COVID-19 & the Opioid Crisis: Harm & Harm Reduction at the Intersection

By: Melissa Ricci

MA Program, Thesis Stream

McMaster University, Department of Health, Aging, & Society

Supervisor: Dr. Mat Savelli

Committee: Dr. Meredith Griffin & Dr. Gavin Andrews

Summer 2021

Table of Contents

Preface **3**
Acknowledgements **5**
Abstract **6**
Chapter 1: Literature Review & Methodology **7**
Chapter 2: Bathrooms & Lockdown: Mid-March to Early April, 2020 ..... **25**
Chapter 3: Frontline Workers, Constant Change, & Lived Experience **40**
Chapter 4: Encampments **64**
Chapter 5: Conclusion: Harm & Harm Reduction During Intersecting Crises **85**
References **103**

Preface

When I applied to the Department of Health, Aging, & Society for my MA, my plan was to complete a project that was very different from the thesis you are about to read. At the time, I was interested in the recent legalization of recreational cannabis in Canada: I wanted to examine how attitudes about the drug were changing in light of its new legal status. I was excited to study a fascinating societal shift as it happened in real-time.

Like many people around the world, however, my plans changed with COVID. When the pandemic started, I was working as a registered nurse in a supervised injection site. At work, I saw how people were experiencing two public health emergencies at once: the ongoing opioid crisis and the new coronavirus pandemic. Like my coworkers, and countless other frontline health professionals in Hamilton, I saw the consequences of this intersection on every shift: the coronavirus itself, a toxic drug supply, service closures, and the consequences of multi-level policy shortcomings, such as the housing crisis and the ongoing criminalization of recreational opioids. It all felt very, very bleak.

After a particularly stressful shift, I called my thesis supervisor and explained that pursuing my cannabis project just didn't feel right anymore. Together we formulated a new plan: in the spirit of medical history and critical health studies, I would write a story about what was happening in Hamilton in the first months of the pandemic. As I conclude this preface, I have just finished the first draft of this project. In the few months since I conducted data collection, I have heard even more stories to be shared, problems to be solved, and angles to explore. The pandemic and the opioid crisis are still happening, after all, and Hamilton has already changed significantly since the first wave of COVID. For now, though, I want to situate this paper in a

broader conversation about how we might reimagine harm reduction (and our society) for the future.

Acknowledgements

First and foremost, I would like to thank everyone who took part in this study: without your input there would be no thesis. I am especially grateful for your willingness to participate in a research project during a global pandemic, when you obviously had many other commitments. Thank you for everything you do for harm reduction in our city.

I would also like to thank my thesis committee members, Dr. Meredith Griffin & Dr. Gavin Andrews – thank you for your time, energy, and input. Thank you, as well, to the Department of Health, Aging, & Society: I feel so lucky to have pursued this degree with such a welcoming group.

Gratitude is especially in order for my thesis supervisor and friend, Dr. Mat Savelli: I can't thank you enough for your generous comments on *very* early drafts, flexibility, and timely answers to my frantic questions. I owe you a giant bag of jujubes when the world reopens.

I would also like to thank (in no particular order):

- my parents, Debbie & Chris, for their constant encouragement
- my partner, Taylor, who provided invaluable support, perspective, and caffeine
- and my cats, Mary Sanderson & Roy Donk, even though their proofreading skills need some work

Abstract

This project utilized an interdisciplinary approach to explore what harm and harm reduction meant during intersecting public health emergencies, the opioid crisis and the coronavirus pandemic. Using thematic and historical analysis, I analyzed interviews with frontline workers, news coverage, and municipal government documents to understand how people conceptualized the opioid crisis during coronavirus (and vice versa). On the whole, I found that harm reduction was a central aspect of the efforts against the opioid crisis in Hamilton. However, there were discrepancies in how it was practiced and understood. Generally, harm reduction was presented in municipal government documents as a medical intervention that involved, for example, the provision of new needles and naloxone kits to prevent disease and death. Such a practice was indeed important to address the unique harms at the intersection of COVID and the opioid crisis. However, to frontline workers and activists, harm reduction was a much broader term: it included services that were crucial to daily life, such as food and washrooms; the right to safe housing; and broader social and structural interventions, such as the decriminalization of opioid use. The context of the coronavirus pandemic, which exposed people who use opioids to unique harms, exacerbated the disparity between these definitions: harm reduction was simultaneously presented as a narrow, medical practice and a broad, political intervention.

Chapter 1: Literature Review & Methodology

Introduction

On May 6, 2020, *CBC Hamilton* published an article titled "Fears a potent new street drug and lack of naloxone will mean a 'crisis within a crisis'" (Craggs, 2020). Healthcare and social service workers were reporting that new varieties of fentanyl, a potent opioid, were causing overdose and, presumably, death in the community. Hamilton was clearly in the throes of an opioid overdose crisis, but this was not the only public health emergency at play: a novel coronavirus, COVID-19, had triggered a state of emergency in Ontario and a months-long, city-wide lockdown (City of Hamilton, 2020). City bylaws and public health guidance meant that more people were using drugs alone; in conjunction with the changing drug supply, overdoses were consequently more likely to occur and less likely to receive bystander intervention (Craggs, 2020). To compound the matter further, naloxone, a drug that can reverse opioid overdose, became harder to access in light of lockdown-related service changes (Craggs, 2020). Between the time Hamilton entered lockdown and *CBC Hamilton* published this article on fentanyl, drug-related deaths increased approximately 25% in Ontario: according to preliminary data, Hamilton had the highest increase in the province (Ontario Drug Policy Research Network, Office of the Chief Coroner for Ontario, Public Health Ontario, & Centre on Drug Policy & Evaluation, 2020).

This thesis explores how the opioid crisis and the COVID-19 pandemic have converged in Hamilton, Ontario. While the opioid crisis has been unfolding for years, as I will outline in subsequent paragraphs, the COVID pandemic is a very recent issue. Not only has the coronavirus pandemic led to widespread service changes throughout the city, it has interrupted efforts to end the opioid crisis, which has direct and immediate ramifications for people living at the centre of these two emergencies. For example, a common piece of advice to prevent accidental overdose death is for opioid users to not use the drugs alone; this directly contradicted advice to keep

distance from others to prevent the spread of COVID-19 (Tyndall, 2020). I explore how the Hamilton community, broadly speaking, navigated this tension: how did the COVID pandemic affect responses to the opioid crisis (and, in turn, how has the opioid crisis affected COVID response)? To engage with these broad questions, I conducted interviews with workers on the frontlines of the opioid crisis, analyzed local media coverage of the crises, and consulted municipal government documents related to the intersection of COVID and the opioid addiction epidemic. Taken together, these sources tell the story of how these health crises intertwined in the first months of the pandemic, between March and November, 2020.

Before I outline the structure of this thesis, it is important to clarify how key terms are used in the coming chapters. To begin, it is crucial to explain the difference between a pandemic and an epidemic: a pandemic is a global spread of disease, whereas an epidemic is an international spread of disease: COVID is a pandemic, the opioid crisis is an epidemic (Grennan, 2019). In the body of this thesis I will use such terms to represent COVID-19 (the pandemic, coronavirus, or COVID) and the opioid crisis (the opioid epidemic). Referring to the people at the intersection of these health crises, I have used a variety of terms such as “opioid users” or, most often, “people who use drugs”. There is a large body of literature in the social sciences on language (especially people-first language), stigma, and identity (see, for example, Broyles et al. (2014) in favour of people-first language, and Gernsbacher (2017) which suggests that such language can be stigmatizing). My thesis will not explore this discussion at length. While I am cognizant of the impact of language and its ramifications on stigma and identity, such debates are ongoing. In the spirit of postmodernism and the constructivist nature of knowledge, there is no universal truth and therefore no single correct way to refer to someone. These ideas are fluid and ever-changing. As such, I use a number of terms to refer to people who use drugs.

The outline for this thesis is as follows: in this opening chapter I provide a brief history of the opioid crisis in Canada and the harm reduction approach to opioid use. Beyond that, I draw upon medical history to briefly outline how social context can shape how societies react to drug use and outbreaks of infectious disease. Following this literature review, I discuss the methodological considerations and methods used in this interdisciplinary project, including thematic and historical analysis. Finally, I outline some limitations of my research and the plan for the subsequent chapters of this thesis.

Ultimately, I argue that harm reduction has been one of the key facets of Hamilton's opioid crisis strategy, but the phrase is not used with any degree of consensus in the city. Public health documents and city council agendas, for example, present harm reduction as a largely individual and medical practice, encompassing programs such as the distribution of naloxone kits and sterile injection supplies. Frontline harm reduction workers, though, understand the phrase in a much more holistic sense: in addition to the aforementioned medical interventions, their vision of harm reduction also involves social supports such as housing and access to washrooms. The context of COVID has clarified exactly how people use this phrase with different meanings and intentions: as programs changed and closed around the city during the pandemic, the limitations of a biomedical, individualized approach to harm reduction became apparent. Programs like needle exchanges were still operating, for example, but rates of overdose and death continued to escalate: in short, biomedical programs were not enough to prevent the harms of the opioid crisis during COVID. The municipal government has long understood harm reduction as a narrow, medical practice; such is true for many other organizations around the city. The coronavirus pandemic, however, exposed people who use opioids to new harms and worsened existing social

problems: according to frontline workers, a biomedical harm reduction practice became increasingly inadequate.

Indeed, scholars have suggested that biomedical, institutionalized harm reduction programs may reinforce neoliberal, individual responsibility while ignoring social or structural factors that limit personal agency (Keane, 2003; Rhodes, 2009; Roe, 2005). The city's COVID measures, I argue, reflected such values: the local government favoured biomedical aspects of harm reduction, but services and programs were less available in the context of coronavirus public health restrictions. As such, personal agency was limited by COVID prevention and legislation. When public health guidance for the pandemic did not consider the perspective of people who use drugs, for example, the health of this group was not seen as a priority. Not only were people who use drugs exposed to new forms of harm because of the pandemic and related service changes, there were few supports in place for people at the intersection of these emergencies. Scholars have long suggested that there is a tension between institutionalized harm reduction programs and grassroots harm reduction advocates, who often call for the decriminalization and destigmatization of drug use (Keane, 2003; Watson et al., 2020). The COVID pandemic, on the whole, has brought this tension to the forefront. To move forward, it will be necessary to reimagine harm reduction as it is practiced in Hamilton, broadly speaking. The final chapter of this thesis offers some suggestions on this front.

Literature Review

If one looks for constants throughout recent human history, two things, among others, become evident: 1) humanity has consistently experienced outbreaks of infectious disease, such as COVID-19 and HIV/AIDS; and 2) humans have a long, complicated relationship with substance use. Both of these occurrences are socially situated: when one examines how a society

responds to infectious disease or panics around substance use, it is clear that social factors and context shape such responses. The methodology section of this chapter includes a brief discussion of how context can influence a community's efforts to address infectious disease. This section of the literature review focuses primarily on the opioid crisis and harm reduction programs, exploring how both have shaped by the society in which they are situated.

The Opioid Crisis & Harm Reduction

The opioid crisis, also known as the opioid epidemic, has been an issue for over a decade in Canada: tens of thousands of Canadians have died as a result of issues with opioid use and drug supply (Ontario Drug Policy Research Network, Office of the Chief Coroner for Ontario, Public Health Ontario, & Centre on Drug Policy & Evaluation, 2020). Opioids are a class of drug that are primarily used as analgesics; such drugs can include morphine, heroin, and fentanyl. Opioids are used for both medical and recreational purposes, and over the past years the drug supply of illicit, recreational opioids in Canada has become stronger and more unpredictable, leading to an epidemic of accidental overdose and death (Tyndall, 2020). Between 2016 and 2018, as an example, over 11 000 Canadians died from opioid-related causes, such as overdose (Taha, Maloney-Hall, & Buxton, 2019). In the first three months of 2020 alone, at least 1000 Canadians died from opioid-related causes, and these numbers seem to be rising in the context of COVID-19 (Ontario Drug Policy Research Network, Office of the Chief Coroner for Ontario, Public Health Ontario, & Centre on Drug Policy & Evaluation, 2020).

Beyond overdose deaths, there are myriad other health consequences related to opioid use and the opioid crisis. People who use opioids often experience significant medical and social hardships, such as trauma, chronic pain, homelessness, addiction, and mental illness; opioid use is also heavily stigmatized, and this stigma can have negative social and economic consequences

for both users and society as a whole (Morin et al., 2017; Firestone & Fischer, 2008; Fozouni et al., 2019; Webster, Rice, & Sud, 2019). Such stigma can manifest in how opioid users are treated in the healthcare system, for example, or in stigmatizing news representation, which can perpetuate harmful beliefs about addiction and drug use. Given the widespread ramifications of the opioid crisis, it is important to examine how the epidemic has been understood and constructed by Canadian society.

Social perceptions of drugs are constructed: the meaning of a drug can fluctuate between medicinal and recreational depending on time and place (Crocq, 2007). Scholars suggest that the opioid crisis, for example, has been happening in Canada for nearly a decade, but opioid use was not always considered a crisis. Since the meaning of drugs can be fluid, changes in popularity (or perceived popularity) of a drug can lead to panics around the spread of these drugs and their addictiveness (Jenkins, 1994). Such historical drug panics are often tied to social values around drug use and its construction: take, for example, the panic over marijuana use in Canada in the 1930s, which reflected xenophobic views of increasing emigration from Mexico (Johnston, 2020; Jenkins, 1994; Netherland & Hansen, 2016). Sometimes, then, concerns regarding drugs are not a result of the drugs themselves but a reflection of who is associated with using a drug.

The media can offer rich insight into the stigmatization and construction of opioid use and the opioid crisis. Generally, the media plays an important role in perpetuating drug scares and reinforcing normative social values (Johnston, 2020). Coverage of opioid use in Canadian media, for example, reflects and reinforces the attitudes of society as a whole. News articles on the topic often point to a tension between so-called legitimate users, such as people who became addicted to prescription opiates after a medical procedure, and addicts, who are usually represented as members of stigmatized groups, such as people living in poverty or homelessness

(Webster et al., 2019). The former group is often portrayed with sympathy while the latter group is not given the same consideration, at least in the case of media portrayals. As well, concerns around opioid use are often related to fears about reduced productivity in a capitalist society (Race, 2008). Importantly, such stigmatizing views of addiction are related to indifference and inaction in the context of the opioid crisis (Tyndall, 2020). In fact, when media depictions focus on causes of the opioid crisis, these stories are likely to blame individuals, such as physicians or dealers, and draw attention away from important players such as the pharmaceutical industry or the government (Webster et al., 2019). Clearly, the way that opioid use is presented in the media in Canada and, as an extension, Hamilton, can reflect broader assumptions about people who use drugs. Media representations, then, reflect and reinforce social norms around who deserves sympathy and who is responsible for this public health emergency.

Criminalization and enforcement have been some of the main approaches to address addiction, which suggests that illicit opioid users are immoral, deviant criminals who must stop using these drugs (Taha, Maloney-Hall, & Buxton, 2019). Such assumptions have influenced how Canada has approached the opioid crisis as a whole. Enforcement strategies, however, have been largely ineffective in reducing opioid use and opioid-related deaths. When the federal government enacted the National Anti-Drug Strategy in 2007, for example, overdose deaths continued to rise in the face of continued criminalization (Morin et al., 2017). In 2012, concerns arose over the liberal prescribing of oxycontin, a powerful and widely available opioid: in a failed attempt to reduce opioid use and death, changes were made to the availability of the drug but death rates continued to climb (Morin et al., 2017). Scholars suggest that the drug market slowly shifted to include more potent, less predictable drugs, such as fentanyl, which is related to a higher likelihood of overdose and death (Tyndall, 2020). In the face of failed law enforcement

strategies, which only seemed to cause shifts in the drug market, the opioid crisis continues to affect the lives of countless Canadians.

As a result of these failed attempts to reduce opioid-related deaths, Hamiltonians have increasingly turned to harm reduction programming. Harm reduction programs generally treat substance use as an inevitable, amoral issue; instead of encouraging drug users to abstain, these programs focus on ways to reduce substance-related harms (Race, 2008; Smith, 2012). Such harms might include overdose, accidental death, or illness from reused drug supplies, such as syringes or pipes. Harm reduction has become increasingly popular in Canada in recent years, and Canadian initiatives include programs such as naloxone distribution and supervised consumption and injection sites (Morin et al., 2017). Harm reduction programs aim to prevent opioid-related death and disease among people who use drugs.

The harms experienced while using drugs are not only a result of personal drug use. Harm reduction programs do encourage personal responsibility for drug-related risk, which suggests that people who use drugs should take initiative to seek out these services to protect their health (Moore & Fraser, 2006; Rhodes, 2002). However, the harms one experiences while using drugs are not limited to the experience of the drug itself: these harms can be closely tied to broader social policy, such as government funding for welfare and healthcare (Rhodes, 2002). For example, scholars have suggested that injection drug use is associated with a higher risk of HIV transmission, and decreased government spending on healthcare can increase rates of the virus in general (Rhodes, 2002). Indeed, there are myriad other factors that influence harm: unstable housing, lack of finances, mental illness, and the criminalization of drugs can limit one’s ability to practice harm reduction or self-care (Boucher et al., 2017). As I explore in the following chapters, the COVID pandemic exposed people who use drugs to additional sources of

harm. Thus, the context in which one uses opioids is just as important to one's health as the drugs themselves.

Clearly, social context has remarkable influence on the health of drug users. The relatively narrow focus of hegemonic, biomedical harm reduction practice has become an area of concern for academics, who argue that the movement has become separated from its roots. Harm reduction programming originated in the 1980s in light of the HIV/AIDS epidemic and the policing of drug use in the 1960s and 1970s (Rhodes, 2002; Roe, 2005). Activists, concerned with rising rates of HIV infection, risked arrest for distributing drug paraphernalia when they chose to hand out new needles to reduce the spread of the virus (Smith, 2012). While the harm reduction movement was initially one of grassroots activism, it has since become a public health movement led by medical professionals, and some argue that it has lost its political focus as it has become institutionalized (Roe, 2005; Smith, 2012). When a movement becomes mainstream, as in the case of harm reduction and public health organizations, these programs may be less willing to challenge harmful norms and social structures. By focusing on the immediate, often medical, harms associated with drug use, there is less attention paid to upending social structures that can cause harm, like the criminalization and stigmatization of drug use (Smith, 2012). Importantly, there are no federal or provincial harm reduction policies in Canada, which means that the provision of such services is inconsistent throughout the country (Hyshka et al., 2019). While harm reduction does indeed save lives and prevent disease, the institutionalization of such programs means that services and professionals can directly or indirectly benefit from being involved in such programming or, as an extension, the ongoing criminalization and stigmatization of drug users (Roe, 2005; Smith, 2012). While having widespread support for harm reduction in Canada is crucial in the ongoing fight against the opioid crisis, these critiques

highlight how the practice of harm reduction has changed, for better or worse, and the importance of social context in understanding the ramifications of such interventions.

Another criticism of harm reduction relates to its construction of harm. While harm reduction as an ideology encourages people to view drug use as an amoral practice, the distinction of what is harmful can be a moralizing, normative one (Race, 2008). For example, some scholars have suggested that harm reduction programs and policies have focused primarily on biomedical and epidemiological data, and have not acknowledged that drug use can be pleasurable or offer other benefits (Watson et al., 2020). Even the use of harm reduction as a response to drug use could suggest that recreational drug use is an immoral, abnormal, harmful practice that needs mollification. Further, the decision to access harm reduction services is also presented as a personal, ethical choice. Critics of mainstream, institutionalized harm reduction programming suggest that these programs aim to transform drug users into rational, productive citizens, and that harm reduction ignores the structural and social context that encourages drug use while limiting personal agency (Kennedy & Coelho, 2019). Further, assuming everyone is able and willing to practice harm reduction can ignore the influence of material and structural factors that might make such programs harder to utilize (Moore & Fraser, 2006). Some critics have gone as far as suggesting that harm reduction programs are sites of discipline that treat drug users as something that need to be cleaned out of a neighbourhood (Kennedy & Coelho, 2019). While there are some benefits to the widespread adoption of harm reduction, there are clearly some issues that arise when trying to reconcile this activist movement with neoliberal ideas about health. It may not be possible to fully separate harm reduction from normative views of health and responsibility. Such considerations are especially important in Hamilton, where, as I will

discuss in subsequent chapters, harm reduction has become a key intervention during the opioid crisis and the COVID pandemic.

Methodology & Methods

Historical & Thematic Analysis

Social context is especially important when studying the intersection of the COVID pandemic and the opioid epidemic. As such, this thesis integrates aspects of historical and thematic analysis to provide insight into the myriad ways in which these public health emergencies shaped one another. To conduct this project, I utilize a number of disciplinary perspectives: social history, primarily, as well as aspects of sociology, anthropology, and critical nursing theory. At a fundamental level, I draw from constructivism and postmodernism. This section provides my rationale for such methodological decisions, after which I outline the methods used for this project: a thematic and historical analysis of interviews with frontline workers, city council agendas, and local news coverage.

To start, a discussion of historical analysis. Historical analysis does not always utilize an explicit methodology or theoretical underpinning (Hooker, 2010). Medical history seems to be an exception, especially the social history of medicine: the tradition often takes a relativistic, constructivist view of knowledge. The social history of medicine is grounded heavily in postmodern thought, which argues that there is no such thing as an absolute truth (Cooter, 2007; Mitchell, 1996). Constructivism is a useful ontological and epistemological framework for understanding disease in society. In many ways, a disease cannot exist until there is a consensus that it does: no illness or patient can exist in a vacuum as disease is inherently a social experience (Duffin, 2010; Porter, 1985). As such, illness and disease are not amoral categories, but rather they reflect underlying assumptions and morals that are embedded in

medical practice (Jordanova, 1995; Rosenberg, 1989). Thus, disease is just as much an issue of class, race, bias, and social status, to name a few examples, as it is biology: all of these factors influence when, how, and why a disease is acknowledged, diagnosed, and treated.

While history as a discipline has roots in positivism, the social history of medicine integrates important aspects of postmodernism to move away from positivistic understandings of health and illness (Cooter, 2007). If there is no such thing as an absolute truth, then the construction of social truths becomes especially important in the context of health and illness. Social history, especially, examines the perspective and experience of populations that have historically been marginalized in health research. This can include equity seeking groups and people with marginalized identities, such as racialized communities or people living in poverty (Fass, 2003; Hooker, 2010; Samuel et al., 1985). While early medical history examined medical records and doctors, social historians have sought to focus on the numerous ways in which marginalization, health, and treatment overlap (Cooter, 2007; Pickstone, 2011). Construction of knowledge in this context can relate to ideas of identity and responsibility for one's health, for example. There are many ways in which health and marginalization are intertwined. People may be marginalized and ill, they may be ill because they are marginalized, or they can be marginalized because they are ill. Unlike cultural history, which also utilizes postmodernism but seeks to understand how and why categories of marginalization change over time, social history can explore how these categories of identity can influence society, history, and health (Fass, 2003; Hooker, 2010). As such, utilizing a social history approach, drawing on constructivism and postmodernism, is especially important for a project that explores the health consequences of epidemics, pandemics, and marginalization. While the pandemic is a relatively

recent event, utilizing aspects of social history helps to tell the story of this time and the relationship between these public health emergencies and marginalization more broadly.

Historians are able to engage with illnesses of the past with curiosity, complexity, and detail (Sheard, 2018). Take the early days of the HIV/AIDS epidemic as an example of the benefits of an historical approach to understanding illness. Duffin (2010) explains how early reactions to this health crisis were indicative of the broader social values at this time. In the 1980s, many people drew on moralistic explanations and blamed personal behaviours, such as homosexuality and IV drug use, for the rise of this disease and its perceived threat to then-modern society. These perspectives reflected broader social values of the era, such as capitalist notions of personal responsibility and normative views of sexuality, and such opinions influenced decisions around how the disease was defined and treated at the time. Social history is clearly a useful tool to understand how social status, social context, and disease intertwine. In the context of the opioid crisis, which has affected many people who use drugs, social history is important to understand marginalization and its consequences in the context of COVID.

To tell this historical story of COVID and the opioid crisis in Hamilton, I conducted a qualitative, thematic analysis of several different types of data, including interviews with frontline harm reduction workers, local news coverage, and municipal government agendas. Thematic analysis is a useful tool for examining interviews and media coverage: the method is flexible and can be used with any number of theoretical underpinnings, so long as these underpinnings are made clear (Braun & Clarke, 2014; Braun & Clarke, 2006). Conducting a postmodern, constructivist thematic analysis, then, examines the underlying social conditions that influence how meanings are produced and reinforced in society (Braun & Clarke, 2006). Media sources are specifically useful for such an analysis: the media can shape public

perceptions through representing (or not representing) specific issues, and these representations can serve as a proxy for social norms, values, and understandings of specific issues (Gamson et al., 1992; Johnston, 2020; Webster, Rice, & Sud, 2019). Through an analysis of the perspectives of frontline workers, municipal council agendas, and media coverage, thematic analysis explored how COVID and the opioid crisis were constructed, understood, and prioritized by numerous groups in the city, reflecting the intersection between illness and social context.

To conduct a thematic analysis of news coverage, municipal documents, and interviews I followed the process outlined by Braun & Clarke (2006). To start, I familiarized myself with the data through transcription and initial readings. Afterwards, I coded interesting sections of data and then looked for themes across these codes. There are two types of themes that these authors suggest: semantic themes, which are surface meanings, and latent themes, which reflect underlying ideas, assumptions, and ideologies; latent themes, then, can reflect the construction of knowledge (Braun & Clarke, 2006). After I identified latent themes, I reviewed them in relation to the coded data to ensure that the themes aligned with the codes, after which I named and defined these themes. I then wrote this thesis to reflect the overall story of the data collected, which I argue is also useful from an historical perspective. Both historical analysis and thematic analysis aim to tell a story of the data, which I used to explore the intersection of these public health emergencies in Hamilton.

The process of thematic analysis shares many components with historical analysis, which identifies themes in literature, delineates social categories and relationships, and analyzes throughout the writing process (Hooker, 2010). As such, I integrated thematic analysis and historical analysis as I explored how COVID interventions shaped the response to the opioid

crisis, and vice versa. I focused specifically on how these intertwined initiatives shaped the health of people who use drugs, a demographic at the epicentre of both emergencies.

Methods

This study incorporated several different sources of data, including interviews with frontline workers engaged in harm reduction, local news coverage, and municipal government documents. Data was collected between August and November 2020 and encompassed the period between March and November, 2020. During the collection period, I conducted eleven interviews with frontline harm reduction staff from approximately eight social service organizations. These interviews focused on the experience of working in harm reduction during the first months of the COVID pandemic in Hamilton. I recruited participants by sending emails to organizations in Hamilton that practice harm reduction. While I did not explicitly recruit by word of mouth, some interviewees told me that they had received my contact information from another study participant. To respect the anonymity of these participants, as the harm reduction community in Hamilton is quite small, I have not included any identifying features in this thesis, such as participants' professions, genders, or workplaces.

After finishing these interviews, I collected news coverage on COVID in Hamilton and its relationship to relevant themes such as opioid use and overdose; homelessness; and social service changes. These news articles were primarily sourced from local news coverage, such as the *Hamilton Spectator* and *CBC Hamilton*, but also included national coverage of local issues, such as in the case of an article from the *Globe & Mail*. I analyzed 207 news articles written between March 2020, the start of the pandemic in the city, up until November 2020. I chose this cut-off as it corresponded with the city's decision to clear a large encampment, which was an important event in the city at the intersection of COVID and the opioid crisis. Collecting these

articles involved searching the websites of these news agencies for key terms, such as “opioid” and “homeless”. Articles were excluded from analysis if they did not fall within the aforementioned time period or focus on the situation in Hamilton.

Finally, I analyzed various city council agendas from the City of Hamilton website. I focused on agenda documents as the agendas were often more detailed than the minutes of said meetings; the documents I analyzed included meetings held between March and November 2020. In addition to city council agendas, I explored the agendas and documents of other relevant city committees, such as the Board of Health and the Emergency and Community Services Committee. In total, this included the agendas from 18 meetings and well over 3000 pages of minutes and correspondence. There were not detailed agendas or minutes available for every meeting, nor do these documents include confidential, in camera discussions; as such, I was unable to fully reflect the entire perspective of city council. Accordingly, these municipal documents were used in conjunction with other sources to examine the COVID pandemic and opioid crisis from multiple perspectives.

Limitations and Areas for Further Research

As I mentioned in the section on historical analysis, social history aims to centre marginalized voices. I have structured this project around the treatment and perception of people who use drugs in the city of Hamilton during the COVID pandemic. While I have aimed tell the story of the opioid crisis and COVID, centring the experience of people who use drugs, I decided to interview frontline workers in harm reduction agencies instead of the people who use drugs themselves. I have experience as a frontline harm reduction nurse and wanted to be conscious of the power of my position, avoiding any actual or perceived coercion while recruiting participants. As a result, my thesis includes primarily data that has been collected from outside

the lived experience of someone in the midst of the opioid crisis. While some of the interviewees did self-identify as peer workers, meaning they are people with lived experience of drug use, many organizations in the city require peer workers to be in active recovery, no longer engaging in substance use: these participants could speak to the realities of using substances but not during COVID. Several news articles did include interviews with encampment residents, so there are some sources that include firsthand perspectives. While I believe I am able to provide compelling insight into the opioid crisis in the time of COVID, I do hope that future research will encompass the actual experience at the centre of this story.

In addition, my work as a nurse may have influenced the content of my interviews with frontline workers. To start, some of this influence was likely positive: I believe that I was able to glean a deeper understanding of the situations explored in these discussions. Since I was already familiar with many key terms and organizations that were mentioned, participants could use their time to answer interview questions without, for example, defining medical terms. However, I do acknowledge that the nature of working in such a small field may have limited what participants felt comfortable sharing in their interviews, despite assurances of confidentiality and anonymity. While some people may have felt more comfortable sharing with someone who likely had experienced similar circumstances, it is important to acknowledge that some may have felt the need to censor themselves.

What's Next?

The subsequent chapters of this thesis aim to provide a chronological and thematic account of the pandemic in Hamilton. Chapter Two begins during the first lockdown, using the example of bathrooms to explore service closures at this time and how such closures affected the health of people who use drugs. Following this discussion of bathrooms, Chapter Three

analyzes the perspectives of frontline workers and their understandings of harm reduction and the needs of opioid users in Hamilton during COVID. In Chapter Four I tell the story of the homeless encampments in the city. Encampments were a contentious, visible political issue during the first months of the pandemic, and the discussion around encampments provides insight into the complex nature of pandemic response and social context. The thesis concludes with a discussion of harm reduction during the first wave of the pandemic and makes suggestions for areas of improvement for COVID and future pandemics.

Overall, I argue that the COVID pandemic has elucidated and exacerbated discrepancies in how harm reduction is practiced and understood in Hamilton. The body of this thesis explores the various definitions of harm reduction as employed in conversations with frontline workers, news coverage, activists' correspondence, and city council documents. I examine how harm reduction was simultaneously presented as both a narrow, biomedical intervention and a broad, political practice. I unpack this tension to explore how harm reduction could be reimagined to better support the needs of people who use drugs, calling back to the grassroots, political origins of the movement.

Chapter 2: Bathrooms & Lockdown: Mid-March to Early April, 2020

"There was this brief moment when COVID hit where everybody was like, "We're all in this together! Money is no object! We're gonna move mountains! We're gonna keep everybody safe!" … But at the same time I spent ten weeks on meeting and emailing and falling asleep and waking up… like pleading for people to get bathrooms. They were all closed. And every opportunity I got I was like making impassioned speeches about how undignified it was for people to be shitting themselves."

–Interview with Hamilton harm reduction worker

Introduction

In the middle of March, 2020, the City of Hamilton identified its first cases of COVID-19. This initial period of the pandemic was marked by urgent and rapid interventions. Over the course of only a few days, the city shuttered services and any businesses deemed "non-essential" were closed for a period of at least two weeks (City of Hamilton, 2020a; Ontario, 2020). The Province of Ontario declared a State of Emergency and enacted the Emergency Management and Civil Protection Act, giving the municipality of Hamilton the ability to redeploy staff, restructure programs, and respond to the pandemic as necessary (City of Hamilton, 2020c). Governing bodies moved quickly to try and prevent the spread of coronavirus. How, though, would these pandemic measures influence ongoing efforts aimed at the opioid crisis?

Using bathrooms as an example, this chapter outlines the events of mid-March to early April, 2020, the period in which Hamilton saw its first cases of COVID. During this time there were many important developments that directly influenced programs to address the opioid crisis: services closed or changed their hours; people were released en masse from the Hamilton-Wentworth Detention Centre (also known as the Barton Street jail); the city introduced a physical distancing bylaw; and agencies around the city experienced unique challenges, such as

shortages in personal protective equipment. This period was one of both uncertainty and innovation in frontline care.

Overall, I argue that the pandemic was prioritized over other health issues. While agencies did work to continue harm reduction programming and other important social services, the health of opioid users, especially those experiencing homelessness, was negatively impacted by stringent and universal public health measures to reduce the spread of COVID-19. The negative effects of these measures were not necessarily the intended consequences of such an approach; they were but a symptom of broader, systemic issues related to the ongoing stigmatization and criminalization of opioid use and homelessness. While some of these interventions did prevent the spread of coronavirus, the effects were not universally positive.

This is not to say that COVID public health measures were unnecessary or universally harmful, of course. In fact, many researchers suggest that COVID prevention was especially important for those affected by the opioid crisis. Many people who use opioids, especially by injection, experience homelessness, and homelessness has been associated with higher COVID morbidity and mortality (Khatri & Perrone, 2020). As well, opioid use is often linked to living in congregate settings, like shelters, encampments, or prisons, where the virus could spread more easily (Guilamo-Ramos et al., 2020). Using drugs, especially injection drugs, could increase someone's likelihood of contracting COVID or dying from it: people are more likely to use drugs in groups, increasing the likelihood of exposure to the virus, and certain drugs, including opioids, could exacerbate the effects of coronavirus on the respiratory system (Guilamo-Ramos et al., 2020; Mukherjee & El-Bassel, 2020). Clearly, preventing the spread of COVID was important to people at the intersection of COVID and the opioid crisis. The ramifications of these

interventions, though, were far-reaching and led to unintended, negative health outcomes for people who use opioids.

Importantly, harm reduction work was ongoing at this time. Such initiatives focused largely on biomedical outcomes: programs offering naloxone and new drug use supplies, for example, continued to operate, but advocates and frontline workers argued that important aspects of harm reduction, such as hygiene or rest stations, were unavailable amid widespread service closures. Harm reduction, then, was operating under a narrower scope than it should, according to frontline workers and activists. This narrow model of harm reduction was not new: indeed, most existing harm reduction programs focused on ameliorating the medical issues associated with drug use. As COVID unfolded, however, frontline workers noticed that the pandemic exacerbated existing social issues, such as homelessness, while exposing people who use drugs to novel harms, such as the virus itself. Those at the intersection of COVID and the opioid crisis experienced unique health challenges, and biomedical harm reduction was increasingly inadequate in this context. To frontline workers, adopting a broader practice of harm reduction – one that included bathrooms and food, for example – would have been especially helpful during intersecting health emergencies that shuttered facilities around the city. The context of pandemic, then, highlighted the growing disparity between these conflicting definitions of harm reduction: the practice had been an institutionalized, biomedical practice even before the pandemic, and coronavirus interventions clarified the shortcomings of such an approach.

Service Closures & Changes: What Was Essential?

"I still have a memory of like, the flood of email notices: this is closing, this is closing, this is closing, this is closing, over and over and… like, what are people gonna do? Everything's closing. Like, food programs are closing in the name of public health."

– Interview with Hamilton harm reduction worker

Service closures and service changes were one of the first methods used to address COVID in Hamilton. After the Province declared a State of Emergency on March 17, services deemed non-essential, such as restaurants, libraries, and recreation programs, were ordered to close (Ontario, 2020). Public health guidance from provincial and municipals sources encouraged, and, in some cases, mandated, people to keep a distance of two metres from those not in their household (City of Hamilton 2020a; City of Hamilton 2020b; Hamilton Spectator, 2020b). On the whole, only essential businesses were allowed to stay open. What, though, was considered essential, and what does this reveal about the government's priorities at this time?

City documents deemed certain infrastructure and emergency services as essential: the fire department, ambulance, police, and waste collection, for example, were all able to continue operation (City of Hamilton, 2020a). A March 17 press release did mention that shelters and drop in services would continue, and that the city had arranged for isolation centres for "shelter residents and homeless/street involved individuals" (City of Hamilton, 2020a). Harm reduction programs, though, were not mentioned in municipal or provincial press releases. Frontline workers in harm reduction were unsure whether their programs would be deemed essential. Staff in one program wondered whether they could stay open under the new State of Emergency (Interviews 3, 6). Ultimately, many of these programs did continue to operate, albeit in a modified form; such modifications often included screening clients for symptoms, mandatory masking, and rules around keeping distance from other people. Notably, many services switched to online or phone formats, which are not accessible for many people experiencing homelessness (Interview 6). Research on outreach efforts amid the opioid crisis emphasizes that people who use drugs and are homeless are less likely to benefit from telemedicine programs (Guilamo-

Ramos et al., 2020; Schlosser & Harris, 2020). COVID-related service changes in Hamilton, then, did not always reflect the reality of how people access such services.

As a result of service restrictions and limitations, harm reduction agencies and social services were forced to adopt a narrower focus in their work. While still explicitly performing harm reduction, frontline workers expressed that their work excluded essential aspects of a harm reduction approach. Adjunct programming, such as drop-in groups or visits from health-care specialists, were mostly cancelled (Interviews 2, 10). Other crucial social services, such as meal programs or laundry facilities, either closed or switched to take-out style options (Hamilton Spectator, 2020b; Interview 6). People who were homeless had fewer places to go to eat, drink clean water, spend time, or perform personal hygiene (Hamilton Spectator, 2020b; Interview 9; Moro, 2020b). Access to bathrooms was a particular point of concern.

Prior to the pandemic, washrooms served a number of important functions for people who use opioids, especially those experiencing homelessness, such as cleanliness, safety, and a way to reduce stigma. Given the known correlation between opioid use and homelessness, such facilities were especially important during the opioid crisis (Fozouni et al., 2019). In one frontline worker's words, harm reduction "is also being able to use a shower and a bathroom… if folks can't use the bathroom, they're gonna go elsewhere and that puts folks in danger, right? … you're highly vulnerable to sexual assault, to being followed afterwards" (Interview 6). These risks were especially significant for women, people engaged in sex work, and anyone who was menstruating: regular hygiene would be especially important in these scenarios and was much harder, if not impossible, to practice without bathroom access (Interview 6). Beyond immediate health consequences or physical danger, one interviewee described the shame that people faced when they did not have a bathroom. In this story, a woman was "peeing on the building" and

started "crying… she doesn't have a urination problem, she has a no-bathroom problem. And then being shit on and ridiculed and dehumanized for having to go when there's no place to go" (Interview 9). In addition to the dehumanization and embarrassment of urinating outside, washroom closures made it harder for people to avoid stigma related to homelessness. One interviewee, who identified as having lived experience of homelessness, explained how:

> Homelessness is already pretty dehumanizing. But you can kind of hide in plain sight when you're homeless, as long as you can look clean and put together, and you can sometimes pull that off in a library bathroom… if you're in a shelter space at night sometimes you can pull it together to look like you're not homeless. Which, if anybody is wondering, is the goal of everybody who's homeless. We wanna look like we're not homeless… there's a lot of stigma attached to being homeless. So you're going to try to avoid that at most cost…. COVID has made it so you can't pull that off at all. (Interview 7)

Bathroom closures directly affected people experiencing homelessness and the opioid crisis. Without washrooms, COVID became a much more dangerous and stigmatizing experience. Harm reduction, to frontline workers, involved much more than new supplies or naloxone. Bathrooms were an important and overlooked aspect of the city's response to the opioid crisis and homelessness. While initial lockdown measures may have been necessary to curb the spread of COVID-19, workers questioned the value of such a limited definition of essential services.

Change & Challenge: Decarceration, Penalization, and Equipment Shortages

In addition to COVID-related service closures, the first few weeks of the virus' arrival in Hamilton were also marked by rapid changes in healthcare and social services. One notable consequence of COVID was a mass release of inmates from the Hamilton-Wentworth Detention

Centre, also known as the Barton Street Jail. Inmates at Barton are generally people awaiting bail, trial, or those serving sentences of less than two years (O'Reilly, 2020b; O'Reilly, 2020a). There was pressure from the public and community activists to prevent the spread of COVID by releasing as many people as possible from the chronically overcrowded facility (Benzie, 2020; Kaufman, 2020; Hamilton Spectator, 2020a). Inmates at Barton cited safety concerns, arguing that the facility did not have the supplies to prevent COVID and that there were no changes to cleaning processes at the jail; these concerns escalated when a staff member tested positive for the virus (Frketich & O'Reilly, 2020; Hamilton Spectator, 2020a). Ultimately, many people were released from the facility, though advocates argued that there was little transparency in this process: over a thousand inmates were decarcerated in Ontario in the first two weeks of the pandemic, but activists and family members were given little insight into how these decisions were made and whose release would be prioritized (O'Reilly, 2020b).

Living in a congregate setting, such as a prison, increased one's likelihood of contracting COVID (Guilamo-Ramos et al., 2020; O'Shea et al., 2020). Releasing people from a crowded institution would reduce their likelihood of contracting COVID, then. However, frontline workers and prisoner rights activists questioned what supports were available for people who were released from prison, many of whom had longstanding issues with opioid addiction. Harm reduction staff were quick to draw a link between incarceration, decarceration, and homelessness: "[the release of Barton inmates] increased our homeless population, because usually we arrest half our homeless and we incarcerate them for petty fucking crimes so we don't have to see them" (Interview 9). Media coverage, in the period before COVID, echoed that there has been a clear link between penalization and homelessness. One specific group of police officers known as the ACTION team was responsible for handing out hundreds of tickets to

people in Hamilton's downtown core, mostly for panhandling or loitering (Bennett, 2016). Interviews with people who were homeless in the years before COVID highlighted their experiences with mental health and addiction, arguing these factors contributed to their likelihood of becoming incarcerated, homeless, or both; high recidivism rates were linked to a continual cycle of jail and homelessness (Moro, 2018).

In Ontario and Canada, more broadly, there are many ways that people are penalized for homelessness. Depending on the culture and discretion of municipal police, there are a variety of tools that can be implemented to punish people who are visibly homeless, such as tickets for loitering or public intoxication (Gaetz, 2013). There is also a clear relationship between the ongoing penalization of drug use and homelessness: people with addictions to opioids are more likely to be incarcerated and homeless upon release from incarceration, and the risk of overdose is highest immediately after release (Mukherjee & El-Bassel, 2020). Supports for ex-inmates, then, were especially important during the opioid crisis and COVID. There were, put simply, more people released from prison who were more likely to be homeless, at risk of opioid overdose, and unable to access important, lifesaving services. Hamilton did have harm reduction services during COVID, but these arguably did not address some of the most significant harms of opioid use, such as criminalization, incarceration, and homelessness.

As organizations scrambled to meet the developing needs of the community, public health guidance and bylaws continued to change. One strategy to prevent COVID was the development and implementation of physical distancing bylaws. New legislation gave bylaw officers and police the ability to give tickets for failing to stay two metres away from people from different households (City of Hamilton City Council, 2020). Within the first two weeks of these new rules, there were reports of homeless Hamiltonians receiving fines in public places

(Moro, 2020c). I argue that these bylaws were a microcosm of the ideology behind the initial COVID measures, broadly speaking. The bylaw operated under the assumption that everyone in the city had a home, and failed to account for the fact that many people were forced to spend long periods of time in public places, especially in light of COVID-related closures. When the city released the final version of this bylaw, it included a clear section on exemptions – people who would not be ticketed if they came within two metres of someone from outside of their household. The only people included in this exemption were bylaw officers and other law enforcement officials (City of Hamilton City Council, 2020). Even in the face of public pressure from activists and medical professionals, the bylaw exemption excluded homeless Hamiltonians.

As the pandemic continued to unfold, healthcare organizations around the city faced additional challenges in the form of equipment shortages. Personal protective equipment (PPE) was of paramount importance in the wake of COVID. Early in the pandemic, masks, gowns, goggles, and face shields became important topics of political discussion. There were widespread shortages of face masks and respirators throughout the province (CBC News, 2020). Harm reduction organizations and social services in Hamilton were not immune to these problems. The city's Consumption and Treatment Services (CTS), also known as an overdose prevention site, experienced a shortage of PPE at the end of March (Moro, 2020). Another medical organization that was performing COVID testing for clients in homeless shelters had trouble finding swabs to complete their tests (Moro, 2020a). These shortages were not unique to harm reduction organizations. Everyone in the city was hard-pressed to source enough protective equipment to meet the needs of their organization. These shortages, though, combined with constantly shifting and emerging guidance regarding the new virus, made the first few weeks of the pandemic an uncertain time for frontline workers and clients alike.

Indeed, COVID-related restrictions had already limited the type and scope of work these frontline staff were able to conduct. During interviews with harm reduction workers, people cited numerous ways that their work had been affected: there were limitations on the number of people in the physical space, staff had to screen clients for COVID symptoms, and some organizations reported a decline in the overall number of people using their services (Interviews 3, 6, 10). These changes were concerning for a number of reasons. Important supplies such as new needles, pipes, and naloxone, which can reverse opioid overdoses, were harder to access. One worker at a drop-in program told me that their site saw a notable increase in the number of people accessing harm reduction supplies: this drop-in was not a formal harm reduction program, but did offer naloxone and paraphernalia on site (Interview 10). Service users were forced to adapt to ongoing closures and limitations, which could have impacted their ability to find harm reduction supplies or services.

An important aspect of harm reduction in Hamilton during COVID was access to naloxone. Pharmacies, which were able to dispense this drug for free, did remain open during the early weeks of the lockdown (Craggs, 2020). However, frontline workers stressed that this was not typically how opioid users would access naloxone. A harm reduction worker relayed that, both before and during COVID, people typically got naloxone kits from drop-in programs and harm reduction agencies, many of which had closed or reduced their hours during the pandemic (Interview 4). Agencies that did try to distribute naloxone were not always able to do so as there were rules around how such drugs must be dispensed (Interview 4). Harm reduction programs that were open were not necessarily able to serve users in the same way, which further reduced access to naloxone. One harm reduction program saw a large decrease in the number of people attending, and staff speculated that this was as a result of the enforcement of public health rules

and distancing bylaws (Interviews 2, 3). While it is not possible to understand fully how people who use drugs shifted their harm reduction habits during this time, overall it became clear that the initial pandemic response changed the way people sought to limit harms at both a personal and program level. Clearly, COVID protocols were required to reduce the spread of the virus. How, though, did such protocols influence the opioid crisis? I explore this question further in the next chapter, where I discuss the experience of frontline workers in greater detail, focusing on the challenge of balancing two public health emergencies with very different needs.

Innovation & Cooperation

Looking at the early weeks of the pandemic, it is easy to feel an overwhelming sense of dread. This was a time of unprecedented challenge and uncertainty. I do want to stress, though, that the Hamilton community did engage in some innovative work to support the health of people in the midst of the opioid crisis and COVID.

Organizations almost immediately started outreach programs. Some of these services had never done outreach before, and workers saw it as a way to find out what their clients and community members needed – some groups started to explicitly practice harm reduction when they had not done so before, as a result of what they were hearing from clients (Interviews 2, 4, 10, 11). For some agencies, this included the provision of naloxone kits or new needles when they may not have done so before COVID. Other organizations, including those that were already practicing harm reduction, attempted to meet other needs that resulted from the closure of other services, such as meal programs, by offering food and water to clients (Interview 6). In interviews, workers repeatedly identified one of the central tenets of harm reduction as "meeting people where they're at": the early weeks of the pandemic were a testament to their determination to do so in light of an evolving health emergency and lockdown measures.

There were other efforts to protect the health of people at the intersection of these health crises. The city opened an isolation program to help create distance in the shelter system; this often involved housing people in hotel rooms (Van Dongen, 2020b). There was a mass swabbing effort conducted in Hamilton shelters, isolation hotels, and homeless-serving agencies (O'Shea et al., 2020; Van Dongen, 2020b). The study published on this effort credited the infection prevention measures implemented by shelter staff as a crucial component of reducing the spread of COVID among these services (O'Shea et al., 2020). Despite shortages of swabs and other protective equipment, health workers tried to keep their clients and patients safe.

There were other examples of collaboration and innovation throughout the city that would continue throughout the next months of the pandemic. Frontline workers reported high levels of communication between agencies (Interviews 7 & 9). Indeed, O'Shea et al. (2020) credited this collaboration with a low case rate in the shelter system in Hamilton. In terms of PPE shortages, the 3D printing community in Hamilton started to print face shields for social services (Bron, 2020). Some frontline workers even mentioned unexpected benefits of pandemic restrictions, including office closures that actually made it easier to arrange government benefits for their clients (Interview 6). The flexibility and responsiveness of the Hamilton community, especially the harm reduction community, was an important factor in protecting the spread of COVID amidst the already-devastating opioid crisis.

Around the beginning of April, the city started to sanction and open more formal support programs. These included rest and hygiene centres, often located in churches, and an overflow shelter at the FirstOntario Centre (La Grassa, 2020; Moro, 2020d; VanDongen, 2020a). These sites sought to provide people with washrooms, more places to spend time, and to allow for more distancing in the shelter system. Not everyone in the city was pleased with these decisions,

though: the FirstOntario Centre shelter, for example, proved to be a contentious political issue during the time it was open, and this controversy will be discussed in detail in a later chapter.

Conclusion, and a Final Note on Toilets

As a result of widespread washroom closures, the city provided temporary public toilets in various locations in the city (Moro, 2020b). The corner outside of the FirstOntario Centre, where York Street and Bay Street meet, was one such location. To advocates and harm reduction workers, though, this was not enough to meet existing need. Even after the city opened rest and hygiene centres, interviewees told me repeatedly that there were not enough bathrooms around the city after restaurants, malls, libraries, and coffee shops closed; in four separate interviews I heard stories about workers running into a client who had soiled themselves in a public place (Interviews 4, 6, 9, 7).

To some harm reduction researchers, public restrooms are especially important during the opioid crisis. Fouzoni et al. (2019) suggest that, to people who use drugs, especially those who are homeless and use opioids, public washrooms offer a safe, semi-private place to use: factors such as available water, clear lighting, and having people nearby in case of accidental overdose can all protect someone's health. Closing public washrooms, then, could have negative effects on the health of opioid users. While COVID has undoubtedly complicated the nature of public health interventions, the effects of the opioid crisis are still ongoing and influenced by the closure of facilities like washrooms. Clearly, it is quite challenging to respond to one public health emergency in isolation: the effects of intervening in one area can have negative implications on efforts in another.

On this note, one interviewee expressed concerns with how everyone had seemed to adapt a "one size fits all" approach to the pandemic when one singular approach could not

possibly meet the needs of everyone in the city (Interview 4). As I mentioned in the first chapter, the way a society addresses a pandemic is often indicative of its underlying values and structure. In this way, the lack of public bathrooms is a perfect example of how and why Hamilton, broadly, reacted to the pandemic. People who are homeless, people who use drugs, people without cell phones or other technology: these populations were unable to access important, often lifesaving, services. In what one interviewee (Interview 3) called the "hierarchy of who gets service", it is clear that a substantial demographic in Hamilton was not considered in the implementation of COVID measures, including those using opioids or experiencing homelessness. Such considerations were not made during service closures and lockdowns, nor were such concessions always incorporated after the fact. The examples of public washrooms and bylaw tickets illustrate of the inflexibility of such an approach and its harms to people at the intersection of COVID and the opioid crisis.

This exclusion, however, could have simply been a factor of the speed with which these changes were implemented. Even if this decision were made quickly, though, the choice had to originate from somewhere: if people were forgotten in this process, it is indicative of underlying ideas about homelessness, opioid use, and whose health warrants protection. Perhaps, though, the question of why these regulations exist is less immediately pressing than understanding the effects of such interventions. It is understandable that quick decision-making is hard to do with any nuance. When a society is forced to make choices that were previously unthinkable, it can be challenging to understand how and why such decisions were made, especially given the lack of insight and transparency into this process.

Overall, the early weeks of the pandemic demonstrated how the COVID pandemic made harm reduction work more challenging in Hamilton. The pandemic, as well as initiatives to

prevent its spread, exposed people who use opioids to unique harms, such as the disease itself and a lack of bathrooms. This context highlighted the shortcomings of a biological approach to harm reduction, which has become institutionalized in Hamilton's municipal organizations and many city-sanctioned services. The month of March clarified how advocates and frontline workers utilized a broad definition of harm reduction, which included access to showers, bathrooms, and food, which are intrinsically necessary to protecting health. By contrast, the city itself operated with a definition of harm reduction that was narrowly focused on medical concerns. While medical programs are undoubtedly important in the ongoing effort against the opioid crisis, it is important to remember that humans, especially those experiencing homelessness, often rely on public spaces and public programs to meet their basic needs. This is particularly true for people who use injection drugs, as using in groups and sharing supplies can be a key component of survival (Schlosser & Harris, 2020). Such supports are especially important given the likelihood that the stress of COVID could increase someone's likelihood of relapse and overdose (Guilamo-Ramos et al., 2020; Rodda, West, & LeSaint, 2020). While programs such as needle exchanges are an important part of harm reduction, they are only one way that people can protect their health while using opioids.

Harm reduction has many meanings. Sometimes, it is services that are funded by the city or province, like a needle exchange program or a drop-in. Sometimes harm reduction can involve private businesses, like restaurant bathrooms and food from coffee shops. It is obvious, though, that the pandemic has clarified how the harms of opioid use extend far beyond the drugs themselves: oftentimes, harm reduction is access to a bathroom.

Chapter 3: Frontline Workers, Constant Change, & Lived Experience

During the first months of the pandemic it seemed like everyone was celebrating frontline workers. In Hamilton, citizens hung signs showing their support, especially in locations experiencing outbreaks (Pearson, 2020). Around the world, people clapped and cheered for healthcare workers (Booth, Adam, & Rolfe, 2020). In Ontario, the provincial government raised the wage for workers who had been providing health or social services during the first wave of the pandemic (Gillis, 2020). While many people focused on the efforts of healthcare workers specifically, there were also programs and initiatives aimed at supporting other essential workers, like grocery store employees (Shah, 2020). While much of the province was in lockdown, Hamiltonians were keen to show their support for frontline staff.

How, though, did these workers experience the first months of the pandemic? I spoke with eleven frontline workers from a variety of harm reduction and social services in Hamilton. While this chapter considers the period between March and November, 2020, many interviewees focused on events that happened in the early days of the pandemic, between March and May. I have drawn attention to the timing of such comments to highlight how the first weeks of the pandemic were particularly critical for people on the frontlines of two public health emergencies. Overall, working at the intersection of COVID and the opioid crisis was a challenging experience, rife with constant change and uncertainty. The unique nature of providing care at the intersection of two public health emergencies led to ethical challenges while balancing these oft-conflicting priorities.

This chapter begins with an examination of how COVID protocols made addressing the opioid crisis more difficult, especially since information on the novel virus was changing so quickly. COVID-related interventions were often given priority over opioid-related harm

reduction, and these COVID measures often conflicted directly with existing initiatives aimed at reducing the harms of the opioid crisis. As well, frontline workers argued that hegemonic pandemic guidance was unable to fully address the needs of homeless Hamiltonians, especially those who use opioids, and may have made it more difficult for people who use drugs to access services.

The second section of the chapter examines how COVID became a harm associated with opioid use. This occurred because of limitations in how COVID guidance could be applied during the opioid crisis, and because of social harms associated with opioid use during COVID, including stigma. Further, public health guidelines for harm reduction during the opioid crisis were largely biomedical, focused on, for example, the provision of new needles and naloxone kits. The context of the pandemic response, which included service closures and physical distancing requirements to prevent the spread of COVID, exposed tension in how harm reduction was being practiced throughout the city: to frontline workers at this time, this biomedical definition of harm ignored important social aspects of harm reduction, such as interpersonal connection and rapport building. While this cleavage predates the pandemic, it became deeper and clearer in its wake, as the pandemic and efforts to slow its spread exposed people to unique harms and worsened existing social issues, such as stigma.

Importantly, COVID-era initiatives to reduce the effects of the opioid crisis did not integrate the perspective of people who use drugs themselves, often referred to as "peers"; guidance for COVID was similarly directed from a top-down approach. As a result of this oversight, frontline workers suggest that peer perspectives and lived experience are necessary to formulate effective guidelines for public health crises.

Navigating Unsteady Terrain: Preventing the Spread of COVID During the Opioid Crisis

"It's also been challenging being a service provider in the sense that we don't really have all the answers right now, 'cause nobody does" –Interview with Hamilton harm reduction worker

To frontline workers, the first weeks of the pandemic were a time of great uncertainty. Public health guidance seemed to change with alarming regularity as the pandemic unfolded and researchers gleaned new information about how to prevent the spread of the virus: one participant said that information on COVID prevention was "changing not only every day but sometimes a couple of times a day" (Interview 5). To workers on the frontlines, though, trying to deal with COVID made addressing the opioid crisis much more difficult. Staff identified two key COVID measures that made it harder to reduce the harms of opioid use. These issues included staff use of personal protective equipment (PPE) and the implementation of screening and masking rules for clients. Despite the fact that I did not include any specific questions about PPE in my interviews, every single participant flagged that using protective equipment made working amidst the opioid crisis more difficult. It was especially challenging for two reasons: it complicated the process of providing medical care during overdoses and made it harder to build rapport, a practice that workers elucidated as a key dimension of harm reduction.

Before I discuss these concerns, it is important to understand what protective equipment was used during COVID. Generally, public health authorities acknowledged three ways that COVID could spread: through touch contact with the virus; through droplets expelled from an infected person (e.g. a sneeze or cough); or through aerosols, a microscopic form of droplets (Ministry of Health [MOH], 2020). While these categories of transmission were used for COVID, they are standard practice in infection prevention and control in the medical field at this time. All pathogens are categorized according to their route of transmission, and each method of transmission requires different types of protective equipment, ranging from simple hand-washing to a personally fitted medical mask called an respirator, or n95 (MOH, 2020). Importantly,

aerosol particles are small enough that they can travel through standard medical or cloth masks, a widespread method used to prevent the spread of COVID in Hamilton ("Face coverings and masks by-law", 2020; Public Health Ontario [PHO], 2012;). At the time of writing, there is still a debate unfolding as to whether COVID spreads through droplets or aerosols (Lancet Respiratory Medicine, 2020). When COVID was present in aerosolized particles, anyone in the area needed specialized equipment: this uncertainty directly affected how quickly and safely one could react during an opioid overdose.

To understand the confounding effects of COVID guidance, one must first consider what an overdose response typically looks like. Attending to an overdose generally requires a multi-pronged approach, which should be done as quickly as possible to prevent oxygen deprivation and death. This can involve naloxone to reverse the effects of the drug; oxygen therapy or ventilation support to help with breathing; and CPR if the respiratory depression is severe enough to stop the heart. Sometimes, overdoses require mechanical ventilation via a device called a bag-valve mask, which forces air into the lungs of the person who is overdosing. Importantly, intervening during an overdose involves a great deal of physical contact and exposure to someone's airway, which could contribute to the spread of respiratory diseases such as COVID. How, then, were workers to balance the risk of COVID transmission, which spreads through respiratory secretions, and the need to quickly provide aid during overdoses?

In the first months of the pandemic, the Ministry of Health, a federal agency, released COVID guidelines specific to overdose reversal in Consumption and Treatment Services, also known as supervised injection sites (Interview 3; MOH, 2020). This document, and emerging public health research at the time, identified that using a bag-valve mask could create aerosolized particles of the coronavirus and called for aerosol protective equipment, such as n95s, to be used

any time mechanical ventilation was required (MOH, 2020). While this document was developed specifically for Consumption and Treatment Services, these guidelines were utilized by staff in a number of harm reduction settings.

Even with this guidance, workers felt unsure how to prevent the spread of COVID (Interviews 1-6). Staff who regularly intervened during opioid overdoses voiced concerns about the time needed to don respirators should an overdose require bag valve masks: if someone stopped breathing during an overdose, staff would have to stop to get an n95, which prolonged the amount of time the overdosed person went without oxygen (Interviews 1-3). One worker told me that their organization had widely adapted the protocols outlined by the Ministry, but there was still uncertainty as to how long the virus would linger as aerosols in the air if someone did have to use a bag valve mask on-site: some sources said three hours, others said ten minutes, a discrepancy this interviewee called “the big debate” (Interview 2). This difference in time proved to be significant: if there were aerosol particles of virus in the air, the service space would have been infectious for anyone not wearing specialty protective equipment. If these particles lingered for three hours, clients looking to access harm reduction services would have been unable to do so for a significant portion of the day, a noteworthy closure in light of the widespread service changes that had occurred throughout the city. As well, there was still a city-wide shortage of protective equipment, as outlined in the previous chapter: if the virus was floating in the air for an undetermined amount of time, staff were hard-pressed to find the correct equipment to prevent the spread of COVID. This caused notable stress for frontline workers, who were balancing conflicting priorities: the need to stay open and reverse opioid overdoses, as well as the need to protect themselves from COVID with specialized equipment. If staff did contract COVID, they would have, in many cases, been unable to work until they were no longer

infectious: such staffing shortages could have further exacerbated the service closures happening throughout the city. Not only did staff need to protect the health of their clients, their own wellbeing was crucial to ongoing harm reduction efforts.

In addition to PPE for overdoses, every organization represented in this study had specific rules around protective equipment use at work. There were a number of strategies implemented to prevent the spread of COVID. Many programs reduced their capacity to allow for more distance between people in the service and required that staff wear masks. It was also common to screen clients for symptoms. These protocols were largely developed by provincial and municipal public health organizations such as Public Health Ontario and the Ministry of Health (MOH, 2020; PHO, 2012). While staff did agree that such practices helped reduce the spread of COVID, many interviewees noticed how such service changes made it harder to practice certain aspects of their job, such as building rapport with clients.

Frontline workers explained how connecting with service users can be an important aspect of harm reduction**.** Scholarly literature on harm reduction has reiterated this point: breaking down the barrier between clients and service providers can be a way to address the harms of both social isolation and drug use itself (Boucher et al., 2017). Although rapport was seen a central aspect of harm reduction, pandemic protocols often took priority. Some workers were unsure how to interact with people who could be potentially carrying COVID (Interviews 2, 8, 10). At some programs, staff found it hard to maintain both physical distancing and personal relationships with clients (Interviews 6, 9, 10). Other workers noted that PPE made it harder to develop rapport with service users, especially in light of service capacity changes. One interviewee told me that their organization had been forced to set time limits for people using the service, which made it harder to have meaningful personal interactions with service users. This

worker was quick to note the value of these conversations, as "nobody talks to homeless people, nobody wants to engage with them, especially injection drug users… so taking away that bit of connection I think made a big deal to folks and it made a big deal to me" (Interview 6).

Other interviewees noted how the physical act of wearing protective equipment like masks, face shields, and gowns made it harder to develop rapport and communicate meaningfully with clients: facial expressions, for example, were literally masked by COVID protective gear (Interviews 1, 2, 10). PPE created "a barrier in building rapport and having empathetic conversations, because you can't really see your face," which made it harder to convey "empathetic cadence, and facial expressions and body language and everything" (Interview 1). While reducing the spread of COVID was unquestionably important during a pandemic, it became harder to provide empathetic harm reduction services. To address the COVID pandemic and public health regulations, staff were forced to compromise aspects of their work that they identified as central to a harm reduction approach, such as open access to services and meaningful personal connection. Important social aspects of harm reduction were given less priority than the prevention of COVID.

Overall, workers were dealing with two conflicting goals: the need to provide harm reduction services for a crisis that can cause immediate death, and the need to keep clients safe from a virus that could cause death in the future. Two sources of tension in this regard were client masking and client screening. One strategy to reduce the spread of COVID was to screen service users for symptoms at the doors of agencies or programs. Notably, many of the symptoms of COVID overlap with the symptoms of opioid use and withdrawal, such as nausea or diarrhea (MOH, 2020; Pergolizzi, Raffa, & Rosenblatt, 2019). As such, many people using opioids or going through withdrawal would have screened as a potential case of coronavirus

when trying to access services, which limited their access to potentially lifesaving programs. One interviewee also noted that many people who were sleeping rough had symptoms that overlapped with COVID: "cough, cold, shortness of breath, fatigue" were "par for the course" when people had to sleep outside, for example (Interview 10). Indeed, homelessness has been correlated with unique health challenges, such as tuberculosis and chronic obstructive pulmonary disorder, which both have respiratory symptoms (Frankish, Hwang, & Quantz, 2005). These conditions could have, again, made it harder to access lifesaving services where people were being actively screened for COVID symptoms. This overlap called into question the usefulness of a uniform screening tool for harm reduction services.

Beyond these issues with the screening questions themselves, staff reported that many people using harm reduction services were hesitant to engage in screening processes and mandatory masking. While I did not interview service users for this project, several interviewees did offer possible suggestions for this resistance. Three people pointed to the fact that homelessness and opioid use expose people to a great deal of risk – violence, harassment, exposure, and so on - and an invisible virus likely seemed less concerning in the context of the dangers of daily living (Interviews 4, 5, 10, 11). Other frontline staff argued that public health guidance did not adequately address the unique needs of people experiencing homelessness, such as mental health needs or a lack of masks, and these hegemonic guidelines were not accessible to everyone (Interviews 2, 4, 5, 9, 10, 11). The challenges with public health guidance are explored in the following section, though this tension is important to note while understanding how people at the intersection of these crises negotiated and prioritized various harms.

At many times, it was a precarious balancing act to both respect the wishes and limitations of service users while protecting the health of staff and other clients. One worker explained this tension:

> If you're dealing with violence, and sleeping outside, and mental illness, and addictions, and all of this stuff, especially using opioids, which are super fucking dangerous, I understand that the thought of getting sick from a virus that you can't see probably seems quite minimal compared to what you endure on a daily basis, right? So on one hand I get why people don't wear masks. On the other hand, it's my job to maintain a safe space for people… and it's not just the safety of staff, although obviously that is a concern, but it's the safety of other people who are in the space, because a ton are immunocompromised. (Interview 10)

Staff, trying to balance various COVID- and opioid-related harms, sought to keep everyone as safe as possible. Overall, this balance was difficult to strike, if not unattainable. One interviewee told me a story about trying to encourage mask use with a client:

> She had refused to wear a mask and she was just going about her daily business… and I said to her, I said you know, people are dying, this is a serious thing, and she looked at me and she started bawling her eyes out and she said you just scared the hell out of me, and that was one of the worst experiences of my life, I was like, oh my god, trying to explain to somebody the vulnerabilities of what's going on in the community and how vulnerable they are and how vulnerable their kids could be and anybody else they come in contact with, and the severity of the virus. (Interview 11)

There were various reasons someone may not have been able to wear a mask. Trauma, mental illness, difficulty breathing, and a lack of clean masks were all possible explanations, and many

of these were deemed medical exemptions under the Ontario Human Rights Code ("Face coverings and masks by-law", 2020; Ontario Human Rights Commission, 2020). Some interviewees mentioned that many people experiencing homelessness during COVID had little or no access to the internet, news, or phones, which made it harder to learn about COVID and prevention (Interviews 2, 9, 11). Regardless of the circumstances, trying to adhere to COVID safety guidelines made it hard for frontline workers to reduce the harms of the opioid crisis.

COVID as Harm: Biological and Social Aspects of Harm Reduction

"It's been harder to do my job" –Interview with Hamilton harm reduction worker

As harm reduction was (and is) one of the primary responses to the opioid crisis in Hamilton during COVID, it is important to understand how the practice has instrumentalized the concept of harm. In addition to the biological risks of drug use, such as infection or death, scholars have explained how harm reduction has, at times, sought to address social harms such as the criminalization and stigmatization of use (Keane, 2003; Marlatt, 1996). While not all opioid use is harmful – indeed, substance use can serve some important functions, such as coping, pleasure, or enjoyment –biomedical harms have been given priority in formalized harm reduction initiatives (Watson et al., 2020). This biomedical focus has been a key component of Hamilton's city-sanctioned harm reduction programs, which have largely been conducted from a public health perspective.

Perhaps unsurprisingly, the pandemic itself became an opioid-related harm as both an individual, biomedical issue as well as a social or structural harm. This development occurred for two reasons: because of public health guidance that did not adequately incorporate the intersection of these issues, which increased someone's likelihood of either contracting COVID or experiencing an overdose; and by exacerbating the stigma experienced by people who use

drugs in society. By practicing harm reduction in a narrow, biomedical sense, and approaching COVID in a similar fashion, neither issue was adequately addressed.

To start, a discussion of contradictions: some of the most common harm reduction advice for opioid use directly contradicted the public health guidelines for reducing COVID risk. This exposed people who use drugs to harms from COVID, the overdose crisis, and unsuitable public health guidance that did not consider the experience of using drugs during COVID. For example, Hamilton Public Health guidance has long-suggested that overdose risk is lower when people use in groups, carry naloxone, and use in a public place ("Opioids", 2018). To reduce the risk of coronavirus, however, the same agency released an update in March, 2020, which encouraged Hamiltonians to keep their distance from others and avoid in-person contacts where possible (Hamilton, 2020). Thus, opioid users seeking to follow public health advice were caught between two contradictory messages: use drugs together in public, but minimize in-person contact and stay indoors. While public health bodies did release some COVID-specific information for opioid use, "mostly the stuff on using drugs was just a repeat of old information, don't use alone, do a test dose, make sure you're still accessing new needles" (Interview 5). These guidelines did not consider how such criteria contradicted COVID guidance. In addition to the service closures outlined in Chapter Two, and the implementation and enforcement of physical distancing bylaws, harm reduction seemed to be at a crossroads. Opioid users and, in many ways, the frontline workers who served them, were unable to address one public health crisis without

risking exposure to another.

- **Opioid crisis:**
  - Never use alone
  - Do CPR (if overdose occurs)
  - Use a small "test dose" to start
  - Carry naloxone, use new gear every time
  - Call 911 (if overdose occurs)
- **COVID:**
  - Isolate from others
  - Keep 6 feet of distance
  - Changing drug supply
  - Service closures & changes
  - By-law enforcement and penalization of close contacts

Figure 3: Public health guidance for preventing opioid harms, compared to pandemic public health guidance and community issues related to COVID

On the whole there were many strategies implemented to reduce the spread of COVID at harm reduction services: masking and screening guidelines, as well as capacity restrictions and time limits, were used by organizations around the city to reduce the spread of COVID. All of these strategies were developed and, in many cases, mandated by provincial and municipal public health organizations. Advocates were quick to penalize this "one-size-fits-all approach" (Interview 4, 5). Frontline workers recognized that common COVID-related advice, such as universal masking and hand-washing, would not be accessible to their clients, many of whom were homeless and no longer had access to washrooms amid the service closures outlined in the previous chapter:

> There were some things where we never really got a good answer… for example, this idea of universal masking. There isn't really anything to say, okay, but if you don't have clean laundry should you be using the same, reusable cloth mask every day, you know? There was a lot of public health guidance that didn't take into account people who are homeless in particular… there was nothing really out there to say, here's what

> individuals should be doing if they don't have access to those hygiene facilities. (Interview 5)

These oversights were especially pertinent to public health advice for safely providing overdose care during COVID. While there was specific guidance for Consumption and Treatment Services (also known as a safe injection site), interviewees argued that the initial public health guidance did not provide extensive information on overdoses that took place in the community. This oversight meant that people who use drugs were not given adequate consideration in COVID prevention or opioid overdose guidelines, which could have increased their likelihood of experiencing harms from either issue. Nasal naloxone, which can be sprayed into the nostril of someone who is overdosing, was a noteworthy source of confusion during COVID. The nature of constantly shifting COVID information meant that it was unclear if using nasal naloxone could generate aerosol particles of the coronavirus (Interview 5; Interview 4). If using nasal naloxone did lead to aerosol spread, anyone in the immediate area of this overdose would have been exposed to microscopic particles of COVID that could travel through standard face masks. While services did also provide injectable forms of naloxone, a qualitative study of bystander naloxone use indicated that some people felt uncomfortable using needles in an emergency and preferred nasal naloxone kits (Keane, Egan, & Hawk, 2018). As such, clarifying the safety of nasal naloxone was an important and unanswered aspect of harm reduction during COVID that appears to have been overlooked, at least initially, by public health organizations. Not only was it harder to intervene during overdoses with unclear data, but this could have exposed people to COVID as well.

Frontline staff also told me that they had noticed changes to the drug supply, and that they had observed more overdoses and deaths in the community (Interviews 4, 5, 9). While this

change could have been a result of any number of COVID-related issues – disruptions to the supply chain, border closures, and unpredictable drug potency in Canada – it is impossible to know what exactly caused this issue, as drug supplies do not always change in predictable ways during pandemics (Giommoni, 2020; MacKinnon, Socias, & Bardwell, 2020). Regardless of why the drug supply changed, what was especially important was that more people were overdosing. However, people had little information on how to intervene safely during COVID. Two workers told me that the advice given by public health was to call 911 immediately and refrain from doing CPR, but public health guidance was initially also unclear about whether CPR could produce aerosols (Interviews 4, 5). This limited information, in conjunction with uncertainty regarding the safety of nasal naloxone, meant that many people were unsure how to safely intervene if someone had an overdose in the community. In short, the guidance given did not reflect how people were actually behaving in these scenarios. One interviewee described the issues with COVID-related advice and its inapplicability for homeless and opioid-using Hamiltonians:

> at the beginning [the messaging] was all about like staying home, staying home, staying home, and it was just as if people who were homeless didn't exist… I think the problem with public health guidance is that, like, it's so technical, and it comes from a review of the evidence which doesn't necessarily reflect people's actual lives, right? For example, call 911 early and don't respond to an overdose if you don't have to was the public health guidance, whereas people in the community are, like, "cool, when I call 911 the cops show up and this is somebody I love who's overdosing in front of me," so there's such a gap between those two things, between official recommendation and what people actually do, and what they actually need. (Interview 5)

Public health guidance on reducing the spread of COVID did not necessarily reflect how people actually live, especially those whose agency can be compromised by their social situation. By focusing only on the biological harms of opioid use, such as the need for naloxone, these guidelines did not consider the social harms of drug use – such as criminalization and incarceration. Clearly, incorporating the lived experience of those who were actually using these guidelines could have improved their relevance. Advocates called for a more nuanced approach to these guidelines and, in some cases, released their own advice (Interviews 4, 5, 9). One organization in Toronto, the Toronto Overdose Prevention Society, released a "beautifully illustrated" guide on responding to overdoses during COVID from a "community-informed perspective"; this guide was used by some professionals and organizations in Hamilton (Interview 5). Such guides can function as an important form of harm reduction, one that balances the harms of COVID with the need to provide care during overdoses in the community.

Clearly, the COVID pandemic complicated the process of practicing and understanding harm reduction. There are many different types of drug-related harms, and this list arguably expanded to include COVID and inadequate guidelines. How, then should harm reduction look in such a context? At the time of writing, there is no consensus on what, exactly, harm reduction is. However, there are commonalities in how harm reduction has been conceptualized in the literature. In general, scholars have argued that harm reduction programs are lower-barrier services for people to come as they are, without the expectation of decreased drug use or abstinence: to such programs, the primary goal would be to reduce the harms associated with drug use, not to reduce drug use itself (Lenton & Single, 1998; Marlatt, 1998; Marlatt & Witkiewitz, 2010). In a North American context, harm reduction programs are often situated within a public health framework: these programs tend to be medicalized and narrow in scope,

focusing primarily on the reduction of biomedical harms (Boucher et al., 2017). Indeed, the needs assessment for a supervised injection site in Hamilton utilized this focus: despite an acknowledgement that harm "can come in many forms, including negative health, social and environmental impacts", the quantitative data used in this report focuses only on medical statistics such as emergency room visits and rates of blood-borne infections (Hopkins et al., 2017).

As COVID became a priority in harm reduction organizations, workers noticed how these protocols sometimes made programs less accessible or welcoming for service users. Some services saw a reduction in the number of clients they were seeing, and workers questioned if this was as a result of COVID protocols or a change in the organization's social environment when stringent COVID measures were implemented (Interviews 2, 3, 6). One employee described how their workplace, before COVID, was a "laissez faire… community-oriented experience" where people were free to come and go from the building as they pleased; when the pandemic hit, however, COVID protocols led to locked doors and screening, and "a lot of clients lost that sense of camaraderie, so to speak" (Interview 2). While preventing COVID was undoubtedly important, providing an environment where people feel free of stigma can be an important aspect of harm reduction. If people felt welcome and accepted, they may have been more willing to utilize a potentially life-saving service. Harm reduction, ideally, was not just needles and naloxone but a welcoming environment. COVID measures made providing such an environment more challenging, if not impossible.

The widespread COVID guidelines implemented throughout the city could also have worsened stigma towards homeless Hamiltonians. One interviewee pointed to a stigmatizing assumption among coworkers that "because one was homeless this meant they were 'dirty' or

more susceptible to contracting the virus" or if someone had mental illness they would be seen as "not able to wear a mask and clean [their] hands regularly with hand sanitizer, [and] must have COVID"; in some cases, staff would interact with this person less frequently (Interview 2). While some literature has claimed that certain aspects of homelessness, including the use of congregate living spaces such as encampments or shelters, could have been responsible for increased COVID risk, this did not mean that every homeless person had COVID (Tyndall, 2020). Some scholars have argued that people experiencing homelessness have become a scapegoat for society's inability to prevent COVID spread, despite structural factors that limit their ability to adhere to public health guidelines such as hand-washing (Chang, Agliata, & Guarinieri, 2020).

Most commonly, interviewees reported observing this stigma among their coworkers or other medical staff. In one interview, a frontline worker reported that some of their coworkers were hesitant to work with clients who were unable to adhere to COVID protocols, even if they were unable to do so because of severe mental illness:

> We've become quite rigid when we are trying to keep things sterile… but if someone is psychologically unwell, they're not able to have such control over motor function, and, you know, it would be very difficult to get someone to follow instructions to wear a mask if they're really unwell psychologically… I feel like a lot of our clientele that come in were not able to adhere to these new public health rules so I feel like staff would be more intimidated or reluctant to help people. (Interview 2)

This is a clear example of how COVID-related processes and anxieties served to worsen the stigma of mental illness and homelessness. While clear considerations have been made for mental illness in the Ontario Human Rights Code, and staff were still required to provide

services in this context, fears around COVID contributed to the stigmatization of mental illness and homelessness when clientele were unable to adhere to infection prevention protocols. The example also touches on the concept of balancing risk during COVID: clients experiencing severe mental illness still need access to harm reduction services, but how were staff meant to keep themselves and other clients safe when adhering to public health measures was not possible? This tension was a source of additional stigma for service users, who were already experiencing the stigmatization of drug use.

There were also incidents of stigma from healthcare providers, such as paramedics and hospital staff. Such stigma may have compromised the medical care that clients received. Two separate interviewees had called paramedics during an overdose, and these staff noticed that the paramedics were either slow to react or hesitant to interact with the person overdosing, which interviewees attributed to a fear of contracting COVID (Interviews 2, 3). When the paramedics arrived, they were "extremely reluctant and stigmatizing… the paramedic wouldn't even approach [the client], was really worried that [the client] would just have COVID and would just give it to them" (Interview 3). Frontline workers of all stripes were, inarguably, experiencing anxiety around COVID exposure: however, this should not compromise the care that healthcare professionals provide, especially in life-or-death situations.

One of the most prominent examples of stigma was published in a national news article in *The Globe & Mail* in April. Frontline nurse, Elise Nagy, a staff member at the Consumption and Treatment Services site in Hamilton, had called a local emergency room to let them know that a client was coming to the hospital with an infection. The article outlined the interaction with the emergency room nurse who fielded the call:

> [Elise Nagy] was asked by the charge nurse on the other end of the line when her workplace – a supervised consumption site – would be shutting down. Ms. Nagy, a registered nurse, replied that the supervised consumption site would not be shutting down. It is an essential service. The charge nurse was "upset" by that, Ms. Nagy says, and asked her why one of their patients was "taking up" one of the hospital's designated isolated rooms for COVID-19 cases…. "She then proceeded to tell me that their emergency beds 'should be reserved for patients who make better life choices.'" (Hayes, 2020)

The idea that addiction is a personal choice is nothing new. It is a long-held, stigmatizing belief that someone who uses drugs is personally at fault for their addiction (Olsen & Sharfstein, 2014). One can see, though, how COVID worsened this stigma. Hospitals in the city were scrambling to address the pandemic and had minimal protective equipment to do so, especially in the first few months. The emergency room nurse's comments are a clear reflection of the ongoing stigmatization of drug use, exacerbated by the challenge of prioritizing two public health emergencies with very different needs. I do not mean to excuse these stigmatizing comments – in fact, quite the opposite. I argue that strict hospital protocols and stringent public health policies worsened the existing stigmas around drug use. COVID protocols – such as the decision to close non-essential services – were not responsible for the comment that people who use drugs should "make better choices". However, the context of the pandemic provided an avenue to express these views.

Sometimes, stigma was perpetuated by the policies of organizations practicing harm reduction, especially those that only started practicing harm reduction with the onset of the pandemic. This stigma was a direct result of a narrow, biomedical focus. As I mentioned in the

previous chapter, many agencies and programs in Hamilton started providing some harm reduction services, such as new drug use supplies or naloxone kits, to meet the need that resulted from COVID service changes and closures. To some interviewees, the attitudes and policies of the organization had not quite caught up to this decision: these workers questioned their organization's ability to practice harm reduction in a holistic sense. One worker told me that, in their experience collaborating with clients and other social services, many organizations and workers were not familiar with the harm reduction approach despite providing certain services or suggesting that they were able to provide harm reduction (Interview 7). Two workers told me that their organizations, or others in the city, would not let people access programs if they were using drugs or even if they just had paraphernalia on them (Interviews 7, 11). Such programs were, arguably, utilizing aspects of biomedical harm reduction, by providing naloxone and new needles, but may have actually perpetuated the harms of opioid use by denying other services. Harm reduction as an ideology does not punish people for drug use (Marlatt, 1998). However, some scholars have argued that when harm reduction is institutionalized it may serve to reinforce certain harmful power dynamics, through focusing primarily on security and surveillance, for example (Watson et al., 2020). As such, the decision to evict service users for signs of drug use reflected stigmatizing ideas of drug use as an inherently harmful practice in need of control and punishment and, therefore, perpetuated the stigmatization and criminalization of drug use. As a result, this extremely narrow definition of "harm reduction", practiced by some organizations and espoused by municipal public health bodies, was called into question by workers. COVID-prevention measures in the city – such as service closures and changes – may have inadvertently exposed people who use drugs to additional sources of stigma in the name of harm reduction.

The pandemic, then, served to highlight the shortcomings of an institutionalized, biomedical understanding of harm reduction.

Peer Perspective & Innovation

One way to reduce shortcomings in public health guidelines could be to integrate the experience of people who use drugs, also known as “peers”. Many interviewees were overwhelmingly in favour of developing programs and guidelines alongside people who use drugs, ideally through paid employment (Interviews 2, 4, 5, 7, 9). One interviewee credited the input of people who use drugs as having profound influence on their organization’s ability to address to the opioid crisis during COVID: “people who use drugs have so much knowledge. They’re the ones who were like, yeah the drug supply is more expensive, it’s more toxic… [they] know these things and are living these things… they’re the first source of information” (Interview 5).

Despite pleas from frontline workers to include people who use drugs in the decision-making process, this advice was not always heeded. One interviewee noted that, often, many decisions around drug policy and harm reduction at the municipal level have been made without the input of people experiencing this reality (Interview 4). When organizations did invite people to contribute a “peer” perspective, it was often open only to those who were in recovery from substance use, i.e. abstinent, and this did not reflect the reality of someone who was actively using substances (Interviews 7, 9). One frontline worker, who performed outreach alongside workers engaged in active substance use, noted the importance of collaboration with the people who might have been seeking services from such agencies: “working alongside peer workers gave me more insight to their lived experience,” this worker said, and noted that empathy and compassion were just as important as understanding the opioid crisis from an intellectual or

statistical standpoint (Interview 8). In light of the extreme stigma that opioid users and homeless Hamiltonians have experienced during COVID, including people who are actively using substances could provide important insight to improve the policies that affect this population.

Indeed, some of the most innovative solutions in the early days of COVID were a result of direct input by people who use drugs themselves, whether they were actively using substances or in abstinence-focused recovery. One organization in the city initiated an Overdose Prevention Line, where callers could use substances while on the phone with someone who would call for emergency services if needed (Grenfell Ministries, 2020a). The Line, its founders stated, was developed from the experience of people who use drugs, who had been supporting each other in this way for years (Grenfell Ministries, 2020a). Clearly, integrating the knowledge and experience of people who use drugs provided innovative and useful services that could mitigate the effects of the opioid crisis during COVID, when many services were limited or closed. In addition to the Line, this organization also started a substance use management program, which sought to help people who use drugs to taper or detox from substances in their home (Grenfell Ministries, 2020b). One interviewee noted that many detox programs or withdrawal centres had limited their capacity or were not accepting clients from outside of the city (Interview 1). As a result, this at-home program provided a service that was harder to access during COVID. The input of lived and peer experience was a catalyst to meeting the needs of the community.

In interviews, frontline staff noted how services had expanded their scope to meet the needs of clients or people who use drugs in the community. Some agencies started providing outreach, food, or clothing when they had not done so before, because of input from service users (Interviews 1, 2, 4). Other staff pointed to increased collaboration between agencies in the city, either to improve access to COVID-related knowledge or to update their protocols for harm

reduction during this time, as documents that were released did not meet the needs of their clients (Interviews 3, 5). Again, to make a service that meets the needs of its users, it was (and is) important to consult the people who use them.

Conclusion

The first wave of COVID was, undoubtedly, a stressful time for frontline workers. The realities of COVID restrictions and protocols, in many ways, compounded with efforts against the opioid crisis, meaning that organizations were struggling to reduce the spread of COVID during to an opioid crisis that was arguably getting worse. While there were some supports available for staff – such as counselling programs, phone lines, or funding for therapy – staff felt overwhelmingly uncertain about their ability to protect themselves, their coworkers, and their clients from both the spread of COVID and the worsening overdose crisis (Interviews 1, 2, 6, 10, 11). People who use drugs were at the intersection of COVID and the opioid crisis; the responses (or lack thereof) to these issues worsened the stigma towards drug use and homelessness at this time. This stigma may have also led to health consequences such as poorer medical care. In this sense, COVID became a harm associated with opioid use. This harm occurred on an individual level, when people could have been exposed to the virus during an overdose, for example, and at a structural level, when inadequate guidance and stringent public health measures exposed people who use drugs to additional stigma. In the context of these new harms and worsened social issues, frontline workers observed the shortcomings of biomedical harm reduction and called for broader, structural interventions. While considering the perspective of people who use drugs may not have fully solved these problems, I argue it is a necessary step in mitigating the harms of the ongoing opioid crisis when biological interventions are inadequate. Harm reduction aims to "meet people where they are" (Marlatt & Witkiewitz, 2010). Engaging with a peer

perspective at a program- and policy-level seems to be a way to do just that, especially when circumstances on the ground change, as they did dramatically with the arrival of the pandemic.

Chapter 4: Encampments

"You want to turn Hamilton into Sanfrancisco (sic)? Shit, urine, needles and other harmful Paraphernalia on our streets. You want taxpayers to pay for garbage collection, water supply and port potties (sic). Pet food support food catering pest control is there anything else." – email from Hamilton city councillor Terry Whitehead (as cited in Moro, 2020, Sept 14)[1]

Introduction

During the first months of the coronavirus pandemic in Hamilton, one of the most contentious and high-profile political issues was that of encampments. These clusters of tents throughout the city, which were largely populated by houseless Hamiltonians, became a fixture in local news coverage in the summer of 2020. This reporting came to a head during a high-profile legal case, launched by local activists, which sought to protect the rights of residents to live in these camps without police clearing their belongings. To such activists and other local frontline workers, these sites offered an informal network of support during the opioid crisis and less exposure to COVID than indoor shelters: encampments, then, were conceptualized as an important aspect of harm reduction at this time. To city officials, however, these camps were a legal issue that needed to be cleared, a matter of safety and by-law adherence.

For this project, which studies the intersection of the COVID pandemic and the opioid crisis, encampments are an important point of discussion for two reasons. First, the encampments were manifestations of ongoing and overlapping public health emergencies, including COVID, the opioid crisis, and a shortage of affordable and supportive housing in the city. This chapter explores how these camps arose as a result of numerous, intersecting issues, and how encampments served as an informal method of harm reduction for people at the centre of these

[1] Most of the news articles on encampments were written by a small group of authors. To provide a clear timeline, I have chosen to deviate from standard APA in-text citation style to include the full date of publication, not just the year.

crises. The second reason to examine these encampments relates to how they were conceptualized and understood during this time. Since these encampments, in many ways, existed because of a complex overlay of numerous health issues, studying how people discussed these encampments provides rich insight into how people understood the overarching health issues themselves. Like studying weather patterns to make sense of climate, examining how people understood and discussed these encampments can elucidate how people conceptualized the wider issues at hand, such as COVID, the opioid crisis, and the broader stigmatization of drug use and homelessness.

Importantly, discussions about encampments highlighted discrepancies in how the phrase harm reduction was used throughout the city. To activists and frontline workers, harm reduction necessitated a broad scope beyond the medical effects of opioid use. It was crucial to address the social and structural harms of opioid use and homelessness, which are correlated: opioid use has been linked to an increased likelihood of homelessness (Fozouni et al., 2019). While many people experiencing homelessness do not use drugs, there is a significant enough overlap between these issues that it is not possible to address homelessness without also discussing opioid use. As such, comprehensive harm reduction for opioid use often involves addressing homelessness at the same time. Many frontline workers and advocates understood the importance of this connection and advocated for a broad, political approach to harm reduction for the opioid crisis, one that involved safe housing and protected the rights of encampment dwellers.

To city officials and programs, however, harm reduction was limited to a very narrow, biomedical scope, as discussed in previous chapters. Treating encampments as a criminal issue meant that homelessness and drug use, by proxy, were seen as criminal issues as well. The

municipal government may have adopted aspects of harm reduction in its publicly funded programs, but still conceptualized drug use as a moral issue in need of enforcement. Clearly, harm reduction has become institutionalized as a narrow, biomedical practice throughout Hamilton's government and its organizations, which has, broadly speaking, limited the ability to meet the needs of people who use these services. COVID highlighted such shortcomings and exacerbated tensions in how harm reduction is defined throughout the city.

Drawing on examples from local news coverage, municipal documents, interviews with frontline workers, and publications from local harm reduction activists, I outline several ways that encampments were conceptualized at this time. To start, I explore how encampments were seen as a visible representation of several, intersecting health issues, such as the opioid crisis, COVID, and a shortage of affordable and supportive housing in Hamilton: this claim was made by frontline workers, activists, and in letters from concerned citizens to city council and the local newspaper. While housing shortages predated COVID, the pandemic made it clear that homelessness exposed Hamiltonians, especially those using drugs, to unique harms that were worsened by COVID-related service changes. From this perspective, encampments were an important aspect of harm reduction during the opioid crisis and COVID, which contradicted the city's stance on these camps. While many Hamiltonians saw encampments as harm reduction, these camps became a tangible target of public stigma, reflective of broader opinions and conceptions of homelessness and drug use. Such sources constructed encampments as a criminal, legal issue in need of police intervention and enforcement. This opinion was reinforced in other editorial pieces and letters to city council from concerned citizens. Harm reduction, to the city's government and many of its organizations, was only a practice to reduce the biological harms of drug use.

As an important note, neither side of the encampment debate actually wanted these tent sites to exist. To activists, these camps were only necessary because of shortcomings in supportive and affordable housing: ideally, with adequate housing and support, nobody would need to live in encampments. According to social workers in an anonymous letter to the *Hamilton Spectator*, people living in encampments experienced “hardships, such as harassment, violence, and discriminatory treatment” and did not have “access to basic necessities, like water, showers, and washrooms (Anonymous, 2020, Aug 14). Such camps were necessary from a harm reduction perspective but, ultimately, still more harmful than permanent supportive housing. To the city and other citizens, however, these sites needed to be cleared by police because they were a public nuisance and criminal issue. I explore both sides of this argument to draw conclusions about what, exactly, harm reduction meant during the pandemic. To frontline workers and activists, harm reduction was a broad practice that required social and political intervention, such as affordable housing and policies to protect encampment residents. To city officials, however, harm reduction was a limited biomedical practice that had little to do with homelessness. The social context in which encampments arose – the intersection of multiple health emergencies – exacerbated and elucidated this rift.

A Brief, Recent History

Encampments existed in the city for years, long before the coronavirus pandemic (Moro, 2020, Aug 22). However, these tent sites became much more visible and high-profile during COVID. The city of Hamilton currently defines encampments as any tent or group of tents where people are living outdoors (Hamilton, 2021). At the beginning of the pandemic, there were reports of encampments around the city, with mostly fewer than ten inhabitants each. As the summer unfolded, however, certain encampments grew larger and became the focus of

widespread discussion and political debate. The encampments outside of the FirstOntario Centre at York and Bay (home of the portable toilets from Chapter Two) and the encampment on Ferguson Avenue North, outside of the Wesley Day Centre, a drop-in centre with food and washrooms, were two main sites. At its peak, one frontline worker estimated that the Ferguson St. encampment had over 150 residents (Interview 9). These sites were well-populated, highly visible, and extremely contentious.

As these camps began to grow in size, city authorities cited concerns around the legality of encampments, especially in relation to municipal bylaws (Moro, 2020, July 29). The city's reaction to this growth, especially in the first months of the pandemic, was to have the police forcibly clear these sites. Consequently, two advocacy groups, Keeping Six (whose membership includes many people who use drugs) and the Hamilton Social Medicine Response Team (HAMSMaRT) worked with local lawyers to file an injunction to prevent the dismantling of these sites (Keeping Six [K6], 2021). This sparked a months-long legal challenge that became the centre of a public debate on encampments, homelessness, and COVID.

To the aforementioned activist groups, and many frontline workers I interviewed, the development of these encampments was a natural result of many ongoing issues in the city during (and before) COVID: a lack of supportive and affordable housing, the mass release of prisoners from the Barton St. Jail, and COVID-related service changes and closures. For example, there were few bathrooms available in during COVID, as outlined in Chapter Two. Some have suggested that two large encampments arose outside the FirstOntario Centre and on Ferguson Avenue, partly because of the washrooms available in this area (Interviews 4, 6, 9; Mowat, 2020, Aug 17). To frontline workers and activists, these camps were an inevitable consequence of what was happening during COVID and how city officials addressed

homelessness during this time. Many of these issues predated the pandemic but became especially obvious and urgent in its wake.

As a result, activist groups sought the injunction to prevent the clearing of encampments. From their perspective, these camps were not an ideal housing arrangement; however, encampments were a logical consequence of how Hamilton, broadly speaking, reacted to homelessness. For example, city-sanctioned shelter programs were not accessible to many individuals, even before COVID; many shelters actively penalized people for drug use or the possession of paraphernalia, even if unused (City of Hamilton, 2020, July 13). In addition, these programs were chronically operating at- or over-capacity and did not have enough room for the people who needed to use them. If the city was unable to support people who needed shelter, activists sought to protect their right to live in camps without police involvement. In July, activists and lawyers were granted an initial injunction to prevent the city from clearing the encampments (K6, 2021).

The municipal government, at this time, largely viewed encampments as a legal, criminal issue. City officials disagreed with frontline workers, arguing that no one had been denied access to shelter between April and August, 2020 (Moro, 2020, Aug 22). From this perspective, people who lived in encampments were deliberately choosing to break the law despite the availability of alternative shelter programs. Ultimately, nine out of twelve city councillors voted to challenge the encampment injunction in court (Craggs, 2020, Aug 22). If the injunction was overturned, the city and police would have been legally able to dismantle any and all encampments. The dominant attitude at city hall was that encampments were a criminal problem that needed to be cleared.

After the Superior Court granted the initial injunction to prevent the clearing of encampments, it was extended into September, and, ultimately, the city reached a compromise with advocates to allow for the city to dismantle some encampments (K6, 2021). There are, at the time of writing, processes in place to permit residents to live in encampments indefinitely if they meet certain criteria, such as having an addiction ("Bylaw enforcement protocol", 2020). Residents who meet these criteria can set up encampments in specified areas away from, for example, heritage sites and playgrounds. Other encampments, especially large tent sites and camps that house people without acute needs, are dismantled by city staff. After this decision, the city's largest encampments, including the one on Ferguson and the camp outside FirstOntario Centre, were cleared by police in October 2020. At the time of writing, there are still small encampments dispersed throughout the city as the pandemic continues to unfold.

Encampments at the Intersection

The first story on encampments was published at the end of April, 2020. At this time, about ten people were living in tents on the grounds of Sir John A. MacDonald (SJAM) school in the downtown core, an encampment described, at the time, as "large" (Van Dongen, 2020, April 28). At SJAM, police and city officials cleared the site and reportedly offered inhabitants "a safer place to ride out the COVID-19 crisis", which included city-sanctioned shelters and hotel isolation rooms (Van Dongen, 2020, April 28).

This first news story on encampments, an early example of the city's response, proves to be a useful microcosm of this chapter's central argument. The camp at the centre of this story arose, in many ways, because of COVID, the opioid crisis, and a longstanding housing crisis in Hamilton. To start, COVID: fears around COVID spread and COVID-related service changes were commonly mentioned by residents as key reasons for why they chose to stay in

encampments. Shelters and congregate living spaces exposed people to a higher likelihood of COVID transmission and outbreak (Guilamo-Ramos et al., 2020). Some people saw personal tents as a way to mitigate that risk. For instance, one encampment resident, interviewed for the Van Dongen article quoted above, explained that his pneumonia increased his probability of COVID complications, which made him hesitant to seek a space in shelter. Although the city presented shelters as safer than encampments, this may not have been the case for many people experiencing homelessness during the pandemic.

As well, the decision to clear smaller encampments in the name of COVID safety could have led to the development of larger encampments in the city. Some activists suggested that large encampments grew because smaller ones, like that at SJAM, were dismantled by police in the early days of the pandemic (Moro, 2020, July 14). When the city decided to clear smaller encampments, residents may have been more likely to move their camp towards sources of support, such as social services and peers, which may have led to the development of larger encampments such as that outside of the Wesley Day Centre on Ferguson Avenue. As outlined in the previous chapters, there were also service closures around the city, which made it more challenging for people to access services such as shelters, food, and washrooms. It is unsurprising, then, that two of the largest encampments grew right outside of locations with accessible washrooms and food. Not only did these camps develop because of COVID service restrictions and concerns around infection, the city's decision to dismantle these sites could have led to the development of larger camps, as well as more crowding (and therefore higher COVID risk). Clearing camps in the name of COVID may have exposed people to conditions that were ultimately higher risk than a small encampment.

In addition to fears around COVID spread, there were significant issues with emergency shelter availability and accessibility. There were many reasons encampment residents were unwilling or unable to use a shelter or hotel program, such as an inability to bring one's pets, theft, property damage, COVID spread, strict curfews, and aggressive behaviours (Craggs, 2020, July 14; Moro, 2020, Aug. 22; Van Dongen, 2020; April 28). One frontline worker, in letters to the municipal government, argued that many shelter users were routinely restricted from accessing these services for a variety of reasons: behaviour, drug use, possessing a can of beer, or "just because they [had] drug paraphernalia on them", even a single unused needle (City of Hamilton, 2020, July 13, p. 178). According to one local activist, if someone in the male shelter system refused to work on a housing plan they could be banned from emergency shelter for sixty days (Kroetsch, 2020, Oct 23). Clearly, the shelter system was not accessible to everyone who needed it, especially those using opioids.

There were also capacity issues that meant many shelters were full, especially in the women's system (Craggs, 2020, May 15; Interviews 4, 10). One frontline worker sent a letter to city hall for the September Emergency & Community Services meeting. In this letter, they described some of the issues with shelter access in Hamilton. I have included an excerpt of this letter as I believe it provides a comprehensive overview of the concerns of frontline workers at this time:

> One narrative from the city is that there is shelter space available, but most shelters are at capacity and as a result the city funds overflow spaces. Overflow beds are less than dignified mats on the floor in a congregate setting. One of the women's overflow spaces sees between 15-25 people a night. Even when there is space, some individuals are ineligible to access services due to service restrictions. Couples face a unique challenge because there is only one family shelter in the city, but it is regularly at capacity and prioritizes families with children. Couples are encouraged to go into separate shelters, meaning they are forced to choose between leaving their closest support at their most vulnerable moments and having a place to sleep at night. Most shelters have congregated living spaces where residents are required to share their space with strangers, this has been especially difficult in the midst of a pandemic due to the fear of contracting COVID-19. Many individuals in need of shelter have experienced trauma, so being in close quarters with strangers can be re-traumatizing and individuals are more susceptible to theft and violence.
>
> Shelters have restrictive rules and regulations, which are particularly challenging for individuals living with significant and persistent mental health and addiction issues. For example, all shelters have curfews, limit family visits, and no pets allowed. Pets provide therapeutic value and are often the only family someone has. Also, the shelter system does not adequately support people living with mental illness, who often have difficulty adhering to the rules. As a result, residents are often service restricted due to disruptive behaviour and substance use. Many residents are discharged from shelters for a prolonged refusal to engage in finding housing, although it is difficult to secure an address in a housing crisis due to low income and lack of affordable units. These are not ideal conditions to successfully obtain safe and affordable housing. We must acknowledge and understand that the repercussions of this are directly connected to the encampments.

Figure 1: Letter submitted by frontline worker to City of Hamilton Emergency Services Committee (City of Hamilton, 2020, Sept 10, p. 103)

In my interviews, workers reported that there were frequently insufficient shelter spaces, and that people were regularly turned away for having drug use supplies or using substances (Interviews 4, 7, 9, 10). "Half of my job," one staff said, "is getting said no to by overnight shelters… because the women's shelters in Hamilton are always over capacity" (Interview 10). Frontline workers observed the reasons people may have been unable to access or stay in shelter, but city accounts and media representation read as though everyone was given open access to such programs. These discrepancies leave much room for interpretation, one such analysis being that people choose to forego shelter programs to stay in encampments and create nuisance for the city. Such a narrative can reinforce the stigmatizing idea that homelessness is a personal choice and criminal behaviour (Belcher & DeForge, 2012). Two commonly held, stigmatizing attitudes

present both homelessness and addiction as personal choices (Gaetz, 2013; Olsen & Sharfstein, 2014). The city, as it insisted that there were adequate spaces in the shelter system and that no one had been denied emergency shelter over the summer, may have reinforced such notions and ignored the broader factors – such as restrictive rules or inadequate space – that made emergency shelter harder to utilize. Focussing on individual actions blamed these individuals for circumstances that were likely out of their control, which downplayed the importance of systemic factors, such as restrictive shelter rules and inadequate space.

Beyond the emergency shelter system, the city had a shortage of affordable and supportive housing, likely a result of reduced investment from the federal and provincial government (Gaetz, 2013; Moro, 2020, Aug 22). These issues existed long before COVID but became a focus in the wake of the encampment lawsuit. In an opinion piece published in the *Hamilton Spectator*, two leaders of a neighbourhood association described how encampments were "the result of years of underinvestment in public housing" (Murphy & Eby, 2020, July 25). Even if affordable housing is a multi-level governmental issue, finding ways to address it during the pandemic became the responsibility of the municipal government in Hamilton. As COVID unfolded, municipalities in Ontario were given authority to delegate staff and funding. By the end of the first wave, Hamilton received over nine million dollars in emergency funding from the provincial and federal government (City of Hamilton, 2020, June 19). Even with this additional money there were still people sleeping rough. Hamilton's government was, in many ways, being forced to compensate for provincial and federal shortcomings that left people homeless.

To compound the issue further, there was no data on how many people were homeless during the first wave of COVID. Hamilton typically performs a Point in Time count once a year, a process that physically counts everyone experiencing homelessness on a given night. However,

the 2020 count was delayed due to COVID: as a result, there was no updated data on how many people were homeless or sleeping rough in the city (Mowat, 2020, Aug 17). As well, many people were facing pandemic-related financial challenges, such as job or income loss, and eviction (Mowat, 2020, Aug 17). While the provincial government had initially placed a moratorium on evictions, this expired a few months into the pandemic, leading to hundreds of applications to evict tenants in Hamilton (Van Dongen & Moro, 2020, Aug 4). These factors, combined with the mass release from the Barton Jail outlined in Chapter Two, meant that there were likely many more Hamiltonians living on the street than would typically be seen in the spring. Supports for housing were crucially needed, and encampments served to fill some of these gaps.

Encampments as Harm Reduction

Encampments served an important function for people during COVID: they provided a safer place to stay during widespread service closures and, importantly, the opioid crisis. In both local interviews with encampment residents, which were often included in press coverage of the topic, and my own interviews with frontline workers, encampments were discussed as a way to reduce the harms of COVID, homelessness, and the opioid crisis. Since many people were experiencing homelessness as a result of structural issues with the housing and shelter programs in the city, there were few places for people to go. In addition to the shortage of publicly available bathrooms, as outlined in Chapter Two, some have suggested that encampments arose as a way to cluster around available services and keep each other safe (Interviews 4, 6, 9; Mowat, 2020, Aug 17).

As the opioid crisis continued to unfold and programs around the city were shuttered, encampments served as an informal harm reduction service. People living in encampments

would have “safety in numbers”: people could watch each other’s belongings to prevent theft, provide aid during overdoses, and have easy access to outreach workers and medical doctors, who could easily locate the larger encampments that developed over the summer (Interviews 1, 3, 4, 6, 7, 9; Moro, 2020, July 30; Van Dongen, 2020, May 1). As well, at such sites people could feel “safe and secure when surrounded by others who [were] going through the same difficulties” (Anonymous, 2020, Aug 14).

Living outside also reduced the risk of contracting COVID, which is thought to be less contagious in well-ventilated areas. While encampments were clearly not without their issues – frontline workers and advocates argued that permanent housing would be much safer and that there were indeed issues that arose from having large groups of people living in small locations without, for example, waste management systems – these sites did serve an important function for people at the intersection of various public health emergencies (Interviews 4 & 7; Mowat, 2020, Aug 17; Van Dongen, 2020, July 31).

Encampments served to reduce the likelihood of COVID transmission, but they were also a way to reduce the harms associated with drug use. As mentioned, shelters throughout the city prohibited drug use and thus did not operate within a harm reduction framework. While there is no single definition for what harm reduction means in practice, it is generally understood that such programs do not penalize people for their use – programs that focus on punishment or reducing drug use are not in line with a harm reduction model (Marlatt & Witkiewitz, 2010). The prohibition of drug use in Hamilton’s shelters meant that these spaces barred people who were actively using. Nonetheless, such rules did not stop use on-site; people would routinely use in private spaces, such as washrooms (Interview 9; Interview 7; Moro, 2020, Aug 22). It would have been extremely difficult, if not impossible, to choose to stop one’s addiction in hopes of

accessing a shelter program. As such, encampments – where people could use drugs without eviction, even if they did risk arrest by police –served as an alternative for people who used substances during COVID.

This notion of encampments as harm reduction is one that challenges individualized, biomedical views of harm reduction that are espoused from a public health framework. As mentioned in previous chapters, harm reduction, from a public health perspective, is often presented as a medical issue: it requires naloxone kits, new needles, and access to overdose prevention sites. Harm reduction, then, is a personal choice to behave in ways that ameliorate the harms of drug use and drug use only. For frontline workers and activists, though, harm reduction had a much wider definition that warranted structural and political interventions: for example, legal protections to preserve the right to reside in encampments, as this practice could reduce the harms of both COVID and the opioid crisis.

Encampments as Criminal: The Construction of a Crime

Though many activists and workers understood harm reduction and encampments as issues of social justice, such views were not held by everyone in the city. As the pandemic continued through the summer, city officials and police continued to dismantle encampments. After police cleared the camp at Sir John A. MacDonald in April, some encampment residents moved to Jackie Washington Park, a nearby municipal park (Van Dongen, 2020, May 1). Within a few days, police also dismantled this encampment. Despite calls from activist groups to allow the camps to remain, the city continued to dismantle encampment sites, sometimes removing or destroying personal belongings in the process (Craggs, 2020, May 15; K6, 2021). Dismantling these encampments did not eliminate their presence; clearing small encampments may have led to larger encampments, and advocates argued that clearing large encampments would cause

people to disperse around the city in smaller groups, farther away from social services (Craggs, 2020, May 15; Interview 9; K6, 2021). The city, then, claimed that these camps violated the bylaw and removed these tents (Hamilton, 2020, Oct 7).

Encampments, then, were a legal "issue". I have used the term "issue" in quotations since the construction of encampments as a legal matter was, in many ways, a subjective interpretation. To start, the appeal to understand encampments as a legal issue was grounded in city bylaws. To the lawyers involved in the encampment injunction process, the city had the authority to define and enforce to its own bylaws as it saw fit; there was some flexibility in how bylaws were interpreted (Moro, 2020, July 21; Moro, 2020, July 29). Indeed, there are bylaws in the city that are not consistently enforced. Take snow removal as an example. Hamilton has a bylaw that requires property owners to clear their walkways after a snowfall, and there have been so many bylaw complaints because of improperly removed snow that a group of citizens is currently petitioning city council to pay for snow removal throughout the city (Mitchell, 2020). It seems as though not all bylaws are consistently utilized, nor do they always achieve their desired outcomes. The decision to target encampments, then, could reflect broader, stigmatizing perceptions of homelessness (and drug use) during COVID: if the city can decide what bylaws are enforced and they decide to penalize citizens sleeping rough, this decision presents homelessness and encampments as a moral, criminal act, not a necessary aspect of harm reduction during a global crisis.

The bylaw in question was one that prohibited camping in a public park, a sub-section of the commonly cited "parks bylaw" (Hamilton, 2015). While there were encampments that were not in city parks, such as the camp outside of FirstOntario Centre, coverage of the court injunction focused primarily on the legality of encampments in parks. Whether this bylaw was

ethical or enforceable during COVID is an important question, though admittedly beyond the scope of this project. What I do explore in this section is how news coverage and city documents appealed to this notion of legality in discussing encampments. By presenting encampments as a legal problem, the issues that were related to these camps – such as homelessness and opioid use – were presented as deviant, criminal acts. This is noteworthy as the parks bylaw is not a criminal law – the Canadian Criminal Code has no mentions of camping, trespassing in public parks, or similar topics (Government of Canada, 2021). These bylaws were independently developed and implemented by the City of Hamilton. While news articles and city councillors did not specifically appeal to this bylaw as a criminal law, the broader narrative of this issue constructed it as such.

As an important note, there were no written mentions of the opioid crisis in council minutes during this time. Many of the council meetings on encampments were held in camera, so the only information that is publicly available from this time is news coverage and voting records. Though most councillors voted to pursue the dismantling of encampments, their rationales and perspectives are not accessible to the public. A few councillors, though, were particularly vocal about their perspectives on encampments, and many of these comments were published widely in local media coverage. This section, then, utilizes these sources to explore how, to such individuals, encampments were not an understandable phenomenon or aspect of harm reduction. Instead, encampments (and, by extension, homelessness and drug use) were criminal issues in need of enforcement.

I do want to note, first, that most news coverage portrayed encampments in a sympathetic light. In the section above, the majority of news articles I cited pointed to the structural issues that led people to live in encampments in the first place. These stories did not blame residents for

their housing situation, nor did they explicitly suggest these encampments were a result of criminal decisions being made. Rather, local journalists interviewed encampment residents to understand their firsthand experience, and this coverage could have been responsible for spreading empathy or support for these sites. However, this section will point to the coverage on the legal aspects of the encampment issue that were inevitably covered in the news.

One city councillor was especially vocal about his disdain for encampments and the activists involved in protecting them, and these opinions were widely published in the local media. Importantly, opinions covered in the media can serve to shape public opinion on homelessness (Calder et al., 2011). Clearly, then, such perspectives could have been influential at a time when many people were experiencing homelessness in a visible way. Longstanding municipal councillor Terry Whitehead, who was quoted at the start of this chapter, was possibly the most vocal critic of encampments in the city. His opinion piece on the matter was a point of discussion in local media for several weeks. In this piece, and many other interviews and public comments, he presented encampments as dirty places full of feces and used needles; he called homeless people "agents of chaos"; he called for local activists to be held accountable in court for their support of these camps; and he claimed that people in housing near encampments were "living through hell" (Moro, 2020, Sep 3; Moro, 2020, Sep 14). While Whitehead may not have referred to the encampments themselves as decidedly criminal acts, he conflated them, and the people who lived in them, with disorder and chaos, places in need of control. In his opinion piece, he described encampments as "a vortex for drug dealers, users and criminal activity" (Whitehead, 2020, Aug 9). Indeed, there may have been a higher proportion of people using drugs in these camps, and this was likely because of structural barriers that made shelters less accessible to people with addiction. Given the established link between opioid use disorder and

homelessness, these comments may have had ramifications on how the public perceived the opioid crisis during the pandemic.

Constituents in Hamilton, through letters to city council and local media, also contributed to the idea that encampments were a criminal issue. While the majority of these letters were in support of the rights of encampment dwellers, other correspondence presented encampments and their inhabitants as scary, dirty, or a safety risk. Such letters often asked for the police to enforce the bylaws and clear the camps. In one letter sent to city council, a constituent suggested that the municipal government should “focus on the things that really matter in this city and clean up the bum infestation along York Boulevard between Bay and MacNab” (the location of the FirstOntario encampment). The letter continued, saying:

> I called the police and they say they cannot enforce the law and remove the eye sore because the city allows [the encampment] because of COVID. COVID is being used as an excuse for everything these days and that includes your incompetence to deal with the things that actually matter in this city, such as enforcing the basic laws that maintain order and ensuring the liveability of this city for the productive citizens of this city…. We all have problems in life and some deal with those problems and others just feel sorry for themselves and use drugs or alcohol to make it go away. (City of Hamilton, 2020, Aug 21, p. 128)

Another letter, sent to the *Hamilton Spectator* opinion section, asked for the City to “balance the needs of the homeless with the needs of the rest of the public”, and cited safety concerns around the FirstOntario encampment: “equipment and homeless clog the sidewalk. There is no chance for physical distancing, and I don’t feel secure, so I have to walk on the road. This is not safe, pleasant, or fair to me” (Koba, 2020, Aug 1). While this letter did not directly accuse

encampment residents of crime, the author did ask the judge to consider the safety of constituents – a request that also presented encampments as a legal issue.

Another way that encampments were constructed as a criminal act was through the selective use of statistics. One of the subtlest examples comes from a graph charting the frequency of calls to police on Ferguson Avenue. This graph was published in an article that covered the resolution of the encampments injunction, which permitted the city to clear larger camps. The graph, shown below, outlines calls to police about the encampment on Ferguson Avenue, comparing the summer to the time before the pandemic:

Figure 1: Graph of police calls to Ferguson Avenue, from Craggs (2020, Sept 30).

At first glance, this data seems straightforward: before the pandemic, there was a relatively consistent number of calls to this area, but as people started to camp on Ferguson the number of calls increased drastically. Not only does the graph suggest that the camp itself is solely responsible for the rise in calls, it ignores the reasons why these calls were made. Were the calls made by encampment residents, nearby workers, or because people were uncomfortable seeing so much visible homelessness in one area? Literature on the criminalization of homelessness

suggests policing, as well as bylaws, can be utilized to control the activity of homeless citizens in the interest of wealthier constituents; this could be especially noteworthy given the likelihood for homeless people to become scapegoats as a result of an inability to adhere to COVID guidance, such as social distancing or hand-washing (Chang et al., 2020; Gaetz, 2013; Stuart, 2015). In conjunction with the stories published on incidents of crime at these camps, it is hard to know whether these calls to police were indicative of actual issues at the camps or whether police were receiving calls from a place of judgment and stigma.

Conclusion

Encampments served a number of purposes during COVID. They provided homeless Hamiltonians a safer place of refuge from the opioid crisis and COVID; they served as informal networks of support; and they helped doctors and social service workers connect to their clients, who were more likely to stay in one place when they were allowed to camp near social services. Frontline workers and activists knew, though, that encampments were not the ideal option for people in these sites: permanent and supportive housing was always identified as the goal. The government of Hamilton's response, which was to penalize encampment dwellers, highlighted a tension at the core of how harm reduction was defined and understood during a time of intersecting crises. To frontline workers, who directly worked with people experiencing these emergencies, encampments were an important aspect of reducing the structural harms that resulted from a lack of investment in supportive housing, the ongoing opioid crisis, and a pandemic that made accessing traditional shelter programs more challenging. To some others, though, this survival tactic was considered a criminal, legal issue. The municipal government, on the whole, has implemented some aspects of harm reduction, especially those that focus on biomedical harms. The COVID pandemic, however, has served to highlight the limitations of

this medical model, as people who use drugs experienced the harms associated with the ongoing criminalization of drug use and homelessness. Frontline workers identified these shortcomings and called for a broader, political practice of harm reduction at a time of numerous, intersecting crises. Important social issues, like housing shortages, may have predated COVID, but the pandemic made their consequences more severe. COVID exposed people who use opioids to unique harms, worsened existing issues, and exacerbated the cleavage between the city's understanding of harm reduction and what was workers saw on the front lines.

Chapter 5: Conclusion: Harm & Harm Reduction During Intersecting Crises

"Simple policy change would create a whole new world… nobody has to die" –Interview with Hamilton harm reduction worker

Introduction: Postmodernism & Social Context

The previous chapters have outlined how harm reduction, broadly speaking, was practiced in the city of Hamilton during COVID. As I conclude this thesis, I want to spend some time exploring possible solutions for some of the issues I have examined: ways that harm reduction could be reimagined to encompass the harms of both the opioid crisis and COVID, or future pandemics. Some scholars have argued that pandemics are likely to become more frequent and consequential in the future (Bedford et al., 2019). As such, this chapter addresses suggestions for this likelihood.

This project utilized postmodernism and constructivism to understand harm reduction and how the meaning of this phrase can be fluid. From a postmodern perspective, there is no such thing as an absolute truth: understanding the construction of meaning is crucial to understanding health (Cooter, 2007; Mitchell, 1996). The social context of the period between March and November, 2020 was a complex one: the coronavirus pandemic and the opioid crisis were ongoing, and the city, as a whole, was trying to address these issues. There were harm reduction programs operating at this time, but there were discrepancies in what harm reduction practice meant among advocates, frontline staff, and city officials. Harm and harm reduction can mean, and have meant, many different things: harm reduction can involve biomedical programs that focus on reducing the risk of blood-borne infections, for example, as well as activism to decriminalize drug use (Morin et al., 2017; Smith, 2012). Sometimes, harm is conceptualized as

a dichotomy between individual, often biomedical, harms, such as overdose or blood-borne infections, and structural or social harms, such as the stigmatization and ongoing criminalization of drug use.

What the COVID pandemic has made clear, then, is how the individual-level harms, such as biomedical risks associated with opioid use, were inseparable from the broader social context in which they occurred: even if city programs provided needles or naloxone kits, people were still using drugs in an environment where it was illegal to do so and the drug supply was toxic as a result. Clearly, social, structural harms were closely linked with individual harms, and may have even caused these individual harms in the first place. This was especially true in Hamilton, where harm reduction has been practiced in an individual, biomedical sense. If city-funded programs reportedly practiced harm reduction, but still penalized people for their use, as in the case of shelter programs that evicted people with drug paraphernalia, then harm reduction was not happening in a holistic sense. This discrepancy may have actually reinforced both individual and structural harms by, for example, exposing people to conditions that made overdose more likely, such as using alone. Reconceptualising harm, then, should consider how these individual harms are a linked to broader social structures[2]. To adequately prevent the harms of opioid use, it is critical to understand how compounding structural factors – such as the housing crisis and the response to COVID-19 – can influence the health of people who use drugs during the opioid crisis.

What Is Harm?

---

[2] While I had started this project as one grounded in postmodernism, as the project unfolded I wondered how the results or analysis may have been different had I engaged with a poststructualist epistemology instead, engaging with broader social discourses instead of local, individual meanings.

Before I discuss how harm reduction could look, it is important to understand what exactly harm meant during these two intersecting crises. To start, the obvious: biomedical harms associated with opioid use. As harm reduction has become increasingly popular in Canada, programs have generally focused on the biological harms of opioid use such as overdose and blood-borne infection (Morin et al., 2017). These risks are often individualized: though high overdose rates can affect an entire community, to reduce one's risk of overdose, for example, one must personally choose to seek out and use naloxone kits and follow public health advice geared towards the opioid crisis. Such biomedical programs encourage people who use drugs to take personal responsibility for reducing the risks associated with their use (Rhodes, 2009). Indeed, participating in such behaviours can be lifesaving.

During COVID, however, it was clear that individual harm was inseparable from the harm experienced by a community. The drug supply changed and became more dangerous: early data from the pandemic indicates that Hamilton had one of the highest rates of overdose and overdose death in the province (Ontario Drug Policy Research Network, Office of the Chief Coroner for Ontario, Public Health Ontario, & Centre on Drug Policy & Evaluation, 2020). This phenomenon could have been a result of many issues, such as border closures, a disrupted supply chain, or other, unknown factors (Giommoni, 2020). People were still experiencing the same harms that they had before the pandemic, but the confounding influence of shifting drug supplies and service closures made these harms much more severe. On this topic, COVID-related closures, as outlined in Chapters Two and Three, meant that lifesaving supplies – such as needles, pipes, and naloxone kits – were harder to access. Beyond that, other harm reduction services had reduced hours and capacity, which likely meant that more people were using alone, risking a higher likelihood of overdose. Some facilities in Hamilton were practicing particular

aspects of harm reduction, but ultimately would not allow people to use or have paraphernalia on site; as a result, people were likely exposed to additional harms in the form of stigmatization and potential overdose if, for example, they left these programs to use elsewhere. Even with programs that sought to reduce individual harm, the influence of social and structural harm continued: someone might have been willing to use a naloxone kit, for example, but may have been unable to access this service amid COVID closures and service changes. While COVID prevention was undoubtedly necessary, such interventions may have had unintended consequences for people living through the opioid crisis.

Opioids, then, were not the only source of biomedical harm during this time. The COVID pandemic made opioid use much more dangerous for two reasons: because of the virus itself and because of how the city addressed to the virus, broadly speaking. Responding to an overdose – either in a harm reduction service or in the community – could have exposed responders to respiratory secretions that could contain the virus. As well, the public health guidance for COVID did not adequately consider the ongoing opioid crisis, especially in the first few months of the pandemic. In harm reduction services, changes to protective equipment protocols and overdose processes meant that providing time-sensitive aid during an overdose may have taken longer in some cases (e.g. when manual ventilation was used), potentially compromising the health of the person overdosing. While, in this case, it would be important for staff to protect themselves with specially fitted respirators (e.g. n95 masks), donning this equipment could have prolonged the overdose response. As well, the risk of contracting COVID during an overdose was especially concerning and unclear in the early months of the pandemic, before municipal and provincial public health bodies were able to clarify the risk of both CPR and nasal naloxone.

Not only were people more likely to overdose during this time, intervening during overdoses was harder and riskier.

On this note, COVID prevention measures, generally speaking, were conducted from a biomedical perspective, one that frontline workers acknowledged was too narrow to meet the needs of everyone in Hamilton. Overall, interviewees critiqued this “one-size fits all approach” and how it did not consider people who were actively using opioids or experiencing homelessness during COVID. For example, service closures during the first lockdown made it nearly impossible for people to access public washrooms, which caused significant health issues: not only were people were unable to wash their hands to prevent the spread of the virus, this lack of facilities may have increased the risk of stigmatization and sexual assault. Not only did harm include the risks of opioid use but it also encompassed the broader environment in which one was using. While public health guidance did help save lives and prevent COVID spread, this hegemonic biomedical guidance could have been harmful for people at the intersection of COVID and the opioid crisis.

In terms of the broader environment, Chapter Four outlined shortcomings in the housing sector in Hamilton, including a lack of affordable, supportive housing, and accessibility issues within the emergency shelter system. People living in congregate settings – such as crowded emergency shelters – were thought to be more likely to contract COVID (O’Shea et al., 2020; Tyndall, 2020). Other limitations of the Hamilton shelter system, such as the restriction of drug use or paraphernalia, likely contributed to the development of large encampments throughout the city. These camps served as an informal method of harm reduction for both COVID and the opioid crisis, but many were cleared by police. In this sense, COVID, stigmatization, and homelessness were all harms that arose at the intersection of COVID and the opioid crisis in

Hamilton. The harms experienced while using opioids, then, were not only a result of the drugs themselves but reflective of the social context in which this use occurred.

In a much broader sense, the stigmatization and criminalization of opioid use have caused many of the drug-related harms experienced during COVID. Take criminalization as an example. Many frontline workers argued that the drug supply was so toxic during COVID because recreational opioid use was (and is) illegal in Canada. Indeed, Tyndall (2020) suggests that the drug supply in Canada has been toxic for years, and that the drug supply has not been regulated because it is illegal. Clearly, drug toxicity is linked to the criminalization of drugs. However, the supply has also become increasingly toxic during COVID. Regardless of what caused these changes in drug supplies, the ongoing criminalization of recreational opioid use has caused overdose, death, and the stigmatization of opioid use.

Defining harm during COVID was especially important as Hamilton’s city-sanctioned services practiced harm reduction – in a limited, medicalized sense - but still actively penalized and criminalized opioid use. The implications of this harm, and its intersection with various forms of identity, could be an area for future study to more fully understand the experience of COVID and to help prepare for future pandemics. People who used opioids during the COVID pandemic, especially those who were simultaneously experiencing homelessness, experienced numerous forms of discrimination and stigmatization. The sources of this stigma were varied: stigma may have been a result of attitudes towards homelessness, the ongoing stigmatization and criminalization of drug use, or someone’s inability to adhere to COVID public health protocols.

As well, in all of my primary research for this project I encountered almost no discussion of how various aspects of identity – such as race, gender, or sexual orientation – influenced the harms people experienced while using opioids. While this may have been a result of my

interview questions, which were focused only on the experience of frontline work, COVID has highlighted how individual harms are linked to structural harms, such as criminalization and racism. Indeed, a few news articles mentioned the link between colonialism, homelessness, and Indigeneity (see, for example, Moro, 2020, Aug 22), and some interviewees did mention the specific harms that women and LGBTQ+ people experienced with bathroom access and shelter restrictions. However, despite a history of disproportionate criminalization and imprisonment for racialized people who use drugs, media coverage on the opioid crisis in North America has focused predominantly on white users, and some have argued that this bias in coverage means that certain people with addiction are viewed with more empathy than others, especially when addiction is seen as an issue of public health (Netherland & Hansen, 2016). Further, the media often neglects stories of overdose deaths among Indigenous users in Canada, reflecting ongoing colonial attitudes around Indigeneity and drug use: Indigenous drug use is assumed to be so common it is not even noteworthy when someone dies (Johnston, 2020). Put simply, opioid use has become associated with whiteness and constructed as a public health issue as a result, even if criminalization still happens throughout much of society. Importantly, as I will explore in a later section, some of the only mentions of harm reduction in city council documents were included in calls to defund the Hamilton Police Service. There was, outside of these agendas, little discussion of how the experience of harm could differ throughout the city based on broader structural factors such as racism, homophobia, transphobia, or sexism. To adequately define what harm means during a pandemic, it would help to address these systemic factors and their relationship with individual, biomedical harms of both COVID and the opioid crisis. Overall, the pandemic has clearly highlighted areas where harm reduction could expand to include the broader harms of opioids, such as stigma, criminalization, and discrimination.

What Is Harm Reduction?

Harm reduction can mean many different things, even and especially during a pandemic. While many are familiar with biomedical iterations of harm reduction – programs that focus on reducing the biological harms of drug use, such as overdose or blood-borne infections – there are myriad other harms that warrant reduction.

Throughout the previous chapters, I have outlined how advocates called for increased access to services such as showers, food, and bathrooms, and many argued that these were important aspects of harm reduction. As mentioned in Chapter Four, harm reduction could also involve encampments to help mitigate the effects of COVID, the opioid crisis, housing and shelter shortages, to protect the health for people at the intersection of these issues until permanent housing is available. While the aforementioned supplies, programs, and practices have not generally been considered as a part of harm reduction in Hamilton, they proved to be crucial in mitigating the harms of both COVID and the opioid crisis. To reduce harm at this intersection, people also need the necessities of daily living that were unfortunately harder to access as a result of pandemic shutdowns and restrictions. In fact, in the initial needs survey to determine the scope of the supervised injection site (or CTS) in Hamilton, food and showers were rated as among the least important services that could be offered in this harm reduction program (Hopkins et al., 2017). During the COVID pandemic, however, it seems that this need has changed: food and showers were mentioned as a priority by every worker I interviewed. As pandemic restrictions took effect, services closed and this exposed people who used opioids to additional harms, such as a lack of toilets, while worsening existing structural issues, such as a lack of affordable housing and an inaccessible shelter system. While city officials and programs still practiced biomedical harm reduction, frontline workers called for broader reforms: harm

reduction as both an individual practice and a social intervention. Given Hamilton's ongoing lack of affordable housing, for example, in conjunction with the likelihood of future pandemics, it would be prescient to broaden the practice of harm reduction beyond the medical.

Frontline workers also clarified how harm reduction requires a welcoming environment that does not penalize people for their drug use. This is especially pertinent in a society that, on the whole, criminalizes opioid use and addiction. Clarifying how, exactly, harm reduction functions amid the widespread enforcement of drug laws is important. This tension arose over the summer in light of the movement to defund the Hamilton police. Activists called on the municipal government to reduce or eliminate police funding in the wake of anti-black racism and violence perpetuated by police in Ontario. Interestingly, much of this correspondence called for the government to redirect these funds to community services such as housing and harm reduction – this correspondence contained the majority of the times that the phrase "harm reduction" was mentioned in city council agendas. Many of these letters acknowledged the shortcomings of the criminalization of homelessness and addiction:

> An increased police presence does not keep us safe, rather it directly threatens the lives of our most vulnerable communities (BIPOC, the LGBTQ2S+ community, unhoused people, street-based sex workers, people with disabilities, people experiencing poverty, etc.). Instead of investing in policing, our city must prioritize alternatives like… harm reduction services. (City of Hamilton, 2020, June 24, p. 97)

Other letters called for the Hamilton Police Service to implement harm reduction in its training (City of Hamilton, 2020, June 3). Such letters highlighted a fundamental tension in the definition of harm reduction. Harm reduction, as a diverse ideology, generally does not include the criminalization of addiction: drug use is accepted as an amoral issue (Keane, 2003). As such, it

makes sense for activists to have requested harm reduction and housing in calls to defund the police: if harm reduction does not penalize people for use, then money for these services could come from the organizations that have been penalizing people who use drugs.

However, the policing/harm-reduction distinction is not necessarily a dichotomy. The criminalization of opioid use is ongoing, even with the advent and adoption of harm reduction programs in Hamilton. These calls to redirect police funding to harm reduction services, in addition to highlighting the ways in which people might view these programs as a counterpoint to criminalization, exemplified challenges in the institutionalization of such programs. This has been a source of tension in the harm reduction movement, broadly speaking: often, harm reduction programs are focussed on harms that are widely accepted and not open to debate – as in the case of overdose prevention and needle distribution through public health programs (Keane, 2003). As mentioned, harm reduction is largely biomedical in Hamilton and has been integrated into city services such as public health. However, harm reduction initially started as a grassroots political movement which sought to challenge the political and structural causes of harm, such as criminalization: as a result, community activists have often aligned more closely with harm as an issue of inequality and have been more willing to challenge the sources of this inequity, like the criminalization of drug use (Roe, 2005). The calls to defund the police, then, are one example of how this grassroots and community activism can address aspects of structural harm.

Harm reduction, to activists, is not just a medical issue: it is a structural, social problem related to how the city prioritizes and funds services. The ramifications of such funding decisions were especially obvious in the context of COVID, where homeless Hamiltonians and people using drugs were not adequately considered in pandemic prevention. Redirecting funds away

from police and into existing biomedical harm reduction programs, though, or encouraging the development of harm reduction policing services, may serve to reinforce the power dynamics that perpetuate existing drug harms, such as stigmatization and criminalization. Determining the bounds of harm reduction as an ideology could be an important area of study in harm reduction activism amid the movement to defund the police.

In a much broader sense, it would be beneficial for people who use drugs if structural harms, such as the criminalization or stigmatization of drugs, did not exist in the first place. To many activists and advocates, the decriminalization of illicit opioid use would reduce or eliminate many of the harms experienced by people who use drugs. In fact, research does suggest that the people who experience the most harms from opioid use are the people who use illicit opioids (Buchman, Leece, & Orkin, 2017). While I cannot say that decriminalizing drugs would singlehandedly solve this issue, there is some compelling evidence that decriminalizing drugs for personal use can reduce substance-related harms. In 2001, Portugal decriminalized the personal use of drugs and shifted to a health-oriented response, offering people treatment or administrative sanctions instead of imprisonment. Afterwards, the country saw fewer drug-related harms, such as death and blood-borne infections (Hughes & Stevens, 2010). While, again, it is impossible to determine whether decriminalization itself actually caused these improvements in Portugal, there could be benefits associated with simply incarcerating fewer people. As noted in Chapters Two and Four, communal living spaces such as prisons can be a risk factor for COVID spread. There is also a higher risk of opioid overdose when someone is released from incarceration (Mukherjee & El-Bassel, 2020). Decriminalization, then, could directly reduce the harms associated with both COVID and the opioid crisis. While decriminalization would involve

federal lawmakers, and is therefore outside of the purview of the municipal government, the city as a whole could advocate for decriminalization on a federal level.

As well, moving to decriminalize all aspects of homelessness would prevent the spread of disease during a pandemic and provide humane treatment to people living without housing: these are important aspects of structural harm reduction for opioid use. The harms one experiences while using opioids are compounded by additional sources of marginalization (Buchman, Leece, & Orkin, 2017). Homelessness, then, may expose someone to additional harms related to both opioid use and the pandemic itself. If, as outlined in Chapter Four, shelters are confined, crowded spaces where the risk of COVID transmission is higher, then respecting the rights of encampment dwellers could reduce the spread of COVID. In fact, the Centres for Disease Control and Prevention identified that dispersing encampments can contribute to the spread of COVID (Centres for Disease Control and Prevention, 2021). Ideally, the federal and provincial governments could contribute additional funding to spur growth in the supportive housing sector. Until then, however, respecting the rights of encampment dwellers could be a useful strategy to prevent COVID and the spread of future pandemics. As well, it is important to ensure that people experiencing homelessness or addiction are not unnecessarily criminalized in widespread public health measures, such as physical distancing bylaws. If criminalization and stigmatization are harmful to people who use drugs, then it is also important that nobody is penalized for their housing status. This is, and has been, especially important during a pandemic when governments are given additional law enforcement privileges, as was the case of physical distancing bylaws in Hamilton**.** Harm reduction during COVID, then, is encampments, permanent housing, and could include policies to prevent the criminalization of homelessness.

Moving Forward: For Future Pandemics

While this project only focussed on the first eight months of COVID in Hamilton, the lessons learned from this period can be useful for future pandemics, especially in their early days, when methods of viral transmission could be unclear and supplies of PPE may not be adequate. First, it will be crucial to ensure that existing harm reduction programs – such as needle exchanges and naloxone distribution – are not disrupted. In the early days of COVID in Hamilton, many of these programs closed or reduced their hours, which made lifesaving supplies and services harder to access. While COVID safety protocols were undoubtedly an important aspect of the city's pandemic strategy, frontline staff questioned the universal relevance of these decisions for people who use drugs, especially those who were homeless during the first wave of COVID. As well, some workers argued that these programs needed more capacity in general, even before the pandemic: some interviewees called for another Consumption and Treatment Services (CTS) site, as the city currently only has one program and has enough need for at least one more site (Interviews 1 & 4). According to a 2019 article from *CBC Hamilton*, the city has been approved for another CTS site (Mowat, 2019). However, at the time of writing it has not yet opened.

In the future, should another pandemic arise – especially one of uncertain transmission, like COVID – implementing outdoor services, outreach programs, contactless harm reduction delivery, and innovative, remote services could help provide widespread access to harm reduction. Essentially, if it is the case that most viruses are more infectious inside, where people are in close contact and breathing the same air, then providing services outdoors could be a way to reduce risk while still ensuring access to such services. This could involve, for example, organizing an outdoor CTS. This would also improve access to harm reduction services for people who smoke substances as well, as many harm reduction programs in Hamilton are geared

towards injection drug use. Navigating intersecting public health emergencies can be challenging, but finding ways to address each issue could help keep people safe: prioritizing certain aspects of each, such as face mask availability for COVID and enough CTS space for the opioid crisis, would help strike a reasonable compromise when approaching two issues with oft-conflicting guidance. If people are to use drugs in groups but isolate from others during COVID, for example, then a simple solution such as universal access to masks and enough space between service users could mitigate risks from both issues. Providing access to phones or internet, as well, could increase access to remote services and improve physical distancing. Innovative solutions that meet existing needs on all fronts are critical, and many examples of such programs have been outlined throughout this thesis.

In addition, ensuring access to therapies such as opioid agonist treatment (e.g. methadone) can reduce harms during a pandemic, when drug supply chains could be disrupted. While programs such as methadone clinics continued to operate during COVID, some clinics emphasized telemedicine and phone visits instead of in-person operation. Ensuring these physical spaces remain accessible to people without cell-phones or the ability to participate in telemedicine would serve to maintain access to these potentially lifesaving drugs (Lam, Sankey, Wyman, & Zhang, 2020). As well, many health professionals have been calling to expand access to safe supply, a program that provides medical grade opioids by prescription as a safer alternative to illicit drugs (Tyndall, 2020). Safer opioid programs could reduce the criminalization of opioid use as well, as people could be less likely to participate in drug deals, for example (Tyndall, 2020). Safe supply programs, then, could reduce the individual harms (overdose) and structural harms (criminalization) for people at the intersection of the opioid crisis and a future pandemic.

Beyond safe supply programs, drug testing programs could be lifesaving as well. Providing access to drug testing – which indicates the chemical makeup of substances – could help reduce morbidity and mortality as well. Since 2019, some community organizations in Toronto have offered drug testing to service users (Maghsoudi et al., 2020). Providing clear information about the content of drugs can help people make informed decisions about their use. The opioid crisis is a complex issue that would benefit from numerous, varied interventions: a multi-pronged approach that integrates drug testing, opioid maintenance therapy, and safe supply could reduce overdose deaths, especially during times of social upheaval and increasingly toxic drug supplies.

Perhaps most importantly, as mentioned many times throughout this thesis, it is important to include people who use drugs themselves when formulating public health guidelines. In the case of COVID, as the city navigated PPE shortages and determined how, exactly, to best prevent the spread of the pandemic, outreach and peer-informed programs, such as the overdose prevention line, were instrumental in mitigating the damages of the opioid crisis. While starting to gather peer perspectives would undoubtedly be much more challenging during a pandemic, the COVID experience could be a useful starting point to develop emergency plans should similar situations arise in the future. Lived experience was especially important during COVID as it highlighted how harm reduction should not just be a medical intervention, but must include access to washrooms, hygiene products, face masks, food, and shelter (or, at the very least, encampments). Creating a contingency plan that is informed by the people who are experiencing these harms will be crucial for a robust harm reduction practice during future pandemics. Further, incorporating such lived experience into public health guidelines would arguably make these policies more useful and effective. For example, the screening questions mentioned in

Chapter Three were not applicable to people who use opioids or were going through opioid withdrawal, as withdrawal and coronavirus share many symptoms. There could be several solutions to this issue: routine access to testing, a specific set of screening questions that are tailored to people who use opioids, or the removal of these testing criteria completely to improve access to harm reduction services. If COVID can be more harmful for people who use drugs or those who are experiencing homelessness, then creating comprehensive public health guidance would be a way to reduce the harms of both the pandemic and the opioid crisis.

In a broader sense, it may be useful for Hamilton agencies to create a guideline of harm reduction best practices. Historically, many Canadian harm reduction advocates and policy writers have resisted the idea of creating standardized practices and procedures: they have argued that these could limit an organization ability to practice harm reduction in a way that fully meets the needs of their community (Hyshka et al., 2019). If harm is a specific, localized phenomenon, creating guidelines for Hamilton could prevent discrepancies in how the phrase is used. Currently, as has been demonstrated throughout this project, harm reduction is not a phrase that is used with much consensus in the city. Take this example from a city council agenda. First, some background: in Chapter Two, I outlined how the city had opened an overflow shelter at the FirstOntario Centre. As the city aimed to return this space to its original use, the shelter planned to relocate eastward to the old Cathedral Boys School. Good Shepherd, a local social service, was in charge of facilitating this shelter and opening a new overflow shelter in this space. City councillor Nrinder Nann sent out a letter to her constituents explaining various aspects of Good Shepherd's plans:

How does Good Shepherd's approach to substance use differ from that of police? Good Shepherd strives to work within a harm reduction framework. We provide sharps containers and harm reduction kits at our sites. We host harm reduction and addiction services in our programs. We have no desire to further stigmatize or criminalize people due to their substance use. We do, however, advise shelter residents that drug use in shelter is not permitted. We will discharge an individual from the shelter if there is persistent evidence of onsite drug use (unsafe disposal of needles, impairment that puts individual, other clients and/or staff at risk). We are also vigilant in discouraging drug trade on or near our sites.

Figure 1: Excerpt from correspondence regarding Cathedral Boys overflow shelter (City of Hamilton, 2020, 16 September, p. 252)

This is an example of an organization decidedly practicing only some aspects of harm reduction without actually allowing drug use. Such a conception of harm reduction could, in fact, contribute to the ongoing penalization and stigmatization of drug use and addiction in Hamilton. As such, it could help to clarify what, exactly, harm reduction means to Hamilton agencies on the whole. Since the phrase clearly has a wide range of meanings and priorities, creating a central definition could help provide comprehensive harm reduction services that are relevant to people in this city at this time. Guidelines for Hamilton could specify, for example, that organizations that espouse harm reduction values must provide equitable access to services regardless of whether someone possesses paraphernalia or has been actively using. Indeed, this may be a challenging balance to strike in a society that still overwhelmingly criminalizes drug use. However, finding ways to allow people to access services without being punished for their use could also prevent stigmatization and overdoses (i.e. people would be less likely to use outside or alone).

In a Dream World…

I concluded my interviews by asking participants what Hamilton could do differently, in a dream world, to support people who use opioids during COVID. Most people pointed to a combination of immediate, proximal issues, such as CTS funding and availability, as well as

broader, systemic problems, like income inequality and the criminalization of drug use in Canada. Future pandemics aside, one thing is clear: harm and harm reduction have changed in the wake of the pandemic. While the structure of this project was not one that explicitly evaluated how people viewed harm reduction before and after COVID, it became obvious that the pandemic and all of its challenges have changed the harms associated with drug use: COVID exposed people to unique harms and worsened existing social problems. Frontline workers noticed these shortcomings as gaps in the biomedical model of harm espoused by the municipal government and its services. Beyond Hamilton, harm reduction programs have generally focused on individual behaviours (Boucher et al., 2017; Rhodes, 2009). However, this project has shown that individual behaviours are not always possible to modify in a way that could reduce harm: if there are no bathrooms, showers, or shelter spaces, and harm reduction gear is harder to access, how are people meant to reduce the risk of overdose? To move forward and support the health of people who use drugs, especially for the remainder of the COVID and during future pandemics, reimagining how our society might look is of the utmost importance. Reducing harm is important, but so is creating a society that makes it possible to practice harm reduction. In a dream world, these harms would not even exist in the first place.

References

Anonymous. (2020, August 14). Homeless people deserve a say on city's encampments. *The Hamilton Spectator.* https://www.thespec.com/opinion/contributors/2020/08/14/homeless-people-deserve-a-say-on-citys-encampments.html

Belcher, J. R., & DeForge, B. R. (2012). Social stigma and homelessness: The limits of social change. *Journal of Human Behaviour in the Social Environment, 22*(3), 929-946.

Bennett, K. (2016). ACTION cops police the 'same 25 people, day in, day out' sergeant testifies. *CBC Hamilton*. https://www.cbc.ca/news/canada/hamilton/action-cops-police-the-same-25-people-day-in-day-out-sergeant-testifies-1.3851779

Benzie, R. (2020). Canadian Civil Liberties Association urges release of 'releasable' prisoners to curb COVID-19 spread. *The Hamilton Spectator.* https://www.thespec.com/ts/news/gta/2020/03/22/canadian-civil-liberties-association-urges-release-of-releasable-prisoners-to-curb-covid-19-spread.html

Booth, W., Adam, K., & Rolfe, P. (2020, March 26). In fight against coronavirus, the world gives medical heroes a standing ovation. *The Washington Post.* https://www.washingtonpost.com/world/europe/clap-for-carers/2020/03/26/3d05eb9c-6f66-11ea-a156-0048b62cdb51_story.html

Boucher, L. M., Marshall, Z., Martin, A., Larose-Hébert, K., Flynn, J. V., Lalonde, C., Pineau, D., Bigelow, J., Rose, T., Chase, R., Boyd, R., Tyndall, M., & Kendall, C. (2017). Expanding conceptualizations of harm reduction: Results from a qualitative community-based participatory research study with people who inject drugs. *Harm Reduction Journal, 14*(18). https://doi.org/10.1186/s12954-017-0145-2

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Braun, V., & Clarke, V. (2014). What can "thematic analysis" offer health and wellbeing researchers? *International Journal of Qualitative Studies on Health and Well-being, 9,* 1-2.

Bedford, J., Farrar, J., Ihekweazu, C., Kang, G., Koopmans, M., & Nkengasong, J. (2019), A new twenty-first century science for effective pandemic response. *Nature, 575*(7781), 130-136.

Bron, S. (2020, March 31). "We're makers": Hamilton team 3D printing personal protective gear amid COVID-19. *The Hamilton Spectator*. https://www.thespec.com/news/hamilton-region/2020/03/31/were-makers-hamilton-team-3d-printing-personal-protective-gear-amid-covid-19.html

Broyles, L. M., Bingswanger, I. A., Jenkins, J. A., Finnell, D. S., Faseru, B., Cavaiola, A., Pugatch, M., & Gordon, A. J. (2014). Confronting inadvertent stigma and pejorative language in addiction scholarship: A recognition and response. *Substance Abuse, 35*(3), 217-221.

Buchman, D. Z., Leece, P., & Orkin, A. (2017). The epidemic as stigma: The bioethics of opioids. *The Journal of Law, Medicine & Ethics, 45*(2017), 607-620. DOI:10.1177/1073110517750600

Calder, M. J., Hansard, A., Richter, A., Kovacs Burns, K., & Mao, Y. (2011). Framing homelessness for the Canadian public: The news media and homelessness. *Canadian Journal of Urban Research, 20*(2), 1-19.

CBC News. (2020, April 6). Ontario has only 1 week supply of 'critical' protective equipment left, premier says. *CBC Toronto.* https://www.cbc.ca/news/canada/toronto/covid-19-coronavirus-monday-online-learning-starts-1.5523011

CBC News. (2020, August 22). CHCH reporter turns over memory card after 4 men confront her near FirstOntario Centre. *CBC Hamilton.* https://www.cbc.ca/news/canada/hamilton/chch-reporter-homeless-encampment-first-ontario-centre-1.5696614

Centres for Disease Control and Prevention. (2021). Interim guidance on unsheltered homelessness and coronavirus disease 2019 (COVID-19) for homeless service providers and local officials. *CDC.* https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/unsheltered-homelessness.html

Chang, J., Agliata, J., & Guarinieri, M. (2020). COVID-19 – enacting a 'new normal' for people who use drugs. *International Journal of Drug Policy, 83*(2020). https://doi.org/10.1016/j.drugpo.2020.102832

City of Hamilton (2015). *By-law no. 01-219: To manage and regulate public parks.* Hamilton. https://www.hamilton.ca/sites/default/files/media/browser/2015-05-06/01-219parksbylaw.pdf

City of Hamilton. (2020, March 17). *City of Hamilton COVID-19 update – March 17, 2020.* Hamilton. https://www.hamilton.ca/government-information/news-centre/news-releases/city-hamilton-covid-19-update-march-17-2020

City of Hamilton. (2020, April 8). *City provides immediate economic relief to taxpayers and enacts new bylaw to promote and regulate physical distancing during the COVID-19*

pandemic. Hamilton. https://www.hamilton.ca/government-information/news-centre/news-releases/city-provides-immediate-economic-relief-taxpayers

City of Hamilton City Council. (2020, April 8). *City council revised agenda, April 8 2020.* Hamilton. https://pub-hamilton.escribemeetings.com/FileStream.ashx?DocumentId=221459

City of Hamilton. (2020, April 17). *Statement by mayor Fred Eisenberger on declaration of emergency for the City of Hamilton.* Hamilton. https://www.hamilton.ca/government-information/news-centre/news-releases/statement-by-mayor-fred-eisenberger-declaration

City of Hamilton (2020, May 8). *COVID-19 update: Update from the City of Hamilton.* Hamilton. https://www.hamilton.ca/government-information/news-centre/news-releases/covid-19-update-updates-city-hamilton-15

City of Hamilton. (2020, June 3). *City council – revised agenda.* Hamilton. https://pub-hamilton.escribemeetings.com/FileStream.ashx?DocumentId=224727

City of Hamilton. (2020, June 19). *Emergency & community services committee revised agenda*. Hamilton. https://pub-hamilton.escribemeetings.com/FileStream.ashx?DocumentId=225993

City of Hamilton. (2020, June 24). *City council meeting agenda.* Hamilton. https://pub-hamilton.escribemeetings.com/FileStream.ashx?DocumentId=235299

City of Hamilton. (2020, July 13). *Emergency & community services committee revised agenda.* Hamilton. https://pub-hamilton.escribemeetings.com/FileStream.ashx?DocumentId=228842

City of Hamilton. (2020, August 21). *City council – revised agenda.* Hamilton. https://pub-hamilton.escribemeetings.com/FileStream.ashx?DocumentId=239844

City of Hamilton. (2020, September 10). *Emergency & community services committee revised agenda*. Hamilton. https://pub-hamilton.escribemeetings.com/FileStream.ashx?DocumentId=237177

City of Hamilton. (2020, September 16). *City council agenda: Sept 16, 2020.* Hamilton. https://pub-hamilton.escribemeetings.com/FileStream.ashx?DocumentId=238240

City of Hamilton. (2020, September 30). *Bylaw enforcement protocol.* Hamilton. https://www.hamilton.ca/sites/default/files/media/browser/2020-09-30/bylaw_enforcement_protcol.pdf

City of Hamilton (2020, October 7). *News releases: City encampment bylaw in effect starting today*. Hamilton. https://www.hamilton.ca/government-information/news-centre/news-releases/city-encampment-bylaw-in-effect-starting-today

City of Hamilton. (2021). *City of Hamilton encampment response.* Hamilton. https://www.hamilton.ca/social-services/housing/city-hamilton-encampment-response#:~:text=For%20general%20questions%20about%20encampments,call%20905%2D546%2D2828.

Cooter, R. (2007). After death/after 'life': The Social History of Medicine in postmodernism. *Social History of Medicine, 20*(3), 441-464.

Craggs, S. (2020, May 6). Fears a potent new street drug and lack of naloxone will mean a 'crisis within a crisis'. *CBC Hamilton.* https://www.cbc.ca/news/canada/hamilton/naloxone-1.5556548

Craggs, S. (2020, May 15). 'This is my family:' City urged to allow tent encampments during COVID-19. *CBC Hamilton.* https://www.cbc.ca/news/canada/hamilton/encampments-1.5570167

Craggs, S. (2020, July 14). Hamilton to examine homeless encampment issue, but seems no closer to allowing them. *CBC Hamilton.* https://www.cbc.ca/news/canada/hamilton/encampments-1.5649214

Craggs, S. (2020, September 1). City looks at less waste collection at encampments after someone hit a worker there. *CBC Hamilton.* https://www.cbc.ca/news/canada/hamilton/hamilton-homeless-encampments-1.5706830

Crocq, M. (2007). Historical and cultural aspects of man's relationship with addictive drugs. *Dialogues in Clinical Neuroscience, 9*(4), 355-361.

Duffin, J. (2010). *History of medicine: A scandalously short introduction*. University of Toronto Press.

Face coverings and masks by-law. (2020). *Hamilton.* https://www.hamilton.ca/coronavirus/face-coverings-and-masks-by-law

Fass, P. S. (2003). Cultural history/social history: Some reflections on a continuing dialogue. *Journal of Social History, 37*(1), 39-46.

Firestone, M., & Fischer, B. (2008). A qualitative exploration of prescription opioid injection among street-based users in Toronto: Behaviour, preferences, and drug availability. *Harm Reduction Journal, 5*(30), 1-10.

Fozouni, L., Buchheit, B., Walley, A. Y., Testa, M., & Chatterjee, A. (2019). Public restrooms and the opioid epidemic. *Substance Abuse, 41*(4), 432-436.

Frankish, C. J., Hwang, S. W., & Quantz, D. (2005). Homelessness and health in Canada: Research lessons and priorities. *Canadian Journal of Public Health, 96*(2), S23-S29.

Frketich, J. & O'Reilly, N. (2020). Employee at Barton Street jail has COVID-19. *The Hamilton Spectator.* https://www.thespec.com/news/hamilton-region/2020/03/27/employee-at-barton-street-jail-has-covid-19.html

Gaetz, S. (2013). The criminalization of homelessness: A Canadian perspective. *European Journal of Homelessness, 7*(2), 357-362.

Gamson, W. A., Croteau, D., Hoynes, W., & Sasson, T. (1992). Media images and the social construction of reality. *Annual Review of Sociology, 1992*(18), 373-393.

Gernsbacher, M. A. (2017). Editorial perspective: The use of person-language in scholarly writing may accentuate stigma. *The Journal of Child Psychology and Psychiatry, 58*(7), 859-861.

Gillis, W. (2020, April 25). Ontario's front-line workers getting pay hike of $4 an hour during pandemic. *Toronto Star.* https://www.thestar.com/news/gta/2020/04/25/ontarios-front-line-workers-getting-pay-hike-of-4-an-hour-during-pandemic.html

Giommoni, L. (2020). Why we should all be more careful in drawing conclusions about how COVID-19 is changing drug markets. *International Journal of Drug Policy, 83*(2020). https://doi.org/10.1016/j.drugpo.2020.102834

Government of Canada. (2021). *Criminal code*. Justice Laws Website. https://laws-lois.justice.gc.ca/eng/acts/c-46/

Grenfell Ministries (2021a). *Overdose prevention line.* Grenfell Ministries. https://www.grenfellministries.org/overdose-prevention-line

Grenfell Ministries (2021b). *Substance use management program.* Grenfell Ministries. https://www.grenfellministries.org/at-home-withdrawal-management-progr

Grennan, D. (2019). What is a pandemic? *Journal of the American Medical Association, 321*(9), 910. doi:10.1001/jama.2019.0700

Guilamo-Ramos, V., Benzekri, A., Thimm-Kaiser, M., Abram, M., & Hagan, H. (2020). Participation of the nursing workforce to address COVID-19 among people who use alcohol, tobacco, and drugs. *International Journal of Drug Policy, 83*(2020). https://doi.org/10.1016/j.drugpo.2020.102831

Hamilton Spectator (2020, March 20). Hungry for help: COVID-19 pandemic shutters some homeless meal programs. *The Hamilton Spectator.* https://www.thespec.com/news/hamilton-region/2020/03/20/hungry-for-help-covid-19-pandemic-shutters-some-homeless-meal-programs.html

Hamilton Spectator (2020, March 25). Barton inmate says 'we're just sitting ducks' if COVID-19 starts to spread inside. *The Hamilton Spectator.* https://www.thespec.com/news/hamilton-region/2020/03/25/barton-jail-inmate-says-we-re-just-sitting-ducks-if-covid-19-starts-to-spread-inside.html

Hamilton Spectator (2020, August 22). Hamilton police searching for men who accosted TV reporter, took memory card. *The Hamilton Spectator.* https://www.thespec.com/news/crime/2020/08/22/hamilton-police-searching-for-men-who-accosted-tv-reporter-took-memory-card.html

Hooker, C. (2010). History and social change in health and medicine. In I. Bourgeault, R. Dingwall., & R. de Vries (Eds.), *The Sage handbook of qualitative methods in health research* (pp. 265-286). Sage.

Hopkins, J., Scott, F., Cheng, L., Kang, A., Kaushal, S., Khoee, K., Bourns, L., Maver, R., Bergstrom, K., Munro, A., Higgins, A., & Baker, S. (2017). Hamilton supervised

injection site: Needs assessment & feasibility study. *Hamilton.* https://www.hamilton.ca/sites/default/files/media/browser/2017-11-30/hamilton-sis-study-report.pdf

Hristova, B. (2020, October 15). Hamilton to begin dismantling large tent encampments throughout city. *CBC Hamilton.* https://www.cbc.ca/news/canada/hamilton/encampments-removed-1.5763089

Hyshka, E., Anderson-Baron, J., Pugh, A., Belle-Isle, L., Hathaway, A., Pauly, B., Strike, C., Asbridge, M., Dell, C., McBride, K., Tupper, K., & Wild, T. C. (2019). Principles, practice, and policy vacuums: Policy actor views on provincial/territorial harm reduction policy in Canada. *International Journal of Drug Policy, 71*, 142-149. https://doi.org/10.1016/j.drugpo.2018.12.014

Jenkins, P. (1994). The ice age the social construction of drug panic. *Justice Quarterly, 11*(1), 7-32.

Johnston, G. (2020). The kids are all white: Examining race and representation in news media coverage of opioid overdose deaths in Canada. *Sociological Inquiry, 90*(1), 123-146.

Jordanova, L. (1995). The social construction of medical knowledge. *Social History of Medicine, 7*(3), 361-381.

Kaufman, M. (2020, March 23). Why we must open the doors of Barton jail. *The Hamilton Spectator.* https://www.thespec.com/opinion/contributors/2020/03/23/why-we-must-open-the-doors-of-barton-jail.html

Keane, C., Egan, J. E., & Hawk, M. (2018). Effects of naloxone distribution to likely bystanders: Results of an agent-based model. *International Journal of Drug Policy, 55,* 61-69. https://doi.org/10.1016/j.drugpo.2018.02.008

Keane, H. (2003). Critiques of harm reduction, morality and the promise of human rights. *International Journal of Drug Policy, 14*(3), 227-232.

Keeping Six. (2021). *Encampment advocacy.* https://keepingsix.org/encampments/

Kennedy, L., & Coelho, M. (2019). "Absolutely the worst drug I've ever seen": Risk, governance, and the construction of the illicit fentanyl "crisis". *Theoretical Criminology, 00*(0), 1-21.

Khatri, U. G., & Perrone, J. (2020). Opioid use disorder and COVID-19: Crashing of the crises. *Journal of Addiction Medicine, 2020*(14), e6-e7.

Koba, H. (2020, August 1). Letters to the editor: I don't feel safe. *The Hamilton Spectator.* https://www.thespec.com/opinion/letters-to-the-editors/2020/08/01/aug-1-little-praise-for-trudeau-and-other-letters-to-the-editor.html

Kroetsch, C. (2020, October 23). We must choose compassion over compliance. *The Hamilton Spectator.* https://www.thespec.com/opinion/contributors/2020/10/23/we-must-choose-compassion-over-compliance.html

La Grassa, J. (2020, April 9). FirstOntario centre will become a shelter for Hamilton's homeless during COVID-19. *CBC Hamilton.* https://www.cbc.ca/news/canada/hamilton/homeless-population-shelters-covid-19-hamilton-1.5527529

Lam, V., Sankey, C., Wyman, J., & Zhang, M. (2020). COVID-19: Opioid agonist treatment guidance. *META:PHI.* http://metaphi.ca/assets/documents/news/COVID19_OpioidAgonistTreatmentGuidance.pdf

Lancet Respiratory Medicine (2020). COVID-19 transmission: Up in the air. *Lancet, 8*(12), 1159.

Lenton, S., & Single, E. (1998). The definition of harm reduction. *Drug and Alcohol Review, 17,* 213-220.

MacKinnon, L., Socias, M., & Bardwell, G. (2020). COVID-19 and overdose prevention: Challenges and opportunities for clinical practice in housing settings. *Journal of Substance Abuse Treatment, 119*(2020), 1-3.

Maghsoudi, N., McDonald., K., Stefan, C., Beriault, D. R., Mason, K., Barnaby, L., Altenberg, J, MacDonald, R. D., Caldwell, J., Nisenbaum, R., Leece, P., Watson, T. M., Tupper, K. W., Kufner, L., Scheim, A. I., Werb, D., & Drug Checking Services in Toronto Working Group. (2020). Evaluating networked drug checking services in Toronto, Ontario: Study protocol and rationale. *Harm Reduction Journal, 17*. https://doi.org/10.1186/s12954-019-0336-0

Marlatt, A. G. (1996). Harm reduction: Come as you are. *Addictive Behaviours, 21*(6), 779-788.

Marlatt, G. A., & Witkiewitz, K. (2010). Update on harm-reduction policy and intervention research. *Annual Review of Clinical Psychology, 6*(1), 591-606.

Mitchell, D. (2020, February 12). Hamilton considers plan for clearing snow from city sidewalks at taxpayers' expense. *Global News.* https://globalnews.ca/news/6538079/hamilton-sidewalk-snow-removal-budget/

Mitchell, D. P. (1996). Postmodernism, health and illness. *Journal of Advanced Nursing, 23*, 201-205.

Moore, D., & Fraser, S. (2006). Putting at risk what we know: Reflecting on the drug-using subject in harm reduction and its political implications. *Social Science & Medicine, 62*(2006), 3035-47.

Morin, K. A., Eibl, J. K., Franklyn, A. M., & Marsh, D. C. (2017). The opioid crisis: Past, present and future policy climate in Ontario, Canada. *Substance Abuse Treatment, Prevention, and Policy, 12*(45), 1-7.

Moro, T. (2018, November 5). Triple jeopardy: Drugs, jail, the street. *The Hamilton Spectator.* https://www.thespec.com/news/hamilton-region/2018/11/05/triple-jeopardy-drugs-jail-the-street.html

Moro, T. (2020, March 25). Supervised injection sites short protective equipment amid outbreak. *The Hamilton Spectator.* https://www.thespec.com/news/hamilton-region/2020/03/25/barton-jail-inmate-says-we-re-just-sitting-ducks-if-covid-19-starts-to-spread-inside.html

Moro, T. (2020, April 2). COVID-19: Doctors, nurses ‘swabbing’ homeless for virus are short supplies. *The Hamilton Spectator*. https://www.thespec.com/news/hamilton-region/2020/04/02/covid-19-doctors-nurses-swabbing-homeless-for-virus-are-short-supplies.html

Moro, T. (2020, April 2). COVID-19: Few washrooms for Hamilton homeless amid crisis. *The Hamilton Spectator.* https://www.thespec.com/news/hamilton-region/2020/04/02/covid-19-few-washrooms-for-hamilton-homeless-amid-crisis.html

Moro, T. (2020, April 6). COVID-19: ‘Physical distancing’ fines of $750 issued to homeless people by Hamilton police. *The Hamilton Spectator.* https://www.thespec.com/news/hamilton-region/2020/04/06/covid-19-hamilton-police-urged-to-not-ticket-homeless-during-pandemic.html

Moro, T. (2020, April 8). COVID-19: Hamilton’s St. Patrick church offers respite to homeless during virus crisis. *The Hamilton Spectator.* https://www.thespec.com/news/hamilton-

region/2020/04/08/covid-19-hamiltons-st-patrick-church-offers-respite-to-homeless-during-virus-crisis.html

Moro, T. (2020, July 14). Homelessness: Hamilton advocates urge city to let encampments be. https://www.thespec.com/news/hamilton-region/2020/07/14/homelessness-hamilton-advocates-urge-city-to-let-encampments-be.html

Moro, T. (2020, July 21). Tents not the problem, Hamilton outreach group says amid council criticism. *The Hamilton Spectator.* https://www.thespec.com/news/hamilton-region/2020/07/21/tents-not-the-problem-hamilton-outreach-group-says-amid-council-criticism.html

Moro, T. (2020, July 29). Hamilton advocates pursue legal action against city on homeless encampments. *The Hamilton Spectator.* https://www.thespec.com/news/hamilton-region/2020/07/29/hamilton-advocates-pursue-legal-action-against-city-on-homeless-encampments.html

Moro, T. (2020, July 30). City can't break up homeless camps, Superior Court rules. *The Hamilton Spectator.* https://www.thespec.com/news/hamilton-region/2020/07/30/hamilton-advocates-secure-10-day-injunction-against-the-removal-of-encampments.html

Moro, T. (2020, August 7). Injunction extended: City can't break up Hamilton homeless camps until September. *The Hamilton Spectator.* https://www.thespec.com/news/hamilton-region/2020/08/07/injunction-extended-city-cant-break-up-hamilton-homeless-camps-until-september.html

Moro, T. (2020, August 22). For those living on Hamilton's margins, tents instead of shelter beds. *The Hamilton Spectator.* https://www.thespec.com/news/hamilton-

region/2020/08/22/for-those-living-on-hamiltons-margins-tents-are-better-than-shelter-beds.html

Moro, T. (2020, September 3). Hamilton doctor calls councillor's homeless encampment email 'disheartening'. *The Hamilton Spectator.* https://www.thespec.com/news/council/2020/09/03/hamilton-doctor-calls-councillors-homeless-encampment-email-disheartening.html

Moro, T. (2020, September 14). Integrity complaint filed against Hamilton councilor Terry Whitehead over email. *The Hamilton Spectator.* https://www.thespec.com/news/council/2020/09/14/integrity-complaint-against-hamilton-councillor-terry-whitehead-over-email.html

Moro, T. (2020, October 7). Hamilton city councillors blame 'activists' for homeless encampments. *The Hamilton Spectator.* https://www.thespec.com/news/council/2020/10/07/hamilton-city-councillors-blame-activists-for-homeless-encampments.html

Moro, T. (2020, October 16). Hamilton shelters see spike after encampments cleared. *The Hamilton Spectator.* https://www.thespec.com/news/hamilton-region/2020/10/16/hamilton-shelters-see-spike-after-encampments-cleared.html

Mowat, J. (2019, December 9). After 8 months, Hamilton has chosen its 2nd safe injection site. *CBC Hamilton.* https://www.cbc.ca/news/canada/hamilton/second-safe-injection-location-1.5387376

Mowat, J. (2020, August 17). COVID-19 impact on city's homeless population unclear, officials say more data needed. *CBC Hamilton.* https://www.cbc.ca/news/canada/hamilton/covid-homeless-impact-ham-1.5685336

Mukherjee, T. I., & El-Bassel, N. (2020). The perfect storm: COVID-19, mass incarceration and the opioid epidemic. *International Journal of Drug Policy, 83*(2020), 1-3. https://doi.org/10.1016/j.drugpo.2020.102819

Murphy, A., & Eby, J. (2020, July 25). It's time the city offered homeless people true support. *The Hamilton Spectator.* https://www.thespec.com/opinion/contributors/2020/07/25/its-time-the-city-offered-homeless-people-true-support.html

Netherland, J., & Hansen, H. B. (2016). The War on Drugs that wasn't: Wasted whiteness, dirty doctors, and race in media coverage of prescription opioid misuse. *Culture, Medicine, and Psychiatry, 40*, 664-686.

O'Reilly, N. (2020, April 1). Who is getting released from the Hamilton-Wentworth Detention Centre amid the COVID-19 pandemic? *The Hamilton Spectator.* https://www.thespec.com/news/hamilton-region/2020/04/01/who-is-getting-released-from-the-hamilton-wentworth-detention-centre-amid-the-covid-19-pandemic.html

O'Reilly, N. (2020, April 13). Demonstration in solidarity with inmates at Barton Street jail. *The Hamilton Spectator.* https://www.thespec.com/news/hamilton-region/2020/04/13/demonstration-in-solidarity-with-inmates-at-barton-street-jail.html

O'Shea, T., Bodkin, C., Mokashi, V., Beal, K., Wiwcharuk, J., Lennox, R., Guenter, D., Smieja, M., Bulir, D., & Chong, S. (2020). Panemic planning in homeless shelters: A pilot study of a coronavirus-19 (COVID-19) testing and support program to mitigate the risk of COVID-19 outbreaks in congregate settings. *Clinical Infectious Diseases, 2020*(ciaa743). https://doi.org/10.1093/cid/ciaa743.

Olsen, Y., & Sharfstein, J. M. (2014). Confronting the stigma of opioid use disorder – and its treatment. *Journal of the American Medical Association, 311*(14), 1393-1394. doi:10.1001/jama.2014.2147

Ontario (2020, March 17). *Ontario enacts declaration of emergency to protect the public.* Ontario Office of the Premier. https://news.ontario.ca/en/release/56356/ontario-enacts-declaration-of-emergency-to-protect-the-public

Ontario Drug Policy Research Network, Office of the Chief Coroner for Ontario, Public Health Ontario, & Centre on Drug Policy & Evaluation (2020). Preliminary patterns in circumstances surrounding opioid-related deaths in Ontario during the COVID-19 pandemic. *Public Health Ontario.* publichealthontario.ca/-/media/documents/o/2020/opioid-mortality-covid-surveillance-report.pdf?la=en

Ontario Human Rights Commission (2020). COVID-19 and Ontario's Human Rights Code – questions and answers. *Ontario Human Rights Commission.* http://www.ohrc.on.ca/en/news_centre/covid-19-and-ontario%E2%80%99s-human-rights-code-%E2%80%93-questions-and-answers

Opioids (2018). *Hamilton Public Health.* https://www.hamilton.ca/public-health/health-topics/opioids

Pearson, M. (2020). Sign of the times: Banners honour front-line workers at Stoney Creek's Clarion, Lakeview seniors homes. *Hamilton News.* https://www.hamiltonnews.com/community-story/9922766-signs-of-the-times-banners-honour-front-line-workers-at-stoney-creek-s-clarion-lakeview-seniors-homes/

Pergolizzi, J. V., Raffa, B. R., & Rosenblatt, M. H. (2019). Opioid withdrawal symptoms, a consequence of chronic opioid use and opioid use disorder: Current understanding and

approaches to management. *Journal of Clinical Pharmacy and Therapeutics, 45,* 892-903. DOI: 10.1111/jcpt.13114

Pickstone, J. V. (2011). Histories of science, technology, and medicine. *Isis, 102*(1), 123-135.

Porter, R. (1985). The patient's view: Doing medical history from below. *Theory and Society, 1985.*

Public Health Ontario. (2012). *Routine Practices and Additional Precautions.* Public Health Ontario. https://www.publichealthontario.ca/-/media/documents/b/2012/bp-rpap-healthcare-settings.pdf?la=en

Race, K. (2008). The use of pleasure in harm reduction: Perspectives from the history of sexuality. *International Journal of Drug Policy, 19*(2008), 417-423.

Rhodes, T. (2002). The 'risk environment': A framework for understanding and reducing drug-related harm. *International Journal of Drug Policy, 13*(2002), 85-94.

Rhodes, T. (2009). Risk environments and drug harms: A social science for harm reduction approach. *International Journal of Drug Policy, 20*(3), 193-201.

Rodda, L. N., West, K. L., & LeSaint, K T. (2020). Opioid overdose-related emergency department visits and accidental deaths during the COVID-19 pandemic. *Journal of Urban Health, 2020*(97), 808-813.

Roe, G. (2005). Harm reduction as paradigm: Is better than bad good enough? The origins of harm reduction. *Critical Public Health, 15*(3), 243-250

Rosenberg, C. E. (1989). Disease in history: Frames and framers. *The Milbank Quarterly, 61*(Suppl 1), 1-15.

Samuel, R., Breuilly, J., Clark, J. C. D., Hopkins, K., & Cannadine, D. (1985). What is social history? *History Today, 35*(3), 42-57.

Schlosser, A., Harris, S. (2020). Care during COVID-19: Drug use, harm reduction, and intimacy during a global pandemic. *International Journal of Drug Policy, 83*(2020). https://doi.org/10.1016/j.drugpo.2020.102896

Shah, M. (2020, March 21). Grocery chains install checkout shields, raise wages in response to coronavirus pandemic. *Global News.* https://globalnews.ca/news/6713693/grocery-stores-coronavirus-canada/

Smith, C. B. R. (2012). Harm reduction as anarchist practice: A user's guide to capitalism and addiction in North America. *Critical Public Health, 22*(2), 209-221.

Stuart, F. (2015). On the streets, under arrest: Policing homelessness in the 21st century. *Sociology Compass, 9*(11), 940-950.

Taha, S., Maloney-Hall, B., & Buxton, J. (2019). Lessons learned from the opioid crisis across the pillars of the Canadian drugs and substances strategy. *Substance Abuse Treatment, Prevention, and Policy, 14*(32), 1-10.

Tyndall, M. (2020). Safer opioid distribution in response to the COVID-19 pandemic. *International Journal of Drug Policy, 83*(2020). https://doi.org/10.1016/j.drugpo.2020.102880

Van Dongen, M. (2020, March 25). Quick COVID-19 tests and hotels used to protect Hamilton's homeless. *The Hamilton Spectator.* https://www.thespec.com/news/hamilton-region/2020/03/25/quick-covid-19-tests-and-hotels-used-to-protect-hamilton-s-homeless.html

Van Dongen, M. (2020, April 8). COVID-19: City of Hamilton to open homeless shelter in downtown area. *The Hamilton Spectator.* https://www.thespec.com/news/hamilton-region/2020/04/08/city-of-hamilton-to-open-homeless-shelter-in-downtown-arena.html

Van Dongen, M. (2020, April 28). Homeless tent encampment cleared from downtown Hamilton school property. *The Hamilton Spectator.* https://www.thespec.com/news/hamilton-region/2020/04/28/homeless-tent-encampment-cleared-from-downtown-hamilton-school-property.html

Van Dongen, M. (2020, May 1). Homeless campers told to leave Hamilton park days after being forced off school property. *The Hamilton Spectator.* https://www.thespec.com/news/hamilton-region/2020/05/01/homeless-campers-told-to-leave-hamilton-park-days-after-being-forced-off-school-property.html

Van Dongen, M. (2020, July 31). Hamilton community garden shuts down after being used as 'emergency washroom' during pandemic. *The Hamilton Spectator.* https://www.thespec.com/news/hamilton-region/2020/07/31/hamilton-community-garden-shuts-down-after-being-used-as-emergency-washroom-during-pandemic.html

Van Dongen, M., & Moro, T. (2020, August 4). Hamilton landlords applied to evict hundreds of tenants over unpaid rent during COVID state of emergency. *The Hamilton Spectator*. https://www.thespec.com/news/hamilton-region/2020/08/04/hamilton-landlords-applied-to-evict-hundreds-of-tenants-over-unpaid-rent-during-covid-state-of-emergency.html

Watson, T. M., Kolla, G., van der Meulen, E., & Dodd, Z. (2020). Critical studies of harm reduction: Overdose in uncertain political times. *International Journal of Drug Policy, 76*(2020). https://doi.org/10.1016/j.drugpo.2019.102615

Webster, K., Rice, K., & Sud, A. (2019). A critical content analysis of media reporting on opioids: The social construction of an epidemic. *Social Science & Medicine, 244*(2020), 1-9.