“Everyone here [is] a customer”: lessons learned in co-designing housing-based harm reduction with older people who have experienced homelessness.

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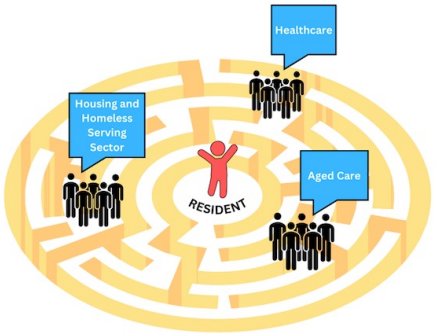
Background

Older Canadians are experiencing **homelessness at unprecedented rates,** many of whom
(1) use substances in response to chronic pain, physical & mental ill health, life transitions[1,2,3]
(2) experience increased isolation, functional decline, and **barriers to care associated with substa**
(3) need tailored interventions including **harm reduction services**[4,5]

Input needed from older people with lived experience to ensure accessible & acceptable innovati

Rise of **neoliberalism** in Canada (1990’s)
- Emphasis on **individualism**, reduced government responsibility
- Defunding/privatization of health services**; time-limited, project-based funding**
- Sector & service **labyrinth**: siloed and competing for resources
- **Funder/externally-determined accountabilities**



Study Objective

What lessons have been learned about the implementation of housing-based harm reduction programming for older people with experiences of homelessness?

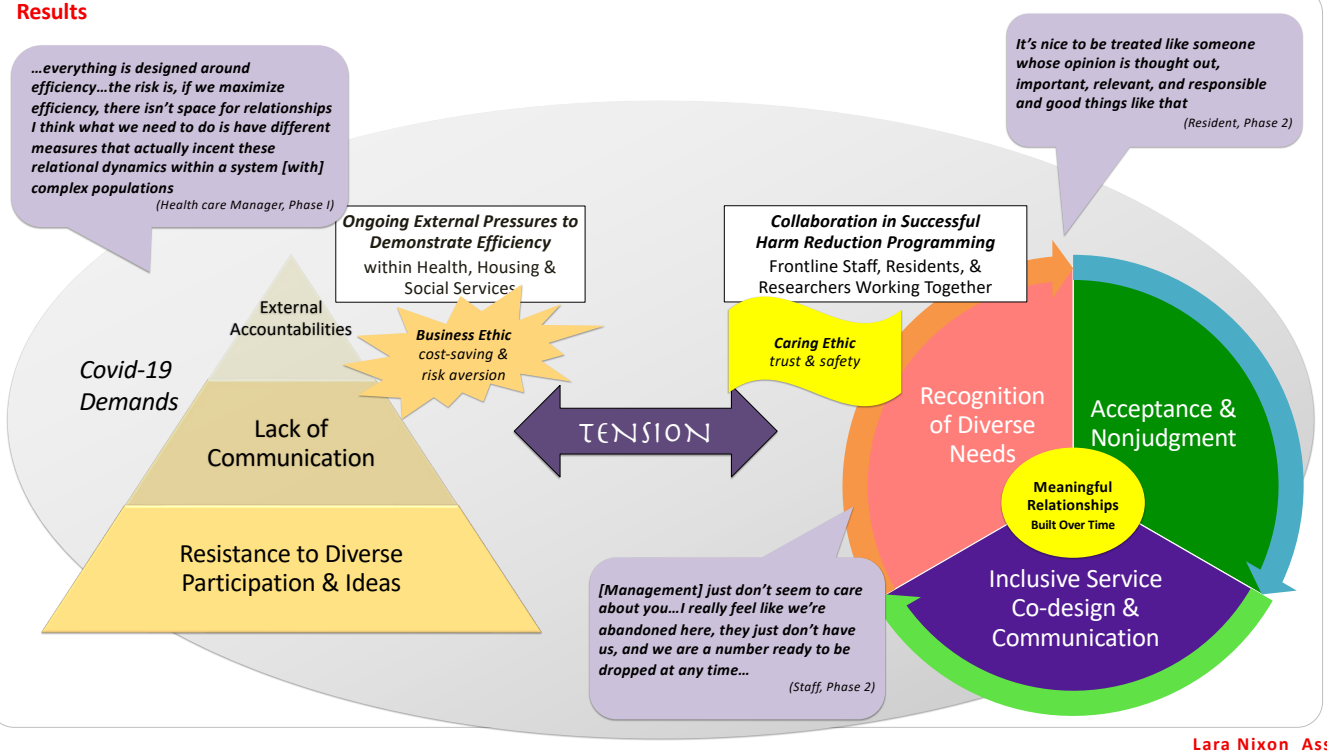
Methods

This study critically examines a 3-year pilot project (2019-2022) of harm-reduction programming co-designed, implemented and evaluated in collaboration with older people with experiences of homelessness (OPEH) residing at “Harbour House”, a congregate supportive living setting for OPEH unable to secure housing elsewhere.

EDI & SGBA+ Considerations
The overall pilot project was co-designed in collaboration with residents, staff, and the research team and guided by **Community-Based Participatory Action Research (CBPAR)[6].**
- Equity-deserving older residents in the intervention site provided direct input into project conceptualization, study design, data collection strategies, and intervention co-design.
- A core group participated in a citizen advisory group, “The Exchange”; met monthly to intensively guide the project, participate in NGT sessions, and co-author knowledge products.

Qualitative process evaluation
(a) Nominal Group Technique Meetings[7]: two sequential meetings with residents (2) and intervention staff (8); thematic analysis to identify key learnings
(b) Semi-structured interviews: secondary analysis (n= 52), Phase 1 needs assessment with cross-sectoral service providers (12), and Phase 2, intervention site residents (19) and staff (20)

Results



Conclusions

- CBPAR methods are beneficial to creating innovative services and enhancing health equity, especially among populations facing multifaceted forms of marginalization such as OPEH.
- Successful harm reduction programming requires meaningful relationships grounded in trust built over time, which support and enhance harm reduction services.
- Measures of success determined externally, based on neoliberalism, emphasize efficiency and a competitive, business ethic over trust-building and a caring ethic.
- Unintended consequences include increased marginalization and substance-related harms for OPEH.

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