Abbotsford
Substance Use
System Access
Journey Mapping
Project

Preliminary Findings Report

CONTENTS

Long story short, toxic drug supply, not enough beds, hard to access treatment because it's just so long and drawn out and where do we go from here?

— interview participant

EXECUTIVE SUMMARY

This research was conducted by the Centre for Advancing Health Outcomes in partnership with local stakeholders. The purpose was to identify barriers and facilitators to accessing substance use services (SUS) in Abbotsford, with a particular focus on the experiences of unhoused individuals through the lens of frontline workers. The research team recruited frontline workers from **25 different local agencies**. **We conducted 27 interviews, 4 focus groups, and 4 days of field observation with a total of 49 participants**. It should be noted that this report presents preliminary findings of qualitative data. We have not yet conducted additional community engagement with our findings in order to collectively develop strategies for action.

The visual schematic depicted below on pp 18–19 reflects an overall motif in the data and presents four main components that influence SUS access:

+ contextual environment
+ client motivation
+ housing status
+ SUS barriers at access points

While potentially mitigated by relationships, timely service provision, and stabilization, the four components were also further exacerbated by an overall lack of resources, the severe toxicity of the drug supply, the nature of substance use disorders, and significant delays in accessing services. The totality contributes to an overall "vortex effect" that keeps people trapped in cycles of illicit substance use and deprivation with little to no hope of ever getting out. Overall, while many frontline workers have access to support, they are experiencing considerable feelings of hopelessness that are also reflected in the journeys of their clients.

This report presents several themes that provide further insights into the visual schematic and address the following:

DISPROPORTIONALITY IN SUPPLY AND DEMAND:

Participants reported a severe lack of supply in treatment and housing options to meet current levels of demand.

DETRIMENT OF DELAYS:

Participants reported significant negative impacts of delays on SUS access, including death.

TOXICITY OF SUPPLY:

Participants reported toxic drugs as complicating or compounding health outcomes, service access, environmental contexts and motivation.

ACUTE NEED FOR STABILIZATION:

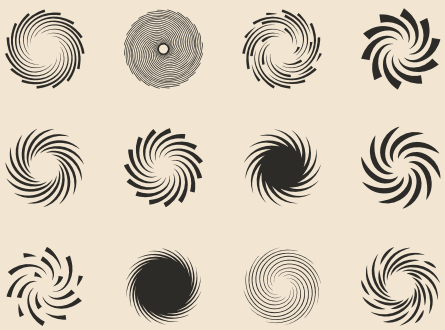
Participants reported deficits in service options that provided necessary stabilization, such as stabilization capacity in detox and treatment centres and additional sober housing.

RELATIONSHIPS AS A KEY ASSET:

Participants reported their relationships—both with colleagues and clients—as their most necessary asset, yet policies and practices do not appear to capitalize on these relationships.

NOTE ON METAPHOR

While frontline workers displayed resiliency and had access to resources, an overall feeling of bleak hopelessness and powerlessness pervaded the data. Peer research associates explored several metaphors that would best represent complex depictions in the data of perennial hopelessness and lack of successful engagement with SUS. One metaphor was the "looping superhighway," with barricaded off-ramps reflecting a sense of the inevitability of cyclical journeys of substance use and housing instability. Our team also explored a vortex metaphor, which portrays the cyclical nature of circumstances as well as the propelling forces of barriers and downward pull towards hopelessness that saturated the data. A metaphor from one of the peer research team members was one of fog, where the toxicity of the supply, numbed motivation, and unstable and resource-poor environments create a thick fog from which frontline workers attempt to effectively connect with clients in those moments when they emerge asking for help. We hope to convey all these evocative metaphors in visual representations of our data throughout this report.



Every time I get up in the morning, I pull out my phone and look at the end of shift report and I just say my little prayer, "Please don't let it be someone I know."

— interview participant

The victories are so few and far between.

— focus group participant

BACKGROUND

In the context of a toxic drug emergency in BC that is now the leading cause of death for residents aged 10-59, unimpeded access to substance use services (SUS)[1] has never been more imperative. Despite significant provincial efforts to address the crisis, municipal governments have increasingly borne the impact of socially-contingent public health issues in their neighbourhoods and within their institutions, and municipal-level stakeholders often have very little control over the systems that support community wellbeing.

The Centre for Advancing Health Outcome's previous work in the Fraser Valley through the Fraser East Overdose Response project found that there are many stressors involved in accessing substance use services, both for oneself and on behalf of others (Fernando et al, 2022; Hawkins, 2023). In 2023, the City of Abbotsford approached Advancing Health with the idea for a collaborative research project that would identify barriers and facilitators to accessing SUS with a particular focus on unhoused individuals living in Abbotsford. The purpose was to generate evidence that would provide municipal stakeholders tools to advocate for improvements in the systems. The ultimate aim of project stakeholders is that people in Abbotsford experiencing homelessness who need and want help will be able to access that help.

This project was conducted under the supervision of the principal investigator Dr. Amy Salmon and received ethics approval from the University of British Columbia Providence Health Care Research Ethics Board (ID #H23-03707). This report presents preliminary findings from data collected between February and June of 2024.

1 *Substance use services (SUS) includes a continuum of services such as harm reduction outreach, residential treatment, withdrawal management (detox), substance use counselling, or other harm reduction-oriented responses such as safer supply, opioid agonist therapy (OAT), drug checking, or witnessed consumption.

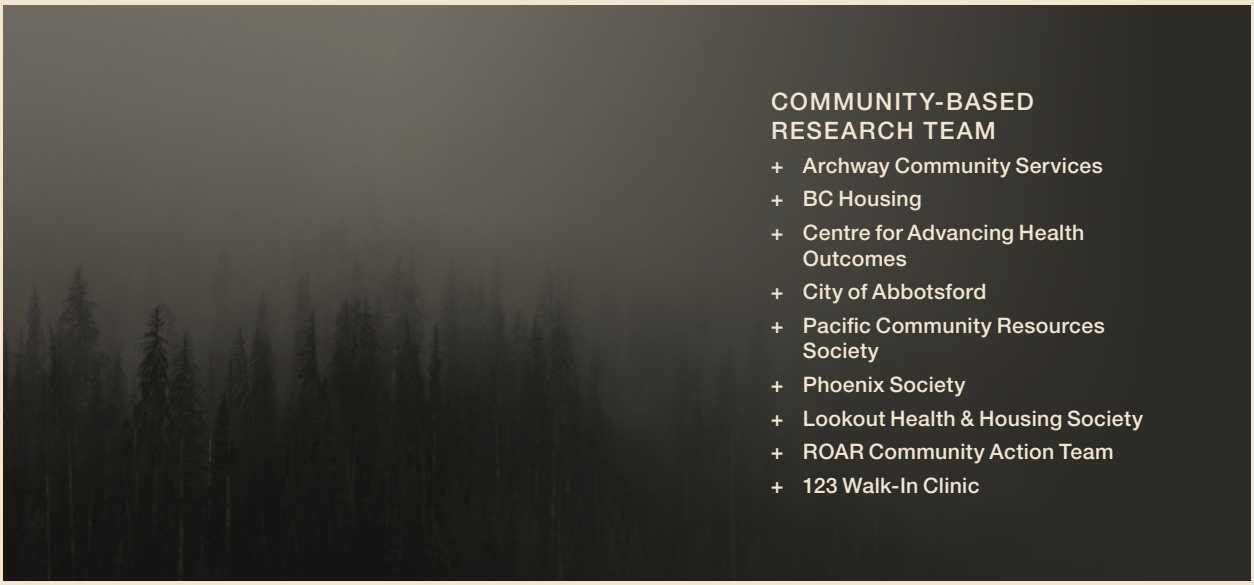
METHODS

Methodology

Our study employed a Community-Based Participatory Action Research (CBPAR) approach, engaging the community at every stage of the research. The ultimate focus in CBPAR is on responding to findings and identifying needed changes, and consultation and public engagement form a key part of the research agenda (Brydon-Miller et al., 2011; Kral & Allen, 2016). Accordingly, at the outset of the project, researchers spoke with representatives in the health care sector, people with lived and living experience, frontline workers, municipal staff, and managers from the non-profit sector. **Our research team was comprised of administrative, frontline and managerial staff from multiple sectors who had input at every stage of the research**, including selection of the study population, formulation of the research questions, design of the research tools, participant recruitment, data collection and analysis, and knowledge translation. For team members conducting research activities, additional training in research methods was provided by researchers at Advancing Health.

It's very frustrating that you can't help people that are asking for help.

— interview participant



COMMUNITY-BASED RESEARCH TEAM

+ Archway Community Services
+ BC Housing
+ Centre for Advancing Health Outcomes
+ City of Abbotsford
+ Pacific Community Resources Society
+ Phoenix Society
+ Lookout Health & Housing Society
+ ROAR Community Action Team
+ 123 Walk-In Clinic

Design

The team decided on a qualitative research design that deployed **semi-structured interview, focus group, and field observation tools** to better understand the multifaceted journeys of unhoused or precariously housed individuals who are attempting to navigate access to SUS.[2] Qualitative tools offer valuable evidence to support the improvement of systems of care serving populations experiencing inequities (Browne et al, 2012; Shelton et al, 2022), as they provide a deeper, experiential lens that can be missed with quantitative approaches (Griffith et al, 2017).

Frontline workers[3] were identified as the most appropriate study population for several reasons: As individuals who regularly navigate service systems, they have acquired a high level of knowledge and experience of these systems. Also, frontline staff have contact with multiple clients at a time, so greater levels of SUS access outcomes could be represented as opposed to mapping individual journeys. Lastly, for clients experiencing housing instability, community consultation highlighted that frontline workers are most likely the ones attempting to access SUS on their clients' behalf, rather than the clients accessing services independently (i.e. without the aid of a support worker). A limitation of this approach is that we cannot speak to the experiences of clients who may have been attempting to access SUS on their own, or individuals who may be in need of SUS but did not attempt to access them.

2 Note on language: For the remainder of this document, these individuals will be described primarily as "clients." We acknowledge that there are other terms employed in different sectors such as "participants," "patients," "service users," or "PWLLE." "Clients" was the term most used by research participants, and we also use it here while recognizing its limitations as a label that encompasses the diverse needs, desires, and circumstances of people living precariously. We will also be using language to describe SUS that is most commonly used by participants, such as "detox" for inpatient withdrawal management or "treatment" for intensive residential treatment programs.

3 We define "frontline worker" in this research as someone who, in the course of their professional role, is attempting to access SUS on behalf of individuals experiencing housing instability who want to reduce or eliminate their consumption of the illicit supply. This could include outreach workers, staff at OAT clinics, substance use counsellors, or shelter/supportive housing employees. Employees of the health authority were not included as part of the study population. In keeping with CBPAR principles of addressing structural inequities and manifest power differentials in the ways we gather and produce knowledge (Meyerson, 2023), we focused our research on populations that, for better or worse, are not employed by sectors that make decisions about SUS.

The following research questions guided our activities:

+ How do professional service providers experience accessing SUS on the behalf of their clients?
+ What barriers and facilitators to accessing services do service providers most routinely experience?
+ What resources do they use when accessing services on others' behalf?
+ How do these experiences, barriers, facilitators, and resources influence substance use service access for their clients?

Rather than focusing a journey mapping lens on one particular service, these questions were intended to generate insight into the experiential journeys of individuals accessing SUS in a broader systemic approach.

Recruitment

We used a combination of purposive and snowball sampling to recruit participants. Purposive sampling ensured that a diversity of perspectives serving different populations across multiple sectors were represented, and snowball sampling leveraged the social networks of local participants and enhanced the credibility and reach of the research. All participants gave informed consent in accordance with research ethics board protocols.

Data Collection

Peer research associates and researchers conducted 27 semi-structured interviews, 4 focus groups, and 4 days of participant observation. Interviews explored the following: the nature of participants' roles and their general approach with clients; the scope of needs of their client base and what they believe should be available to meet those needs; resources or assets that help them do their jobs effectively; any protocols, policies or other factors that help or hinder them access SUS on behalf of clients; common scenarios they encounter accessing SUS on behalf of clients; the resulting impact on them and their clients. Focus group questions covered similar topics but were necessarily limited in depth due to multiple participants. They explored best and worst case scenarios of helping clients achieve their goals; specific things that help or hinder their clients access SUS; resulting impacts. Participant observation involved shadowing front-line workers as they navigated SUS on behalf of their clients, paying special attention to the environment in which they work and in which their clients are situated, interactions with their clients, resources utilized, and barriers encountered.

Data Analysis

The qualitative data was analyzed according to principles of reflexive thematic analysis (Braun and Clarke, 2021; Byrne, 2022). Researchers and trained peer research associates went through a collaborative and iterative 6 stage process that included listening to audio files and reading transcripts, generating initial categories of data inductively, producing initial codes in NVivo software, re-coding and generating candidate themes, reviewing themes, and collaborating on visual representations of final themes for knowledge translation. Findings were repeatedly brought back to the community-based team for discussion. Team members with access to project data included 4 professional researchers, 4 community-based peer researchers, and 1 student.

Artwork: *Tornado* | Alex Diaconu

RESULTS

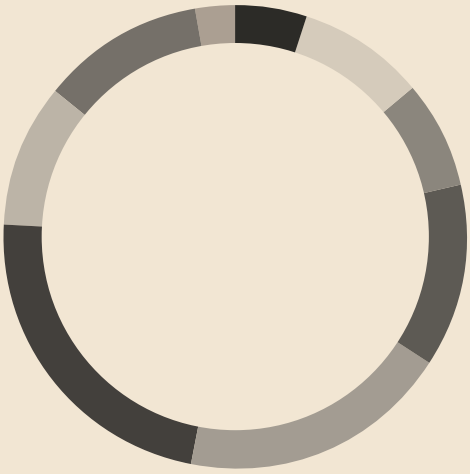
Participants

From February 2024 to July 2024, we recruited 49 participants from 25 different agencies, conducting 27 semi-structured interviews, 4 focus groups, and 4 days of participant observation alongside frontline workers.

Participants came from organizations representing multiple sectors, with some specifically serving several distinct populations of interest.

EMPLOYMENT CATEGORIES[4]

Counselling	4
Criminal Justice	7
Government	6
Health	10
Housing	15
Outreach	18
Peer	8
Shelter	9
Treatment	2



POPULATION-SPECIFIC[5]

Participants also included frontline workers whose roles and organizations addressed population-specific issues. These included Indigenous (3), older adults (2), South Asian (3), youth (3), women (2), and men with involvement in corrections (3).

MORE PARTICIPANT DATA →

4 Participants could be included in more than one category. Outreach includes roles where participants work directly in encampments. Harm reduction services such as OAT and drug checking are included in the health category, but delivery of harm reduction supplies (such as clean supplies and Naloxone) is included in the outreach category.

5 These are participants whose role and/or organization had a specific focus on sub-populations.

PARTICIPANTS CAME FROM 25 DIFFERENT AGENCIES AND ORGANIZATIONS:

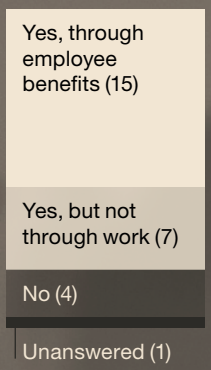
+ Abbotsford Community Hub Centre
+ Abbotsford Drug War Survivors
+ Abbotsford-Matsqui Impact Society
+ Abbotsford Police Department
+ Archway Community Services
+ BC Housing
+ BC Corrections
+ Cedar Outreach Society
+ Connective Support Society
+ Corrections Canada
+ Cyrus Centre
+ Fraser Valley Aboriginal Friendship Centres Association
+ Ground Zero Ministries
+ Kinghaven Peardonville House Society
+ Lookout Health & Housing Society
+ Ministry of Children & Family Development
+ Mountainside Harm Reduction Society
+ Pacific Community Resources Society
+ Phoenix Society
+ Ryse Supportive Services
+ Salvation Army
+ SARA for Women
+ Sparrow Community Care Society
+ Unlocking the Gates
+ 123 Walk-In Clinic

PARTICIPANT QUESTIONNAIRE DATA

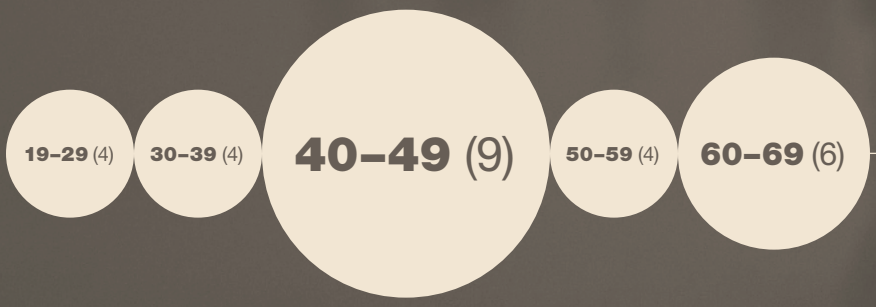
For additional contextual depth to the analysis, 27 interview participants answered a questionnaire regarding their demographic and employment information.

AFFORDABLE SUPPORT ACCESS:

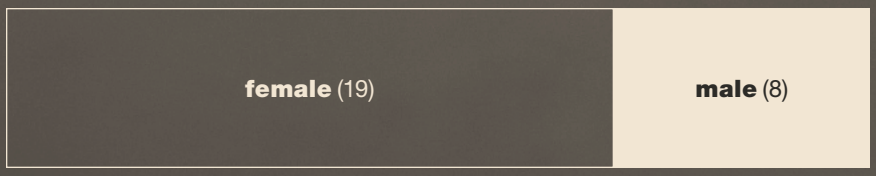
"Do you have access to mental and emotional support that you can afford?"



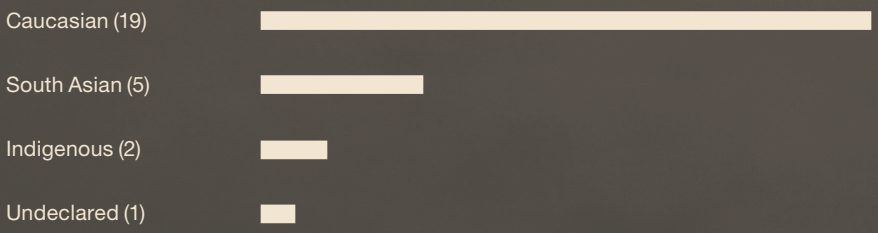
PARTICIPATION BY AGE (YEARS)



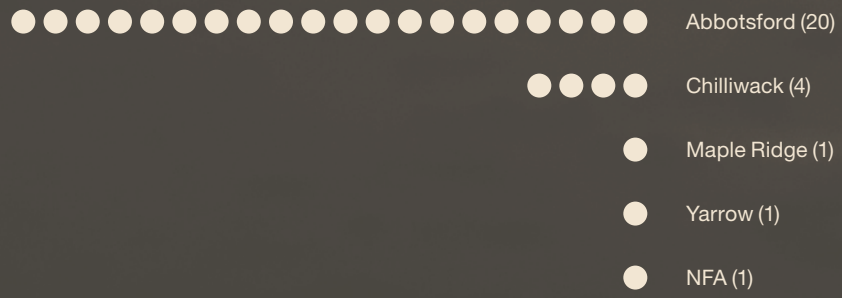
PARTICIPATION BY GENDER



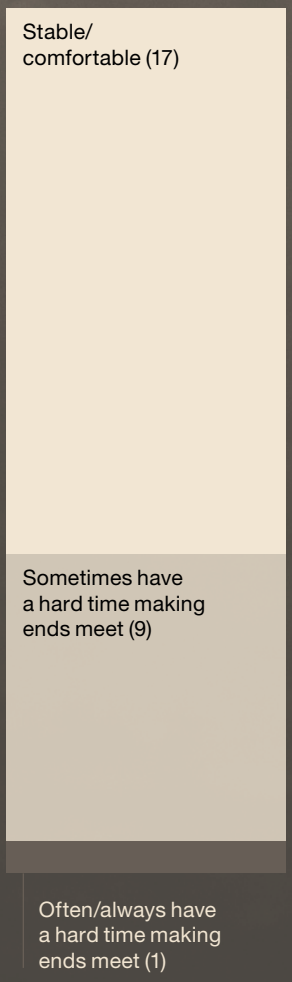
PARTICIPATION BY ETHNICITY

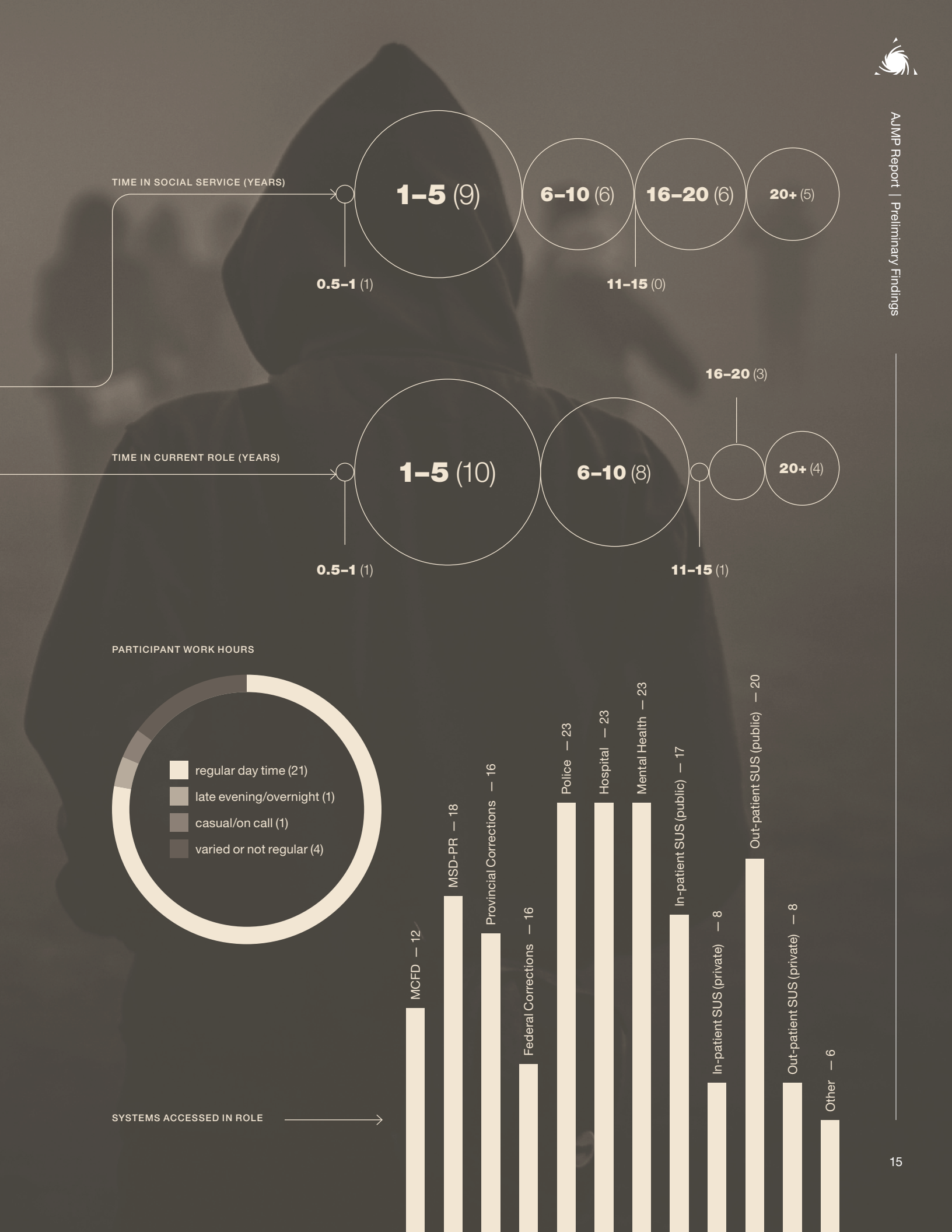


PARTICIPATION BY TOWN OF RESIDENCE



PARTICIPATION BY FINANCIAL SITUATION




TIME IN SOCIAL SERVICE (YEARS)
1–5 (9)
6–10 (6)
16–20 (6)
20+ (5)
0.5–1 (1)
11–15 (0)
TIME IN CURRENT ROLE (YEARS)
16–20 (3)
1–5 (10)
6–10 (8)
20+ (4)
0.5–1 (1)
11–15 (1)
PARTICIPANT WORK HOURS
regular day time (21)
late evening/overnight (1)
casual/on call (1)
varied or not regular (4)
SYSTEMS ACCESSED IN ROLE
MCFD — 12
MSD-PR — 18
Provincial Corrections — 16
Federal Corrections — 16
Police — 23
Hospital — 23
Mental Health — 23
In-patient SUS (public) — 17
In-patient SUS (private) — 8
Out-patient SUS (public) — 20
Out-patient SUS (private) — 8
Other — 6

Those small goals like having access to peer witnessing when you're in the welfare line. Those very small things can be accessed a lot more. But when we talk about the larger scale things like getting into detox or getting into treatment, the percentage is exponentially lower.

— focus group participant

Mapping client journeys in research can involve **developing an "ontological framework" that functions as a visual schematic demonstrating the relations between concepts and categories in the process**, capturing key elements of the journey, relationships between elements, and implicit rules that govern reality (McCarthy et al. 2016). While reality is more complex than any visual schematic, the ontological framework should generate understanding of the social phenomenon under study (Stevens, 2022). The ontological framework provides structure for emerging themes, which in turn generate insight into elements of the system that require reconsideration.

Ontological Framework

Frontline workers depicted two main goals of their unhoused clients relative to substance use services: 1) maintaining current levels of illicit substance use while reducing risk by accessing harm reduction services; 2) reducing or eliminating illicit substance use (often with the concomitant goal of housing and increased stability in their lives).

For those who wanted to maintain their current levels of use, frontline workers described relative availability and ease of getting harm reduction tools such as clean supplies and Naloxone directly to the camps. **For their clients who do not express a desire to change their substance use, frontline workers generally expressed a satisfactory ability to employ harm reduction approaches**, but their ability to reduce harms is severely hampered by the toxicity of the supply discussed further below. While not discussed prominently in the data, it is worth noting that a number of practitioners of drug checking described significant benefits to their services, including giving clients potentially life-saving knowledge of what was in their drugs as well as heightened accountability to drug dealers.

The remainder of this report is concerned with clients whose goal is to reduce or eliminate their use. We intended our ontological framework to be both visually evocative and indicative of the experiential realities of clients accessing SUS. For these clients, **it became obvious that the relative success or failure of meeting their goals involved more than whether or not a bed was available in detox**. As frontline workers described client journeys accessing SUS to reduce or eliminate their use, **four main components emerged that have a major influence on these clients' journeys: environment, motivation, substance use access and availability, and housing**.

01 — ENVIRONMENT

While a smaller number of participants highlighted inherent human dignity and socially-enhanced survival mechanisms found in the camps, the environment was primarily described as inherently unstable and chaotic, with clients' being unaware of time, dates, or even circumstances surrounding their own lives such as when they had last showered or where they slept the night before. Many clients are continually surrounded by others accessing the illicit supply, and their situations of homelessness were most often predicated by significant levels of trauma. Depictions of theft, violence, and predation saturated the data. While positive relationships and pride in one's space emerged during participant observation, **the dominant narrative was one of chaos, deprivation, and precarity** that was compounded by the nature of substance use disorders, a significant lack of personal resources, and the toxicity of the supply.

02 — MOTIVATION

While we did not ask any direct questions about client motivation, the topic surfaced in every interview and focus group. Our data depicted motivation as both complex and highly relevant. Participants brought up many different factors related to their clients' motivation: precipitating life events, stigma and shame, fear of confronting trauma or the unknown, system complexity, mental health, desperation or discomfort, and the need for purpose and meaning. **The most often-mentioned factors influencing motivation were the levels of drug toxicity, the nature of substance use disorders (described as the inherent "pull" of addiction), a lack of resources, and wait times and delays**. Frontline workers attested little or no success without client motivation.

03 — HOUSING

It would be difficult to overestimate the importance of housing in frontline worker narratives of SUS access. Housing was depicted in terms of a stark lack of affordable options combined with high levels of need. **The difficulties of reducing use while in low barrier housing and the resulting need for additional sober living options was a common refrain**, as well as the conditions of numerous unregulated, privately operated recovery houses that presented environments of further predation and precarity. Without stable and suitable housing, frontline workers attested to a near impossibility of success.

04 — SUBSTANCE USE ACCESS POINTS

Barriers in pathways to substance use access were heavily discussed and are further outlined in the inset below on pp 20–23. Frontline workers generally described harm reduction approaches as relatively easily available. While this included OAT services, **accessing prescribed safer supply or OAT was also complicated by the living environment of individuals experiencing homelessness, the toxicity of the illicit supply, and the lack of client choice**. The Rapid Access to Addictions Care (RAAC) clinic was widely appreciated but likewise coupled with complications with client choice, the environment and the current toxicity of street drugs. The most common barriers, aside from the main components discussed in this schematic, **were significant lack of detox and treatment options** as well as prohibitive or problematic policies.

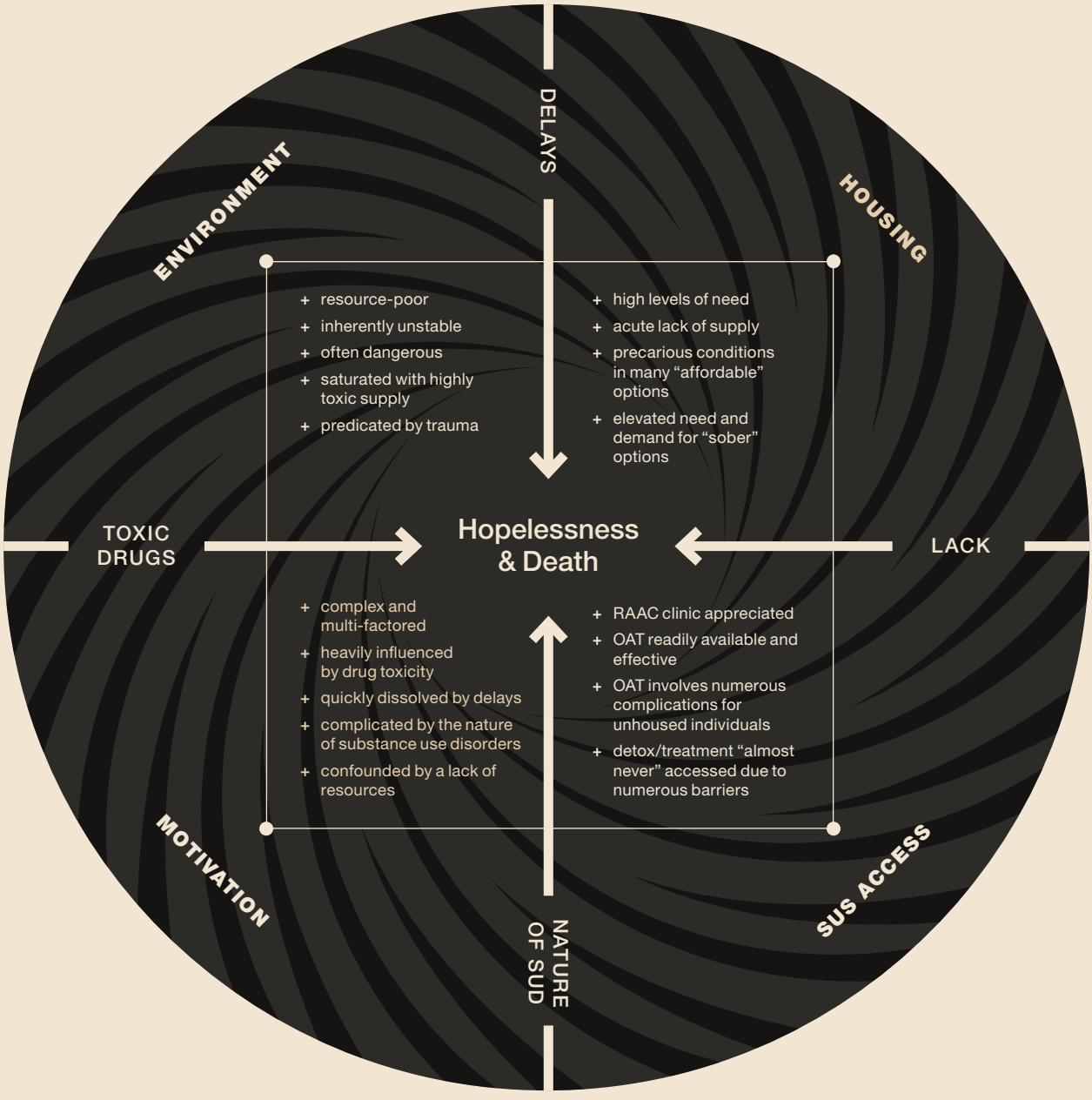
The **relationships between these four components in the data is complex and will be described further below** in the themes.[6] In general, assets or facilitators are counteracted by significant barriers. The predominance of these barriers produces an overall "vortex effect" that leads to significant levels of hopelessness—both for frontline workers and for their clients—and death. Very little obviated the feeling of overall bleakness; however, **three main facilitating factors** provided the most significant "pull" towards meeting client goals: **relationships** (both the frontline worker with their client and the relationships and collaboration between frontline workers); **timely resources**, which are generally not available at major points of client demand; **stability**, which counteracts the most significant barriers presenting in the client journeys. The most common overall barriers were **drug toxicity, lack of resources, the nature of substance use disorders, and delays in service provision**. Other helping and hindering factors are also depicted in the ontological schematic, with size indicating levels of saturation in the data.

6 It could be helpful to think of these components in reference to the concept of recovery capital (Best and Hennessy, 2022), a framework that considers personal, social and community-based assets that help to initiate and sustain recovery from substance use disorders.

The most common overall barriers were **drug toxicity, lack of resources, the nature of substance use disorders, and delays in service provision.**

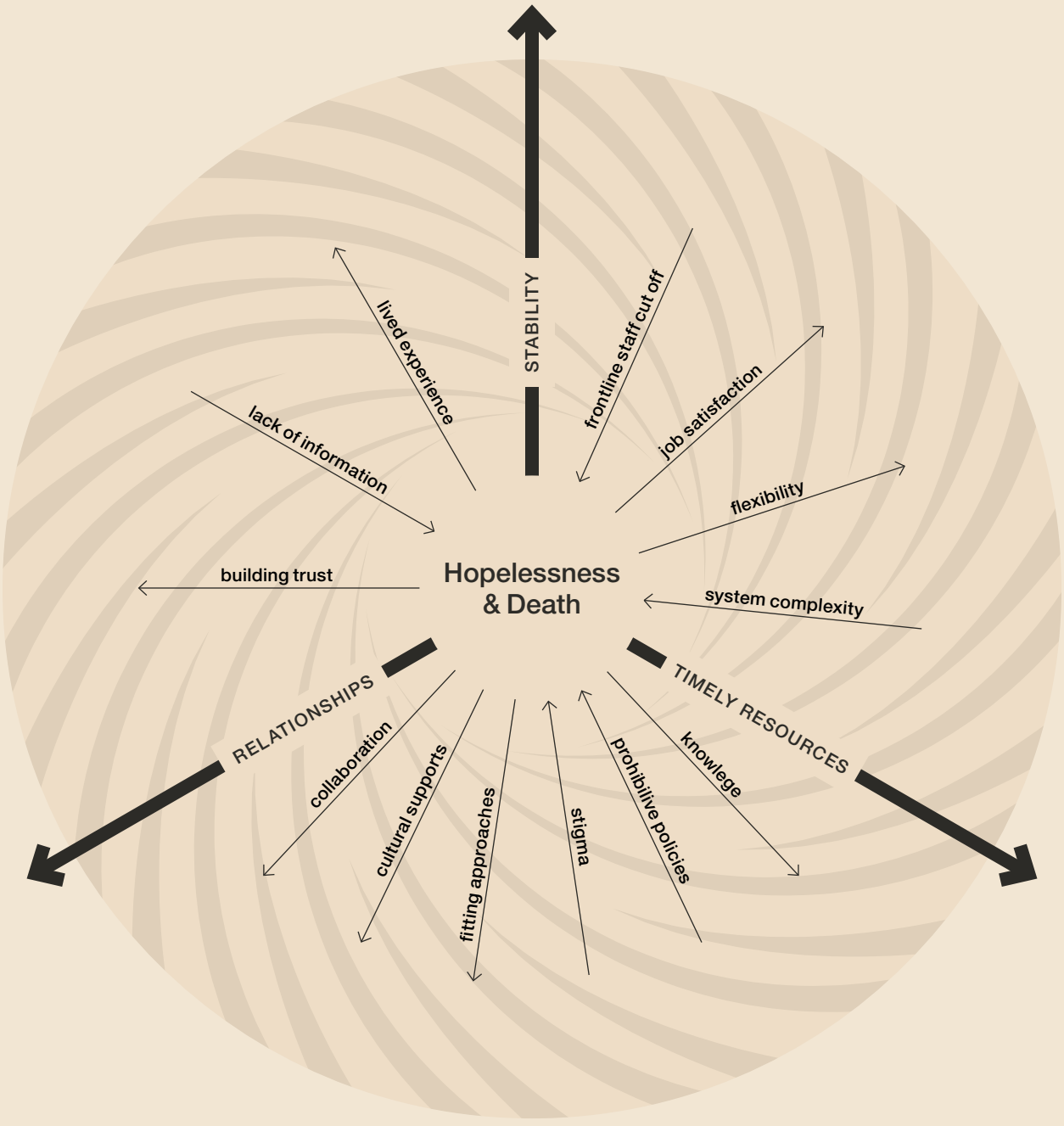
The dominant narrative was one of chaos, deprivation, and precarity that was compounded by the nature of substance use disorders.

The difficulties of reducing use while in low barrier housing and the resulting need for additional sober living options was a common refrain.



The most often-mentioned factors influencing motivation were the levels of drug toxicity, the nature of substance use disorders (described as the inherent "pull" of addiction), a lack of resources, and wait times and delays.

Accessing prescribed safer supply or OAT was also complicated by the living environment of individuals experiencing homelessness, the toxicity of the illicit supply, and the lack of client choice.



Three main facilitating factors provided the most significant "pull" out of the vortex (i.e., meeting client goals): **relationships** (both the frontline worker with their client and the relationships and collaboration between frontline workers); **timely resources**, which are generally not available at major points of client demand; **stability**, which counteracts the most significant barriers presenting in the journey.

Definitions

IHART
Integrated Homelessness Action Response Teams operated by Fraser Health Authority (FHA), these teams are made up of nurses, social workers, outreach support workers, peer support workers and mental health clinicians.

OAT
Opioid Agonist Therapy offered by public and private clinics, OAT provides access to medications such as Suboxone and Kadian that reduce withdrawal symptoms in patients with a diagnosed opioid use disorder.

RAAC
Rapid Access to Addictions Care operated by FHA, the RAAC clinics provide access to addiction medicine assessments.

SUSAT
Substance Use Services Access Team operated by FHA, the SUSAT phone line provides access to a team that provides navigation of addictions services

Access Point Barriers

This section describes the most commonly reported barriers situated at access points to SUS services, particularly detox and treatment. Frontline workers expressed an understanding of reasons why some of these barriers might be in place; nevertheless, they maintained that the lack of flexibility in these policies and practices severely hampered their ability to meet their clients' expressed needs. Throughout the data, there appeared to be a significant disconnect between the perspectives of frontline workers who had direct contact with their clients and intake staff responsible for service access.

It is important to note that information to corroborate these accounts (such as numbers of available beds, size of waitlists, wait times, and certain policies and procedures) is not available from publicly available sources. This research depicts client journeys as they are experienced by frontline workers, and the barriers discussed below convey an important part of the difficulties of their reported experiences.

BARRIER 01 — DELAYS

Delays were the most often mentioned barrier and saturated nearly every topic. Delays are discussed further in this report as a main theme. Frontline workers' reports of delay times varied widely, from a minimum of 2–3 weeks for detox to a minimum of 6–8 weeks for treatment, and very often delays were reported in significant excess of these times, such as 6 weeks for detox and 3 to 6 months for treatment. Harmful impacts from these delays included a loss of motivation, an erosion of trust in the frontline worker-client relationship, and, in some cases, death.

They're coming off a binge of using, and they just say, "I can't do this anymore. Help me." It's very stressful as a frontline worker. [..] I don't have a lot of tools at my disposal for someone who's wet and cold and threatening to kill themselves at the door of the shelter, because I've got no resources to help them. — interview participant

And now they don't trust you, because "you said I could go to detox, and then I can't go." - focus group participant

BARRIER 02 — DOVETAILING TREATMENT/DETOX

Frontline workers expressed an understanding of the practical necessity of ensuring a client had a bed in treatment before going to detox (unless the client had access to other supports and wanted detox but not treatment, in which case limited detox beds reportedly eliminated that person from eligibility) or ensuring that a client was appropriately stabilized (most often through detox) before accessing treatment. Nevertheless, participants described a near impossibility of "dovetailing" these services when clients were living outside. For unhoused individuals seeking access to detox and treatment, services failed to meet their needs in a manner adapted to the inequity of their access to support systems.

Because it's hard enough to line up the detox when you're on the street, but trying to line that up and be in contact with the treatment center at the same time you are dealing with detox… I understand they want someone to have the bed lined up, but it's definitely a barrier for somebody who doesn't have a phone and who can, yes, who can barely even survive, doesn't even know where they're going to eat for supper. — interview participant

So it's trying to tell treatment, "Hey, I'm going to detox. Will you have a bed for me?" "Well, when are you going to detox?" "I don't know. I'm on the list." "OK, well, what, do we keep an open bed for you for the next month, month and a half?" So, yes, it's ridiculous. — interview participant

Take a look at some of the bottlenecks in service. So, from my perspective, I think detox is the big one. — focus group participant

BARRIER 03 — UNREALISTIC RESOURCE REQUIREMENTS

Frontline workers repeatedly mentioned the impossibility of clients' being able to fulfill policies and procedures required to access SUS while not having access to basic supports such as a phone, ID, and transportation. Multiple participants talked about clients' being requested to call detox, sometimes every day, to confirm a bed, and frontline workers were not allowed to make these calls for them. In this instance, frontline workers did not express an understanding of why this policy was in place and found it frustrating and prohibitive for connecting their clients to SUS.

I've called SUSAT, but they always want the client to call them. Not all of them have a phone, right, so again, and they don't have a fixed address, so how is SUSAT even going to follow up with them? — interview participant

That's another problem, is they're not able to get their phones charged. So these treatment centers aren't able to get a hold of them and you're off the waitlist really fast. — focus group participant

Or the fact that they only do intake exactly at 9am and 1pm and if you miss it by a little bit, you're out. - interview participant

And now what will happen is Creekside, the detox centre, is aiming for about a week to 10 days before that treatment intake date, and they will call and they will say, "Does So-and-so still want the bed in detox?" "Yes, they do." "Well, is he with you?" "Well, no he's not." "Well we need to talk to him to confirm that." "Well I saw him yesterday. I know he still wants it. He's excited." "Well we have to hear that from him." "OK, can you give me a few hours to go find him?" "Well I really need to know by noon." It's currently 11:25. "OK, that's great. Thank you." So I run around like a crazy person, either find the person or do not, and report back to Creekside either the good news or the bad news. And if I haven't found the person to confirm that he wants to take that bed, he gets turned down, and the next person on the list gets a shot. — interview participant

BARRIER 04 — REFERRAL RESTRICTIONS

The lack of access to basic resources was also compounded by current referral policies. Frontline workers who had been in the field for longer periods of time frequently referenced previous policies that they experienced in the past as more successful, with less wait time. Currently, participants reported that all referrals to detox and treatment needed to go through SUSAT or RAAC, which involved delays and sometimes being cut off—either the frontline worker from their client's journey, or the client with services. Frontline workers repeatedly expressed frustration that they were unable to make referrals directly to Fraser Health-funded treatment facilities or represent clients to intake staff. Participants told numerous stories where their relationship with the client, and their clients' expressed desires, did not appear to be considered valid by intake staff.

Creekside—you'd call up, you knew that worker by name, you call the next day, that person got in. But then it became centralized, and just kind of, you got lost in that process. And so good days were when somebody would answer the phone and there was more success. There were more stats and more people coming back with testimonies. Now we're seeing more people falling through the cracks and dying. — interview participant

One example was an individual wanting treatment. And so I gave them options of who I could refer them to, and they chose – at first they chose Indigenous space RAAC. And then that individual had a hard time connecting with the client. And then – so I referred to IHART. And then IHART kind of made a barrier for that and said, you know, "This individual said they wanted treatment, but they haven't asked us about it. So we're waiting until when we see –" because they already see him for wound care already. And they just kind of were, like, "Well, he hasn't approached us about it, so we didn't ask him." — interview participant

BARRIER 05 — DRUG OF CHOICE LIMITATIONS FOR DETOX

Participants reported that clients whose primary drug of choice is methamphetamines or stimulants (anything other than alcohol, opiates, or benzodiazepines) do not have the option to access detox beds. Yet participants described the ability to detox "in community" while staying at a shelter or in an encampment as impossible given the surrounding conditions. Additionally, this policy does not appear to address the complexities of poly-substance use common amongst those accessing a street supply.

Most folks who are living unstably housed, or who are in a chaotic relationship with substances, they aren't even accessing the same substance every day. — focus group participant

But crystal meth is not just crystal meth. It's crystal meth and it's probably, you know, benzo or a little bit of tranquilizer or something in it. So that's disappointing. — interview participant

The idea that a person who's using amphetamines or crystal meth doesn't need to detox. That's insane. Those people are coming in with the worst psychosis going, right? A lot of times that goes away unless there's an underlying mental health issue, right. But that stuff could be picked up in detox. — interview participant

BARRIER 06 — COMPLICATIONS WITH OAT

Nearly all participants described OAT as an effective approach for reducing risk and enhancing stability; nevertheless, participants frequently described various complications with OAT for unhoused clients. While frontline workers expressed an understanding of the risks of relapse and the dangers of the street supply, they nevertheless expressed dismay that many of their clients did not want to be on OAT but were required to be on OAT in order to access detox or treatment. They also mentioned multiple issues with dispensing and titration that were complicated by chaotic and resource-poor environments, the extreme toxicity and complexity of the supply, and the high levels of tolerance of their clients. A few participants also mentioned financial incentives to pharmacies in making OAT services available without any corresponding accountability for adapting practices to fit client needs; some even recounted the practices of some vendors to bribe encampment residents with cash rewards for transferring prescriptions to their pharmacies.

I'm finding, like, a lot of people that actually want to go to recovery, or want to go to detox, they don't want to have to take an opiate replacement. Like, that's not a choice that they have anymore. And that's unfortunate. Why does someone have to be on methadone or Suboxone or Kadian for the rest of their life? Why? […] I understand the liability. I understand the high risk of, you know, fatal overdoses. I get that. — interview participant

And then there's drugs that just simply don't come with carries at all, which are the most useful ones usually, like Kadian and hydros, so you have to be there every day for them. - focus group participant

It's a damned if you do and damned if you don't kind of situation, because if we put people on dailies, it's very difficult for them to get from their camp all the way up to whatever pharmacy it is that they have to do their daily witness, and get those consistently. They're going to miss multiple days, and they're going to have to be re-prescribed and it's a whole mess. Then if you give them carriers now, you know the more vulnerable people, their carriers are being stolen or they're overusing and that's also super difficult. — focus group participant

Themes

Thematic analysis brings “meaning making” to the data; themes dive more deeply into the descriptive content and address “So what?” questions. The themes depicted below describe the most salient relationships between the main components in the ontological framework and the various barriers and facilitators of successful engagement with SUS that these components present.

THEME 01

"I just don't understand why there isn't more": Severe disproportionality in supply and demand

Treatment, housing. I'd say those are the top two. — interview participant

It would be difficult to overestimate the preponderance in the data of the need for additional detox and treatment beds. While official numbers of beds do not seem to be publicly available, **frontline workers heavily, and many times urgently, reported the need and client demand for detox and treatment that was not facilitated by the current supply**. Twenty-four out of 27 interviewees and participants in all focus groups mentioned this as an acute need without any prompting from the researcher. Repeatedly, **participants attested that they "rarely" or "almost never" are able to get clients into detox or treatment** when their clients are looking to access these services. Frontline workers attested to feeling a sense of powerlessness and hopelessness when they were continually unable to meet clients' often desperate desires for help in this way.

There's nothing really other than a referral and a doctor's appointment at RAAC. I've never gotten anybody into recovery. — focus group participant

If I could pick them up and take them to detox and drop them off, they would go right now. It's just so difficult to even get into detox. — interview participant

They have 12 beds for, what, 1.5, 2 million people? And in my opinion it is complete ass-backwards. — interview participant

There's nothing, there's just not enough detox treatment available. — interview participant

Likewise, housing surfaced repeatedly in the data as both an urgent need and a necessary factor in successful engagement with SUS. While some frontline workers spoke of the availability of low barrier beds, **the environment in these facilities was largely reported as not conducive to reducing or eliminating the use of street drugs or providing much-needed holistic support**. Participants also spoke of the crisis of affordability and the impossibility of any of their clients in accessing market housing. For clients who desire increased stability and decreased substance use, appropriate housing presented an acute need, the lack of which severely hampered their goals.

Housing. Detox. Treatment. — interview participant

Because even trying to get housing is nearly impossible these days. — interview participant

They're in a shelter and it's like, there's drugs everywhere. […] Stable housing, lack of stable housing is a huge, huge cause. — interview participant

I don't think completing treatment with no place, no safe place to go is going to provide a lot of hope. — interview participant

I know treatment centres work very diligently in creating housing plans. But with the housing crisis, I can see that being a very difficult effort. So: having proper housing available—sober living housing available to people post treatment. — interview participant

"Something other than a wing and a prayer": Detriment of delays and windows of opportunity

It's hard because people are dying. I have clients who have died before they went to treatment while they were actively waiting. — focus group participant

Nearly every participant attested to significant delays in access to detox and treatment for clients experiencing homelessness. In reference to the very small amount of clients who managed to access treatment, language such as "luck," "lottery," or "the stars magically aligned" was common as opposed to what participants believed should be an effective, timely pathway to SUS for those who expressed willingness. Frontline workers reported that for **their clients, who are resource-poor and living in precarious environments, delays have a deleterious impact on service access**, primarily because of the impact of these delays on client motivation.

It's just, I guess, luck and timing, like is there going to be a bed open, because if there's not, it's, "There's nothing we can do about that, and you're just going to have to sit tight and wait." — interview participant

Getting into anything, it takes too long, and they just give up. — interview participant

It's easier to use and go hang out in the tent with your friends or your street family than it is to try again because it just doesn't happen fast. — interview participant

Frontline workers repeatedly spoke of a "window of opportunity" when a client expressed what participants' felt was a sincere and even desperate desire to "get clean," using language such as "I'm done," or "I'm ready, I need out." However, **when confronted with significant delays (described in terms of weeks or even months), alongside the discouragement accompanying a severe lack of resources (such as phones, ID, transportation), clients were left to a street environment heavily saturated with drug use and the inherent nature of a substance use disorder for which they were trying to receive help**. The direct result of this was a loss of motivation.

And it's hard, and can be discouraging to be like, "Honestly, I want that for you also, so bad, but it's going to be months until you get there." Which hurts and sucks. And sometimes they're like, "What's the point? Might as well just stay in my tent, do my drugs, do my thing." Yeah. —an interview participant

When you have that short window when that person is ready to change and then you can't provide anything for them, they fall aside and they're back on the street again. — focus group participant

And then in the process of waiting for treatment, they die from an overdose. It's happened way too many times. — interview participant

Frontline workers who had lived experience with homelessness and illicit substance use introduced the concept of **"emergency response", meeting clients at the moment of their expressed desire for detox or treatment and providing an immediate and appropriate bridge to services**. The majority of participants repeatedly spoke of their belief that when people in such desperate conditions ask for help, the system should have resources to meet them when they are ready.

I mean people on the street, when they're ready – they're finally ready, there's nowhere to take them. There's nowhere to get them started. — interview participant

It shouldn't even be a question. If somebody wants to go it should just be like, basically like the Emergency Room. If you want to go, you just go and get in. It shouldn't even be a second thought. — interview participant

Rapid access, set it up like triage. If someone wants to get clean you treat it like an emergency. […] In some of these instances you've got to strike while the iron is hot so to speak. You can't let it cool off. If we're working with somebody anything could happen. — interview participant

THEME 03

"Open my eyes, use, blur": Toxicity of supply as a major confounding factor

It's why everybody looks like a zombie. It's really, really bad. It's not good. — focus group participant

The toxicity of the illicit supply of drugs was depicted in the data as a major confounding factor, both in terms of its potency and the complications of drugs such as benzodiazepines or Xylazine being added to fentanyl and fentanyl analogues. Participants described **multiple health complications** such as brain injury, flesh wounds, and injuries that can happen when someone is "out of it" that are difficult to treat because many clients were reluctant to attend the Emergency Room, either due to the impacts of the drugs themselves or experiences of stigma. Multiple participants described an increasing number of clients' losing limbs due to untreated complications from Xylazine, changes in personality or mental capacity from multiple overdoses, and an overall "zombie effect" from the potency of the supply.

They're so into their own little magical world that nothing's wrong. "Oh yes, it's just a sore. It's just a little bit of flesh-eating disease, no problem, it'll go away." But they can't stop using. — focus group participant

But they have multiple of these overdoses throughout the time. I've seen people over the course of a few years lose 40 IQ points. They're almost like children now. — interview participant

The toxicity levels also impact service access. **Participants described the necessity of a consistent supply that was almost impossible to achieve while living outside**. Prescribing effective doses of OAT and determining appropriate titration presented challenges for clients due to unknown substance composition, chaotic environments, and high levels of tolerance. Frontline workers expressed the belief that while most physicians understood these complications, the medical system as a whole was having a hard time keeping up with the illicit supply. Lack of SUS access complicated by the toxic supply resulted in further harm, cycles ofrelapse or even death.

It's a system that also was designed for people who use heroin. Fentanyl is not heroin. — focus group participant

The consistency of a supply, being able—like most folks who are living unstably housed, or who are in a chaotic relationship with substances, they aren't even accessing the same substance every day. — focus group participant

I just lost a client to a Fentanyl overdose because she kept going to OAT, it wasn't enough so she would use a little bit and it just continued until it snowballed-snowballed-snowballed and OAT just was basically invalid for her, would not work. It wasn't applicable and she ended up passing from an overdose. It was really sad. — interview participant

The most common impact participants' cited was the loss of motivation, primarily due to a **loss of capacity**, such as the ability to make functioning decisions, remember things or even having an awareness of one's own surroundings. This perspective was reflected in the importance frontline workers placed on the moments when their clients displayed a desire for detox; they believed that **when people are "out of it" for so often and so long, brief moments of clarity and desire for change should be met with immediate access to withdrawal management beds with stabilizing capacity**.

Now it's like they use and instead of just being out of it for 20 or 30 minutes, they're out of it for two or three hours. Then the second it starts to wear off they need to use again. There's no break for them. The drugs are just so bad and that's why a lot the homelessness is getting worse too because people don't have that power or that will anymore because these drugs are so bad. — interview participant

By just the strength of some of the substances that are on the street right now, inpatient withdrawal management is necessary for a lot of people. — interview participant

"You can't get off street drugs on the street": Need for stabilization

You need to get people out of the cycle. But you can't do that if they're living outside. — focus group participant

In reference to client journeys in meeting their goals for SUS access, it should be noted that **the most often reported demand was to "get clean" or "get off" street drugs**, particularly combined with an expressed desire for **increased stability**. It is also important to note that **frontline workers reported that in recent years, they "never," "almost never," or "rarely if ever" successfully assisted someone in meeting these goals while that person was on the street**. This places frontline workers in a position of powerlessness, where they feel that they have no options to help people who are asking for it. A sense of hopelessness pervaded the data.

When they come to us, they want to quit street drugs. — interview participant

Housing. Stability. And either using less or not using at all. — interview participant

It's hard to watch people who are on a waitlist for something and then end up dying in our community because they can't get the help that they need when they need it. — interview participant

The inherent instability of the environment on the streets featured prominently in the data, confounding efforts to access SUS at multiple points on the continuum of services. **Unstably housed clients most often lacked critical resources such as a phone, ID, or transportation options, which caused them to heavily rely on frontline workers for service access; however, their lack of resources was also combined with a chaotic relationship with substances involving unpredictable lifestyles, and frontline workers could not reliably connect with them at critical junctures, particularly when frontline workers themselves were prohibited by policy from making direct referrals to services**. In addition, OAT or safer supply involve complications (discussed further above) when accessed on the street, and detox and treatment were reported as extremely limited and lacking in stabilizing options for people who are highly motivated but coming off the street and who may not have things "sorted" (ID, mental health medication, appropriate OAT dosage, etc.).

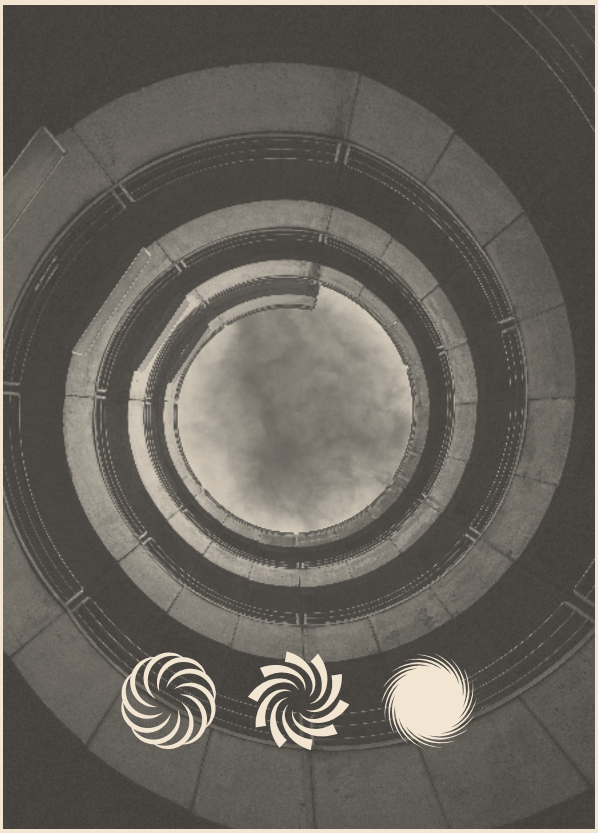
They've expressed that, really, it comes down to no hope in that scenario. Because they're in that environment. — interview participant

Some individuals who come into our organization's shelters and stuff, they're looking towards abstinence. And when you're in an environment where everyone's using, it's really hard. — interview participant

If you're going to go spend the night in camps, and you've been given a little bit of Suboxone, and your friend has fentanyl, you're likely going to use the fentanyl. — focus group participant

Most of our clients know about the RAAC clinic, but maintaining the relationship and carrying on with your recovery through that access is difficult if you live on the street, for sure. — focus group participant

All of this is, of course, exacerbated by the critical lack of housing options. **Participants described housing as the main stabilizing factor in successfully engaging SUS**, and they reported that most available housing options lacked stability in terms of both safety and sobriety. Participants described clients' difficulty accessing affordable housing options after leaving treatment, with predatory landlords operating false "recovery homes" or low barrier housing with conditions that made access to the toxic supply more likely, contributing to a continuing cycle of addiction and homelessness. Even for clients who mainly wanted to reduce their use and stabilize on OAT, living in a low barrier housing environment was described as detrimental to their goals, as the availability of fentanyl and lack of restrictions and support often precipitated increased use.



THEME 05

"You build a human connection": Relationships are a key but under-utilized asset

Trust is a huge thing. — focus group participant

Throughout the data, frontline workers described relationships—with other providers, with internal colleagues, and with clients—as one of their most valuable assets. Particularly in an environment with limited resources, relationships with other providers was perceived as a key facilitator in connecting clients with supports. In addition, positive relationships with internal colleagues was frequently cited as helpful in building resiliency and mitigating burnout. Participants also highlighted the importance of building relationships with clients. While frontline workers exhibited different approaches, they frequently spoke of the importance of trust and acceptance. One participant used the metaphor of emerging from a thick fog—a fog of toxic drugs, numbed motivation, chaotic instability, and chronic substance use. In the temporal moments of clarity when a client emerges above the fog and asks for help, **it is most likely a frontline worker who is the person who has built up the trust to meet that client at their point of need and request**.

What is the point of someone going to detox, not having any housing, or not having any supports set up after the fact, and then just putting them right back where they started, it's not effective. Like, it's not going to work, obviously. — focus group participant

You know, that cycle of going to treatment and finding some hope and getting 90 days, maybe, clean, and then being discharged to a shelter. Right? What's the point? It doesn't work. They're losing hope. — interview participant

Some of the housing that's provided in the community is substandard. It's not monitored. So there could be five people that get housed in this particular building, and they're still actively using. It's their safety, the client's safety that I get concerned about. It's the quality of the home that they're being provided. And their vulnerability with some landlords. — interview participant

Some of our housing I won't even – I won't even try to put a client there because they are likely to live there until they come out in a body bag. And I'm not down for that. […] Or places that call themselves sober living, but take your whole welfare cheque and give you Mr. Noodles, and half the people there are doing drugs. — interview participant

There's the official website about what you do. And then there's the personal partnerships you build to try to get stuff done because you recognize there's no—there's just not enough. — interview participant

Accepting that somebody cares about them despite that they're living in a tent with lice and physical disabilities and mental health. I think that's a big one for clients. That I'm worth it. Learning to trust at least one person so they can anchor to get to the next step. — interview participant

The importance of this provider-client relationship exacerbated feelings of dismay and powerlessness when frontline workers were cut off at the entry point to SUS access. Participants spoke of the need for consistency and open communication, and many

felt that current referral policies left them in the dark. There also appeared to be a **lack of information flow between the SUS system and frontline workers**. While not ubiquitous in the data, confused accounts of policies, procedures and available services indicated a certain level of disconnection. In addition, frontline workers appeared to be left out of discharge planning or even being notified as a contact person when clients completed various steps along the continuum of services. This had a discouraging effect on frontline workers, who felt that it eroded the trust they had worked hard to build with clients.

> *You build a connection with a client, and help follow them through. I mean, it's exhausting for someone who provides that care, because being able to walk with someone for two years, or whatever, is hard. But to be able to have someone that you have connected with that in some way follows you throughout that, would be huge.* — **interview participant**

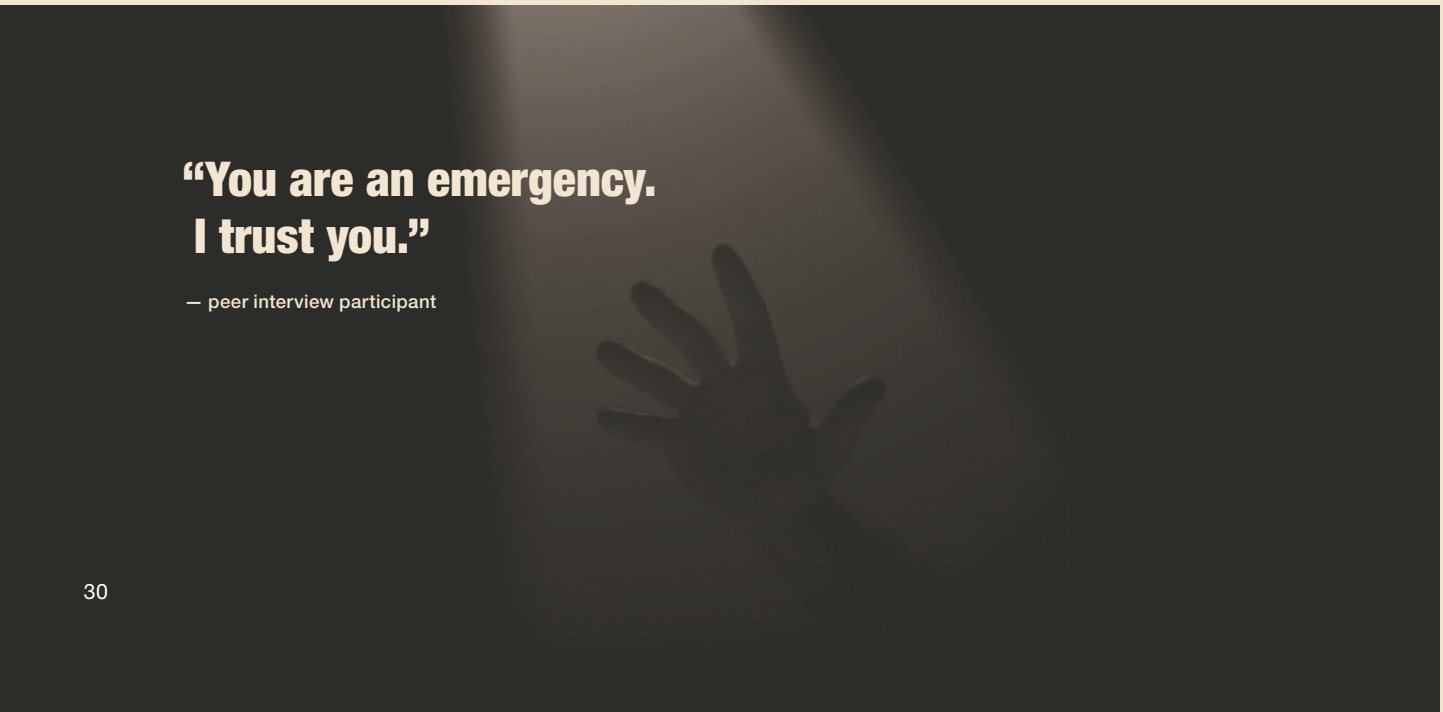
> *So, the thing with a lot of outreach workers is we don't know what happens a lot of the times after.* — **interview participant**

From their depictions of the process of accessing SUS on behalf of clients, **frontline workers did not seem factored into the SUS system as an integral asset. This appears to be a misuse of the time-intensive relationship built with clients that other SUS access points lack**. Frontline workers are in excellent positions to assist clients in building and maintaining recovery capital; however, current SUS systems do not appear to be effectively integrating them as such. On the other hand, municipal efforts to build stakeholder connections through initiatives such as Abbotsford ACCESS, the Integrated Outreach Meeting (IOM), or Community Homelessness Information Application (CHIA) were lauded as both commendable and valuable. Overall, however, frontline workers felt cut off from clients at multiple points in the system even though they spend their working days building trust and connection with clients. It is important to note here the importance of supports for frontline workers; the majority of frontline workers reported being financially stable and had access to mental and/or emotional support that they could afford, which provides an important buffer in dealing with significant levels of challenges related to their work.

> *We have no idea what the plan is, so we can't help.* — **focus group participant**

> *You cannot just say goodbye and drop the ball. And that's what's happening. And they give up, and they feel helpless and hopeless.* — **interview participant**

> *ACCESS is probably the best thing I have seen in a community in a long time for bringing people together. The city trying to actively bring partners to the table to collaborate, it's awesome.* — **interview participant**



"You are an emergency. I trust you."

— peer interview participant

NEXT STEPS

The purpose of this project is to acquire a deeper understanding of the experiential journeys of unhoused or unstably-housed individuals who are attempting to access SUS in order to provide municipal stakeholders with tools to advocate for improvement in these experiences. This report presents some preliminary findings from the data analysis; although the data analysis was conducted collaboratively with the community-based team, at the time of writing, these findings have not yet been brought to the community. These next step recommendations, therefore, are also preliminary and contingent upon consultation.

FURTHER ENGAGE KEY COMMUNITY STAKEHOLDERS

Share findings with community-level stakeholders, including study participants and adjacent stakeholder groups such as Abbotsford Drug War Survivors, IOM members, or Abbotsford ACCESS.

SHARE FINDINGS WITH THE PUBLIC

Using a video documentary (currently in pre-production), engage the public with broader insights in order to decrease stigma and increase understanding within the community at large.

ENGAGE SYSTEM STAKEHOLDERS

Share findings with decision-makers at Fraser Health Authority, BC Housing, and other relevant provincial ministries through creating opportunities for municipally-backed collective knowledge sharing.

LEVERAGE ABBOTSFORD ACCESS

Collaborate with ACCESS members to increase information flow and connections between staff at the service provision level who implement policies and frontline workers who encounter these policies on behalf of clients.

Multiple knowledge translation tools and methods could be employed in pursuing these next steps, such as meal-based dialogue, film screenings, digital infographics, or other additional knowledge translation materials. In congruence with CBPAR approaches, the community-based research team and municipal stakeholders will design and deploy further strategies after findings are initially disseminated and validated.

NOTES FROM THE FIELD: SMALL SNAPSHOTS OF FRONTLINE WORK*

Conversations in Kendra's Office

The walls of Kendra's office have photos all over them. One side consists of people she's lost, the other side has photos of survivors, some in better shape than others. The side with those lost has about 3 times as many photos as the side with those in recovery. Since 2015, the number of deaths continues to increase exponentially. 2015: 1, 2016: 1, 2017: 4, 2018: 11, and onwards. In 2023 it was 29. As of now, June 25, 2024, she's lost 12 so far. Her arms are littered with colorful tattoos of birds representing loved ones who have perished.

Kendra's world revolves around these relationships. As we look at the walls, she helplessly recounts memories of her people, detailing their unique and beloved quirks. She is a keeper of stories. The wall functions as a memorial to those who now only exist in the minds and hearts of Kendra and her community—those most affected by the toxic drug emergency. The wall serves as a way to value people. They are seen, known. It is also a point of connection for any of the clients walking in there: Everyone knows someone up there.

Kendra talks for an hour about deficits in the system, providing example after example. Story after story. Throughout, the importance of human dignity, the need for frontline workers and the relationships they work so hard to build, and the precariousness of timing emerge like beams of light through a fog of delayed responses, bottlenecks, stigma, and toxic drugs.

Outreach in Julie and Larissa's Van

We get into the van, which Julie calls "the office." Where the back row of seats would be has been filled to the top with harm reduction materials, organized in various buckets, boxes, bags, and one white bathroom shelving unit that contains about 5 drawers full of more materials. Julie shows me a tray of harm reduction supplies and explains all the items. Straws, screens, foils, push sticks, vitamin C. Her immediate breadth of knowledge is staggering.

We walk out to a gravel parking lot where a shelter used to be. Julie and Larissa marvel at the weirdness of seeing the lot totally empty, when just a few weeks ago there were 40 shelter beds there. They comment that there's a lot of hype in the media around how many new shelters and services are being created, but in reality, what is called "additional" is often actually a replacement because existing locations are torn down to make the new locations. And it still isn't enough.

As we walk around one encampment, the care with which many people have tried to make their spaces more homey, more private, or more beautiful stands out. One of the men follows us out from an encampment as we leave. His legs are covered in open wounds. The flesh is literally falling off of his legs. Julie gives him some antiseptic gel. When we get back in the van, Julie and Larissa talk about the state of his legs and many others like him. They say these folks do get help from IHART when they come around, but it's not consistent, so clients often try and attend the wounds on their own, but they are in such an unclean environment that this often causes more problems. Julie and Larissa talk about how this is caused by "tranq," which is eating away at the tissue. Fentanyl is not just fentanyl anymore; it's combined with veterinary tranquilizers and benzos. The effects of these are hard to reverse. The benzos cause such severe brain damage that within a few weeks they've watched people they've known, who have been doing drugs on the street for a long time, take these newer substances and then quickly decline cognitively to where they are barely recognizable.

We also talk for a while about how important it is to know peoples' stories. Julie says someone the other day said to her, "I need you to carry my hope for me."

*These anecdotes were lifted from extensive field notes taken during the participant observation phase of data collection. Most of the details of the many interactions in shelters, on the sides of the roads, and in encampments have been removed to protect the privacy of both spaces and people. The anthropologist conducting the participant observation was struck with the depth of human dignity and its violations from stigma and toxic drugs, as well as the frontline workers' tremendous fortitude and authenticity of care.

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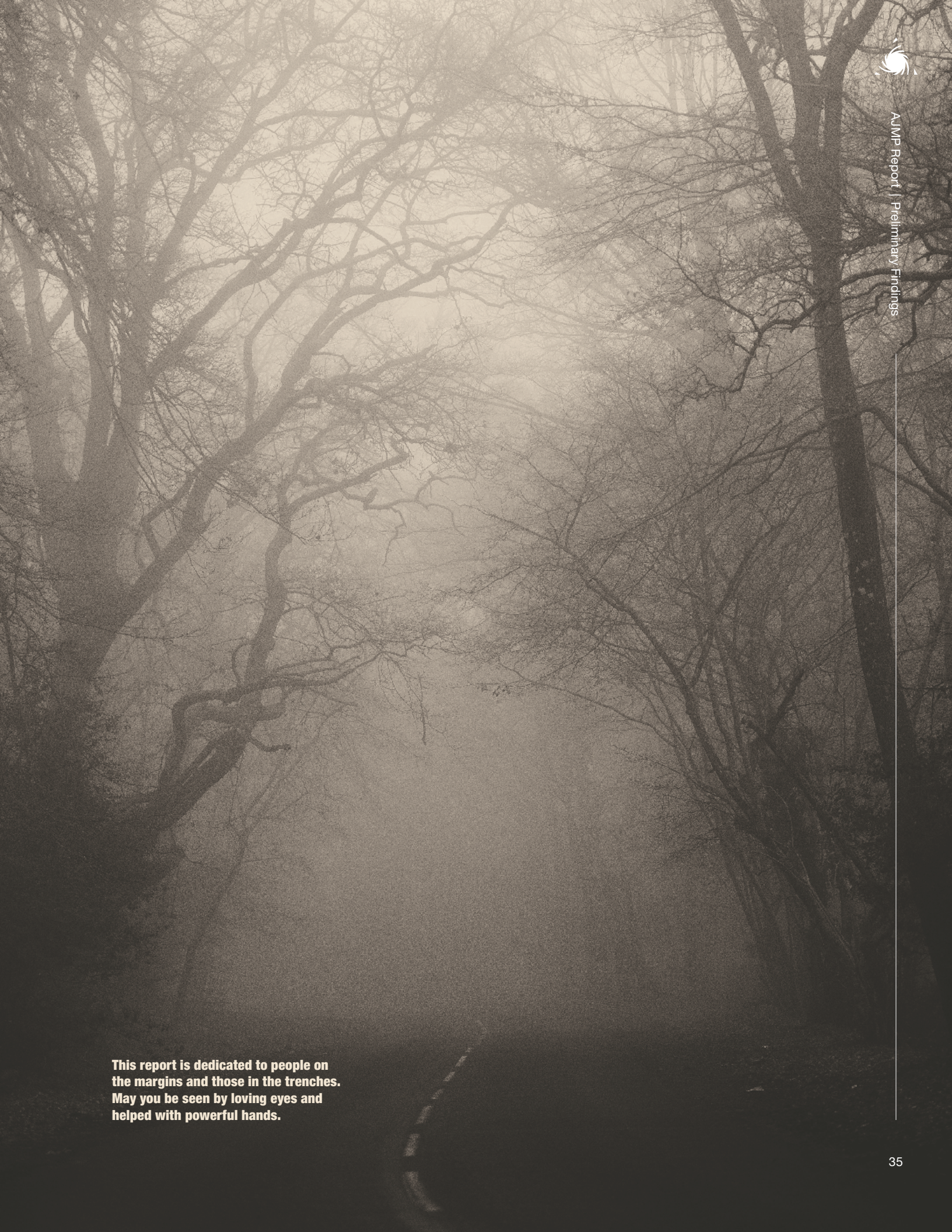

This report is dedicated to people on the margins and those in the trenches. May you be seen by loving eyes and helped with powerful hands.

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