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Overdose Prevention Centre Provision, Policy and the Lived Experience of People Who Use Drugs: Rapid-Ethnographic Analyses in Sandwell, UK, Vancouver, Canada, and Athens, Greece

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Abstract

Background

Fatal overdose among people who use drugs is a rising crisis in the UK, Canada, and Greece, with research illustrating how these individuals also face significant health inequities. Whilst Overdose Prevention Centres (OPCs) are now central components of Canada's public health system, in both the UK and Greece, these interventions are novel and geographically limited.

Objectives

To date, no qualitative body of work has focused on the lived experiences of people who use drugs within varying international drug policy settings explicitly as a means of advancing our understanding of the impacts of OPCs or the potential barriers people face in accessing these services. As a body of work comprising 5 distinct papers, this thesis attempts to fill this gap.

Methods

Papers 1-4 employ rapid-ethnographic methods (≈200 of participant observation per location, focus groups, interviews, street-ethnography) in each setting, as well as several participatory approaches in collaboration with people who use drugs (community consultation, peer data collection, analyses and dissemination). Paper 5 is a commentary with no primary data.

Results

In paper 1, findings evidence the need for safer environments for people using drugs in public and semi-public settings in Sandwell, UK. Exposure to the threat of public and police interaction in semi-public drug use spaces leads to rushed injection practice, hampers poor

venous health management, and increases risk of injection-related harms. Participants were enthusiastic about the concept of an OPC and its potential to reduce injecting-related risks, drug-related death, provide safety, and prevent traumatic experiences with police. Participants also highlighted concerns about negative public perceptions of their community, viewing an OPC as a potential solution to improving community relations by reducing drug-related litter.

In paper 2, results suggest that at a Vancouver based housing facility, the on-site OPC is underused due to a variety of structural factors, the most prominent being the lack of inhalation services. This lack of service provision exacerbates overdose vulnerability and stigma. Continued drug consumption in the vicinity of the building and in non-monitored areas inside the building creates challenges for staff in identifying potential overdoses and exposes residents who do not consume drugs to drug use within the building.

In paper 3, findings highlight how a Vancouver-based OPC had a regular clientele who described their attendance as routinized, credited to four distinct factors: 1) the accessible location, 2) the on-site auxiliary services, 3) the diversity of harm reduction provision and 4) the atmosphere. Exploring the concept of atmosphere in more depth revealed that it was characterized by the safety, familiarity and inclusivity experienced within the service. Together these factors facilitate a strong sense of belonging in attendees regarding the service and its community of staff and clients.

Paper 4 aimed to qualitatively evaluate the operational strengths and weaknesses of Athens' Drug Consumption Room (DCR) from the viewpoint of its clients and people who use drugs locally in public settings who do not access the DCR. Regular DCR clients reported increased physical, structural and emotional safety as well as increased connection with auxiliary health and social services, staff and peers. Those who did not use the facility could see potential benefits but noted several operational and contextual barriers.

Paper 5 sets fourth the argument for conceptualizing DCRs, OPCs, SCSs as 'Inclusion Health Interventions' and explores the potential policy implications for Europe of this shift in analytical lens.

Conclusions

This thesis documents the immediate benefits provided by OPCs: they save lives, reduce public drug use, and create environments where people who use drugs feel safer, more dignified and can access auxiliary services that may otherwise be unavailable. Despite this, each case study also identifies barriers to the design and delivery of these services and offers recommendations on how to optimize client experience, engagement and access. Based predominantly on an analysis of the narratives of potential and actual OPC clients, the finding that crosscut all case studies is that the lived experience of people who use drugs can provide a key resource in the design and delivery of harm reduction services which aim to support their survival, health, social inclusion, and broader well-being.

Acronyms and Definitions

Overdose Prevention Centre (OPC), Drug Consumption Room (DCR), Supervised Consumption Site (SCS): at their core these are spaces in which people can use pre-obtained substances under the supervision of trained professionals who are able to intervene in the case of an overdose. Whilst various models of operation exist, ranging from highly medicalized facilities, through to low-barrier facilities which can entail a gazebo in a park equipped with naloxone, oxygen, sanitary surfaces and trained individuals, these offer the same immediate intervention aiming to safeguard from drug overdose and ultimately death. Each of the five papers that make up my thesis give a contextually specific definition and use the term that is most common to that specific location. To maintain consistency, outside of the papers, I use the term OPC to describe the intervention of focus.

Acronyms	Definition
AOP	Alley Outreach Project
BBV	Blood Borne Virus
BC	British Columbia
CBPM	Community Based Participatory Research
CBPR	Community Based Participatory Method
DCR	Drug Consumption Room
DSPI	Department of Social Policy and Intervention
DTES	Downtown Eastside
HIV	Human Immunodeficiency Virus

HOPS	Housing Based Overdose Prevention Service
OECD	Organisation for Economic Co-operation and Development
OPC	Overdose Prevention Centre
RC	Resource Centre
RCT	Randomized Control Trial
SCORE	Sandwell Community Outreach Resource and Education
SCS	Supervised Consumption Site
UK	United Kingdom
US	United States
UNODC	United Nations Office on Drugs and Crime

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Acknowledgments

My past three and half years in Oxford, and by extension this DPhil thesis, have been shaped by several mentors and communities of which I have been a part. The guidance, encouragement and friendship I received from these individuals and groups enriched my doctoral experience, both personally and academically, beyond anything I could have imagined before starting.

Before starting my DPhil, I was repeatedly told two things. I'll come back to the second later, but the first was that a PhD is most likely going to be a lonely and isolating experience. I am pleased to say that thanks to my friends at the Department of Social Policy and Intervention (DSPI), for me, this has not been the case. Although we have all been working on vastly different research topics, the DSPI community and the camaraderie amongst fellow DPhil students has made this journey feel like a shared endeavour. Whilst studying in the beautiful Oxford libraries has undoubtedly been one of the great joys of my last few years, being able to work, take coffee breaks, have lunches and celebrate birthdays and academic milestones amongst friends all navigating the same challenges has truly added to my DPhil experience.

Secondly, a thank you to the University of Oxford Rugby Football Club and the Oxford Chabad Society - two environments which offered me physical, social and spiritual outlets away from my studies. Looking back, I can't picture myself in Oxford without the sense of belonging and support I got from these two communities.

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Coming back to the second thing I was often told before starting the DPhil: the relationship one has with their supervisor(s) can make or break their time as a doctoral student. For me, I can wholeheartedly say that these three relationships have been pivotal in shaping my time as a doctoral student. I started my PhD journey with Dr Benjamin Chrisinger as my sole supervisor. However, even before I was admitted to DSPI, back in 2019, when my initial application got rejected and Ben kindly offered to meet with me and support my second application, I knew that he would be a great mentor. Despite two more supervisors coming on board and Ben moving institutions, he remained incredibly supportive and generous with his time. Whether guiding my research, helping me build my wider academic network or simply helping me navigate the wider pressures and challenges of the DPhil, he has been an invaluable mentor. Next, Dr Gillian Shorter, who initially joined the supervisory team as the drug policy expert of the group, quickly became a mentor for every facet of my academic experience. From supporting me in publishing papers, to helping me forge relationships with third sector organizations, to inviting me to speak with her at esteemed policy venues, Gillian has consistently gone above and beyond to support and open doors for me. I sincerely hope we can keep working together long into the future. Finally, Professor Dave Humphreys, who although joined my supervisory team halfway through my time at Oxford, has been supporting me from my very first week at DSPI. Whether it was helping me prepare for funding interviews, helping me manage relationships with partner organizations or providing detailed feedback on my drafts, Dave has been a consistent source of support. While my supervisors have each had different styles of mentorship, they have each given me concrete examples of how to support students and be effective supervisors and I hope to one day carry this forward and repay their kindness through my own support to students.

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1. Introduction

1.1. Background and Rationale

Initiated by the United States' President Richard Nixon in 1971 and subsequently exported globally, the 'War on Drugs' policy approach has sought to control the production, distribution and possession of illicit substances through law enforcement (Bowling, 2011). Despite the explicit aim of eliminating drug-related crime and drug-related harm, including drug-related death, this approach to drug control, characterized by the mass incarceration of low-level drug offenders, has proven ineffective (Cohen et al., 2024; McCoy, 2021). Globally, as the policy emphasis on supply reduction and consumer enforcement has intensified, the number of people who use drugs (Humphreys et al., 2022), the potency of widely available illicit drugs (Beletsky & Davis, 2017) and the violence associated with drug markets have all increased (Pereira, 2024). In the past decade, this combination of unintended consequences has driven a global spike in drug-related deaths (UNODC, 2024), primarily in OECD countries. Simultaneously, it has created a socio-political climate which enables and propagates the marginalisation, stigmatization and structural vulnerability of people who use drugs (Cohen et al., 2024).

In the past ten years, the likelihood of fatal overdose for people who use drugs in the United Kingdom (UK) and Canada have skyrocketed and in Greece people who use drugs face significant health inequities (UNODC, 2024). Canada ranks second in the world for drug overdose deaths per million, recording 7,162 overdoses in 2023 (Statistics Canada, 2024). In parts of the UK, people who use drugs are 13 times more likely than the European average to die from a fatal overdose and a third of all drug-related deaths in Europe are recorded in the UK (EMCDDA, 2021). In Greece, although rates of fatal overdose are comparably low, in recent years rates of Human Immunodeficiency Virus (HIV) and Hepatitis C amongst populations of people who use drugs have surged and research highlights significant barriers to health services and poor health outcomes compared to the general population (Sypsa et al., 2021). In recognition of the clear inadequacy of the dominant policing response, and in an effort to reduce the well-evidenced negative iatrogenic effects of the War on Drugs (Sarang et al., 2010; Zhang et al., 2022), to varying degrees, in each of these three countries, public health responses to drug use have emerged centred on harm reduction.

Harm reduction refers to policies, programmes and practices that aim to minimise the negative health, social and legal impacts associated with drug use, drug policies and drug laws (Harm Reduction International, 2024). The harm reduction approach originated in the 1980s as activists, doctors and policymakers sought a non-punitive, health-based response to the growing HIV crisis amongst injection drug users (Roe, 2005). Over time, it has expanded beyond drug policy to other areas of public health, including sexual health, tobacco control, and alcohol use (Hatsukami & Carroll, 2020; Marlatt & Witkiewitz, 2002; O'Leary & Polosa, 2020; Sansone et al., 2022; Warner, 2019). Despite this broader application, around the world and to varying extents, evidence-based drug-related harm reduction interventions have emerged, predicated on health equity, and human rights (Barratt & Lines, 2023; Hathaway, 2002). These interventions include: (1) needle and syringe distribution programs to reduce the transmission of blood borne disease and infection (Fernandes et al., 2017), (2) naloxone distribution to widen access to opioid overdose reversal medication (Chimbar & Moleta, 2018), (3) overdose prevention centres to engage the most marginalised drugs users with health services, reduce rates of fatal overdose and infection, and offer a refuge from police violence (Caulkins et al., 2019; Magwood et al., 2020) and (4) more recently, safe supply programs which provide people who use drugs with pharmaceutical-grade, regulated alternatives to the often fentanyl-tainted drugs acquired on the black market (Ivsins et al., 2020).

Scholars have theorized how these harm reduction policies and interventions emerged from a shift in the way activists, scholars and public health officials theorized harm (O'Hare, 2007; Rego et al., 2021; Roe, 2005). Where previously, individual, behavioural risk factors were seen as paramount to intervening upon the production of harm, a new focus on the economic, political, and socio-structural factors producing, reproducing and propagating harm emerged (Rhodes, et al., 2006). Over the past two decades, a large body of literature has aimed to better understand how these structural determinants manifest in the lives of people who use drugs (Briggs et al., 2009; Boucher et al., 2017; Collins et al., 2019 Dertadian & Askew, 2024; Ivsins & Marsh, 2018; Ivsins & Yake, 2020; Khenti, 2014; Rhodes et al., 2007; Rhodes, 2002, 2009; Rosino & Hughey, 2018; Scher et al., 2023). In an effort to both advance theory and develop contextually relevant harm reduction interventions (Askew et al., 2022; Briggs, 2009; Ritter et al., 2018; Salazar et al., 2021), disciplines including anthropology, public health, and sociology, have increasingly employed research methodologies which value the lived and living experience of people who use drugs, primarily through qualitative, ethnographic methods.

Despite this recent push, there remains a prioritization of quantitative metrics and methods of assessment in the evaluation of harm reduction services (Duncan et al., 2021). As such, whilst most evaluations capture quantifiable public health and public order outcomes (Kennedy et al., 2017) important place-specific questions remain unanswered related to the way in which people experience OPCs, their impact on broader experiences of structural harms or how structural determinants (e.g., criminal drug law and policing practices) impact the ability of people who use drugs to access services. With this context in mind, this DPhil thesis aims to fill a gap in the drug policy literature pertaining to the study of OPCs and the lived experience of people who use drugs by conducting rapid-ethnographic studies in three cities: Sandwell, UK (no OPC), Vancouver, Canada (multiple OPCs of varying models) and Athens, Greece (one fixed, integrated OPC). Across each setting, local and national drug policies and policing practices also vary. A deeper discussion on why OPCs were chosen as the intervention of focus and why Sandwell, Vancouver and Athens were chosen as case studies is provided subsequently.

1.2. Why this Research? Exploring Positionality

At the age of 16, as a high school student in Vancouver, Canada, I was introduced to the Alley Outreach Project (AOP), a charity that partnered with our school. AOP worked with schools across the city to give assembly talks, run workshops and offer outreach opportunities to students. Its aim was to educate young people on the causes, realities and potential policy responses to the city's visible homelessness, public drug use and overdose crisis. Spending four years working with this charity, first as a student volunteer and then on the board of directors during my undergraduate degree was an eye-opening experience. While it left me with many unanswered questions about how and why social inequality was so starkly visible in a highly developed country like Canada, it was a formative period which sparked my enduring interest in this topic.

Having arrived in Canada at the age of 12, I moved back to the UK after high school to complete my bachelor's degree in Anthropology and Philosophy at Durham University in the north of England. With my parents and siblings still living in Vancouver, when it came to writing my undergraduate thesis, I decided to return home to focus my project on Vancouver's Downtown Eastside (DTES). Specifically, I wanted to explore media portrayals of this neighbourhood and the relationship between public discourse and the ongoing overdose crisis, which, (although today this figure has risen over 130%) in 2018 had taken the lives of 1,562 people in the province of British Columbia (BC) (Norton et al., 2022). For this project, I interviewed journalists, public relations professionals, drug and housing service providers in the DTES and families of overdose victims. This was my first exposure to the deep-rooted structural forces entrenching and propagating preventable social phenomenon such as poverty, homelessness and overdose. Prior to this, my understanding of these issues was likely shaped by a neoliberal, individualistic lens, pervasively ingrained through the media and TV I consumed during my upbringing. Having reflected on this the past few months, my early views very much framed such challenges as personal failings rather than the results of historically situated, systemic, social, political and economic forces. This early project during my undergraduate degree fundamentally challenged this perspective.

Following my first independent research project, I went on to pursue a masters in anthropology at the University of Waterloo, located just outside of Toronto, Canada. As part of this program, we had the opportunity to conduct a six-month ethnography. Having recently read the likes of Gabor Maté, Phillipe Bourgeois, Diddier Fassin, Michel Foucault, Johann Hari and Forest Stuart, I became deeply interested in the political mechanisms that uphold the War on Drugs, and how these policies are experienced by its victims. These authors were connecting macro policies such as criminalization and austerity to what I had witnessed in the DTES throughout my teenage and now early adult years. This growing interest coincided with my discovery of the concept of harm reduction and specifically supervised consumption sites, which from the offset, struck me as shockingly pragmatic. After a few discussions with my then MA supervisor

Dr Jennifer Liu (who, for the record, was the first academic to inspire and encourage me to pursue a PhD), I decided to approach a Vancouver based harm reduction provider and spend the six months in one of Vancouver SCSs. Having been so focused on the ways in which communities like the DTES were policed in my studies, I chose to focus the ethnography specifically on clients' experiences of the mechanisms designed to control or shape their behaviour during the ongoing overdose crisis.

This period was formative not only for my understanding how harm reduction services operate, but as my first experience spending extensive time with individuals living on the streets. These six months offered me a new perspective on the internal dynamics of homeless communities and the encampments in which many reside. Instead of the violent, chaotic or disorganized settings I had imagined, I observed a level of community care, and cohesive internal social structures that I had only previously read about (Schonberg & Bourgois, 2009; Stuart, 2016). Despite the daily hardships people faced, including police brutality, interpersonal violence, health co-morbidities and overdose, there was a profound sense of mutual support and resilience that deeply shaped my understanding of the DTES and made me question the discourse I would continue to hear in the media and from politicians about the prevailing drivers of poverty and inequality in Vancouver.

By the end of my master's degree, I knew I wanted to continue working with these communities, with the aim of harnessing people's insights and lived experiences to inform policymakers in a way that was more accurate and reflective of the needs and barriers of those living on the streets. I applied to eight doctoral programs across Canada and the UK. At the same time, the COVID-19 pandemic was starting to take shape. And so, I had moved back home to Vancouver and began working for the Lookout Health and Housing Society, the same organization where I had conducted my master's research, to work as a harm reduction worker. In this role, I was trained to work in the injecting rooms and smoke tents to respond to overdoses as well as with the shelter teams that housed many of the clients who accessed the harm reduction services in the DTES. In this frontline role, I became acutely aware of pressures faced by staff but also how their relationships with clients had a profound impact on clients' well-being and outcomes. I would regularly sit for long periods chatting with clients, about their days and, at times, their broader life experiences. Through these moments I gained a deeper understanding and appreciation for the humanity of this demographic, one so often dehumanized in the media and prevailing public discourse.

At the end of my first year in this role I learned that I had been rejected from all the PhD programs I had applied to. My plan now was to wait until the next academic cycle whilst I continued to work in this sector. A few months later at the beginning of 2020, with my second round of applications under review, I moved to London, England to begin a new role as an outreach worker for St. Mungo's, a homelessness charity similar to Lookout. In this new role, my job would be to go out into the community early in the morning (between 5am-9am) and late at night (between 10pm-2am) to locate and support people experiencing homelessness in the London Borough of Hammersmith and Fulham.

This was my first exposure to the realities and lived experiences of a completely different welfare system and broader drug policy environment. In contrast to Vancouver, where harm reduction principles permeated every service I interacted with, the application of these concepts was largely absent in London. Outreach workers did not carry naloxone, housing was often conditional on abstinence and people living on the streets seemed significantly more isolated, both from peers and formal support networks. Whilst poverty and homelessness were far more visible in the DTES, people seemed happier, more connected and better able to access resources when they felt ready. By comparison, in London I found services to be much higher-barrier, less dynamic and less able to accommodate the needs of the most vulnerable community members. Among staff, I observed tensions between the expectation to provide low-barrier, empathic social support whilst at the same time being trained on the prevailing mindset that emphasized abstinence from drugs (ahead of broader health and social well-being) and an individualistic approach to social "recovery" and reintegration (Cloud & Granfield, 2008). This approach seemed to permeate the attitudes of outreach, shelter and housing first staff in their work supporting clients, the majority of whom had multiple complex needs and vulnerabilities (issues related to mental health, physical health, criminal records and social isolation were common) beyond their substance use.

Through my conversations with people accessing these services I also noticed contrasts in their sense of self-worth. In Vancouver, many saw themselves deserving of health, housing and harm reduction services. In London however, I frequently encountered people with the belief that they were to blame for the circumstances they found themselves in and somehow unworthy of these supports, a perspective I found disheartening but equally one which I believe to be a direct result of the structural stigma, created and perpetuated by both the criminalization of vulnerable people who use drugs (Scher et al., 2023) and negative, shaming portrayals of poverty, much more prevalent in British media and culture (Chauhan & Foster, 2014; Janky et al., 2014).

Gaining this comparative perspective by being immersed in the homelessness sector of two seemingly similar political and policy environments, Canada and the UK, left me wanting to explore the question of how people experience homelessness and harm reduction services based on the prevailing policy contexts in which they are situated. My time working in the UK highlighted to me that clients were rarely consulted on their perspectives or experiences of services. As a result, many interventions missed the mark on addressing people's most pressing needs, instead staff were incentivised to focus on key performance indictors like "number of street engagements" or "number of services signposted to clients". In reality, people were seeking much more substantial support which did not require them to conform to specific, rigid expectations about who was deserving of care (Reeve, 2017). As I progressed into the DPhil and began expanding my reading across the wider drug policy, harm reduction and homelessness literature, I carried with me these formative experiences and the recurring questions that arose during my time as a frontline worker. Chief among them was how people experience these different policy contexts and how these insights could be better harnessed to design more effective, humane and context-specific interventions and policy responses.

Reflecting on my positionality during my DPhil fieldwork, I was acutely aware of my status as an outsider in these harm reduction spaces, despite my prior experience. While I made efforts to mitigate the potential impact of my positionality on the processes of data generation, (which is discussed in more depth in each of the papers) certain dynamics were unavoidable. Firstly, the title of 'doctoral student at the University of Oxford' brought with it inherent assumptions of power and privilege. This often manifested in people being initially sceptical of engaging with me or questioning my understanding of their experiences. Comments such as "you are clearly just a book person" were common across all four field sites at the offset of fieldwork. Also, as a white male who had have never personally experienced the hardships that that come with being racialized, experiencing homelessness or using illicit substances in such deprived social conditions, my engagement with these topics and questions is based on my very personal lived experience. However, I believe that my background and experience remains important, particularly given the inherently interpretive nature of qualitative (and, in particular, ethnographic) research (Denzin, 1997; Thorne, 2016). From the methodological and analytical choices made throughout this project, to the way I engaged with the broader literature and my own generated data, my years of working in the sector and witnessing first-hand the impact that SCSs/OPCs/DCRs have in the lives of their clients undoubtedly shaped my perspective and approach to research. Being trained to think about and deliver harm reduction interventions as fundamentally low-barrier endeavours, designed to support people regardless of whether they are seeking to stop or continue using drugs, again has influenced how I interpreted both the wider literature and data generated through this DPhil. From the offset of this project, my aim has been consistent: that this research can inform policy and practice in ways that not only safeguards but tangibly improves the health and social outcomes for some of society's most vulnerable and structurally marginalised citizens.

1.3.Research Questions and Objectives

The aim of my doctoral work is to centre the lived experience of people who use drugs within differing drug policy climates as a means of drawing out explicit place-based policy recommendations, as well as identifying analytical comparisons of existing models of OPCs and communities where they are not yet implemented. I conducted rapid ethnographies in three cities, each with their own distinct climate of drug policy embedded locally and nationally: Sandwell, UK, Vancouver, Canada and Athens, Greece. Through these case studies, my research attempts to answer two primary research questions: (1) in what ways is the lived experience and quality of life of people who use drugs shaped by their ability to access harm reduction interventions; (2) what policy implications for the delivery of OPCs can be derived from the lived experiences and perspectives of clients and potential clients?

1.4.Thesis Outline

Paper	Title	Research Question(s)	Data and Methods	Results	Publication Stage
Paper 1: Sandwell, UK	Exploring the Need for Overdose Prevention Centres in England: A Qualitative Community-Based Participatory Study on the Experiences and Perspectives of People Who Use Drugs in Public and	Based on the Lived Experiences of People Who Use Drugs, is an OPC an appropriate and necessary intervention in Sandwell?	1-Focus Groups (20 participants over 3 sessions) 2-Street-based ethnographic interviews (20 participants) 3-Photo ethnography	1-There is contemporary evidence specific to the UK on the need for safer environments for people currently using drugs in public and semi-public settings. 2-Participants' physical surroundings and exposure to the threat of public and police interaction influences rushed consumption practices and makes it much more difficult for people to	Published in the International Journal of Drug Policy. DOI: https://doi.org/10.1016/j.drugpo.2025.104816

	Semi-Public Environments		4-Ethnographic field sessions	manage poor venous access, resulting in injection-related harms. 3-An OPC was perceived by people who use drugs as an effective intervention to mediate these risk factors, as well as rates of drug-related death and drug-related litter experienced in their community.	
Paper 2: Vancouver, Canada 1	Resident and Staff Experiences of Structural Barriers to a Housing-Based Overdose Prevention Site in	In what way can the lived experiences and perceptions of residents and staff within a low-barrier supportive housing unit with a	1-Non-partciipants observation (≈200 hours)	1-The HOPS is being underutilized due to a variety of structural factors, the most prominent of these being the lack of inhalation services. 2-This lack of service provision exacerbates overdose vulnerability and	Published in the Canadian Journal of Public Health. DOI: https://doi.org/1

	Vancouver, Canada: “There is a double standard if you smoke”	housing-based overdose prevention site (HOPS) be used to inform the design and delivery of HOPS?	2-Focus groups (15 participants over 3 sessions) 3-Ethnographic interviews (20 participants) 4-12 interviews with staff (not reported on in paper)	shapes a number of harms experienced by residents. 3-Continued drug consumption in the vicinity of the building and in non-monitored areas inside the building creates challenges for staff in identifying potential overdoses as well exposes residents who do not consume drugs to drug use within building.	0.17269/s41997-025-01007-7
Paper 3: Vancouver, Canada 2	Characterizing ‘Atmosphere’: Exploring determinants of regular service	In what way can the lived experiences and perceptions of daily clients and staff within a community centre	1-Non-partciipants observation (≈200 hours)	1-The service had a regular clientele who described their attendance as routinized, credited to four distinct factors: 1) the accessible location, 2) the on-site auxiliary services, 3) the	In press with the Harm Reduction Journal.

	attendance amongst integrated supervised consumption site clients in Vancouver's Downtown Eastside	with an OPC be used to inform the design and delivery of such services?	2-Focus groups (25 participants over 5 sessions) 3-Ethnographic interviews (20 participants) 4-15 interviews with staff (not reported on in paper)	diversity of harm reduction provision and 4) the atmosphere. 2-Exploring the concept of 'atmosphere' in more depth revealed that it was characterized by the safety, familiarity and inclusivity experienced within the service. 3-Together these factors facilitate a strong sense of belonging in attendees regarding the service and its community of staff and clients.	
Paper 4: Athens, Greece	Benefits and Barriers: A Rapid-Ethnographic Study on the	In what way can the experiences and perceptions of clients, staff as well as people	1-Non-partciipants observation (≈200 hours)	1-Regular DCR clients experienced a wide range of benefits from accessing the facility.	Under review with the Harm Reduction Journal.

	Perspectives of (Potential) and Actual Clients of Athens' Drug Consumption Room	who do not access services but who would benefit from the OPC, offer insights into the operational strengths and weaknesses of the new Athens site?	2-Focus groups (25 participants over 5 sessions) 3-Ethnographic interviews (25 participants) 4-12 interviews with staff (not reported on in paper)	2-Despite having an awareness of the potential benefits of service attendance, non-DCR clients described several contextual and operational barriers which reduced their ability and willingness to access the site.	
Paper 5: A Commentary on OPCs as 'Inclusion	Exploring Drug Consumption Rooms as 'Inclusion Health Interventions':	N/A	N/A – Commentary Piece	With a view towards the future of DCR implementation in Europe, we position DCRs as effective 'inclusion health interventions'. The shift in analysis from DCRs as a purely harm reduction	Published in the Harm Reduction Journal. DOI: https://doi.org/1

Health' Interventions	Policy implications for Europe			or overdose prevention intervention to one of 'inclusion health' could work towards a wider recognition of their effectiveness in addressing broader health and social inequities. At a policy level, this shift could result in increased political support for DCRs as recognized interventions, which through their design, effectively promote social inclusion.	0.1186/s12954-024-01099-3

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2. Theoretical and Empirical Foundations

Several theoretical frameworks are discussed in each of the five papers. However, the foundation of my own thinking with regards to the questions and general orientation of this thesis is based on theoretical positions and bodies of evidence within the broader public health and drug policy literature. In this section, I briefly outline: 1) the existing evidence-base regarding OPCs, 2) risk environment theory, and 3) conceptualizations of structural violence and vulnerability.

2.1. Overdose Prevention Centres (OPCs) as Evidence-Based Interventions

In North America (Kolla et al., 2022) and increasingly in European contexts (Krausz et al., 2021), the addition of fentanyl and other synthetic derivatives (e.g., carfentanil, synthetic cannabinoids) is driving localized spikes in rates of overdose. In many OECD countries, the past decades overdose crisis has highlighted the risks, including death, associated with the use of illicit drugs. For people who inject drugs, the sharing of needles is associated with the transmission of blood borne infection, including HIV, Hepatitis B and Hepatis C (Wood et al., 2006). Additional risks include collapsed veins, abscesses and emboli (Dunleavy et al., 2019). People who inject drugs and use drugs in street-based settings also demonstrate higher levels of social marginalisation, homelessness, unemployment and lower health outcomes than people who practice other modes of consumption (Kerman et al., 2020). Within communities, public injecting can also produce in increased levels of drug related litter, drug-related crime and interpersonal violence (Latkin et al., 2005; Marshall et al., 2008). Shifting drug supplies and preferred consumption practices have also intensified the risks associated with smokable drugs

(Ivsins et al., 2024; Kral et al., 2021), exemplified through spikes in smoking-related overdose (Megarian et al., 2024; Parent et al., 2021).

These risks are significantly heightened for individuals who use drugs alone or in unsupervised settings, where the likelihood of fatal overdose increases due to the absence of timely intervention (Norton et al., 2022). People experiencing homelessness, poverty, or other forms of social marginalization face additional barriers to safer drug use, including limited access to sterile equipment, healthcare, and stable housing, the absence of which all contribute to elevated health risks (Kerman et al., 2020). Furthermore, the unregulated nature of illicit drug markets, particularly the proliferation of synthetic adulterants such as fentanyl and its analogues, has drastically increased the unpredictability and lethality of street drugs, especially among people who smoke rather than inject (Bardwell et al., 2022). Within the broader context of drug prohibition and criminalization, in comparison to the general population, these overlapping structural vulnerabilities place people who use drugs at disproportionate risk of harm, entrenching cycles of marginalization and poor health outcomes (Zigon, 2018).

OPCs are socio-medical interventions which allow people who use drugs to consume under the supervision of harm reduction practitioners in safe and sanitary environments (Shorter et al., 2022). Typically, injection, ingestion and nasal inhalation are the sole permitted modes of use, but increasingly, due to the aforementioned risks, facilities are being amended to allow for supervised smoking (Bourque et al., 2019). Staff also offer safer injecting advise and can refer clients to auxiliary services including, health, housing, employment, medical and detox (Poitier et al., 2014). Systematic reviews of quantitative evaluations (Levengood et al., 2021; Poitier et al., 2014), demonstrate that OPCs significantly reduce the harms associated with drug use. Reductions have been measured pertaining to rates of: (1) drug-related mortality, (Marshall et al., 2011; Rammohan et al., 2024), (2) ambulance call-outs (Salmon, 2010), (3) transmission of bloodborne infections (Killion et al., 2024; Lim & Panagiotoglou, 2024; Rubin & Suran, 2017). Further, no evaluation has recorded adverse effects on community-level crime (Caulkins et al., 2019; Davidson et al., 2021; Hall & Ratcliffe, 2024; Panagiotoglou et al., 2024) or public disorder (Kennedy et al., 2017), within their vicinity. Finally, evaluations also demonstrate a positive impact on increasing access to auxiliary services for marginalised people who use drugs (Kerman et al., 2020; Nassau et al., 2022) and cost savings for local health services (Andreson & Boyd, 2010; Baroumi & Zaric, 2008; Behrends et al., 2024; Cousien et al., 2024; Kahir et al., 2022).

The complex nature of OPC interventions presents a range of challenges to rigorous evaluation. Caulkins et al (2019) suggest that in addition to the ethical implications of withholding lifesaving interventions within the context of a randomized control trial (RCT), because OPCs often emerge as community-based initiatives, they are typically not designed or implemented in ways which permit RCTs. Highlighted through a systematic review of available studies, the vast majority of the quantitative evidence in their favour reports on associations and does not allow for definite causal inference (Caulkins et al., 2019). For example, in evaluations of INSITE (Vancouver) and MISC (Sydney), the two OPC sites where a large percentage of the global evidence derives from, authors note an association between increased safer injection practices between frequent clients of the OPCs, in comparison to those who visited infrequently (Kerr et al., 2005; Stoltz et al., 2007). Both sets of authors acknowledge that this could be a product of behavioural changes from accessing the site, however, it may also be a result of selection bias. Despite not being able to conduct RCTs, a recent systematic review by Kennedy et al (2022) highlights how quasi-experimental evaluations report favourable or null effects on most primary outcomes, including overdose, ambulance call-outs, drug related litter, drug-related crime and rates of referral. This has been argued to justify moving forward with OPCs in communities demonstrating need (Satel, 2019). Despite the absence of RCTs and limitations is asserting causal inference, a rich body of literature, across time and contexts exists demonstrating both the need and holistic benefits of OPCs in the lives of people who use drugs and local community stakeholders (Shorter et al., 2023).

2.2. Review of the Existing Evaluations on the Need and Impact of OPCs

Across contexts, rapid response to 'crises' (e.g., spikes in rates of HIV and/or fatal overdose) or acts of 'civil disobedience' (e.g., unsanctioned interventions in the face of preventable harm) by civil society actors have typically been the pre-requisites for the implementation of OPCs (McCann & Temenos, 2015). Post-implementation evaluations are more common than pre-implementation feasibility studies. Those that do exist (for examples see Nicholls et al., 2022, 2025; Parkes et al., 2022; Satel, 2019; Scher et al., 2025; Southwell et al., 2022) focus primarily on the perspectives and recommendations of local stakeholders, including people who use drugs, regarding the design and provision of OPCs. In local contexts, data associated with drug-related death, drug-related harm, crime, and litter are weighed against the existing international evidence-base to justify the opening of local services.

Systematic reviews by Lange & Bach-Mortensen (2019) and Kryszajtys et al (2022) usefully summarize pre-implementation and post-implementation qualitative evaluations. However, most studies included in these reviews are from Canada. This is likely due to the requirement in Canada that a feasibility study be conducted before implementation can be approved (Orsmond & Cohn, 2015). This review of pre-implementation stakeholder assessments situates the context of my first paper which assess the need for an OPC in Sandwell, UK from the perspective of local people who use drugs in public and semi-public settings. The review of post-implementation stakeholder assessments situates papers two, three and four of this thesis, which examines the perceived impact of OPCs from the perspective of clients, an important stakeholder group not always included in quantitative evaluations.

2.3. Pre-Implementation Stakeholder Assessments

Across contexts, in relation to perceived benefits, people who use drugs, substance use, health and emergency service professionals typically believe that OPCs would increase safety for people who use drugs, both from police apprehension and street-based violence, but also in relation to safer injecting practices and the chance of fatal overdose. Whilst these views are equally held by police and policymakers, they typically placed more of an emphasis on cost-reduction and community well-being (Lange & Bach-Mortensen, 2018; Watson et al., 2013). In relation to concerns of prospective OPCs, people who use drugs were typically worried that the OPC would be too far away and inaccessible to those in the community who need it and that police would interfere in its daily operations (Southwell et al., 2022). Other community stakeholders were concerned about proximity of the OPC to their residence, business and or local school (Bardwell et al., 2017; Kolla et al., 2015; Strike et al., 2016). Although not expressed by people who use drugs, all other stakeholder groups typically voice concern that an OPC would increase the number of people using drugs in the community (Kryszajtys et al., 2022; Lange & Bach-Mortensen, 2018).

Specific recommendations regarding the implementation of OPCs were common within included studies. Typical input from stakeholders relates to four key areas: 1) operational considerations (e.g., site rules, site capacity, referral options, staffing, opening hours, peer involvement, entry restrictions, typology of drugs permitted, modes of administration permitted and physical separation between people who inject and people who smoke), 2) location (e.g., integrated within existing community health services, proximity to community health services, away from schools and recreation grounds), 3) appropriate service model (integrated, mobile, fixed) (Kryszajtys et al., 2022; Lange & Bach-Mortensen, 2018), and 4) policing practices in relation to site (Bardwell et al., 2017; Watson et al., 2018). Accurately understanding stakeholder perceptions, including those of people who use drugs, is not only crucial for informing the development of OPCs which are contextually relevant and meet the needs of local communities, but they can also assist in better understanding the acceptability dimension of intervention design (Sekhon et al., 2017), including political barriers to implementation.

2.4. Post-Implementation Stakeholder Assessments

In conjunction with quantitative evaluations aiming to capture statistically measurable outcomes of OPCs, a number of post-implementation stakeholder evaluations have been conducted. The aim of these qualitative evaluations is to ascertain tangible impacts in the lives of both people accessing the service and the wider community (Lange & Mortensen., 2018; Kryszajtys et al., 2022). Across stakeholder groups, the increased safety, including reduced mortality rates of people who use drugs was cited as an important benefit. The positive educational influence on safer injecting practices, as well as the provision of sanitary supplies and supervision by harm reduction workers was also described as an important intervention decreasing the prevalence of injury and disease transmission. Additionally, positive relationships between staff, peers and clients were described as integral to the successful functioning of sites. People who use drugs, staff and wider stakeholders all described the ability of OPCs to increase access to auxiliary services for community members using drugs as a highly favourable outcome. Finally, across sectors, local business and residents report decreases in drug-related litter (Kryszajtys et al., 2022; Lange & Bach-Mortensen, 2018; Bancroft & Houborg, 2020).

The majority of ongoing concerns for OPC clients were with regards to regulations and restrictions (e.g., drug sharing, age, pregnancy, levels of intoxication, assisted injections). Logistical concerns were also expressed regarding waiting times, and hours of operation. There is also a large body of qualitative literature, across contexts, describing how poorly adapted policing practices can impede people who use drugs' ability to access OPCs (Bardwell et al., 2019; Scher, 2020; Urbanik & Greene, 2021; Greene et al., 2022; Watson et al., 2020) which is often reflected in the experiences of clients. The primary concern of staff and management following implementation was with regards to staff physical safety and mental health problems resulting from client behaviour and high levels of stress. Lastly, wider stakeholders remained concerned that OPCs increased drug use and loitering in the vicinity of sites. In line with expressed concerns, recommendations from stakeholders revolved primarily around the regulatory and logistical concerns cited above. For clients, recommendations related to drug sharing, opening hours, and exclusion criteria.

Although the reviews by Kryszajtys et al (2022) and Lange & Bach-Mortensen (2018) specify the dates of publication of each included article, they do not specify how long after the opening of each site the post-implementation evaluations were conducted. Lange & Mortensen (2018) caution that 17% of included studies were published from 15 years ago or more and may not reflect the opinion of present-day stakeholders in environments with longer term OPC provision. Additionally, as explained by Kryszajtys et al (2022), OPC feasibility studies are localized interventions that should not be generalized across contexts. Despite acknowledged limitations, these reviews offer important insight into the findings which were common across contexts. These provide suggestions for relevant considerations in contexts where researchers may be unable to conduct robust pre-implementation feasibility studies. For the locations of my case studies, the Athens site opened in April 2022 and the Vancouver site has been in operation for over seven years. As such, the above synthesis of stakeholder perceptions offers important insights with regards to generalizable considerations for when studying OPCs and their impacts.

2.5. Risk Environment

Although the practical steps being taken to reduce risks of HIV transmission in humanitarian settings were being well documented in the early 2000's (Panday & Galvani, 2019; Stover et al., 2002), Rhodes (2002) developed the 'the risk environment framework' as a way of more accurately recognizing the shifting public health focus and theoretical lens of HIV interventions from addressing individual behaviours to the environmental factors which increase risk and harm (Ibragimov et al., 2022). Rhodes (2002) defines the 'risk environment' as "the space – social or physical – in which a variety of factors interact to increase the chance of harm occurring" (p.88). Concerning drug-related harm, the 'risk environment framework' conceptualizes risk as the intersection of physical (drug-use setting), social (group norms), economic (income inequality) and policy (drug criminalization) domains and manifesting at multiple (macro and micro) levels (Rhodes, 2002).

Where individual-level change interventions are limited in their capacity to sustain change (Rhodes, 2009), the 'risk environment framework' allows us to explore intervention options exogenous to individual behaviour. The 'risk environment framework' has been widely applied to the conceptualization of drug policy and interventions to reduce drug-related harms (as described in figure 1). This lens of analysis also calls in to question neoliberal conceptualizations of individual responsibility, shining light on the role of structures, social and political institutions in the propagation of structural violence and the creation of risk within specific environmental contexts (Rhodes, 2002). Understanding risk as socially situated encourages policymakers to consider human suffering and environments of deprivation through a human rights lens and importantly as preventable through policy (Rhodes, 2003).

		Micro-environment	Macro-environment
Physical	*Risk*	Drug using, injecting and sex work locations Drug injecting in public spaces Prisons and detention centres	Drug trafficking and distribution routes Trade routes and population mobility Geographical population shifts and population mixing
	Intervention	Creating safer drug using sites (e.g., sharps disposal, lighting) Developing supervised injecting facilities Prison-based harm reduction interventions and alternatives to prison	Changes to trafficking interdiction policies Interventions at truck stops and train stations Cross-border interventions Changes to immigration laws and routine enforcement practices
Social	*Risk*	Social and peer group "risk" norms and intimate partner violence Local policing practices and "crackdowns" Community health and welfare service access and delivery	Gender inequalities and gendered risk Stigmatisation and marginalisation of drug users Weak civil society and community advocacy
	Intervention	Social network and peer-based interventions Shelters for homeless and for battered partners Police partnership and training projects Developing low threshold accessible services for drug users	Fostering collective actions and political mobilization for social and human rights in combination with policy changes Mass media and social marketing of harm reduction Strengthening civil society infrastructure and self-help
Economic	*Risk*	Cost of living and cost of health treatments Cost of prevention materials Lack of income generation and employment	Lack of health service revenue and spending Growth of informal economies Uncertain economic transition
	Intervention	Subsidised and free treatment Distribution of free prevention materials Micro-economic enterprise and employment schemes	Increase investment in harm reduction relative to enforcement National health insurance schemes Laws governing employment rights
Policy	*Risk*	Availability and coverage of clean needles and syringes Program-level policies governing distribution of materials Access to low-threshold and social housing	Public health policy governing harm reduction and drug treatment Laws governing possession of drugs Laws governing protection of human and health rights
	Intervention	Scaling-up pharmacy-based syringe provision Secondary syringe distribution programmes Hostel-based and housing neighbourhood development	Legal reform enabling the scaling-up of harm reduction Legal reform enabling the protection of drug user rights National policy changes regarding public health strategy

Source: Rhodes (2009)

Figure 1: Table - Drug-Related 'Risk Environment Framework'

Within the context of the overdose crisis, harm reduction interventions operate on the logic that it is not just the potency of illicit substances which cause harm (Tyndell & Dodd, 2020). Whether it be safer supply programs (which provide pharmaceutical grade substances with the context of a of a deadly black market drug supply) (Ivsins et al., 2020), needle and syringe distribution programs (to reduce the risk of injury and disease transmission) (Resiak et al., 2021) or low-barrier shelters (to provide shelter for people experiencing homelessness with multiple intersection vulnerabilities) (Watson et al., 2017), each intervention is actively attempting to intervene upon a dimension of the individuals 'risk environment'.

OPCs emerged from the straightforward recognition of the risk environments associated with street-based drug use and the paramount necessity for safer environments for people who use drugs. McNeil & Small (2014) synthesize existing OPCs literature produced within the context of the 'risk environment framework'. They note that beyond micro level risk reduction such as providing clean injecting supplies, a safe and sanitary injecting environment and supervision in the case of overdose, OPCs mediate the macro environmental forces (e.g., policing, poverty) that "leave marginalised people who use drugs without spaces that they can occupy without the fear of arrest" (McNeil & Small, 2014, p.156). Their review highlights the capacity of the 'risk environment framework' to unearth safer environment interventions that simultaneously address factors across social, structural and environmental contexts (Rhodes et al., 2006).

In 2019, Collins *et al.* extended the risk environment theory by proposing the use of the term 'intersectional risk environment'. Acknowledging the original framing has been and still is central to current modes of examining the production of risk and harm, the authors argued that its use in highlighting the relationships and complexities between broader social, political, environmental factors in the lives of vulnerable groups remained challenging. To better account for the relational, interconnected nature of social positions (e.g., race/gender), and socio-structural factors (e.g., poverty/drug policies), the intersectional risk environment framework sought to highlight "how outcomes are products of processes and relations that are embodied, reflected, and challenged while situated within social, historical, and geographic contexts"

(Collins et al., 2019, p.1). These theoretical framings have been central to my conceptualization of this thesis and the data generated within it.

2.6. Structural Violence and Vulnerability

To understand how and why individuals that belong to a certain group face unequal hardships, sociologist Johan Galtung (1969) introduced the concept of structural violence. Since its inception, the term has gained traction across disciplines as a way of diverting blame away from marginalised individuals towards the power imbalances hidden within social hierarchies (Farmer, 2004). Benson (2008) elaborates to illustrate the application of structural violence to the context of both marginalised individuals and groups:

> *"social arrangements that systematically bring subordinated and disadvantaged groups into harm's way and put them at risk for various forms of suffering" (p.590).*

Despite the explicit emphasis on 'structural' within the term itself, it is, in fact, an approach that combines the everyday experiences of individuals within a group, with the recognition that these experiences are the embodiment of structural violence. Through this lens, structural violence can be understood as a critique of the idea of one's agency within a hierarchy and in particular, the neoliberal ideology of personal responsibility. Instead, this approach shifts the blame to the systemic, structural factors (e.g., patriarchy, slavery, colonialism, poverty, gender, sexual orientation, migrant/refugee status) implicated within the inequality being examined and exogenous to the individual (Rylko-Bauer & Farmer, 2016).

Different from interpersonal or physical violence, structural violence is embedded in to our social, political and economic structures. Galtung (1990) explains that poverty, racism, unjust criminal persecution and gender inequalities are examples of how “unequal power shapes unequal life chances” (p.291). Manifestations of structural violence are often legitimized through social machinery such as law (Bastos, 2012) and institutions (Jackson & Saddler, 2022). Scheper-Hughes (1996) suggests it is then normalized and rendered invisible through everyday internalization by people in positions of marginality:

> *“invisible does not mean secreted away and hidden from view, but quite the reverse…. the things that are hardest to perceive are often those which are right before our eyes and therefore simply taken for granted.” (p.889)*

Drug policy, more specifically its ubiquitous ties to the criminal justice system is one of society’s most clear-cut mechanisms perpetuating structural violence (Rhodes, 2009). Sarang et al (2010) and Holland (2022) discuss how global approaches to drug policy often prioritize enforcement, with the aim of a drug-free society over evidence-based interventions, with more pragmatic, public health and human rights objectives. The focus on questioning the arrangements that propagate avoidable harm is at the heart of structural violence theory (Rhodes, 2008). For instance, within the context of the overdose crisis in Canada, this lens is especially useful when theorizing the reluctance of governments to enact more structural reforms, such as decriminalization (Scher et al., 2023) and widespread safe supply implementation (Karamouzian et al., 2023), despite provincial statistics on drug-related death being higher than car crash, suicides and homicides combined (Nagy & Jones, 2021).

Through the lens of structural violence, scholars have linked the states enforcement of drug laws (policing practices), to direct and indirect iatrogenic negative effects (Zigon, 2018). By increasing marginalisation and reducing access to health services, the policing of people who use drugs has led to increased rates of HIV, overdose, tuberculosis, bacterial infections, and violence (Kerr et al., 2005; Werb et al., 2008; Wood & Kerr, 2005). Indirectly however, by targeting vulnerable and often racialized populations (Khenti et al., 2014), drug laws and their subsequent enforcement work to justify social and moral beliefs regarding people who use drugs (De Maio & Ansell, 2018).

Several ethnographies have used the framing of structural violence to analyse the decision-making processes of people engaging in black-market economies. In his seminal piece on Puerto Rican drug dealers in East Harlem, Bourgeois (2003) provides a detailed account of how political-economic forces offer few viable means of survival other than criminal activity. His 2009 book, '*Righteous Dopefiend*' examines the ways in which San Francisco's homeless population is pervasively impacted by structural forces, constraining decision-making ability related to drug use and safer injection practices. Similar ethnographic accounts such as *'Enforcing Order: An Ethnography of Urban Policing'* (Fassin, 2013) and '*On the Run: Fugitive Life in an American City'* (Goffman, 2009) offer insights into how drugs policing propagates structural violence in the lives of people in economically deprived urban areas. By immersing themselves in these communities, ethnographers such as Bourgeois (2003, 2009), Fassin (2013), Goffman (2009), Stuart (2017) and Zigon (2018) each present strong cases for how drug policy and in particular the enforcement of drug laws is a clear-cut example of how agency is hindered by law, policy and state action. Bardwell et al (2019, 2021), Boyd et al (2018, 2022), Urbanik et al (2022), Lavalley et al (2024), McNeil et al (2015), Pijl et al (2021) all offer contemporary examples of how structural violence has been applied to the analysis of people accessing OPCs. In these studies, the application of a structural violence framework has provided valuable insights to topics from gender-based violence and policing practices, to barriers to service engagement and access to housing.

Whereas structural violence examines the creation and manifestation of these broad, social, economic, political, systemic harms, in the mid-2000's, scholars within the field of drug policy began using the term structural vulnerability to identify the specific ways individuals and groups experience risk due to their social positioning (Bardwell et al., 2019; Fleming, 2024; Lopez et al., 2013; McKenna, 2014; Nichols & Blondeau, 2025; Queseda et al., 2011; Richardson et al., 2015). Instead of the dominant macro lens of analysis, structural vulnerability accounts specifically for the ways people's agency is constrained by factors such as legal status, poverty, race, and institutional discrimination. Within the drug policy literature, scholars have used the term to provide a more precise analysis of how individuals navigate policy systems which directly contribute towards poor health and social outcomes based on their specific position within these systems and social structures (Scher et al., 2024).

For the purpose of my thesis, I use Bardwell et al.'s (2021) conceptualization of structural vulnerability and 'structurally vulnerable people who use drugs' as a way of referring to the multiple vulnerabilites experienced by particular groups of people who use drugs (e.g., people who inject illicit drugs, impoverished and homeless/unstably housed individuals, sexual minorities, Indigenous peoples) due to their marginalized positions within social hierarchies (p.2). Within each of the studies, the introductions speak to the context specific socio-structural forces such as stigma, discrimination, poverty, and criminalization which intensify vulnerabilities in each of Sandwell, Vancouver and Athens.

2.7. References

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3. Methodology

The methods used in thesis were employed with the specific purpose of achieving its primary aim: to centre the lived experience of people who use drugs within differing drug policy climates as a means of drawing out explicit place-based policy recommendations. Whilst each paper contains detailed methods sections, several methodological choices cross-cut all parts of the thesis: 1) each paper was qualitative in nature to capture the experiences and perspectives of people who use drugs, 2) each paper uses rapid-ethnography as a means of rigorously, yet quickly drawing out place-based policy recommendations relevant to research partner service providers and local policymakers, 3) to varying degrees, to increase internal validity, each study leverages participatory approaches and 4) each study involves structurally vulnerable people who drugs both as collaborators and as participants, bringing with it specific ethical considerations. To address these similarities, this methods section examines the specific social and policy contexts of each study, explores the application of rapid-ethnographic methods in the existing drug policy literature, briefly examines the contemporary use of participatory research, and finally explores several of the ethical considerations that arose throughout the course of this research.

3.1. Contextualizing Case Study Sites

The locations of my case studies and fieldwork have been selected for both practical and analytical purposes. The UK, Canada and Greece have each developed and implemented OPCs and wider harm reduction policies and interventions to different degrees and therefore sit at interesting and varied stages of drug policy development. Reflecting these policy differences, the lived experience of people who use drugs in these settings, particularly those using drugs in public and semi-public street-based settings (Parkin & Coomber, 2011) and living in situations of marginality will vary. As is standard in ethnographic practice, data collection occurred via spending time with participants as they go about their daily lives (LeCompte & Goetz, 1983). Within the context of my research, these sites were harm reduction service providers frequented by participants.

It is also important to note how these case sites were chosen from a practical perspective. With my experience working in the field of harm reduction in both Canada and the UK, I always wanted my PhD to have some level of comparison drawing on case studies from each country. Having worked in Vancouver with the Lookout Health and Housing Society before starting my DPhil, I maintained my relationship with them over the years. As such, it was an obvious choice to partner with them and to return to the city I grew up, worked in and had conducted prior research in. In addition, Vancouver has an incredibly rich and complex relationship with the topic of drug policy and associated public health responses. Sandwell emerged as the second field site. Originally, my aim was to work with police departments in the UK to understand how they envision adapting neighbourhood policing practices should an OPC be implemented. Between October and December 2021, my attempts to approach police departments was unsuccessful. It was at this time that I reached out to Drug Science, a UK drug policy think tank, who subsequently put me in touch with Dr Gillian Shorter and Mat Southwell who were about to start a project looking at the need for and feasibility of an OPC in Sandwell, UK. They were looking for a research assistant for their project, and the following month I joined their research team with the understanding that I would be able to use the generated data for my DPhil. Part of my role in this project was writing a report based on this research as well as comparative case studies (see Southwell et al, 2022), which was to be presented to policymakers at an event at the UK House of Commons. In preparing this report I was asked to visit Athens and interview local policymakers as well as the management of OKANA, the

Greek organization running the then brand new OPC. Six months after that initial visit, I, along with my supervisors thought that due to the novelty and highly medicalized nature of the facility, it would be a fascinating addition to the case study approach of my thesis. Following my initial visit, OKANA agreed to partner for this qualitative evaluation. Although very similar populations from a socio-structural perspective, each site varies in OPC model: 1) no OPC in Sandwell, 2) a Vancouver housing-based overdose prevention service within a supportive housing unit, 3) a Vancouver based OPC within a low-barrier day centre and 4) a fixed-site medicalized OPC in Athens.

3.1.1. Sandwell, UK

Sandwell is a town in the UK with a population of 341,900 (as of 2022) bordering the west of Birmingham, in the West Midlands region of England and spanning an area of 86 km². In 2019, Sandwell was ranked 12th most deprived of England's 317 boroughs (Sandwell Metropolitan Borough Council, 2022). Sandwell is estimated to have a higher rate of people using opiates and/or crack cocaine (11.68 per 1000) than England (8.85 per 1000) and the West Midlands (9.61 per 1000) (NHS England, 2021). Local service provider data suggests in 2021, 48% of people who use opiates in Sandwell were not in treatment including substitution treatment or otherwise (Stevens et al., 2022). Analysis of service provider and local government data suggests that there are approximately 250 people who are experiencing homelessness or who are unstably housed who are likely to be injecting opiates (Stevens et al., 2022). In theory, this population would be the primary target population of any intervention like an OPC which sought to respond to overdose, mitigate drug administration harms and connect people with housing, treatment, and/or other desired services.

Despite the aforementioned rise in drug-related deaths in the UK, the British government has repeatedly refused to consider OPCs as a legitimate public health response. In the past two years, the Government has received numerous independent recommendations calling for the piloting of OPCs, including: the House of Commons Health and Social Care Committee on drug policy, the Advisory Council on the Misuse of Drugs, the Scottish Drug Deaths Taskforce, the Faculty of Public Health and the Drug Science Independent Working Group on Enhanced Harm Reduction (Holland et al., 2022). An unsanctioned site in Glasgow also provided evidence that it could save lives, respond to health care challenges, and prevent overdose deaths in a UK context (Shorter et al., 2022), without unintended consequences or harms. Although the Scottish Government bypassed Westminster, opening the UKs first sanctioned site in Glasgow in January 2025 (Glasgow City HSCP, 2024), plans to trial OPCs in other UK contexts were omitted from the recent 10-year drug strategy published by the Home Office (UK Government, 2021).

The project I worked on as a research assistant assessing the need and feasibility for an OPC in Sandwell was mixed-methods. There was an initial quantitative analysis conducted by Stevens et al (2022) which gathered baseline data related to the number of injection drug users, rates of drug treatment coverage, drug-related litter, drug-related crime, homelessness, drug-related hospitalizations and injury in Sandwell. This report determined that despite relatively low numbers of drug-related deaths in comparison to other areas of the UK, Sandwell would be an appropriate place to trial an OPC due to the high number of people using drugs in street-based settings who are not currently engaging with drug treatment services. The second part of the study was purely qualitative and is the basis of my first paper (Scher et al., 2025). On June 6th 2022, myself and other members of the research team presented the preliminary data at the

House of Commons at a parliamentary symposium titled '*Saving Lives – Piloting OPCs in the UK'* with an accompanying report (Southwell et al., 2022).

3.1.2. Vancouver, Canada

Vancouver's Downtown Eastside (DTES) neighbourhood is an area characterized by high levels of poverty, high prevalence of drug use, extensive social housing (Ivsins et al., 2022) and high levels of drug-related overdose (BC Coroners Service, 2024). The DTES is often referred to in urban the planning literature as 'Canada's poorest area code' (Linden et al., 2013) and over the past decade has become known as 'the epicentre of Canada's overdose crisis' (Perrin, 2020). In response, a number of novel overdose response measures have been first piloted and then permanently implemented in the DTES, in efforts to curb the ongoing overdose crisis. These include the implementation of community drug checking services (Long et al., 2020), take home naloxone programs (Burton et al., 2021), injectable and oral opioid agonist treatments (e.g., methadone, slow-release morphine, injectable hydromorphone) and safer supply programs (Ivsins et al., 2020; Ledlie et al., 2024; McNeil et al., 2022).

In 2003, the City of Vancouver introduced 'Insite', North America's first OPC (Young & Fairbairn, 2018). Since then, in line with a national drug strategy promoting a wider implementation of harm reduction interventions, the DTES has become home to nine OPCs of various sizes and models (integrated, stand-alone, and mobile) (Vancouver Coastal Health, 2025). As a result, the participants of my research who use these sites were able to provide valuable, post-implementation insights in a unique context where many different OPC options are available.

3.1.3. Athens, Greece

In the last decade, Athens has experienced the impacts of the 2010 financial crisis more severely than any other European city (Ifanti et al., 2013; Karanikolos et al., 2013; Vandoros et al., 2013). There has been a sharp increase in the number of people living in poverty which has correlated with a significant rise in urban homelessness (Arapoglou & Gounis, 2017) and rates of HIV amongst populations of people who use drugs (Sypsa et al., 2015). Athens continues to face challenges such as a new surge in HIV cases linked to difficulties delivering HIV prevention and broader harm reduction services during the COVID-19 pandemic (Roussos et al., 2023).

Within this context, in April 2022, 9 years after its initial closure, OKANA (Harm Reduction International, 2022), re-opened Athens' DCR; this time with full legal and financial backing from local and national authorities (Southwell et al., 2022). Taking into consideration the recommendations of drug user advocates (such as the European Network of People Who Use Drugs) and visits with European harm reduction partners, 'Steki 46' as it's known by locals, incorporates all of the desired elements of a holistic medical model enhanced harm reduction service: 1) geographically, it is conveniently located a few hundred meters from both the densely populated open-air drug scene and a nearby hospital for referrals, 2) the architectural design of the building is trauma-informed (promoting a sense of calm, safety, dignity, empowerment and well-being for all occupants) with an open-plan and a welcoming feel to it and 3) it offers community members who use drugs an array of auxiliary services all in one building (GP practice, counselling service, food bank, washing machines, showers, employment assistance and pro-bono legal clinic).

Despite the re-opening of this robust, medicalised DCR model, efforts to reduce the co-morbidities of structurally vulnerable people who use drugs have been hindered by a continuing lack of coverage of needle and syringe programs and a lack of urban social housing (Karamiditriou et al., 2021; Maloutas et al., 2020; Roussos et al., 2022). My DPhil study is the first qualitative evaluation of the newly opened OKANA DCR. Conducting an evaluation in such a rapidly developing context has allowed for real time policy recommendations regarding both the potential successes of the DCR as well as potential barriers to its uptake.

3.2. Rapid Ethnography

Although there is slight methodological variation due to logistical and contextual factors, each case study is defined as 'rapid-ethnographic'. Vindrola-Padros (2021) defines rapid ethnography in relation to the following characteristics: (1) the research must be carried out over a short, compressed or intensive period (approximately 90 days, however the ethnographic fieldwork component can be substantially shorter) of time; (2) the research captures relevant social, cultural and behavioural qualitative data and is focused on human experiences, perspectives and practices; (3) the research engages with anthropological and other social science theories promoting reflexivity and (4) data must be collected from multiple sources (various stakeholders implicated in the topic of focus), ideally uses multiple modes of data collection and is triangulated during analysis. The strengths of this approach lie in its ability to produce research with a "nuanced understanding of lived experiences while prioritizing efforts to rapidly inform interventions and decisions that address urgent health and social issues" (Collins et al., 2020, p.384). In each city, research was split into two phases and combined a number of exploratory qualitative approaches. Phase one comprised an in-depth content analysis, as appropriate, in each city of the following: (1) municipal, regional and national-level policy documents; (2) relevant legislation; and (3) literature pertaining to the political impetus behind the emergence of OPCs and harm reduction interventions more broadly. The second phase comprised a period of 1-3 months of ethnographic fieldwork at an OPC or harm reduction provider.

Within the context of North America's concurrent overdose crisis and COVID-19 pandemic, rapid ethnography emerged as a popular approach to research (Collins et al., 2020). Since 2018, nine studies, in Vancouver alone, have been published leveraging the utility of rapid-ethnography. Each study was either framed in the context of the COVID-19 pandemic, the overdose crisis or both simultaneously. Topics include: gendered-based violence in and around OPCs (Boyd et al., 2018), policing practices in relation to OPC clients (Collins et al., 2019), characterization of overdose incidents involving fentanyl (Mayer et al., 2018), housing provision during COVID-19 for OPC clients (Collins et al., 2019, 2020), the accessibility of drug checking services during COVID-19 for OPC clients (Bestos et al., 2021), OPC peer worker conditions during COVID-19 (Kennedy et al., 2019) and gender-based health disparities for women accessing an OPC during COVID-19 (Collins et al., 2022)

In the discussion section of these papers, authors highlight that the objective of their study was to explicitly make timely recommendations to policymakers and service providers. Collins et al (2019a, 2020b, 2022c, 2022d), Bestos et al (2021) and Kennedy et al (2019) also discuss how the rapid-ethnographic approach lends to the involvement of peer researchers. In each study, researchers conducted between 100h-225h of participant observation. This averages out to approximately 13 to 30 eight hour days of immersion within the field site. Taking on board these examples of best practice in rapid ethnography, the research design of my DPhil case studies each incorporate two to five weeks of fieldwork, employ multiple modes of data collection (street-based interviews, focus groups and one-on-one interviews) and engage multiple stakeholder groups: OPC client and staff.

In relation to the place-specific, population-specific questions I attempted to answer in each of my studies, there a several scholars who point towards the validity of such an approach. Whilst none of the papers in my thesis are explicitly comparative in nature, I do offer a brief comparative analysis in the discussion section of this thesis. Studying multiple case studies within the same broad body of work is also said to hold analytical strengths. Within the context of a DPhil, there may be logistical and methodological difficulties of conducting multi-site fieldwork-based research, in the past decade, the social sciences have seen an increase in the number of comparative ethnographic projects. Abramson and Gong (2020) specify that whereas ethnographies have traditionally been characterized by single-site analysis, a comparative approach:

> *"provides analytical possibilities that are challenging or impossible in traditional single-case studies—for instance, enrichening interpretation through contrast, aiding in causal inference, showing how different contexts shape ostensibly similar phenomena, or revealing similarities across seemingly different objects" (p.3)*

Flazon (2016) explains that through the maintained commitment to detailed observation, validity, reliability and generalizability are possible across policy contexts. Abramson and Gong (2020) agree that:

> *"participant observation actually provides an irreducible tool [for researchers] by allowing the observation of situated causal processes that other methods are ill-suited to capture" (p.19)*

Within the context of drug policy research, ethnographers have routinely sought to improve our understanding of processes, meaning and theory by going between two or more cases through deliberate, in-depth comparison. Alexander (2012) suggests that in seeking to understand how local manifestations of the globalised expansion of the 'War on Drugs' is experienced by different populations, the 'telling of stories' and 'showing of pervasive structures', renders comparative ethnography a valuable tool. Prominent examples include: Rodger (2011) who compares policing practices directed towards ibogaine users in West Africa and those in the US, Stack (2022) who compares the impacts of the 'War on Drugs' on a range of Mexican villages along drug trafficking routes, Canedo et al (2022) who examine the experiences of young people who use drugs in Vancouver and Lisbon, Hernandez et al (2022) who examine survival strategies for people who use drugs across three cities in Mexico, Argentina and Ecuador and Wallace et al (2019) who utilize a qualitative comparative approach to the study of three Vancouver-based OPCs. Using detailed contextual comparison, these authors successfully demonstrate how structural factors such as housing, poverty, access to health care and in particular localized drug policies, influenced by global processes, intersect to impact the lives of people who use drugs. By moving beyond the single-site micro lens, and with more depth than macro-level quantitative studies, the findings of these studies highlight the remarkable similarities in both lived experiences and policy processes. Many of these comparative studies conclude that resembling survival strategies, behaviours and expressions of meaning by participants across field sites demonstrates the deeply engrained nature of globalized political forces. Canedo et al (2022), Hernandez et al (2022) and Wallace et al (2019) explain that striking the balance between presenting detailed ethnographic data and providing adequate analysis is difficult within the confines of word limits, and that books would be better suited for these kinds of analyses.

3.3. Participatory Approaches

Although I had qualitative and ethnographic research experience prior to starting my DPhil, I was unaware of the term ‘participatory research’ or how the concept of ‘participation’ could be leveraged to increase the validity and ethical orientation of my research. I was first introduced to this approach when I joined the Sandwell project under the guidance of Dr Gillian Shorter. From the offset, this study included the views of people who use drugs in the research design and ethics application. Within days of officially joining the research team, I had my first experience of sitting-in on a community consultation and seeing first hand from experienced academics and community experts the value of orienting research processes towards the authentic needs of communities. Coincidentally, at the same time, my other supervisor Dr Benjamin Chrisinger was commissioned by the University of Oxford Social Science Division to conduct a rapid scoping review on best practices in participatory research; he subsequently brought me on board to assist (Scher et al., 2023). This combination of practical, hands-on experience in Sandwell, combined with my in-depth exposure to the academic literature on how best to implement this approach to research offered me the foundation to carry forward participatory approaches into the rest of my DPhil.

There is growing recognition that research can be strengthened through meaningful involvement of individuals with lived and living experience of the issues under study, whether through direct engagement in the various steps needed to start, complete and disseminate research, or directly in leadership roles (Marrone et al., 2022; Wallerstein et al., 2020). By fostering deeper collaboration with non-academic partners, researchers, academic institutions and funders can enhance the quality of research through processes, and ultimately findings, which are more closely attuned to the realities of the communities of focus. Such collaboration, however, requires careful attention to power dynamics and the redistribution, where possible, of decision-making authority between academic researchers and community stakeholders. As outlined in Scher et al (2023) there are multiple strategies to address the common ethical, logistical, and structural challenges that arise during such research (Brownson et al., 2018; Duea et al., 2022; Lenette et al., 2019).

In our review we found that definitions varied widely on the exact characteristics of participatory research. As such, in our paper we took a values-based approach and characterized participatory research as an approach to research which adheres to broad principles of respect, inclusivity, accessibility, reflexivity as well as the need to be ethically grounded throughout. Vaughn and Jacquez (2020) introduce the concept of "participation choice points" to highlight how decisions about engagement can be made and negotiated at each stage, ensuring transparency and a more equitable distribution of power in the research process. Their definition acknowledges that depending on the resources available, full community participation from the beginning to the end of a project will not be possible for everyone. As such, researchers, regardless of their methodological orientation, can incorporate participatory approaches to the various stages of their research process (for examples of quantitative projects leveraging participatory methods, see: Brown et al., 2017; Chambers, 2010; Mayoux & Chambers, 2005; Potter & Desai, 2006).

In each of my case studies, I attempted to incorporate some level of participation. As mentioned, in Sandwell, I joined a project which already had participatory elements strongly embedded at every stage. Whilst in the Vancouver case studies (papers 2 and 3), I was only able to incorporate a pre-data collection community consultation, and in my Athens case study (paper 4) incorporated a community consultation, peer research data facilitation and even peer researcher dissemination. These “participatory choice points” are discussed in depth in each of the papers.

Case Site	Community Consultation	Peer data Collection	Observational Community Ethnographic Field Sessions	Peer Data Coding	Peer Data Analysis	Peer Dissemination
Paper 1: Sandwell, UK	X	X	X	X	X	X
Paper 2: Vancouver, Canada (HOPS)	X					
Paper 3: Vancouver, Canada (Integrated-OPC)	X					
Paper 4: Athens, Greece	X	X	X	X	X	X

Figure 2: Table - Participatory approaches to DPhil thesis

3.4. Ethical Considerations

Questions related to informed consent and appropriate, ethical participant compensation are particularly important when conducting research with structurally vulnerable people who use drugs. Due to the centrality of these questions, scholars continue to debate a range of practical and ethical positions. In this section, I address a few of these positions as a means of contextualizing the ethical choices I made in each of my four empirical studies. Rooted in the values of autonomy and self-determination, it is an ethical and legal obligation for researchers to obtain informed consent from research participants (Miller & Boulton, 2007). In order for informed consent to be considered valid, it must comprise three elements: (1) relevant information must be provided outlining the details of involvement in the research (research aims, compensation, data protection, anonymity etc), (2) the participant must be competent to make decisions regarding their involvement and must fully understand the material information being presented to them and (3) the participant must be able to engage in the research in a voluntary manner as an autonomous moral agent (Appelbaum et al., 2010).

Within various social science and medical sub-fields, there is ongoing debate on whether people who use drugs can provide informed consent (McCall et al., 2020). At the minimum, people who use drugs are typically identified as a ‘vulnerable population’ requiring additional safeguards in the research process (Bell & Salmon, 2012). The impact of potential intoxication or withdrawals, during research participation (Aldridge & Charles, 2008), unintended coercion related to paying participants (Barratt et al., 2007) and an inability to determine their own self-interests due to existing structural vulnerabilities (mental health, social marginalization and criminalization) (Anderson & Dubois, 2007), have all been cited as reasons for omitting people who use drugs from research processes.

Contrarily, studies have contested these arguments for exclusion. Regarding people who use drugs' ability to give informed consent, Harrison et al. (1995) found that people who inject drugs' comprehension of the consent process was comparable to participants of the same study who did not inject drugs. Bell & Salmon's (2011) qualitative study found that women who use drugs rejected the notion that their capacity to provide informed consent was impaired and actively affirmed their capacity to provide consent. The authors suggested that the assumption that people who use drugs are unable to provide informed consent was "stereotypical, discriminatory and misunderstood the central features of addiction" (p.193). Secondly, regarding cash payment compensation for people who use drugs, research suggests that financial motivations are an important contributing factor in people who use drugs willingness to engage in research (Abadie et al., 2019; Bell & Salmon, 2011; Strickland & Stoops, 2015). I found this to be the case in Sandwell (Southwell et al., 2022) where participants explained how although the financial incentive of participation contributed to their initial willingness to engage with the research, as fieldwork progressed reasons for participation were multifaceted. These included increased social connection with fellow participants, a desire to influence the design of future services in their local area and an ambition to influence national level policy within the realm of harm reduction (Scher et al., 2025; Southwell et al., 2022). Today, although still controversial within certain sub-fields of drug policy and addiction research, broadly speaking, financial incentives for research engagement are viewed as "an ethical and respectful acknowledgement of their [people who use drugs'] time and expertise" (Bell & Salmon, 2011, p.194).

A growing number of publications (Askew et al., 2022; Brown et al., 2019; Greer et al., 2019; Salazar et al., 2021; Scher et al., 2023; Souleymanov et al., 2016; Souleymanov & Allman, 2016; and many more) as well as numerous civil society bodies (e.g., the European Network of People Who Use Drugs and the Canadian Coalition of People Who Use Drugs) assert that it is crucial that people who use drugs have equal access to participate in research and the process of evidence-making and that this right is balanced with well-placed concerns around potential harm. These bodies outline best practice ethical guidelines for acquiring informed consent, compensating participants and conducting ethical research with people who use drugs (Aldridge & Charles, 2008; Barratt et al., 2007; Souleymanov et al., 2016; VANDU, 2010). As such, I have followed this guidance and sought informed consent through varied and appropriate means in relation to the three qualitative modes of data collection being used in my research. Additionally, I offered same-day cash compensation for all participants and peer researchers within each case study. Questions of consent and compensation are additionally addressed in the methods sections of each of the papers in this thesis as well as my ethics application (see Appendix 7).

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4. Exploring the Need for Overdose Prevention Centres in England: A Qualitative Community-Based Participatory Study on the Perspectives of People Who Use Drugs in Public and Semi-Public Environments

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4.1. Abstract

Background

Overdose prevention centres (OPCs) have been implemented as a harm reduction response in 17 countries; with one just opened in the UK. Within a context of rising rates of drug-related death, this study aimed to assess the need for an OPC in Sandwell, England, by examining the experiences and perspectives of local people who use drugs.

Methods

Qualitative data were collected through three focus groups, 20 street-based interviews with people who use drugs, and observations from four ethnographic field sessions. This was a community-based participatory project and included community consultation during study design and peer researcher participation during data collection, analysis and dissemination.

Results

Findings evidence how the threat of public and police interaction in semi-public drug use spaces leads to rushed injection practice, hampers poor venous access management, and increases risk of injection-related harms. Participants were enthusiastic about the concept of an OPC and its potential to reduce injecting-related risks, drug-related death, provide safety, and prevent traumatic experiences with police. Participants also highlighted concerns about negative public perceptions of their community, viewing an OPC as a potential solution to improving community relations by reducing drug-related litter.

Conclusions

There is an urgent need for OPC implementation, given current risks from rushed injection practices, the lack of safe spaces, and the increasing presence of nitazenes and other unexpected contaminants in the UK drug supply. The assertion from local people who drugs that an OPC would be an appropriate and effective intervention requires prioritisation by policymakers.

4.2. Introduction

The UK is amid a public health crisis, marked by rising premature mortality among some of its most marginalised citizens – people who use drugs (Angus et al., 2023; Holland et al., 2022). In 2023, England and Wales recorded 5,448 drug-related deaths (approx. 9.3 per 100,000) (Office for National statistics, 2023). Similarly, in this period in Scotland, the number of recorded deaths reached 1,172 (approx. 19.3 per 100,000) (National Records of Scotland, 2024). These figures signify a drastic increase since 2007, with Scotland experiencing a 157% rise in drug-related fatalities, with an 106% increase in England and Wales during this period (Office for National Statistics, 2023). With the recent detection of new and highly potent synthetic opioids, nitazenes, within the UK drug supply, including in the West Midlands where this study was conducted, (Pucci et al., 2024), there is a concern that drug-related fatalities could increase in the coming years without increased investment in harm reduction interventions (Holland et al., 2024). Overdose risk is additionally exacerbated by socio-environmental factors such as homelessness (Doran et al., 2022; Yamamoto et al., 2019). In the UK, the most recent estimates suggest 354,000 people experienced homelessness in 2024, with numbers rising (Shelter, 2024).

Within the context of this rise in drug-related deaths, the UK Government has received several independent recommendations calling for the piloting of Overdose Prevention Centres (OPCs)[1] (Faculty of Public Health, 2022; Holland et al., 2022; House of Commons Home Affairs Committee, 2023). An unsanctioned site in Glasgow provided evidence that these facilities can be effectively implemented in the UK (Shorter et al., 2022). Despite these calls to action and increased government investment in the wider drug treatment sector (Stevens, 2022), plans to trial OPCs were not included in the UK governments' recent 10-year drug strategy (Home

Office, 2022). Scotland recently opened Glasgow's first legally sanctioned OPC (Glasgow City HCSP, 2024). Although in Glasgow policymakers have overcome political challenges regarding the establishment of an OPC, in the rest of the UK, their implementation continues to face opposition (Guise et al., 2023; Holland et al., 2022).

OPCs provide supervised, safe and sterile environments for people to consume illicit substances. Trained professionals are present to respond to overdoses and provide harm reduction advice. International evidence compiled in systematic and other reviews (Kennedy et al., 2017; Levengood et al., 2021; Shorter et al., 2023) suggests that by providing spaces of safety, trust, and social inclusion (Scher et al., 2024; Stevens et al., 2024) OPCs can reduce the harms associated with drug injection practice and help people to connect to health and social supports. Internationally, studies suggest OPCs reduce mortality and morbidity risks of people who use them, as well as demands on emergency medical services (Bouzanis et al., 2021; Levengood et al., 2021). By providing sterile injecting equipment and harm reduction advice, these sites promote safer injecting practice which reduces risk of HIV and hepatitis C transmission, also skin and soft tissue infections and associated sequelae (Doran et al., 2020; Fischer et al., 2019; Harris et al., 2020; Lalanne et al., 2024; Small et al., 2012). Notwithstanding variations in models and capacities of services, OPC implementation can be an appropriate and effective response in settings where people are at risk of overdose, injury and infection from the consumption of illicit substances, use drugs in isolation and/or do not have anywhere safe, secure, or sterile (Shorter et al., 2023).

The context of focus for this study is Sandwell, a town in the UK with a population of 341,900 (as of 2022) bordering the west of Birmingham, in the West Midlands region of England and spanning an area of 86 km. In 2019, Sandwell was ranked 12th most deprived of England's 317 boroughs (Sandwell Metropolitan Borough Council, 2022). Sandwell is estimated to have a higher rate of people using opiates and/or crack cocaine (11.68 per 1000) than England (8.85 per 1000) and the West Midlands (9.61 per 1000) (NHS England, 2021). Local service provider data suggests in 2021, 48% of people who use opiates in Sandwell were not in treatment including substitution treatment or otherwise (Stevens et al., 2022). Analysis of service provider and local government data suggests that there are approximately 250 people who are experiencing homelessness or who are unstably housed who are likely to be injecting opiates (Stevens et al., 2022). In theory, this population would be the primary target population of any intervention like an OPC which sought to respond to overdose, mitigate drug administration harms and connect people with housing, treatment, and/or other desired services.

The aim of this study was to capture the current lived experiences of people who use drugs in local street-based settings. Rhodes et al (2006) note that quantitative, epidemiological data often focuses on individual-level risk practices, such as needle and syringe sharing, and can overlook the way in which the physical, policy and social environment shapes vulnerability to risk and associated health harms. Ethnographic, qualitative methods which attend to the interplay of environment and risk are therefore, well placed to complement epidemiological data and inform effective community-responsive interventions.

Participatory methods of knowledge generation, including through *"representative participation*" (Gallegos et al., 2023) of the local community of focus, are recognised to enhance research relevance and applicability (Moore et al., 2019). Here the community affected by the issue or intervention of focus are central to the design and undertaking of the knowledge production surrounding it (Scher et al., 2023). While previous research has explored how people who use drugs in the UK navigate their drug use in the absence of safer drug consumption environments, (Hunt et al., 2007; Ng et al., 2004; Parkin, 2017; Parkin & Coomber, 2011a, 2011b), this has not focused on the need or applicability of OPCs within a localized UK context or incorporated community participatory methods in doing so.

Safer Environment Interventions and the Risk Environment

While definitional terms vary (e.g., overdose prevention centre, supervised consumption site, drug consumption room) across countries, legal, and drug policy contexts, spaces in which people can consume drugs with oversight can be characterized as 'safer environment interventions' (Ivsins et al., 2023; McNeil & Small, 2014; Rhodes et al., 2006; Yoon et al., 2023). Qualitative research highlights an interplay between three recognised environmental risks informing implementation: 1) injection urgency due to fear of interruption or apprehension when consuming drugs publicly, 2) challenge of finding private spaces in which to consume drugs, and 3) issues of hygiene and physical safety, often compromised by the conditions of the surrounding physical environment (i.e., unsanitary surfaces, absence of essential amenities like adequate lighting or clean water, debris, isolated environments increasing overdose risk). Fear of adverse contact and violence from the police and others in the environment is also reported as a common reason for people to use OPCs, where they exist (Stevens et al., 2024). In describing such settings, Parkin and Coomber (2009) demarcate between 'controlled' and 'uncontrolled' public consumption sites. Here, 'controlled' consumption sites are public places like toilets, car parks, parks, or stairwells commonly frequented by the public. These locations are either fully or partially monitored by staff, typically have electronic or manual surveillance and are regularly cleaned. They provide ways to discreetly use drugs in spaces which are much closer to where people may already be during their daily activities. In contrast, 'uncontrolled' consumption sites, offer less protection from environmental risk factors, police contact, and violence. They are often more secluded and less organized and structured. These sites include spaces such as abandoned buildings, alleyways or canal banks –producing significantly more risk with no one close by to respond or call emergency services in the case of an overdose.

Given this contextual, theoretical and empirical background, the primary research question of this study was: based on the lived experiences and perspectives of people who use drugs, is an OPC an appropriate and necessary intervention in Sandwell?

4.3. Methods

This article reports on qualitative data from the second part of a wider feasibility study investigating the potential applicability of an OPC in Sandwell. Part one comprised an initial quantitative assessment (Stevens et al., 2022) which gathered baseline metrics related to: 1) Injecting drug use, 2) Rates of homelessness, 3) Drug treatment coverage, 4) Drug-related deaths, 5) Drug-related litter, 6) Drug-related hospitalizations and non-fatal overdoses, 7) Blood-borne viruses (BBVs) and 8) Crime. This initial quantitative investigation highlighted that there was a substantial population of people who use drugs in Sandwell who are not currently in treatment and who are experiencing homelessness, it was deemed appropriate to follow-up with phase two of the study. This article represents part 2 of the feasibility study and looked to assess the current lived experiences of people who use drugs in Sandwell as a means of determining the potential need and applicability of an OPC. We applied a community-based participatory research (CBPR) approach, leveraging a variety of qualitative methods of data generation including focus groups, street-based interviews, rapid-ethnographic fieldnotes, and photo-ethnographic data collection. This research was funded by Drug Science, an independent scientific research, policy and advocacy organization in the UK. Co-authors AS, MH, MS, GWS and BDS are part of the Drug Science Enhanced Harm Reduction Working Group.

Community-Based Participatory Method (CBPM)

The experiential knowledge and perspectives of people who use drugs is essential to understand the realities of drug use (Boucher et al., 2017). Views of community interest holders are important and are reported elsewhere; (see Southwell et al., 2023), often, policies and interventions are conceived without meaningful inclusion of the voices and experiences of those most affected (Madden et al., 2021). The CBPM approach used in this study emphasizes meaningful involvement of community members throughout the research process (Israel et al., 2005). This involvement can manifest in various ways, such as through community review panels, advisory groups, or by employing community members as peer researchers within the research team (Damon et al., 2017). Particularly appropriate when conducting research with communities who have historically been marginalized from research processes, CBPM recognizes the increased richness of data, and broader impacts of research when collaborating meaningfully with communities with lived and living experience (Brush et al., 2020). Despite the evidence-base highlighting the benefits of this approach, drug policy activists have highlighted systemic power imbalances and issues to its use within drug policy research, offering several recommendations for such imbalances to be addressed and in particular for ways in which research can be led by people who use drugs (Simon et al., 2021).

Research Team and Partnerships

This study was conducted with two organizations comprising people who use drugs: Coact Technical Support Limited and the SCORE team (as seen in table 1). Coact is a peer-led technical support agency. All their technical consultants have dual expertise as people who use drugs and drug user organisers with a range of technical skillsets and professional backgrounds. The SCORE team (Sandwell Community Outreach Resources Education) are a group of people who currently use drugs, who were brought together and trained by Coact members in this research project. The founding group of 12 peers were recruited from the local community of people with opioid dependence to establish a peer-to-peer Naloxone programme. From this group, six people who inject drugs were recruited as peer guides to support the design and delivery of this study. For more information on the SCORE Team see Southwell et al (2022). This research was also conducted in partnership with Cranstoun, a charity which provides drug treatment and harm reduction services in Sandwell.

Recruitment and Sampling

Recruitment for focus groups was done through a combination of snowball and purposeful sampling (Naderifar et al., 2017). Within the Cranstoun drug service where harm reduction supplies are dispensed, staff discussed the scope of the project and focus group schedule with people who were eligible to participate. People who signed up to take part were encouraged to discuss the study with eligible members of their local peer network. Participants were eligible for the study if they were over 18 years old, had a history of injecting drug use locally, could provide informed consent, and have English language proficiency.

For the street-based interviews, participants were identified and approached by a peer-guide and MS at known local drug consumption environments. The project was verbally introduced by MS and a peer-guide and an information sheet was presented and discussed with the potential participant. After giving verbal consent, participants were interviewed by MS and BDS (and GWS on one occasion) in a range of locations in which public drug use occurred. To ensure privacy, all interviews were conducted away from others so the conversation could not be overheard. These included: pavements, parks, canal banks, abandoned residential buildings and churches and car parks. Eligibility for these interviews were the same as the focus groups, except participants also had to have a history of injecting in local public and or/semi-public environments.

Data Collection

Rapid-ethnographic data collection was conducted over four, three-day blocks totalling twelve days. Each block followed an identical format. Day 1 comprised a community clean-up session supported by the SCORE team in which fieldnotes and photo-ethnographic evidence were generated in relation to public and semi-public injecting environments and associated debris, and the SCORE teams' interactions with the public. Day 2 included focus groups at the Cranstoun facility with local people who use drugs and day 3 comprised rapid-ethnographic field sessions where the research team were led by peer guides into local street-based settings known to them as being public and semi-public drug consumption sites, to collect photo-ethnographic data and conduct rapid-ethnographic interviews. This facilitated triangulation of findings for a more complete qualitative research inquiry than one form of data collection alone (Malina et al., 2011).

Figure 3: Photo - SCORE members leading community clean-up of an abandoned building used as a consumption environment

Focus Groups

In total, 20 participants, (15 men and 5 women), attended one of three focus groups. Sessions ranged from 27 to 45 minutes and were located in the local Cranstoun building. The study was introduced by MS and then moderated by BDS. The focus group question guide was semi-structured and although each session varied based on the tempo, direction, and situational prompts of the group conversation, the pre-determined questions were aimed at 1) exploring current experiences of drug use (public or otherwise) (e.g., where do you currently consume drugs?, how would you describe these environments?, do you face any challenges in these environments?) and 2) exploring people's opinions on OPCs (e.g., have you ever heard of an OPC, if so how would describe it?, if one existed in your local community do you think you would use it, if so, why?; is there anything that would stop you from going to one?). Focus groups were audio recorded and subsequently transcribed for analysis.

Ethnographic Interviews and Photo-Ethnographic Data

We conducted 20 street-based interviews, of which 14 were with male participants and 6 with female participants. Interviews ranged from 4 to 22 minutes and were conducted during our ethnographic field sessions. These sessions were carried out in one of the four neighbourhoods identified as priority areas of Sandwell: Bearwood, West Brom, Cape Hill and Great Bridge. Priority areas were decided based on 1) areas of Sandwell with high recorded rates of drug-related litter and 2) input from the SCORE team with regards to known public and semi-public drug consumption settings and 3) insights from the Cranstoun outreach team on where they distribute harm reduction equipment.

Figure 4: Photo - GWS and BDS conducting rapid-ethnographic interview outside of a hostel where residents frequently inject in the bushes and alleyway

The primary aim here was to engage with people who may not wish to attend a treatment service building to take part in a focus group and to potentially obtain different responses from those who may not be interested in treatment services presently (Kaneva, 2024). Interviews were also semi-structured and contained the same question guide as that of the focus groups. Due to the time constraints of interviewing in public, less verbal prompts from the researcher were used although we noticed prompts related to the physical environmental generated different unprompted responses (i.e., people directly commenting on environmental factors or telling us stories of things that had occurred in that specific setting). Data from these interviews was generated through the form of handwritten notes and key quotes were recorded and read back to the participant to check for accuracy.

We also collected photo-ethnographic data of the public and semi-public drug consumption environments observed during the ethnographic fieldwork and community clean up sessions. Although most photos did not contain any peers or participants and focused solely on the environments themselves, in the few instances people were included, informed written consent was provided. To adhere to ethical standards of photo-ethnography, no identifiable features of study participants were captured within the drug consumption settings (i.e., faces were blurred out or backs turned to the camera) (Wright, 2018).

Compensation and Consent

Participants received £25 reimbursement to take part in a focus group and £10 to take part in a street-based interview. Focus groups were audio recorded, and participants gave written consent of their participation – recordings were then transcribed verbatim. Verbal consent is often preferred to written consent in street-based interviewing as the physical barrier of securing written consent can put off potential participants and undermine the research (King & Woodroffe, 2019). In line with best practice, individuals were fully briefed on the purpose of the conversation, asked their permission to take notes, received summaries back of the conversation to check accuracy, and any identifying details were removed from field notes. There were multiple points of verbal consent at the start of the conversation, through the explanation of the research, and at the end of the conversation.

Ethics

Cranstoun provided logistical support to form the SCORE team by 1) offering peer payments for the initial peer-naloxone program, 2) providing office space for the SCORE team to conduct meetings, 3) assigning a member of Cranstoun staff to support the administrative elements of the group and 4) advertised the formation of the group to their clients who accessed harm reduction supplies. They provided a space for us to conduct focus groups and a member of staff to facilitate the community clean up sessions. Cranstoun staff were not present during the street-based interviews or focus groups.

Ethical approval for was granted by Queen’s University Belfast Faculty of Engineering and Physical Sciences Ethics Committee on 11/02/2022 reference EPS 21_319. To ensure the confidentiality and anonymity of participants, identifying details were removed from individual quotations.

Data Analysis

The scope of the research focused specifically on the lived experience of people who use drugs in public or semi-public settings, centring relevant social, cultural, and behavioural data. Data analysis applied the Braun and Clarke (2006) six stage thematic analysis, commencing with a process of familiarization with the data, whereby BDS, GWS and MS read transcripts and fieldnotes, wrote analytic memos, and collectively developed a thematic codebook to work systematically through the data, identifying relevant and meaningful information related to our research questions, as well as novel concepts inductively. As part of this process, BDS and MS ran a participatory coding session, discussing the transcripts, initial codes and themes with the SCORE team who refined, synthesized, and challenged the initial coding process. This session produced new observations and highlighted additional topics of focus. As an example, the SCORE team requested that more emphasis was put on the experiences of having to rush the injection process and the specific practices adopted to avoid environments and situations in which this may occur. Following this participatory coding session, BDS, GWS, and MS re-examined transcripts and refined the analysis until all the data were systematically organized using the final coding framework (Braun & Clarke, 2021).

4.4. Results

We present our results under two overarching themes 1) risk dynamics in current drug consumption environments and 2) perspectives on OPCs, each with sub-themes relating to the relationship between participants' experiences, the contextual and environmental settings in which they occur, and how these factors shape participants’ views on a potential local OPC.

Theme 1: Risk Dynamics in Current Drug Consumption Environments

Through this theme, we describe an understanding of the nuanced relationship between multiple risk dynamics where drugs are consumed. This focus highlights how these environments are shaped by wider forces that produce structural vulnerability, as suggested by Rhodes et al. (2012). Importantly, participants outlined how an OPC could have a direct positive impact on the harm described within each of the sub-themes.

Subtheme 1: Consumption spaces of privacy, convenience, and necessity

From the offset, we were interested in better understanding if and where public and semi-public drug use was taking place. These accounts offer insight into the diverse spaces used to consume drugs in Sandwell, and why some of these public and semi-public, 'controlled' and 'uncontrolled' spaces were used. The SCORE team guided us through this investigation, taking us to meet people who used drugs in locations often unknown to local drug treatment and social services. One participant spoke of how it was hard to know how many individuals there were as people chose locations which were hidden from public view, often in an uncontrolled way:

> *"It's not visible, its car parks, bin sheds, anywhere out of the way. It's hard to estimate numbers because it is so hidden." (Street-Based Interview 12, Male)*

Figure 5: Photo - Residential building bin-shed used as a consumption environment

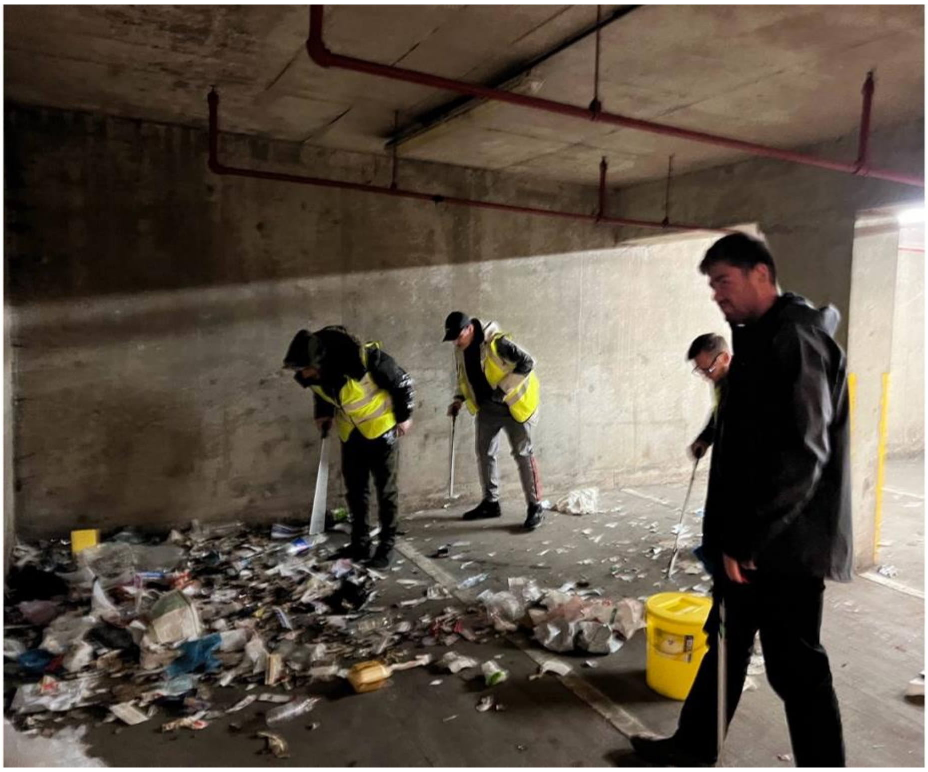

Figure 6: Photo - SCORE team and BDS clearing Sandwell city centre car park used as a consumption environment

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Participants emphasized their desire for privacy as a primary motivator for seeking isolated locations. This presents challenges for local drug services in relation to reaching individuals who may be at risk of experiencing an overdose. Participants, particularly those experiencing homelessness, spoke often about the constant search for privacy:

> *"Someplace like an old factory where people aren't working and it's empty…like sheds, just where it's empty and people don't go…parks as well." (Focus-Group Participant 19, Male)*

While chosen locations were often isolated to ensure privacy, we encountered individuals who also reported convenience as an important factor when selecting drug consumption locations. Participants who either lived or generated their income in public or street-based settings, would consume drugs close to the location that they acquired them. Ideal drug consumption locations were sought which were hygienic and warm such as toilets in coffee shops and fast-food chains, with lockable doors. But even these were not always accessible:

> *"Somewhere to go, clean, safe, now we really struggle. We have to score [acquiring drugs] which is easy, the hard bit is finding somewhere to go…I use mainly in the McDonalds toilets." (Street-Based Interview 16, Male)*

In other situations, however, drug consumption locations were used more out of necessity than choice, in an urgent need to ease or prevent drug withdrawals and where the semi-public environments described above were not available:

> *"I went in the bushes this morning. Because I had nowhere to go. It's one of them. When you're rattling [experiencing withdrawal symptoms] that bad, you will go wherever you got to go." (Focus-Group Participant 4, Female)*

Figure 7: Photo - Visible needle litter on footpath along the canal bank

Figure 8: Photo - Bushes used as consumption environment in a children's playground

Subtheme 2: Urgency and Venous access

Although the drug consumption environments we were taken to and told about were either very isolated or in settings where participants could find privacy by locking themselves away, it was apparent that this was not always the case. Contrasting his home environment to a highly exposed 'uncontrolled' semi-public environment, this participant described the anxiety that results from the constant threat of public exposure:

> *"Obviously, when you're home, you're more comfortable…you can take your time, you're more comfortable in your space…But when you're out, let's say in a bush…you've got no thoughts in your head and you're rushing. Is anybody looking? Is anybody coming past? You just try to get [inject] yourself very quickly." (Focus-Group Participant 3, Male)*

While this participant's experience of drug use is influenced by his social environment and in particular rushed administration due to the threat of being seen, many participants discussed the desperation of an interplay between needing to rush and being prevented from doing so effectively due to poor venous access:

> *"It normally takes me up to 30 mins to find a vein and it is the feeling of being rushed which makes you fuck up a hit." (Street-Based Interview 5, Female)*

Participant accounts illustrated the benefits of being able to prepare and use drugs in a home, or an environment in which they felt safe, such as the ability to change needles and take time in drug administration without the fear of being disturbed. For many, feeling a need to rush exacerbated issues relating to poor vein health:

> *"You know when you've got to change the needles that many times and you're rattling for that long...I'm losing more [of the drug] than I'm getting. Especially when people walk past and you've got to stop and take the needle out and do this and do that. You haven't got time to do that. But when you're in a room or at home you can take as much time as you want. Change as many needles as you want" (Focus-Group Participant 4, Female)*

Once again, this participant's experience of poor venous access, heightened by the need to rush within the environments in which drug consumption currently takes place, illustrates how tangible physical harms within these environments are produced:

> *"I've got about 17 abscesses all over my legs and lumps all over my legs and that's through like not having the pins, using the same pins and rushing to try and get it you know. My whole legs are just full of bumps and full of red marks." (Focus-Group Participant 6, Female).*

Descriptions of being rushed and experiencing a sense of urgency within the consumption process were widespread. Participants linked the presence of a 'room', 'home' or OPC, as a legitimate safeguard to the tangible physical and psychological health impacts of these experiences:

> *"Well, I wouldn't have to worry about people looking at what I'm doing [if I had access to an OPC} ...You're always constantly worrying when you do it on the streets. Who is walking past? Are there any cars that can see me? How many needles do I have to use? When you're in either a consumption room [OPC] or at home, you can take all the time in the world you can use all the needles, right? You haven't got to waste it [the drug]. I had to squirt mine away this morning because I've seen people and I've seen a baby. I've seen the child look at me…so I knew I had to stop. I couldn't do it after that. It was gone." (Focus-Group Participant 4, Female)*

Emphasizing the multiple impacts of a lack of privacy, this participant highlights both the desire for an OPC in Sandwell but also the multiple ways in which an OPC would support their health and well-being as well as diminish the visibility of public drug use. She expresses concerns about being observed and rushed while using drugs in public, again emphasizing the importance of privacy and the ability to take time for a safer consumption process. As noted above, the reference to using multiple needles reflects the interplay between poor veinous access, injecting urgency and health harms experienced by many people who inject drugs in the UK (Harris & Rhodes, 2011), particularly those who are unstably housed.

Subtheme 3: Safety and Experiences with Police

Police intervention was frequently mentioned by participants as a threat to their safety. The involvement of police in prohibiting or facilitating the acceptability of an OPC was commonly raised by participants as a concern:

> *"But then you get stopped by the police and you say, oh, hang on a minute. I'm trying to get to this drug consumption room, what would happen?" (Focus-Group Participant 2, Male)*

These concerns were expressed both in relation to getting to the site in the possession of drugs but also when leaving, given a vulnerability to attention and/or arrest after attending a service in which drugs are known to be consumed:

> *"Would the drugs be taken off ya? Would you be nicked [arrested]? How would you leave? How would you even go about doing it?" (Focus-Group Participant 4, Female)*

As we explored these anxieties deeper, participants' perceptions of the way police would react and implement policies around an OPC were a direct result of their lived experience with local police in Sandwell. Many described hostile interactions with police:

> *"Police can be horrible, especially when they catch you using, I was withdrawing bad and the police took the pin, kicked it straight out of my*

> *hand. They squirted it straight out too…they don't help me they just fuck with me." (Street-Based Interview 16, Male)*

This participant describes his perception and experience of law enforcement as not just unsupportive but as a continual threat. The violence of having a syringe kicked out of their hand and the contents emptied in the context of extreme withdrawal can leave a profound and enduring scar among people navigating already challenging circumstances. Experiences of policing as exacerbating the daily struggles of existence on the street, including the ability to generate income were common, as related by another participant: "*Police treat us bad enough as it is with begging…it surprises me how blind the police are to our problems here." (Street-Based Interview 4, Male)*. We experienced these dynamics also during ethnographic observations. During an interview on the main high street in the Bearwood neighbourhood, a police van pulled up next to us. The officers did not interact with us or get out of their vehicle, but both stared over intently for approximately five to ten seconds before driving off. Immediately the participants tone changed: *"See how they are fucking staring at us here, the Old Bill [English slang for police], it's ridiculous." (Street-Based Interview 8, Male).*

Despite these negative experiences and concerns about an OPC potentially increasing vulnerability to arrest both before and after attending, after, most participants then reflected on the benefits of an OPC in shielding people from the police gaze during the act of injecting, in which they were the most vulnerable to threat and associated health harms:

> "*People would feel so much safer with no hassle [from police]. I see people injecting with pins [needles] in their arm looking around, ready to run off with the pin in their arm they're so scared" (Street-Based Interview 12, Male).*

Evident in the quote above and others noted, is the way in which policing was experienced as exacerbating injecting risks and associated health harms. In framing an OPC as a site of refuge from the police (e.g., *"a drug consumption room would keep us safe from police" Street-Based Interview 2, Male)* the violence of policing was positioned by some as an even greater threat to the self than that of an opioid overdose: *"People won't go in [to an OPC] to be safe from overdose but actually safe from police" (Street-Based Interview 13, Female).*

Theme 2: Perspectives on OPCs

Participant accounts illustrated the personal impacts of drug-related death in Sandwell. OPCs were perceived as a tangible and effective response to reduce fatal overdoses in Sandwell, welcomed by participants. Broader impacts of OPCs were also mentioned, including in relation to reduction of drug related litter, indicating the potential for an OPC to mediate public perceptions of people who use drugs in Sandwell and reduce associated stigma.

Despite the relatively low rates of drug-related death noted in the quantitative feasibility assessment (Stevens et al., 2022), it became evident that study participants shared personal experiences of losing friends and loved ones in this way. During the participatory coding, these narratives were identified by the SCORE team as significant, underscoring the deep-rooted, and longer-term impact on people. During discussions on the political justification for OPCs, SCORE members expressed frustration that the life-saving potential of OPCs alone was not considered sufficient to justify their implementation. The community trauma of drug-related deaths and how this is compounded by perceptions of political disregard highlights an urgent need for interventions that effectively address and mitigate this loss of life:

> *"I've seen too many people die on the street... I've lost two of my friends, no I tell a lie, three of heroin overdoses... It [an OPC] is a really good idea, and I'd use it myself, I really would." (Focus-Group Participant 4, Female)*

Personal experiences deeply shaped this participants' perspective on the need for OPCs. Witnessing multiple deaths on the street instilled in her a sense of urgency to prevent further loss of life and a desire to enact personal safety strategies. With a current lack of services providing immediate assistance through the supervision of overdose situations, some participants discussed previous instances in which they felt helpless in trying to respond to themselves:

> *"When someone overdoses, then there would be someone there to help... I've done it where the guy has overdosed and I didn't know what to do...I was high myself at the time and I just didn't know what to do." (Focus-Group Participant 12, Male)*

This account exposes the disheartening reality faced by individuals who encounter overdoses without access to appropriate assistance. This also highlights the importance of a range of naloxone distribution mechanisms including peer-led naloxone programs to reach individuals. The participants vulnerability and sense of helplessness in the face of a life-threatening situation again underscores the vital need for an intervention which could provide prompt medical support but also alleviate the burden and panic experienced by individuals witnessing overdoses. Finally, when discussing the way in which an OPC could be evaluated moving forward, overdose prevention was often highlighted as the primary goal: "*The main one is the number of deaths we're keeping down*." (Focus-Group Participant 5, Male). This statement reflects a broader understanding among people who use drugs of the positive impact these centers can have on rates of drug-related death, even where such deaths are less common in other parts of the region or nation. Such experiences, and so the desire to use OPCs, would likely be higher in areas with even higher rates of drug-related death, such as Blackpool, and several other towns in the north of England, south Wales, and the deindustrialized cities of Scotland.

Participants also noted that discarded injecting equipment was an issue in their local area, demonstrating through expressions of responsibility how an OPC could enhance public safety, through providing a site for safe use and disposal of needles and syringes:

> *"Members of the public, kids going to school comes past dirty needles, I've heard mum's mention it to people, you know, it's disgusting mate, at least with one of these rooms [OPC], you've got everything and you can just throw it away safely." (Focus-Group Participant 7, Male)*

Repeated accounts in which used needles in public spaces were framed as posing risks to members of the public, particularly children, indicated a desire not only to reduce public risk, but to redeem perceptions of their community as 'irresponsible' and mitigate associated stigma. An OPC was seen to facilitate these aims: *"It would make things cleaner, no more pins [needles] in bushes and under bridges and kids' play areas". (Street-Based Interview 20, Female)*

Overall, these testimonies demonstrate participants' perception that the implementation of an OPC in the local area could promote cleaner and more inviting community spaces. By fostering a sense of wellbeing for all community members, there is an implicit hope that stigma towards people in their communities of drug use would also reduce. By facilitating this and enacting a safe space from policing and associated health harms, OPCs were perceived as acceptable and welcome to people who used drugs in semi/public spaces. Despite framing the threat of policing as, at times, more of a concern than that of overdose, the potential for an OPC to save lives cannot be overstated, given the collective trauma held among participants experiencing drug-related deaths in their community and the feeling of abandon when no solutions are seen to be forthcoming.

4.5. Discussion

Latest data in the UK show the highest rates of drug related death ever recorded (Office for National Statistics, 2023). The concerns around drug related death figures are echoed globally (HRI, 2024). This study highlights how the increased toxicity of both Sandwell (Pucci et al., 2024) and the wider UK illicit drug supply (Holland et al., 2024) and individual level practice do not act alone to produce harm (Tyndell & Dodd, 2020), but intertwine with the broader physical and policy environment to increase risk. Narratives of participants relating drug use in isolated (eg., abandoned building) and/or inaccessible (e.g., a locked toilet stall) environments illustrate the way in which overdose risk is incorporated into the fabric of daily lives. This may also place individuals who use drugs in more conflict, this time with community members such as businesses, transport operators, and cafes/restaurants. In more visible public and semi-public settings, feeling rushed by the potential threat of police apprehension and public interaction, severely impacted peoples' ability to manage poor venous access during the consumption process. This not only exacerbated people's anxiety and stress within these settings but also shaped drug-related injuries, including infections and abscess. As a means of mitigating these environmental factors, an OPC was perceived by participants to be a welcome and acceptable intervention. Accounts of concern about 'drug related litter' illustrated how an OPC could offer a potential respite from public stigma through the reduction of discarded injecting equipment. Importantly, an OPC was framed as a potential haven from the violence of street policing, and a way in which community lives might be saved and community trauma honored, if not reduced.

Drawing on the work of Parkin & Coomber (2008), we categorized the identified hidden consumption environments in Sandwell as 'controlled' and 'uncontrolled'. The abandoned buildings, factories, secluded canal banks and other concealed urban spaces we were shown were characteristic of 'uncontrolled' spaces. 'Controlled' locations such as supermarket toilets and parks, were described both in relation to the situational necessity as well as the convenience they offered, including momentary privacy from the public or police. A distinct differentiation between these two environmental categories, included that 'uncontrolled' settings contained a multitude of environmental risks outside of the control of the individual. As highlighted in the existing literature on public drug use (Briggs et al., 2009; Collins et al., 2019; Malins et al., 2006; Small et al., 2007), due to the lack of supervision, these 'uncontrolled' environments offer minimal safety mechanisms in the event of an overdose. Concealed from public view, in such locations it is improbable that passers-by would be aware of an overdose event. Despite 'controlled' environments offering benefits such as a privacy through a lockable door and potentially increased hygiene, in both types of settings, people who use drugs gain no respite from the structural vulnerability that they experience (i.e., reduction in potential threat of police apprehension, overdose or health risks from current consumption environments). Such risks would be reduced through the provision of an OPC.

Our examination of current consumption environments in Sandwell highlights the interplay between *"situational necessities"* (Rhodes et al. 2007, p. 276) and the socio-physical risk environment of people who use drugs. The decision to use drugs in less secure settings (such as the participant who described being seen by a mother and children whilst using in a publicly exposed bush) reflects immediate pressures and environmental constraints (Harris et al., 2020). Use in this way is dictated by the absence of safer alternatives, and motivated by the need to address the immediate risk of physical and psychological distress of opioid withdrawal (Harris et al., 2022). With limited physical opportunity for alternate spaces, individuals describe concern about their use in public spaces and the impact, but factors of opportunity, immediacy, and craving drive their behaviour (Rhodes et al., 2007; Shorter, 2023).

Poor vein health and related health complications are reported globally amongst people who inject drugs (Harris & Rhodes, 2011; Jain et al., 2021). In Sandwell, poor venous access was a central issue that was repeatedly emphasised alongside the challenges of injecting in public or semi-public spaces. Within these discussions the broader environment (e.g., feeling rushed due to the threat of police or public apprehension) was described as impacting their ability to manage veinous access. An OPC would provide a context in which such health complications could be better managed through technological intervention (vein scanners), advice from trained harm reduction practitioners, and through providing the time and space to prepare and consume drugs in a calm and secure environment (Stoltz et al., 2007).

Fear of law enforcement is a barrier to the implementation of safe injecting practices within public and semi-public settings, and potentially for the operation of an OPC if it were available. While individual officers hold potential to act as supportive agents for people experiencing social marginalization in such environments (Ryland & Scher 2024), the default heuristic was that police were a threat to people using drugs and a reason for seeking out isolated and risky locations. Undoubtedly, fear of consequences drives risky behavior, such that the personal risks are weighted to avoid policing at the expense of health (Miller et al., 2023; Shorter, 2023). If an OPC were to be implemented in Sandwell, it would be important to note the fear and anxiety caused by actual or feared interactions with the police. The statements from participants suggest that even the mere presence of the police in the vicinity of an OPC and/or involvement in its set up could be enough to dissuade people from accessing a service. Again, as echoed by others, this speaks to the importance of involving whole communities in opening an OPC including those who do and do not use drugs to encourage their use (Shorter et al., 2023).

Reviews of global literature show OPCs can be effective in engaging already marginalised and structurally vulnerable people who use drugs with auxiliary health, housing and drug treatment services (Bardwell et al., 2019; Luchenski et al., 2018; Marshall et al., 2011; Shorter et al., 2023). Previous quantitative research from Sandwell suggests that there are approximately 250 people who are experiencing homelessness and a significant population of people who inject drugs who are not engaged in treatment and are particularly vulnerable to overdose (Stevens et al., 2022). This study complements these findings by highlighting both the public and semi-public environments in which drugs use is occurring but also participant perspectives that a well-designed OPC may help alleviate some of the harms perpetuated within these environments. Systematic reviews on OPCs suggest that a primary reason people who use drugs are so willing to use them is their ability to offer spaces of respite from the types of environments described in this paper (McNeil & Small, 2014; Stevens et al., 2024., Yoon et al., 2022).

Whether it is a medicalized, peer-led, mobile, or integrated OPC, there exists a range of models for a potential service (Shorter et al., 2023). Each of these models have characteristics need to be carefully matched to a specific geographical and contextual setting. The aim of this paper was not to argue or suggest which model would be appropriate for Sandwell, the findings of this study suggest there is a need for a safer environment intervention. Drug-related death was perceived by participants as something crucial that an OPC could impact upon; as part of a suite of other harm reduction initiatives (Dyer et al., under review). While harm reduction initiatives such as peer-to-peer naloxone programs can reduce overdose risk, and are crucial in contexts of toxic drug supply, there is a clear need for an intervention which will offer an alternative consumption environment to the ones people are currently exposed to and safeguarded against overdose within the community.

4.6. Limitations

While the collaboration with Cranstoun facilitated various logistical aspects of the research, the involvement of their clients in the research could create an environment that might influence participation and responses. Specifically, participants may feel pressured to provide responses that align with the perceived expectations of the organization or their involvement in the study, particularly as peer researchers and in the context of the focus groups could change what was revealed in the group. Additionally, individuals who are hesitant or unwilling to engage with Cranstoun may have been less likely to participate or come forward as peer researchers or participants limiting the diversity of our study sample. In conducting street-based ethnographic data collection, we hoped to reduce this influence and speak to as many community members as we could who were not engaged with drug treatment or harm reduction services at present. Future research however could consider alternative recruitment strategies to facilitate broader and more inclusive engagement with people who use drugs.

4.7. Conclusion

The aim of this study was to address the question of whether an OPC is an appropriate, and necessary intervention in Sandwell, as perceived by individuals who might benefit from such a service. The narratives provided by participants highlight structural risk dynamics that shape experiences and harms in current controlled and uncontrolled, public and semi-public drug consumption environments. These were being sought out for reasons including convenience, urgency, and necessity and fell short of an ideal environment. Harms including poor vein health and other issues were increased by rushed injections due to the threat, privacy, and concerns about negative experiences of interactions with police and the public. Police interference was a particular concern for participants, including fears about how they were currently treated by police, and how they might be treated if there were an OPC. In addition to shifting the environment in which people currently consume drugs, participants believed an OPC could have a positive impact on reducing rates of drug-related death and wider harm. Additionally, participants believed an OPC would facilitate a reduction in drug-related litter which they would hope could improve community relations. Descriptions of harms caused within such environments urgently emphasise the need for safe, sterile, and supportive private spaces for people in Sandwell and similar places – which could be provided by an OPC (alongside other harm reduction interventions). We therefore conclude that descriptions of current drug consumption environments and the lived experiences of people who use drugs within them, should be strongly considered by policymakers and other interest holders when deciding on the implementation of OPCs in the UK.

4.8. References

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5. Resident and Staff Experiences of Structural Barriers to a Housing-Based Overdose Prevention Site in Vancouver, Canada: “There is a double standard if you smoke”

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5.1. Abstract

Background

Most overdoses in British Columbia (BC), Canada, occur within housing settings. In response, the provincial government is increasingly implementing housing-based overdose prevention sites (HOPS). Within the context of a contaminated drug supply, and changing consumption practices, there is little research examining the effectiveness of HOPS. The aim of this study was to explore qualitatively how residents and staff experience HOPS, focusing on how this intervention fits into the day-to-day operations of a low-barrier housing facility.

Methods

This study was undertaken at a non-profit housing and emergency shelter facility, with a HOPS in Vancouver, BC. We employed rapid-ethnographic methods including six weeks of non-participant observation (»200 hours), three focus groups, 20 informal interviews with residents, and 10 semi-structured interviews with staff. Data was analysed in an inductive thematic approach.

Results

Our results suggest that facilities' HOPS is underutilized because of a variety of structural factors, the most prominent of these being the lack of inhalation services. This lack of service provision exacerbates overdose vulnerability and stigma. Continued drug consumption near the building and in non-monitored areas inside the building creates challenges for staff in identifying potential overdoses and exposes residents who do not consume drugs to drug use within the building.

Conclusion

Housing provision which provides a safer consumption environment to include those who smoke drugs is urgently needed to support both individuals who smoke and those looking to transition from injecting to smoking.

5.2. Introduction

Canada continues to face an unyielding overdose crisis. There have been 47,162 apparent opioid toxicity deaths reported between January 2016-March 2024 and drug deaths have now surpassed all other forms of accidental death combined (Public Health Agency of Canada, 2024). This overdose crisis has largely been driven by a shift in the drug supply, marked by the proliferation of synthetic opioids such as fentanyls, and many other synthetic analogues at unexpected strengths (Pardo, 2021).

On April 14th, 2016, British Columbia (BC) declared a public health emergency. To better respond to rapidly escalating numbers of drug-related deaths, this declaration provided the legislative and financial support required to expand the delivery of harm reduction interventions (Fischer et al., 2019). Although primarily implemented in Vancouver, such interventions include safe supply programs, opioid agonist treatment (OAT), expanded naloxone distribution policies and programs, drug checking services, and various models of overdose prevention sites including housing-based overdose prevention sites (HOPS) (Strike & Watson, 2019). Although Canadian service coverage remains limited (they exist predominantly in BC), HOPS are designated spaces within housing facilities where residents' drug use (typically limited to injecting and snorting) is supervised by either peers or other members of staff who can respond in an overdose event (Bardwell et al., 2017).

Despite these innovations, BC remains the Canadian province most severely affected by drug-related deaths. In 2023, BC recorded 2,511 drug-related deaths, the largest number on record (BC Coroners Service, 2024). Fentanyl was detected in 85% of these deaths with most occurring when people smoked their drugs (71%), followed by nasal insufflation (15%), injection (12%) and oral consumption (6%) (BC Coroners Service, 2024). Over time, methods of drug consumption and the mode of consumption associated with overdose has shifted. Before 2016, most drug-related deaths in BC resulted from injection (Parent et al., 2021). Qualitative studies have revealed that peoples' motivation for switching from injecting to smoking (primarily fentanyl) includes difficulties accessing veins, a desire to reduce the risks associated with injecting, fewer financial constraints, reduced stigma, increased pleasure, and more perceived control over the intensity of effect (Harris et al., 2020; Kral et al., 2021; Pijl et al., 2023).

Evidence both globally and BC specific highlights the structural and environmental links between housing and overdose risk (Bardwell et al., 2019; Collins et al., 2020; Ivsins et al., 2022; Milaney et al., 2021; Norton et al., 2022). A primary risk factor is people using alone in their rooms. This behavior is driven by several contextual and structural barriers including a desire for privacy, a perceived safer alternative to other available consumption environments, and exclusion from available supervised consumption environments (Fleming et al., 2024a, 2024b; Papamihali et al., 2020; Winiker et al., 2020). So far in 2024, 83% of drug deaths in BC have occurred inside (48% in private residences and 35% in other residences including social and supportive housing, single room occupancies, shelters, hotels and other indoor locations) and 16% occurred elsewhere (e.g., vehicles, sidewalks, streets, parks etc.) (BC Coroners Service, 2024). In response, a growing number of housing facilities for people who use drugs have integrated housing-based overdose prevention sites (HOPS).

A growing body of public health research has examined housing interventions which reduce overdose vulnerability (Bardwell et al., 2019; Collins et al., 2020; Fleming et al., 2024a, 2024b;

Ivsins et al., 2022; Milaney et al., 2021; Wallace et al., 2018). Despite this, no research has focused explicitly on HOPS in facilities housing residents who use drugs and residents who do not, or on the perspectives of staff within these facilities. Our study sought to respond to this research gap by studying a mixed housing setting and incorporating the views of staff to get a holistic understanding of the operational context of HOPS and their host housing facilities.

5.3. Methods

Study Setting

The setting for this study was a housing facility with a HOPS in Vancouver, BC, outside of the Downtown Eastside. This housing facility incorporated three separate resident programs. The first was an emergency shelter program, with people living in shared dorms in the basement. The second was a temporary accommodation program where residents room on the ground and first floor for up to three months. Finally, the third program on floors 2-4 was for long-term tenants who had provincial social housing. All residents, regardless of which program they were a part of, were assigned case workers to help resolve their housing insecurity and support them in accessing other health, social and legal services (e.g. employment assistance, primary care, mental health support, drug treatment, applying for ID or social welfare assistance). All services were provided on-site or through referral to services in the local neighborhood. Meals, laundry, medication dispensing, storage, and a common room with a tv, video games and computers were available on-site. All residents could access harm reduction supplies from the front desk, as well as the HOPS next to the front desk which has been in operation since November 2018.

HOPS vary in design and operational context (e.g., staff or peer monitored, self-initiated monitoring, virtual monitoring with cameras) (Collins et al., 2020). Here, when we refer to HOPS, we mean a designated monitored space, accessible to all residents for injecting or snorting drugs. This specific HOPS was a small room connected by two doors, one to the reception for staff access, and one leading to the common room for residents. Residents needed to check in with staff and disclose what they intended to consume before they could enter. The staff entrance door had a window allowing staff to check on residents. Staff set a re-occurring 2-minute timed alarm at their desk once someone had entered as a reminder to conduct a check. The room comprised a stainless-steel desk with a mirror in front. Around the walls were colorful shelves with harm reduction supplies, pieces of artwork and posters with harm reduction advice. Only one person could use the room at a time and there was no time limit for use. Staff encouraged residents to relax in the common room post consumption as a monitoring strategy. Naloxone and oxygen were available to respond to an overdose.

Data Generation

Between March and April 2023, we conducted 6 weeks of rapid ethnography, a conceptual and methodological approach which allows for the generation of quick, in-depth insights and timely recommendations regarding policy and practice based on lived experience (Vindrola-Padros, 2021). Given the relatively short timeframe of fieldwork, qualitative methods were employed with the specific aim of rapidly, yet accurately, capturing and describing how the HOPS and wider operational policies of the facility were perceived and experienced by residents and staff. This was a pragmatic approach to evaluate the key features of the service (Vindrola-Padros & Vindrola-Padros, 2017) and the strengths and weaknesses of the current delivery. Methods of data collection included: 1) non-participant observation, 2) a community consultation, 3) focus groups with residents, 4) ethnographic interviews with residents, and 5) semi-structured interviews with staff (including, reception staff, caseworkers and management).

Non-Participant Observation

Lead author (BDS) completed approximately 200 hours of non-participant observation where between 9am-5pm on weekdays, he shadowed staff during intakes and case planning sessions, spent time with residents during mealtimes and in the common room. Although he could not be in the HOPS with clients, he spoke with them before and after they used the room. This initial period enabled him to build rapport with residents and staff prior to the focus groups and interviews. It was not possible to get consent from every person present during the non-participant observation period, therefore, fieldnotes collected were generalized and did not refer to specific residents or events.

Ethnographic Interviews with Residents

During this period, BDS conducted 20 informal, one-on-one ethnographic interviews (see appendix 3 for protocol). Handwritten notes captured key quotes which were subsequently read back to participants to check for accuracy. The total informal ethnographic interview participant group included: 16 men, 3 women, and 1 transgender woman, 15 of whom self-identified as White, 3 as Black and 2 as First Nations/Metis/Inuit. Prior to each interview the study was explained and written consent was gained. These conversations also presented the opportunity to inform interviewees about the focus groups which would take place at a later stage.

Focus Groups

In the final two weeks of fieldwork, three, five-participant focus group discussions (n=15 participants) were conducted and facilitated by BDS. The total focus group participant group included 12 men, 2 women, and 1 transgender woman, 11 of whom self-identified as White, 3 as Black and 1 as First Nations/Metis/Inuit. Ages ranged between 34 and 60 years of age. Focus groups were audio recorded and subsequently transcribed. Recruitment was done through purposive sampling, with most participants identified from built rapport during the earlier fieldwork stage. Focus groups ranged between 29-44 minutes. A focus group protocol (see appendix 2) of eight open-ended questions covered residents' daily experiences in the facility and with the HOPS. Residents who used drugs and those who did not were invited to partake in the focus groups to attain a holistic and representative sample of client experiences. We did not collect demographic data in relation to who used the HOPS, however, over the course of the fieldwork there were only five residents who used the room, and they all took part in both the interviews and focus groups.

Staff Interviews

Ten one-on-one interviews were conducted with staff (see appendix 4 for protocol). We were only permitted to interview staff during their breaks, which restricted interview duration to between 5-17 minutes. Questions were oriented towards understanding staff perspectives of the day-to-day operations of the facility and the HOPS.

Ethics and Ethical Considerations

Staff were not compensated for their participation, however, focus group participants were compensated CAD$15 and resident interviewees were compensated CAD$10. To protect anonymity, age and ethnicity was not recorded for the staff and age was not recorded for the resident interviews. The project received ethical approval from the University of Oxford Central Ethics Committee R84228/RE002 and the board of the host organization. Residents also verified and commented on the protocol during a community consultation which took part in the fourth week of fieldwork. See COREQ checklist (appendix 1) for further details on method and researcher positionality (Tong et al., 2007). To ensure privacy and anonymity, each interview and focus group was conducted in a private room. Recognizing some individuals may not feel comfortable speaking freely during an interview located in the service they are being asked to reflect on support (Hameed et al., 2018), we attempted to mitigate potential bias by reassuring participants their responses would be anonymous. The approved, anonymised ethics protocol is hosted on the Open Science Framework (DOI 10.17605/OSF.IO/VS4AT).

Data Analysis

Focus group and staff interview transcripts, resident interview notes, and non-participant observation fieldnotes were imported into NVivo Software and coded by BDS using six steps of inductive thematic analysis (Braun & Clarke, 2006). This process involved: 1) data familiarization whereby BDS read transcripts and fieldnotes, 2) BDS wrote analytic memos and developed initial codes (29 from resident interviews, 59 from focus groups and 26 from staff interviews), 3) BDS developed a thematic codebook to work systematically through the data, identifying relevant, meaningful information related to the research questions, 4) all authors reviewed, collaboratively defined, and finalized the themes, and 5) BDS wrote the first draft of the manuscript, with review and editing by all authors. Although informed by our understanding of the Risk Environment Framework (Rhodes, 2002) and how environmental, social and policy factors produce risk within housing environments (Braubach & Fairburn, 2010; Ivsins et al., 2022), all codes were developed inductively from the data.

5.4. Results

Three central themes were derived from the narratives, experiences, and perspectives of residents and staff: 1) Structural barriers to HOPS accessibility, 2) Experiences of residents and staff around the building, 3) Experiences of residents and staff within the building.

1) Structural barriers to HOPS accessibility

Residents and staff described several structural factors which directly influenced people's willingness and ability to access the HOPS. These included: 1) the stigma of accessing the room and the fear of it affecting treatment by staff, 2) restrictions on HOPS capacity and consumption practices, and 3) exclusion of people who smoke their drugs.

Stigma of accessing the room and the fear of it affecting treatment by staff

Residents repeatedly perceived stigma from staff associated with those who used the HOPS. This produced anxiety, primarily stemming from the belief that by accessing the room and, in turn revealing their drug use, staff would view and treat them differently to the residents who did not use drugs:

> *"Fear of judgment, you still have to admit it out loud and that is a huge step for a lot of people. So I think people still believe that if they use the room staff will treat them differently or put something in their file."* (Resident Interview 17, Trans-Female, White)

The notation on "their file" reflected a fear this could cause a formalized, permanent marker of their drug use and a way to monitor their drug use. Certain staff corroborated this sentiment, noting that despite the HOPS, residents were still worried about being stigmatized around their drug use and particularly the amount used. Their fears had foundation as this staff member stated:

> *"They don't want to be stigmatized. They think they're being judged...And on some level I think there's some truth to that. They don't want us knowing how much they use."* (Staff Interview 2)

Fieldnotes from observations showed staff explained HOPS policies and procedures during resident intakes in a clear, neutral manner and encouraged service access. However, new residents would have to feel comfortable disclosing their drug use during the initial intake, often before rapport with staff had been built. Understandably, new residents did not always feel comfortable doing this.

Restrictions on HOPS capacity and consumption practices

The rules of the HOPS were oriented around managing capacity, accounting for staffing numbers, and abiding by broader provincial policies governing such harm reduction services. One key rule was only one person could use the HOPS at a time. This had a profound impact on couples who managed and supported each other's consumption practices:

> *"They should have a couples [HOPS] room…it just sucks to be split up when we could be together outside. We still sometimes use outside or we go to an OPS where they do let us use together, but that is back in the Downtown Eastside."* (Resident Interview 6, White, Female)

By not accommodating social dynamics surrounding people's drug use, couples described being pushed to use outside the building or having to commute far from their new residence to stay together. Many others, used in pairs or groups to mitigate health risks or manage existing physical health issues. In this focus group, participants describe why this can be problematic:

> - *"Someone should be able to do the needle for you, to doctor, it's very important.* (FG Participant 14, White, Male)
> - *I'm usually the one that cooks it and helps her.* (FG Participant 13, White, Male)
> - *And you aren't able to help her?* (Moderator)
> - *No, they won't listen or let us in together.* (FG Participant 13, White, Male)
> - *The thing is [I] have that problem [as well]. It's serious, I can't do it [inject] myself because I can't see that well.* (FG Participant 15, Indigenous, Male)
> - *You end up wasting it or having to get more.* (FG Participant 13, White, Male)
> - *Or poking away and having to heal a whole bunch of places you missed. Then it brings infection and...you gotta go to the hospital."* (FG Participant 14, White, Male)

Not being able to use as a pair or help one another, something people described doing in other consumption settings, resulted in people either losing/not maximizing their dose, or experiencing injecting related harms and increased chance of hospitalization.

Exclusion of people who smoke their drugs

Noted both in the fieldnotes and in resident testimonies, there were residents who injected drugs for whom the HOPS was accessible and was effectively reducing risk of their fatal overdose:

> *"I think it's a good thing because I dropped yesterday and they were really fast on getting me back up."* (FG participant 15, Indigenous, Male)

Perspectives of residents who did not use drugs also reflected the increased safety to people who inject drugs:

> *"I don't use the [HOPS] room, it doesn't bother me but I am glad they have a safe place to go. It must be scary on the street."* (Resident Interview 3, White, Male)
>
> *"I don't use but I am glad that they have it for the safety of those who do use"* (Resident Interview 15, White, Female).

There was also a recognition that *"the larger percentage of people here...don't use needles"* (FG Participant 11, White, Male)". Participants perceived a fundamental gap in service provision of the HOPS as it had no facilities to support people who smoke their drugs or transition from injecting to smoking. Staff understood this and regularly encouraged people to access alternative supervised smoking sites:

> *"So in this facility no, but we do strongly advise them to go down to the [different OPS facility which does permit smoking], where they do have an open-air space where they can actually smoke their drugs and be monitored in the same way."* (Staff Interview 6)

As fieldwork, focus groups, and interviews progressed, the lack of smoking provision was a major barrier to people accessing the HOPS. This was acknowledged by residents who repeatedly made comments such as *"there must be a way to offer people a safe place to smoke as well"* (Resident interview 20, Indigenous, Male). This finding is reflected in the subsequent themes.

2) Experiences of residents and staff around the building

The HOPS did not possess the required ventilation systems or policy framework to support people who smoked drugs. This resulted in people being pushed into more marginal settings, often either outside of the entrance on the front steps, or in the alley way behind the facility. This increased risks and harms for residents and posed challenges for staff trying to keep residents safe.

Navigating risks and harms smoking drugs around the building

By using outside, residents placed themselves in an environment which produced intense, real, feelings of self-stigma. Here, this participant adds how attempts to switch from injecting to smoking were complicated because of the absence of safe space for smoking:

> *"As an opiate user there is a lot of stigma. I've been using drugs since I was 8 years old and…I am trying to stop with the needles but there is no safe space for me to smoke. Now I have to stand out hiding on the corner by the cops and that does make me feel like a junkie. It makes being here very complicated."* (Resident Interview 10, White Male)

This participant re-affirms the discrepancy in the harm reduction options available to those who inject and those who smoke by describing how those who inject can mitigate overdose risk and shield from the elements, whereas residents who smoke have no other option but to use in unsafe, exposed environments:

> *"I don't use needles and do think it is a good thing but then again there is a double standard. If you use needles you have a safe space but if you smoke your dope like me then you are out in the fucking cold or you get kicked out. Like now I am still using in the alleys in front of people when I'm supposed to be getting away from all of that. But if I decided to inject now I would be fine."* (Resident Interview 9, Indigenous Male)

Participants described using outside as a risk factor for overdose, irrespective of their housing status:

> *"I've lost 30 people in the last year and I don't want to become another statistic but I'm still having to use in an alley despite now having this housing."* (Interview 10, White Male)

Together these quotes highlight the limitations of an injection only HOPS, and the increased risk of harms and overdose for residents who smoked versus those who injected their drugs.

Staff challenges in responding around the building

Both ethnographic fieldnotes and staff accounts documented how staff attempted to monitor use outside. When staff knew a resident was going outside to smoke drugs, they encouraged use in a location monitored by the cameras. This acted as an informal supervised consumption environment and allowed staff to intervene if an overdose occurred, allowing them to recognize the overdose, call an ambulance, and administer naloxone. This was a compromise, one which was not ideal for staff or residents:

> *"They have to go outside, and the problem is that we ask them to use around the corner so that they're on camera, but people don't want to be on camera."* (Staff Interview 2)

Residents or members of the public would come into the building to alert front desk staff if someone was overdosing near the building. Staff had a rota for conducting perimeter checks of the building to increase their chance of intervening with an overdose. Despite this, overdose was a common occurrence:

> *"Yeah, people have gone down all around this building from smoking."* (Staff interview 10)

Overdoses near the building were common and attributed to people smoking their drugs. As alluded to in this previous quote, instances of overdose were not confined to outside the building.

3) Experiences of residents and staff in the building

As a result of perceived or actual barriers discussed in the first theme, people sought environments within the building to consume drugs - particularly for smoking. This was an important issue for residents who did not use drugs who witnessed drug use at their home, and by staff who worked to keep people safe.

Client experiences and challenges

Drug use outside of the HOPS but in the building was commonly described and observed: *"Loads of people are still using in the washroom"* (Resident Interview 17, White, Trans-Female). Participants described logical reasons for seeking such alternative locations: *"It's...pissing it down [raining] out...who wants to go out there to use? Come on."* (FG Participant 11, White Male). In addition to avoiding bad weather and the harms associated with preparing and consuming drugs in those conditions, participants also described how navigating such risks had to be balanced against the tangible risk of losing their space with the accommodation provider. This interaction between participants speaks to this risk:

- *"So I know I'm not allowed to use...you're not allowed to smoke drugs down in the bathrooms...but you know there are going to be people using*

> *the safe injection [room]…I don't use needles so I don't use that room…[but] if I got caught using downstairs…I would risk my bed here."* (FG Participant 11, White, Male)
>
> - *Even though there is a bathroom down there and that is a very risky thing to do…because I'm risking my stay, right, but at the same time you don't care because it's raining outside."* (FG Participant 14, White, Male)

Consuming drugs in a locked, inaccessible washroom, brings additional risks beyond overdose. This participant describes an instance in which the smoke from someone consuming drugs set off the fire alarm:

> "Somebody was smoking crystal meth two weeks ago in the bottom bathroom… someone went down and…two minutes later the fire alarm was pulled. Then somebody upstairs was doing the same...and I started to wonder, it's not smoke [from a fire] that's causing the fire alarm, it's...somebody doing crystal...or...crack [which] is causing the fire alarm [to go off]." (FG Participant 9, White, Male)

The decision by some residents to seek out alternative drug consumption locations again highlights the need for interventions which support residents who smoke drugs. By reducing overdose risk, the visibility of drug use in the building and secondary issues such as the likelihood of a false fire alarm, such interventions would benefit all of those who live in the facility, whether or not they smoke drugs.

Staff challenges responding to smoking within the building

Staff described the challenges smoking in the building presented for them in their day-to-day work. They also referenced the key deterrent strategy which was a zero-tolerance policy for drug use inside the building, resulting in eviction if caught:

> *“Multiple times here…this person came in was told hey, do not use or you'll be kicked out and what ends up happening? We find drug paraphernalia...laid out on his bed, ready to use or he’s laid out with a pipe on this chest.”* (Staff Interview 4)

Dorms were shared between people who use drugs and people who did not or who had recently begun drug treatment. A key concern was triggering people who were newly abstinent into potential relapse.

> *“It is an issue…especially in the downstairs bunk area, because we have a mix of people who are trying to get clean and people who are still deep in their addictions…and so you got people...using in the bathroom at 2-3 in the morning and some who [are] trying to get off.”* (Staff Interview 4)

Staff concerns were often centered on overdose risk, and hidden drug use amounting to overdose events in which they could not intervene. Staff expressed that *“mostly the biggest challenge is keeping people safe”* (Staff Interview, 7) suggesting that the current provision may not keep both residents who use and those who don’t use safe. Despite the HOPS being used by residents who injected drugs, responding to overdose or having to enforce rules around use inside the building continued to take up a substantial amount of staff time.

5.5. Discussion

As provincial and federal governments seek to refine harm reduction provision and respond to trends in local drug consumption practices, it is helpful to understand gaps in the design and delivery of existing services. The experiences and perspectives of participants in this study highlight some structural barriers around smoking in this facility, likely replicated in other sites in BC and North America, where there is a shift from injecting to smoking in BC. This shift from injecting to smoking is often in response to the risks associated with injecting and is demonstrative of people attempting to reduce their own personal health risks (Harris et al., 2020). This like others, recognizes that emphasizing only individual behavior change, cannot reduce intersectional risk (Collins et al., 2020).

Being or feeling surveyed within the context of HOPS usage, or being supervised through cameras outside of the building, may dissuade some from accessing the current harm reduction intervention on offer. Existing research highlights the myriad forms of surveillance found across harm reduction programs such as disclosure at intake, ongoing check-ins with staff and monitoring post consumption (Scher, 2020). In this context, the feeling of surveillance may be alleviated by employing peer workers to directly supervise HOPS clients. Research examining facilitators to community-based overdose prevention services suggests that peer-run services where the frontline staff are not directly implicated in the delivery of auxiliary services such as case management, may help residents feel more comfortable and more likely to attend (Ivsins et al., 2023). Structural barriers, including those prohibiting people from using together or sharing their drugs dissuaded people from accessing OPS'. Rhodes et al. (2017) note people may want to use together to overcome physical impairment or difficulties accessing veins although it is not without risks including around relational dynamics even when in a safe, secure, and supervised environment (Boyd et al., 2018; Collins et al., 2019; Pijl et al., 2021).

Although the HOPS was being accessed by residents who injected drugs, i.e. their risk was not increased by the environment; risk and harm was produced through the lack of smoking provision and led to the HOPS being under-used. Most residents resided in shared dorms and did not have their own rooms which they could lock. Therefore, most of the drug consumption happened outside of the building and in washrooms, increasing the risk of overdose and jeopardizing safety. Safety, trust, and inclusion are key mechanisms in which consumption spaces are effective (Stevens et al., 2024); staff, constrained by space and requirements to operate under are unable to change the risk environment. Residents reported stress and anxiety associated with drug use in the absence of a safe space where they could smoke. Building on the findings of Collins et al (2020) our findings highlight how *the "privileging of injection drug use in HOPS can reinforce fatal overdose vulnerability"* (p.7). Whilst infrastructure change may be required, there are a range of solutions, piloted in other contexts, which could be considered to support this population and their desire to minimize risks (Shorter et al., 2023).

Staff and residents who do not use drugs were also impacted by people being pushed into consumption environments inside and outside of the building. Previous research has suggested that witnessing drug use in a shelter setting, can act as a trigger for relapse (Binswanger et al., 2012). Safety, for all residents, encompasses interpersonal and environmental factors, in addition to overdose or relapse risks. Ensuring a safe environment for all residents is crucial, however, staff and management are often constrained by operational policies and resources at the micro and macro level (Kerman et al., 2023; Collins et al., 2019). For this reason, it's essential that federal and provincial leadership support the needs of all residents in such facilities, whilst acknowledging the pressing overdose context.

People are at significantly more risk of overdose when not housed (Milaney et al., 2021). As such, solutions to reduce the likelihood of people using drugs in unsafe environments or even dropping out of housing programs due to the inability of services to cater for their consumption practices are imperative (Kerman et al., 2023). In this facility, there was already some provision for people who smoke drugs through safe smoking supplies dispensed at the front desk. This however did not reduce the risks associated with their immediate consumption environment.

The influence of the environment on risks affecting people who use drugs is widely known (Collins et al., 2019; Rhodes, 2009), and this study echoes risks highlighted in other housing settings where HOPS have not been implemented.

Inhalation provision is common in supervised consumption settings in Europe (Bourque et al., 2019) and provides example models for adoption in Canadian HOPS settings (Shorter et al., 2023). There would be considerable benefit to adapt HOPS to support residents who smoke. Ideally, they would have capacity for a minimum of two people at a time to account for important social dynamics pertaining to people's drug use. Peers may also provide crucial support in monitoring, preventing, and intervening in overdose situations. Employing peers would also reduce the pressures on existing staff (Kennedy et al., 2019), who are under considerable pressure managing current macro and micro risks at the HOPS. Effective inclusion health interventions which can evolve to meet the diverse health and social needs of clients in addition to managing overdose risk (Scher et al., 2024) can bring benefits for both staff, residents and communities. Building purpose-made ventilated rooms alongside current injecting rooms, although ideal, may not be feasible. Instead, an adaptation could take the form of a supervised inhalation tent in a secure outside area such as a courtyard or garden (Borque et al., 2019; Pijl et al., 2021).

5.6. Limitations

Given that some of the ethnographic interviews were only five minutes in length, there is a chance that critical aspects of participant experiences in the service may have not been conveyed in depth. Similarly, aspects of intersectional risk environments (e.g., poverty, race, gender, stigma, etc.) may have been underrepresented. Although resident views were triangulated with those expressed during the focus groups, staff views may be incomplete given these interviews were the sole source of data collection. As such, while the rapid nature of this study allowed us to quickly capture rich data and make timely recommendations within an urgent policy context, a longer form ethnography may still be warranted. Additionally, the study was conducted within a single housing setting in Vancouver, BC, which limits the generalizability of the findings to other settings or regions. Conducting the interviews and focus groups within the setting of interest may also have influenced participant responses, however by reaffirming anonymity we hoped to mitigate this influence. Finally, this study did not quantitively measure the rates of use of the HOPS. It would have been useful to capture its uptake alongside participant experiences and perspectives.

5.7. Conclusion

Seeking to respond to a gap in the public health literature, our qualitative study captures the experiences and perspectives of residents, both who use and don't use drugs, and staff within a supportive housing facility with a HOPS in Vancouver, BC. Although residents who injected drugs benefited from the harm reduction outcomes of the HOPS, particularly safeguarding from fatal overdose, our findings suggest this HOPS is underutilized due to several structural factors, the most prominent being the lack of inhalation services. This lack of service provision and the creation of an environment in which people conceal their drug use, shapes several harms for both residents who use drugs and those who don't. It additionally creates challenges for staff responding to drug consumption near the building and in non-monitored areas inside the building. As such, there is an urgent need for policymakers to consider changing modes of drug consumption within existing housing-based harm reduction interventions and broader policy responses to combat the ongoing opioid crisis.

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6. Characterizing 'Atmosphere': Exploring determinants of regular service attendance amongst integrated supervised consumption site clients in Vancouver's Downtown Eastside

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6.1. Abstract

Background

Research has explored barriers and facilitators to supervised consumption sites (SCS) in Canadian settings. Despite this, little is known about what factors drive individuals to initiate and sustain engagement with SCSs in contexts where multiple SCS options are available, such as Vancouver’s Downtown Eastside (DTES). The aim of this study was to understand the structural, contextual, and operational determinants of regular SCS attendance.

Methods

Rapid-ethnographic fieldwork was conducted over a six-week period at an integrated SCS in Vancouver’s DTES. This comprised an initial five-week period of non-participant observation (≈200 hours) followed by a community consultation regarding the research design and question protocols. Qualitative data were then collected through five focus groups (n=25) and 20 semi-structured interviews with regular service attendees.

Results

Our findings highlight several important factors related to the determinants of regular service attendance. Firstly, the service had a regular clientele who described their attendance as routinized, credited to four distinct factors: 1) the accessible location, 2) the on-site auxiliary services, 3) the diversity of harm reduction provision, and 4) the atmosphere. Exploring the concept of atmosphere in more depth revealed that it was characterized by the safety,

familiarity and inclusivity experienced within the service. Together these factors facilitated a strong sense of belonging in attendees regarding the service and its community of staff and clients.

Conclusion

Within the context of an ongoing overdose crisis, our findings highlight SCS service characteristics which facilitate routinized engagement. These insights can guide the development of more effective, client-centred harm reduction policies.

6.2. Ethnographic Vignette

It's the Monday of my second full week of fieldwork, it's 6pm and from within the building we can all hear the rain clattering down against the plastic tarp covering the smoke tent outside. In here, all eight of the white round tables are crowded with people sitting eating grilled cheese sandwiches and sipping on hot coffee and tomato soup. There are even people standing lining the sides of the room, all positioned to have a direct view of the big screen TV bolted to the back wall. Although the common area is often busy, tonight the Vancouver Canucks are playing and people are excited by the prospect of seeing their home ice hockey team break their five-game losing streak. I'm sitting at a table with four indigenous men whose attention, like clockwork, is predictably shifting between their food and the TV. They also happen to be the only table supporting the Chicago Blackhawks, "*It didn't matter we were in Canada, on the reserve we all supported the Chicago Blackhawks*", John a man in his 60s tells me. I'd met John earlier that afternoon, whilst spending time chatting with people in the smoke tent. For over an hour, John held the attention of five of his peers, recounting stories of his hockey accolades as a teenager. For the next 60 minutes though, as his world narrowed and he blocked out staff attempts to offer him a coffee refill, it was clear he was not going to be taking his eye off the TV.

The other tables around us were all full. As I looked around, I spotted a few people wearing faded Canucks jerseys, others passing food down to their dogs under the tables and a few slumped over, nodding off shortly after coming out of the consumption room. Competing with the hum of chatter, cheers and occasional jibes at the referees, the sound of the hockey commentary is turned up to full volume - the atmosphere feels remarkably like a sports bar.

What strikes me most however is how *at home* everyone seems – relaxed, laughing, at ease and surrounded by a community they feel connected too. This ease feels rare in spaces occupied by people who are so often excluded from communal, public spaces of recreation - people living with visible disabilities, mental health challenges, drug dependency, alcoholism and homelessness. In this room though, those labels seem irrelevant. Evidenced through people's body language, there is no tension in their posture or guardedness in their faces. People are simply relaxed and engaging with both the space and people around them, as anyone would at a sports bar, amongst friends.

A few days later, I happened to see John again, this time in the evening after a day of fieldwork. I was on the number seven bus, one of the cities trademark blue and grey public buses. Morning and night the number seven would weave me all the way from the westside of the city, along the beachfront, through the financial district, past Rogers Arena (the Canucks stadium) and into the Downtown Eastside. I was sitting at the back right-side of the bus, looking out at the expensive shops and restaurants we passed by, a mere few hundred meters away from the DTES. It was here that I noticed John, slowly stepping onto the bus with two big clear plastic bin bags, one full of cans he had collected during the day and another with a sleeping bag and a few bottles clinking around at the bottom. Not noticing me himself, John sat down towards the front of the bus.

Looking forward at John, I could see that his body language was completely different to our encounter a few days previous. He sat hunched over his seat, his shoulders drawn tight, his hands clutching at the tops of the plastic bags. His eyes were fixed on the floor, avoiding eye contact with other members of the public. As I continued to observe, it became clear why. A few people had moved away from him and others glanced on uncomfortably, taking note of his sleeping bag and other visible markers of marginality. The relaxed, easy confidence he had shown in the common room—the way he commanded attention with his stories in the smoke tent—was gone. Here, his body seemed to shrink under the intense, judgmental gaze of the public – he was visibly embodying the stigma he was experiencing. Being at this early stage of my fieldwork, thoughts, questions and ideas had started to emerge in my head with regards to the people and environment I was embedding myself in. As we continued along the bus route, I jotted down three questions: 1) What is different about these two settings John finds himself in? What is it exactly that sets the social dynamics of these spaces apart so drastically? What mechanisms are present in the creation of atmospheres of belonging where stigma and social marginality vanish?

6.3. Introduction

In 2023, there were a total of 7,162 drug-related deaths in Canada (Statistics Canada, 2024), placing it third in the world for overdose deaths per million, just behind the United States and Scotland (Commonwealth Fund, 2025). The province of British Columbia (BC) has experienced approximately a third of the country's deaths despite it representing only 13% of the national population (Williams-Yuen et al., 2020). Within BC, Vancouver stands out. With overdose rates surpassing those of any other Canadian city, Vancouver's Downtown Eastside (DTES) has been coined by many as the epicentre of Canada's opioid crisis as well as Canada's poorest area code (Scher, 2020).

There are several factors which make the DTES unique within the Canadian overdose crisis. As Vancouver's oldest neighbourhood, this area was historically home to the cities original booming industrial economy, nightlife, hotels, and government buildings. Despite this early success, the DTES experienced economic decline as industry migrated to more affordable areas away from the downtown core (Liu & Bloomley, 2013). The cost of housing in Vancouver is high, the DTES comprises the majority of Vancouver's affordable housing, homeless shelters, social and drug treatment services. As such, the DTES is home to Vancouver's most marginalised and structurally vulnerable citizens (Bourgeois et al., 2017). It is more ethnically diverse, male dominated, older, and with fewer financial resources than anywhere else in Vancouver and is home to most of Vancouver's homeless population (City of Vancouver, 2020). Additionally, the DTES has experienced some of Canada's most severe forms of neighbourhood policing (Scher, 2020; Small et al., 2012; Timney, 2023; Xiang et al., 2023) and gentrification (Masuda et al., 2020; Tolfo & Doucet, 2022) as municipal and provincial governments have sought to control and shape the visibility of poverty within its public spaces without necessarily providing the resources to alleviate it. Local advocacy groups such as the Vancouver Area Network of People Who Use Drugs and the Pivot Legal Society have led successful campaigns for the legal sanctioning of federal supervised consumption sites (SCS) (Fafard, 2012), and the provincial decriminalisation of drugs for personal possession (Steward, 2023).

Evaluations of SCSs often focus on their effectiveness as interventions to reduce adverse health (measured by overdose and the sharing of equipment) and public order (measured by public injecting, drug-related litter) outcomes (Kennedy & Karamouzian, 2017). These provide a key role in summarising effects and addressing public and political opposition, including efforts to harmonise data across jurisdictions (Ziegler et al., 2019; Stevens et al., 2024). However, it is also important to understand how these sites are experienced in practice (Duncan et al., 2021; Ivsins et al., 2023). Everyday interactions, relationships, and the social and material organization of these spaces remain relatively underexplored in the literature and undervalued in the policy realm.

Whilst many SCSs are the only harm reduction intervention of their kind in a given area, little is known about how individuals make choices when multiple SCS options are available. This line of analysis expands the understanding of how and why SCSs are effective in positively impacting clients' well-being (Moore & Fraser, 2006; Jauffret-Roustide, 2023; Piatowski et al., 2024). The theoretical exploration of the material and relational dynamics and organization of other settings (e.g., hospital setting interventions or retail environments) has been widely investigated (Narang et al., 2015). Here, the recognition of the importance of *atmosphere* (the pervading character, feeling, or mood of a place or situation) on service quality has shaped the real-life environmental design of these interventions. An increased focus on these aspects of SCSs could similarly shape our understanding of SCS to improve service delivery (Shorter et al., 2023).

Despite being a relatively small neighbourhood of approximately 4 km^2 there are nine SCS in the DTES (Vancouver Coastal Health, 2024). These services operate through a range of models, from more medicalized sites such as INSITE, which contains clinical staff and on-site primary care, drug treatment and social services, through to lower-barrier services such as the SisterSquare Tent which is a peer-run supervised injection and smoke tent. Services also vary in their permitted modes of drug consumption; some allow for either injecting or smoking or a combination of the two. Whilst extensive research has evaluated the general barriers and facilitators to attendance little is known about what factors drive individuals to initiate engagement and continue engaging with SCS services in socioenvironmental contexts, like the DTES, where multiple SCS options are available.

In this paper we explore how SCS clients conceptualize their relationship to a specific SCS and the wider facility in which it is embedded. Although previous research has acknowledged that many SCS have a core group of regular clientele (Kosteniuk et al., 2021; Scher, 2020; Tyndall et al., 2006), the dynamics of these relationships have not been explicitly studied. By focusing on client-service dynamics this research seeks to advance our understanding of client decision making and the specific aspects of SCSs which foster sustained engagement and subsequent inclusion health outcomes (Scher et al., 2024).

6.4. Methods

Study Setting

This study took place at a low-barrier, harm reduction day centre in the DTES, which for the purpose of this study we anonymize to the Resource Centre (RC). It hosts a six-booth supervised injection room staffed by two health workers stationed at a desk at the back of the room adjacent to the booths. The room is decorated with artwork made by clients and posters with harm reduction advice. There are two doors; an entrance door which opens onto the front of the facility and an exit door which connects the SCS to the common room. In the back there is a supervised inhalation tent, staffed by a peer worker, which can accommodate six people. Although called a tent it is more of a gazebo, with two of the four sides open to allow for ventilation, a table, six chairs and naloxone, an oxygen machine and a juice and water station.

The facility also has a large common room with eight large circular tables where people relax and spend time once they have visited one of the consumption spaces. Here, people can watch

TV, play board games, card games and sit during the four meals cooked fresh in the on-site kitchen and served throughout the day. There is a reception desk where clients can seek advice, access services on offer, and access harm reduction equipment. There are on-site washing machines, showers, and toilets. Once a week there is also a pro-bono legal advice clinic. The staff team is made up of both peers and harm reduction staff with approximately equal split. The facility encourages clients to become involved with the peer worker program as well as the twice-daily job draw, where any client can put themselves forward to complete small jobs around the facility in exchange for cash that same day. Observations and fieldwork occurred throughout the entirety of the facility.

Overview of Methods

To explore how SCS clients conceptualize their relationship to the SCS and broader RC community, data collection comprised six weeks of rapid ethnographic fieldwork at the RC. Rapid ethnography is a research approach that takes place over a shorter period than traditional ethnographies (usually around 90 days or less) and focuses on capturing social, cultural, and behavioural insights through multiple qualitative methods and the prioritization of researcher reflexivity (Vindrola-Padros, 2021). It involves engaging a range of implicated stakeholders and triangulation in the analysis. This included: 1) a community consultation, 2) five weeks (≈200 hours) of participant observation and fieldnotes, 3) focus groups with regular clients, 4) informal rapid-ethnographic interviews with clients, and 5) semi-structured interviews with staff, including management and peer workers (although staff perspectives will be reported elsewhere).

Research Team and Partnerships

Fieldwork and data collection was conducted by BDS who had previously worked for the host organization between 2019-2021 both in the RC and in other of the organizations housing and harm reduction services. GWS, BWC and DKH supervised the project, contributing to design, analysis, and write-up, and although not present in Vancouver, met regularly with BDS online to discuss fieldwork and emerging findings.

Recruitment, Sampling and Compensation

Recruitment for focus groups was done through a combination of snowball and purposeful sampling (Naderifar et al., 2017). During the initial five weeks of participant observation BDS immersed himself within the day-to-day operations of the RC, in the consumption spaces and common room where participants would go to relax and socialize once they had consumed drugs. During this period, he built rapport with clients and discussed the scope of the project and upcoming focus group dates with eligible participants. People who signed up were also encouraged to discuss the study with eligible members of their peer network. Eligibility was defined as: 1) aged 18+ years 2) used the RC on a regular basis, 3) provided informed consent and 4) could speak English. Interview eligibility matched focus groups. Participants received $15 reimbursement to participate in the community consultation and focus groups and $10 to participate in an ethnographic interview. Prior to all focus groups and interventions, the scope of the study and details of participation was explained, participants had the opportunity to ask questions, they were informed that they could end their participation at any time and written consent was sought for all participants.

Community Consultation and Data Collection

During the fifth week of participant observation, BDS facilitated a community consultation with six clients. Here, the group discussed the research design and question protocols, and feedback was given to ensure the questions were correct given the scope and aims of the study and that these questions were being asked in a trauma-informed manner in line with best practice (Clare, 2022). Focus groups and interviews were conducted over the final two-week period. Multiple methods of qualitative data collection afforded triangulation of findings (Malina et al., 2011).

Five focus groups were conducted which lasted 40-60 mins and contained four to six people per group (total n=25). Participants were aged 30-56 years (Mean=52; SD=10.3). Seven participants self-identified as Indigenous and 18 self-identified as White. There were two females, 22 males and one who self-identified as non-binary. Six were housed, 8 in temporary or emergency shelter accommodation and 10 self-identified as unhoused. Focus groups took place in a private room in the building next door to the RC which was a housing facility operated by the host organization. The question protocol was semi-structured, and participants were asked questions related to their experiences using the supervision consumption and other services at the RC, their views on operational policies, their experiences with other local harm reduction services and the impact they believed the RC had in their lives. These included questions such as: “How often and why do you come to the RC?”, “How would you describe your relationship with staff?”, “Which services within the facility do you tend to use?”, “How would you compare the RC to other similar services in the DTES?” and “Has the RC impacted your life beyond the immediate harm reduction benefits of consuming drugs whilst supervised?”. Participants were recruited by BDS from the SCS room and the smoke tent. Following initial engagement, BDS would accompany participants next door to the private meeting room. Once he had the desired number of people, he explained the scope of the project, assisted people in completing the consent forms and demographic questionnaires. Focus groups were audio recorded for subsequent transcription. Snacks, and soft drinks were provided during the sessions.

One-on-one interviews generate different responses to focus groups – this is especially true in qualitative research with vulnerable groups who may not feel comfortable opening up in group settings or who may be influenced by peer responses (Litosseliti, 2018). Using both methods to triangulate findings offers a more complete picture of the topic of interest (Caillaud & Flick, 2017). Rapid-ethnographic interviews were conducted by BDS, who took handwritten fieldnotes and recorded verbatim quotes of importance. These quotes were then read back to participants at the end of interviews to make sure they accurately reflected the meaning of what they were conveying. Individual interviews were semi-structured and followed a question protocol relating to their experiences within the DCR, their perceptions of other local services and their relationship with peers and staff. Questions included: "How does your attendance to the RC fit into your routine?", "What are your main reasons for coming to the RC?", and "Is there every anything that happens here which you are unhappy with or that you would like changed?". These interviews lasted between 5 and 15 minutes and took place in the RC in an area of the common room or courtyard away from other clients. Due to these interview sessions being done relatively quickly and to ensure anonymity, we only gathered limited demographic data related to gender and ethnicity. The sample included three women and 17 men with five self-identifying as Indigenous, one as Black, one as Asian and 13 as White (total n=20).

Ethics

Ethical approval for this study was granted by the University of Oxford Central Ethics Committee on 11/03/2023 reference R84228/RE002 as well as internal ethical approval from the host organisation. The approved, anonymised ethics protocol is hosted on the Open Science Framework (DOI 10.17605/OSF.IO/VS4AT). In line with best practice, to ensure the confidentiality and anonymity of participants, individual names were omitted from this article and were not associated with individual quotations (Wiles et al., 2006). During focus groups and ethnographic interviews, staff were not present and could not hear what was being said.

Data Analysis

Data analysis comprised of the Braun & Clarke (2006) six stage reflexive thematic analysis, commencing with a process of familiarization with the data, whereby BDS read transcripts and fieldnotes, wrote analytic memos, and developed a thematic codebook to work systematically through the data, identifying relevant and meaningful information related to our research questions, as well as novel concepts inductively. Following this initial coding, BDS and GWS re-examined transcripts, and all authors refined the analysis until all the data were systematically organized using the final coding framework (Braun & Clarke, 2021).

6.5. Results

We present our results under three central themes, each with sub-themes related to the narratives, experiences, and perspectives of clients in relation to the RC, its impact in their lives and the dominant determinants of service utilization:

Theme	Sub-Theme
1. Routine and Regular Attendance	
2. Determinants of Service Utilization	2.1. Location
	2.2. Diversity of harm reduction provision
	2.3. Integration of services
3. Characterizing ‘atmosphere’	3.1. Safety
	3.2. Familiarity
	3.3. Inclusivity
	3.4. Belonging

Figure 9: Table - Themes and sub-themes of the views of RC clients

1) Routine and regular attendance

From the start of fieldwork, two aspects of the SCS were visibly apparent. First, the service was in high demand and as a result both the consumption spaces (injection room and smoke tent) and common area, were typically busy from the very start of the day until closure. Secondly, it appeared that most clients attended the service daily. Fieldnotes frequently highlighted the busyness of the service, an observation corroborated by participants:

> *“You’d be amazed at how this place helps. It’s always packed and it’s an amazing place for the population to get help, both day and night.” (Interview Participant 6, White, Male)*

The high demand speaks to the impact the service has in the lives of its clients. For many, attending the SCS was less about sporadic visits centred purely around harm reduction, but as a space which helped establish a routine and daily structure, as this participant explains:

> *"For me I go there in the morning and get my coffee and then at one o'clock, you got a bit of food they give out and I appreciate that too…it's at a set time and it's always there." (Focus Group Participant 18, White, Male, 58 years old, Unhoused)*

Many participants highlighted the predictability of the timings of the service. This was echoed by participants who described the service as a hub for other structured, meaningful activities that helped them establish routine and activities which they enjoyed:

> *"I like it just because nine in the morning until nine in the afternoon, I go in there and I can grab a rag and spray bottle and can wash my bike and just do things to keep busy." (Focus Group Participant 24, White, Male, 41 years old, Temporary Accommodation/Shelter)*
>
> *"I think it is routine, especially for coffee and football on Sundays." (Focus Group Participant 23, White, Male, 52 years old, Housed)*

For many, being able to come to the RC acted as an anchor in their daily lives. As was recorded in depth in the fieldnotes, many participants chose to solely access this facility despite the wide range of comparable services on offer in the DTES. This was exemplified through comments such as e.g. *"I am homeless in a tent but me and my buddies are sensible with it… I use here exclusively." (Interview Participant 6, White, Male).*

2) Determinants of service utilization

2.1. Location

Participants consistently spoke about the importance of the SCSs location, repeatedly highlighting this as a key reason why they chose to access this SCS. Often, proximity to where people lived, worked, and accessed other services were important practical consideration:

> *"I live and work next door, so this is really convenient." (Interview Participant 7, Indigenous, Male)*
>
> *"It's a good location, it's close to my pharmacy and where I live. I come here every day really." (Interview Participant 16, Black, Male)*

The usefulness of the proximity of the service to other convenient, used services and structures was also narrated by people who have mobility issues. For example, one service user stated:

> *"It's very close to where I stay and I really struggle to get around." (Interview Participant 2, Indigenous, Male)*

In addition to reflections on spatial and temporal needs, the location of the service was discussed in relation to its relative distance from the central core of the DTES. For some it was far away from structures and settings they wanted to avoid; that the service was slightly outside of this core was seen as a positive although they did not give a reason as to why:

> *"It allows you to get away from it all. It's a little bit outside that main core, right?" (Focus Group Participant 13, White, Female, 37 years old, Temporary Accommodation/Shelter)*

This sentiment was highlighted by an additional participant who was explicit about the perceived benefits of being outside of the neighbourhood core. In this case, it was about being separate from others, about safety, and about 'stuff' they did not want to be exposed to:

> *"It's off the beaten path. It's not in the core of the DTES. This place is…a good couple of blocks away from the real hardcore stuff…it's away from all that. So when you step out, you're not stepping over people you know." (Focus Group Participant 19, Indigenous, Non-Binary, 54 years old, Temporary Accommodation/Shelter)*

This 'stuff' was elaborated to explain the higher concentration of people 'nodding off' (losing consciousness) or overdosing in street-based settings in the neighbourhood core and speaks to the impact of this daily reality.

2.2. Diversity of harm reduction provision

Participants frequently highlighted the diversity of harm reduction services on offer, with many expressing how *"great the harm reduction services are here"* (Interview Participant 2, Indigenous, Male). The accommodation of people who smoked drugs was key to many people's regular attendance:

> *"Without the smoke tent we would all be using alone. Everyone always focuses on injections but all my friends use the tent too."* (Interview Participant 9, Indigenous, Male)

This sentiment was common, as seen in this focus group excerpt where the fact that this facility supports a wide range of consumption practices is emphasized:

> *Speaker 1 (Focus Group Participant 6, White, Male, 54 years old, Unhoused) – "This is actually a place where you can smoke…many of them don't, like INSITE [a more*

> *medicalized SCS in the DTES] doesn't….that makes a difference because lot of people like smoking."*
> *Moderator – "Do you think that's a good thing?"*
> *Speaker 1 (Focus Group Participant 6, White, Male, 54 years old, Unhoused) – "Definitely a good thing".*
> *Moderator – "Why?"*
> *Speaker 1 (Focus Group Participant 6, White, Male, 54 years old, Unhoused) – "Lots of people like smoking and to have a place…where you can do it…not worried. It's either that or the street…and the street is windy…for the smokers…it kind of sucks."*
> *Speaker 3 (Focus Group Participant 8, White, Male, 51 years old, Temporary Accommodation/Shelters) – "We have always had injection sites but for years we never had a place to smoke…smoking on the street is a lot but more of a hassle. They should have more around town."*
> *Speaker 9 (Focus Group Participant 9, Indigenous, Male, 55 years old, Unhoused) – "I've noticed since I've been down here almost 10 years. There's a lot more smokers than there are pokers…and so there's a greater need for smoking tents and a lot of people smoke their drug like me, that's what I do exclusively."*

The diversity of harm reduction provision at this facility was greatly valued. For these participants, the smoke tent met their practical harm reduction needs and symbolized a more inclusive model of harm reduction which provided for a wider group of people who use drugs, a place for 'pokers' and 'smokers'.

2.3. Integration of services

Participants highlighted the integrated nature of the SCS as a key motivator for regular attendance. The ability to access multiple resources in one location was particularly significant, especially for individuals experiencing homelessness or precarious housing:

> *"I just found that it had the most resources that I could use in one place, and it's open the longest which surprised me when I came to Vancouver that there is no 24-hour shelter or drop-in centres. You get to a certain point, maybe 9 o'clock and then you're on your own…and you got to go hang outside in the cold, no matter what." (Focus Group Participant 9, Indigenous, Male, 55 years old, Unhoused)*

Whilst this participant explains that other services do offer similar resources, opening times tend to be restrictive. For many, especially individuals experiencing homelessness, being able to get out of the cold and access basic necessities such as food, water and hygiene facilities during anytime of the day was incredibly important and distinguished this service from others:

> *"It's warm, its inside, food, bathrooms, I live in a tent and don't have those things and you get really grungy, it's not nice really. My tent is clean but still this place really helps with that." (Interview Participant 15, White, Female)*
>
> *"It's great they give you a place to just sit and be. When I was homeless this place kept me alive. Small things, the laundry and the food make a huge difference. Gloves, hats, it's the small things we don't get from anywhere else." (Interview Participant 4, Indigenous, Male)*

Finally, despite a high number of food banks and SCSs in the DTES, laundry services are not common. This offering at the RC was described as significant: "*There's no laundry within 40 blocks…other than this building." (Focus Group Participant 3, Indigenous, Male, 48 years old, Unhoused)*. This observation highlights a significant gap in the availability of basic amenities within the DTES. The SCSs inclusion of a laundry facility positions it as a unique and highly valued resource amongst a range of washing spaces for self and clothing; however, other key issues include shelter from the weather, food provision, and the simplicity of having a place to be, and be accepted.

3) Characterizing 'atmosphere'

In addition to the location, the provision of diverse harm reduction services and the integration of the SCS with a wide array of other health and social services, participants frequently noted how the atmosphere of the service differed to that of other local services. Statement such as *"I like joining my friends and the atmosphere and people are generally nicer than down in the* *other places" (Interview Participant 19, White, Male),* were common. During focus groups and interviews, this was something that we probed further. Our analysis suggests that descriptions of atmosphere were characterized by the creation of a safe, familiar and inclusive environment. This enabled participants to feel a strong sense of belonging to the facility which encouraged regular service engagement.

3.1. Safety

When discussing the atmosphere of the service, participants frequently mentioned the importance of safety as a precondition for positive experiences in the facility:

> *"This place is open to everyone, it's safe, we can mingle and not feel stressed." (Interview Participant 2, Indigenous, Male)*

Here, the participant framed safety as physical protection and an emotional state fostered by the space. The ability to "mingle" without stress suggests that the SCS facilitates social interactions in a way that contrasts with the chaotic (or threatening) environments participants may encounter elsewhere. However, that people were not concerned about it being open to everyone, suggests it feels well managed as a space. The facility and the atmosphere in it were often framed in contrast to other environments they frequent in the DTES, acknowledging the many structural challenges faced by neighbourhood residents:

> *"I stay this side of Main, there is too much chaos on the other side. There is more of a desperation to feed their addiction down there." (Interview Participant 3, White, Male)*

In addition to interpersonal safety, participants conceptualized safety and the provision of harm reduction services in relation to their potential interactions with the police and the potential for criminalization:

> *"It's very thoughtful the SCS and the smoke tent. It does what's on the tin, you feel safe and aren't being bugged by the cops*." (Interview Participant 5, Indigenous, Male)

Despite the facility creating a place of safety and refuge, violence still occasionally occurred within the facility. This was described as severely disruptive to the atmosphere of the service and deterring attendance, at least temporarily:

> *"Violence generally dissuades people so if there is a big fight it will be a bit more quiet the next day." (Interview Participant 3, White, Male)*

In these situations, staff were able to instil trust in clients and re-establish order by swiftly and appropriately managing situations. This was seen as an important aspect of the safety of the facility and was again contrasted to how such situations are handled in other similar services:

> *"I come here almost every day and it is the staff and the community which make it feel safe. Like yesterday there was a fight but staff got them out pretty quickly and the peers really help with that. At some of the others places, these incidents can drag out for hours." (Interview Participant 20, Asian, Female)*
>
> *"At the other places towards main (the neighbourhood core), people get bear sprayed and as a result the staff are just a lot more strict and on edge." (Interview Participant 12, White, Female)*

These accounts underscore the role of staff and peers in diffusing conflict and restoring order. The efficient resolution of incidents was often contrasted with other services where conflicts either escalated or persisted. In addition to physical or emotional safety as a determinant for regular service access, safety also played an important role in creating a space where positive social experiences can occur:

> *"It's nice to be using around others, it's just nice. You feel safe but it's also more enjoyable." (Interview Participant 6, White, Male)*

The emphasis on enjoyment suggests that the SCS fulfils pragmatic health needs of clients and emotional and social ones, providing a rare space that people who use drugs can occupy without fear of physical violence, stigma or apprehension from police.

3.2. Familiarity

Familiarity with staff, other clients and the service emerged as a crucial factor in fostering a sense of comfort and trust among participants. The relationships developed overtime were frequently described as facilitating continued service engagement. Again, this aspect of the service was presented in contrast to other local services:

> *"It's the comfort, it's the same people that come over and over so we feel safe, it's comfort we don't otherwise have." (Interview Participant 18, White, Male)*

This sentiment was echoed by another participant who compared the community at the RC to that of a family:

> *"It's a couple of things but to me I agree it's the atmosphere. It's basically a family, the same group people that come in every day. You see your face…you see the same people, it's a core." (Focus Group Participant 3, Indigenous, Male, 48 years old, Unhoused).*

This quote highlights how repeated interactions with the same individuals can foster a sense of stability and predictability. For some, the facility served as a primary meeting place, enabling social connections, and alleviating social isolation common amongst people experiencing homelessness:

> *"All my friends come here, it's where we meet and hangout and eat because a lot of us aren't able to provide it for ourselves." (Interview Participant 4, Indigenous, Male)*

Being around familiar people also made people feel cared for in their immediate interactions. This contrasted to the experiences people had in street-based settings:

> *"I know everybody and they know me and we watch out for each other as best as we can. We have a smoke but then watch TV and actually enjoy the high instead of just being kicked out on to the street." (Interview Participant 18, White, Male)*

Although most clients used drugs and accessed the two supervised consumption spaces, there was a small portion of service attendees who accessed the common area exclusively. The peer support and familiarity extended to all clients:

> *"I like all the different characters here and we all know each other. I mean I don't use [drugs], I hate people doing it in front of me. I don't like watching it but here we can all be together and not have to see it." (Interview Participant 19, White, Male)*

In addition to peer relationships, participants consistently praised staff for their role in fostering a welcoming and approachable service. Familiarity with staff enhanced the sense of safety and comfort:

> *"The staff here are more friendly and fair than [anonymized name of other local service being described], it feels less community [there]. Here there are more regulars, and you really get to know the other people that come here." (Interview Participant 20, Asian, Female)*
>
> *"Staff, they're more personable and they understand, some of them have been there, done that and some of them haven't but the ones that have…they don't pretend that they're better than anyone else, you know, they just understand." (Focus Group Participant 9, Indigenous, Male, 55 years old, Unhoused)*

The impact of staff in creating a welcoming environment, also extended to the role of peer workers, in particular their ability to foster a sense of trust and relatability with clients:

> *"Having peers makes it much less intimidating. I know these guys and know that they are trustworthy." (Interview Participant 7, Indigenous, Male)*

Familiarity in relation to fellow clients, staff and peer workers were all central in the creation of a welcoming environment where people felt comfortable, safe and trusting of the people around them.

3.3. Inclusivity

Inclusivity, and more specifically the sense that the service was non-judgmental, everyone was welcome and that no one would be discriminated against was frequently highlighted as a key factor which encouraged attendance. One interviewee described the importance of not feeling pressured by external agendas, such as religious affiliations, which they had experienced at other services:

> *"A lot of the other places are run by Catholics and this place doesn't push anything like that on us." (Interview Participant 14, White, Male)*

This reflects how inclusivity is enhanced by neutrality in the service's ethos, allowing individuals to access support without feeling alienated or judged. The non-punitive nature of the facility also emerged as significant, with participants expressing appreciation for its welcoming policies and the difficulty of being excluded:

> *"Everyone here is friendly and it's pretty hard to get kicked out." (Interview Participant 4, Indigenous, Male)*

For some, the inclusivity extended to specific living circumstances, such as the challenges faced by couples experiencing homelessness:

> *"It would affect me a lot if this place was shut down. It's so hard to find couples shelters so we camp out back and use this place for all of our food, laundry and anything help wise really because at the moment the shelters won't take us." (Interview Participant 12, White, Female)*

This participant underscored the importance of inclusivity for marginalized groups, such as couples who are often excluded from shelter settings in the DTES or made to stay separately. Another recurring theme during interviews and focus groups was the minimal barriers to accessing basic resources within the RC:

> *"I'm grateful because this is a place which is welcoming without questions. I can get food with no bullshit questions, a shower with no bullshit questions. I just prefer it that way." (Interview Participant 14, White, Male)*

Inclusivity within the client group was evidenced through the diverse client group. Participants described how the service facilitates an environment which is welcoming for a wide array of marginalised groups, something other services struggle with:

> *"There's different types of people that integrate really well here and that is only because they've worked hard to integrate well here. There are the hard, skilled drug users that understand the alcoholics and the non-drug users and the staff and it's like each group…are all working all together. The staff are not overbearing, which happens at other places. The drug users are not too aggressive to the alcoholics that piss them off. The alcoholics are not too aggressive to the drug users. It's just everybody's integrated, softly, slowly and then it's worked well and everybody knows each other." (Focus Group Participant 1, Indigenous, Male, 56 years old, Unhoused)*

These observations suggest that inclusivity is not just about providing a space but about cultivating an atmosphere and culture of mutual respect and understanding, supported by staff who can mediate tensions effectively. Finally, the service's ability to accommodate pets, common amongst residents of the DTES, yet an uncommon policy feature in similar facilities, was important for participants whose pets were central to their well-being:

> *"It is a dry place I can be with my dogs, most of them [other local SCS] don't allow dogs…my dogs are cold and I'm tired, and it's a place to charge my phone, I'm sleeping in a car and I don't feel good and my car is full of mould and I need the place to recharge my brain I guess. I need hot water for tea. There's a lot of things…you need for a day. Honestly, if I had the chance to be with my family and my kids [I would be] but I can't so this is where I can be right now and I choose this place because they love my dogs." (Focus Group Participant 13, White, Female, 37 years old, Temporary Accommodation/Shelter)*

The service's inclusivity stems from its ability to meet a wide range of needs without judgment or exclusion; and shows the exhaustion people experience trying to meet their basic survival needs outside the centre. Intentional and proactive inclusivity worked to foster an environment where individuals feel respected, valued, and supported.

3.4. Belonging as a primary outcome

The combination of safety, familiarity and inclusivity created a space where individuals felt a genuine sense of belonging to both the service and the community within it. This characterization of the service as a "living room" underscores its role as a communal space where often marginalised individuals were able to relax:

> *"It would affect a lot of people if this place closed. A lot of people would go astray. This is the living room for a lot of homeless people." (Interview Participant 5, Indigenous, Male)*

Others described the facility as their second home:

> *"This place is more open and welcoming, the staff, the people, I have nothing bad to say…It's like my second home and for a lot of other people it is as well." (Interview Participant 5, Indigenous, Male)*

These descriptions contrasted to how people referred to other services locally, with statements such as *"it feels more family oriented than the others places, I feel more like a stranger in those spaces" (Focus Group Participant 11, White, Male, 64 years old, Housed)*. At the RC there was a real sense of collective solidarity amongst clients, which again contrasted the isolation often experienced in other settings they frequented:

> *"People smoke out back, away from the street and we are all here together to save people. Here it is very much if today I have for me, I'll give to him because I don't know if I will have enough for tomorrow." (Interview Participant 13, White, Male)*

Participants echoed these sentiments, describing in detail the sense of belonging they felt because of the long-standing relationships built within the facility:

> *"It's a safe place where people can be at to socialize, eat, wash, and just be. I have been coming here since 89' and it's the friends, my friends, the culture and the continuance of being a part of something and here it feels like that. We've all been through a lot here but this place appreciates us anyways." (Interview Participant 17, White, Male)*

As a clear space for communal solidarity, the acceptance felt and sense of belonging described was often done in relation to the mutual hardships people had experienced. This final focus group excerpt encapsulated all of the points discussed above:

> *Speaker 5 (Focus Group Participant 15, White, Male, 55 years old, Temporary Accommodation/Shelter) – "I consider it partly to be my home".*
> *Speaker 3 (Focus Group Participant 13, White, Female, 37 years old, Temporary Accommodation/Shelter) – "I guess it's the living room".*
> *Speaker 4 (Focus Group Participant 14, White, Male, 58 years old, Housed) – "Yes, like I said it's a living room for a really dysfunctional family. And it's a safe place…even though shit happens…shit happens everywhere but here it's a safe place".*
> *Moderator - What makes it safe?*
> *Speaker 4 (Focus Group Participant 14, White, Male, 58 years old, Housed) – "I think just because for the most part, it's a dysfunctional family. I think you get in fights with your dysfunctional family, but physically, you know, it's pretty rare that there's a visible altercation, mostly it's just verbal yelling and screaming and you know, in other places…you don't know the people because faces change and they don't go there daily. Like it seems like for a lot of people, it's a daily thing. Like they come get their morning coffee and they might leave and then they come back and or they might hang out for a couple of hours, watch the hockey game or watch the basketball game or the price is right or whatever, and then they take off and you know, for a lot of these people all they have is a tent and that's one room…so it's claustrophobic and in there it's not claustrophobic and again, a lot of familiar faces."*

These reflections illustrate how belonging is reinforced through routine, shared experiences, and the familiarity of both the people and the environment. Unlike other transient spaces, this service fosters a stable and predictable community dynamic that many participants likened to family. This combination of safety, familiarity and inclusivity fostered a strong sense of belonging amongst regular attendees.

6.6. Discussion

Drawing on the perspectives and experiences of regular clients of the RC, the results of this study highlight the specific factors that foster regular attendance and engagement with the two supervised consumption spaces and the range of other services available on-site. Atmosphere was central to attendance. Exploring participant characterizations of 'atmosphere', our results speak to the specific manifestations and experiences of safety, familiarity and inclusivity within the RC which supported belonging and encouraged routine attendance. Through this analytical lens, the RC emerges as a unique site which fosters social inclusion, in the wider context of a structurally unsafe environment.

Most clients attended the site regularly, if not everyday, with the service fitting into their daily routine. Whether it was to access the harm reduction services, meals, engage with staff or simply socialize with peers, the RC was described as a space which allowed for partaking in meaningful, productive daily activities. Observational research indicates that globally, individuals in good health engage in highly routinized health behaviours (Arlinghaus & Johnson, 2018). Despite this, a large body of research, from a range of settings, highlights how individuals who experience homelessness, or who live in precarious socioeconomic conditions struggle to identify meaningful daily activities and subsequently organize them into routines (Simpson et al., 2018). For people experiencing homelessness or vulnerable housing, a range of structural barriers impede capacity to maintain continuity with occupations and interests, including limited financial resources, social isolation, and lack of transportation (Piat et al., 2015; Sample & Ferguson, 2020). Others note how the majority of people's time is occupied by surviving, and as daily challenges vary it can be difficult to incorporate wellbeing or other activities alongside (Shorter & Scher, 2025). Simpson et al (2018) explain that for people experiencing homelessness, much of their daily routine encompasses "searching for a physical space and then negotiating ways to remain in that space without being forcibly removed" (p205). By acting as a space of safety to engage in productive activities, socialize, access basic necessities and build a productive routine, our findings suggest that harm reduction spaces like the RC act as a powerful anchor and countering force to the structural barriers to stability experienced by similar populations in other settings (Chapleau, 2010; Patterson et al., 2015; Shukla et al., 2023).

Location and the diversity of harm reduction services offered in the RC emerged as important in encouraging regular service attendance. Prior research has identified that proximity of SCSs to where people live, work and access drugs is a key service facilitator (Allen et al., 2015a,b; Southwell et al., 2021). Service location and distance in relation to the location people's other daily activities (residence, employment etc) has also been noted as of importance in relation to other drug services such as methadone clinics (Bonifonte & Garcia, 2022; Joudrey et al., 2020). Our findings highlight how proximity to other essential services such as pharmacies or shelter facilities also ensured that the RC was easily accessible. Interestingly, participants also noted the fact that the RC was slightly removed from the core of the DTES as being a positive. The urban drug scene of the DTES has been identified as an important risk environment that negatively shapes the health of its community members (O'Carroll & Wainwright, 2019). Social and cultural capital operating specifically outside the centre of the DTES, including supportive networks of friends, social services, drug treatment services and harm reduction services have similarly been identified as positive determinants of health and social well-being (Fast et al., 2010; Knight et al., 2017). These resources can promote positive behaviour change (Shorter, 2023). Being slightly removed from this neighbourhood core and offering such services was corroborated by participants as having a positive impact of their lives.

Participants affirmed the importance of both the diversity and quality of the harm reduction services on offer at the RC. In recent years the drug scene of the DTES has shifted from a predominance of injecting to smoking (Ciccarone & Bourgois, 2016; Jozaghi et al., 2016, 2018). As a result, most fatal overdoses in this neighbourhood now occur from smoking versus any other mode of consumption (Ivsins et al., 2024). The inclusion of interventions which accommodate different forms of drug consumption to reflect the evolving drug scene was a key feature that differentiated this SCS to others in the DTES. Beyond the immediate health, public health and public order impacts of broadening the scope of harm reduction provision (Kennedy & Karamouzian, 2017), providing services for people who smoke drugs signals that the RC is a service and environment which is welcoming, non-judgmental and supportive of all people who use drugs and are at risk of overdose in the DTES.

Above all 'atmosphere' was frequently repeated as what set the RC apart from other local services and as the primary determinant of regular attendance. To better understand this, we specifically coded the various ways participants described this term. Participants emphasized the safety offered by the service, both in relation to the ability for the supervised consumption services safeguarding their lives, but also safety from the interpersonal (physical violence) and structural violence (criminalization and apprehension from police) experienced on the street. Beyond physical and structural safety, this term was used to describe the emotional state experienced in the RC. For example, participants valued the staff's ability to quickly resolve conflicts, which contrasted sharply with other local services where violent incidents could escalate without effective intervention. This ability to manage conflict and maintain order was described as crucial for fostering an environment in which clients feel safe, respected, and able to access services without fear of harm or disruption. These findings support previous descriptions of safety within the SCSs; that conflict cannot necessarily be avoided, but can be managed well (Kerman et al., 2020; Kolla et al., 2017; McNeil & Small, 2014; Scher et al., 2024; Stevens et al., 2024).

The role of ‘familiarity’ was also frequently described as a key contributor to the positive atmosphere of the RC. When probing these comments deeper, participants described an appreciation for the predictability of the environment, in service operations and through their relationships with staff, peers and other clients. This sense of familiarity, in particular with peers, created a foundation of trust that facilitated engagement (Chang et al., 2021; Greer et al., 2016; Marshall et al., 2015; Piatkowski et al., 2024). Research from SCS as well as other health and social care settings suggests that trust in staff, along with continuity of care and relationships, is a significant predictor of service retention, in particular for ‘hard-to-reach’ populations (Boyd et al., 2021; Ferrer et al., 2022; Gilson et al., 2005; Ostergaard, 2015). The familiarity with which clients engaged with staff, peers and the service as a whole was frequently recorded in the fieldnotes and was specifically noted by clients through the use of terms such as ‘family’, ‘second home’ and ‘community’ as a way of describing the meaningful social connections formed and sustained through the service. In previous work, we have hypothesized that this sense of belonging as facilitating broader social inclusion outcomes (Scher et al., 2024), though this finding is yet to be discussed in-depth in the empirical literature and merits further investigation. Additionally, participants explained that by being in a safe and familiar setting, they were able to maximize the aspects of pleasure associated with their drug use as opposed to rushing or experiencing stress during consumption. The importance of accounting for the role of pleasure within the context of drug use has been noted by other scholars who emphasize the potential role in increasing service engagement (Duncan et al., 2017; Duff, 2008; Nicolls & Hunt, 2025).

Finally, inclusivity emerged as a core value associated with the atmosphere of the RC. Participants repeatedly emphasized the welcoming, non-judgmental nature of the service alongside several distinct markers of inclusivity. Firstly, unlike some of the faith-based organisations in the DTES, participants felt like the RC was explicitly free from religious or political agendas. All facilities within the service were open to everyone, including people with pets, couples and people who did not use drugs (e.g., to access food, the common room and hygiene facilities). The mission of the RC is to support all local community members. As such, despite most clients using drugs, all described benefits resulting from the policies of inclusivity. Inclusivity has been noted by several other scholars as a key service facilitator in the nature and broader policy orientation of harm reduction services (Austin et al., 2023; Beck et al., 2024; Owczarzak et al., 2020; Shorter et al., 2023).

The combination of safety, familiarity and inclusivity fostered an environment and an experience with the service that cultivated a strong sense of belonging amongst regular service attendees with regards to the service and its community. Scher et al (2024) outline in depth the theoretical basis for the emergence of social inclusion in the context of integrated SCS services. The manifestation of this theoretical finding was evident in the narratives of RC clients. Indeed, people described a strong sense of acceptance, connection, recognition and both physical and political safety in relation to the RC and its community (Mahar et al., 2013; Yuval-Davis, 2006). Although a relatively unexplored outcome within the context of harm reduction services, such spaces of belonging work to counteract the isolation, alienation and stigma experienced by many structurally vulnerable and socially marginalised people who use drugs (Bourgeois et al., 2017). By providing a space where individuals can form meaningful social connections, access robust auxiliary health and social support, and experience a sense of community, harm reduction programs like the RC can contribute to long-term positive outcomes, including increased positive health and social outcomes and ultimately improved well-being (Tran et al., 2021).

6.7. Policy Implications

This study raises several important policy considerations and implications for the design, delivery and conceptualization of SCS and harm reduction services like the RC. The role of integrated SCSs, like the RC, in fostering daily routine and meaningful social connections and activities (e.g., peer work), highlights their broader value beyond the immediate harm reduction, biomedical, public health outcomes typically cited as justifications for their implementation. As such, where possible, policymakers should prioritize integrating auxiliary services (e.g., food, hygiene facilities etc) into low-barrier SCSs. The clear significance of the location of the RC as a determinant of service attendance underscores the need for thoughtful urban planning to ensure SCSs are accessible yet situated in areas that promote a sense of safety for potential clients.

As noted by other scholars (Ivsins et al., 2024; McNeil et al., 2015), our findings demonstrate the need to support people who smoke drugs as a means of ensuring harm reduction provision supports all people at risk of overdose. Despite its clear importance, ‘atmosphere‘ as a theoretical concept within the context of SCSs remains relatively unexplored. Fostering a safe, familiar, inclusive SCS environment encouraged regular service attendance and ultimately increased positive outcomes for clients. In addition to increasing the number of peer staff to promote such service characteristics, additional low-barrier policies (Olding et al., 2020) such as the inclusion of people with pets, couples and people who are not at a service explicitly to use the supervised consumption services but who may benefit from the other on-site auxiliary services should be encouraged.

Many SCS evaluations to date have been quantitative, with ecological, modelling, cross-sectional and cohort study designs employed to isolate certain elements of service delivery as a means of measuring effect (Duncan et al., 2021). The recognition of the importance of atmosphere in facilitating service engagement and continuation suggests that perhaps additional interpersonal, relational core outcomes (Shorter et al., 2024) should be investigated, along with the prioritization of more qualitatively driven methods of data collection.

6.8. Conclusion

The findings of this study highlight several important factors related to the determinants of regular service attendance of integrated SCSs like the RC. Firstly, the service had a regular clientele, many who attended daily. Regular service attendance was credited to four distinct factors: 1) the accessible location, 2) the on-site auxiliary services, 3) the diversity of harm reduction provision and 4) the atmosphere. Exploring the concept of atmosphere in more depth revealed it was characterized by the safety, familiarity and inclusivity experienced. In addition to highlighting important factors which could increase access to SCSs in other settings, these findings highlight the success of integrated SCSs in offering support which addresses not just the immediate health and harm reduction needs of clients but also important social needs which foster stability. Future research should explore how these social dimensions of harm reduction services influence broader, long-term outcomes and how they can be more effectively incorporated into the design and implementation of SCS and in other contexts.

6.9. References

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7. Benefits and Barriers: A Rapid-Ethnographic Study on the Perspectives of Potential and Actual Clients of Athens’ Drug Consumption Room

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7.1. Abstract

Background

In April 2022, a new Drug Consumption Room (DCR) opened in Athens' city centre. To date, no qualitative research has evaluated the operational strengths and weaknesses of the site from the viewpoint of DCR clients and people who use drugs locally in public settings and do not access the DCR.

Methods

Rapid-ethnographic fieldwork was conducted over a seven-week period. This comprised an initial five-week period of non-participant observation (≈200 hours) followed by a community consultation regarding the research design and question protocols. Qualitative data were then collected through five focus groups with 24 regular DCR clients and 25 street-based interviews with non-DCR clients who consume drugs in public settings.

Results

Regular DCR clients reported increased physical, structural, and emotional safety and increased connection with auxiliary health and social services and staff and peers. Those who did not use the facility could see potential benefits but noted several operational and contextual barriers. These results are presented through three themes (1) Safety, (2) Connection and (3) Barriers, each with several sub-themes.

Conclusion

Addressing DCR barriers could increase service access, reduce the presence and visibility of public drug use and improve public health outcomes for people who use drugs in Athens. Indeed, some of these barriers have been addressed since the research was conducted (eg., by expanding operating hours, increasing the number of staff with lived experience, offering on-site drug checking), illustrating the value of evaluating the efficacy of a DCR from the perspective of actual and potential clients.

7.2. Introduction

Athens experienced severe social and economic impacts from the 2010 global financial crisis (Panori & Psycharis, 2018). This led to a sharp increase in numbers of people living in poverty, urban homelessness, and rates of HIV (Arapoglou & Gounis, 2017; Syspa et al., 2015). Despite harm reduction interventions being scaled up during the HIV outbreak of 2011 (Flountzi et al., 2022), Athens continues to face challenges, including a new surge in HIV cases linked to difficulties in delivering HIV prevention, including a lack of needle and syringe coverage during the COVID-19 pandemic and limited urban social housing (Roussos et al., 2020; Sypsa et al., 2023). People experiencing homelessness in Athens also frequently face food and hygiene insecurity (Sypsa et al., 2020).

In April 2022, a policy window shaped by the urgency of safeguarding vulnerable populations during the COVID-19 pandemic (Rigioni & Tammi, 2024), led to the expansion of several progressive drug and housing interventions, including: 1) the expansion of the city's housing first programs, 2) the liberalization and expansion of national naloxone policy and 3) the opening of a drug consumption room (DCR). Nine years after the closure of Athens' first DCR site (Harm Reduction International, 2022), and now with support from national and local level politicians (Southwell et al., 2022), OKANA, who operate and oversee most of Greece's drug services, opened a DCR. In addition to overdose supervision and response, the site, called Steki 46, provides a range of on-site services as well as a robust off-site referral system for auxiliary health and social care programs. Like many DCRs globally (Shorter et al., 2023), the primary aims of Steki 46 are to prevent and intervene in overdoses, provide harm reduction advice, provide sterile equipment and offer on-site primary healthcare, mental health services and social services or refer off-site (see Methods for more information on the DCR). As secondary aims, the DCR also works to reduce public drug consumption and drug-related litter in the community (Kennedy et al., 2017). In Athens, the facility also acts as the hub for OKANA's outreach team which operates across the city.

The aim of this study was to conduct a rapid-ethnographic evaluation to provide immediate policy recommendations to OKANA on how to build on the strengths of the service and expand access. Most DCR evaluations rely on service user perspectives; here, we seek to expand understanding of the experiences and potential barriers faced by those who could benefit from the service yet do not access it (Urbanik & Greene, 2021). To develop a holistic understanding of Steki 46's model of operation and service design, we captured a range of perspectives, including: 1) people who regularly attend the DCR, 2) people who use drugs locally who do not access the service and 3) DCR staff. In this paper, we analyse the perspectives of DCR users and DCR non-users. The perspectives of staff will be reported elsewhere.

7.3. Methods

Study Setting

This study took place at the Athens DCR and in the immediately surrounding neighbourhoods. This DCR is a medicalised model, with on-site GP, nurses, psychologists, counsellors and social workers to offer wrap-around support. On the ground floor there are twelve injecting booths and an inhalation room with space for four people. The ground floor has a medical room for the on-site doctor, a kitchen, toilets, washing machines, showers and a courtyard garden for clients. On the second floor of the building there is a common room with board games, cards games, TVs, meeting rooms, a kitchen from which food is distributed to clients throughout the day, a cold-water station, a coffee machine, and offices for the on-site social workers, pro-bono legal workers, employment assistance staff. The third floor has more offices for the various professional staff and the fourth floor is the central hub and main office of the 'streetwork' outreach team who use the building as a base for outreach trips throughout the day, across the city. Observations and fieldwork occurred throughout the building, with client focus groups and staff interviews taking place on the second floor. Interviews with people who did not access the service but used drugs in public occurred in street-based settings. These interviews were conducted in three separate open-air drug scenes, in locations where the 'streetwork' team conducted their outreach activities. These tended to be alleyways and urban parks with a high density of people consuming drugs. These locations were all within 500m-2km radius of the DCR.

Rapid-Ethnographic Approach

This study used a rapid-ethnographic approach. Rapid-ethnography is defined by four distinctive characteristics (Vindrola-Padros, 2018): (1) the research must be carried out over a short, compressed or intensive period of time; (2) the research captures relevant social, cultural and behavioural qualitative data and is focused on human experiences, perspectives and practices; (3) the research engages with anthropological and other social science theories promoting reflexivity and (4) data must be collected from multiple sources (various stakeholders implicated in the topic of focus), using multiple modes of data collection and is triangulated during analysis. The strengths of this approach lie in its ability to produce research with a "nuanced understanding of lived experiences while prioritizing efforts to rapidly inform interventions and decisions that address urgent health and social issues" (Collins et al., 2020, p.384).

Overview of Methods

The methods of data collection were chosen specifically for their ability to rapidly observe and capture the ways in which clients as well as those who do not use the DCR, view and engage with the service. Data collection comprised seven weeks of fieldwork, including: 1) a community consultation, 2) five weeks (≈200 hours) of participant observation and fieldnotes within the DCR, 3) focus groups with regular clients, 4) informal street-based rapid-ethnographic interviews with people who do not use the service and 5) semi-structured interviews with staff and management (which will be reported elsewhere).

Research Team and Partnerships

This study was conducted as part of the doctoral work of BDS, with fieldwork led by NP, a graduate student in addiction studies at the University of Athens and CA, project manager with the European Network of People Who Use Drugs and the Greece based Peer Network of Users of Psychoactive Substances. Both researchers are local to Athens and CA has a deep knowledge of the local community and environment. CA has lived and living experience of drug use and utilization of harm reduction and OST services in Athens and has worked as a peer researcher on several other related projects. GWS, BWC and DKH supervised the project, supporting design and analysis off site, meeting regularly with the research team.

Recruitment and Sampling

Recruitment for focus groups was done through a combination of snowball and purposeful sampling (Naderifar et al., 2017). During the initial five weeks of participant observation NP immersed himself within the day-to-day operations of the DCR, on the ground floor and second floor (consumption and post-consumption spaces). During this period, he built rapport with clients and discussed the scope of the project and upcoming focus group dates with eligible participants. People who signed up were encouraged to discuss the study with eligible members of their peer network. Eligibility was defined as: 1) aged 18+ years 2) used the DCR regularly, 3) provided informed consent and 4) could speak Greek. Participants in the street-based interviews were approached by CA who introduced the project to them. Those who wished to take part would move to a private location. NP would then conduct the interview. Interview eligibility matched focus groups. Additionally, participants had to have experience of consuming drugs in local public and or/semi-public environments.

Community Consultation, Data Collection and Compensation

Following the five-week period of participant observation, CA led a consultation with six DCR clients. Here, the group discussed the research design and question protocols, and feedback was sought to develop the questions alongside the aims of the study, and to be trauma informed in line with best practice (Dickert & Sugarman, 2005). Rapid-ethnographic data collection was conducted over the final two-week period. Typically, in the morning we conducted a focus group and, in the afternoon, would accompany the 'streetwork' outreach team to conduct street-based interviews before returning to conduct 1-3 staff interviews. Multiple methods of qualitative data collection afforded triangulation of findings (Malina et al., 2011).

Five focus groups were conducted which lasted 40-60 mins and contained four to six people per group (total n=24). Participants were aged 30-56 years (Mean=44; SD=6.4). One participant self-identified as Black, two preferred not to say, 22 self-identified as White. There were 7 females and 18 males, 9 were housed, 4 in temporary or emergency shelter accommodation and 11 self-identified as unhoused. The question protocol was semi-structured, and participants were asked questions related to their experiences using the DCR, their views on operational policies and if they would add to or change anything about the services on offer within the facility. These included questions such as: "How often and why do you come to the DCR?", "How would you describe your relationship with staff?", "Which services within the facility do you tend to use?" and "Has the DCR impacted your life beyond the immediate harm reduction benefits of consuming drugs whilst supervised?". Participants were recruited from the DCR by NP and CA, who would then accompany them upstairs to the private meeting room. Once the team had the desired number of people, CA explained the scope of the project, assisted people in completing the consent forms and demographic questionnaires. NP then conducted each focus group and ensured that the session was audio recorded for subsequent transcription and translation. Snacks, coffee, and soft drinks were provided during the sessions.

Ethnographic street-based interviews were conducted by NP, who took handwritten fieldnotes and wrote down verbatim quotes of importance. These quotes were then read back to participants at the end of interviews to make sure they accurately reflected the conversation. Interviews were semi-structured and followed a question protocol relating to their experiences of street-based drug use, their perceptions of the DCR and rationale for not using it. Questions included: "How would you describe your experiences of using drugs in locations like this?", "Have you heard of the DCR, if so, what are your views on the facility?", "Do you ever attend the facility, if not, why?". These interviews lasted between 5 and 15 minutes. To support anonymity, no names were taken and we only gathered gender information. Participants in the community consultation/focus groups received €15 reimbursement; those participating in a street-based interview received €10.

Ethics

Ethical approval for this study was granted by the University of Oxford Central Ethics Committee on 11/03/2023 reference R84228/RE002 as well as internal ethical approval from OKANA. The approved, anonymised ethics protocol is hosted on the Open Science Framework (DOI 10.17605/OSF.IO/VS4AT). OKANA also provided logistical support through 1) office space for focus groups, 2) snacks and drinks for clients during the sessions, 3) safeguarding support for street-based interviews. During focus groups and street-based interviews, staff were not present and could not hear what was being said. All participants gave written consent. It is also important to note that the overall ethical approach of this study was strongly informed by the authors varied prior research experience with similar populations as well as CA's experience both as a member of and experience conducting research with this population group. Ethical questions and trade-offs were frequently considered by the research team in a way which specific to this particular study context and participant group.

Data Analysis

Data analysis comprised of the Braun & Clarke (2006) six stage reflexive thematic analysis, commencing with a process of familiarization with the data, whereby BDS and NP read transcripts and fieldnotes, wrote analytic memos and collectively developed a thematic codebook to work systematically through the data, identifying relevant and meaningful information related to the research questions, as well as novel concepts inductively. These codes were then reviewed by CA, GWS, BWC and DKH who refined and challenged the initial coding process until all the data were systematically organized into a final coding framework (Braun & Clarke, 2023).

7.4. Results

Following the coding of transcripts, three central themes emerged, each with several sub-themes related to the perceived and experienced benefits and barriers of the Athens DCR. Themes incorporate the views of both daily DCR service users and people who use drugs in public, street-based settings, or a combination of the two (see Table 1).

Theme	Sub-Theme
1. Safety	1.1. Physical safety
	1.2. Structural safety from police and criminalization
	1.3 Safety from stigma and desire for privacy
2. Connection	2.1. Access to basic necessities
	2.2. Built relationships in the DCR
3. Barriers	3.1. Stigma
	3.2. Operational barriers
	3.3. Physical barriers

Figure 10: Table 1 - Themes and sub-themes of the views of people who use drugs (who do and do not use the Athens DCR)

1. Safety

1.1. Physical safety

Participants regularly contrasted the environment of the DCR to that of the 'piazzas', the local term for open-air drug scenes. This comparison often centred around the physical safety afforded by the DCR, as highlighted by one participant who described the sense of relief experienced when accessing the service:

> *"The benefits, well it is a breath of fresh air away from the road, from the piazza, it's a safe place." (Regular DCR Client, White, Male, 40-45 yrs, Housed)*

Expanding on this, another participant described how the DCR offers respite for people who use drugs and experience homelessness:

> *"It is a place that provides security. Many younger people without shelter cannot sleep at night. They run all night right and left and come here during the day, they use early [in the day] and many times after using you see them get sleepy. They're tired, they're finished, and you see them come over here and look to get a little sleep...in a sheltered space they know won't take away their things." (Regular DCR Client 2, White, Male, 40-45 yrs, Unhoused)*

The ability to rest without fear of being robbed was seen as a significant benefit. This was reiterated by non-DCR users: *"Over there, there is security, while out on the street there is none and you can be easily robbed." (Non-DCR User, Interviewee 8, Male).* Alongside providing a safe environment, the knowledge there would be a swift medical response to keep people alive during an overdose was commonly cited as a primary benefit and reason they attended the DCR:

> *"You know that there are doctors here so there is no chance of you dying." (Regular DCR Client, Black, Male, 45-50 yrs, Unhoused)*
>
> *"When something happens to me they [staff] are there to help me. [Even] just watching me, I feel safe." (Regular DCR Client, White, Male, 35-40 yrs, Unhoused)*

The non-verbal reassurance provided by the presence of staff, even when no intervention was needed, was a vital aspect of participants' sense of security and trust in staff. Safety was also discussed beyond that of physical safety, with this participant associating safety with the harm reduction equipment available within the DCR:

> *"With the scanner I can see the veins that are to be punctured. This is very helpful." (Non-DCR User, Interviewee 21, Male)*

Despite street-based interview participants not accessing the DCR, there was a general awareness and understanding of the ways in which the DCR would offer increased safety from overdose, theft, and injection-related harms.

1.2. Structural safety from police and criminalization

For many, protection from police apprehension and the risk of criminalization was a key motivator for attending the DCR:

> *"The fact that there is a place...where we will not be bothered by the Law is a good thing...it is a place where I can use without the constant fear of the police." (Regular DCR Client, White, Female, 35-40 yrs, Housed)*

Supporting this statement, this participant described how the fear and anxiety of police harassment and rushing the injection process to avoid police detection led to physical injuries. Such injuries are rare when an individual can take their time in the DCR:

> *"The benefit is that you're not being chased by the police, the stress of use especially if it's intravenous and you see the cops in front, you can easily do something wrong, as I suffered. I put a pinch of sisha [methamphetamine] together and then saw the cops in front of me [and rushed]...I have had an abscess from that which is still slowly recovering." (Regular DCR Client, White, Male, 35-40 yrs, Unhoused)*

Mistrust of the police also related to whether they would respond appropriately in the event of an overdose:

> *"This is where the DCR is needed because when something happens inside, staff will...help you…if I'm outside, I don't know if the police will call the ambulance." (Regular DCR Client, White, Male, 35-40 yrs, Temporary Shelter Accommodation)*

Police were perceived not to prioritize the health and safety of people who use drugs. This fear extended to various other aspects of criminalization such as arrest or processing through the courts, which would also have implications such as the confiscation of drugs, and potential withdrawal:

> *"The security you get here is that you will not be taken to court, your fix will not be taken. You don't know how much I...do to get my dose, and then it just gets taken away." (Regular DCR Client, White, Male, 50-55 yrs, Unhoused)*

In contrast, many expressed a sense of relief knowing they could use the DCR without fear of arrest or harassment, specifically contrasting interactions with police (and other community members) to those they experienced with staff:

> *"There you feel safe from the residents and from the police. There I can ask about medical problems and they treat us like human beings." (Non-DCR User, Interviewee 15, Female)*

1.3. Safety from Stigma and Desire for Privacy

There was agreement from regular clients that by ensuring privacy, the DCR provided emotional safety from stigma; there is respect and dignity not often experienced in public settings and everyday encounters with the public. Contrasting the privacy offered within the service, this participant described feelings of shame and emotional discomfort experienced when using drugs in public settings:

> *"For me I come here [because] I don't like to use on the street. I don't want everyone who passes by to see me." (Regular DCR Client, Black, Male, 45-50 yrs, Unhoused)*

Participants described the relief of not using in public and particularly how the DCR helped reduce the visibility of drug use in public, particularly around children:

> *"Children now don't have to see me. I…come and do it [use drugs] here because otherwise I do it on the sidewalk. Imagine being with your child...and explaining to them what that is, having that bad conversation." (Regular DCR Client, White, Male, 45-50 yrs, Temporary Shelter Accommodation)*
>
> *"I come here in the morning hours more. Why? Because I'm on the street and homeless I can't sit out on the step, because the police are pushing me away, the shops are kicking me of their steps...especially now with tourists. In the morning, when the whole world is out and about kicking me out...I'm ashamed, so I see this place as a shelter to hang out, to take some time to myself and drink some coffee. (Regular DCR Client, White, Male, 40-45 yrs, Unhoused)*

These dual perspectives, where participants reflected both on their personal relief of no longer using in public spaces and exposed to ill-treatment from the public, and the broader benefits for the community in the reduction of public drug use, demonstrates how the DCR generates important benefits for the whole community, in particular shielding others (eg., children) from visible drug use.

2. Connection

2.1. Access to basic necessities

When asked what they valued at Steki 46, service users highlighted the tangible benefits to their daily lives through access to auxiliary services, food, hygiene facilities and others which provide basic necessities:

> *"It is the clean space, medical care and toilets, because I am homeless [and] the main problem is [accessing] toilets. The bathroom, the washing machine…the*

> *supervision of the doctor is a bonus on top of that. It all helps immensely. Also, the referrals to the hospital, to legal aid…they all help." (Regular DCR Client, White, Male, N/A yrs, Temporary Shelter Accommodation)*

Many who participated in focus groups were either in situations of homelessness and/or severe financial precarity. In this context, the provision of regular snacks, sandwiches, coffee, and other donated meals was an essential resource:

> *"This is a very big help. Coffee for example…finances are difficult, [this] is what will make the most difference to the people outside. Some days when I am broke, it really helps me to come and eat a cheese pie…lunch food not just snacks." (Regular DCR Client, White, Male, 40-45 yrs, Housed)*

For individuals without a stable income, items like coffee or a sandwich made a meaningful impact. For individuals with pre-existing health conditions such as diabetes, access to food at the DCR was both a convenience and a necessity for their well-being. One participant reflected on how the staff ensured he received this support:

> *"[I am diabetic], when my blood sugar drops they give me something sweet. They make sure I...stay safe. I really like that. The people here help immensely...I am pleased to be a member here." (Regular DCR Client, White, Male, N/A yrs, Temporary Shelter Accommodation)*

These essential provisions contributed to service users' perception of care and belonging within the DCR, highlighted by this participants description of themselves as a 'member', a term encompassing a sense of belonging to the service. Whilst many began by describing the immediate, practical benefits of these auxiliary services, their accounts frequently expanded to encompass the more formal, institutionalized care they were able to access through support by DCR staff:

> *"For so many years I couldn't cut down, but the guys that work here helped me. They also encouraged me into a treatment program....this place has made me realise that I can really make an effort to escape this life." (Regular DCR Client, White, Male, 40-45 yrs, Unhoused)*

DCR staff supported participants' personal efforts toward change, particularly in relation to drug treatment. Previously dismissed as unattainable or unappealing by many clients, the DCR was a place where the idea of recovery, or at least reducing or making healthier choices around their drug use, became a tangible goal.

2.2. Building relationships in the DCR

Many participants described the positive social connections created in the facility. Field notes captured how only half an hour from when the DCR would open in the morning, the second-floor lounge was nearly always busy with clients watching TV, playing cards, and Tavli (Greek backgammon) with staff and clients having coffee and cigarettes on the balconies. Engaging in activities with peers and staff had positive effects, including alleviating boredom, described as a common trigger for substance use:

> *"Here you will find other people to socialize with...do other things that fill up your time because many times you drink or use drugs out of boredom." (Regular DCR Client, White, Male, 50-55 yrs, Housed)*

Many regular attendees also described positive relationships with staff in the context of them connecting clients to services as well as the care and respect they exemplified when working with clients:

> *"In the beginning, I wondered about why it exists, but there happened to be a girl, a member of staff, who showed great interest [in me] ...She helped me to deal with anything I needed, from benefits to whether I was interested in going into a detox program." (Regular DCR Client, White, Male, 30-35 yrs, Unhoused)*

The ability of staff members to guide clients through complex service systems, whether related to benefits, healthcare, detox or drug treatment programs, was a frequent theme in participants' accounts. The positive impact of these interactions is further described by this participant:

> *"I got my ID through the DCR with the social worker, she was very helpful. She is much more helpful than if I would have gone alone to the office…that's another good thing…when there is someone in front of you who...sees that you know someone [a*

> *member of staff], everybody behaves a lot differently. Because they are very...discriminatory towards us in hospitals…we are not taken seriously." (Regular DCR Client, White, Male, 50-55 yrs, Housed)*

This description of staff advocacy underscores the critical role played by staff in addressing the broader social inequalities that affect clients' ability to access wider health and social services. Participants described how staff with lived experience were particularly effective in communicating with clients and addressing their needs:

> *"The staff are very flexible, there are also ex-users and this plays a big role. They understand us even better and are very flexible with us and polite." (Regular DCR Client, White, Male, 40-45 yrs, Housed)*

Supportive staff played an important role in clients' ability to access services, feel respected in potentially hostile environments, and establish a sense of trust with the facility. For many, these positive relationships were central to their continued engagement.

3. Barriers

3.1. Stigma

For some, the formality of the DCR, combined with concerns about being judged, deterred them, as noted by this participant:

> *"They feel more at home in the piazza. They feel like they are being mocked or feel a bit uncomfortable [in the DCR]." (Regular DCR Client, White, Male, 35-40 yrs, Unhoused)*

For individuals who feel more at ease in the less regulated space of the piazza, the transition to the DCR, which can appear more clinical or formal, may exacerbate feelings of alienation: *"I consider the space like a dentist's office...that doesn't work for me."* (Non-DCR user, Interviewee 9, Male). This participant for instance who now attends the service regularly, recalled how "What was difficult...was actually showing the drugs at first". (Regular DCR Client, White, Male, 35-40 yrs, Unhoused) The act of presenting drugs for consumption in a supervised setting can evoke vulnerability and anxiety, as people using the facility may fear judgment from staff or peers; and it diverges from street-based practices where drugs are hidden. This sentiment was corroborated by a participant who highlighted the sense of isolation, combined with feelings of apprehension about entering an unfamiliar space without peer support: *"I don't know anyone there and I don't feel comfortable going alone." (Non-DCR User, Interviewee 3, Male).*

3.2. Operational barriers

The overarching system of surveillance in the DCR, though for the purpose of reducing and responding to risk (e.g., overdose response), was acknowledged by many through comments such as: "in the DCR there is surveillance" (Non-DCR User, Interviewee 3, Male) and created discomfort for some people. A concern voiced by several participants was the feeling of being watched, either by staff or through cameras when using drugs:

> *"There is the fear that there are cameras watching me there, I would like there to not be any." (Non-DCR User, Interviewee 23, Male)*

This system of surveillance and risk reduction extended to specific moments within the intake and consumption process. For example, people who did not use the service cited the length of time from arrival at the facility to when you can consume drugs as a significant barrier. These experiences were again framed within the context of the unpleasant experiences of withdrawal:

> *"I have been once and only once. It is a time-consuming process. When I'm...going through withdrawals or very high I don't feel like spending it [time] there." (Non-DCR User, Interviewee 18, Male)*

The need for immediate relief, and time for the structured intake process to occur was described as a clear barrier to service engagement. Attendees valued the medical care provision, however, for some, the time spent checking in with a doctor each time they wished to use the site was additionally a barrier:

> *"When you are sick, you don't have the time to do paperwork, to see a doctor or any of those things, you don't have time for that." (Non-DCR User, Interviewee 6, Female)*

The waiting was particularly challenging when experiencing intense withdrawal symptoms as some clients presenting to the service experienced. While medical oversight is a core feature of the DCR, these experiences highlight how it may not serve the immediate needs of their client group. There was also some identified differences in the DCR compared to the street:

> *"Not everyone can fit into one mould, workers can't understand users. I…enter and they ask me what substance I have on me. I often use with my friends by doing small transactions but inside they don't let us do any transactions or share. It is very different to how we would use on the street." (Non-DCR User, Interviewee 12, Male)*
>
> *"In the DCR there are many limits, there is surveillance, documents that you have to fill out. While on the street there are no limits, no rules" (Non-DCR User, Interviewee 3, Male)*

These participants explain how the DCR environment did not mirror socially driven consumption practices, habits, or rituals that people were able to practice in other environments, particularly in relation to sharing or exchanging drugs, a sentiment echoed by others who found that restrictions around mutual aid, such as being able to inject or assist a friend during consumption, was a reason for service avoidance:

> *"I've went when it first opened. Often the ones who don't want to go, it's because here in the square or on the street there is more help. There [the DCR]...your friend cannot inject you, while here...people can do things like that." (Non-DCR User, Interviewee 19, Female)*

Beyond these social dynamics of drug use, certain higher-risk injection practices were not permitted, resulting in continued use within public environments where such injecting practices were not controlled or managed:

> *"Over there, it is forbidden to shoot in the neck or the artery. One may not want to go there because it is forbidden." (Non-DCR User, Interviewee 10, Female)*

One final and notable operational barrier which was discussed was the service restriction for people who were in opioid substitution treatment programs (OST). This was observed during the ethnographic fieldwork and noted by this participant:

> *"Many users do not come because...if you are in an OST program you cannot come to use." (Regular DCR Client, White, Male, 50-55 yrs, Unhoused)*

Someone who uses drugs in public settings explained they are now disqualified from accessing the DCR despite having built important relationships with members of staff:

> *"The staff there are like my family looking after me. But since I'm in a substitution program I can't go there...it's forbidden." (Non-DCR User, Interviewee 20, Male)*

The sense of disconnection experienced by this participant highlights how important the social aspect of the DCR can be for individuals who may otherwise be socially marginalised.

3.3. Physical barriers

Despite the many benefits which framed beliefs around why people attend or should attend the DCR, several physical barriers were described. Distance was perceived as an important factor which may dissuade people from attending:

> *"I, [live] by Victoria square which is ten minutes away, but for someone who lives far away I don't think they will come to the DCR. So it would be good if more existed." (Regular DCR Client, White, Female, 45-50 yrs, Unhoused)*

For individuals interviewed in public settings, the urgency and necessity to alleviate the withdrawal symptoms of drug dependence was often cited as the primary reason for not being able to commute long distances once they were possession of substances:

> *"If I am sick [from withdrawal], I use in the first place that I can find…if I am sick I will use anywhere...500m seems like 500km when you are sick" (Non-DCR User, Interviewee 6, Female)*

Additionally, regular attendees identified a lack of awareness amongst the local population of people who use drugs as a barrier to the service. Participants explained that beyond simply knowing about the service, people needed to be given a better understanding of exactly what takes place at the DCR and assurances they would be comfortable in that environment:

> *"A lot don't even know about it, they might have heard it as an idea, but they haven't come to see for themselves. It would be great if one day staff came to pick them up to take them…or [came] to show them pictures of the DCR at the piazza. They should invite them...they are suspicious and don't dare to take the step to come over here and see." (Regular DCR Client, White, Female, 40-45 yrs, Housed)*
>
> *"When you are homeless, you generally have a lot of phobias, that's why people can be suspicious. Especially to give one's name, for it to be written down, even during intake people may wonder, why do they want to see the drugs I have?" (White, Male, 45-50 yrs, Temporary Shelter Accommodation)*

These reflections underscore the notion that simply having a service available is not enough; active outreach is necessary to break down the barriers of suspicion and unfamiliarity. When we interviewed people in public settings, these sentiments were echoed:

> *"Many people don't know about it. Some may think that the police are cooperating and there may be a check if you go to this place." (Non-DCR User, Interviewee 16, Male)*

The recurring theme of safety, both physical and emotional, emerges here, once again emphasizing the need for the DCR to communicate how the service will treat them with dignity, respect and ensure anonymity.

7.5. Discussion

The overarching narrative from this study was the Athens DCR is helping achieve the stated objectives of responding to overdose and connecting more people to on-site and referred auxiliary, health, social and drug treatment services. However, there remains a visible community who continues to use drugs in the public spaces (Hadjikou et al., 2021). People who regularly attended the DCR, many of whom experienced housing and financial insecurity and substance dependence, experienced positive outcomes echoed in the international literature (Levengood et al., 2023; Shorter et al., 2023; Yoon et al., 2022). Regular clients also spoke to potential barriers that may prevent others from accessing the service – opinions supported by the experiences and perceptions of people who used drugs in public settings. These non-DCR users also spoke to additional barriers that regular service attendees had not mentioned. Despite this, non-DCR users had an awareness of the positive outcomes associated with DCR attendance. If the identified physical and operational barriers related to specific policies and design features of the Athens DCR can be adapted to meet the needs of the population currently not accessing the site, there is an evidenced desire from local non-DCR users to access the service.

The results from this study align with the positive outcomes described in existing qualitative evaluations of fixed-site DCRs cited above. Firstly, the primary aim of the DCR is to supervise drug use and manage overdose risks before, during and after the consumption event – in essence, keep people safe (Shorter et al., 2023). This perceived feeling of safety, particularly around 'staying alive' (Stevens et al., 2024) was discussed at length by participants and demonstrates an interest and motivation of clients to manage their health, echoed in the existing literature (Ali et al., 2023; Levengood et al., 2021; Marshall et al., 2011; Poitier et al., 2014).

Clients’ conception of ‘safety’ goes far beyond the traditional public health metrics used to define safety; instead citing a broader conceptualization of the term in relation to environments and situations in which structural violence manifests: protection from police and criminalization and safety as refuge from the stigma experienced within public consumption environments. This eliminates the need to rush the injection process, hide out in unsanitary and secluded drug consumption environments, and safeguards against the threat of physical violence, and stigma all reoccurring themes within qualitative studies of urban drug scenes (Degenhardt et al., 2023; Ickowicz et al., 2017; Levitt et al., 2020; Parkin & Coomber, 2009; Trayner et al., 2020; Rhodes et al., 2006, 2007, 2009; Southwell et al., 2022; Vallence et al., 2018).

Food insecurity and a lack of access to basic hygiene facilities is a significant issue for people experiencing homelessness or vulnerable housing situations in Athens (Arapoglou et al., 2021; Arapoglou & Gounis, 2015; Stamouli et al., 2024). Our participants describe how the DCR bridges this gap in service provision by providing food, showers, washing machines, and toilets; and how elsewhere these needs are not met. The value placed on the provision of these services speaks to the level of need that exists regarding people's most immediate needs of safety, food, hygiene, housing – all unrelated to their drug use. Thinking about the concept of intersectionality and in particular the intersectional risk environment (Collins et al., 2019), many of the clients of this facility experience intersecting forms of vulnerability (eg., food insecurity, homelessness, mental and physical health issues, etc). Athens’ DCR is an example of how harm reduction services can successfully act as an engagement point for people who may not otherwise access auxiliary health and housing services, and as such is an inclusion health intervention (Scher et al., 2024). For those who do progress from the DCR into treatment whether abstinence or opioid substitution therapies and who lose access to the DCR, it is unclear where they would access this support.

The second floor of the building, where clients can move onto once they have finished in the consumption space supports and facilitates increased feelings of socialization and belonging. Here, individuals relax with peers without the risks or fears that arise within the public environments. Such environments support broader behaviour change and wellbeing (Foreman-Mackey et al., 2019; Shorter, 2023; Stevens et al., 2024). Finally, participants spoke to reductions in public drug use which they saw and attributed to the presence and availability of the DCR. These perceptions of Athens' DCR contribute to an important evidence base highlighting the tangible benefits to individuals and wider communities of implementing such facilities in communities where there are substantial numbers of people who use drugs. As noted by Urbanik and Greene (2021), barriers to DCR utilization are contextually specific and therefore site-specific research is imperative in order for individual services to adapt to increase access.

Given the multiple benefits of the Athens DCR, asserted by regular attendees, it is equally important to highlight the perceived barriers of people who could benefit from the service, yet who do not. In our interviews with non-DCR users, many of the stated barriers were contextual, however, others were very much a product of policies typical in medicalized DCRs. Other studies have examined such barriers through several theoretical frameworks (Urbanik & Greene., 2021; Ivsins et al., 2023; Xavier et al., 2021), however in this paper we group them under the categories of: 1) operational barriers, and 2) physical barriers. For each barrier, we make recommendations which could lead to greater use of the DCR.

A primary barrier to people accessing the DCR was the distance of the service from Athens' 'piazzas'. Many explained that beyond consuming drugs with peers in these locations, crucially, people are often unable or unwilling to commute long distances to the DCR. Mobile DCR units which go out to these existing drug scenes could be effective (Shorter et al., 2022, 2023). DCR attendees suggested there may be a lack of awareness regarding the operational policies of the DCR amongst the wider population of people who use drugs. DCR non-attendees expressed that this lack of information made them feel apprehensive about attending. More direct outreach campaigns, preferably led by peers would help expanded local knowledge around the DCR, make people feel more at ease and expand access. This phenomenon has been reported in other harm reduction settings where individuals knew that a facility had been opened but had limited knowledge or understanding of the specific practices that occurred within it (Beck et al., 2024; Paquette et al., 2018; Shorter et al., 2023).

Several people, both who attended the DCR and did not, perceived self and actual stigma as a barrier. Individuals expressed apprehension around attending as they were unsure how they would be treated by staff or how they would feel being around professional, non-peer staff members. Recent research examining the perceptions of staff from drug services in Athens, has suggested that there does exist a level of stigma towards people who use drugs (Temenos et al., 2024). Whilst this may not be the case for staff in Athens' DCR, peer workers as active members of the staff team to welcome new clients is an evidence-based method of making both the intake and general service of a DCR a less intimidating or stigmatizing experience (Ivsins et al., 2023; Kennedy et al., 2019; Pijl et al., 2021).

Interviewees cited the fear or being recorded or watched over during the consumption process as a barrier. This finding has been noted elsewhere and has led to DCRs being theorized as sites of governmentality (Fischer, 2004; Scher, 2019, 2020), where under the biomedical guise of harm reduction, behaviour is monitored. Indeed, the DCR's emphasis on safety may deter individuals who equate privacy with freedom. Whilst supervision and surveillance is the central component to keeping people safe within supervised consumption facilities, making small adaptations to DCR policies, such as having a peer worker do the frontline supervision, with clinical staff in the background to intervene should an overdose occur, could make individuals feel more relaxed (Kennedy et al., 2019; McNeil et al., 2014). Also, better advertising that people's personal information and details of service attendance (frequency, substance consumed, etc) will not be passed on to other health and social care agencies may also have a positive impact on service uptake.

As noted by Urbanik & Greene (2021), the emphasis on risk reduction within DCRs, may be at odds with the needs for people who could benefit from the service. Issues arise when the environment and permitted practices within DCRs do not reflect the positive elements of socialization, pleasure or consumption ritual obtained or performed outside facilities (Clua-Garcia, 2020; Duncan et al., 2017, 2021). Non-DCR users specifically cited the extended time to arrive at the site, fill in paperwork, meet with the doctor and then access the consumption space as a deterrent, again specifically within the context of experiencing withdrawals. Where possible, policies could be reviewed related to the mandatory check to acknowledge withdrawal whilst maintaining operational licences. Where efficiencies are possible, this will avoid unwanted situations in the DCR where individuals leave and consume drugs in public or isolated locations with risks to the individual and the public.

Several other restrictions around the consumption process existed, for example: no sharing of drugs, no assisted injecting, no sharing of booths. Whilst these restrictions are typical of more medicalized DCRs and have been reported widely in other global contexts (Cassie et al., 2022; Ivsins et al., 2023; Urbanik & Greene, 2021; Xavier et al., 2021), participants in Athens cited such policies as factors dissuading access. For example, during the intake process which took place upon each use of the service, the doctor would ask what and how much an individual was about the consume. A 'harm reduction conversation' would ensue. Here the doctor would sometimes recommend the person take less than planned or split their dose into smaller batches. Although this was not mentioned during interviews with people who use drugs, it was described during staff interviews. These conversations and the power dynamics in these conversations are unlike those which could occur on the street and could dissuade people already apprehensive around the DCR experience.

Finally, several individuals reported as they were enrolled in OST programs, a key evidence-based harm reduction tool, they could not access the facility. Whilst the purpose of OAT is to support individuals in achieving their treatment goals (Nosyk et al., 2011; O'Connor et al., 2021) and reduce overdose risk by halting their consumption of drugs from the illicit market, this restriction also meant that an important support system of socialization and auxiliary services was cut off from this client group. Additionally, the subsequent inability of these clients to access the DCR when enrolled may lead some individuals to use in riskier, unsupervised settings, undermining harm reduction objectives of the service. Amending this policy could be considered to expand access to the DCR and auxiliary health and welfare services.

7.6. Policy Implications

A significant proportion of non-DCR users understood the ways in which the DCR could benefit them - by reducing overdose risk, safeguarding them from physical and structural violence common on the street, increasing their access to auxiliary services and offering privacy during the consumption process. With this awareness in mind, we believe that implementing the recommended changes to DCR policies could effectively reduce the current barriers described in this paper. Not only will this allow more people to benefit from the DCR, but it will also decrease the prevalence of public drug use currently present within Athens' city centre (Hadjikou et al., 2021).

7.7. Limitations

We explore participant perspectives at a specific point in time (May/June 2023). It is important to note that views may change, especially given the service has adapted certain policies, such as expanding their operating hours, increasing the number of DCR staff with lived experience, increased numbers of mobile DCRs in Athens and on-site drug checking services, all which may have increased access to the site and altered client perspectives. Transcripts were translated from Greek to English. Although this was to a professional standard, there may be some nuance and context which was lost in how people communicated. Our findings may also subject to selection bias, with participants potentially holding different perspectives to individuals who declined to be interviewed or could not be reached (Collier et al., 2004). This limitation is important to consider, as it may affect the diversity of viewpoints captured in our study. Finally, the views of people who access services are context specific and highly localized, our findings may not represent the realities of other communities in which DCRs are implemented and future research should look to assess benefits and barriers in other contexts as a way of adapting local DCR policies.

7.8. Conclusion

This study highlights both the current successes and limitations of Athens' DCR. Whilst the facility is undoubtedly preventing and responding to overdoses, providing essential health and social care services and reducing the impacts of structural violence for those who experience homelessness or who would otherwise consume substances in public settings, there remains a substantial number of people who do not access the site who use drugs in public settings. These participants identified physical and operational barriers, such as restrictive consumption practices and the timeliness of the intake and consumption process as factors which discouraged them from accessing the DCR. Addressing these barriers through more flexible policies, expanded outreach and communication of the DCR and integrating peer workers could increase service access. More broadly, adapting these policies to be more reactive to the needs of local people who use drugs could reduce the presence and visibility of street-based drug use and improve public health outcomes for people who use drugs in Athens.

7.9. References

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8. Exploring Drug Consumption Rooms as ‘Inclusion Health Interventions’: Policy Implications for Europe

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8.1. Abstract

People who use drugs are among the most socially excluded groups in Europe. Qualitative research on Drug Consumption Rooms (DCRs) has reported various benefits to clients, including increased feelings of well-being, safety and connection, however, few studies have explored in-depth client narratives of belonging and social inclusion. In this article, we explore this literature and describe the ways in which DCRs foster social inclusion and feelings of belonging amongst their clients. With a view towards the future of DCR implementation in Europe, this argument positions DCRs as effective 'inclusion health interventions'. The shift in analysis from DCRs as a purely harm reduction or overdose prevention and response intervention to one of 'inclusion health' could work towards a wider recognition of their effectiveness in addressing broader health and social inequities. At a policy level, this shift could result in increased political support for DCRs as recognized interventions, which through their design, effectively promote social inclusion.

8.2. Introduction

In June 1986, the frst drug consumption room (DCR) in both Europe (EU) and the world opened in Berne, Switzerland. Today there are 101 DCRs of varying models across 13 EU countries (EUDA, 2024). Where implemented, these facilities successfully reduce overdose risk, connect structurally vulnerable people who use drugs with auxiliary services, and reduce public drug consumption and drug related litter (Caulkins et al., 2019; Levengood et al., 2021; Shorter et al., 2023; Stevens et al., 2024). DCRs are typically evaluated based on their ability to impact upon public health and public order outcomes (Kennedy et al., 2017). While the significance of these outcomes is important, so too, are the broader social dimensions of drug use and risk reduction and, in particular, the mechanisms of how these interventions initiate engagement and keep people engaged with supervised consumption and related auxiliary services (Stevens et al., 2024).

Understanding the ways in which clients experience DCRs helps to mitigate unintended consequences such as service avoidance or service discontinuation (Biancarelli et al., 2019; Chan et al., 2019; Paquette et al., 2017). In addition to understanding barriers or exploring peoples' negative experiences with DCRs, understanding positive experiences can help maximize potential service facilitators and the value of a service. While measuring core public health priorities is important (Shorter et al., 2022; 2023), expanding these core outcomes to include ethical considerations and an exploration of the value added to people's lives beyond traditional biomedical public health metrics is essential (Rance et al., 20211; Yoon et al., 2022).

Whilst qualitative research has reported various benefits of DCRs, such as increased well-being, safety and connection (Fairbairn et al., 2008; Kappel et al., 2016; Kerman et al., 2020; McNeil et al., 2014), in this article, we describe the ways in which DCRs foster social inclusion and feelings of belonging amongst their clients. With a view towards the future of broader DCR implementation in Europe, this argument positions DCRs as effective ‘inclusion health’ interventions (Marmot, 2017), building on a recent realist review describing overdose prevention centres or DCRs as spaces of safety, trust, and inclusion (Stevens et al., 2024). This realist review drew on 391 articles and described how DCRs work through contexts, mechanisms, and outcomes applying realist methodologies (Pawson et al., 2005). Here, we draw primarily on qualitative findings, and explore the theoretical basis for DCRs to be seen as explicitly inclusion health interventions in Europe. The shift in analysis from DCRs as a purely harm reduction intervention to one of ‘inclusion health’ could work towards a wider recognition of their effectiveness in addressing broader health and social inequities beyond overdose mitigation and response, that DCRs send the ‘right message’ (Luchenski et al., 2017; Oudshoorn et al., 2021). At a policy level, this shift could result in increased political support for DCRs as recognized interventions, which through their design, could work specifically to promote social inclusion (Shorter et al., 2023).

8.3. Context

Over the last 2 decades, rates of fatal overdose have remained steady in most EU countries (Pierce et al., 2021; Van Amsterdam et al., 2021). Despite this, experts have raised concerns, warning that these numbers could spike in the coming years due to the recent appearance of synthetic opioids within the illicit drug market (Alho et al., 2020; Di Trana et al., 2022; Holland et al., 2024; La Maida et al., 2020). Scholars have suggested that policy opportunities to expand

DCRs across the EU have been created by both the COVID-19 pandemic (Rigoni & Tammi, 2024) and the political necessity for policymakers to respond to increased localized rates of overdose (Unlu et al., 2022). Research across fields of study seeking to optimize the design, delivery and client experience of DCRs is therefore timely. Typically implemented in urban settings with high, concentrated numbers of people who use drugs, the consistent objective of these services, irrespective of the model of operation (mobile, stand-alone, integrated, or temporary) (Shorter et al., 2023) is to offer a safe, hygienic and supportive environment for people to consume illicit substances under the supervision of trained staff (traditionally a variety of peer workers, harm reduction workers, nurses, or doctors). Whilst the primary aim may be to respond to overdoses, evaluations have highlighted that offering supervised, well-resourced alternatives to public drug consumption environments can produce several additional positive effects (Kennedy et al., 2017; Levengood et al., 2021; Shorter et al., 2023). These include reductions in substance-related mortality (Marshall et al., 2011), substance-related ambulance callouts (Salmon et al., 2010), reductions in community-transmission of bloodborne infections including HIV and Hepatitis C (Fischer et al., 2019; Small et al., 2012) and reductions in public drug consumption (Pardo et al., 2018). Studies have also noted their ability to mitigate wider risk factors such as interactions with police (Collins et al., 2019; Urbaik et al., 202), facilitate access to wider care and support (McNeil et al., 2014), and increase perceived feelings of safety and trust (Stevens et al., 2024). Additionally, researchers have noted increases in social inclusion and feelings of belonging in relation to these services (Foreman-MacKey et al., 2019; Kerman et al., 202; Mercer et al., 2021; Oudshoorn et al., 2021; Rance & Fraser, 2011, Rickard et al., 2022), findings under-investigated and under-theorized within the literature.

8.4. Theoretical Background

Social exclusion

Scholars (Abrahmson, 2017; Abrams et al., 2007; Reimer, 2004) have described social exclusion as a common feature of societies globally and to this day it remains a persistent problem in Europe (Cuesta et al., 2024; Madanipour, 2015). Although related to the concept of poverty, social exclusion is a term which extends beyond a purely financial indicator to encompass broader structural barriers that prevent individuals or groups from participating fully in society (Madanipour, 2015; Samiyeva, 2022; Whiteford, 2020). Madanipour (2011) suggests that social exclusion is an "institutionalized form of controlling access to places, activities, resources, and information" (p.189).

Originating in France in the early 1970s, the term 'social exclusion' gained prominence across European social policy literature as it recognized the interplay and compounding nature of factors such as poverty, inadequate and insecure housing, poor health, restricted access to health and social services (Room, 1995) and its impact on participation in democratic, legal and welfare systems (Atkinson et al., 2000). Since then, the concept has been applied and recognized far beyond Europe. For example, a large body of historical social policy literature in North America has examined the ways in which exclusionary policies were devised during the eras of colonisation and slavery (Brockie et al., 2023; Galabuzi, 2008; Madanipour, 2015). Likewise, in South America, Asia and Africa, practices which excluded people and groups along lines of race and socio-economic status were distinctive of colonial control. These histories have led to enduring disparities in relation to access to resources, health and social services and civic participation (Coplan, 2009; Du Toit, 2004; Harms, 2016; Ngan et al., 2013).

Today, spatially, exclusion is often made visible through deprived inner-city or peripheral urban areas (Hubbard et al., 2017; Madanipour, 2011; Wacquant, 2010). Across global contexts, scholars have emphasized the importance in both recognising and better understanding the nature of social exclusion as a way of influencing policies which promote the right of all citizens to participate in societal institutions and civic life. Scholars have also argued that a central role and duty of democratic governments is to shape social policies in ways which prevent exclusionary processes (Parvin, 2018; Room, 1995).

Structurally vulnerable people who use drugs often face multiple forms of social exclusion. Bardwell et al. (2018) define this population as people that experience “significant vulnerability based on intersecting social and structural factors, including but not limited to: (1) structural inequities, such as drug policies and laws; (2) perceptions, stereotypes, and social norms that stigmatize particular behaviours (e.g., addiction, injection drug use) and groups (e.g., Indigenous peoples, women, immigrants); and, (3) social inequities in terms of power, status, class, and income” (p.41). Challenges like housing insecurity, homelessness, substance use, food insecurity, and stigma can work to further alienate people from society, including health and social services (Belcher & De Forge, 2012; Buchanan, 2004; Kuleza, 2013; Marinucci et al., 2023; Reilly et al., 2022; Da Silveira et al., 2018; Tyler, 2021). These characteristics and experiences are frequently reported among DCR clients (Collins et al., 2019; Magwood et al., 2020; Shorter, 2023; Wood et al., 2006). This exclusion is compounded by policies that criminalize drug use (Scher et al., 2023) which create barriers to services and can work to push people who use drugs into unsafe, often isolated settings, thus, increasing the risks of mortality, morbidity, and health inequities (DeBeck et al., 2017; Sarang et al., 2010; Strathdee et al., 2015). The high prevalence of HIV and hepatitis C among people who inject drugs in Europe (Thomadakis et al., 2024) underscores the compounded social exclusion and health inequities faced by this population (Aldridge et al., 2018) and in DCRs particularly (Newman et al., 2015).

Beyond services and policies which seek to mitigate risks and adverse outcomes, addressing social exclusion requires the creation of services, environments, opportunities and experiences that actively counteract exclusionary forces (Luchenski et al., 2017). Within this framework, the concept of belonging emerges is a key element (Ingram et al., 2020). A need to feel connected to others is a basic human need (Maslow, 1970). By fostering a sense of belonging to services we not only improve peoples' subjective experience of inclusion but also the accessibility and impact of the service being utilized (Blank et al., 2016). The intertwined notions of social inclusion and belonging are central to understanding both why people feel valued, connected, and empowered within DCRs but also the broader potential impact of conceptualizing them as inclusion health interventions.

Belonging

Mahar et al. (2013) suggest that a perceived sense of belonging refers to feeling accepted and connected to a group or community. When describing the politics of belonging, Yuval-Davis (2006) states that belonging is dependent on being valued and recognized within political and cultural life. Practically this means having equal rights and civic recognition as other group members. Additionally, perceived feelings of physical and political safety (not being targeted by members of a community) have been described as key to one's sense of belonging to that community (Everett, 2009). Belonging is in essence the glue which allows individuals to feel connected to wider social groups (Chin, 2019) Within drug policy literature, a perceived lack of belonging among people who use drugs has been associated with social exclusion resulting from the structural processes described previously (Bardwell et al., 2018; Ingram et al., 2020).

A contemporary interpretation of belonging has led to its introduction to the sociological discourse surrounding social inclusion, the opposite of social exclusion (Raman, 2023). In psychological terms, inclusion supports opportunity alongside capability and motivation for successful behaviour change (Shorter, 2023). Social inclusion refers both subjectively to a sense of belonging and objectively to a physical, structural, and political involvement within the community (Hacking & Bates, 2008). Social inclusion has been described as the political manifestation of belonging and entails having rights, connectedness, citizenship and equal access to health care within the community in which the individual or group is situated (Ware et al., 2007). The social exclusion of structurally vulnerable people who use drugs is associated with a perceived lack of belonging to their communities and wider societies (Blank et al., 2016; Seddon, 2006). Social exclusion is a product of perceived or actual stigma due to value and/or moral judgements on peoples 'identities' (Goffman, 1963). This social stigma, through interactions with others, can lead to self-stigma and poorer wellbeing and quality of life (Long & Jespen, 2023; Scher et al., 2023). When analysing the existing evidence from participant experiences of DCRs, it becomes clear that these interventions can and should be conceptualized as powerful interventions for fostering belonging both in relation to the physical space of the DCR but also to their wider community and society (Shorter, 2023; Shorter et al., 2023). This appears true for both sanctioned and unsanctioned sites (Bergamo et al., 2019; McNeil & Small, 2019; Shorter et al., 2022).

8.5. Discussion

DCRs as 'inclusion health interventions'

Health inequities arise from and are compounded by social determinants like employment, stigma, and housing rather than just healthcare access (Tan & Lourdesmay, 2023). Social, economic, policy, and physical environments also influence individuals' vulnerability to health risks, rather than solely individual behaviours (Rhodes, 2002). Through this recognition, inclusion health interventions focus on addressing the multiple complex health and social needs of the most socially excluded and vulnerable groups in society (Marmot, 2018). This approach to research, service design and policy (Aldridge et al., 2018) goes beyond the traditional scope of health equity, which primarily seeks to ensure fair and equal access to healthcare resources to reduce disparities (Braveman, 2023). While health equity seeks to address systemic inequalities in healthcare distribution and outcomes, inclusion health broadens the focus to encompass the social and interpersonal dimensions of inclusion by bringing into focus both healthcare needs as well as the broader determinants of health such as housing, education, and social support (Campos-Matos et al., 2019). Finally, inclusion health acknowledges that factors such as stigma and social exclusion can have profound effects on health and well-being (Corrigan, 1998; Goldberg, 2017), in particular in creating barriers to service access (Marmot, 2018). Inclusion health offers a framework for research, service provision and policy that considers these wider factors and barriers aiming to reduce stigma and foster a sense of belonging and participation among vulnerable populations (D'Eloia & Price, 2018; Long & Guo, 2023), all of which are key components of DCRs.

8.6. Implications

The conceptualization of DCRs as inclusion health interventions provides a framework for policy development that goes beyond overdose mitigation to addresses the complex health and social needs of structurally vulnerable people who use drugs in Europe. Indeed, DCRs have extended social and community functions which can support and facilitate the 'wrap-around services' that are often reported as inaccessible to vulnerable populations in Europe (Canavan et al., 2012; Carmicheal et al., 2023). Shifting this frame of analysis could have important implications for future adaptations and expansions of DCRs. Below we outline four ways in which future DCR policy and practice could work to promote broader social inclusion and civic engagement among often marginalised people who use drugs.

Integrating health and social services

Although funding and logistical constraints mean that comprehensive DCRs with on-site health and social services are not possible or appropriate in every context, as an intervention, integrated DCRs or DCRs which are well linked with external services are effective in widening access to services for people who may not engage with other, more traditional forms of health and social care (Shorter et al., 2023). One of the primary implications of viewing DCRs as inclusion health interventions is to highlight their unique ability as points of engagement towards a range of other services. Moura et al. (2024) survey of EU DCRs highlights that many DCRs already provide a wide range of auxiliary services and crucially consult service users with regards to what and when services should be offered. To be clear, overdose prevention and response should remain a priority, and inclusion health services should only be offered, by consent, to effectively reduce social exclusion and bridge the gap between healthcare, social services, and structurally vulnerable people who use drugs (Luchenski et al., 2018). Unsanctioned sites should also be linked to wider service provision (Shorter et al., 2022). When evaluating the effectiveness of individual sites, expectations regarding auxiliary services should be realistic and tailored to each site's capacity.

Increasing client involvement

Actively and meaningfully including clients in the planning, implementation, and evaluation of DCRs (Marshall et al., 2015) promotes feelings of belonging and increases the chance of service continuation. In recent years, an increasing number of participatory studies (Scher et al., 2023; Valdez & Garcia, 2021) have evaluated DCRs by working with peer interviewers (Berg et al., 2024; Parkes et al., 2022) and peer guides during ethnographic field sessions. Whilst clear and distinct benefits have been noted in relation to the quality of the data generated and the experiences of those involved, scholars, and activists (Damon et al., 2017; Neufeld et al., 2019; Ritter et al., 2018; Simon et al., 2021) caution against ways in which community-based participatory research can reproduce and reinforce stigma and harms if not done correctly and instead encourage 'community led' projects to mitigate unintended risks. Lastly, services should consider expanding the practice of employing peers in DCRs as it enhances the client experience by making people feel more comfortable and willing to engage (Chen et al., 2023; Kennedy et al., 2019). Additionally, it provides opportunities for clients to contribute to its operations (Woolhouse et al., 2013) which can offer a high degree of purpose and meaning (Greer et al., 2021).

Expanding civic participation

A central element to the concept of inclusion health is the creation of environments and avenues through which people can participate in society. In this respect, by providing on-site or referring to of-site services that help individuals register to vote, obtain identification, and access benefits, DCRs have great potential in facilitating civic engagement. This practice is already done in many DCRs around Europe (Moura et al., 2024). Community volunteering through the DCR can also enhance whole community cohesion and integrate people who use drugs with the neighbours located around the DCR (Southwell et al., 2022). By offering these opportunities, DCRs can strengthen individuals' sense of stability whilst reinforcing their status as equal citizens deserving of rights, opportunities, and equal access to healthcare (Oudshoorn et al., 2021). Finally, a strong message about the importance of inclusion health policies and interventions is sent by the symbolic presence of DCRs in communities as places where individuals are treated with dignity and respect (Stevens et al., 2024). It emphasizes once more the importance of viewing people who use drugs as citizens rather than patients or criminals, as currently instructed through criminal law (Scher et al., 2023).

Implications for researchers and funders

Re-framing DCRs as inclusion health interventions could create a shift in the way in which researchers and funders seek to evaluate them as interventions. Firstly, this could result in researchers designing more interdisciplinary evaluations that use qualitative, community-engaged methods to assess the broader impacts of DCRs beyond the traditional public health or public order metrics (Kennedy et al., 2017). This approach would encourage the examination of not just immediate health or community outcomes but also long-term social inclusion and community social cohesion outcomes (Cooper et al., 2014) and compliment initiatives to standardise measurement in DCRs internationally (Shorter et al., 2023). Funders could also come to recognize the value of broader, more holistic evaluation metrics that go beyond traditional indicators to include measures which speak to the social inclusion and well-being of clients as a direct result of their ability to access DCRs.

8.7. Conclusion

DCRs have broad potential to address social and health inequities, beyond their proven harm reduction benefits. By framing DCRs as inclusion health interventions, we highlight how by providing or facilitating access to services such as health and housing support, legal aid, and employment assistance, DCRs reduce barriers to service access whilst working to address both immediate health needs and the broader factors that contribute to social exclusion and structural vulnerability. Adapting the current view of DCRs from a purely harm reduction intervention to one of inclusion health could work to foster increased political support for them as evidence-based interventions which reduce overdose risk whilst simultaneously addressing multiple factors which contribute towards social exclusion.

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9. Discussion

This DPhil project was guided by two overarching research questions: (1) in what ways is the lived experience and quality of life of people who use drugs shaped by their ability to access harm reduction interventions; (2) what policy implications for the delivery of OPCs can be derived from the lived experiences and perspectives of clients and potential clients? Question two is discussed in depth in each of the papers and reveals an important finding that crosscuts all of the case studies: the lived experience of people who use drugs should be prioritized as a key resource in the design and delivery of harm reduction services which aim to support their survival, health, social inclusion, and broader well-being. In each case study, there are clear examples of OPC service design and policy which increase access to services and produce positive results, described by participants in tangible and clearly impactful ways. At the same time, in each location, policies are enacted which restrict access to services.

Question one however will in large be the focus of this discussion section. The reason for this is that I believe any attempt to answer the first question must be rooted in context. Specifically, any in-depth academic exploration of SCSs, DCRs, OPCs and the people who access them, must situate the macro, structural contexts in which they operate and in which their clients live. Of particular importance, beyond the effects of the harm reduction services of focus in each paper, participant narratives highlight the ways in which structural factors restrict people's ability to lead more safe, healthy, socially connected and fulfilled lives. In this discussion section I will be 1) summarizing the findings of each paper, 2) highlighting the contribution to knowledge of this thesis, 3) highlighting it's limitations and 4) discussing the research implications that emerge from the findings of this DPhil thesis.

9.1. Summary of Findings

In paper one, the aim was to assess the need for an OPC in Sandwell, England, by examining the experiences and perspectives of local people who use drugs. Methodology consisted of focus groups (20 participants over three sessions) and street-based interviews (n=20) with local people who use drugs in street-based settings, ethnographic field session and photo-ethnography. Findings evidence the need for safer environments for people currently using drugs in public and semi-public settings in the UK. Exposure to the threat of public and police interaction in semi-public drug use spaces lead to rushed injection practice, hampered poor venous access management, and increases risk of injection-related harms. Participants were enthusiastic about the concept of an OPC and its potential to reduce injecting-related risks, drug-related death, provide safety, and prevent negative experiences with police. Participants also highlighted concerns about negative public perceptions of their community, viewing an OPC as a potential solution to improving community relations by reducing drug-related litter.

In paper two, the aim was to explore qualitatively the ways in which residents and staff experience a housing-based overdose prevention service (HOPS), with a particular focus on how this intervention fits into the day-to-day operations of a low-barrier housing facility in Vancouver, Canada. Methodology consisted of non-participant observation (≈200 hours), focus groups (15 participants over three sessions), rapid-ethnographic interviews with residents (n=20) and semi-structured interviews with staff (n=12). Our results suggest that at this facility the HOPS is underused due to a variety of structural factors, the most prominent of these being the lack of inhalation services. This lack of service provision exacerbates overdose vulnerability and stigma. Continued drug consumption in the vicinity of the building and in non-monitored areas inside the building creates challenges for staff in identifying potential overdoses and exposes residents who do not consume drugs to drug use within the building.

In paper three, the aim was to understand the structural, contextual and operational determinants of regular SCS attendance in the context of the Resource Centre (RC) in Vancouver. Methodology consisted of non-participant observation (≈200 hours), focus groups (25 participants over five sessions), rapid-ethnographic interviews with clients (n=20) and semi-structured interviews with staff (n=15). Findings highlight several important factors related to the determinants of regular service attendance. Firstly, the service had a regular clientele who described their attendance as routinized, credited to four distinct factors: 1) the accessible location, 2) the on-site auxiliary services, 3) the diversity of harm reduction provision and 4) the atmosphere. Exploring the concept of atmosphere in more depth revealed that it was characterized by the safety, familiarity and inclusivity experienced within the service. Together these factors facilitate a strong sense of belonging in attendees regarding the service and its community of staff and clients.

In paper four, the aim was to qualitatively evaluate the operational strengths and weaknesses of Athens' DCR from the viewpoint of DCR clients and people who use drugs locally in public settings who do not access the DCR. Methodology consisted of non-participant observation (≈200 hours), focus groups with clients (25 participants over five sessions), rapid-ethnographic interviews with people who use drugs in public settings who do not access the DCR and semi-structured interviews with staff (n=12). Regular DCR clients reported increased physical, structural and emotional safety as well as increased connection with auxiliary health and social services and staff and peers. Those who did not use the facility could see potential benefits but noted several operational and contextual barriers. These results are presented through three themes, each with several sub-themes.

Paper five outlines the argument for conceptualizing DCRs, OPCs, SCSs as 'Inclusion Health Interventions' and sets out the potential policy implications for Europe.

9.2. Contribution to Knowledge

In each of Sandwell, Vancouver and Athens, structurally vulnerable people who use drugs experience significant harms. As such, the methods in this thesis were designed explicitly to uncover in-depth yet relatively quick results with the aim of informing potential policy solutions to these harms. Exploring research questions new to these three diverse global drug policy settings, the combination of rapid-ethnographic and participatory methods generated rich data drawn directly from the lived experiences of people who use drugs. This multi case-site approach allowed for a range of findings, some uniquely context specific, some that cut across these distinct policy environments. Taken together, across the four empirical papers, the findings of this thesis contribute to advancing theoretical and methodological understandings across several key areas: (1) how the risk environment framework applies across different drug policy contexts, (2) the barriers and facilitators of OPC access, (3) the framing of DCRs as 'inclusion health' interventions, (4) the relationship between drug-related harms and a range of macro-social structures, (5) the strengths of rapid-ethnographic and participatory case study methods for harm reduction research.

9.2.1. Risk Environments and Responses Across Drug Policy Contexts

Although the 'risk environment' of public and semi-public drug consumption settings and safer environment intervention responses such as OPCs have been theorized internationally (Ivsins et al., 2022; McNeil & Small, 2014; Rhodes et al., 2006; Yoon et al., 2023), they remain relatively undertheorized in the UK and Greece. As such, by investigating risk environments in these two geographical settings, papers one and four make significant theoretical contributions by highlighting the multitude of risks and harms faced by structurally vulnerable people who use drugs in the absence of sterile and supportive environments. Specifically, the first paper of this thesis highlights how the dichotomy between "controlled" and "uncontrolled" consumption environments (Parkin & Coomber, 2009) provides a valuable lens for understanding the risks associated with different types of environments in which non-residential drug use is occurring in Sandwell. Analysing the perspectives and experiences of people consuming drugs in these environments substantiates how "controlled" environments, while offering some degree of privacy and hygiene, fail to mitigate the structural vulnerabilities and risks people face. Building on the work of McNeil & Small (2014), this analysis advances theoretical discussions about the socio-physical risk environment (Rhodes et al., 2006) by emphasizing the need for interventions that address not only physical safety but also the broader socio-structural determinants of health and harm. Similarly, paper four brings to light experiences of physical harm from peers, the public and police, the threat of criminalization as well as the tangible impacts of stigma experienced by structurally vulnerable people who use drugs within public settings in Athens.

Both of these papers underscore the limitations of framing safer environment interventions solely in terms of physical safety and supervision (i.e., physical safety from overdose and risks of violence). Participant experiences, in both settings, of being rushed, threatened, or constrained by law enforcement and the threat of public visibility bring to light how fear, stress, and the broader criminalization of drug use exacerbate health risks (Harris et al., 2020). For the population in Sandwell, poor vein health and the occurrence of injecting-related injuries, resulting from these experiences was extremely common, whereas in Athens participants spoke more directly about the clear lack of basic necessities required for survival and how policing practices further constrain their ability to navigate these precarious situations. By situating safer environment interventions within the wider context of the structural vulnerability and environmental risks of participants, this paper highlights the distinct ways in which an OPC could theoretically mitigate them. This framing complements and expands existing theoretical models that position safer environment interventions as a response to immediate environmental risks (McNeil & Small, 2014; Yoon et al., 2023).

The risk environment framework also arose as a valuable lens of analysis in paper two in relation to the Vancouver based HOPS. Due to their relative novelty as harm reduction services, as well as the reluctance of service providers to draw attention to their highly politicised implementation, HOPS are relatively undertheorized (other than a few studies also conducted in Canadian settings, see Bardwell et al., 2019; Collins et al., 2020; Flemming et al., 2024a, 2024b; Galarneau et al., 2023; Ivsins et al., 2022; Lew et al., 2022). With this context in mind, this study makes an important theoretical contribution to the harm reduction and wider drug policy literature by advancing our understanding of how both residents who use drugs, residents who don't, and staff, experience HOPS in the context of shifting drug consumption practices. Again, building on Rhodes' (2009) concept of the "risk environment," the findings of paper two showcase how structural factors exogenous to individual behaviour, such as the lack of inhalation facilities, surveillance, and restrictive policies, contribute to increased vulnerability for people who smoke drugs. As noted by Collins et al (2020), the examining of such structural barriers challenges the prevailing privileging of injection-based interventions in the field of harm reduction, which often marginalize those who engage in other modes of consumption, such as smoking.

An exploration of drug-related risk environments and safer environment interventions is of value in each context at this specific moment in time. Given the continual rise in drug-related deaths and the opening of the UK's first site in Glasgow, there is renewed appetite for debate surrounding the implementation of OPCs (Atkinson et al., 2019; Parkes et al., 2022; Stevens, 2024). In Greece, research continues to highlight the growing health inequities experienced by people who use drugs (Arapoglou & Gounis, 2017; Roussos et al., 2024; Syspa et al., 2021, 2023; UNODC, 2024). And in Canada, both federal and provincial governments are seeking to adapt harm reduction service designs and policies to be more responsive to the needs of people most at risk of overdose (Belzak & Halverson, 2018; Klein, 2024). As such, these theoretical insights make a timely contribution to the ongoing academic and policy discourse.

9.2.2. Barriers and Facilitators of OPCs

Systematic reviews compiling the breadth of qualitative studies examining client experiences of OPCs (Magwood et al., 2020; McNeil & Small, 2014) highlight: 1) experiences of risk reduction by reshaping environmental contexts of injection drug use, 2) characterizations of OPCs as refuges from drug scene violence, 3) OPCs facilitating access to health and social care resources, 4) law enforcement practices as a barrier to client engagement and 5) restrictive operational policies as a barrier to client engagement. Several of these studies employ 'barrier and facilitator' analyses (Bardwell et al., 2019; Ivsins et al., 2023; Nassau et al., 2022; Urbanik & Greene, 2021). Recently, this conceptual framework has been criticized as "*relying on assumptions of linear, unidirectional processes, universally desirable outcomes, and binary thinking which are at odds with the rich understanding of context and complexity needed to respond to the challenges faced by health services and public health*" (Haynes & Loblay, 2024, p.1371). While research on OPCs has repeatedly identified barriers and facilitators to service access across contexts, less attention has been given to what influences regular attendance explicitly. Additionally, no research has yet explored barriers and facilitators specific to Athens' OPC, where many people continue to use drugs in nearby public spaces. This thesis addresses both gaps: paper three examines factors affecting regular attendance at a site in Vancouver, while paper four focuses on the Athens case.

With the aim of advancing academic understanding related to how clients maximize benefits of service attendance, the aim of study three was to focus explicitly on regular service attendance. In doing so, this study offers a new theoretical perspective through which to determine the success of a service. Through this lens, in addition to the importance of geographical service placement, diversity in harm reduction provision and the presence of on-site auxiliary services (which have been reported in previous studies), the narratives of participants highlight the importance of 'atmosphere' in sustaining engagement. More specifically, characteristics of safety, familiarity and inclusivity enable sustained engagement through producing a sense of belonging amongst clients in relation to the service and its community members. Unlike traditional barrier and facilitator research, this study has attempted to peel back the layers of complexity that exist with regards to people's reasons for initial and sustained engagement with harm reduction services. Other than Duncan et al (2020), this concept has yet to be explored in relation to OPCs.

Almost expectedly, in study three, participants valued a diversity of on-site auxiliary services and supervised harm reduction spaces that support both people who smoke and people who inject drugs. Beyond these findings, the primary insight was that the defining characteristics of 'atmosphere' foster and facilitate feelings of belonging towards both the service and its broader community contributes to the emergent theoretical discourse put forward in paper five on the role of belonging and social inclusion within harm reduction spaces (Scher et al., 2024). This framing challenges the dominant biomedical discourse within drug policy that OPCs are primarily spaces for mitigating and responding to harm (Race, 2012; Rhodes, 2009). Instead situating them as sites that actively promote social and emotional well-being that promote stability in different but equally important ways to the health focused outcomes typically reported. Paper five outlines how this theoretical finding has important implications for policy and practice which have yet to be discussed in the literature.

In a 2023 scoping review of qualitative research on barriers and facilitators to OPCs, Ivsins et al analysed the participant demographics of the forty-two papers which were included for review. Of these, the majority explored the views of people who already accessed OPCs. In practice this means that study participants are potentially speculating on potential barriers for those who do not access sites. The lack of breadth of the populations included in such studies was acknowledged by the authors as a limitation to the current global research on barriers and facilitators to OPC. Due to the visible presence of public drug use in Athens and with the aim of trying to understand how these individuals perceive the present barriers, I was interested in exploring the views of people who in theory are the target demographic of this intervention, yet do not access it. Challenging the prevailing reliance on service user perspectives within OPC evaluations, paper four uncovered rich, site-specific findings on current contextual and operational barriers. These findings rapidly informed policy recommendations discussed in the paper.

Being the first-time barriers had been investigated at this site, in discussions with both actual and potential clients, the broad concept of surveillance emerged as a clear barrier. These perceptions emerged both in relation to peoples' conceptualisation of how they would experience the DCR having never attended, and from experiences had during their initial engagements which ultimately led to them not seeking out further assistance. Whilst acknowledging that the primary purpose of surveillance is to mitigate and manage risk within such consumption spaces, a handful of papers have criticized the operationalisation and enactment of various forms of governmentality through surveillance. These practices are suggested to concretise methods of risk management and social control at the expense of potential increases in access or benefits to service users (Fischer et al., 2004; Michaud et al., 2023; Scher, 2019, 2020). These studies critique the rigid, medicalized practices of many supervised consumption settings globally. These practices can include, but are not limited to, mandatory medical checks, restrictions on consumption practices, the visible presence of cameras around facilities and the panoptic design of immediate consumption spaces.

Building and adding to this relatively small theoretical foundation, paper four interrogates how harm reduction spaces can inadvertently reproduce power imbalances and exclusionary dynamics, even as they aim to provide care and support. Exploring and engaging with these critical theories of governmentality offer insights into operational policy recommendations which could strip back certain aspects of surveillance as a means of prioritizing important social and relational aspects of people's drug use. At present, several characteristics of autonomy, socialization and privacy are constrained and disrupted within overly medicalized harm reduction environments. Recommendations are highlighted in the paper.

Paper two focuses explicitly on structural barriers to a HOPS in Vancouver. More broadly it contributes to the evolving literature on social dynamics within supervised drug consumption spaces. Participants described in detail how relational aspects of drug use including the desire to use with others for safety, mutual support, and enjoyment were important service facilitators, yet were overlooked in the intervention design. While assisted injecting is typically banned as a harm reduction practice due to the high-risk nature and legal liability risks of the practice (Xavier et al., 2021), this study adds to the critical discourse by suggesting that restrictive policies prohibiting peer-supported practices, however well-intentioned, may inadvertently act as a barrier, undermining the effectiveness of HOPS by pushing people to use in unsupervised, unsafe or unsanitary environments. As evidenced in paper two, the front entrance and back alleyway of the housing facility was regularly used as a consumption space which exacerbated harms and risk for both people consuming in these settings and staff.

Finally, and probably most importantly, this study highlights the need for policymakers and service providers to recognize the local shift from injecting to smoking and its implications for the delivery of harm reduction services like HOPS. The theoretical framing of a more inclusive practice of harm reduction, one that leans into client focused, evidence-based service facilitators provides a foundation for reimagining HOPS, and harm reduction interventions more broadly. This approach enables rapid responses to shifting risks in settings like Vancouver where consumption practices have changed, whilst the threat of overdose has continued to rise.

Whilst it was not the explicit original intention, papers two, three and four all explore and advance knowledge in relation to barriers and facilitators to OPCs in relation to different OPC models and across diverse drug policy contexts. This represents a clear and significant contribution to knowledge of this thesis.

9.2.3. DCRs as Inclusion Health Interventions

Although paper five ends with a set of distinct policy recommendations, the premise of the paper is inherently theoretical. This is due to its primary function of introducing the framework of ‘inclusion health’ to the analysis of DCRs as interventions. Unlike traditional health equity approaches which solely prioritize increased access to healthcare, the framing of DCRs as ‘inclusion health interventions’ brings focus to their ability, as interventions, to act upon the social, economic, and policy dimensions that shape structural vulnerability and social exclusion (Bourgois et al., 2017). By situating DCRs within this framework, the paper highlights their capacity to address intersecting social determinants of health, such as stigma and housing instability, which often impede access to care and perpetuate exclusion (Marmot, 2018). This framing challenges the previously mentioned traditional biomedical approach of evaluating DCRs which is primarily based on core public health and public order outcomes. Instead, this framing encourages researchers, policymakers and the public to conceptualize these harm reduction spaces as ones which facilitate about a range of positive outcomes specifically through their ability to counteract exclusionary forces.

This contribution builds on existing scholarship on inclusion health from outside the field of drug policy by integrating the subjective experiences of DCR clients. Examining these experiences, the paper highlights the roles of safety, trust, and belonging in promoting and facilitating inclusion and health equity outcomes. This novel framing deepens our understanding of the interplay between harm reduction practices and social inclusion, offering a new lens through which to evaluate the broader, potentially more holistic and socially oriented impacts of these services. Over the past few years, I have heard from a range of stakeholders how DRCs work by ‘keeping people alive’ until they are ready for drug treatment.

Hopefully what this thesis has shown and what I attempted to put forward in this paper is that even for people who are continuing to use drugs, these harm reduction facilities create and sustain a multitude of positive outcomes for individuals and communities.

9.2.4. Links Between Drug-Related Harms and Macro-Social Context

SCSs, DCRs, OPCs emerged overtime as interventions to predominantly address the multitude of harms associated with unsupervised drug use, particularly overdose, disease transmission and the physical and structural harms experienced in public and semi-public urban drug consumption environments. Through an analysis of the narratives of potential and actual clients, this thesis has documented the immediate benefits these spaces provide: they save lives, reduce public drug use, and create environments where people who use drugs feel safer, more dignified and can access services they potential wouldn't otherwise be able too. While they clearly play an important role where implemented in mitigating and managing broad harms, including death, they ultimately function as temporary or partial solutions to deeper systemic inequities (Gowan et al., 2012).

Without addressing the root causes of overdose, including economic deprivation, criminalization, underfunded drug treatment and supportive housing systems, stigma and the gendered and racial disparities associated with these issues, SCSs, DCRs, OPCs will remain essential, yet insufficient responses to a crisis rooted in structural violence (Tyndall & Dodd, 2020). Although overdose rates are driven by the ever-increasing toxicity of the global illicit drug supply (Cano et al., 2023; Martins & Sampson, 2015; Russell et al., 2023), as straightforwardly expressed by Dasgupta et al (2018) "*until we recognize the structural* *determinants of health we will continue to fail in our efforts to turn the tide of the opioid crisis"* (p.182).

Economic Deprivation

Most participants across the three cities were unemployed, homeless, or precariously housed. These conditions shaped not only their drug use but also their broader experiences of health and social instability. A large body of research notes the associations between economic deprivation, social marginality and overdose rates (Altekruse et al., 2020; Fink et al., 2024; Frankenfeld & Leslie, 2019; Gutkind et al., 2023; Heyman et al., 2019; Van Draanen et al., 2020). In practice, financial constraints limit people's access to basic necessities like stable housing and healthcare, all of which contribute to social and physical vulnerabilities associated with overdose. For people who use drugs, these vulnerabilities, including the environments in which they consume substances intersect with and exacerbate substance use patterns (Collins et al., 2019). These findings have been shown to be particularly acute when contrasting overdose rates across low-income and high-income neighbourhoods within same cities (Van Draanen et al., 2020).

Particularly visible in Vancouver (Burnett, 2014; Tolfo & Doucet, 2022) and Athens (Alexandri, 2018; Avdikos, 2015), mechanisms of gentrification can also act to intensify overdose risk. Typically accompanied by strict anti-homelessness by-laws and policing-led initiatives to reduce the visibility of poverty, gentrification compounds economic deprivation by eroding community networks and displacing people from spaces where they once felt a sense of belonging (Johnson, 2024; McKelvie, 2020; Song & Levine, 2024). Without a focus on poverty and economic deprivation as primary structural conditions which drive overdose risk, it will continue to persist. Ultimately, these conditions leave harm reduction interventions to manage only the most immediate consequences of deep rooted systemic socioeconomic failures (Souleymanov & Allman, 2016).

Underfunded Drug Treatment and Supportive Housing Systems

The chronic underfunding of drug treatment and supportive housing services has exacerbated the vulnerabilities faced by people who use drugs (Alexiou et al., 2023; Livingston, 2020; Boberly, 2019). Since the early 2000s, all three countries have seen significant declines in funding for these critical services (Ortiz & Cummins, 2013). In Athens, austerity measures implemented during the 2008 economic crisis led to widespread cuts in public health funding, including programs for drug treatment and housing support (Ifanti et al., 2013; Karanikolos & Kentikelenis, 2016; Tsiboukli, 2015). Participants in Athens frequently cited the lack of accessible drug and housing services as major barriers to improving their quality of life. In Vancouver, despite its reputation as a leader in harm reduction, funding for long-term supportive housing and comprehensive drug treatment programs has failed to keep pace with the growing need (Nowell & Masuda, 2020). In both Vancouver case sites discussed in papers two and three, participants described lengthy waitlists for drug treatment as well as being discharged from short-term programs without adequate follow-up support. These experiences are widely reported in the existing literature (Phillips et al., 2014; Prangnell et al., 2016; Vipler et al., 2018). Additionally, long program waitlists and time lags between placements leaves individuals in precarious situations, increasing their reliance on OPCs as a stopgap measure rather than a pathway to stability, in some cases even leading to ambivalence towards drug treatment all together (Fast, 2021). Similarly, in Sandwell, participants highlighted a perceived absence or inaccessibility of publicly funded drug treatment and supportive housing programs.

Cuts to local authority budgets in the UK have decimated funding for these services, leaving many to rely on third sector organizations or navigate life without support (Drummond, 2017; Lewer & Bibby, 2021; Freibel et al., 2022; Price, 2024). This chronic underfunding perpetuates poverty, homelessness, and substance use, and is associated with increased drug-related mortality across local authorities in the UK (Koltai et al., 2021).

Criminalization

Nearly every country around the world (115 out of 128) uses criminal law to address drug-related issues in society (Harm Reduction International, 2024). Still, a substantial and ever mounting evidence base suggests that the criminalisation of drugs for personal possession plays a central role in shaping negative health outcomes for people who use drugs (DeBeck et al., 2017). Whilst scholars (De Pozo et al., 2021) and police (Greer et al., 2022; Zakimi et al., 2022) debate the extent to which the possession of drugs as a sole offence is enforced, at the time of this research, in all three of Canada, Greece and the UK, drugs were criminalised under the law. Therefore, expectedly, experiences of criminalization were discussed by participants in all four case sites.

There was not always space in the various papers to discuss in depth the harms reported by individuals as they attempted to navigate their lives as criminalized individuals. However, it was evident that being dependant on a criminalized substance shaped their interactions with law enforcement, healthcare, social services and ultimately the OPCs themselves. In all three countries, criminalization created a climate of fear and distrust, in particular towards law enforcement. For example, in Athens, participants described being harassed by police near the city’s only drug consumption room, undermining its effectiveness as a safe space. Although this finding was not central in the presentation of the paper, it reflects broader trends in policing practices reported in other harm reduction settings (Collins et al., 2019; Holeska, 2022; Urbanik et al., 2022; Watson et al., 2021) that limit access to services and push people who use drugs further into the margins of society (Bacon & Spicer, 2023; Fassin, 2013).

The impact of criminalization extends beyond individual interactions with law enforcement. It perpetuates multiple levels of stigma, including structural stigma which frames people who use drugs as criminals rather than individuals deserving of care and support (Scher et al., 2023). This stigma reinforces barriers to employment, housing, and healthcare, creating a cycle of exclusion and marginalization (Shahid & Neufeld, 2024). In Vancouver, many participants described how criminal records from minor drug offenses prevented them from securing housing or stable employment. Similarly, in Sandwell, participants highlighted how the absence of safe spaces to consume drugs was compounded by a punitive approach to drug use by local police. Including, narratives of police discarding drugs and equipment, with no offer of social or medical support to individuals who were struggling with acute symptoms of withdrawal. In legislative and policy environments of criminalization, such interactions between agents of the state, who are empowered to enforce the law, are natural.

As a body of work, this thesis contributes to broader theoretical debates within drug policy by questioning the efficacy of criminalization as a strategy for addressing drug-related harms. The pervasive fear of law enforcement reported by participants across all four settings not only reinforces existing critiques of punitive drug policies (Bratberg et al., 2023; Kleinman & Morris, 2021; Maher & Dixon, 2017; Ryland & Scher, 2024; Scher et al., 2023; Seddon, 2006; Stevens et al., 2024; Virani & Haines-Saah, 2017) but also highlights the role of safer environment interventions, such as OPCs, in creating spaces of respite from both micro-level environmental risks and macro-level structural inequalities from the harms perpetuated by these policies and practices.

Gendered Dimensions of Structural Violence

A growing body of global evidence demonstrates that women – *"especially marginalized women and gender diverse persons – are differentially impacted by drug-related risks and harms in comparison to cisgender men who use drugs"* (Collins et al., 2019, p.43). Scholars (Austin et al., 2023; Boyd et al., 2018; Collins et al., 2019; D'Orsogna et al., 2023; Perri et al., 2022) note that despite this, policy responses, including harm reduction interventions are predominantly gender neutral and do not account for important structural, gender-specific challenges which could be contributing towards overdose risk (e.g., sex work, loss of child custody, assisted injections). Whilst women were underrepresented in each of the studies that make up the body of this thesis (and this will be discussed in the limitations section of this thesis), in each, we got a glimpse of some of the unique challenges associated with gender. As noted by previous researchers (Colledge et al., 2020; Larney et al., 2017; Robertson et al., 2020; Wheeler et al., 2022), due to women generally having smaller surface veins than men, they may be more likely to have difficulties accessing veins and therefore be more reliant on others to assist with the injection process throughout their injecting careers. Despite being underrepresented in the samples of papers one and two, female participants spoke to both the experiences of these issues and also the resulting social dynamics of not having safe spaces which accommodated such supported injecting practices.

It is well evidenced that in uncontrolled settings, gendered power dynamics related to injection drug use can exacerbate health risks (Brothers et al., 2024; Doran et al., 2020; Harris et al., 2019). Whilst women in the Vancouver integrated-SCS setting and in Athens did not speak about specific instances or experiences, they frequently, at higher levels, discussed fears of violence both in the facility and in the wider community. Existing research discusses disparities in the gendered experience of harm in the context of people who inject drugs in public or semi-public settings. For example, studies have shown that women are more likely to "go second", reusing injecting equipment when injecting with a male partner (Sheard et al., 2008; Wurcel et al., 2018), less likely to engage with harm reduction services due to their gender neutral design (Boyd et al., 2018; Collins et al., 2019; 2020), and be more likely to be victims of physical and sexual violence in street based settings (Argento et al., 2017; Bourgeois et al., 2004; Kitson & O'Byrne, 2020; Marshall et al., 2008).

Despite the data pertaining to staff experiences and perceptions not highlighted in all the studies included in this thesis, across contexts, staff explained to us how many of the women they encounter initially avoided OPCs and other harm reduction services due to fear of encountering abusive partners or being stigmatized as unfit mothers. Such descriptions are widely reported in the existing literature (McCartin et al., 2022; Meyers et al., 2021; Schamp et al., 2020; Stone, 2015; Van Olphen et al., 2009). Echoing the recommendations of the scholars noted in this section, gendered experiences of structural violence highlight the need for harm reduction services that account for these specific vulnerabilities.

Racism

Racial injustices throughout both the historical development and contemporary manifestation of the war on drugs are well documented (Godkhindi et al., 2022; Fornilli, 2018; Provine, 2011). Similarly, racism within broader healthcare systems and research practices are widely acknowledged but remain largely unresolved (Ahlberg et al., 2019; Feagin & Bennefield, 2014; Hamed et al., 2022, 2024). Whilst race and racism did not emerge directly through the narratives of participants in the various case studies, it is particularly important to note the historical and racial contexts of the three cities and countries in which they are embedded, as it is well evidenced that racial disparities both in the delivery of services and in the policing of the war of drugs complicate the structural conditions faced by people who use drugs.

In Vancouver, colonial legacies of dispossession and systemic racism remain very much visible to this day (Lavalee & Poole, 2010; MacDonald & Steenbeek, 2015). Indigenous populations are vastly overrepresented in provincial and national prison populations, overdose morbidity rates (Butsang et al., 2025) and in the numbers of people who access SCSs (Boyd et al., 2022; Milaney et al., 2022). These statistics reflect the intergenerational trauma and structural inequities experienced by Canada's indigenous populations. As a glimpse into this, indigenous participants discussed their dislike of the Vancouver Canucks, explaining how they and the people they grew up with always tended to support non-Canadian teams. Although anecdotal, this preference, underscores how colonial violence shapes not only structural inequities but also the cultural affiliations (e.g., a rejection of Canadian identity), and everyday experiences of Indigenous peoples in Vancouver and Canada more broadly.

Sandwell, an outer suburb of Birmingham is more ethnically diverse than most other parts of the UK. In 2021, 57% identified as "White British" compared 82% in the rest of the UK. "Asian or Asian British" followed by "Black, Black British, Caribbean or African" make up the 2nd and 3rd most represented ethnic group in the area (Sandwell Census Overview, 2021). Racial discrimination in the policing of drugs, in particular through stop and search practices have been widely reported and theorized in the UK (Baroness Casey Review, 2023; Miller et al., 2020). Whilst such narratives did not emerge in the Sandwell study, racialized participants did express more intense cultural manifestations of community stigma towards their drug use which they noted as a factor which could act as a barrier if an OPC was implemented in their local community. This supports the findings of Devonport et al. (2023), Douglass et al. (2023), Wanigaratne et al. (2003) and Rosales et al. (2022) who all evidence how across the UK ethnic minorities are less likely to access drug services. Again, whilst not all these factors arose in the Sandwell study, the above authors attribute these disparities to a combination of factors, including systemic racism in drug policing, heightened community stigma, and a lack of culturally sensitive service provision that adequately addresses the needs and concerns of these populations.

In Athens, once again, race or ethnicity did not emerge as an important factor in the narratives of participants. This is most likely because despite a high population of migrants living in marginal social conditions in the city centre, they did not feature in the study sample. It is however important to note that experiences of structural racism in Greece are reflected in studies exploring the experiences of migrant populations who use drugs, when accessing healthcare and drug services. Feelings of isolation and anxiety in these care settings are attributed to the inadequate provision of culturally sensitive services; for example a lack of communication support leading to language barriers (Michalis et al., 2023; Papadakaki et al., 2017). Additionally, migrants in Greece report higher levels of healthcare discrimination compared to other European countries, particularly among women and those with chronic health conditions (Gil-Salmeron et al., 2021). Finally, stigma from health and social care professionals towards people who use drugs is documented in Athens (Temenos et al., 2024). Together these findings may have been a factor in driving the lower observed rates of ethnic diversity in the Athens DCR client group.

9.2.5. Methodological Contribution

The methods used in thesis were employed with the specific purpose of centring the lived experiences of people who use drugs within differing drug policy climates as a means of drawing out explicit place-based policy recommendations. Discussed in each paper, as well as in the methods section of this thesis, the combination of rapid-ethnographic as well as participatory approaches used throughout each of the empirical papers makes a novel contribution to the range of methods used in drug policy research. In the context of harm reduction each paper also makes valuable contributions to theoretical discussions related to research ethics and best practices working with structurally vulnerable people who use drugs as well as the staff who work with them. It is also important to note that although papers one and four contained more participatory elements, each study started with a community consultation which shaped the questions and ultimately the direction of the research.

Firstly, an important theoretical contribution of paper one lies in the study's methodological engagement with the voices of people who use drugs. By documenting how participants perceive and articulate the need for an OPC in Sandwell, the paper centres the agency and expertise of people who use drugs in identifying the most appropriate responses to the risks they face. Whilst each of the papers in this DPhil engage in some form with participatory approaches, this first paper, from design through to dissemination, was entirely participatory (Scher et al., 2023, 2025; Southwell et al., 2022). The approach aligns with and extends critical harm reduction literature that advocates for the inclusion of lived experience in shaping policy and practice (Bardwell et al., 2019; Akash & Wimplove, 2023). This approach builds on the recommendation of Greer et al (2018) who envision and set forth a framework for CBPR which *"aims to democratize knowledge by involving community members in the research process* *itself and promotes social transformation rather than simply the generation of knowledge"* (p.1).

Paper two also offers a novel methodological perspective by including diverse voices, exploring how the design of harm reduction services impact not only residents who use drugs but also those who do not, as well as the staff tasked with implementing these programs within mixed housing settings. The competing priorities of staff, who first and foremost are concerned with the safety of all residents, are critical to the successful implementation of HOPS yet remain highly undertheorized. Narratives of staff continuing to respond to overdoses around the building despite the presence of a designated supervised consumption space highlights the need for more research into how to better support both staff and clients who continue to experience risks within their living environments. Such findings would not be uncovered without a methodological focus on their experiences. Paper three takes a similar broad approach to gathering all possible views within the harm reduction service allowing the themes and narratives which triangulate across clients and staff as well as focus groups and interviews.

Finally, in a 2023 scoping review of qualitative research on barriers and facilitators to OPCs, Ivsins et al analysed the participant demographics of the forty-two papers which were included for review. Of these, the majority explored the views of people who already accessed OPCs. In practice this means that study participants are potentially speculating on potential barriers for those who do not access sites. The lack of breadth of the populations included in such studies was acknowledged by the authors as a limitation to the current global research on barriers and facilitators to OPC. Due to the visible presence of public drug use in Athens and with the aim of trying to understand how these individuals perceive the present barriers, I was interested in exploring the views of people who in theory are the target demographic of this intervention, yet do not access it. Challenging the prevailing methodological reliance on service user perspectives within OPC evaluations, this study uncovered rich, site-specific findings on current contextual and operational barriers. As noted by Collins et al (2022), the use of rapid ethnography is particularly useful in research contexts like these which require quick findings to inform policy related to rapidly escalating rates of drug-related death. These papers contribute to this body of literature.

9.3. Limitations

This thesis has several limitations. Whilst each individual paper addresses limitations specific to that study, here, I highlight the limitations which cut across the entire thesis. These limitations relate primarily to methodological constraints and limitations stemming from my individual positionality.

Firstly, joining a participatory research team as a research assistant for the Sandwell study, I was shown by the academics, community experts and peers, first-hand, how to conduct rigorous and ethical participatory research. Subsequently, without the required resources, (in terms of time, money and expertise), I then intended to replicate this by myself in Vancouver and Athens. As such, the Vancouver and Athens papers were conducted with participatory elements but did not live up to the complete level of participation that I had originally intended. This limitation reflects both logistical constraints, such as limited time for building trust and relationships in certain field sites, my position as a researcher navigating complex ethical and institutional approval processes and funding for my research in terms of being able to properly renumerate community partners. Greater engagement with people who use drugs in shaping the research questions, study design, data collection, analysis and dissemination would likely have enhanced the depth and applicability of the findings and future research by myself and others looking to investigate the questions in this thesis could address this by embedding participatory frameworks into all stages of the research process, as was done in Sandwell.

Secondly, the samples in each case study were not as demographically or experientially diverse as is most likely the local populations of people who use drugs. Participants across sites tended to be white men, despite local diversity of potential participants implicated in the research questions. Having spent a substantial period of observation in each site prior to data collection, I can attest to this. I believe that this limitation is a result of both the lack of diversity of clients (eg., female and racialized people who use drugs) who feel comfortable accessing harm reduction services, but also from minority groups not feeling confident or trusting in engaging with research. This lack of diversity limits the extent to which the findings can represent the broader population of people who use drugs in each community. In doing so, the findings of this thesis may potentially be overlooking important intersections of identity, stigma and broader structural experiences in their communities. I intend to learn from this experience and take this issue into account in both the planning and fieldwork stages of future research projects.

Thirdly, the decision to minimize demographic data collection for ethical reasons and participant comfort may have inadvertently constrained the contextualization of participant experiences in the result sections of the four empirical papers. When the Vancouver HOPS paper was under review with the *Canadian Journal of Public Health*, this was highlighted by the editors and is something I wish I had considered when planning the case studies and the various methodological approaches. While the rich narratives offered valuable insights, capturing additional demographic information, such as age, ethnicity, and housing status, could have added a layer of depth to understanding how structural factors intersect with individual experiences.

Finally, although there were multiple co-authors on each of the papers included in this thesis, ultimately, each of these studies were qualitative and interpretive in nature. As such, these findings, to a degree, represent my own analytical lens. Although methodological procedures such as documentation of analytical processes, triangulation of data sources and multiple coders were employed to enhance the trustworthiness of the findings it is very possible that other researchers might draw different conclusions from the same data. The richness and volume of the data, along with recurring patterns and themes, support the robustness of the conclusions, but this inherent subjectivity is an acknowledged limitation of interpretive research. Although I discuss this in depth in the positionality statement in my methods section, my personal experiences growing up in Vancouver, working for multiple years as a harm reduction worker in OPCs, supportive housing and outreach teams undoubtedly shaped the lens through which I approached this research and interpreted the data. While this semi-insider perspective provided valuable insights and allowed me to be comfortable conducting fieldwork in sometimes challenging settings, it may also have introduced bias in the framing of research questions and interpretation of findings. Reflexivity was a core component of the research process, but it is important to acknowledge that my professional background and personal, political support of the evidence-base and the importance of harm reduction practices likely influenced my interpretations.

9.4. Implications for Future Research

The five papers that make up this thesis provide an in-depth exploration of localized place-based questions related to the experiences of structurally vulnerable people who use drugs; specifically in relation to people who could or currently benefit from SCSs, DCRs, OPCs access. The findings from this thesis have important implications for future research on these experiences.

Firstly, the Vancouver sites present as low-barrier and the Athens site as a medicalized facility. It would be useful to further build out questions such as: "does increased clinical oversight really facilitate risk reduction as much as is believed by providers?"; "do these potential gains in risk reduction and medical intervention warrant the high-cost of operation compared to lower barrier, more basic facilities?"; "is there a way to accurately quantify and outline the balance between the paradigms of risk reduction and clinical oversight whilst increasing access to as many people as possible?". As illicit drug consumption and rates of overdose continue to rise across most OECD countries (Pierce et al., 2021; Rivera & Freidman, 2024; Van Dem Brink et al., 2022) and as the implementation of OPCs continues to expand globally (Harm Reduction International, 2024), exploring such questions will be crucial to ensure maximal service access for all those at risk of overdose (Scher et al., 2024; Shorter et al., 2023).

A strength of this thesis is its focus on current experiences within pressing drug policy settings. However, the literature on OPCs could be further strengthened through longer term evaluations. Whilst each of my four empirical papers examines lived and living experience, it does so with a relatively short-term lens of analysis. Additionally, paper five introduces the concept of 'inclusion health' with a short-term argument of immediately fostering belonging and social inclusion amongst regular service attendees. Except for the well-recognized VIDUS longitudinal cohort study in Vancouver (from which a large number of papers have been published over the past 20 years on questions related to sociomedical outcomes of structurally vulnerable people who use drugs), the experiences of people who access OPCs and their ability to achieve improved health, housing, employment, and other broad social outcomes over a longer period remains relatively unexplored. An extended evaluation of these metrics over time would be useful in further validating the findings of this thesis; findings which speak positively to the broader impact of these services beyond overdose mitigation and response.

Finally, from a methodological perspective, this thesis has contributed to a growing field of research which centres the lived experiences of people who use drugs in questions related to appropriate harm reduction service design. Whilst this aspect of my DPhil is explored in depth in the methods section, future research could work to formalize and expand participatory models of research and policy development. Although there are best practice examples of this approach in the field of drug policy (Aldridge & Charles, 2008; Barratt et al., 2007; Souleymanov et al., 2016; VANDU, 2010) future research could build on the various participatory approaches set forth in this thesis to explore how co-production can increase the validity of findings as well as answer new questions which are restricted within traditional qualitative and quantitative research paradigms. In this same vein, this thesis has highlighted the value of using rapid ethnography in research contexts requiring timely recommendations for stakeholders, be that drug service providers, policymakers, emergency services or others. Whilst maintaining academic rigor in methodological processes, this thesis highlights how this approach brings forth the voices of people affected by a particular issue in a varied and in-depth way, not constrained by the dominant issue in traditional ethnography: the length of time needed in the field. As evidenced through this research, rapid ethnography and participatory methods are both methodologically and ethically complimentary (Sangaramoorthy & Kroeger, 2020; Vindrola-Padros, 2021). These two approaches should continue to be combined, and I hope to take this forward in my future research agenda.

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10. Conclusion

Over the past decade, rates of fatal overdose have surged in Canada and the UK. In Greece, rising rates HIV and Hepatitis C, along with significant, well-evidenced barriers to healthcare, highlight broader health inequities for structurally vulnerable people who use drugs. In all three countries, these factors have prompted a shift away from the globally dominant punitive approach to drugs and the people who use them. However, whilst OPCs are now central components of Canada's public health system, in both the UK and Greece, these interventions are novel and geographically limited. The four case studies of this thesis, located in Sandwell, UK, Vancouver, Canada and Athens, Greece, explicitly centre the lived experiences of structurally vulnerable people who use drugs as a means of advancing understanding related to both the impacts of these services and potential barriers people face in accessing them. Implementing rapid ethnographic methods and a range of participatory approaches, this thesis highlights the critical role that OPCs can play in reducing drug-related harms, preventing overdose deaths, and fostering safer, more supportive environments for people who use drugs. Across these three diverse policy settings, the findings underscore both the life-saving potential and broader inclusion health outcomes of these interventions, as well as the structural barriers that can limit their accessibility and effectiveness.

This research also demonstrates how beyond the immediate dangers of overdose death borne from exposure to a tainted and unpredictable drug supply, the socio-structural conditions surrounding drug use such as policing, housing, and stigma shape the experiences of people who use drugs and their ability to access harm reduction services and achieve broader well-being. A key finding across all case studies is the importance of incorporating the perspectives of people who use drugs into service design, policy development and research evaluation methodologies. Doing so is essential for ensuring that OPCs and similar interventions are responsive to the needs of those they seek to serve, ultimately enhancing their impact on health, social inclusion, and community well-being.

11. Appendices

Appendix 1: Submission of Thesis Requirement Checklist

Component Required	Included	Location
Thesis Title	X	Thesis Document: Title Page
Thesis Abstract	X	Thesis Document: Pages 5-7
Thesis Outline	X	Thesis Document: Pages 25-30
Introduction and background to the research topic	X	Thesis Document: Chapter 1
Conceptual literature review/theory paper	X	Thesis Document: Chapter 2 and 8
Three empirical papers with substantive findings	X	Thesis Document: Chapters 4-7
Conclusions	X	Thesis Document: Chapter 10
Statements of authorship certifying that the papers represent the work of the candidate	X	Appendix 2
Research ethics forms	X	Appendix 8

Appendix 2: DPhil Statement of Authorship

Paper 1 - Title: Exploring the Need for Overdose Prevention Centers in England: A Qualitative Community-Based Participatory Study on the Perspectives of People Who Use Drugs in Public and Semi-Public Environments

Authors: Benjamin D. Scher[1], Mat Southwell[2]; Magdalena Harris[3]; Alex Stevens[4]; Benjamin W. Chrisinger[1,5]; David K. Humphreys[1]; Gillian W. Shorter[6, 7]

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[2] Coact Technical Support Limited, Bath, UK
[3] Department of Public Health, Environments and Society, London School of Hygiene and Tropical Medicine, London, UK
[4] School of Law, University of Sheffield, Sheffield, UK
[5] Department of Community Health, Tufts University, Medford, Massachusetts, United States
[6] School of Psychology, Queen's University Belfast, Belfast, UK
[7] TreAdd Research Group on Treatment and Addictions, Tampere University, Finland

MS, MH, AS, GWS conceptualised the study and wrote the ethics application. MS, GWS and I conducted the fieldwork, data collection, data analysis and interpretation of the results. I wrote the first draft and all co-authors contributed to the comments and editing, with MH in particular offering edits which significantly strengthened the methods, results and discussion sections.

Mat Southwell

Magdalena Harris

Alex Stevens

Benjamin W. Chrisinger

David K. Humphreys

Gillian W. Shorter

Paper 2 - Title: Resident and Staff Experiences of Structural Barriers to a Housing-Based Overdose Prevention Site in Vancouver, Canada: “There is a double standard if you smoke”

Authors: Benjamin D. Scher[1], Benjamin W. Chrisinger [1,2] Dave K. Humphreys[1], Gillian W. Shorter [3,4]

[1] Department of Social Policy and Intervention, University of Oxford, Oxford, UK
[2] Department of Community Health, Tufts University, Medford, Massachusetts, United States
[3] Drug and Alcohol Research Network, School of Psychology, Queen’s University Belfast, Belfast UK
[4] TreAdd Research Group on Treatment and Addictions, Tampere University, Finland

I confirm that I completed the majority of writing in this paper. I conceptualised the study, wrote the ethics application, conducted the fieldwork, data collection and data analysis. All co-authors contributed to the interpretation of the results. I wrote the first draft and all co-authors assisted with comments and editing.

Benjamin W. Chrisinger

David K. Humphreys

Gillian W. Shorter

Paper 3 - Title: Characterizing ‘Atmosphere’: Exploring determinants of regular service attendance amongst integrated supervised consumption site clients in Vancouver’s Downtown Eastside

Authors: Benjamin D. Scher[1], Benjamin W. Chrisinger [1,2], Dave K. Humphreys[1], Gillian W. Shorter [3,4]

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I confirm that I completed the majority of writing in this paper. I conceptualised the study, wrote the ethics application, conducted the fieldwork, data collection and data analysis. All co-authors contributed to the interpretation of the results. I wrote the first draft and all co-authors assisted with comments and editing.

Benjamin W. Chrisinger

David K. Humphreys

Gillian W. Shorter

Paper 4 - Title: Benefits and Barriers: A Rapid-Ethnographic Study on the Perspectives of Potential and Actual Clients of Athens' Drug Consumption Room

Authors: Benjamin D. Scher [1], Nikolaos Poulopoulos[2], Christos Anastasiou[3, 4], Benjamin W. Chrisinger [1,5] , David K. Humphreys[1], Gillian W. Shorter [6,7]

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[4] Greek Peer Network of Users of Psychoactive Substances, Athens, Greece
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[7] TreAdd Research Group on Treatment and Addictions, Tampere University, Finland

I confirm that I completed the majority of writing in this paper. I conceptualised the study and wrote the ethics application. NP, CA and I conducted the fieldwork, data collection, data analysis and interpretation of the results. I wrote the first draft and all co-authors assisted with comments and editing.

Nikoloas Poulopoulos

Christos Anastasiou

Benjamin W. Chrisinger

David K. Humphreys

Gillian W. Shorter

Paper 5 - Title: Exploring Drug Consumption Rooms as ‘Inclusion Health Interventions’: Policy implications for Europe

Authors: Benjamin D. Scher[1], Benjamin W. Chrisinger [1,2] , Dave K. Humphreys[1], ,Gillian W. Shorter [3,4]

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[4] TreAdd Research Group on Treatment and Addictions, Tampere University, Finland

I confirm that I completed the majority of writing in this paper. I conceptualised the study and wrote the first draft. All co-authors assisted with comments and editing.

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Benjamin W. Chrisinger

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David K. Humphreys

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Gillian W. Shorter

Appendix 3: Paper 1 COREQ Checklist and Protocols

Title: Exploring the Need for Overdose Prevention Centers in England: A Qualitative Community-Based Participatory Study on the Perspectives of People Who Use Drugs in Public and Semi-Public Environments

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist (items 1-5 relate to positionality and personal characteristics of the authors and can be included in the final table after the peer-review process to maintain anonymity)

No	Item	Guide Questions/Description	Response
Domain 1: Research Team and Reflexivity			
1.	Interviewer/facilitator	Which author/s conducted the interview or focus group	See methods section of manuscript.
2.	Credentials	What were the researcher's credentials? E.g., PhD, MD	BDS: BA, MA, significant experience working with and conducting research with people who use drugs MS: lived experience and significant experience working with and conducting research with people who use drugs MH: BA, MA, PhD, lived experience and significant experience working with and conducting research with people who use drugs AS: BA, PhD, significant experience working with and conducting research with people who use drugs BWC: BA, BUEP, MUEP, PhD, significant experience conducting research with marginalised groups DKH: BSc, MPhil, PhD, significant experience conducting research on the topic of drugs and alcohol GWS: BSc, PhD, significant experience working with and conducting research with people who use drugs

3.	Occupation	What was their occupation at the time of the study?	BDS: Doctoral student MS: Managing and technical director at Coact (HIV, drug use and harm reduction consultancy) MH: Professor of Inclusion Health Sociology, London School of Hygiene and Tropical Medicine AS: Professor in Criminal Justice, University of Kent BWC: Associate Professor of Evidence-Based Policy Evaluation, University of Oxford DKH: Professor of Social Policy Evaluation, University of Oxford GWS: Reader in Clinical Psychology, Queen's University Belfast
4.	Gender	Was the researcher male or female?	BDS: Male MS: Male MH: Female AS: Male BWC: Male DKH: Male GWS: Female
5.	Experience and training	What experience or training did the researcher have?	Relevant experience and training outlined in detail in thesis.
Relationship With Participants			
6.	Relationship established	Was a relationship established prior to study commencement?	MS, MH, AS, GWS had conducted research and consultancy work with the host organization prior to this study and respective fieldwork taking place. Additionally, there was a period of participative development in the months leading up to the fieldwork which allowed the research team to build rapport with the community and eventual peer researcher prior to the commencement of the fieldwork and data collection.

7.	Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. *personal goals, reasons for doing the research*	The majority of focus group participants were involved in the participative development phase where these details were discussed and a community consultation was conducted regarding the research design and methodology. For the ethnographic interviews, participants were briefed on the purpose of the study and also informed that this project was part of the first authors PhD project. It was conveyed to both interview and focus group participants that the goal of the project was to better understand the current lived experiences of people who use drugs in Sandwell.
8.	Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? e.g. *Bias, assumptions, reasons and interests in the research topic*	During the community consultation and prior to each interview and focus group, the interviewer discussed his previous research and professional experience working in the homelessness and drug policy sector as well as his wider interest in better understanding how to improve services and outcomes for people who use drugs. In these discussions, participants were given the opportunity to ask questions relating to the interviewer and the project.
Domain 2: Study Design			
Theoretical Framework			
9.	Methodological orientation and Theory	What methodological orientation was stated to underpin the study? *e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis*	This study was oriented through a rapid-ethnographic approach. Additionally, although informed by our understanding of the Risk Environment Framework (Rhodes, 2002) and in particular the ways in which environmental factors produce risk within public and semi-public environments. All codes were developed inductively from the data.
Participant Selection			

10.	Sampling	How were participants selected? *e.g. purposive, convenience, consecutive, snowball*	See methods section of manuscript.
11.	Method of approach	How were participants approached? e.*g. face-to-face, telephone, mail, email*	See methods section of the manuscript.
12.	Sample size	How many participants were in the study?	See methods section of manuscript.
13.	Non-participation	How many people refused to participate or dropped out? Reasons?	N/A
Setting			
14.	Setting of data collection	Where was the data collected? e.*g. home, clinic, workplace*	Focus groups were conducted in a secure room within the Cranstoun drug service. Rapid ethnographic interviews were conducted in the public and semi-public settings in which we were introduced by the peer researchers to people who use drugs.
15.	Presence of non-participants	Was anyone else present besides the participants and researchers?	Not during the focus groups however during the rapid ethnographic interviews, the peer researchers were present.
16.	Description of sample	What are the important characteristics of the sample? *e.g. demographic data, date*	See methods section of manuscript.
Data Collection			
17.	Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	The question protocols were developed by all of the authors and discussed during consultations with the SCORE team (see manuscript for details).

18.	Repeat interviews	Were repeat interviews carried out? If yes, how many?	No.
19.	Audio/visual recording	Did the research use audio or visual recording to collect the data?	Audio and handwritten notes, see methods section of manuscript.
20.	Field notes	Were field notes made during and/or after the interview or focus group?	Yes, see methods section of manuscript.
21.	Duration	What was the duration of the interviews or focus group?	See methods section of manuscript.
22.	Data saturation	Was data saturation discussed?	Data saturation was discussed by the research team. Originally, we intended to conduct 5 focus groups but felt that along with the interviews, data saturation had been reached and so stopped at 3 focus groups.
23.	Transcripts returned	Were transcripts returned to participants for comment and/or correction?	Focus group and staff interviews were not returned to participants for comment and/or correction however rapid-ethnographic interview notes and quotes were checked for accuracy by all participants following the interview.
Domain 3: Analysis and Findings			
Data Analysis			
24.	Number of data coders	How many data coders coded the data?	The lead author, GWS and MS led on the initial coding framework however these codes were discussed and adapted collaboratively with the SCORE team during a participatory coding session.
25.	Description of the coding tree	Did authors provide a description of the coding tree?	Yes, a description of the various codes is included in the main text.

26.	Derivation of themes	Were themes identified in advance or derived from the data?	Themes were derived from the data.
27.	Software	What software, if applicable, was used to manage the data?	Due to the participatory nature of the coding, codes were developed manually using word and then subsequently important into NVivo 6 software. Zotero version 6 was used as a reference management software.
28.	Participant checking	Did participants provide feedback on the findings?	Yes, the SCORE Team provided feedback on the codes, interpretation of the findings and contributed to the dissemination of the results through a stakeholder meeting with local policymakers and at a drug policy conference.
Reporting			
29.	Quotations presented	Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? e.*g. participant number*	Yes.
30.	Data and findings consistent	Was there consistency between the data presented and the findings?	Yes.
31.	Clarity of major themes	Were major themes clearly presented in the findings?	Yes.
32.	Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	No.

Focus Group Protocol

- What features do you think are important in a harm reduction service?
- What might the barriers and facilitators be to accessing or attending a service?
- How do you think we should measure the success of the service?
- How would you describe the environments in which your currently use drugs?

Probe for:

  a. Sense of community ownership and agency, how can we make potential services a space for them?
  b. How relaxed do they want it to be?
  c. Medical, health or other supports they think are important?
  d. What would you like staff to do?
  e. What role do you think peers should play?
  f. Do they feel there is a need and where generally?
  g. What range of equipment is needed?
  h. What should the house rules be?
  i. How do we support meaningful PPI engagement going forward?
  j. What should the service look like (fixed or mobile? opening hours? Location? Etc)
  k. How can we reduce risks in the environment?
  l. Is there anything we have missed?

1. What do you think would encourage people to come to the facility for the first time?
    a. Probe: you, others, or any specific groups
2. What do you think would encourage people to come back to the facility multiple times?
    a. Probe: you, others, or any specific groups
3. What would put people off coming to the service?
    a. Probe: you, others, or any specific groups
4. How would we know if the service was a success
    a. Probe for: success for the peers,
    b. service providers,
    c. police,
    d. policy makers,

    e. specific groups,
    f. you
5. Is there anything else you would like to add?

Rapid-Ethnographic Interview Informal Protocol/guide (People who use drugs in public and semi-public settings)

Introducing self

- E.g. Hello, I am Ben/Mat/Gillian, I'm a researcher from (organisation) working with Drug Science aiming to talk to people in the Sandwell/Birmingham area about their views on drug services. **Would you have a moment to talk with me?**

Conversationally introducing the purpose of the conversation

- Seeking opinions on a potential enhanced harm reduction service or drug consumption room in Sandwell/Birmingham as appropriate
- Want to understand the views of people who live in the area on what they think would be useful or not so useful and the idea of what the service might be like
- That this information will be captured in field notes, which are anonymous notes which do not identify a person or a location, but summarise key points in a conversation
- The only time when we would have to pass on information is if you tell us that you: 1) are planning to seriously hurt yourself or someone else or 2) that you are involved in or aware of, a case of child neglect or abuse. Even in this rare event, we would talk to you about it first.
- That this information is part of a study for Drug Science that will also be used in the doctoral thesis of BDS. The field notes will be summarised and grouped and used to inform future services
- That they are welcome to stop the conversation at any time without any issue
- That the field notes which relate to the conversation will be reflected to them and they can remove anything which they feel does not reflect their views
- That the summary of the notes will be fed back to Cranstoun/Change Grow Live, and it might be used in presentations or publications.
- **Does this all sound ok and do you have any questions for me?** (any questions will be addressed before proceeding and **they will be asked if they are still happy to chat?)**

Semi-structured questions may include

- How would you describe the current environments in which you use drugs?
- What do you think about the idea of a drug consumption room in Sandwell/Birmingham?
- What do you think would make it a success?
- Do you see any reasons why people might not use it?

- What should we measure to determine if it is working?
- Do you have anything else you would like to tell us?

Conversation close

- **In my notes I have written that you said x, y, z (summary of conversation) just checking you are happy this reflects our conversation**
- Thank them for their time and goodbye.

Appendix 4: Paper 2 COREQ Checklist and Protocols

Title: Resident and Staff Experiences of Structural Barriers to a Housing-Based Overdose Prevention Site in Vancouver, Canada: "There is a double standard if you smoke

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist (items 1-5 relate to positionality and personal characteristics of the authors and can be included in the final table after the peer-review process to maintain anonymity)

No	Item	Guide Questions/Description	Response
Domain 1: Research Team and Reflexivity			
Relationship With Participants			
6.	Relationship established	Was a relationship established prior to study commencement?	Yes, the author had worked and conducted research for and with this organization for two years, three years prior to this study and respective fieldwork taking place. This included working at the site involved in this study. He also conducted his MA fieldwork at one of this organization's different sites in the same city.
7.	Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. *personal goals, reasons for doing the research*	All participants were briefed on the purpose of the study and also informed that this project was part of the first authors PhD project. He also disclosed that he used to work for the host organization but was no longer affiliated with them in any way. It was conveyed to both interview and focus group participants that the goal of the project was to better understand the ways in which residents and staff experienced and perceived the on-site OPS room. It was also explained that this was part of a PhD project which conducted similar research in Birmingham (UK) and Athens (Greece).
8.	Interviewer characteristics	What characteristics were reported about the	During the community consultation and prior to each interview and focus group, the interviewer discussed his previous research and professional

		interviewer/facilitator? e.g. *Bias, assumptions, reasons and interests in the research topic*	experience in HOPS and OPS as well as his wider interest in better understanding how to improve services and outcomes for people who use drugs. In these discussions, participants were given the opportunity to ask questions relating to the interviewer and the project.
Domain 2: Study Design			
Theoretical Framework			
9.	Methodological orientation and Theory	What methodological orientation was stated to underpin the study? *e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis*	This study was oriented through a rapid-ethnographic approach. Additionally, although informed by our understanding of the Risk Environment Framework (Rhodes, 2002) and in particular the ways in which environmental, social and policy factors produce risk within housing environments (Braubach & Fairburn, 2010; Ivsins et al., 2022), all codes were developed inductively from the data.
Participant Selection			
10.	Sampling	How were participants selected? *e.g. purposive, convenience, consecutive, snowball*	See methods section of manuscript.
11.	Method of approach	How were participants approached? e*.g. face-to-face, telephone, mail, email*	Participants were approached face-to-face in the facility.
12.	Sample size	How many participants were in the study?	See methods section of manuscript.
13.	Non-participation	How many people refused to participate or dropped out? Reasons?	3 people turned down the opportunity of participating in a rapid ethnographic interview, 5 people turned down the opportunity of participating in a focus group and no staff turned down a semi-structured interview.

Setting			
14.	Setting of data collection	Where was the data collected? e.g. *home, clinic, workplace*	In a secure room within the housing facility.
15.	Presence of non-participants	Was anyone else present besides the participants and researchers?	No, not during any of interviews or focus groups however staff were present during the non-participant observation phase of the fieldwork.
16.	Description of sample	What are the important characteristics of the sample? *e.g. demographic data, date*	See methods section of manuscript.
Data Collection			
17.	Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	The question protocols were developed by all of the authors. The protocol was then checked with a resident sample during an initial community consultation. During this meeting residents gave suggestions on appropriate prompts and also suggested additional question (eg., residents suggested that we have a question related to the interactions between residents who use the OPS room and those who don't).
18.	Repeat interviews	Were repeat interviews carried out? If yes, how many?	No.
19.	Audio/visual recording	Did the research use audio or visual recording to collect the data?	Audio and handwritten notes, see methods section of manuscript.
20.	Field notes	Were field notes made during and/or after the interview or focus group?	Yes, see methods section of manuscript.
21.	Duration	What was the duration of the interviews or focus group?	See methods section of manuscript.

22.	Data saturation	Was data saturation discussed?	Data saturation was discussed by the research team. Originally, we intended to conduct 5 focus groups but felt that along with the interviews, data saturation had been reached and so stopped at 3 focus groups.
23.	Transcripts returned	Were transcripts returned to participants for comment and/or correction?	Focus group and staff interviews were not returned to participants for comment and/or correction however rapid-ethnographic interview notes and quotes were checked for accuracy by all participants following the interview.
Domain 3: Analysis and Findings			
Data Analysis			
24.	Number of data coders	How many data coders coded the data?	The lead author led on the coding framework given their role at the site and familiarity with data; however, emerging themes were discussed and amended collaboratively amongst the remaining co-authors.
25.	Description of the coding tree	Did authors provide a description of the coding tree?	Yes, a description of the various codes is included in the main text.
26.	Derivation of themes	Were themes identified in advance or derived from the data?	Themes were derived from the data.
27.	Software	What software, if applicable, was used to manage the data?	NVivo version 12 software was used to transcribe and code the data and Zotero version 6 was used as a reference management software.
28.	Participant checking	Did participants provide feedback on the findings?	No, participants did not provide feedback on the findings.
Reporting			
29.	Quotations presented	Were participant quotations presented to illustrate the themes / findings? Was each	Yes.

		quotation identified? e.g. *participant number*	
30.	Data and findings consistent	Was there consistency between the data presented and the findings?	Yes.
31.	Clarity of major themes	Were major themes clearly presented in the findings?	Yes.
32.	Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	Not in this manuscript, however a longer form version of this paper will be included in the lead authors doctoral thesis will which contain a broader discussion on the minor themes.

Focus Group Protocol (Residents)

Question	*Possible Prompt*
How long have you been staying here?	How did you find out about this facility?
How have you found staff here so far?	Are there any characteristics you particularly like or dislike about the facility? Generally, have you felt safe during your stay here? Is there anything in particular which makes you feel more or less safe?
Have you stayed in any other similar housing facilities?	If yes, is there anything that is different about this one compared to previous facilities you have stayed in? How have you found being in a housing facility where there are some people who use drugs and some people who do not?
What are your opinions of the HOPS room?	What are your opinions of having a HOPS in a facility where some people use drugs and some people don't? Is the current OPS room effective in supporting ensuring access to the residents who could benefit from it? Do people still ever use drugs in areas of the building or the vicinity of the building which are not the HOPS? Is there anything you would change about the current HOPS?

Is there anything that you particularly like or would change about the day-to-day operations of the facility?	How have you found the day-to-day structure of the facility (room opening/laundry/meal/etc times)?
How have you found the other services that are on offer here?	How have you found the style and quality of the case planning here? Do you feel like your needs have been met by the case planners? How did you find the intake process? Was there anything in particular which stood out to you during the intake process?
What are you views on the provision of harm reduction equipment at the front desk?	Are you happy with the harm reduction equipment that is currently provided?
What impact do you think it would have if the HOPS room was closed down?	Who do you think would be most impacted by this?

Rapid-Ethnographic Interview Informal Protocol (Residents)

Question
How have you found your stay here so far?
What are your views on the HOPS? Is there anything you would change about it?
How would you describe the relationship between the staff and residents?
How would you describe the relationship between residents who use drugs and those who do not?
Is there anything you particularly like or dislike about the day-to-day operations of the facility?
Have you felt like your life has changed for better or worse since being a resident here?

Sem-Structured Interview Protocol (Staff)

Question	*Possible Prompt*
In your view how does staying here impact the health and well-being of residents?	In your view is harm reduction an important component of that?
What are your views on the OPS room?	Do you think it is effective in achieving its aims?
Are there any challenges that you face in your day-to-day role?	If yes, what, why and what do you think could be done to alleviate it?

In your view how does this housing facility differ to any of the other facilities provided by this organisation?	If yes, what are the key elements?
How would you describe the relationship between staff and residents?	Are there things which particularly effect this relationship?
How would you describe the relationship between residents who don't use drugs and those residents who do?	Are there things which particularly effect this relationship?
Is there anything that you would change about the how the facility runs?	If yes, what are they and why?
Do you believe that there are any major misconceptions that the public has about facilities such as this one?	If yes, what are why? Do you believe that these misconceptions effect residents in any way?

Appendix 5: Paper 3 COREQ Checklist and Protocols

Title: Characterizing 'Atmosphere': Exploring determinants of regular service attendance amongst integrated supervised consumption site clients in Vancouver's Downtown Eastside

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist (items 1-5 relate to positionality and personal characteristics of the authors and can be included in the final table after the peer-review process to maintain anonymity)

No	Item	Guide Questions/Description	Response
Domain 1: Research Team and Reflexivity			
Relationship With Participants			
1.	Interviewer/facilitator	Which author/s conducted the interview or focus group	See methods section of manuscript.

2.	Credentials	What were the researcher's credentials? Eg., PhD, MD	BDS: BA, MA, significant experience working with and conducting research with people who use drugs BWC: BA, BUEP, MUEP, PhD, significant experience conducting research with marginalised groups DKH: BSc, MPhil, PhD, significant experience conducting research on the topic of drugs and alcohol GWS: BSc, PhD, significant experience working with and conducting research with people who use drugs
3.	Occupation	What was their occupation at the time of the study?	BDS: Doctoral student BWC: Associate Professor of Evidence-Based Policy Evaluation, University of Oxford DKH: Professor of Social Policy Evaluation, University of Oxford GWS: Reader in Clinical Psychology, Queen's University Belfast
4.	Gender	Was the researcher male or female?	BDS: Male BWC: Male DKH: Male GWS: Female
5.	Experience and training	What experience or training did the researcher have?	Relevant experience and training outlined in detail in thesis.
6.	Relationship established	Was a relationship established prior to study commencement?	Yes, the author had worked and conducted research for and with this organization for two years, three years prior to this study and respective fieldwork taking place. This included working at the site involved in this study. He also conducted his MA fieldwork at this site three years prior.
7.	Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. *personal goals, reasons for doing the research*	All participants were briefed on the purpose of the study and also informed that this project was part of the first authors PhD project. He also disclosed that he used to work for the host organization but was no longer affiliated with them in any way. It was conveyed to both interview and focus group participants that the goal of the project was to better understand the ways in which clients and staff experienced and perceived the service. It was also explained that this was part of a PhD

			project which conducted similar research in Birmingham (UK) and Athens (Greece).
8.	Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? e.g. *Bias, assumptions, reasons and interests in the research topic*	During the community consultation and prior to each interview and focus group, the interviewer discussed his previous research and professional experience in facility as well as his wider interest in better understanding how to improve services and outcomes for people who use drugs. In these discussions, participants were given the opportunity to ask questions relating to the interviewer and the project.
Domain 2: Study Design			
Theoretical Framework			
9.	Methodological orientation and Theory	What methodological orientation was stated to underpin the study? *e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis*	This study was oriented through a rapid-ethnographic approach. Additionally, although informed by our understanding of the Risk Environment Framework (Rhodes, 2002) and in particular the ways in which environmental factors produce risk within OPC environments and street-based drug consumption environments (Braubach & Fairburn, 2010; Ivsins et al., 2022).
Participant Selection			
10.	Sampling	How were participants selected? *e.g. purposive, convenience, consecutive, snowball*	See methods section of manuscript.
11.	Method of approach	How were participants approached? e.*g. face-to-face, telephone, mail, email*	Participants were approached face-to-face in the facility.

12.	Sample size	How many participants were in the study?	See methods section of manuscript.
13.	Non-participation	How many people refused to participate or dropped out? Reasons?	N/A
Setting			
14.	Setting of data collection	Where was the data collected? e.*g. home, clinic, workplace*	In a secure room within the facility.
15.	Presence of non-participants	Was anyone else present besides the participants and researchers?	No, not during any of interviews or focus groups however staff were present during the non-participant observation phase of the fieldwork.
16.	Description of sample	What are the important characteristics of the sample? *e.g. demographic data, date*	See methods section of manuscript.
Data Collection			
17.	Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	The question protocols were developed by all of the authors. The protocol was then checked with a client sample during an initial community consultation. During this meeting clients gave suggestions on appropriate prompts and also suggested additional questions (eg., residents suggested that we have a question related to the interactions between residents who use the OPS room and those who don't).
18.	Repeat interviews	Were repeat interviews carried out? If yes, how many?	No.
19.	Audio/visual recording	Did the research use audio or visual recording to collect the data?	Audio and handwritten notes, see methods section of manuscript.

20.	Field notes	Were field notes made during and/or after the interview or focus group?	Yes, see methods section of manuscript.
21.	Duration	What was the duration of the interviews or focus group?	See methods section of manuscript.
22.	Data saturation	Was data saturation discussed?	Data saturation was discussed by the research team. We intended to conduct 5 focus groups and felt that we had reached data saturation at the end of this planned data collection phase.
23.	Transcripts returned	Were transcripts returned to participants for comment and/or correction?	Focus group and staff interviews were not returned to participants for comment and/or correction however rapid-ethnographic interview notes and quotes were checked for accuracy by all participants following the interview.
Domain 3: Analysis and Findings			
Data Analysis			
24.	Number of data coders	How many data coders coded the data?	The lead author led on the coding framework given their role at the site and familiarity with data; however, emerging themes were discussed and amended collaboratively amongst the remaining co-authors.
25.	Description of the coding tree	Did authors provide a description of the coding tree?	Yes, a description of the various codes is included in the main text.
26.	Derivation of themes	Were themes identified in advance or derived from the data?	Themes were derived from the data.
27.	Software	What software, if applicable, was used to manage the data?	NVivo version 12 software was used to transcribe and code the data and Zotero version 6 was used as a reference management software.
28.	Participant checking	Did participants provide feedback on the findings?	No, participants did not provide feedback on the findings.

Reporting			
29.	Quotations presented	Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? e.g. *participant number*	Yes.
30.	Data and findings consistent	Was there consistency between the data presented and the findings?	Yes.
31.	Clarity of major themes	Were major themes clearly presented in the findings?	Yes.
32.	Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	No.

Focus Group and Interview Protocol (Clients)

- Broadly what are your views on the RC?
- Have you noticed any distinct benefits in your life since attending OPCs here in Vancouver?
- Is there anything about this service that makes you want to go back?
- How would you describe the relationship between staff and clients?
- Is there anything that you think should be different about how the RC operates?

- Are there any other services you would like harm reduction organisations like the RC to be able to provide?
- Can you think of anything that acts as a barrier to you being able to access the service? If so, are these specific to the DTES?
- Do you use any other OPCs in Vancouver?
- How far do you travel to access this service?
- Do you use drugs in any other locations other than the RC? If so, how would you describe these locations?
- Have your patterns (time of day/frequency/amount) of drug use changed since you've started attending the RC?
- Do you believe that harm reduction services help to reduce levels of overdose in your community?
- Do you think your community as a whole has benefited from having OPCs? (prompt: local residents, businesses etc).

Sem-Structured Interview Protocol (Staff)

- What is your role here at the RC?
- From your experience working within harm reduction services, do you believe OPCs are having a positive impact?
- How would you describe the experience of service users who access your service?
- How would you describe the relationship between staff and residents?
- Is there anything that you would change about the how the facility runs?
- Do you believe that there are any major misconceptions that the public has about facilities such as this one? If yes, do you believe that these misconceptions effect clients in any way?
- In your view, is this facility different to any of the other OPCs in the neighbourhood?

Appendix 6: Paper 4 COREQ Checklist and Protocols

Title: Benefits and Barriers: A Rapid-Ethnographic Study on the Perspectives of Potential and Actual Clients of Athens' Drug Consumption Room

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist (items 1-5 relate to positionality and personal characteristics of the authors and can be included in the final table after the peer-review process to maintain anonymity)

No	Item	Guide Questions/Description	Response
Domain 1: Research Team and Reflexivity			
Relationship With Participants			
1.	Interviewer/facilitator	Which author/s conducted the interview or focus group	See methods section of manuscript.
2.	Credentials	What were the researcher's credentials? Eg., PhD, MD	BDS: BA, MA, significant experience working with and conducting research with people who use drugs NP: BSc, MSc, experience working as a psychologist with people who use drugs and alcohol CA: lived experience as well as significant experience working and conducting research with people who use drugs BWC: BA, BUEP, MUEP, PhD, significant experience conducting research with marginalised groups DKH: BSc, MPhil, PhD, significant experience conducting research on the topic of drugs and alcohol GWS: BSc, PhD, significant experience working with and conducting research with people who use drugs

3.	Occupation	What was their occupation at the time of the study?	BDS: Doctoral student NP: qualified psychologist and in final stages of MSc in addiction studies CA: project manager PeerNUPS and European Network of People Who Use Drugs BWC: Associate Professor of Evidence-Based Policy Evaluation, University of Oxford DKH: Professor of Social Policy Evaluation, University of Oxford GWS: Reader in Clinical Psychology, Queen's University Belfast
4.	Gender	Was the researcher male or female?	BDS: Male NP: Male CA: Male BWC: Male DKH: Male GWS: Female
5.	Experience and training	What experience or training did the researcher have?	Relevant experience and training outlined in detail in thesis.
6.	Relationship established	Was a relationship established prior to study commencement?	CA had a prior relationship with the management. However in order to build rapport with the client and participant group NP spent five weeks at the site prior the start of data collection.
7.	Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. *personal goals, reasons for doing the research*	All participants were briefed on the purpose of the study and also informed that this project was part of the first authors PhD project. It was conveyed to both interview and focus group participants that the goal of the project was to better understand the ways in which clients and staff experienced and perceived the DCR. It was also explained that this was part of a PhD project which conducted similar research in Birmingham (UK) and Athens (Greece). To bridge this potential gap in knowledge further, CA, who did know a lot of the community members beforehand, spent time answering all questions prior and during data collection.

8.	Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? e.g. *Bias, assumptions, reasons and interests in the research topic*	During the community consultation and prior to each interview and focus group, the interviewer discussed his previous research and professional experience in the DCR as well as their wider interest in better understanding how to improve services and outcomes for people who use drugs. In these discussions, participants were given the opportunity to ask questions relating to the interviewer and the project.
Domain 2: Study Design			
Theoretical Framework			
9.	Methodological orientation and Theory	What methodological orientation was stated to underpin the study? *e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis*	This study was oriented through a rapid-ethnographic approach. Additionally, although informed by our understanding of the Risk Environment Framework (Rhodes, 2002) and in particular the ways in which environmental, social and policy factors produce risk within housing environments (Braubach & Fairburn, 2010; Ivsins et al., 2022), all codes were developed inductively from the data.
Participant Selection			
10.	Sampling	How were participants selected? *e.g. purposive, convenience, consecutive, snowball*	See methods section of manuscript.
11.	Method of approach	How were participants approached? e.g. *face-to-face, telephone, mail, email*	Participants were approached face-to-face in the facility.
12.	Sample size	How many participants were in the study?	See methods section of manuscript.

13.	Non-participation	How many people refused to participate or dropped out? Reasons?	N/A
Setting			
14.	Setting of data collection	Where was the data collected? e.*g. home, clinic, workplace*	In a secure room on the second floor of the DCR.
15.	Presence of non-participants	Was anyone else present besides the participants and researchers?	No, not during any of interviews or focus groups however staff were present during the non-participant observation phase of the fieldwork.
16.	Description of sample	What are the important characteristics of the sample? *e.g. demographic data, date*	See methods section of manuscript.
Data Collection			
17.	Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	The question protocols were developed by all of the authors. The protocol was then checked with a resident sample during an initial community consultation. During this meeting residents gave suggestions on appropriate prompts and also suggested additional question (eg., clients suggested we ask an additional question related to client input into the service).
18.	Repeat interviews	Were repeat interviews carried out? If yes, how many?	No.
19.	Audio/visual recording	Did the research use audio or visual recording to collect the data?	Audio and handwritten notes, see methods section of manuscript.
20.	Field notes	Were field notes made during and/or after the interview or focus group?	Yes, see methods section of manuscript.

21.	Duration	What was the duration of the interviews or focus group?	See methods section of manuscript.
22.	Data saturation	Was data saturation discussed?	Data saturation was discussed by the research team, we believed this was reached at the anticipated mark and so were comfortable finishing fieldwork and data collection.
23.	Transcripts returned	Were transcripts returned to participants for comment and/or correction?	Focus group and staff interviews were not returned to participants for comment and/or correction however rapid-ethnographic interview notes and quotes were checked for accuracy by all participants following the interview.
Domain 3: Analysis and Findings			
Data Analysis			
24.	Number of data coders	How many data coders coded the data?	Following transcription and translation, the lead author led on the coding; however, emerging themes were discussed and amended collaboratively amongst the remaining co-authors.
25.	Description of the coding tree	Did authors provide a description of the coding tree?	Yes, a description of the various codes is included in the main text.
26.	Derivation of themes	Were themes identified in advance or derived from the data?	Themes were derived from the data.
27.	Software	What software, if applicable, was used to manage the data?	NVivo version 12 software was used to transcribe and code the data and Zotero version 6 was used as a reference management software.
28.	Participant checking	Did participants provide feedback on the findings?	No, participants did not provide feedback on the findings.
Reporting			
29.	Quotations presented	Were participant quotations presented to	Yes.

		illustrate the themes / findings? Was each quotation identified? e.g. *participant number*	
30.	Data and findings consistent	Was there consistency between the data presented and the findings?	Yes.
31.	Clarity of major themes	Were major themes clearly presented in the findings?	Yes.
32.	Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	No.

Focus Group Protocol (Clients)

- How often do you attend the DCR?
- How long have you been attending the DCR?
- Have you noticed any differences in your life since attending the DCR here in Athens?
- What specifically about visiting this DCR makes you want to come back?
- How would you describe the relationship between staff and DCR clients?
- Is there anything that you think could be different about how the DCR operates?
- Can you think of anything that acts as a barrier to you or others being able to access the DCR?
- Do you ever use drugs in places other than the DCR? If so, what are the types of locations in which you use drugs outside of the DCR?
- Have your patterns (time of day/frequency/amount) of drug use changed since you've started attending DCRs?
- Do you believe that harm reduction services like this one help to reduce levels of overdose in your community?
- Do you think first responders interact with people well when responding to overdoses in the community?
- How would you describe the broader impact on the community of the DCR?? (prompt: local residents, businesses etc).

Rapid-Ethnographic Interview Informal Protocol (People use who drugs in public settings)

- Do you ever use the DCR? If not why? If not, how would you describe the current environments in which you consume drugs?
- What do you think the goals of a DCR are? Do you believe this DCR achieves its goals? If not, why not?
- What do you think could be done to improve the service?
- Do you see any reasons why people might choose not to use the DCR?
- Do you have anything else you would like to tell us?

Sem-Structured Interview Protocol (Staff)

- Can you please describe to us what this facility does and how it benefits the clients?
- Can you please describe your role in the facility?
- From your experience working within harm reduction services, do you believe the DCR is having a positive impact in the community?
- How would you describe the experience of service users who access your service?
- Do you ever speak to clients to get feedback on their experiences accessing the DCR? If so, has this ever influenced the policies of the DCR?
- How would you describe the views of residents and other stakeholders in the community in relation to the DCR?
- If there was anything you would add to or change about the daily operations of the DCR? If so what and why?
- What is the biggest challenge that you face in your ay-to-day role?

Appendix 7: Dissemination of my DPhil

Over the course of my three- and half-year DPhil, I aimed to engage as much as possible with stakeholders of this research. Before starting my doctorate, I never imagined that dissemination was such a central element to academia, let alone that it would be possible to engage in meaningful policy dissemination as a doctoral student. Engaging with such a wide range of academic, policy, practitioner and community stakeholders has made up some of my most enriching and personally developmental moments of my DPhil. Engagements such as speaking at the UK House of Commons or the UN Commission on Narcotic Drugs, I will truly never forget. Alongside the formal academic, policy and civil society forums in which I presented work, I also want to mention the immense pleasure I gained from being able to speak at over 30 schools around the UK and Canada on the topic of drug policy, harm reduction and homelessness during my time conducting this research. As someone who was first introduced to these topics as a grade 9 high school student in Canada, I hope that these talks sparked interest in the students that attended.

Conferences During DPhil

- **Society for the Study of Addiction PhD Symposium**; Newcastle, UK - *Oral Presenter* - "Overdose prevention centres as 'Inclusion Health Interventions': A comparative rapid-ethnographic study on the experiences of DCR client and staff in Birmingham, UK, Vancouver, Canada and Athens, Greece" (November 2024)
- **Lisbon Addictions**; Lisbon, Portugal – *Oral Presenter* – "Benefits and Barriers: A Qualitative Evaluation of Athens' Drug Consumption Facility" (October 2024)
- **Cranstoun Social Justice Conference**; Birmingham, UK – *Oral Presenter* – "Evaluating Athens' Drug Consumption Room: Lessons for their implementation in the UK" (September 2024)
- **17th Annual International Society for the Study of Drug Policy Conference**; Montreal, Canada – *Oral Presenter* – "Conceptualizing Trade-offs: A Participatory Rapid-Ethnographic Evaluation of Athens' Drug Consumption Facility" (June 2024)
- **67th United Nations Commission on Narcotic Drugs** (side-event hosted by the Portuguese Diplomatic Mission to Vienna); Vienna, Austria – *Guest Panellist* – "A comparative analysis of the Lived Experience of People Who Use Drugs in street-based settings in Sandwell, Athens and Vancouver' (March 2024)
- **67th United Nations Commission on Narcotic Drugs** (side-event hosted by the Greek Diplomatic Mission to Vienna); Vienna, Austria – *Guest Panellist* – "A Qualitative Evaluation of Athens' Drug Consumption Room" (March 2024)
- **Society for the Study of Addiction Annual Conference**; Newcastle, UK - *Oral Presenter* – "Examining the Lived Experiences of People Who Access Enhanced Forms of Harm Reduction: Insights From Two Vancouver Overdose Prevention Centres" (November 2023)
- **Society for the Study of Addiction PhD Symposium**; Newcastle, UK - *Oral Presenter* - "A Qualitative Analysis on Athens' Drug Consumption Room: Preliminary Findings" (November 2023)
- **11th Annual International Network on Health and Hepatitis in Substance Users Conference**; Online – *Oral Presenter* – "A Qualitative Analysis on Athens' Drug Consumption Room: Preliminary Findings" (October 2023)

- **16th Annual International Society for the Study of Drug Policy Conference**, Leuven, Belgium – *Oral Presenter* – “Addressing the ‘Risk Environment’: Understanding Future Service Users’ Perspectives of an Overdose Prevention Centre in the UK” (June 2023)
- **7th Annual Global Law Enforcement and Public Health Association Conference**, Umea, Sweden - *Oral Presenter* – “Understanding the Relationship Between Police and People Who Use Drugs in Street-Based Settings" (May 2023)
- **7th Annual Global Law Enforcement and Public Health Association Conference**, Umea, Sweden - *Oral Presenter* – “The Role of Police within the ‘Risk Environment’: Understanding Future Service Users’ Perspectives of an Overdose Prevention Centre in the UK" (May 2023)
- **7th Annual Global Law Enforcement and Public Health Association Conference**, Pre-Conference Workshop on Harm Reduction, Drug Policy Reform and Policing; Umea, Sweden - *Oral Presenter* – “Harm Reduction in the Context of Criminalization: A Review of the Evidence” (May 2023)
- **Society for the Study of Addiction/Kings College London PhD Symposium**; London, UK - Oral Presenter - “Addressing the Risk Environment: Assessing the Need and Feasibility of an Overdose Prevention Centre in the UK” (April 2023)
- **Cranstoun Social Justice Conference**; Brighton, UK – *Oral Presenter* - “Reducing Drug-Related Harms in Sandwell: the Need and Feasibility of an Overdose Prevention Centre” (February 2023)
- **Society for the Study of Addiction PhD Symposium**; Bristol, UK - Oral Presenter - “Reducing Drug-Related Harms in Sandwell: Assessing the Need and Feasibility of an Overdose Prevention Centre in the UK” (November 2022)
- **US National Harm Reduction Coalition Conference**; San Juan, Puerto Rico – *Oral Presenter* – “The Case for Overdose Prevention Centres: Voices from Sandwell” (October 2022)
- **OX|BER Conference on Participatory Methods**; Oxford, UK – *Oral Presenter* – “Rapid-Review: Interdisciplinary Best Practices in Participatory Research” (July 2022)
- **Drink and Drug News Conference**; Birmingham, UK – *Oral Presenter* – “Assessing the Need and Feasibility of an Overdose Prevention Centre in Sandwell: Understanding Future Service Users’ Perspectives” (June 2022)
- **UK House of Commons Parliamentary Symposium on Overdose Prevention Centres**; London, UK – *Guest Speaker* – “Reducing Drug-Related Harms in Sandwell: The Need and Feasibility of an Overdose Prevention Centre” (June 2022)
- **University of Oxford Symposium for Early Career Researchers in Social Policy**; Oxford, UK – *Oral Presenter* - “Pilot Service Evaluation of an Overdose Prevention Centre in the UK: Understanding Future Service Users’ Perspectives” (May 2022)

Guest Lectures During DPhil

- **University of Oxford, Department of Social Intervention and Policy Evaluation MSc Seminar on Qualitative Methods,** Oxford, UK – Guest Speaker – “Participatory Methods in Social Policy Research” (February 2025)
- **University of Oxford, Department of Social Intervention and Policy Evaluation MSc Seminar on Health Inequality,** Oxford, UK – Guest Speaker – “Social Determinants of Health in Harm Reduction Research” (February 2025)
- **University of Oxford, Department of Social Intervention and Policy Evaluation Methods Hub,** Oxford, UK – Guest Speaker – “Participatory Methods in Social Policy Research” (February 2025)

- **University of Oxford, Nuffield Department of Population Health,** Oxford, UK – Guest Speaker – “Participatory Methods in the Medical Sciences” (November 2024)
- **University of Oxford, MBA Summer School**, Oxford, UK – *Guest Speaker* – “Solving Homelessness: How Technological Innovations are at the Forefront of Britain’s Policy Response” (August 2024)
- **United Nations Office on Drugs and Crime Consultative Symposium**; Online – *Guest Panellist* – “Tailoring Harm Reduction Services to the Needs of Young People: A Review of the Evidence” (November 2023)
- **King’s College London NIHR Health and Social Care Workforce Research Unit Homelessness Webinar**; Online – *Guest Speaker* – “Exploring Low-Barrier Drug and Housing Interventions for People Experiencing Homelessness: Lessons from overseas and the UK” (June 2023)
- **The Public Policy Exchange, Webinar on Drug Misuse and Dependency**; Online – *Guest Panellist* - “How To Reduce Drug-Related Deaths in the UK? The Potential Role of OPCs” (March 2023)
- **Queen’s University Belfast, BSc Seminar Contemporary Issues in Mental Health/Addiction**; Online - *Guest Lecturer* - “Advanced Qualitative Methods in Addiction Research*”* (November 2022)
- **St. Margret’s Institute**; Oxford, UK – *Guest Speaker* – “The Intersection Between Homelessness and Drug Policy: An Overview of the UK” (October 2022)
- **Drug Science Annual Meeting**; London, UK - *Guest Speaker* – “Reducing Drug-Related Harms in Sandwell: the Need and Feasibility of an Overdose Prevention Centre” (July 2022)
- **Oxford Centre for Evidence-Based Intervention**; Oxford, UK – *Guest Speaker* – “Preliminary Findings From a Rapid-Ethnography of Street-Based Drug Use in the UK: The Role of Harm Reduction” (May 2022)

Appendix 8: Research Ethics Forms

Central University Research Ethics Committee (CUREC)

CUREC 2 Form

Higher-risk research involving human participants and/or their data

The University of Oxford places a high value on the knowledge, expertise, and integrity of its members and their ability to conduct research to high standards of scholarship and ethics. The research ethics clearance procedures have been established to ensure that the University is meeting its obligations as a responsible institution. They start from the presumption that all members of the University will take their responsibilities and obligations seriously, and will ensure that their research involving human participants is conducted according to the established principles and good practice in their field and in accordance, where appropriate, with legal requirements.

Before completing this application, please work through the guidance on our website to ensure that you do not need to submit a CUREC 1/1A (minimal-risk review) or CUREC 3 (full Committee review for certain applications to the MS IDREC) application instead. Only type-written forms will be accepted.

Advisory text is highlighted in yellow and should be deleted before finalising the document.

Section A. Research Details

Full title of research	Exploring the Relationship Between Harm Reduction Provision and the Lived Experience of People Who Illegal Use Drugs: A Comparative Rapid-Ethnographic Study Between Birmingham, UK, Vancouver, Canada and Athens, Greece.
Short title of research	Exploring the Relationship Between Harm Reduction and Lived Experience
Principal Investigator (PI) / Student Supervisor	Dr. Benjamin Chrisinger
PI's training in research ethics and research integrity Information about online training	Dr Benjamin Chrisinger completed the Oxford training module, "Research Integrity: Social and Behavioural Sciences" on 21 January 2019, and a Social Sciences Divisional training, "Introduction to Research Ethics" on 24 January 2019. A further CITI ethics course was completed in 2022: Basic Course - Human Research, Group 3 Research Involving Data and Specimen.
Student name and degree programme (if applicable)	Benjamin Scher, DPhil Social Intervention and Policy Evaluation
Department/Institute name	Department of Social Policy and Intervention

University email address	Benjamin.scher@spi.ox.ac.uk
University telephone number	07447454462
Funding Source (required for ethics team use)	Society for the Study of Addiction Doctoral Studentship
State any conflicts of interest and explain how these will be addressed	None

Section B. Researchers

Copy and paste the below 4 rows as necessary to complete for each member of the research team, including student(s) named above, then delete this entire row. Note that **the PI does not need to be entered again** in this section.

Researcher title and name	Benjamin Scher
Department / Institute name or affiliation	Department of Social Policy and Intervention
Role in Research	Doctoral student carrying out the fieldwork and subsequent research
Training in Research Ethics and/or research integrity Information about online training	On 09/08/2022 I completed and passed both the University of Oxford Research Integrity Course and the Research Integrity Course: ‘Research Involving Human Participants’. I have also completed similar training in my masters program as well as during my involvement in other research projects within professional settings.
Date of completion of Information Security training	N/A
Researcher title and name	Dr Gillian Shorter
Department / Institute name or affiliation	Queen’s University Belfast
Role in Research	Co-supervisor
Training in Research Ethics and/or research integrity Information about online training	Committee member – Queen’s University Belfast Faculty of Engineering and Physical Sciences
Researcher title and name	Nikolaos Poulopoulos

Department / Institute name or affiliation	Athens University, Medical School (will have completed MSc in Addiction Psychology by the time we start fieldwork in June)
Role in Research	Research Assistant
Training in Research Ethics and/or research integrity Information about online training	Greek qualified psychologist with experience working for the Greek Army and a Greek non-profit organization working to support people experiencing mental health and homelessness.

Section C. Basic information

Provide a brief lay summary of the aims and objectives of the research. This should cover the questions it will answer, any potential benefits and what you will do to address the question. (Maximum 300 words)	Despite the quantitative evidence supporting overdose prevention centres (OPCs) as a harm reduction intervention to reduce drug-related deaths and increase access for auxiliary support for people who use illegal (in both Canada and the UK) drugs (i.e., predominantly opiates and stimulants purchased on the black market), their implementation in some parts of the world has proven challenging. To date, no international comparative qualitative work has been published on the lived experiences of people who use illegal drugs in relation to harm reduction interventions or the political environments that enable the implementation of such services. Using a comparative qualitative approach (non-participant observation, one on one interviews, focus groups, observation) my doctoral research will be conducted in three cities, each with its own distinct climate of drug policy: Vancouver, Canada, Birmingham, UK and Athens Greece. Through these case studies, my research will answer three primary research questions: (1) in what ways is the lived experience and quality of life of people who use illegal drugs shaped by their ability to access harm reduction services; (2) what policy implications can be derived from both drug users' lived experiences and opinions of harm reduction services (including OPCs) (3) what are the perceptions of community, regional and national stakeholders in relation to OPCs and how do these perceptions impact their development and implementation? The outcome of this research will be a doctoral thesis centring the lived experience of people who use illegal drugs and offering practical insights to policymakers, public health officials and harm reduction providers looking to optimize health service for people who use illegal drugs, reduce drug-related deaths, and better understand the value of enhancing current harm reduction efforts.
List all places where research will be conducted (including any other countries and online)	Birmingham, UK (just stakeholder interviews) Vancouver, Canada (stakeholder interviews and ethnographic fieldwork) Athens, Greece (stakeholder interviews and ethnographic fieldwork)

Anticipated research start date	January 1st 2023
Anticipated research end date (n.b. A maximum of 5 years approval can be granted)	January 1st 2025
Please list any CUREC Approved Procedure(s) you will follow	AP02
Please list any CUREC Best Practice Guidance used to develop your research	CUREC guidelines were used to frame this research and prepare documentation with regards to recruitment, and administration of research activities. Specifically, the below CUREC best practice guidelines were used: BPG 01; BPG 02; BPG 05; BPG 07; BPG 08; BPG 09; BPG 10; BPG 16; Ethical Fieldwork Code of Conduct; Ethical Fieldwork Code of conduct Supplementary Toolkit
Please list any Professional Guidelines used	Social Research Association Ethical Guidelines
Name of departmental / peer reviewer (if applicable)	SPI DREC – Alex Jenkins
Will you submit, or have you submitted, this research for ethical review or consideration elsewhere (e.g. local or collaborator's ethics committee, or other local approval)?	Yes. **Birmingham:** I have approvals from the UK partners as part of the prior ethical approvals. Research approved by The Faculty of Engineering and Physical Sciences at Queen's University Belfast (EPS21_319). I was a member of this research team and was included on this ethics application. **Vancouver:** I have confirmed with Research Ethics BC that local submission of research ethics application in BC is not required as there is application to Oxford and local partner organizations for ethics approval. Athens: I have received ethical approval from OKANA following their internal ethics procedure. With the addition of my approval from the University of Oxford CUREC I am able to commence research in Athens.

Section D. Participants

(n.b. where there is no contact with human participants (in person or virtual) and no observation of them, but only use of data about them, please omit this section, and complete section I instead)

Age range of participants	18 and over.
Are research participants people	The population of focus will be people who use illegal drugs, some of whom may be drug dependant.

who may not be able to give free and informed consent? e.g. those under 18, prisoners, or adults 'at risk'	One important consideration for all phases when working with people who use illegal drugs, is the effect intoxication may have on their ability to provide informed consent. The researcher will therefore be mindful of, and assess, the participant's mental and physical state before they commence any engagement for any phase. If the participant appears to be significantly intoxicated or, conversely, experiencing severe drug withdrawals, then it will be tactfully arranged with the participant that their involvement is postponed as appropriate. Scher is experienced in working in these conditions (e.g. Cole et al., 2005 ; McClatchley et al., 2015; Harris et al., 2020) and has worked with these populations and organisations in previous research capacities.
Anticipated number of participants	Birmingham: Stakeholders 15 Vancouver: Service Users 20-25 (Focus Groups) and 20-25 (One-on-One Rapid-Ethnographic Conversations); Stakeholders 15 Athens: Service Users 20-25 (Focus Groups) and 20-25 (One-on-One Rapid-Ethnographic Conversations with people use drugs in street-based settings not currently engaging with OKANA services); Stakeholders 15
How was the number of participants decided?	The number of participants for both service users and stakeholders is based on comparable studies (including the initial Sandwell case study) and best practice guidelines for reaching data saturation from qualitatively driven drug policy research. These numbers ensure that sufficient in-depth data can be gathered during the anticipated time frame whilst ensuring sufficient data saturation. The focus of fieldwork will be to conduct data collection with people who use illegal drugs through the proposed ethnographic methodology.
Inclusion Criteria	**Service Users:** People who use illegal drugs and access/engage with the harm reduction services I am partnering with (overdose prevention team, naloxone/syringe distribution services, mobile overdose surge response bus, overdose prevention centers). People who are able to provide informed consent. Due to the dual format of focus group and one-on-one rapid ethnographic conversations, participants will have the option of participating in either format or both as they will be deriving different sorts of results (focus group looking at group perception of events, one-on-one rapid ethnographic conversations looking at individual experiences and interpretations. Non-service users (Athens only): In order to understand why some people in Athens continue to use drugs in street-based settings despite the presence of an overdose prevention centre in their local vicinity – we will be conducting street-based

	rapid-ethnographic conversations during our ethnographic field sessions. Inclusion here will be people known to use drugs in street-based settings, identified by the peer research and OKANA outreach worker who will accompany us on our field sessions. **Stakeholders**: Harm reduction service staff, harm reduction service management, policy makers working within the field of drug policy at local, regional and national levels.
Exclusion criteria	**Service Users**: People who access/engage with partner organization services (housing, community engagement, medical services) but do not use illegal drugs. People who fit this criteria but are clearly intoxicated and not able to provide informed consent. Non-service users (Athens only): People who are visibly intoxicated and unable to give informed consent. People who do not use illegal drugs. **Stakeholders:** those with no professional connection with drug policy or drug services.
Please mark 'X' against all planned recruitment methods Provide copies of all recruitment material for review	Poster advert ☐ Flyer ☐ Email circulation ☒ In-person approach ☒ Website ☐ Social media (e.g. twitter, Facebook) ☐ Snowball sampling (recruiting through contacts of existing ☒ Newspapers ☐ Research recruitment sites (e.g. Prolific Academic, Amazon ☐ Existing departmental contacts or volunteer database ☒ Other (please specify below) ☐
How will potential participants be identified and approached?	**Service Users:** There will be an initial three week period where I (or the Athens-based research assistant) will be volunteering with the harm reduction service provider. During this time I will be conducting non-participant observation, gathering generalised fieldnotes related to the day to day functioning of each centre and building rapport with service users. During this period and due to my proximity with potential participants, I will be able to discuss my research in person with people and go into detail about the participant observation aspects of the research as well as the focus groups and one-on-one ethnographic conversations which will take place towards the end of the fieldwork within the physical building of the service provider. This is characterized as purposive convenience sampling. Participants will be

	reimbursed $15 for participation in a 45 min focus-group and $10 for participating in a 10-15 minute one-on-one ethnographic conversation. This process will be repeated twice times within the two different field sites of the drug service provider in Vancouver. Non-service users (Athens only): In order to understand why some people in Athens continue to use drugs in street-based settings despite the presence of an overdose prevention centre in their local vicinity – we will be conducting street-based rapid-ethnographic conversations during our ethnographic field sessions. For these sessions, the research team as well as a peer researcher and a member of the OKANA outreach team will walk on foot within a 500m radius of the OPC. The peer and outreach worker will approach individuals who they know and discuss the research with them. If they would like to participate the research assistant will then approach and beging the rapid-ethnographic interview process. **Stakeholders:** For harm reduction service staff and management I will approach them in person during my time volunteering in the service. Staff and management will then have the option of arranging to set up an online call outside of working hours or to conduct an interview during their 1 hour lunch break. For stakeholders not working within the site, I will approach via email explaining the purpose of the research project and asking for their voluntary participation through the form of an online interview. I will also approach relevant networks such as the Vancouver Area Network of Drug Users and the Vancouver Police Department as well as my own personal and professional networks in each city. In order to ensure an appropriate number and diversity of sample, “snowball, volunteer and convenience sampling” may be used: in the interviews, stakeholders will be asked to recommend others to participate in the research. There will be no incentives for participation from stakeholders. **Recording**: Each consent form and information sheet package will be numbered in advance, and all participants will be encouraged to keep their information sheet with the participant code on the top (e.g. FG01234 code meaning FG focus group, location 01, participant 234). Each number will be matched with pseudonyms.
Will informed consent be obtained from the research participants or their parents/ guardians? If not, please explain why not.	**Non-Participant Observation:** I will not need to gather consent here as I will not be collecting any information pertaining to individual service users, my conversations with them or their behaviours. I will however have approval from the management of the drug service and this will be included in their internal ethics application.

	One-on-one ethnographic conversations (Vancouver): A one-on-one ethnographic conversation is a brief ethnographic conversation which aims to capture the perspectives of service users regarding their experience, perceptions and interpretations pertaining to the OPC and auxiliary services which they frequent. Scher will approach them whilst they are in the service and will accompany them to place within the service which is convenient for service users to discuss their views (there is a small garden at the back of the service which is visible to staff but out of audio reach). Individuals will be explained the purpose of the research and will be notified that anonymised field notes will be taken (which exclude names or any other identifying information other than gender). These will be reflected back to the service user for accuracy and permission to use in publications. Rapid ethnography rarely uses written consent, and indeed the physical barrier of written consent processes can be detrimental to the research (Vindrola-Padros, 2021). It is similar to PPI consultation in it's nature, and, in line with best practice, we will fully brief individuals on the purpose of the conversation, ask their permission, reflect back the conversation for accuracy and remove any details from field notes should it be asked for at the time. As such there are multiple points of verbal consent at the start of the conversation, through the explanation of what the research is for, and at the end of the conversation and all field notes are anonymous at source. Oral consent will be recorded and will linked to a participant code which will be securely encoded on a participant ID sheet should the need arise to retrace and remove any data. One-on-one ethnographic conversations (Athens): Once the introduction has been made by the peer and outreach worker, the research assistant will move away (if necessary) to an area of the pavement which is safe and out of hearing range from others. Individuals will be explained the purpose of the research and will be notified that anonymised field notes will be taken (which exclude names or any other identifying information other than gender). These will be reflected back to the service user for accuracy and permission to use in publications. Oral consent will be recorded and will linked to a participant code which will be securely encoded on a participant ID sheet should the need arise to retrace and remove any data. **Focus-groups:** I will obtain written consent through a consent form following the distribution of an appropriate information sheet/discussion of the contents within the information sheet. Many of the participants will not have

	email addresses which is why consent will be acquired in person and through discussion / distribution of the consent form at the beginning of the focus groups. **In person interviews with staff and management:** I will obtain written consent through a consent form following the distribution of an appropriate information sheet/discussion of the contents within the information sheet. Distribution of the consent form will occur at the beginning of the interview. **Online interviews:** I will obtain written consent through email recruitment and then additional oral consent at the beginning of each interview. They will also receive a copy of the consent form and related information via email.
For each activity or group of participants, explain how informed consent will be obtained from the participants themselves and/or their parents/guardians, if applicable. How will their consent be recorded?	**Non-Participant Observation:** During each initial period of fieldwork, I will not be gathering any information pertaining to individuals, their behaviour or my conversations with them. Many people will be coming in and out of the drug service, as such, I will be unable to gather consent from each person. As a result, I will be gathering generalised fieldnotes for my own contextual understanding relating to the day to day activities of the drug service. This will be approved by the management of the drug service and included in their internal ethics application. **Question Protocol Co-Creation Meeting:** Before my first focus group involving data collection, I plan to hold a consultation meeting with a group of five service users to co-create/discuss the wording of the questions that will be asked in subsequent focus groups. This participatory approach will ensure that questions are as relevant as possible to the lived experiences of service users. At the beginning of this consultation, I will discuss the information sheet and consent form in detail with participants. Their involvement in this consultation will be anonymous and they will still be able to participate in data collection focus group following this session. **Focus-groups**: when discussing the project with service users (potential participants), I will have a concise, language appropriate information sheet on hand that outlines clearly the aims of the project, the methods and what it means to be a participant. At the beginning of the focus-group I will go over the information sheet in detail and discuss the consent form with everyone as a group before they are asked to sign. This will ensure that informed consent is obtained and participants have multiple opportunities to ask questions or decline to participate the study. Participants will also be made aware that non-identifiable data will also be stored on Open Science Framework, to promote data transparency, and allow for future research with this data set.

Rapid-ethnographic one-on-one conversations (Vancouver and Athens): Rapid ethnography rarely uses written consent, and indeed the physical barrier of written consent processes can be detrimental to the research (Vindrola-Padros, 2021). It is similar to PPI consultation in it's nature, and, in line with best practice, we will fully brief individuals on the purpose of the conversation, ask their permission, reflect back the conversation for accuracy and remove any details from field notes should it be asked for at the time. As such there are multiple points of verbal consent at the start of the conversation, through the explanation of what the research is for, and at the end of the conversation and all field notes are anonymous at source (e.g. no identifying information is ever written down other than gender). Rapid ethnography rarely uses written consent, and indeed the physical barrier of written consent processes can be detrimental to the research (Vindrola-Padros, 2021). It is similar to PPI consultation in it's nature, and, in line with best practice, we will fully brief individuals on the purpose of the conversation, ask their permission, reflect back the conversation for accuracy and remove any details from field notes should it be asked for at the time. As such there are multiple points of verbal consent at the start of the conversation, through the explanation of what the research is for, and at the end of the conversation and all field notes are anonymous at source. Oral consent will be recorded and will linked to a participant code which will be securely encoded on a participant ID sheet should the need arise to retrace and remove any data."

Online Interviews: in the email invitations, stakeholders will be sent a copy of the information sheet. In their response they will then either agree or oppose to participating in the study. For those that move forward with an interview I will then orally re-affirm their consent at the beginning of the interview. This will be recorded and logged on an excel spreadsheet. Participants will also be made aware that non-identifiable data will also be stored on Open Science Framework, to promote data transparency, and allow for future research with this data set.

In person staff and management interviews: at the beginning of the interview, before it officially commences, participants will be given the information sheet and consent forms and will have the opportunity to ask any questions and discuss the contents before agreeing to participate.

Section E. Research Methodology

Please mark 'X' against the methods that will be used in your research
Ensure you address each method you will use in your informed consent documents and on this form

Use of casual or local workers (e.g. interpreters)	☐	Audio recording of participant	☒
Interview (refer to guidance in BPG 10: Conducting research interviews)	☒	Video recording of participant	☐
Focus group	☒	Photography of participant	☐
Participant completes questionnaire in hard copy	☒	Physiological recording from participant	☐
Participant completes online questionnaire or other online task	☐	Taking a sample of blood or other bodily fluid from a participant	☐
Use of social media to recruit or interact with participants (refer to guidance in BPG 06: Internet-mediated research)	☐	Participant observation	☒
Analysis of existing records	☐	Covert observation	☐
Participant performs verbal or aural task	☐	Systematic observation	☐
Participant performs paper and pencil task	☐	Observation of specific organisational practices	☐
Participant performs computer based task	☐	Other (please specify below)	☐
Measurement/recording of motor behaviour	☐		

Provide a lay description of the research design and methods. In particular, describe clearly what participants in the research will be asked to do.

The methodological approach used in each city will be identical. Research will be split into two phases and will combine a number of exploratory qualitative approaches. Phase one is pre-fieldwork and will undertake an in-depth document review and content analysis, as appropriate, in each city of the following: (1) policy documents; (2) relevant legislation; and (3) literature pertaining to the political impetus behind the emergence of harm reduction interventions. All publicly available relevant documents will undergo thematic analysis. Phase one for Birmingham has been completed within the context of a previous study, however this phase will apply to Vancouver.

The second phase has already been conducted in Birmingham in a previous research project but will be undertaken in Vancouver and Athens. In Vancouver, this phase will comprise 3 months of fieldwork with the Lookout Health and Housing Society, a non-profit offering harm reduction services to people who use illegal drugs. I will spend three months conducting fieldwork split between two of their different field sites. Initially, I will volunteer in each site for a period of 4/5 weeks. During this period, observational fieldnotes will be gathered pertaining to the daily operations of the service but no identifying information related, direct quotes or observations of individual behaviours will be recorded. This phase will be mainly for me to build rapport with staff and service users and become embedded within the case site. I will also be able to discuss my project with service users and slowly begin the recruitment process. During my second week at each field site, I will conduct a singular question protocol co-creation meeting where, with three to five service users, we will discuss the question protocol for subsequent focus-groups and one-on-one ethnographic conversations. I will conduct focus groups in the third and fourth weeks of fieldwork and also conduct one-on-one ethnographic conversations. This process will be repeated in each of the two field sites.

In Athens, this phase will comprise 5 weeks of fieldwork with OKANA, the Greek government agency which runs all of Greece's drug and harm reduction services, including an overdose prevention centre (OPC) in Athens for people who use illegal drugs in street-based settings. The research assistant will spend 3 weeks volunteering at the OPC. During this period, observational fieldnotes will be gathered pertaining to the daily operations of the service but no identifying information related, direct quotes or observations of individual behaviours will be recorded. This phase will be mainly to build rapport with staff and service users and for this member of the research team to become embedded within the case site. They will also be able to discuss the project with service users and slowly begin the recruitment process. During the forth and fifth week, the research assistant will conduct a singular question protocol co-creation meeting where, with three to five service users, they will discuss the question protocol for subsequent focus-groups and one-on-one ethnographic conversations. In these final two weeks of fieldwork within the OPC, the research assistant will 5 focus groups with 5 participants in each as well as 20 one-on-one ethnographic conversations with service users. We will also conduct these ethnographic conversations with people who use illegal drugs in street-based settings in the 500m vicinity of the service who do not access the OPC. The aim here is to understand what are some of the potential barriers to access. These sessions will be supported by an experienced member of the OKANA outreach team who engaged with and assists this demographic on a daily basis. We will also be assisted by a peer researcher. This method of engaging with community members who currently do not access services was conducted as part of the first case study in Sandwell and was incredibly successful. As a researcher I am experienced in this method of research and am fully confident that with the logistical support of the OKANA outreach team and the oversight of my supervisors who aree also very experienced in this method of data collection that we will have no issue in collection data in a safe and ethical manner.

Finally, I will conduct either online or in-person semi-structured interviews (according to their preference) with stakeholders including service staff/management, local police and public health officials and local, regional and national policymakers implicated within the realm of drug policy. Online stakeholder interviews will be conducted for both Birmingham, Vancouver and Athens.

Will the research include any audio, video or photographic recordings?

Non-participant observation: No direct quotes will be recorded. No information related to interactions with service users will be recorded. Only generalised observations about the day to day operations of the site.

One-on-one ethnographic conversations (Vancouver and Athens): No, solely anonymised field notes will be taken.

Interviews and Focus Groups: Microsoft Teams will be used to record the audio of all interviews and focus groups. This software allows you to record audio and not capture video/visual recording which is what I intend to do. My computer will be open on the app function in front of me during the focus group to pick up the audio, For online interviews, this will be done automatically. Microsoft teams has a function which provides a transcript from recordings to download after the meeting is complete. After the transcript is produced, I will listen to the audio recording and check the transcript for accuracy, making any edits as needed including removing and identifying information. Then the audio file will be destroyed. As a back-up I will also use my iPhone voicenote recording function. This recording will just go to my phone storage and will not be uploaded to the cloud in anyway. Once the teams recording is successfully uploaded, I will delete this voice note of my phone. In the event that I do have to use the voice note, I will upload it to my computer hard drive (not cloud), transcribe manually immediately and delete the recording. All transcriptions will be stored in a password secure 'Nexus 365 One Drive for Business account' and be retained for a minimum of 10 years.

Focus-group protocol co-creation meeting: I will be typing out meeting minutes on my laptop. No audio, video or photographic information will be recorded. No identifiable information from participants will be recorded. No direct quotes will be recorded.

Please detail any expenses or gifts that will be offered to participants
Guidance is available in Best Practice Guidance: 05 Payments and incentives in research.

Following 'peer payment best practices' outlined by the BMC Medical Ethics Journal, the British Journal of Social Work, the International Journal of Drug Policy, the European Network of People Who Use Drugs and the Canadian Coalition of People Who Use Drugs, I will be paying service user participants $15 for involvement in a 1 hour focus-group (including the focus-group protocol co-creation meeting) and $10 for involvement in a 10-25 minute rapid-ethnographic conversation. This figure will be translated in to euros for the Athens case-study. Compensation for people who use drugs is grounded in a number of arguments:1) valuing the unique contributions to research deriving from the involvement of people who use illegal drugs; 2) the Canadian Aids Society, International HIV/AIDS Alliance, suggest that the value of peer work should be viewed from a human rights perspective, and that peer compensation be based on value-added rather than who is deserving; 3) the lived experience of people who use illegal drugs is comparable to the expertise developed through an academic education or years of work experience in a specific industry, as such people should be compensated similarly; 4) participation in research by people who use illegal drugs, is a legitimate, valued form of paid consultancy work as they are offering expertise equivalent to employment and 5) equitable reimbursement should account for the time people take away from other activities at their own personal and financial expense, including hours that would be otherwise spent in the informal market.

During focus groups, pizza and light refreshments will also be provided.

Section F. Ethical Considerations

For guidance on ethical issues, please see http://researchsupport.admin.ox.ac.uk/governance/ethics/resources
(N.B. To complete, double click on the check boxes and select 'checked')

Will the research involve any participants considered vulnerable in the context of the research (e.g. children, elderly, prisoners, adults "at risk")? **If yes,** please describe how they are defined as vulnerable and detail any CUREC Approved Procedures or guidance that will be applied to the	Yes ☒	No ☐

research (for current documents and templates see https://researchsupport.admin.ox.ac.uk/governance/ethics/resources). For research involving children, please state why either CUREC Approved Procedure 15 or 25 cannot be applied wholly to your research.		
The population of focus will be people who use illegal drugs, some of whom may be drug dependant. One important consideration for all phases when working with people who use illegal drugs, is the effect intoxication may have on their ability to provide informed consent. The researcher will therefore be mindful of, and assess, the participant's mental and physical state before they commence any engagement for any phase. If the participant appears to be significantly intoxicated or, conversely, experiencing severe drug withdrawals, then it will be tactfully arranged with the participant that their involvement is postponed as appropriate. Scher is experienced in working in these conditions (e.g. Cole et al., 2005 ; McClatchley et al., 2015; Harris et al., 2020) and has worked with these populations and organisations in previous research capacities. To ensure that all participants considered vulnerable are treated respectfully and ethically, this research will follow guidelines pertaining to qualitative research (BPG 02), psychological distress (BPG 08), conducting interviews (BPG 10), and social science research conducted outside the UK (BPG 16).		
Will unequal relationships exist between participants and those obtaining informed consent? **If yes,** describe the nature of the unequal relationship and how arising ethical issues will be addressed	Yes ☒	No ☐
There is the potential for unequal power relations to exist between service users participating in the research and the researcher. This is primarily due to the potential inability for participants to read through the consent form themselves (due to low literacy skills among this population); and having never been involved in a focus group previously. To mitigate these potential dynamics, I will start focus group recruitment up to a week before to allow participants time to read the information sheets on their own time and digest the conversation I will have with them regarding the research process. This will ensure that they do not feel pressured to say yes immediately and can take time to make their decision. Second, it will be made clear to participants in their consent forms, during initial discussions and at the beginning of the focus groups that they are able to opt out of the research at any time with absolutely no consequence to them and they do not need to provide a reason for doing so. Further, participants will be informed that they are to withdraw from the study for up to 6 months post data collection. In this instance, using the participant code associated with their data, individual thematic analysis and quotes will be retracted. With regards to the one-on-one rapid-ethnographic interview, participants will be explained the details of the study (see appendix 11) and will be able to answer any questions before the conversation commences/any fieldnotes are taken. There will be no power differentials between stakeholders participating in the online interviews.		

Will the research involve questions and/or discussions of contentious and/or sensitive issues (e.g. information relating to ethnicity, political opinions, religious beliefs, physical/mental health or sexual life)? **If yes,** please justify why this is required and provide the questions (or an outline of them) raising the issues that will be used in your research.	Yes ☒	No ☐

The research will involve questions regarding illicit drug use (eg., location of illicit drug use, frequency, and typology) outside of the drug service provider. This is required to ascertain the effectiveness of the intervention and any potential gaps in service delivery. Focus-group questions may bring up sensitive topics related to the use of illicit drugs and potentially drug overdose experienced by themselves or people they know. it is important to note that the following are example questions and although they will be focused on this topic, the wording and specifics of what is being asked will be defined within the focus-group protocol co-creation meeting: 1) What are the contributing factors that make you want to attend harm reduction services? 2) Have you noticed any harms or benefits in your life since attending harm reduction services? 3) Is there anything else you would like harm reduction services to provide ? 4) Where and how do you use drugs? (prompts locations/patterns/time of day/frequency/amount). Has this changed since attending harm reduction services? 6) Do you believe that harm reduction services can help to reduce levels of overdose in your community? 7) How do you think first responders in your community interact with people during overdose responses? 8) How do you think your community would respond to OPCs?

Stakeholder interviews may also contain topics that could be sensitive for people who work closely with those who have experienced overdose: 1) From your experience working within harm reduction services, what is the community impact2) How would you describe the experience of service users who access your service? 3) do you think municipal, state/provincial and federal governments is effective in addressing rates of fatal overdose in the community? (how might it improve) 4) What impact do you think an OPC would have on the community? (prompts: local business, people who use illegal drugs, people who live in the area etc)

All focus groups and interviews will be conducted through a trauma informed lens, informed by best practices on interviews and focus groups related to research with people who use illegal drugs. If a participant is in distress, a key component of qualitative interviewing is for researchers to show concern and compassion for participants. Expressions of empathy and active listening in response to participant distress allows the interviewer to validate the feelings of participants and emphasize elements of participant strength and resilience in coping with trauma. I have been involved in projects that have used focus-groups and interviews with people who use illegal drugs and have undergone trauma-informed interview training in 2019 (at the University of Waterloo) and 2022 (at the University of Oxford).

For the rapid-ethnographic conversations, participants will be asked their views on their perceptions and experiences with the service they are frequenting and as they do so they may speak about their own experiences as a person who injects drugs. I will only record field notes, general observations or particularly poignant quotes and ensure there will be no details or notes which would identify someone (e.g. if someone mentions that they currently have a necrotic infection with details of that experience and that they were offered a referral at the service – this may be recorded as “potential useful feature – wound care advice”). There will be no demographic or identifying characteristics in the field notes other than gender which they will equally be able to opt out of.

Will taking part in the research put participants under any particular burden and/or risk (including risk of prosecution)? **If yes,** describe how risks will be mitigated. If there is a risk of prosecution to the participant, justify why incriminating data are sought. During the consent process, participants should be made aware of the risks of disclosing potentially illegal information and understand what the researchers would do if they were to receive that information.	Yes ☒	No ☐

Focus groups and one-on-one rapid ethnographic conversations will be held with existing service users and community members who may disclose their experiences of using the service and/or using illicit substances in the community which could include sensitive information. Names, places, or experiences disclosed which might identify an individual will be amended to ensure that no-one can be identified by their answers within the focus group transcripts or rapid-ethnographic fieldnotes. At the end of each focus group and one-on-one rapid ethnographic conversation, participants will be asked if there is anything they would like removed from the transcript (when it is produced) or that they would like to say anything to clarify a statement before finishing. Focus group participants will be assured of the confidentiality of their statements and explained the process by which each participant is assigned a participant code which is recorded on an excel spreadsheet, then on a separate excel spreadsheet assigned a pseudonym. This process will happen as soon possible after the focus group (that same day). This information is kept separately so that if a participant wishes to remove their data, the researcher is able to go back into the transcripts and do so.

During the recruitment stage and at the beginning of focus groups and one-on-one rapid ethnographic conversation, participants will be notified that the only time when information would be passed on is they disclose that they: 1) are planning to seriously hurt themselves or someone else or 2) that they are involved in or aware of, a case of child neglect or abuse. Even in this rare event, we would talk to them about it first. This will be governed by local authority guidance and the procedure is given in Appendix 3.

Will the research involve deliberate deception of participants beyond that covered by CUREC Approved Procedure 07? **If yes**, justify why deception is used, describe deception and debriefing process, and include debriefing documents in the application	Yes ☐	No ☒

Could the proposed research affect your own physical and/or psychological safety as a researcher? **If yes,** describe how you will manage this. Explain what safety procedures, structured mentoring or other ongoing support will be in place during this research. Include details of lone working procedures, if applicable.	Yes ☒	No ☐

Conducting focus groups, interviews and qualitative research more generally with people who use illegal drugs can produce conversations related to drug-related death or injury which can be psychologically taxing for the researcher. Having conducted multiple studies with this population and on these topics I feel comfortable managing my mental health in these situations. I will also be scheduling bi-weekly meetings with my supervisors to ensure my mental well-being throughout the research process. Further, I will be aware of resources available to me and will have the ability to seek counselling if needed. I have read the Social Science Division's guidance and training on vicarious trauma and are aware of the emotional risks and what can be done to mitigate them.

Focus groups will be conducted in the building of the drug service provider. Staff will be made aware that the focus group is taking place and will be aware of the start and end time. The room will be audio secure but will have a window through which staff can see through as a means of checking on the focus group whilst not disrupting it. Each focus group will also have a half way point where participants will be able to take a 10 min break. During this period the researcher will be able to discuss any potential issue with a member of staff if required. The researcher will check in at the beginning, midway and at the end of focus groups. Although such problems are unlikely as it is a secure, stable, well-lit and organised space with professional staff right outside of the room in which the focus group is taking place.

In Vancouver, one-on-one rapid-ethnographic conversations will take place in a small garden area in the back of the service. Although it will be far away enough that no one will be able to hear the conversation, this is a highly visible space which will be in the eye-line of other staff on the premises.

In Athens, one-on-one rapid-ethnographic conversations will take place in the community, in central Athens, within a 500m radius of the OKANA OPC. These field sessions will be supported by the OKANA outreach team as well as a peer researcher who are both very well-known in this community and engage with this population on a daily basis. We will also have safety procedures in place such as informing other members of the OKANA team when we plan to start and finish our fieldwork sessions and to notify them at the start and finish of each one. We will all stay together and all times and will each have one another's phone numbers as well as the contact of local emergency services. We will also have daily check ins as a research team during this intensive fieldwork period to make sure that everything is going to plan and that no one has any concerns with regards to their own well-being. Everyone in this research team is experienced in conducting this type of research and will use situational judgment as well as verbally run-through an environmental risk assessment before starting each field session.

How will you ensure the research is conducted according to the details given in this form?

Throughout the course of this project, regular bi-weekly supervisory and project management meetings will take place between Ben Scher, Dr Benjamin Chrisinger and Dr Gillian Shorter, to touch base on the project's progress, and to ensure that all processes in this document are appropriately followed. In Athens, we will also have daily check ins as a research team during this intensive fieldwork period to make sure that everything is going to plan and that no one has any concerns with regards to their own well-being. Everyone in this research team is experienced in conducting this type of research and will use situational judgment as well as verbally run-through an environmental risk assessment before starting each field session.

Please give details of any other ethical and/or safety considerations, including whether there might be any risks or benefits to the wider community.

The Organization/The Community

The provision of harm reduction services is a contentious and often politicised topic. Data and findings from academic publications can be used against drug services in attempt to prevent the service delivery of harm reduction interventions. As a means of protecting the organisations I am working with, their names and the sites in which I am working will be completely anonymized (eg., "a drug service provider on the west coast of Canada"). I will also work with the management of the organisations to ensure that the findings and framing of the results could not be skewed or reported in a way which could damage the organisation. There is however a small chance they will be identified and this is included in their internal ethics application.

How do you propose to deal with / handle any incidental findings?

If participants share incidental information while they are being recorded, only those findings that directly relate to the research questions will be included in our analysis, and in ways that cannot be linked back to the participants (e.g. by removing all possible indirect identifiers from the data, including names of specific locations, or other details that may identify a participant). Findings will be included in the analysis, but they will be de-identified to protect the participant's confidentiality and safety. Any incidental information that does not help answer the research questions will be excluded from the study.

Will any data or information from this study be provided to individual participants?

Yes, on the demographic questionnaire that focus group participants will be completing, they will be asked whether they would like to be sent a copy of the publications that are produced related to this research as well as lay summary of the findings and implications. If so, they will have the option to provide their email address to be sent any publication at a future date.

Section G. Other considerations

Is any part of this research being conducted overseas? **If yes,** please give details below. Explain how you will address any ethical issues specific to the local context. Please provide details of the local review, approval or permission obtained or required. If there will be no local review, explain why not. You may find it helpful to refer to CUREC's BPG 16: Social science research conducted outside the UK. Ensure you complete and submit a travel risk assessment to your departmental safety officer, if your department requires this. (This is necessary to ensure the travel/ fieldwork is covered by the University's travel insurance – see http://www.admin.ox.ac.uk/finance/insurance/travel)Please also address any physical or psychological risks for Oxford researchers and local fieldworkers in the 'Ethical Considerations' section above and discuss these with your safety officer.	Yes ☒	No ☐

Yes, in order to address any ethical issues arising in the local context my research will respect local ethical guidelines:

Birmingham: No additional approvals needed. Research approved by The Faculty of Engineering and Physical Sciences at Queen's University Belfast (EPS21_319). I was involved as a research assistant with the agreement that I would be able to use the data for my DPhil having been included on the ethics application.

Vancouver: “I have confirmed with Research Ethics BC that local submission of research ethics application in BC is not required as there is application to Oxford and local partner organizations for ethics approval.”

Athens: Local ethical approval has been granted by OKANA following an internal ethical review process. I have confirmed with them that this approval, combined with University of Oxford ethics application is satisfactory to proceed with research in Athens.

The above approvals have been sought and granted before the commencement of any fieldwork.

Please list any stakeholder or community engagement that has been, or will be, undertaken in relation to the research.

N/A

Does your research raise issues relevant to the Counter-Terrorism and Security Act (the Prevent Duty), which seeks to prevent people from being drawn into terrorism? **If yes,** please say how you plan to address any related risks. Please see advice on this on our Best Practice Guidance Web Page.	Yes ☐	No ☒

Section H. Data management and handling

All information provided by participants is considered **research data** for the purpose of this form. Any research data from which participants can be identified is known as **personal data**; any personal data which is sensitive is considered **special category data**. Management of personal data, either directly or via a third party, must comply with the requirements of the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018, as set out in the University’s Guidance on Data Protection and Research. In answering the questions below, please also consider the points raised in the Data Protection Checklist and whether, for higher-risk data processing, a separate Data Protection Impact Assessment (DPIA) may also be required for the research. Advice on research data management and security is available from Research Data Oxford and your local IT department. Advice on data protection is available from the Information Compliance team.

Please mark ‘X’ against the data you will collect for your research

Screening documents	☐	Audio recordings	☒
Consent records including participant name or other identifiers (e.g. written consent forms, audio-recorded consent, assent forms)	☒	Video recordings	☐
Consent obtained anonymously (e.g. via online survey)	☐	Transcript of audio/video recordings	☒
Opt-out forms	☐	Photographs	☐
Contact details for the purpose of this research only	☐	Information about the health of the participant (including mental health)	☐

Contact details for future use	☒	Physiological test results / measurements	☐
Field notes	☒	MRI scans	☐
Task results (e.g. questionnaires, diary completion)	☒	IP addresses (refer to Best Practice Guidance 09: Data collection, protection and management for guidance)	☐
Data already in the public domain. Specify the source of the data:	☐	Other (please specify below)	☐
Previously collected (secondary) data	☐		
Bank details for payment	☐		

How and where will each type of data be stored whilst the research is ongoing (until the end of all participant involvement)?

List each type of data selected above, and explain how each will be physically transferred (including movement/sharing of audio files, paper records, electronic downloads etc.) from where it is collected to a suitable storage site (e.g. Nexus365 OneDrive for Business, SharePoint, University servers). State the storage location for each. Do not store unencrypted data in freely available cloud services or unprotected USB drives.
Refer to Best Practice Guidance on data collection, protection and management (BPG09).

Interviews and Focus Groups: Microsoft Teams will be used to record all interviews and focus groups. Microsoft teams has a function which provides a transcript from recordings to download after the meeting is complete. After the transcript is produced, I will listen to the audio recording and check the transcript for accuracy, making any edits as needed including removing and identifying information. Then the audio file will be destroyed. As a back-up I will also use my iPhone voicenote recording function. Once the teams recording is successfully uploaded, I will delete this voice note of my phone. In the event that I do have to use the voice note, I will upload it to my computer, transcribe manually immediately and delete the recording. All transcriptions will be stored in an encrypted password secure ‘Nexus 365 One Drive for Business account’ and be retained for a minimum of 10 years.

Focus-Group Protocol Co-Creation Meeting: I will type out minutes on my laptop which will be stored in the project Nexus 365 One Drive for Business account. All information gathered will be anonymized and no direct quotes or recordings will be taken.

Demographic Questionnaires: I will ask participants to complete a short demographic questionnaire (see attached). These will be completed at the beginning of the focus groups. Information from the questionnaires will be uploaded to an excel spreadsheet and stored in the Nexus 365 One Drive for Business account. One this is uploaded, all hard copies will be destroyed.

Fieldnotes and one-on-one rapid ethnographic interviews: I will be recording hand-written fieldnotes during the period of participant-observation and one-on-one rapid ethnographic interviews. These fieldnotes will be transcribed onto a word document and stored in the ‘Nexus 365 One Drive for Business account’. Once they are uploaded, all hard copies will be destroyed. To record oral consent, each participant name will be assigned a participant code. On a separate excel spreadsheet each participant code will be assigned a pseudonym. (e.g. EI01234 code meaning EI ethnographic interview, location 01, participant 234). Each participant name will be matched with a code which will separately be matched with pseudonyms (which will be stored on a separate excel spreadsheet). Both of these excel spreadsheets will be stored in the secure Nexus 365 One Drive for Business account. For all Greek fieldnotes, both the original copies and translated versions (which will be translated manually by the Greek research assistant who is fluent in English and Greek) will be stored securely in the secure Nexus 365 One Drive for Business account.

For the consent forms and demographic questionnaires, each participant will be assigned a participant code. On a separate excel spreadsheet each participant code will be assigned a pseudonym. (e.g. FG01234 code meaning FG focus group, location 01, participant 234). Each participant name will be matched with a code which will separately be matched with pseudonyms (which will be stored on a separate excel spreadsheet). Both of these excel spreadsheets will be stored in the secure Nexus 365 One Drive for Business account

In addition to the 'Nexus 365 One Drive for Business account', all data will be stored in a secure password protected external hard drive that will be kept in a safe at the University of Oxford.

Will you use a unique participant number on research data instead of participant name?

If yes, state whether or not you will retain a list of participant names against numbers (pseudonymisation via a linkage list). **Where will the list be stored, and when will it be destroyed?**

Focus group and ethnographic interview participant names will be linked to a unique study number which will then be linked to a pseudonyms to contextualize the data being gathered. These numbers will also be linked to the demographic questionnaires. The study numbers and pseudonyms will be stored on an excel spreadsheet and uploaded to the Nexus 365 One Drive for Business Account. All hard copies will be destroyed once these are uploaded.
When including transcript excerpts, any identifying information (street names, names of staff, names of partner services, names of other community services and individuals) will be removed or pseudonymized to assure confidentiality.

Who will have access to the research data?

All the above data saved within the password protected Nexus 365 One Drive for Business account will be available to Ben Scher, Dr Benjamin Chrisinger, Dr Gillian Shorter and research assistant Nikolaos Poulopoulos. Raw data will not be shared with any other individuals or organizations.

If research data is to be shared with another organisation, how will it be transferred / disclosed securely?

N/A

When and how will identifiable data (including audio/video recordings & photos) be destroyed or deleted?

N.B. If any identifiable data will be retained beyond the end of the study and/or indefinitely, please state what data this is, and the reasons for retention (e.g. contact details for future studies; photos used in publication). This must be clearly stated on participant information, and specific consent obtained.

As per UKRI best practice guidelines, all identifiable data (including original identifiable transcripts, consent forms, and participant stipend receipts) will be destroyed after ten years. This fits within the minimum requirements of Canada (7 years) and USA (5 years).

Audio files specifically will be deleted from the recording devices immediately after they have been transferred to a password-protected hard drive for transcription, and audio files on the password-protected hard drive will be deleted immediately after the interviews and focus group discussions have been transcribed, and checked for quality. All paper copies with identifiable data will be shredded using a paper following digitization and transfer to encrypted One Drive account.		
Please confirm that you will store other (non-identifiable) research data safely for at least 3 years after final publication or public release and adhere to any additional research funder policies. For more information about the University policies, please see the University's webpages on research data management. **If 'Yes'**, please give details of who will store the data and on storage format, location and security. **If 'No'**, please provide further details.	Yes ☒	No ☐
In line with UKRI best practice, all non-identifiable research data will be stored safely for 10 years after collection. All electronic data will be stored on OneDrive for Business as well as on an external hard drive located at the University of Oxford. Non-identifiable data will also be stored on Open Science Framework, to promote data transparency, and allow for future research with this data set.		

Section I. Research involving secondary use or disclosure of personal data or special category data

This section of the form is only to be completed for research activity (as part or all of the research) where there is no contact with human participants (in person or virtual) and no observation of them, only use of data about them.

Your research must meet the standards laid down in the Data Protection Act 2018 with respect to the collection, use, and storage of personal data about human participants.

Will you seek data access agreements for these data? **If yes,** List the individual(s) or organisation(s) from which the information will be sourced Attach a copy of the agreement with the individual(s) or organisations in question Provide details of any conditions imposed by the organisation(s) concerning the release of the information **If no,** please explain how and when the agreement of the disclosing organisation(s) will be obtained	Yes ☐	No ☒
N/A		
Could these data be linked back to an individual or individuals? **If yes,** Please explain why data cannot be collected in a way that prevents linkage with an individual/individuals Say how individual consent was obtained for the collection, use or disclosure of linkable data **If no,** you do not need to complete the rest of this section	Yes ☐	No ☒

N/A
How will any personally identifiable data be transferred to you? Please describe the arrangements for any physical transfer of personal data (including paper records and data captured electronically via portable media) from where you are obtaining it to local storage
N/A
Where, and for how long, will personally identifiable data be stored during and after the research? Please outline procedures for ensuring confidentiality, e.g. security arrangements, pseudonymisation etc.
N/A
Who will have access to the personally identifiable data? If data is to be shared with another organisation, other than the researchers listed, how will it be transferred / disclosed securely
N/A
When and how will personally identifiable data be destroyed?
N/A

Section J. Publication and dissemination of results

Will you preregister this research?		Yes ☒	No ☐
If yes, please state the platform where it will be preregistered	Open Science Framework		
How will you disseminate project outcomes at the end of the research?	I plan to disseminate this research through 1) thesis publication 2) publication in peer reviewed journals 3) conference presentation 4) report to the research funder and 5) submission for academic assessment I also intend to provide focus group participants and the partner organisations with a lay summary of the results if they so wish. This will happen in a timely fashion following data analysis The anonymized data will also be stored on Open Science Framework, to enhance the transparency and accountability of our research.		

Section K. Additional questions for applications to the Medical Sciences IDREC

List any standardised questionnaires that will be utilised (there is no need to send a copy)	N/A
List any additional questionnaires designed	N/A

by the researchers – a copy of these must be sent to the MS IDREC for review	
Give details of any biological sample(s) that will be taken (e.g. blood, urine, saliva, faeces)	N/A

Declaration and signatures

In providing signatures, the IDRECs accept either:

Option 1: Email confirmations sent from a University of Oxford email address. Separate emails should be sent by each of the relevant signatories as outlined below, indicating acceptance of their responsibilities.

Option 2: That the form be fully-signed with handwritten (wet-ink) signatures. Please scan these and the rest of the form pages to create a single PDF document and email to us.

The form should be sent with Word versions of all documents by email to:
ethics@medsci.ox.ac.uk (for applications from the Medical Sciences and MPLS divisions)
ethics@socsci.ox.ac.uk (for applications from the Social Sciences and Humanities divisions)
Applications from departments with a departmental research ethics committee (DREC) should first be sent for initial review to the relevant DREC.

Pasted images of signatures cannot be accepted

Principal Investigator (and student if applicable)

I/We, the researcher(s):
Understand our responsibilities as outlined on this form and in the CUREC glossary and guidance
Agree to start this research only after obtaining approval from the IDREC;
Understand that the Principal Investigator must ensure that all researchers are suitably qualified and trained to conduct the research described, or are appropriately supervised until deemed qualified/trained;
Agree to provide additional information as requested by the IDREC before approval is secured and as research progresses;
Agree to maintain the confidentiality of all data collected from or about participants;
Agree to notify the IDREC in writing immediately of any proposed change to the research, and await approval before proceeding with the proposed change;
Agree to notify the IDREC if the Principal Investigator changes and supply the name of the successor;
Will use the data collected only for the research for which approval has been given;
Will grant access to data only to authorised persons; and
Have made arrangements to ensure that personal data collected from participants will be held in compliance with the requirements of UK GDPR and the Data Protection Act 2018.

Principal Investigator (Name)	Dr Benjamin Chrisinger
Principal Investigator (Signature) (Wet-ink signature, not pasted electronic image)	
Date	22-09-2022
Student (Name)	Benjamin Scher
Student (Signature) (Wet-ink signature, not pasted electronic image)	
Date	21-09-22
Name of Co- Investigator	Dr Gillian Shorter
Co Investigator’s signature	

Date	21-09-2022

Acceptance by Head of Department/Faculty or Designated Nominee*
*Another senior member of the department may sign where the head of department is the Principal Investigator, or where the head of department has appointed a nominee. Example nominees include Deputy Head of Department, Director of Research, and Director of Graduate/ Undergraduate Studies.
On the basis of the information available to me, I confirm that:
I am aware of the research proposed and have read this application;
To the best of my knowledge, the proposed design and scientific methodology do not raise ethical concerns;
I support this research in principle, subject to ethical and other necessary reviews.

Head of Department or designated nominee (Name)	[ANONYMIZED]
Head of Department or designated nominee (Signature) Wet-ink signature (not pasted electronic image) *or* The Head of Department/nominee can send an email (including PI name and study title) to ethics@medsci.ox.ac.uk or ethics@socsci.ox.ac.uk confirming the above	[ANONYMIZED]
Date	3 JANURARY 2023