impact of an injection-only OPS was that participants who reported smoking, indicated they did so "outside" or "wherever":

> *"I would say I'm using outside more. I just smoke wherever. Ever since I got out of jail, which was a month ago, I haven't shot up. Well, I think I've shot up once. But I'm trying not to shoot up. I used to shoot up in my neck. I don't know if you could see the tracks? Trying to walk away from that."*
>
> (Danny)

For some, access to a personal tent for shelter at an encampment was preferable to the OPS:*"Now that I got the tent, I don't think I'll be using* [OPS] *very much anymore."* (Heath)

The change to an injection-only site left participants who had previously accessed SCS without a safe and supervised space to smoke drugs. Further exacerbating these harms, many participants also reported that they were no longer able to access clean smoking supplies: "*I still use bubbles which they don't carry anymore."* (Dawn). Likewise, Justin explained: "*The old site offered tubing and bubbles…But now, they don't offer that stuff. So I never have a reason to really go. I've never been on the bus*."

OPS location

Despite the area around the OPS being a service hub, many participants reported feeling uncomfortable accessing or spending time there. To access the OPS, one must walk approximately 10 minutes from downtown, along a high-traffic road and highway-overpass bridge. The bridge's narrow sidewalk left some participants feeling unsafe and vulnerable to vehicle traffic. In addition, several participants reported the bridge area was a frequent site of public intimidation and assault, often by people driving by:

> *"I was walking across the bridge and they thew a soup can right at my face".*
>
> (Madison)

> *"There's people that yell out of their vehicles and throw shit out of their vehicles at us".*
>
> (Antoni)

> *"You know, we'll be by the bridge and the stairs down to the shelter. You'll be sitting on the stairs. And then like these, like, groups of cars come driving by yelling racial slangs or…just, you know, being ignorant or something."*
>
> (Roderick)

For these participants, simply trying to walk to the OPS and/or other social services in the area (e.g., the shelter) placed them at risk of verbal and/or physical assault from passing motorists. These experiences are not uncommon for persons experiencing homelessness, research in other locales has found that homeless persons experience violent and abusive treatment from members of the public while spending time in and travelling through areas where harm reduction services such as SCS are located (Greene, Urbanik, & Geldart, 2022; Joern, 2008; Wachholz, 2005).

Once participants made it to this service hub area, their concerns about the OPS' location did not dissipate, as many viewed the immediate area surrounding the site as unsafe. Participants spoke of large numbers of people congregating near the OPS and frequent conflicts: "*There's more people at the shelter now. It's kind of like a dramatic place now because there's so many different vibes, and a lot of people get into fights. I feel like there's more people using NOT there* [OPS] *because everyone went there* [SCS] *before.*" Holden adds: "*Everyone fights usually at the site there."* Notably, some participants reported feeling this way prior to the OPS opening. Addison was reluctant to access the shelter and OPS: "*Now it's just…parked right in front of the shelter, and I didn't even trust being at the shelter, so*." Ashton similarly described how he used to feel when in the area: "*I didn't feel safe there, I was always looking over my shoulder*." Even participants that indicated currently spending time in the area voiced safety concerns. Megan, who was sleeping at an encampment with the immediate proximity of the OPS explained: "*I stay around the shelter. Right now* [during daylight] *it's okay, but going towards the dark, it's like I have to watch myself*." Not surprisingly, such safety concerns led some PWUD to avoid the area altogether: "*When the* [SCS] *was open, it gave people a better, safe environment…And you know, doing it out here, now we have no choice right? There's no safe, safe zone. So we just go find somewhere where there's no one around and do it* [consume substances]." (Greg). Lastly, when considering the impact of these negative perceptions of safety as a barrier to OPS access, it is important that this impact is understood within the *totality* of other widely documented access barriers and access facilitators (e.g., additional resources that reduce the negative effects of traditional barriers), as what facilitates and hinders OPS access may have varied impacts based on local contexts.

The material, social and affective resources shaping SCS/OPS access

Participants' reasons for frequent SCS access and their limited OPS access attuned us to the interrelationships among the contextual factors shaping service uptake. Several highlighted that the SCS provided them with more comprehensive support and care, including various social benefits. Predictably, its closure left a gap in the City's institutional support structures. Diamond explained: "*A lot of people don't understand* [the impact of the closure]. *People just thought it was a safe consumption site where they didn't understand all the services, other than safe consumption site, I mean"*. Even participants that reported only using alcohol/cannabis recalled SCS access for services because it was a social environment where they felt safe and respected: "*I'm not a wicked drug user but we went in there. They treated us good. They said, 'There's a space in here, you guys can smoke'. And I looked at her, 'Really? Okay!' So we went in there and we smoked a joint. I felt safe*." (Tess). These narratives point to the diverse aspects that encouraged people to access the SCS, as compared to the OPS.

In sharing their SCS experiences, many participants recounted the importance of resources and services *other* than drug consumption supervision. Participants often spoke of the health and social services available, describing the SCS as "*An essential service that was still trying to provide help. Because they had the housing first side, and everything on the other side*." Even though Ashton felt the SCS rushed people through the site, he described SCS services and staff as "*…very supportive…*[because] *they had an addictions' counselor, they had a mental health counselor, they had nurses, they had registered nurses, they had other team members to help with daily activities and whatnot. It was all set up to help people*." Participants' accounts reveal that these services were an important part of their decision to access SCS: "*Health care, social services, addiction* [services]. *That's why you'd go over there*." (Marcus).

In addition to these material resources, SCS access was also facilitated by additional social and affective resources. Many participants described the SCS as a place where they felt accepted, and could socialize with others:

> *"I liked it because you got to go to mic club…You get to sing and they'll make you recordings and send them out to producers and stuff so you can get jobs…when it [SCS] got shut down I hated it cause now there is no place to put the mic club."*
>
> (Ty)

> *"I loved what [the SCS] does. I truly loved their message. They're just tryna get across that like, we're people too."*

Mel emphasized the importance of the SCS as a "*hang out spot*" and how this drew PWUD to access the site: "*it was also a hangout spot because it was open 24/7. So, a lot of people would hang out around there…And if they wanted to do their stuff, they'd walk to the consumption site*." Similarly, Ty speaking about friends who used the SCS, shared: "*They'd* [PWUD] *stay around in that area. When they had that site there, you knew where they all were.*" (Ty). As a place to meet and socialize, the SCS also fulfilled a safety function as participants explained they would go there to "find people" for reassurance they were well and alive: "*Well, you knew where to go to find people. You knew where to go to see if they're still alive. Now you don't know where they are. Cause they could be anywhere now. There's no safe consumption site here, you know, it's just not the same*." (Tess).

Participants' accounts unmask the emotional impact of no longer having access to an SCS where they could confidently locate and/or find out about the well-being of friends and loved ones and how these resource losses contributed to a reluctance to access the OPS:

> *"It's a shitty thing because you can't like really do activities, gatherings. I miss them. I really do. I miss going to mic club. I miss, what's it called again? Teamwork, help builders, skill builders, all of this stuff that got cancelled. Now…it's different, I don't like it. That's why I don't go on the bus."*
>
> (Kiera)

> *"I was sad when it got cut down. What they have right now…we are lacking on services."*
>
> (Anna)

Similarly, after being asked if he had ever accessed the OPS, Antoni drew attention to the need for OPS to offer clients more than a "*safe space*" to consume:

> *"I did [access the OPS] when it first got there just after ARCHES [SCS]closed. And it is not really fixing the issue. It's not giving the resources that's needed. It's giving a place to go and yes, like safe space. And I totally respect that and whatnot. But people at the end of the day don't want to be where they're at 9 times out of 10. They want to have someone that shows they care and has the opportunity to give them the resources to better themselves."*

As a temporary public health measure, the OPS offers limited services and likely due to capacity constraints must strictly adhere to booth time limits. This may explain, at least in part, the absence of the social and affective elements within the OPS. While this operational constraint was out of the control of OPS staff, these limits likely reduced the time clients had to develop relationships with staff and contributed to a more impersonal environment for PWUD. Experiences with staff at the SCS stand in stark contrast to this where participants' accounts show the importance of being able to spend more time with staff: "*I liked them* [SCS staff], *we'd talk, we'd visit sometimes for a couple hours and stuff. They're good people*." (Marcus).

Consequently, the social and affective resources provided through the SCS were not reflected in participants' accounts of OPS access. While participants recognized the SCS provided them with safety, social

comfort/acceptance, and critically, a safe place to congregate and connect with people, the OPS itself and the area surrounding it were described in negative terms. Participants that reported OPS access often recounted an impersonal and rushed experience and were frustrated by the facility's space constraints:

> *"Yeah, so then you do [prepare] your stuff. By then it's already like 10 minutes later, and they're like, 'okay, man, your time's up.' And then I'd be like, 'I didn't get to finish yet.' 'Well, you have to go. You can come back around if you have to.' So, then you have to go out and come back around."*
>
> (Heath)

> *"Well, they should have some certain parts…You know, different levels? I don't know if it's big enough. What are they going to really turn it into? Are they just gonna leave it how it is?! Where everybody gets drunk on this side, fucking argues? [and] girls on that side."*
>
> (Alex)

As Alex alluded to, participants described an unpleasant, and even hostile, environment surrounding the OPS, likely related to its proximity to a local shelter: *"Now you have people ODing, and you have confrontations with other people*." Despite the availability of the OPS, participants described the surrounding area as the location of numerous overdoses: "*Usually when you hear the ambulance and fire truck, usually it means now it's like overdose. And basically, you know where they're going, they're going to the shelter* [laughs] *because that's where majority like [happen]. One day…there were 10 ODs*." Critically, participants described the challenges of spending time in the area surrounding OPS, and this was particularly true of the area immediately surrounding the temporary shelter which the OPS is parked in front of: "*Basically they don't want nobody hanging out front* [of the shelter]. *Only thing they want is if you're coming in, chill out or lay down. That's it.*" While the area was always busy and encampments were observed, participants reported that when they hung out or slept in the area, they were eventually forced to leave: "*They're* [security] *warning–they're telling us 'Oh you can't, you gotta move, or we're calling the cops*."

Operational barrier impacts

Our findings suggest that the three primary elements (location, route administration, added material/social/affective resources) that differentiated participants' SCS and OPS uptake not only facilitated SCS access, but served to overcome some of the traditional operational barriers that have been shown to limit SCS access, such as long waits and insufficient booth times (see Foreman-Mackey et al., 2019; Park et al., 2019). Despite participants' describing the SCS as "*always busy*" and having "*long line-ups*" and being "*packed*", none of the participants who accessed SCS recounted avoiding services because of this. Derek, who often accessed SCS, was not deterred by lining up to enter the SCS even though "*The line was always big."* In contrast, many participants described avoiding the OPS because *"There's only like three booths in there."* (Creston) or "*Because there's only like two or three stalls. And they're usually filled up*." (Madison). Given the number of client visits to SCS, it is hard to imagine how the OPS could sufficiently accommodate these 'new' clients without experiencing long wait times. However, few participants reported wait times as a reason they did not access the OPS. Perhaps this was because many did not view OPS as having long line-ups, especially when compared to the SCS. When asked about lines and waiting for SCS/OPS access, Terry stated: "[The lines are]…*not as long as the consumption site. When the* [SCS] *was open, the line was always big. With the bus, the most I've ever seen the line ever get was seven people in the winter*." By contrast, participants reported high uptake and generally positive experiences with SCS, despite also noting "*long line-ups*." Participants did not appear to experience these longer wait times as a barrier to access, instead reporting on several key benefits that encouraged regular SCS access.

These narratives suggest that although the OPS lacked some of the typical SCS operational access barriers (e.g., longer wait times), this did not appear to increase participants' OPS uptake. Instead, our data suggest that it was participants' concerns regarding location, limits on consumption routes, and lack of social space/activities/services that shaped their more modest perceptions and uptake of the OPS. Consistent with McCullough et al. (2015) point that "[if] there is a contextual element that is particularly strong, this strength may compensate for weaker areas" in service delivery (p. 10), harm reduction services lacking in the contextual elements that matter to PWUD' lives, may limit service uptake, even in the absence of traditional access barriers, like long line-ups and wait times.

Discussion

Alberta's move away from evidenced-based harm reduction approach toward a moralistic abstinence and treatment-oriented policy has significantly altered the province's health and harm reduction landscape, the full impact of which has yet to be fully realised. Though our findings document the negative impacts of the SCS closure on PWUD' lives, it is important to note that given the macro level constraints on harm reduction services, in the absence of the SCS, the OPS—however limited in its services—is and will continue to be, an important interim public health measure. Nevertheless, these findings provide early evidence that Provincial policy shifts have negatively impacted PWUD in Lethbridge, and this impact was likely greater for Indigenous persons and communities in the area (Tailfeathers, 2021). Most participants in this study who had routinely accessed SCS reported not (or very rarely) accessing the OPS to consume. Participants believed the SCS closure led to increases in local overdose deaths (also reflected in official statistics), increased drug paraphernalia in public spaces, broadly decreased perceptions of personal safety, and critically, reduced access to harm reduction services (safe consumption and safe supplies).

Consistent with existing research, our findings suggest that the SCS was a critically important health service for those who chose smoking as their preferred means of route administration, and its elimination has left PWUD with a clear gap in service provision (Bourque et al., 2019; see also Gehring et al., 2022). This is particularly troubling given many participants reported wanting to limit injection drug use and smoke instead, which importantly could have reduced risks of contracting blood-borne viruses and soft-tissue infections (Kral et al., 2021). Additionally, many were deterred from OPS access because they perceived the location as inconvenient and unsafe to access due to threats of verbal/physical assault while travelling to the OPS and concerns over conflict/violence in the immediate area. Ultimately, these safety concerns—in particular, the threat of being assaulted/intimidated on route to OPS—led many participants to choose different, "safer" locations for consumption. It is important to note that such safety concerns are but one factor in a complex array of contextual elements shaping OPS access, and that for a non-trivial number of PWUD, this issue did not wholly preclude OPS access. Indeed, between August 2020-June 2022, the OPS had 88,548 visits (Government of Alberta 2022a). What this finding suggests is that locating SCS in areas perceived to be "safe" by PWUD may encourage greater SCS access. Further, our data suggest that in lieu of a permanent SCS, opening additional OPS in other areas of Lethbridge—specifically, the downtown core—may encourage greater OPS access for some PWUD.

While we are unable to account for all possible factors facilitating access, this study suggests SCS and other harm reduction services may benefit from creating, what Duff (2010) describes as an "enabling place" where "social, material, and affective resources" encourage SCS access and critically, whose benefits of access are *greater* than perceived barriers (e.g., long lines, wait times). The SCS provided a safe, social, multi-service harm reduction environment that realized harm reduction goals through high rates of SCS access, even when participants had to wait in long lines. This is because the SCS meant more to participants than a safe place to consume drugs; it was also a place where they felt

accepted, could access supplementary services, engage in social activities, and make social connections. By contrast, the reported absence (or decrease) in these social, material, and affective resources—whose presence are the necessary foundation for creating an enabling environment—has, at least in part, discouraged participants from OPS access (Duff, 2010).

Participants' perceptions of and experiences with the SCS further support Peterson et al. (2021) argument about how it is important to ensure institutions set in place equitable health policies and opportunities to potentially mitigate the negative impacts of broader public health policy and government action. Our data suggest the SCS provided PWUD with a range of local resources (e.g., smoking room, social space) that served a positive function in their lives, both in terms of health and social outcomes. In particular, the fostering of "relationships and networks" within the SCS (with staff, and other PWUD) served as a critical resource—or support system—that may have helped to overcome traditional SCS access barriers and contributed to greater service uptake.

Research has long documented the importance of social relationships in protecting against negative health outcomes (Brummett et al., 2001; Friedman et al., 2007; Holt-Lunstad et al., 2015, 2018; Umberson & Montez, 2010). Though much of this research has focussed on close family/friend/workplace relationships, others have documented the importance of building positive, trusting relationships between PWUD and service providers (Allman et al., 2007; Ostertag et al., 2006). When SCS provide social connectedness and community, emotional support, and security, health inequities may be reduced (but see Kerman et al., 2013). As such, this study extends the existing literature by further documenting the contextual elements that can increase SCS service uptake, and support Caulkins et al., and Kilmer (2019) argument that in SCS operations "The goal is not simply to have use supervised, but to optimize the design of supervision to achieve the greatest coverage of at-risk individuals […]" (p. 2112). There is a need then to recognize the full breadth of benefits and interventions SCS can provide and to consider the critical importance of providing a safe *and* social space in the implementation of SCS.

For an enabling environment to flourish, Duff (2010) directs us to consider the local context and needs of PWUD in the community and how these may/may not align with 1) the types of resources offered, and 2) how those resources will be used by PWUD. Participants' more modest views and decreased uptake of OPS then must be contextualized in relation to participants' experiences with the SCS, as well as in the context of other local factors (e.g., experiences of assault and intimidation; access to other institutional services; etc.). Accordingly, our findings provide insight into how the initial offering of local harm reduction services can shape PWUD' *expectations and perceptions of* and consequently, access to new/future harm reduction services. Further, careful consideration of locally specific factors that have the potential to impact PWUD' perceptions of and experiences with harm reduction services is needed. For example, it is possible that because Lethbridge is a smaller community with fewer organizational supports compared to larger urban centres, the social aspects of SCS filled an important gap in local service provision, which may be less influential in larger urban settings.

It is this local context that is critical for harm reduction services because it suggests SCS across jurisdictions cannot expect to achieve an enabling place through simple replication of previously successful programs/services, and instead must take into account the potentially unique local contextual elements that will draw in SCS clientele. For example, in Lethbridge, the SCS' successful creation of an enabling environment was achieved through providing resources (safety, acceptance, social activities, health services) that PWUD needed and *wanted* (see Duff, 2010, p. 342). And while it is clear the SCS was an "enabling place", the process by which this occurred—and might occur in other local and temporal contexts—is uncertain and warrants future examination (see Duff, 2010). Future research, in particular, harm reduction service development/evaluation—should further examine the enabling resources (e.g., employment skills, social activities, other health services) developed/operating alongside harm reduction initiatives to provide a more robust understanding of the interrelationships and influence of social, material, and affective resources and how they shape and might develop alongside SCS to provide deeper understanding of the enabling resources, practices and processes influencing access.

There are several limitations of this study. First, this study is based on PWUD' perceptions/experiences of harm reduction services in Lethbridge at one point in time. While participants spoke of their perceptions/experiences of the SCS, this study does not provide for a pre- and post-analysis of PWUD' experiences with the SCS. Further, while we interviewed a notable proportion of local street-involved PWUD, the study's findings may not be entirely representative of other local PWUD' experiences and perceptions of the SCS or the OPS. Lastly, while this study's aim was to capture the perspectives of PWUD, our findings may have been bolstered by including other participant groups, including current/former SCS and OPS staff, shelter staff, and other community advocates.

Conclusion

The overdose epidemic has contributed to a greater willingness among some Governments to include harm reduction—specifically, SCS—as part of their larger strategic response to this public health crisis. And while the Alberta Government had previously fully embraced and supported SCS, changes in Government leadership since then significantly altered this political context. In Alberta, the current Government's adherence to a moralistic, abstinence and treatment approach threatens the future of evidenced-based SCS operations. The closure of Lethbridge's SCS has negatively impacted the PWUD' lives and its replacement with an OPS—while better than no services—does not provide the resources needed to accomplish harm reduction goals in the same way that the SCS did. Future policies and programs should consider how to create SCS spaces where PWUD can safely spend time together and access other programs/resources that may facilitate greater levels of service access and further improve health outcomes for PWUD. Finally, while SCS is an important part of Canada's strategy to address the overdose epidemic, policymakers must provide low-barrier mechanisms for PWUD to access a safer drug supply (Csete & Elliot, 2021; Ivsins, Boyd, Beletsky, & McNeil, 2020).

Ethics approval

The authors declare that they have obtained ethics approval from an appropriately constituted ethics committee/institutional review board where the research entailed animal or human participation.

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Declarations of Interest

We have no conflict of interest to declare.

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