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Research Paper

'It's our safe sanctuary': Experiences of using an unsanctioned overdose prevention site in Toronto, Ontario

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ABSTRACT

Background: Overdose prevention sites (OPSs) are spaces where people can consume drugs under the supervision of trained volunteers or staff and receive help in the event of an overdose. Unsanctioned OPSs are a grassroots response to the current opioid crisis in Canada.
Methods: We used rapid evaluation methods to study the experiences of 30 individuals accessing the smoking and injection services at the first unsanctioned OPS in Toronto, Ontario using semi-structured interviews. Data were analyzed using an applied thematic analysis approach to identify emergent themes related to service user experiences, characteristics of the risk environment, and recommended changes to the service model.
Results: The OPS represented a safe sanctuary and brought a sense of belonging to a community that often experiences discrimination. Valued aspects included: shelter; protection from violence; safety from overdoses; free equipment; information about health and social services; food and beverages; and socializing and connecting with others. Integrating peer workers in the design and delivery of services encouraged service users to visit the site. The OPS changed the risk environment by: providing access to the first supervised smoking service in Toronto; having few explicit rules and a communal approach to making new rules; allowing assisted injection, and negotiating with police to allow people to access the site with minimal contact. Service users noted the need to ensure a safe space for women and recommended extended hours of operation and moving to a more permanent space with heat and lighting for both smoking and injecting drugs.
Conclusion: The unsanctioned OPS in Toronto served an important role in defining new, community-led, flexible responses to opioid overdose-related deaths at a time of markedly increasing mortality. Providing harm reduction services in diverse settings and expanding services to include smoking and assisted injection may increase access for marginalized people who use drugs.

Background

Overdose prevention sites (OPSs) are places – tents, trailers, vans, shipping containers, and spaces within existing community-based organizations and housing facilities (Blythe et al., 2017) – where people who use drugs can inject, smoke, and/or snort drugs under the supervision of trained volunteers or staff, often but not always including a regulated health professional. In Canada, OPSs are designed to be a low budget overdose prevention intervention that can be rapidly implemented and adapted to diverse settings. While most sites also distribute and dispose of drug equipment and offer information about health and social services, they generally do not offer the extensive range of services that are typical of supervised consumption services (SCSs) (e.g., counselling or HIV testing). Community members established the first 'pop-up', unsanctioned, community-organized sites in Vancouver, Canada, as a response to perceived inaction by governments to address dramatic increases in opioid-related overdoses linked to the contamination of the street drug supply with synthetics opioids such as fentanyl (Blythe et al., 2017; Kerr, Mitra, Kennedy & McNeil, 2017; Tyndall, 2018).

In response to a request from the organizers of the Moss Park OPS, an OPS operating in Toronto, Canada, we used a rapid evaluation model (Anker, Guidotti, Orzeszyna, Sapirie & Thuriax, 1993; McNall & Foster-Fishman, 2007) coupled with a risk environment framework (Rhodes, Singer, Bourgois, Friedman & Strathdee, 2005) to answer the

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question: if and how does the OPS alter the risk environment to reduce the risk of overdose? In particular, we conceptualized the risk environment to include the physical (e.g., drug use settings), social (e.g., group norms), economic (e.g., income inequality), and policy (e.g., drug criminalization) contexts that may constrain individual agency to avoid and prevent overdose Rhodes, 2009; Rhodes et al., 2005). In this manuscript, we explore the perspectives of service users about this question.

While a 2012 report recommended the establishment of three supervised injection services in Toronto (Bayoumi et al., 2012), implementation was slow given that sites were required to obtain municipal endorsement, provincial funding, and federal approval, as well as complete construction, hiring, and inspections before opening (Jozaghi, 2016; Kerr et al., 2017). Inspired by the Vancouver experience and alarmed by the high rates of overdose deaths and slow rate of SCS implementation in the city, activists from the Toronto Harm Reduction Alliance (i.e., people who use drugs, people who work in harm reduction programs, and allies) formed the Toronto Overdose Prevention Society (TOPS) and opened an OPS on August 12th, 2017, in Moss Park, a public park located in a downtown east Toronto neighbourhood with high rates of public drug use and overdose (CTV News, 2017). A small group of TOPS members, with backgrounds in harm reduction service delivery and/or lived experience of drug use, organized and managed the services. The OPS was set up quickly and without sanction or funding from any level of government.

The site initially consisted of an injection tent, a smoking tent, and a supply tent. A trailer was later donated by a labour union to replace the injection tent (Pagliaro & Mathieu, 2017). Offering services between 4 pm and 10 pm each day for over 10 months, the site was operated exclusively by volunteers, including members of TOPS, people who use drugs, harm reduction workers from local agencies, and health care providers (Arkell, 2018). From September 2017 to December 2017 (when the study was conducted), there were 3734 visits to the injection service and 4890 visits to the smoking service. During this same time period, there were 139 overdoses at the Moss Park OPS, of which 53 (38%) were reversed with naloxone, and 86 (62%) were reversed with oxygen, monitoring, and stimulation (Kolla et al., 2018). No overdose deaths occurred at the Moss Park OPS.

Although there is a rich literature about SCS (e.g. Potier, Laprévote, Dubois-Arber, Cottencin & Rolland, 2014; Sherman, Hunter & Rouhani, 2017), little is known about service user experiences at OPSs. Unsanctioned, peer-led services have been shown to address unmet needs in Vancouver (Kerr, Oleson, Tyndall, Montaner & Wood, 2005; McNeil, Kerr, Lampkin & Small, 2015, 2014) and an underground supervised injecting facility has been offering services in an undisclosed location in the United States since 2014 (Davidson, Lopez & Kral, 2018). These sites have been shown to engage with particularly marginalized people who use drugs, despite being limited by legal concerns and political acceptability (Davidson et al., 2018; McNeil et al., 2015). We examined service users' experiences in Toronto's first OPS, with a particular focus on how the Moss Park OPS might reduce contextual factors that contribute to overdose risk, such as injecting alone or in unhygienic locations, rushing to inject to avoid victimization or arrest, and reluctance to call for an ambulance when overdoses occur because of fear of arrest.

Methods

In line with the rapid evaluation approach of an emergent program (Beebe, 2012), we conducted semi-structured, qualitative interviews in December 2017 with service users, volunteers, and TOPS organizers of the Moss Park OPS. In this manuscript, we focus on the perspectives of service users, and report elsewhere the perspectives of volunteers and organizers. Using convenience sampling methods, we sequentially approached service users who were referred by shift leaders. Service users were eligible if they had attended the Moss Park OPS at least once prior to participating in our study. In line with the rapid evaluation model, we predetermined the number of interviews (n = 15 smoking tent and n = 15 injection tent) based on recommendations for reaching saturation of key themes (Guest, MacQueen & Namey, 2012) and continued recruitment until reaching this number. One of 3 interviewers (AFM, CS, & MM) explained the purpose of the study to prospective participants, answered any questions and obtained verbal consent before proceeding with data collection. Interviews were conducted in Moss Park between 4 pm and 10 pm, and within sight of the OPS tents and trailer.

Interviews were based on a semi-structured interview guide that was developed in collaboration with the TOPS organizers and explored the experiences of service users at the OPS, and how utilization may have altered their experience of the overdose-related risk environment. Questions focused on: service user characteristics (e.g. drugs consumed and housing status); when, how, and why participants used the service; what they liked about the site; and what they felt needed to be improved. To ensure anonymity and to respect the low-threshold philosophy of the Moss Park OPS, we requested minimal personal information from participants (age, gender, and racial/ethnic background). Interviews lasted between 6 and 25 min and participants received a $20 honorarium for their time.

Interviews were audio-recorded, transcribed verbatim, verified and imported into NVivo Qualitative Data Analysis Software (version 11). Using an applied thematic analysis approach (Guest, MacQueen & Namey, 2012), full transcripts were reviewed first to identify text relevant to the interview guide, including participant demographics, drug consumption patterns, experiences using the site, if and how their experience of the risk environment was changed by using the OPS, and any recommended changes. Preliminary codes were revised upon subsequent reading of the transcripts to capture additional, emerging themes and concepts informed by the 'Risk Environment' framework (Rhodes et al., 2005). Simple descriptive statistics of participant characteristics were computed using Microsoft Excel. The study was approved by the Research Ethics Board of the University of Toronto.

Results

Service users – mostly homeless and/or men (see Table 1) - heard about the OPS through friends, by word of mouth, or by coming across it in the park (67%); as well as from local churches, social services, or through media sources (33%). Service users cited a range of motives for coming to the OPS, including: to reduce their risks from living and using drugs outdoors, to feel a sense of belonging and community, and also to get information about health and social services. In the analysis below, we focus on two broad ways in which the OPS reshaped the risk environment in terms creating a sanctuary that offered protection from the weather, stigma, violence and policing and how it improved the quality of harm reduction service delivery.

Creating a safe sanctuary

Services users noted that the OPS provided sanctuary from many challenging aspects of their lives such as inclement weather; risk of overdoses; protection from street violence and reprieve from fear of arrest. It also reduced community risk from discarded drug use equipment and nuisance from public drug consumption.

> *Two years ago,* [Moss Park] *was crazy. There was rampant drug use, needles everywhere, crack use out in the open. Kids couldn't come here… And since the site has opened, we clean up needles… pick up pipes. And it's a safe place to be now… the drug* (injection service user, male, 25 years).

As well as providing some basic instrumental supports (e.g., refuge from the elements; food; drug use equipment; and disposal) and protection from overdose, the Moss Park OPS was praised as an inclusive space that offered a place of community and a refuge from everyday violence faced by people who use drugs. Service users described the site as a community *'meeting place'* and as *'a hassle-free zone'* for people who often face stigma and discrimination. Participants described it as a '*safe haven… a godsend'*

Table 1
Participant characteristics.

	Smoking tent (n = 15)	Injection Tent/trailer (n = 15)	Total (n = 30)
Age - *Median (range)*	38 (19–52)	35 (25–61)	38 (19–61)
Identified as male *n (%)*	11 (73)	8 (53)	19 (63)
Identified as female *n (%)*	4 (27)	7 (47)	11 (37)
Identified as Indigenous (e.g. Native, Métis, Ojibwa, Cree, First Nations, Iroquois) *n (%)*	4 (27)	9 (60)	13 (43)
Housing Status *n (%)*			
• Outdoors/Parks/Street	13 (87)	7 (47)	20 (67)
• Shelters/Couchsurfing	8 (53)	7 (47)	15 (50)
• Correctional Services	<4	<4	<4
• Personal/Shared Apartments or Transitional Housing	–	5 (33)	5 (17)
Drugs Injected in Past Month *n (%)*			
• Heroin	4 (27)	12 (80)	16 (53)
• Fentanyl	5 (33)	13 (87)	18 (60)
• Cocaine	–	7 (47)	7 (23)
• Crystal Methamphetamine	–	8 (53)	8 (27)
• Other (e.g. methadone, hydromorphone, morphine)	3 (20)	2 (13)	5 (17)
Drugs Smoked in Past Month *n (%)*			
• Crack Cocaine	15 (100)	12 (80)	27 (90)
• Other (e.g. Fentanyl, Crystal Methamphetamine, Cannabis)	8 (53)	–	10 (33)
How learned about the OPS *n (%)*			
• Friends, word of mouth, seeing it in the park	10 (67)	10 (67)	20 (67)
• Local churches, social services or media	6 (38)	4 (27)	10 (33)

and *'our sanctuary… Somewhere that we feel safe, somewhere that we can be comfortable with our addiction'* (injection service user, female, 32 years). The site represented a unique space where service users could be themselves without fear of embarrassment, reprimand, or violence.

Participants pointed to the volunteers (i.e., peers, harm reduction staff from other agencies, health care providers) who created an environment in which everyone felt welcomed, valued, and supported. They expressed gratitude for the friendly and capable volunteers who were generous with their time - *'they're here because they want to be here'* (injection service users, female, 43 years) and valued the relationships that they built with staff who: '*love us until we love ourselves'* (smoking service user, male, 32 years). The OPS offered safety because the volunteers were skilled overdose responders:

> *I seen a couple people OD. And* [the staff] *know what they're doing, and they bring them around… Where they could have died, and they didn't, because they were here.* (injection service user, male, 61 years)

Participants stressed that having peer workers onsite helped them feel more comfortable and at ease and hence making the service more accessible for people who may not access other harm reduction services: '*I feel like I can connect more to somebody that has used heroin or a drug before intravenously* (injection service user, female, 25 years)'. This sense of sanctuary fostered a sense of ownership and collective responsibility for the operation and sustainability of the site: '*I consider* [the OPS] *my baby… I'm here almost every day… This is where I get my solace.* (injection service user, male, 46 years)'

Service users also described how the OPS reduced their exposure to policing when using drugs. In contrast to consuming drugs in public spaces, participants appreciated the sense of security and freedom to take their time when preparing and consuming drugs without fear of arrest or risk of violence.

> [To] *get any amount of security at all is a gift, because usually we're in an alleyway, looking over our shoulder, waiting for police to roll in, or somebody to walk up on us, and trying to get [the drug] ready and trying to get it in us, and the whole nine yards. With the trailer, you don't have that sense of forbearing… It's relaxing. You sit down, and you do your shot.* (injection service user, male, 46 years).

Although the site opened without formal government sanction, the Moss Park OPS organizers negotiated with local police to ensure that service users could use the site without interference. In exchange, the OPS agreed to close the site by 10 pm each night and ensure that a healthcare provider was onsite during all hours of operation. At first, service users were wary of being arrested at the OPS, but noted that lack of police interference over time helped them to develop a sense of security and to feel comfortable consuming drugs onsite.

> *Fucking safe injection site? … The cops, they say it's okay? Bullshit. Next thing you know, I was in there and I had the nurses and people beside me, and I felt safe.* (injection service user, female, 43 years).

> *It took a while for* [my friends] *to become comfortable with* [the OPS], *just because they were worried about police coming and watching us, or the media was here a lot and that made people nervous…but now people have become very comfortable with this site*. (injection service user, male, 25 years).

Nevertheless, some stayed away fearing it was a police 'set-up'. Despite the police committing to staying away from the OPS, service users spoke about some instances of ongoing, overt police monitoring.

> [The cops] *do their best to make their presence known, even though we have an agreement with them … They'll ride by on their bikes. They'll park out front. But we just tell them that 'You can't be here. You gotta go.' If they're not willing to leave, we call the superintendent.* (injection service user, male, 46 years).

Improving the quality of harm reduction service delivery

In addition to creating sanctuary, service users also spoke about ways in which the OPS improved their access to harm reduction supplies and other supports:

> *Usually I don't get to eat nothing all day. But they serve food here, and then they help you out and talk to you and help you out with clothing and everything… and just be able to talk to other people who have addictions.* (injection service user, female, 29 years).

Service users also attended the OPS to receive nursing care for abscesses and other infections. Although the OPS did not have formal referral mechanisms, service users noted that OPS volunteers often helped them to connect with other services, including treatment or detoxification services: '*I've been talking to staff, 'cause I've been wanting to stop, and they kind of pushed me in that direction, to seek help* (smoking service user, male, 52 years)'.

As well as these instrumental supports, service users described how the OPS improved the quality of harm reduction services in four

important ways: access to supervised smoking; having few explicit rules at the outset and a communal approach to making new rules and access to assisted injecting.

The Moss Park OPS provided a structural intervention through its supervised smoking service, a service that was not available anywhere else in the city and in very few places in Canada. Having access to a supervised smoking service brought a sense of recognition and addressed concerns about equity of access to harm reduction services among people who smoked drugs and felt that injection-focused programs overlooked their needs.

> *The other harm reduction sites don't have a smoking place… They definitely should. Because, you can't just turn away people because they choose to smoke their dope instead of injecting it.* (smoking service user, male, 19 years).

> *The important thing you need to do is to remember to treat everybody equally… like not to treat people who smoke crack different than someone who injects… everybody that needs the help.* (injection service user, female, 25 years).

The Moss Park OPS changed the experience of the service environments because it had few explicit rules and those in place were made through the collective decision of organizers, volunteers, and service users.

> The clientele… are kind of making the rules, kind of keeping people in check and stuff like that… You lay a rule down and someone's going to break it, somewhere along the line… You just kind of leave it to the people, they'll make it work, if it's to their benefit… So the people go above and beyond to make sure that this works… it's just kind of 'go with the flow' sort of thing. (smoking service user, male, 51 years)

Behavioural guidelines at the site, included: no smoking in the injection space; no drug dealing; respect everyone; no aggressive behaviour (e.g., fighting or robbing); clean up your space for the person after you; don't stay too long; don't cause trouble; keep your voice down; no '*getting in anybody else's business'* (smoking service user, male, 32 years); and '*just try and make it a relaxing, calm, fun place to be'* (injection service user, male, 25 years). Most participants accessing the services came to know of the rules by overhearing others talking, seeing how others behaved, or that the rules were 'common sense', reasonable and shared: '*We all know each other. We're all on the streets and stuff like that. And there's certain… street rules… like respect each other' (injection service user, female, 29 years*). Others mentioned that volunteers had provided them with a quick overview of expectations. The sense of ownership of and responsibility for the OPS supported the desire for user-defined and observed rules:

> *If people are getting hostile, we'll remind them, like 'Hey. If a fight breaks out here, cops will come and they're going to shut this down.' And people respect that, because people really like this place. It's saving lives.* (injection service user, male, 25 years)

Despite the commitment to 'street-rules' and shared expectations, participants mentioned instances where volunteers intervened in response to aggressiveness, hassling, hustling, dealing, and threats. Most of these problems originated in the smoking tent. Unlike the injection service where there was always supervision inside the tent, volunteers decided if they would sit inside or outside the smoking tent. Some volunteers elected not to go inside the smoking tent because they found it too smelly from the drugs being smoked, too hot because of the outside temperature and/or because they didn't think supervision was needed inside. Participants discussed two problems that arose for the smoking tent - an attempted take-over of the smoking tent by a dealer and harassment of women. One participant noted that the smoking tended to be '*a bit harder for women… they get hassled* [for sex]' (smoking service user, female, 29 years). Following these problems, the smoking tent was redesigned:

> *… they leave one wall down so they* [volunteers] *can see what's going on in there… there hasn't been a fight in the smoking tent since (smoking service user, male, 19 years)*

Although service users perceived that a minimal rules approach improved access, some wanted time limits for the injection trailer to reduce wait times, increase access and reduce problems from too many people 'hanging' around. Wait-times of up to an hour for the injection tent/trailer were reported. Injection service users explained that when there was a line-up at the site, they did not always wait and would inject nearby in the park: '*It takes too long and I'm sick… I'm still being supervised*' (injection service user, female, 26 years). For the smoking tent, service users mentioned that a tricky balance needed to be struck between making the smoking tent comfortable enough for people to want to come, but '*If you make it too nice, you're going to have a lot of people coming and…They're going to want to stay… So you've got to leave it so it's somewhat uncomfortable. (*smoking service user, male, 51 years)

More explicit guidelines and behavioural expectations were later developed in consultation with service users and posted, including: limits to the number of people in the trailer (8 people plus volunteers) and smoking tent (4 to 5 people); no dealing; possess drugs before going into injection trailer; no violence or threats; no weapons; no sexism; no nudity; and a requirement for service users to keep their belongings together. A 20-minute time limit was introduced for the injection trailer with service users who needed to do a second shot exiting and returning. Volunteers were also asked to be more intentional in discussing the rules with new service users.

There was no formal policy developed about assisted injection which created the opportunity for supervised injection for those who could not or would not self-inject. Not all service users were aware that assisted injections could take place. This service was highly valued by those who were aware of it:

> *If you're shaking and you're sick, or … you can't find a vein… I think they should be able to help.* (injection service user, male, 48 years)

> Because nurses are trained… so they can help you use a vein that is less damaged… And some people struggle with injecting, especially if you've been doing it for a long time; your veins are damaged. (injection service user, male, 25 years)

While support for supervised injection was high amongst those aware of it, they also articulated concerns about the impact of potential lawsuits if a fatal overdose or other injection related harm happened following an assisted injection. Some recommended that the OPS use a consent form signed by anyone assisting or receiving an injection to address any legal issues. Three participants expressed disapproval of assisted injection, maintaining that: *'if you can't hit yourself, then don't do it'* (injection service user, female, 29 years).

While the OPS was perceived to be an improved model of harm reduction for the reasons noted above, participants also noted constraints on the ability of the Moss Park OPS to do so. Lack of funding and the volunteer model limited the hours of operation to 4–6 h per day. Service users urged that the hours of operation needed to be extended, particularly in the morning: '*Early in the morning is when everyone's getting their first hit… there's been a couple people lately who have died in the morning time*' (injection service user, female, 29 years). Some participants suggested that a 24-hour service would be beneficial as well as adding more OPSs across the city, including in other public parks: '*We're not going to wait till four o'clock to go inside the tent when we're sick. No, no, no.'* (smoking service user, female, 40 years).

The tents proved to be unsuitable in colder weather, heavy rain or wind storms and during shorter daylight hours. Participants spoke of times that they were unable to use the smoking tent: '*One of the days, it was windy as hell… the winds actually flipped the tent into the air'* (smoking service user, male, 19 years). Attempts to address these

problems first arrived in November 2017, when the Ontario government's Emergency Medical Assistance Team provided the Moss Park OPS with an insulated tent. It was small and open flames necessary to heat or smoke drugs were not permitted inside rendering it unsuitable for drug use. Nevertheless, it was kept and providing a place to store supplies and for service users to warm up on cold days. A trade union later donated a 40-foot trailer with heating and lights to replace the injection tent (Pagliaro & Mathieu, 2017). This was a welcome change for people who had difficulty finding veins: '*The cold… makes my veins, I find, smaller and more deep.* (injection service user, female, 25 years).

Smoking tent users were disappointed when they did not receive a similar 'upgraded space' akin to the injection trailer: '*They're focusing more on the injecting instead of smoking too… they got a big trailer for the injection, but the smoking… they're not really caring about*' (smoking service user, female, 29 years). To smoking service users, this failure to enhance the smoking space reflected ongoing inequities in access to service for people who smoke drugs.

Discussion

The OPS implementation in Toronto was an immediate, grassroots, overdose prevention response that changed the risk environment when governments refused to do so. The Moss Park OPS experience adds to the history of unsanctioned harm reduction programs implemented by community activists to reshape public health policy in Canada (Kerr et al., 2017; McNeil et al., 2014; Small, Palepu & Tyndall, 2006; Wallace, Pagan & Pauly, 2019). Like other OPSs, the Moss Park OPS acted as a workaround solution to a restrictive legal regime and application process for SCSs in Canada (Arkell, 2018; Kerr et al., 2017) and was able to be rapidly rolled-out by community members in response to the opioid overdose crisis (Kerr et al., 2017).

Consistent with literature about other structural interventions (Fairbairn, Small, Shannon, Wood & Kerr, 2008; MacNeil & Pauly, 2011; McNeil et al., 2014, 2015), service users were drawn to the OPS for the 'sanctuary' or 'refuge' it provided from fear or arrest and exposure to everyday violence, as well as the opportunities for social connection. The Moss Park OPS altered the risk environment by offering a low barrier approach designed by and for the community to encourage attendance of people often excluded from other harm reduction services, including people who: smoke drugs such as crack cocaine and need help injecting. While attempting to provide equivalent service to those who inject and smoke drugs, the Moss Park OPS experienced some challenges in doing so. People who smoke drugs tend to be among the most socially disadvantaged populations of people who use drugs (Fischer & Coghlan, 2007; McNeil et al., 2015) and have historically been a difficult population to engage with in health and social services (Strathdee & Navarro, 2010). While sanctioned supervised smoking services have been implemented in European cities (Hedrich, Kerr & Dubois-Arber, 2010; Woods, 2014), implementation has been slow in Canada with only a few cities providing services for people who smoke drugs (Edwardson, 2018; McNeil et al., 2015). The evidence base about these services is sparse (Fischer et al., 2015; Strathdee & Navarro, 2010) and our findings that the Moss Park OPS was greatly valued and used by the target population offers some evidence. Our findings also demonstrate that harm reduction models can be adapted to meet the needs of multiple target groups and the value of concurrent program evaluation in generating evidence to guide future implementation.

The Moss Park OPS and other unsanctioned harm reduction programs informally allowed assisted injection, which has been repeatedly identified as a priority for expanded harm reduction services (Gagnon, 2017; Kerr et al., 2005, 2017; McNeil et al., 2014). This service may be particularly important for women and people with disabilities who disproportionately require assistance injecting (McNeil et al., 2014; Wood et al., 2003). More work is needed to demonstrate the impact and safety of this type of service (Gagnon, 2017; Kerr et al., 2017; Lupick, 2018). Notably, the unsanctioned Moss Park OPS witnessed an increase in community-derived rules over the first few months of implementation, in contrast to the experience in three sanctioned British Columbia OPSs, which saw the gradual loosening of rules over the first few months of implementation in response to community concerns (Wallace et al., 2019). No policy about assisted injection was written until the OPS applied for funding from the provincial government.

Our study has several limitations. First, the results describe perspectives of OPS service users at one point in time, approximately four months after the site opened. Given the flexible and responsive nature of the OPS approach, the findings may not be representative of how the OPS is currently operated. Similarly, these findings were specific to the OPS operated by TOPS in Moss Park and may not be directly transferable to other settings and jurisdictions. The experiences described in this study were from people accessing services at the Moss Park OPS and may not be representative of all people who use drugs in Toronto. All study interviews were conducted in the park within view of the tents and trailer. Although all interviewers were skilled at creating a comfortable interpersonal environment for interviewees, the proximity to the OPS and concern about the impact of their responses on the future of the site may have influenced what they felt comfortable sharing. While we found some evidence that women's experiences differed from men's, future studies should explore gender differences more fully, given that women have been shown to face unique barriers to accessing harm reduction services (Fairbairn et al., 2008; McNeil et al., 2014).

Despite scale up of sanctioned SCSs in Canada, the current overdose crisis and tainted illicit drug supply necessitated more immediate, flexible, responses such as OPSs to prevent overdose-related deaths and harms. Our results suggest that a low-threshold program with few overt rules, operated by community members, led by people with lived experience of drug use, and offering diverse services such as supervised smoking and assisted injection, can successfully attract a wide range of people who use drugs. Implementation of the Moss Park OPS put considerable pressure on municipal, provincial, and federal governments to respond in kind. Through the summer and autumn of 2017, the OPS received highly publicized visits from the mayor of Toronto (Rieti, 2017), the provincial Minister of Health and the provincial premier (Ferguson, 2017). After operating for ten months on an entirely volunteer basis, the Moss Park OPS gained approval, secured provincial funding (Gray, 2018), and moved into a more permanent indoor space in early July 2018 (Sheldon, 2018). The establishment of OPSs demonstrates how extralegal, unsanctioned action can drive policy change.

CRediT authorship contribution statement

Annie Foreman-Mackey: Conceptualization, Formal analysis, Investigation, Data curation, Project administration, Writing - original draft, Writing - review & editing. **Ahmed M. Bayoumi:** Conceptualization, Supervision, Writing - review & editing. **Miroslav Miskovic:** Conceptualization, Investigation, Data curation, Writing - review & editing. **Gillian Kolla:** Conceptualization, Methodology, Writing - review & editing. **Carol Strike:** Conceptualization, Formal analysis, Investigation, Data curation, Methodology, Project administration, Writing - review & editing.

Declaration of Competing Interest

None for all authors.

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