Harm reduction throughout the opioid crisis: A community responds

A conversation with Mr Ronnie Grigg, manager of the Vancouver Overdose Prevention Society.

Jacob L. Stubbs, BKin

ABSTRACT

Mr Ronnie Grigg has been a long-time harm reduction worker in the Vancouver Downtown Eastside and is currently general manager of the Vancouver Overdose Prevention Society. Located at 58 East Hastings St. in Vancouver, British Columbia. The Vancouver Overdose Prevention Society is a not-for-profit organization that oversees hundreds of consumptions daily. The society began as a tent designated for safe consumption and overdose prevention, and was one of the initial community-led responses to the opioid crisis in British Columbia. In 2017, its peer workers—all individuals from the Downtown Eastside community—oversaw more than 100 000 visits to the site, responded to 417 overdoses, and recorded zero deaths. In mid-September 2018, I interviewed Mr Grigg about his experiences in harm reduction and innovations such as the society that arose in response to the opioid crisis. In this interview Mr Grigg describes his experiences as a front-line harm reduction worker during the crisis, his perspectives on the role of overdose prevention sites as an integral component of the health care system, and the need for increased support of the peer workers who staff these sites.

JS: Could you please state who you are and your current position?

RG: My name is Ronnie Grigg, my title is general manager of the Vancouver Overdose Prevention Society (OPS), and I've been a long-time front-line worker in the Downtown Eastside. I previously had a leadership position at Insite, which was a pioneering safe consumption site in Canada, for many years. With the recent proliferation of overdose prevention sites, I've come in to manage OPS, which is also a pioneering site in harm reduction.

How would you describe what you do?

My role, and the role I share with our management team, is very broad. I'm still a front-line worker attending to overdoses, and I manage the staff at OPS. OPS is a fledgling not-for-profit, so I also handle decision making and funding. We've garnered some worldwide attention, so engaging the media and sharing the collective wisdom is also a significant part of my job now.

What has it been like to be a front-line harm reduction worker throughout the opioid crisis?

It was autumn 2014 when powdered fentanyl hit. When fentanyl arrived, Insite, which averaged 10 overdoses per week, went up to 10 per day, overnight. Insite stayed in this 8 to 10 overdoses per day range for 2 years, with spikes during which it got worse. And in the past 2 years it's just continued to worsen.

From my perspective, I've seen that the front-line harm reduction worker has been a neglected part of the narrative. We've often been referred to as the first-first-responders—that is, those who attend an overdose before the first responders arrive. What separates us from first responders like fire and ambulance is that more often than not we know the people's names, we've cared for them day in and day out, we've cared for their loved ones. So there's a different relationship and response from harm reduction workers in the community.

At the height of the crisis there were many nights when you would hear of multiple deaths. One night

Mr Stubbs is a PhD student in the Experimental Medicine Program (Psychiatry) at the University of British Columbia. His work focuses on characterizing the scope and impact of traumatic brain injury in the homeless and marginally housed.

This article has been peer reviewed. Mr Grigg's responses have been lightly edited for clarity and brevity.

Photo: Colin Askey

Ronnie Grigg outside Vancouver's Overdose Prevention Society.

there were four in my shift alone. So we were attending to overdoses, hearing news of someone we cared about dying, processing that grief in the moment, but then also caring for others in their grief. That aspect of trauma for harm reduction workers hasn't really been acknowledged. I don't want to diminish the experience of first responders—they have been deeply affected by this crisis—but for harm reduction workers it's not just the impact of responding to an overdose, it's the grief of a community.

What does harm reduction and low-barrier care mean to you?

An easy way to look at harm reduction is as meeting people where they're at. For the person with sleep deprivation after days of stimulant and opioid use, simply hydrating them is an aspect of harm reduction. Low-barrier care is about the caregiver modifying themselves to provide care for someone who has difficulty accessing care. For example, emergency rooms have barriers for some individuals. Many people in this neighborhood cannot go through the triage process in an ER for whatever reason, whether it be stigma from staff, things escalating quickly, or some other factor.

What gave rise to the Vancouver Overdose Prevention Society?

It was a crisis response. Sarah Blyth—a colleague, friend, and founder of OPS—noticed that the incidences of overdoses were increasing, which began to dominate her days as manager of the Downtown Eastside market. She dedicated a portion of the market to a supervised consumption area under a tent. It was also a bit of an act of community civil disobedience. There were no permissions or exemptions given. This was a crisis and this was the response. No one could come in and say, "take that down," because no one else had a solution. It was initially funded through a GoFundMe campaign, then the provincial health minister at the time recognized the benefit of these sites and called for funding. Three more sites started within 2 weeks—all peer run without embedded clinical support. It was a true community response. Now we have a provincial exemption that acknowledges the crisis-response aspect that allows us to function under the federal exemption standards.

What makes OPS different from government-funded safe injection sites such as Insite?

It's the low-barrier aspect. Our entrance is a gate in an alleyway, so our separation from life in that alley is not much. When I worked at Insite we had limitations to what we could help with. In Health Canada's language, assisted injection is having a health care provider actually pushing the plunger, and we weren't allowed to formally assist injecting people. What needs to

Continued on page 174

Continued from page 173

be acknowledged is that this semantic definition is a barrier for some people. For example, a lot of young females depend on someone else to inject them. At places like Insite, these individuals aren't allowed to have someone else inject them. That's not an issue at OPS; your partner can inject you, you can find someone in the room, etc. At OPS we don't require staff to do any of those things, but we let people ask others if anyone can help. Then someone else on site can help with that injection. If there is a dependency surrounding having someone inject, OPS can accommodate that. Insite was always the hallmark of low-barrier care, but it is interesting with the development of OPS [to realize] how barriered Insite really can be.

OPS can also accommodate a wide variety of forms of drugs. We're the only site in Vancouver that can accommodate inhalation. And there is also an anonymity that people benefit from at OPS, which combined with the low-barrier aspect provides personal agency.

How is the Overdose Prevention Society staffed?

OPS uses the peer model, which is based on persons with lived experience [of addiction and life in the Downtown Eastside], and their role historically has been to bridge between the professional and the one who needs care. Before the opioid crisis teams might have a single peer worker attached to a care model. At OPS the ratio has been upended; we've created teams of peers that are supported by a few nonpeers. During this crisis it's no longer about that peer group supporting professionals, it's about a community taking charge of their own.

These peer community members have such a complex story. There has been something amazing about the community response and about the opportunity for a marginalized group to attend to the needs of their own community. The impact of meaningful work, especially for individuals who struggle to get meaningful work, is massive. But how do we leave the heavy lifting of such a massive crisis to such a marginalized and unsupported population? What are we doing for the trauma and the grief of the peer worker? It's a really complex and nuanced situation.

[Vancouver has] informed policy around the globe. I want people to be proud of that. It might be ugly, it might be confusing, and it might seem chaotic, but we can take care of people in profound ways.

Are there health care providers or first responders at OPS?

No, but we can further define that. Everyone at OPS has naloxone training and overdose management training and experience. But as far as any licensed or professional body, we don't have that.

Is that a funding restraint?

Yes, essentially. I would say it largely boils down to funding. Although there are other constraints, such as WorkSafeBC language with the nurses' unions for example. If someone says, "f***," in my direction, that can be interpreted as verbal abuse. Nurses experience an inordinate amount of abuse in their work environment, but when you put those standards in a front-line environment, WorkSafeBC doesn't have the language to support front-line care. This is a new spectrum of workplace, so workplace language should be informed by us.

What role do you believe OPS is filling that the health care system is not?

Honestly, those in decision-making positions struggled with a response to this question. Perhaps because they are removed from the front-line experience they have difficulty grasping the immensity of the crisis. I was there, boots on the ground, face first, working nights. I was making my requests in the manner that I could, and advocating and supporting the best I could. What I wanted was to increase the number of front-line harm reduction workers—double us up, give us more equipment, just do something. That's what I was advocating for. There was only so much we could do, and it took a long time for our message to be heard. OPS is a community response providing the lowest-barrier harm reduction services for this community, which is invariably saving lives.

Is there more that you think the government or health care professionals can do to support the opioid crisis response or OPS?

Yeah, there's tons they could do. The support of harm reduction workers, specifically, is a huge issue. How does a marginalized person who is making $50 a day working at an overdose prevention site get a day off? How do they get mental health support? The complexity around mental health, this work, and its impact demands an immense requirement from us and others.

I also recently came across a systematic review paper looking at the efficacy of these sites, but they threw out everything besides eight articles. The perspectives of the drug user, the front-line worker, and the peer worker weren't heard. And the hard data isn't everything.

What do you think leads to controversy around these sites, and should they be controversial?

The language. The "enabler" language, "facilitating illegal activity," "harm production" instead of "harm reduction." There's a sort of self-

righteous posturing behind the idea that everyone should be a contributing member of society, have a job, pay their rent or mortgage. This fails to recognize the limits of our cultural organization. There are people here who will never fit into that mold because of mental illness, mental capacity, or trauma. We need to acknowledge that harm reduction is an important care model, and we need to protect it.

I've been living and working in this neighborhood for a long time. So, in some ways, I don't have an effective barometer for controversy. On the other hand, I have a really effective barometer for suffering and needless tragedy. We can respond to this, but the primary barrier is drug policy and access to a clean and safe supply. Let's say that the decriminalization model is trustworthy: instead of a lethal drug supply, one can access a managed, prescribed supply. Let's say that access to care increases, and the associated stigma, violence, and crime decreases. Then maybe it's not that bad to have in my neighborhood, right?

Vancouver has been a global leader in the response to the HIV/AIDS crisis and the experience of HIV/AIDS, and harm reduction. Those are two deeply compassionate experiences, and we've informed policy around the globe. I want people to be proud of that. It might be ugly, it might be confusing, and it might seem chaotic, but we can take care of people in profound ways. I think that's a flag we should wave.

What do you find most encouraging or inspiring about your work?

The response to this crisis has emerged from grassroots efforts. In their words, a bunch of junkies just organized. That reality—people advocating for themselves, people changing the face of health care—that's why all of this exists. It was people experiencing the situation and saying, this change needs to happen. It's important to continue to be innovative and pioneering, and if you lead with compassion, change happens.

When we have staff meetings with all the peer staff we start with two acknowledgments—an acknowledgment of the land and an acknowledgment that we did something significant here. We are the site that innovated this care model. We inform drug policy and care, and now people come to seek out our wisdom. That's inspiring to me. I exhaust my mind, body, and soul caring for people who are suffering unimaginably with grief and trauma. I have two daughters and they are proud of me. That's good, and that's inspiring.

And finally, we're beginning to change the language around prohibition. Arresting our way out of this is not working. This is not moral deviance; it is people who are hurt, traumatized, in pain, whatever. This is a medical crisis, not a moral crisis, and we need things to change. BCMJ

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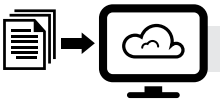

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