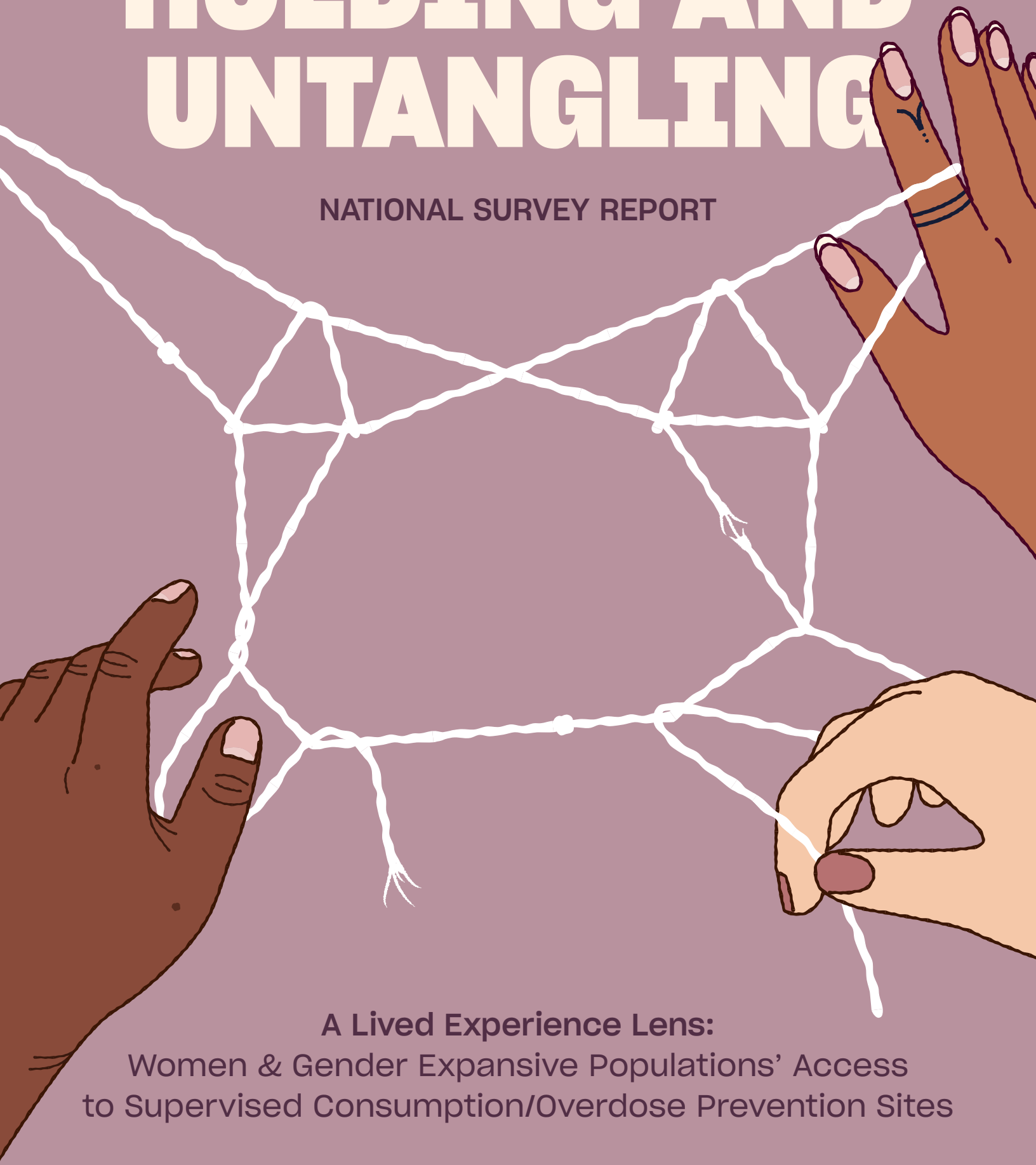
HOLDING AND UNTANGLING

NATIONAL SURVEY REPORT



A Lived Experience Lens:
Women & Gender Expansive Populations' Access to Supervised Consumption/Overdose Prevention Sites

Land Acknowledgement

The portion of Turtle Island (North America) we now call "Canada" has been home to Indigenous peoples – including First Nation, Métis, and Inuit peoples – for millennia. As a national working group, the Women & Gender Expansive Populations (WGEP) Working Group operates all throughout Turtle Island. There are Indigenous people who have been leaders and valued contributors to the project. As well, many of us are settlers and/or ancestral survivors of forced relocation (via slavery or refugeeism) who are now working and living on traditional territories of the First Peoples of this land. To understand and read more about the Indigenous people and territories that exist here on so-called Canada, please go to native-land.ca

The Dr. Peter Centre, the lead organization funding this project, is located on the Traditional Lands and Waters of the Coast Salish Peoples — Sḵwx̱wú7mesh (Squamish), Səl̓ílwətaʔ/Selilwitulh (Tsleil-Waututh), and xʷməθkʷəy̓əm (Musqueam) Nations.

Land acknowledgements are a small part of our commitment to Indigenous Communities. They have become common practice as a way to honour past, present, and future contributions of Indigenous people. Too often, these acknowledgements lack a substantive call to action and end up being a performative example of empty activism. This project strives to do work in alignment with the priorities of the Truth and Reconciliation Commission of Canada. You can view more about the Calls to Action via the National Centre for Truth and Reconciliation by visiting https://nctr.ca. As such, we also need to acknowledge the work of Indigenous communities to gain justice for Missing and Murdered Indigenous Women who are more likely to be the victims of violent crimes. To learn more about this issue please visit https://www.mmiwg-ffada.ca

In doing work on gender, we recognize that forces such as misogyny, transphobia, and transmisogyny are rooted in white supremacy and used as weapons in colonization. The attempted eradication of matriarchs and those who hold genders outside of the binary are examples of such acts of violence, the repercussions of which are still seen and felt today. In doing work through a gendered lens, we hope to aid in shedding light on these acts of bigotry and racism.

Holding and Untangling - A Lived Experience Lens: Women & Gender Expansive Populations' Access to Supervised Consumption/Overdose Prevention Sites: NATIONAL SURVEY REPORT

This report was prepared by the Women & Gender Expansive Populations Working Group, which was guided by the Project Lead, Nat Kaminski, and Gender Equity Consultant, Em Carl. The working group consisted of two tables: a leadership group called the Lived Expertise Leadership Group, who also met with a larger Stakeholders Advisory Committee. The Lived Expertise Leadership Group was made up of Cassandra Smith, Ashley Smoke, Akosua Gyan-Mante, Heath D'Alessio, Amy Rex, Leticia Mizon, Shanell Twan. The Stakeholder Advisory Committee included Katherine Rudzinski, Molly Bannerman, Jade Boyd, Karen Urbanoski, Josie Ricciardi, Carol Strike, Rhiannon Thomas, Sarah Whidden, Natasha Touesnard, Savannah Swann, Courtney Pankratz, Patrick McDougall, Clement Fong, and Corey Ranger.

We would like to thank all of the women and gender expansive people who use drugs, whose contributions to the Women and Gender Expansive Populations (WGEP) project survey informed this report and will inform the future of safe and accessible harm reduction services.

Thank you to all the members of the WGEP Project, the Canadian Association of People Who Use Drugs (CAPUD), and the Dr. Peter AIDS Foundation.

A special thank you to the co-leads, Nat Kaminski (Project Lead) and Em Carl (Gender Equity Consultant) for their leadership in the writing, completion and presentation of this report. Thank you to the Public Studio, Sheila Sampath for the design of the report. Thanks also to Katherine Rudzinski (UofT Researcher), Jennifer Thomas (Copy Editor), Kate Mason (South Riverdale Community Health Centre, Researcher) for editing support and Zoë Dodd (Knowledge Translation Specialist, Dr. Peter Centre/South Riverdale Community Health Centre) for their support on this project.

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EXECUTIVE SUMMARY

The Women and Gender Expansive Populations (WGEP) Project was developed to identify and address access barriers and facilitators at supervised consumption services (SCS) and overdose prevention sites (OPS). This project was led by the Lived Expertise Leadership Group (LEL Group) which is composed of women and gender expansive people who use(d) drugs, in addition to harm reduction service providers and academic researchers who provided input through an advisory committee. In mid-2021, the project team developed and disseminated a survey to collect feedback about the accessibility of supervised consumption and overdose prevention services from women and gender expansive people who use drugs from across Canada. This report summarizes the survey results, provides recommendations from the Lived Expertise Leadership Group with insights from the stakeholder advisory committee, and a comprehensive literature scan. As part of this project, a resource guide and assessment/reflection tool for SCS/OPS operators to improve access for women and gender expansive people who use drugs is also planned.

Methods

Data was collected via self-administered online survey and in-person surveys that were administered by members of the Lived Expertise Leadership Group in the summer of 2021. Eighty-nine survey responses and the perspectives of nine Lived Expertise Leadership Group members were ultimately included. Report findings also included data from a literature/resource scan and input from the lived/living experiences of the LEL Group.

Findings

From the analysis of both the survey results and the literature/resource scan, seven key themes were identified: (1) experiences at SCS/OPS (first impressions, interactions with staff), (2) accessibility and safety of physical spaces and surrounding environments, (3) gender-inclusive and -affirming practices, (4) pregnancy, parenting, and caregiving, (5) staff responses to conflict and violence, (6) hiring and representation, and (7) policies and procedures.

Discussion & Recommendations:

A key concern for participants, which came up throughout the survey and discussions, was safety. The report discusses and makes recommendations for site operators in the following areas:

- Foundational considerations
- Physical site design
- Gender inclusive/affirming practices
- Pregnancy, parenting, and caregiving
- Trauma-informed conflict/violence prevention and intervention
- Hiring and representation
- Data collection and expanded service options

Recommendations:

The Lived Expertise Leadership Group developed a series of recommendations, which can be found at the end of each theme's discussion. The recommendations within this report were made with a sense of urgency. Women and gender expansive populations' needs are not being met. As we continue to grapple with the unrelenting toxic drug death crisis and a desperate need to expand services and support — women and gender expansive populations should be prioritized within new and existing services.

Conclusion

There is an extreme lack of services and support for women and gender expansive populations. Despite the urgent needs, there are currently only two overdose prevention sites across the country specifically for women and gender diverse populations. Supervised consumption and overdose prevention sites are vital, life-saving services for people who use drugs. However, more must be done to ensure and work toward the improved accessibility of these services for women and gender expansive populations. Some of the recommendations in this report can be implemented within existing site structures and resources. Many will require additional funding and advocacy by site operators in solidarity with women and gender expansive populations who use drugs, to change systemic barriers and expand services and support.

INTRODUCTION

Background and Purpose

The unregulated toxic drug death crisis in Canada continues to be a major public health emergency. There are an estimated 20 people dying a day in Canada. There were a total of 40,642 apparent opioid toxicity deaths between January 2016 to June 2023 with an increase of 5% from 2022 to 2023 (Public Health Agency of Canada, 2023). It is estimated that over one-third of people who use drugs worldwide are women, yet one of the main responses to the crisis — supervised consumption and overdose prevention sites have been, and continue to be, male-dominated spaces (Women and Harm Reduction International Network, 2021).

Women and gender expansive populations of people who use drugs have different — and often more severe — experiences of stigma, violence, poverty, racism, and discrimination when compared to cisgender men. According to the Canadian Mental Health Association, "harm reduction services can inadvertently exclude women if social determinants of women's health — including poverty, violence and trauma, pregnancy and mothering, social policies surrounding sex work and housing — are not accounted for and integrated into service planning/delivery" (Xavier, Lowe, & Rodrigues, 2021). Studies have shown that the specific experiences of trauma due to trans-phobia, identity erasure, and gender-based violence increase the risk of substance use-related harms among women and gender expansive people (Nathoo, Poole, & Schmidt, 2018).

Despite calls for more gender-inclusive and gender-affirming practices in both harm reduction service provision and research, harm reduction services see lower proportions of women and gender expansive people, putting them at increased risk of HIV, hepatitis C, gender-based violence, overdose, and death.

> "How can we even begin to trust people with our vulnerable bodies during overdose when they don't respect us when we are conscious?"
>
> **— WGEP LIVED EXPERTISE LEADERSHIP GROUP MEMBER**

Health care interventions that lack gendered approaches fail to address the differential experiences and access needs of transgender, non-binary, and Two-Spirit individuals. There is a scarcity of research into the needs of gender expansive people who use drugs and their comfort with accessing supervised consumption services (HIV Legal Network, 2020). Interventions that are gender "neutral" actually reinforce the gender binary, contribute to erasure and obscure the unique experiences of gender expansive people who use drugs (Collins, Bardwell, McNeil, & Boyd, 2019).

Pregnant and parenting people who use drugs have additional needs and barriers to service access, such as increased experiences of stigma and well-founded fears of child welfare interference — loss of child-custody and apprehensions (Wolfson, Schmidt, Stinson, & Poole, 2021). Services that fail to recognize that substance use alone is an inadequate measure of parenting capacity, and conflate substance use with child mistreatment, often fail to provide suitable services and therefore put both parent and child(ren) at risk of adverse health outcomes. Due to existing colonial and racist systems, this is especially true for Black and Indigenous families (Boyd, 2019; HIV Legal Network, 2020; Kenny, Barrington, & Green, 2015).

The Women and Gender Expansive People (WGEP) Working Group was formed in partnership with the Canadian Association of People Who Use Drugs (CAPUD) and the Dr. Peter Centre (DPC).

The purpose of the WGEP Project is to develop a series of resources that operators of supervised consumption services (SCS) and overdose prevention sites (OPS) can use to identify and resolve access barriers for women and gender expansive people who use drugs. In an effort to ensure input from diverse perspectives for this work, the group undertook a survey of women and gender expansive individuals who use drugs in the summer of 2021.

This project and report was written within the backdrop of mass deaths due to the unregulated drug crisis. It is important for us to recognize that any work related to substance use takes time, strength, and effort when people are dealing with compounding loss, grief, and struggle. This is especially true for those who have lived experience and are working within the crisis as first responders for their friends, family, and community. We want to acknowledge these realities and the importance of support for those in this work, and remain committed to continuing to engage those who are directly affected.

Methods

Given the propensity for SCS/OPS to primarily serve cisgender men, the survey was undertaken to highlight the needs and perspectives of ***women and gender expansive populations***. To ensure that a broad and representative group of participants were able to take part in the survey, it was offered online and in person at various community-based services. Survey questions (**Appendix B**) were developed with input from the project's working group, as well as using knowledge obtained from the literature and resource scan, located in **Appendix A**. The survey was created and administered using Google Forms.

First, the survey link was sent to CAPUD membership, as well as a select list of organizations that operate SCS/OPS. The survey was made available in both English and French. In light of accessibility concerns with an exclusively online approach, select members from the Lived Expertise Leadership Group conducted four separate outreach initiatives to support participants completing the survey in person. Participants reached via outreach efforts were offered a choice of (1) completing the survey privately, with the our team member available for support or (2) having our team member read the survey questions aloud and input the participant's responses.

Once potential participants gained access to the survey, they were automatically screened for eligibility, on the basis of the following criteria: (a) at least 18 years old; (b) uses or has ever used drugs; (c) identifies as a woman (inclusive of trans women), trans man, and/or gender-expansive person (inclusive of Two-Spirit, non-binary, and gender non-conforming identities such as genderqueer or genderfluid).

All survey participants were compensated $40. Online participants were compensated via e-transfer within 24–72 hours of survey completion. In-person participants were paid cash upon completion.

The survey was designed to include both the experiences of people who have used in an SCS/OPS, and those who have not. The survey consisted of three primary components: (1) demographic screener, (2) participants' experiences at SCS/OPS, and (3) considerations to improve the accessibility of SCS/OPS. Participants who reported no previous experience accessing an SCS/OPS automatically skipped Section 2 and were directed to Section 3.

The survey was made available online for three weeks. A week into the survey being live, the team discovered that an automated bot was being used to generate mass responses. The survey was temporarily disabled while the project team removed the falsified responses, which were traced back to a single email address. The project goal was to obtain 100

unique responses. After screening out responses associated with the problematic email, the team was able to validate 89 unique responses.

Upon completion of data collection, the project team examined summary quantitative data and conducted iterative thematic analysis of the qualitative responses. The project team identified key themes and developed recommendations. Group discussions were held with the Lived Expertise Leadership Group while analysing the survey data and were documented. Survey data, discussion, and meeting minutes informed this report and recommendations.

Anonymous quotes from survey participants are distributed throughout this report. The report also includes quotes and written pieces from the Lived Expertise Leadership Group, who are identified by name.

Clarification of Terms

In choosing to use the term "gender expansive," consideration was given to the people we wished to reach and represent through the survey, and the membership of our working groups. This term is intended to be inclusive, but we acknowledge that it may not encompass the gender of every person with whom we engaged during this project. Additionally, the project team prefers the non-hyphenated version of the term "gender expansive." Many terms associated with gender identities end up being hyphenated or even combined, which changes the connotation. For example, the word "transwoman" is frequently used, which implies that a trans woman is different from our shared understanding of a woman. "Trans" is the adjective; "woman" is the noun, in the same way that "cis" is simply a descriptor. For this reason, we found it to be important for words to stand alone so as to not alter their meaning.

Transgender and gender nonconforming

"Transgender" and "gender nonconforming" were the terms we chose to use in our survey. We used the term "transgender," sometimes shortened to "trans," to mean someone who is a gender other than the one coercively assigned at birth based on outward sex characteristics. We used the term "gender nonconforming" as an umbrella term to include people who identify with non-normative identities like genderfluid or genderqueer. Whether a person identifies with either or both of these terms is up to them as an individual, as there is much nuance as to how these terms can resonate with a person.

Non-Binary

Someone who is non-binary does not identify exclusively as a man or a woman. They may identify as both, neither or some combination of the two. Some people may use the aforementioned terms genderqueer or genderfluid to further

describe their non-binary identity, and they may feel they are a combination of masculine and feminine. Some people may use the term agender, meaning they feel they do not align with any existing gender, while still having a sense of gender identity.

Two-Spirit People

Two-Spirit is an Indigenous identity. The term Two-Spirit is an umbrella term for a person who embodies both male and female spirits within them. However, Two-Spirit identities expand beyond this definition, and predate Western conceptions of transness and gender nonconformity. Each nation has their own language to describe these identities, experiences, and roles. Two-Spirit people may also identify and resonate with other terms like trans, gender nonconforming, or non-binary.

> "2-Spirit as a term compartmentalizes all Indigenous Gender Expansive People into an "other" category while claiming inclusivity. Not all Indigenous peoples identify as 2-Spirit, and not all 2-Spirit people are queer. People who identify as 2-Spirit have a variety of views and preferences while also having different experiences and needs from other gender expansive populations. Much of this stems from the history of pre-colonial Indigenous communities, and how gender roles played a part in a healthy, unified community, and survival. Understanding the history of what it is to be 2-Spirit is an integral starting point in being truly gender-inclusive and affirming."
>
> **— ASHLEY SMOKE (THEY/THEM), WGEP LIVED EXPERTISE LEADERSHIP GROUP**

Identity Erasure

Identity erasure means to disregard some parts of a person's identity to impose a role on them that is dictated by the dominant norms of a society. An example of this would be to discount a person's transness, and impose the norms and expectations of an incorrectly presumed gender.

Caregiver

When approaching this project we understood that the community we were working with would include parents and people in caregiving roles. Criminalization and colonization sees the constant removal of children from their families by the state. People who use drugs and especially Black and Indigenous parents are targets of surveillance. Health care, family, society, the law and the system view mothers and birthing parents who use drugs or who are suspected of using drugs more harshly. There may be individuals, family members, and supportive advocates who step in, formally or informally as caregivers, as a means of keeping children in the family or community.

In the survey, when we asked whether participants were parents or "acting as a caregiver for someone else's children," we left this definition open and didn't specify as there are many circumstances in which someone may care for another's children. We wished to pay respect to the different ways families and kinship ties can look.

Gender-affirming Care

Gender-affirming care can refer to medical care, or policies and practices. Related to how to treat people, in a frontline context — practical support on a continuous basis. For example: during overdose, making sure to use a person's correct name and pronouns, announcing out loud when you are going to touch them, and when possible having conversations about consent and where someone is okay with being touched.

Trauma-Informed Care

Trauma-informed care in this survey meant acknowledging people holistically, who have lived whole lives, and the complexity of their experiences. People who use drugs are often subject to repeated traumas on an ongoing basis, and as such, these experiences extend beyond childhood. Trauma-informed care looks like showing understanding and compassion without being patronizing, while questioning one's own biases and expectations around behaviour. In the context of access, perceived "bad" behaviour may be a trauma reaction, and the response should not always be punitive. People seeking support at an SCS/OPS may be deprived of housing and safety, which is why they have to attend these services instead of using at home. People who are homeless are forced to exist solely in public spaces and they are often policed, surveilled, and met with hostility. Scrutiny and violence have repercussions, and there are unrealistic expectations of respectability. An SCS/OPS may feel like a safe welcoming space where a person can be vulnerable and decompress, which for some can look like anger. Approaching people with these realities in mind will help guide appropriate responses, which is at the basis of trauma-informed care.

FINDINGS

The following findings are the results of the self-administered online survey and in-person surveys that were administered by members of the Lived Expertise Leadership (LEL) Group in the summer of 2021.

Participants' demographics

Participants were primarily located in either Ontario or British Columbia. Table 1 details participants' locations by province.

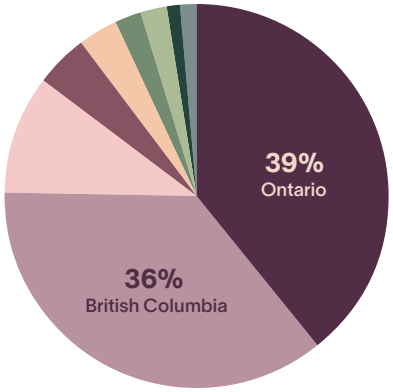


TABLE 1
Where are you located?

39%	Ontario
36%	British Columbia
10%	Nova Scotia
5%	Alberta
3%	Manitoba
2%	Saskatchewan
2%	Quebec
1%	Newfoundland and Labrador
1%	New Brunswick

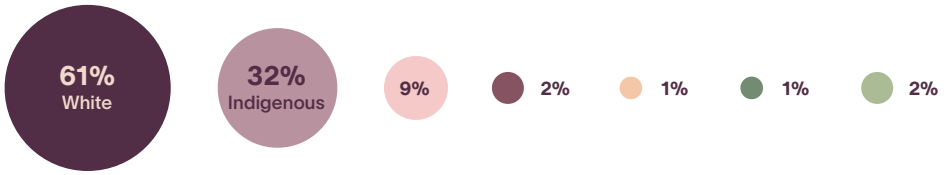
The majority of participants identified as living in urban settings (58%). Table 2 details the full geographical distribution of participants.

TABLE 2
How would you describe where you live?

NUMBER (%)	SETTING
58%	Urban
21%	Suburban
16%	Rural
10%	Off reserve
1%	On reserve
1%	Remote
1%	Prefer not to answer

Participants were also asked to self-identify by racial/ethnic background. While the majority of participants identified as white (European descent) (61%; n=54), there was also representation from both Indigenous (32%; n=28) and Black (9%; n=8) populations. A full summary of self-identified racial/ethnic backgrounds is provided in Table 3 (more than one response could be selected).

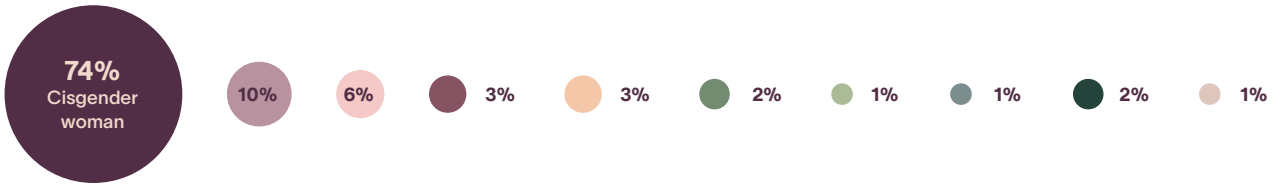
TABLE 3
Racial/Ethnic Background



61%	White (European descent)
32%	Indigenous (First Nations, Métis, Inuk/Inuit)
9%	Black (African, Afro-Caribbean, African Canadian descent)
2%	East Asian (Chinese, Korean, Japanese, Taiwanese descent)
1%	South Asian (South Asian descent, e.g., Indian, Pakistani, Bangladeshi, Sri Lankan, Indo - Caribbean, etc.)
1%	Latino (Latin American, Hispanic descent)
2%	Prefer not to answer

Participants were invited to select the gender option(s) that best reflect how they identify. While the majority of participants (74%; n=65) identified as cisgender women, there was representation from a number of gender identities that participants could select from a list, with a section included for write-in responses (more than one response could be selected).

TABLE 4
Gender Identity



74%	Cisgender woman	**2%**	Gender-fluid
10%	Non-binary	**1%**	Transgender woman
6%	Two-spirit	**1%**	Agender
3%	Transgender man	**2%**	Prefer not to answer
3%	Gender-queer	**1%**	I don't know

Participants were also asked to report their ages. The majority of participants (71%; n=63) were between the ages of 25 and 44 years. Participants under the age of 18 years were automatically taken to the end of the survey as per SCS age restrictions, which restrict access to minors. The full distribution of participants' ages can be seen in Table 5.

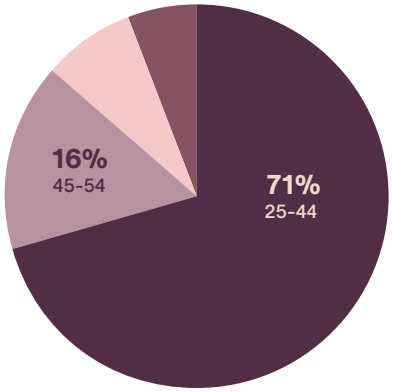


TABLE 5
What is your age?

71%	25-44
16%	45-54
8%	18-24
6%	55-64

Participants were asked what types of drugs they use and could select more than one option. The majority were poly drug users (73% N=65) (more than one response could be selected).

The top seven responses among the 89 participants were as follows:

1. **cocaine:** 62% (N=55)
2. **prescribed opioids:** 48% (N=43)
3. **non-prescribed opioids:** 43% (N=38)
4. **alcohol:** 43% (N=38)
5. **methamphetamine/amphetamines:** 38% (N=34)
6. **benzodiazepines:** 32% (N=28)
7. **gamma hydroxybutyrate (GHB):** 8% (N=7)

Responses indicated that, of the 89 participants:

73% (n=65) **engage in polysubstance use;**
38% (n=34) **use opioids and methamphetamine/ amphetamine and/or cocaine; and only**
12% (n=11) **of participants use opioids only.**

Participants were asked about their typical methods of drug use. The majority of survey respondents smoked their drugs:

69% (N=61) **smoked their drugs;**
60% (N=53) **consumed their drugs orally;**
48% (N=43) **engaged in intravenous drug use; and**
42% (N=37) **snorted their drugs.**

> "I smoke my drugs and when I injected there wasn't many [SCS/OPS] around and none in my area."
>
> **— SURVEY PARTICIPANT**

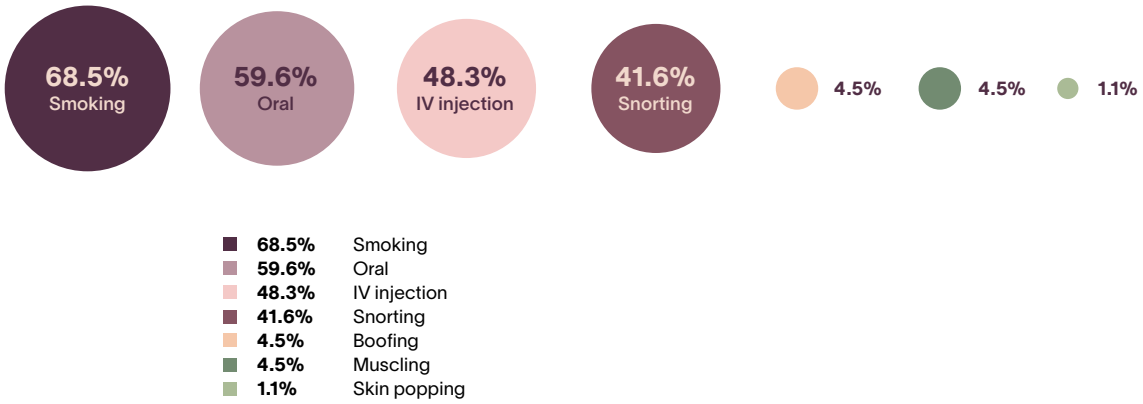
Participants who identified that they used more than one type of drugs would consume drugs using more than one route or method.

Of the 61 people who indicated that they smoke drugs, more than half (n=35) reported that they used opioids.

Access to SCS and OPS for inhalation is limited across the country despite high rates of death where inhalation is the prime route of ingestion.

The full distribution of routes of consumption can be seen in Figure 1 (more than one response could be selected).

FIGURE 1: METHODS OF CONSUMPTION
How do you use your drugs?



THEME 01

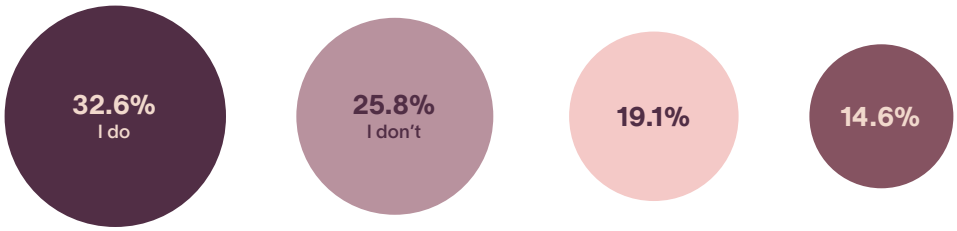
GENERAL EXPERIENCES OF SCS/OPS

“I would feel safer and more welcomed if the SCS/OPS and the organization/people running it were openly welcoming of people regardless of their race, gender, sexuality, class, ethnicity, culture, religion, background, etc. and truly low-barrier with a medical health professional, peers, addictions counsellor that include[s] diversity within the staff members.” **– SURVEY PARTICIPANT**

Accessibility and First Impressions

One third (33%; n=29) of participants responded, "I do" when asked, "Do you or don't you or don't you use SCS/OPS?" Including n=7 write-in responses which indicated experience using at SCS/OPS, 36 participants were eligible to complete Part 2 of the survey. An additional 15% (n=13) stated that they have considered using an SCS/OPS, and 19% indicated that they do not have a site in their community (Figure 2).

FIGURE 2
Do you or don't you use SCS/OPS?



32.6%	I do
25.8%	I don't
19.1%	I don't have an SCS/OPS in my community
14.6%	I have considered using drugs in an SCS/OPS but have not yet

Participants who had not used an SCS/OPS were invited to provide insights on what they would need or like to see in a space, in the hope that they would feel welcome to do so in the future.

Of the participants (n=8) who identified as African, Caribbean, or Black (ACB), none had reported using an SCS/OPS. This finding points to the additional accessibility barriers to harm reduction services that racialized populations experience (Bardwell, Austin, Maher, & Boyd, 2021; Kenny, Barrington & Green, 2015) and are further explored in the discussion.

For the 36 participants who had used an SCS/OPS, the primary way they had heard about the service was through word of mouth; the top three sources were as follows:

- 25% (n=9) **heard from a friend;**
- 22% (n=8) **heard from fellow community members; and**
- 17% (n=6) **heard from outreach teams**

Participants were asked if the SCS/OPS that they use(d) was low-barrier or high-barrier with 37% (n=13) who identified their site as high-barrier (see Figure 3). Participants were then asked to share what they believed made a site low-barrier or high-barrier. A central theme that emerged from these responses was that a low-barrier service was one that had

minimal administrative barriers, and that was primarily staffed by people with living/lived experience of drug use who created non-judgmental environments. Participants who felt sites were high-barrier cited police and security presence, general feelings of a lack of safety, experiences of violence, harassment and stigma, and overly medicalized and sterile environments as contributing factors.

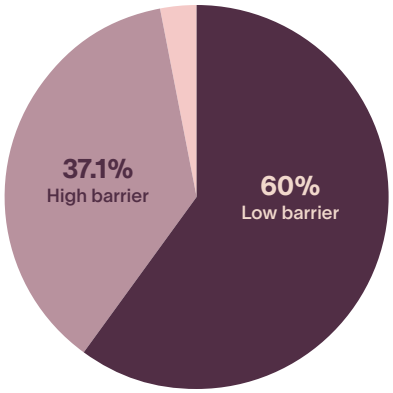


FIGURE 3
Is the SCS/OPS low barrier or high barrier?

60%	Low barrier
37.1%	High barrier
2.9%	Prefer not to answer

Feelings of Welcomeness and Safety

Participants were asked who they saw when entering an SCS/OPS. The majority of comments indicated that staff were welcoming. Participants said they saw "a friendly face," "a peer I knew," "cool staff and clients" or mentioned a "peer support worker," "harm reduction worker," "nurse," or staff members by name. One person wrote, "I remember the person was welcoming, and the experience was comforting."

> "I met one of the nurses who was very helpful and respectful and didn't make me feel judged."
>
> **— SURVEY PARTICIPANT**

Participants were asked, "What makes you feel welcome at an SCS/OPS?" The main factors identified included: staff with living/lived experience of drug use, comfortable waiting and chill spaces, and being adequately oriented to the space during the first visit (e.g., being given a tour, shown where the washrooms are, and/or asked about required equipment).

Participants were also asked if they were comfortable using SCS/OPS services.

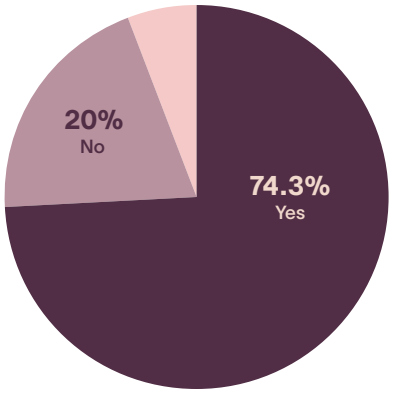


FIGURE 4
Were you comfortable using at the SCS/OPS?

- **74.3%** Yes
- **20%** No
- **5.7%** Prefer not to answer

Some participants identified that they did not use the sites at all, due to a lack of inhalation facilities. There were also substantial fears around surveillance and privacy concerns.

> "Fear of surveillance and reporting, fear of violence, not welcome as a mom, don't provide smoking facility."
>
> **— SURVEY PARTICIPANT**

Participants were asked if they felt comfortable asking staff for information, resources, support and/or referrals.

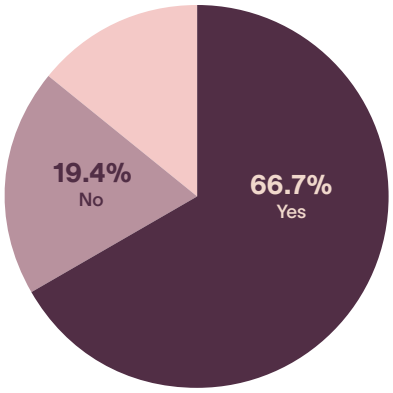
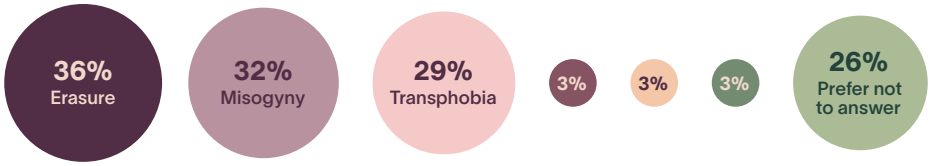


FIGURE 5
Did you feel comfortable asking staff for information/ resources/support?

- **66.7%** Yes
- **19.4%** No
- **13.9%** Prefer not to answer

Participants were asked specifically if they had negative or uncomfortable experiences in the SCS/OPS where staff had intervened. If they answered yes, participants were asked to specify what those experiences were and could select more than one. The top responses are highlighted in Figure 6.

FIGURE 6
Experiences of Stigma/Discrimination at an SCS/OPS



36%	Erasure
32%	Misogyny
29%	Transphobia
3%	Violence
3%	Stigma
3%	Racism
26%	Prefer not to answer

Participants were asked, "Do you feel your external appearance affects how you are treated in an SCS/OPS?" Thirty-one participants responded yes, with 13 of those participants whose responses indicated that they felt their appearance negatively affected their treatment. Throughout the survey, participants described feeling uncomfortable in male-dominated spaces because of their outward appearance, with many citing unwanted male gazes as a source of discomfort, anxiety, and fear. Others described feeling the need to hide their gender identity in order to feel safe accessing services.

"Definitely it impacts how I am treated as I think staff relate better to people they identify with – being more fem definitely allows me to get along with staff better (not identifying as non-binary because it feels unsafe, but being too Barbie-like gets you treated like shit by others at the site *being made fun of or laughed at under their breath* and staff don't step in when someone name calls you)."

— SURVEY PARTICIPANT

Participants were asked if they had ever overdosed at an SCS/OPS. Thirty-one percent (n=11) said that they had.

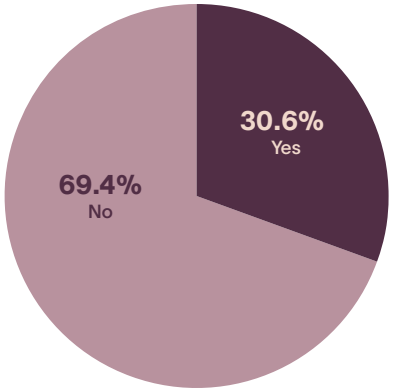


FIGURE 7
Have you overdosed at an SCS/OPS?

30.6% Yes
69.4% No

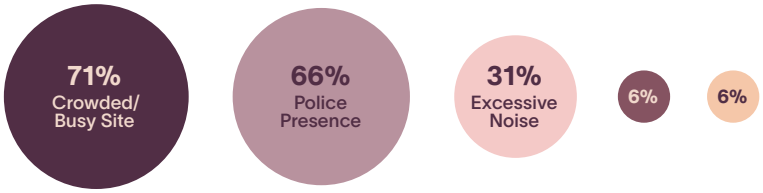
THEME 02

PHYSICAL SPACE AND SURROUNDING ENVIRONMENT

“I feel comfortable when there is a relaxed atmosphere. At sites where people are not permitted to sit together and speak to each other, it feels tense, as though staff are immediately suspicious and distrustful. Also, I appreciate when sites make space for people to nap when needed... There should also be separate spaces for discrete [sic] conversations with staff.” – SURVEY PARTICIPANT

Physical space can make a significant difference in terms of how safe, welcoming, and accessible an SCS/OPS is perceived to be. Participants were asked which aspects of the physical space and surrounding area would influence their perception of — and access to — a site. Highlighted below are the top five responses (more than one response could be selected).

FIGURE 8
What about the outside of a site deters you from accessing?



71%	Crowded/Busy Site
66%	Police Presence
31%	Excessive Noise
6%	Staff Outside
6%	Too many people/use outside

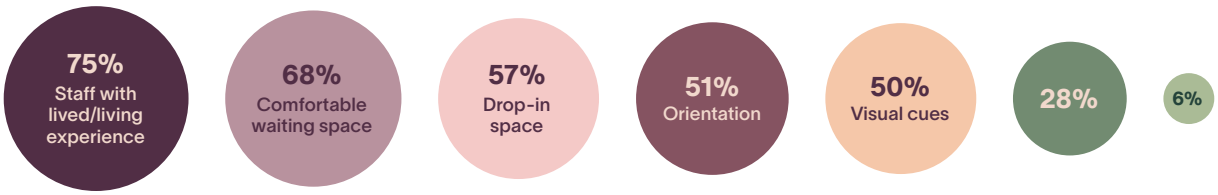
"Lots of noise/aggression makes me uncomfortable. Also environmental things can be good or bad (like lighting and amount of noise). Less people is more comfortable..." – **SURVEY PARTICIPANT**

Multiple participants described feeling uncomfortable in a "medicalized" or "sterile" environment, preferring sites that are more "cozy" and community-oriented, with "comfortable places to sit, "chill-out spaces," and private spaces for sensitive conversations. Others cited cleanliness as an essential element of comfort.

"There also ONE HUNDRED PERCENT should be a booth for people who have complex or vulnerable interactions when under the influence – such as a space that's private for people who go into psychosis or feel unsafe in the larger open area." – **SURVEY PARTICIPANT**

Participants suggested different types of environments to accommodate their various needs. Among the concerns raised was the commonly cited issue of not wanting to be stared at or bothered, by either staff or other participants, particularly cis men. Participants also expressed that they needed both spaces for privacy and for socialization. The table below details the practices/design elements that made or might make an SCS/OPS more accessible (more than one response could be selected):

FIGURE 9
What makes SCS/OPS accessible?



75%	Staff with lived/living experience
68%	Comfortable waiting space
57%	Drop-in space/chill space
51%	Being oriented to the space
50%	Visual cues/messaging/posters
28%	Options for childcare
6%	Prefer not to answer

> "The space is small, and I wish it were bigger so it could be more private, with space for more people. I would like to have privacy when I need to confide in staff, but I also want to share my experiences to offer other people insight if it can help them out." – SURVEY PARTICIPANT

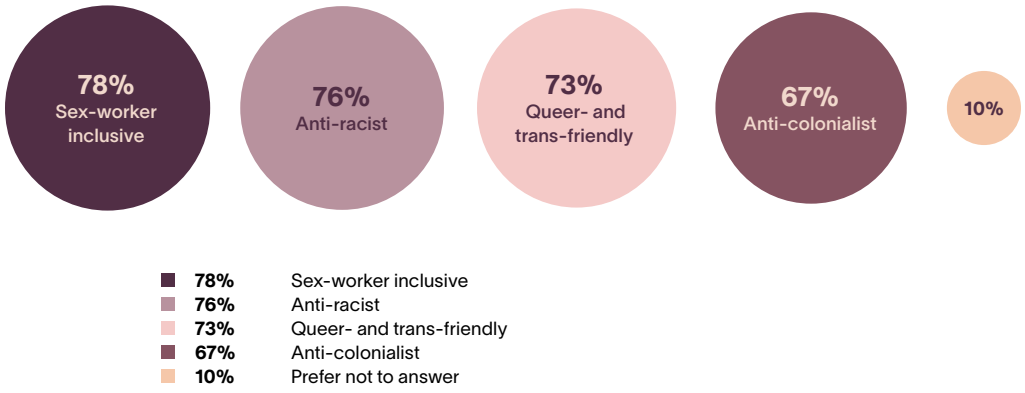
THEME 03

GENDER-INCLUSIVE & -AFFIRMING PRACTICES

"...I am often read as a cis woman despite being non-binary, so I often experience erasure and misogyny. I don't want to deal with the pain of being misgendered when I am there to seek pleasure and relief by using drugs. I also don't want to deal with the pain of being misgendered if I am overdosing, or if a conflict arises, or during any other negative experience, as it compounds the harm that I feel. Safety should be all encompassing" – **SURVEY PARTICIPANT**

Participants were asked what values are crucial for creating a gender-safe and responsive service. The top five responses are highlighted in the table below (more than one response could be selected):

FIGURE 10
What values are crucial for creating a gender-safe and responsive SCS/OPS?



Participants were asked if they were given an opportunity to identify their pronouns and gender identity, and only 58% (n=21) of participants reported that they were.

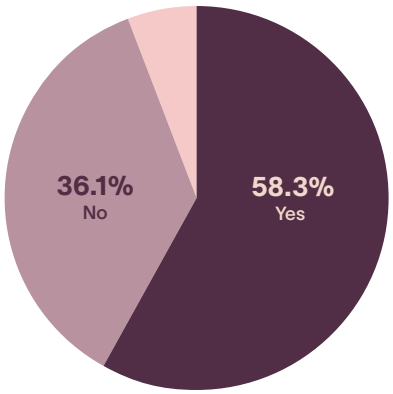


FIGURE 11
Were you given an opportunity to inform staff of your gender and pronouns?

58.3% Yes
36.1% No
5.6% Prefer not to answer

> "I never got my pronouns asked so I feel like they just don't really care/think about LGBTQIA2S+ issues"
>
> **— SURVEY PARTICIPANT**

Additionally, 25% (n=9) of participants did not feel safe informing staff of their gender identity and pronouns.

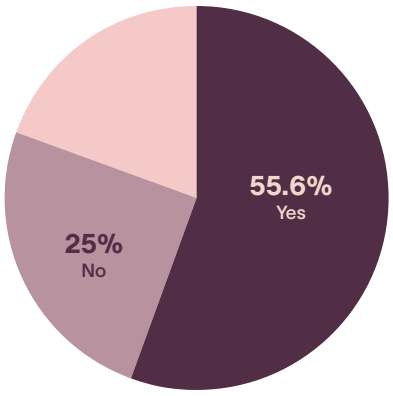


FIGURE 12
Did you feel safe informing staff of your gender and pronouns?

55.6%	Yes
25%	No
19.4%	Prefer not to answer

"I never disclose my non-binaryness [sic] because I pass for female and don't want to be discriminated against." **– SURVEY PARTICIPANT**

When asked, "How can SCS/OPS be more gender-safe/relevant for you?" Some participants noted that seeing themselves reflected in the staff at a site, and women and gender diverse-only hours and spaces, would increase their sense of comfort — and thus utilization — of a site.

One participant noted:

"I think a separate space for women that is OPTIONAL would be immensely helpful." **– SURVEY PARTICIPANT**

There were also calls for all-women SCS/OPS.

"Have an all woman OPS! I hope that can happen. We can have [a] daycare and foodbank there where we can volunteer too." **– SURVEY PARTICIPANT**

Training and staffing were also mentioned as how the SCS and OPS could be more gender-safe/relevant.

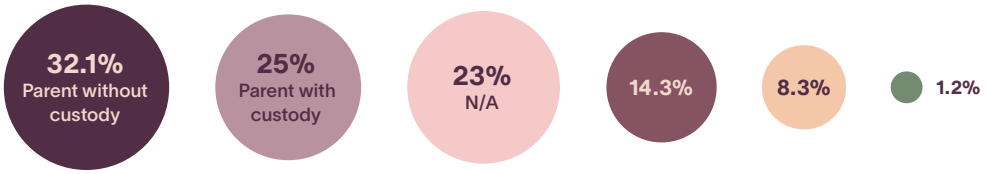
> "More trans/queer/gender diverse staff. Training for staff on gender affirming practice & working with gender diverse populations; trauma-informed practice training." — **SURVEY PARTICIPANT**

THEME 04

PREGNANCY, PARENTING, AND CAREGIVING

Participants were asked if they were pregnant, a parent with custody, a parent without custody, or a caregiver to someone else's child(ren). Responses are detailed below (more than one response could be selected).

FIGURE 13
Are you pregnant or parenting?



32.1%	A parent without custody
25%	A parent with custody
23%	None of the above
14.3%	Prefer not to answer
8.3%	A caregiver for someone else's child
1.2%	Pregnant

Participants were asked questions related to their comfort level in disclosing their pregnancy or parenting status to staff at an SCS/OPS and 19% (n=7) stated that they did not feel comfortable disclosing this information. Owing to the sensitive nature of drug use and parenting, and perceived repercussions around disclosure, no qualitative questions were asked.

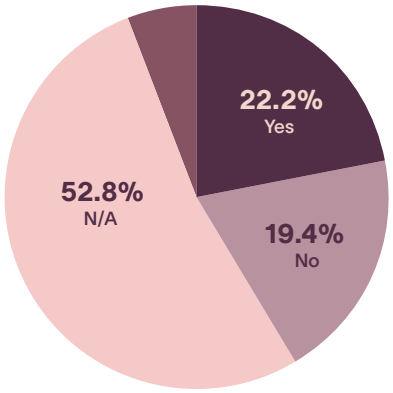


FIGURE 14
If you were pregnant or parenting, did you feel comfortable disclosing that to the staff at the SCS/OPS?

22.2%	Yes
19.4%	No
52.8%	N/A
5.6%	Prefer not to answer

In response to the question about what makes a space feel comfortable or uncomfortable for people who are pregnant/parenting, participants said they had a fear of surveillance and being reported.

"Fear of surveillance and reporting, fear of violence, not welcome as a mom..."

and this fear deterred them from accessing OPS/SCS

"Due to having a child I would never use an SCS."
— SURVEY PARTICIPANT

In response to the question, "How can SCS/OPS be more gender-safe/ relevant for you?", one participant said:

"Side spaces for women, mothers, people who feel uncomfortable and need that service, a place where your kids can play while you're using and can watch them on a screen or something" **— SURVEY PARTICIPANT**

THEME 05

STAFF RESPONSES TO CONFLICT AND VIOLENCE

“Staff seemed to pick their battles: if there was a conflict that was likely to peter out on its own, they would let the people involved resolve it on their own, as sometimes staff intervention can exacerbate a situation. If a situation was clearly escalating, staff would intervene. What I noticed is that some community members would see that staff sometimes left a conflict to be resolved by the people involved, and would accuse staff of not doing anything, even though staff were trying to exercise their own judgment. The same people would likely be pissed if staff tried to intervene and tell them what to do. It’s a double-edged sword” – SURVEY PARTICIPANT

Similar to physical layout, the manner in which staff respond to conflict and violence has a significant impact on how women and gender expansive participants perceive the safety of a space. Participants were asked about witnessing and/or experiencing violence (in any form) at an SCS/OPS. Sixty-one percent (n=22) of participants reported witnessing violence at an SCS/OPS.

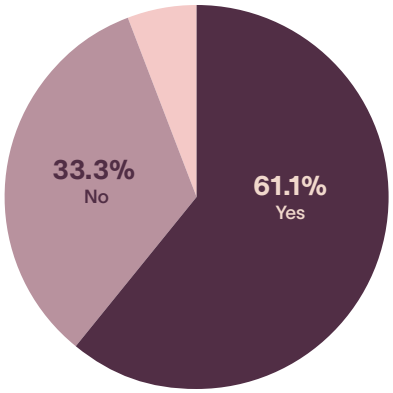


FIGURE 15
Have you witnessed violence at an SCS/OPS?

61.1%	Yes
33.3%	No
5.6%	Prefer not to answer

Participants primarily reported that staff managed conflict and violence fairly, immediately, and with compassion. A recurring comment from participants was that staff were both patient and responsive. A small subsection of participants, however, noted that consistency in responses varied on the basis of which staff were working that day, and that site policies were not always upheld.

Although many survey participants gave positive responses as to how conflict was handled and resolved, there were some write-in answers describing experiences that provide valuable insight on what to avoid in such situations, and why folks may avoid SCS/OPS.

"It was systemic violence by staff... I've seen staff escalate tense situations instead of de-escalating... [with] strict application of rules, instead of listening to needs" **– SURVEY PARTICIPANT**

"Mostly passive, not much staff involvement or awareness, lack of follow-up." **– SURVEY PARTICIPANT**

Participants were asked if they felt comfortable approaching staff if they were in a harmful or potentially harmful situation with a partner. Sixty-seven percent (n=24) of participants indicated that they would feel comfortable approaching staff with this concern.

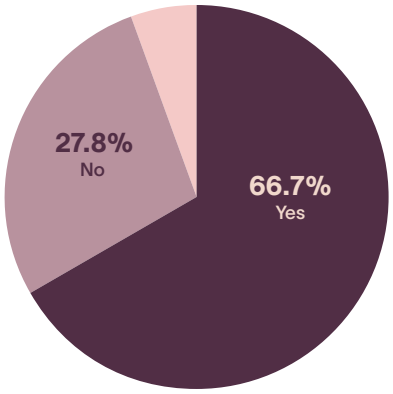


FIGURE 16
Do you feel comfortable approaching staff if you are in a harmful situation with a partner?

66.7%	Yes
27.8%	No
5.5%	Prefer not to answer

"[A]ccess to workers who deal with domestic violence or rape crisis or bad date reporting, they don't need [to] be there just having a phone there so if you and your partner go to different areas they won't know you're asking for help." **– SURVEY PARTICIPANT**

Sixteen participants responded when asked about negative or uncomfortable experiences during which staff intervened. Of those respondents, 11 offered examples highlighting their experiences.

"Yes, staff have made efforts to be discrete [sic], and to put some space between myself and whoever I am in conflict with. They usually offer suggestions, and offer solutions that can involve maintaining space, or offering to mediate, or leaving it up to myself and the other person/people to work it out." **– SURVEY PARTICIPANT**

"...[T]his man got angry with me and started threatening me. Staff stepped in to break it up and ask[ed] both of us if we were okay. I appreciated that they asked the other person if he was okay, too, because it's hard to know what may have happened to someone in the past. Everyone is different, and the reason he got upset could be different than the reason I got upset. He may have had experiences of violence that could have led to his reaction." – SURVEY PARTICIPANT

Participants were asked, "What do you think staff can do to better address conflict or violence in SCS/OPS?" Repeat responses endorsed increased staff training in:

1. **crisis intervention;**
2. **de-escalation;**
3. **trauma-informed mediation; and**
4. **restorative justice.**

Participants also expressed support for timely and strict adherence to "no tolerance" policies relating to:

1. **violence and harassment;**
2. **homophobia;**
3. **transphobia;**
4. **sexism; and**
5. **racism.**

Notably, many participants preferred that staff take a non-reactive and non-punitive approach in some cases of conflict, ensuring maximum service access for all, including those with behavioural challenges. Many participants noted the importance of avoiding long-term service bans as much as possible and addressing policy breaches using a person-centred approach:

"Staff should work to de-escalate a situation, instead of taking an immediate punitive approach which could escalate a situation and potentially lead to a service user being ejected or banned." – SURVEY PARTICIPANT

"There was also a policy of not banning people (unless absolutely necessary), but rather they would ask folks to take a break and come back and have a conversation, and usually people could resume accessing services. This site was the last stop if a person had been banned elsewhere." – SURVEY PARTICIPANT

One participant noted some of the socioeconomic sources of conflict and provided service recommendations:

"A huge thing I've noticed is that a lot of the conflicts are simply the result of theft that happens due to the poverty that clients experience. People steal each other's shit because they have nothing – not that that excuses theft, it just explains why it happens. One thing staff can do is to meet clients' needs as best as they can, and provide the relevant referrals. For example, someone is way less likely to steal someone's dope off the table if they are referred to a food bank, so that it reduces their food costs so that they are not nickel and diming so much for their dope that they would be desperate enough to resort to theft. However, I also understand that these are very deep, systemic factors that SIS [supervised injection site] staff don't always have the full capacity to solve on their own."

— SURVEY PARTICIPANT

THEME 06

HIRING AND REPRESENTATION

“I think women/feminine people are in general less represented in these types of spaces – it’s a weird feeling when it’s all a bunch of cishet men and I’m the only woman/gender diverse person in the room.”

— SURVEY PARTICIPANT

Participants who had used an SCS/OPS were asked if they felt that the staff were representative of women and gender expansive people, Black, Indigenous and People of Colour, and people who use drugs. Of 35 participants, 69% (n=24) believed there was adequate representation, while 20% (n=7) did not. An additional 11% (n=4) opted not to answer.

Note: Aggregating multiple identities in the survey question may have led to confusion for participants, which in turn did not provide a clear picture of the gaps in staff representation. The graph below should be considered with this limitation.

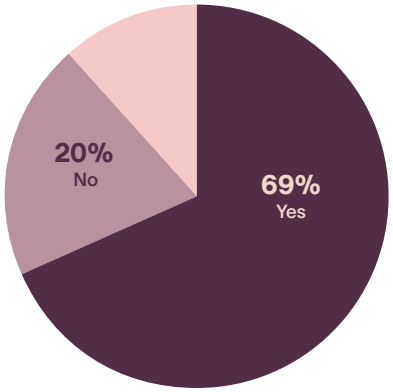


FIGURE 17
Would you say that the staff were representative of women and gender diverse people, BIPOC, and/or PWUD?

69%	Yes
20%	No
11%	Prefer not to answer

Participants noted that SCS/OPS should employ

"staff from different backgrounds"

and that there should be

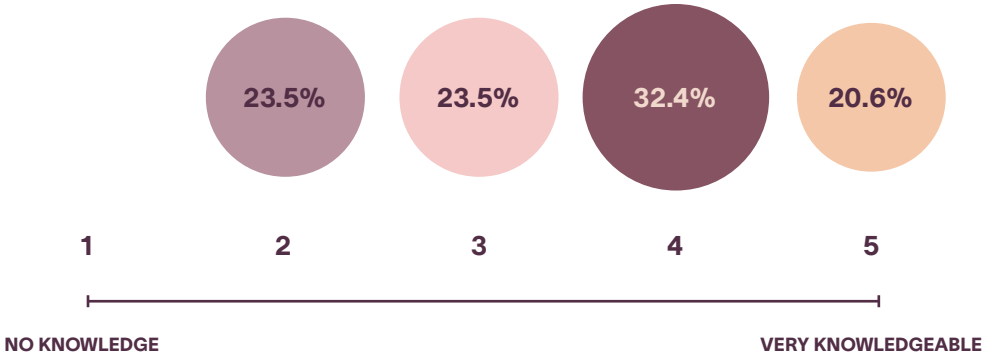
"diversity in staffing."

"We're lucky to have had a queer person who was great to work with at ops [sic]. More visuals though would be great with the focus on hiring queer staff."

— SURVEY PARTICIPANT

Participants were asked to rank their perceived level of staff knowledge related to gender inclusivity, substance use, and issues around race and racialized populations.

FIGURE 18
How would you rate the level of knowledge of staff related to gender inclusivity, issues around substance use, issues around race and racialized populations?



Fifty-three percent (n=18) of participants believed the level of staff's knowledge ranked at 4 or higher. Similar to the previous question, aggregating multiple areas of knowledge within this question probably led to generalized answers.

THEME 07

POLICIES AND PROCEDURES

Recognizing that the experiences of service users are deeply linked to the administrative policies and procedures of the services they access, we asked participants about specific policies and procedures that may influence experiences and perception of a site's accessibility.

Participants were posed a question about being asked for personal information. In particular, we asked if staff members explained to them why certain demographics were being collected. Approximately one-third of participants reported that they had not been informed why they were asked questions and/or were not told what would be done with that information.

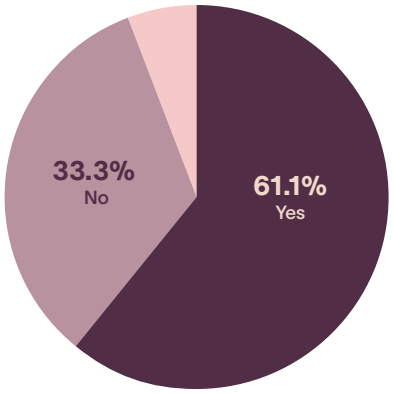


FIGURE 19
Was it explained to you why you were asked demographic questions and what would be done with that information?

61.1%	Yes
33.3%	No
5.6%	Prefer not to answer

Additionally, participants were asked if they felt that they could trust their personal information with SCS/OPS staff.

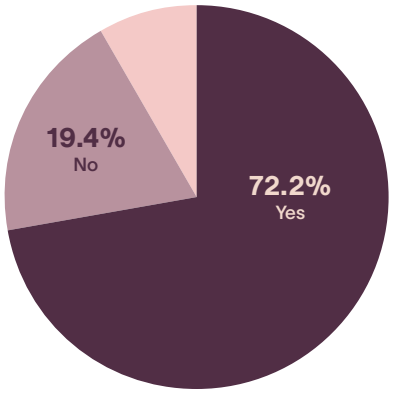


FIGURE 20
Did you feel like you could trust your personal information with SCS/OPS staff when asked?

72.2%	Yes
19.4%	No
8.3%	Prefer not to answer

When asked if participants were allowed to implement their own safety protocols (e.g., peer-assisted injection, splitting and sharing, and/or sitting with a partner or friend), about half (53%) of participants said this was allowed.

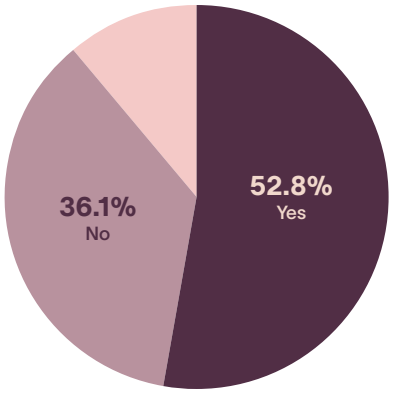


FIGURE 21
Were you allowed to implement your own safety protocols at the SCS/OPS? For example, peer-assisted injection, splitting and sharing, sitting with a partner/friend.

52.8%	Yes
36.1%	No
11.1%	Prefer not to answer

"Staff yelled at someone trying to share with their partner. They could only afford a little amount but both were sick. They accused them of selling drugs inside [and] made the man leave while they lectured the woman who pleaded with them that her partner had to make her shot and hit her. Both ended up using in-behind the place." **– SURVEY PARTICIPANT**

"Women are often harder to shoot up, so we need other people to help, but that is forbidden." **– SURVEY PARTICIPANT**

Participants noted a lack of options for splitting and sharing drugs and a lack of designated spaces for peer-assisted injection as major barriers for accessing SCS/OPS.

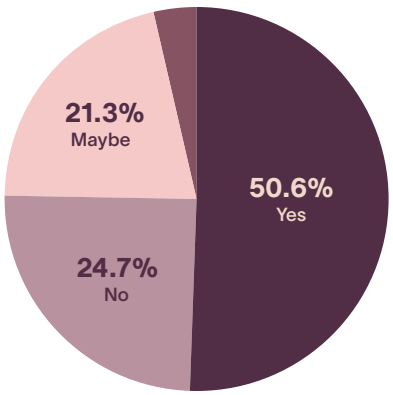


FIGURE 22
If you were allowed to split and share your drugs, would that encourage you to use at an SCS/OPS?

50.6%	Yes
24.7%	No
21.3%	Maybe
3.4%	Prefer not to answer

A recurrent theme throughout the data was the impact of not having adequate spaces for safer inhalation. One participant noted further barriers faced by people who smoke their drugs when asked what makes using an SCS/OPS comfortable or uncomfortable.

"If supervised inhalation were actually available in my city rather than just injection. I wish that you could use the drug testing on site without having to use the site [itself], which is the case in [my city]. Like there's both [barriers]: no safe consumption and also no drug testing for people who smoke." – SURVEY PARTICIPANT

DISCUSSION AND RECOMMENDATIONS

The following sections provide recommendations from the WGEP Lived Expertise Leadership Group, based on analysis of the survey responses and the committee members' living/lived experience.

General experiences at SCS/OPS

Dedicated harm reduction spaces and funding for women and gender expansive populations across Canada are almost non-existent. Women and gender expansive people who participated in the survey described their first impressions and general feelings of welcomeness and safety within current SCS/OPS. Perceptions of service accessibility are not solely influenced by what goes on within an SCS/OPS; they are also influenced by a person's experience before going inside. If a service is housed within a larger organization or institution, the history and reputation of this place will affect service users' perception of and relationship with the space. Everyone in the organization — from frontline staff to the Executive Director/Chief Executive Officer will play a role in creating the overarching culture. Cultivating a welcoming space can rectify past harms and prevent future harm.

The Lived Expertise Leadership Group proposes the following foundational considerations for organizations who operate SCS/OPS or are planning to:

- Prioritize funding for the development and implementation of supervised consumption services for women and gender expansive populations.

- Understand and emphasize the importance of communication and reciprocity at all levels of services and supports where there is engagement with service users. All of these relationships affect women and gender expansive people who use drugs and determine whether they will or will not use a service.

- Foster an understanding of the specific concerns and risks for people who are women and gender expansive (e.g., coercion, violence, harassment) in your community. This work will be advanced by engaging with the community directly and responsively.

- Provide trauma-informed training and capacity building for everybody in the organization on harm reduction, gender, and anti-oppression to cultivate an overarching culture of safety and support.

- Create positive experiences for people who may wish to use a service by being mindful of the outside environment (e.g., who is outside of the space, who or what they see when walking into the space) and the initial interactions they have, as these factors set the tone for a person's relationship with the service.

- Engage equitably and in a person-centred way with everybody who enters the site. This can entail orienting folks to the space and being actively welcoming while respecting their level of engagement.

- Keep services as low-barrier as possible. The medicalization of services is a manifestation of white supremacist patriarchy, which renders services inaccessible to folks who are the most marginalized and these dynamics cause continuous harm. Ensuring that the site's practices and atmosphere are shaped by the people using them allows for organizations to push back against the formalization and sanitization of these spaces.

- Create a mechanism for ongoing input and feedback, like a monthly meeting for regular service users. Provide an honorarium for their time.

"I started doing advocacy work in women's spaces 11 years ago. While the focus was on the experiences of cisgender women, trans communities were intertwined into women's work. This conflation made it difficult to find ways to generate conversations that were intentional attempts to address the equity and inclusion of gender diverse communities. This made it hard to feel safe enough to transition my name and pronouns in both my professional and personal life. As a mechanism of safety, I relied on the comfort and protection of using she/they pronouns. It was only recently that I transitioned my social and professional identity, and began to openly identify as non-binary and use they/them pronouns. While I navigate spaces, I find myself having to evaluate how I will choose to identify and what that means to my safety.

I recognize not everywhere can be safe, or even safer, because spaces are not by default built that way, so I have had to determine what feels right and feels the safest. As someone who does drugs, gave birth and fought for my right to parent I still use and feel a deep connection to the terms mother/mom/mama; and while these terms are often seen as belonging to a gender, I use them because they define the role I play in my child's upbringing and life. I fought to protect that role from the unwelcomed involvement of Child Welfare Agencies and so beyond it being a means to define the role I play in her life; it is a role I won the right to bear, a role many other mothers who use substances are often robbed of. That said, I've also been challenged as to why or how I can justify the use of the term mom/mother. It's confusing, uncomfortable and scary having these discussions with others. It burdens me with the task of educating others at the expense of my privacy and my safety. It also shifts the responsibility of creating safety to the targets experiencing harm. I fear scenarios where I need to correct someone about my name or pronouns because of the reality of becoming their target. I fear being seen as difficult, demanding, impatient and intolerable while suffering the repeated violence of accepting intolerance, unless someone else points it out and makes it a thing. Transphobia doesn't have to look violent or chaotic to be extremely harmful, and respecting pronouns and chosen names is just the first step needed to create equitable, inclusive and safer spaces.

Even in doing this project work, there were moments where things got challenging and harmful and because due to fear, I brushed things away. I was afraid and uncomfortable even in a space where we were addressing the barriers created by the intersections of gender. And here I was experiencing instances of individual and structural gender-based violence. What was different however was having others come forward to uphold the safety in the space and offer support in addressing the issue. Together we came up with a process. That process was important in re-establishing safety for not just me as an individual but the safety of our group. Together we agreed to address issues by being accountable to one another. Without processes and policies, and people to uphold them, spaces can quickly become inaccessible, inequitable, and unsafe. I am always grateful when others step in during those instances whether it is me they are correcting or me they are stepping up for. However, I also recognize it's often left up to the targets of violence and oppression to address harms and create safety. We need our allies to take that on more often if we are going to build systemic change and build accessibility, equity, and inclusion."

— NAT KAMINSKI (THEY/THEM), WGEP CO-LEAD

Physical space and surrounding environment

SCS and OPS indoor, outdoor, and surrounding spaces must be welcoming, comfortable, and have a community feel where drugs can be enjoyed, as well as where people can stay well and where people of all gender identities feel safe. Efforts should be made to **create clean and comfortable spaces that reflect drug use culture.** An SCS/OPS does not need to look like a doctor's office or hospital room to be clean and functional.

> "Staff should also take turns being outside because walking through cis men and cis women especially alone can be frightening, but seeing staff smoking outside or cleaning the area up or being on the phone so when I get fucked with they can put an end to anything being said to me... that would make me feel safer and more confident to go inside because so far I've chosen to instead keep walking and go use in the parkette." – SURVEY PARTICIPANT

The Lived Expertise Leadership Group provided the following considerations when designing the physical space of an SCS/OPS:

- Accessible entrances and exits
- Well thought-out, functional flow of space
- Movable furniture
- Comfortable seating and adequate lighting (lamps at each station)
- Cleanliness (inside and outside of the site)
- Art and greenery
- Spaces for arts-based activities
- Spaces for animals, carts, wagons, bikes, etc.

- Spaces for people who experience psychosis and spaces for private conversations with staff
- Gender-inclusive or degendered washrooms
- Culturally safe symbolism (e.g., flags, medicines, carpets, etc.) and artwork to make the physical space feel more inviting to Indigenous participants
- Maintenance of the surrounding outdoor space (cleaning up discarded needles and garbage as necessary)
- Outreach to the community (particularly to reach smokers and/or folks who may not feel comfortable coming inside)
- Location (accessible to transit, private outdoor space, consideration of surrounding businesses and services to ensure safety, multiple points of entrance and exit)
- Careful consideration of partnerships and co-location of supportive services (consider the historical treatment of people who use drugs with various systems and services that surveil and punish, ensuring partners and supportive services within a site have been client directed/requested and not mandated)

We need to create warm and welcoming spaces for Indigenous peoples by incorporating Indigenous art and symbolism so that we, as Indigenous people, feel not only included but also welcomed with authenticity. There is something so healing and therapeutic in the sound of drumming and hearing the music of our people, which is missing in many spaces that claim to be inclusive. As Indigenous Peoples, we find comfort in medicines and nature, so being able to smell the smudging and see the plants in the space provides a subconscious comfort — an intergenerational comfort. Offering those medicines helps people reconnect with themselves, and may help them find cultural practices they never knew they needed. Having Tobacco so folks can pray to Creator, and other medicines for cleansing and protecting, helps Indigenous clients heal ancestral wounds and feel a greater sense of well-being and connectedness. Indigenous people who use drugs are often shunned from medicines in traditional cultural settings, so having a place that accepts their drug use, while giving them medicines to help with mental health and spirituality helps build a positive, mutually trusting relationship — something that is missing at many sites. **— ASHLEY SMOKE (THEY/THEM), WGDP LIVED EXPERTISE LEADERSHIP GROUP**

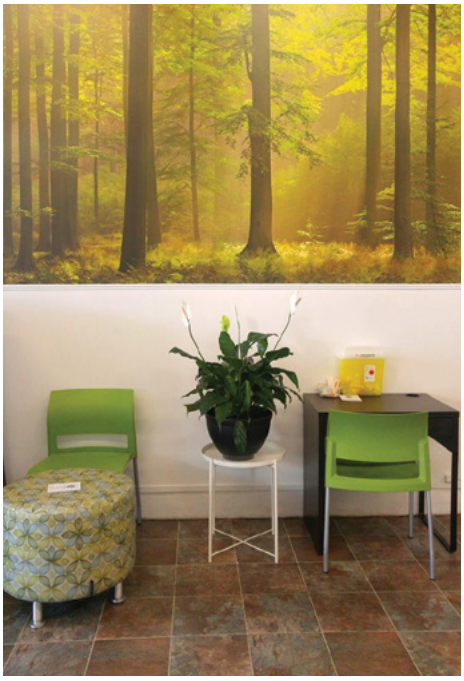
Gender Specific Overdose Prevention Sites - SisterSpace (Vancouver, B.C.) and Safer Use Space (SUS) (Hamilton, ON.)

SisterSpace (Vancouver, B.C.)

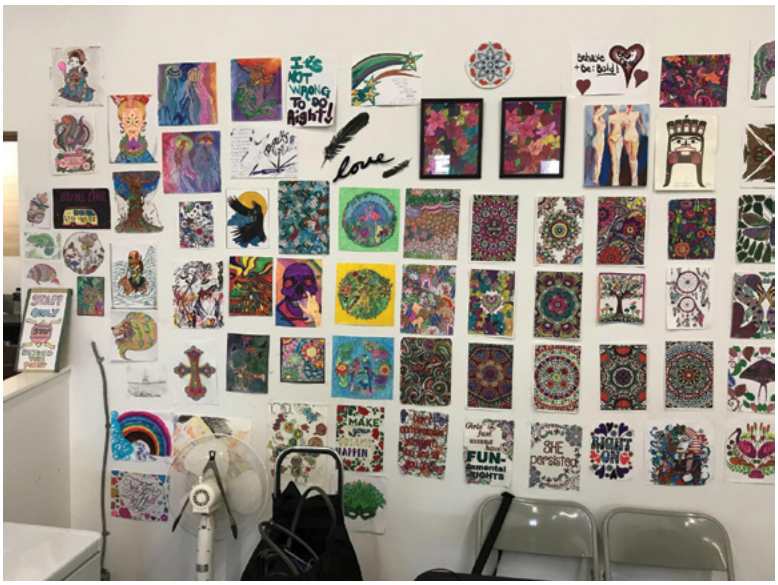
SisterSpace, operated by Atira Women's Resource Society, is the world's first woman-only Overdose Prevention Site, located in Vancouver's Downtown Eastside. Below is a photo of SisterSpace before renovations:

SisterSace before renovations. Photo courtesy of Jade Boyd, PhD.

SisterSpace is lauded as a community-oriented and accessible site, due in part to its physical space. Below is a collection of photos of SisterSpace following renovations.



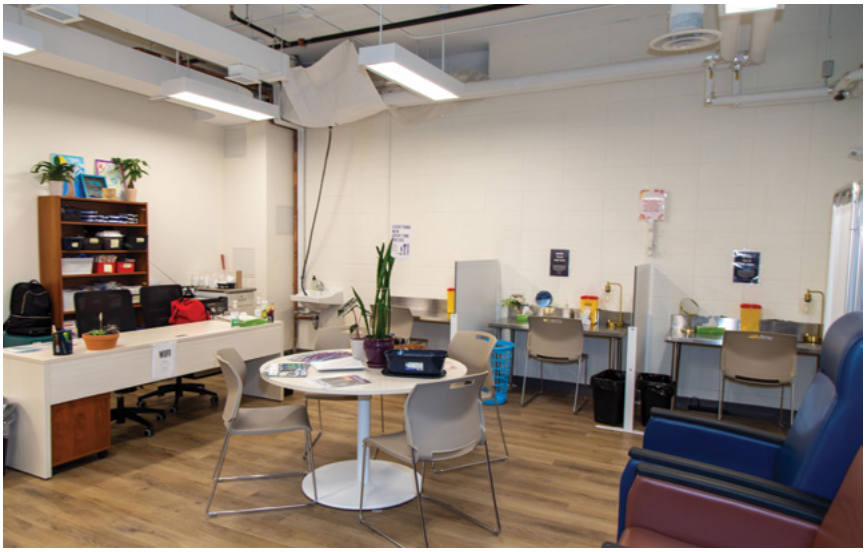
"Surviving isn't enough – I want flowers. Moving from surviving to thriving." – **WGEP LIVED EXPERTISE LEADERSHIP GROUP MEMBER**



Safer Use Space (SUS) (Hamilton, ON.)

The Safer Use Space (SUS) at YWCA Hamilton is a gender-specific safer consumption space. It is co-located in a low barrier overnight drop-in space and within a transitional living program for women, trans, and non-binary people experiencing homelessness. Guests can bring their own illicit drugs into the space, get access to clean harm reduction equipment, consume substances (inject, ingest or snort) and be monitored by both a YWCA Hamilton staff and a worker from Keeping Six. SUS is more than just a safe consumption site, it has become a place of connection, social support and art making!

SUS is operated in partnership with Keeping Six, a community-based organization led by people who use drugs, and HAMSMaRT, the Hamilton Social Medicine Response Team.




BEFORE
YOU DO
YOUR SHOT!

Gender-inclusive and affirming practices

Gender inclusivity and intersectionality should be core SCS/OPS values, and part of all policies and procedures. Awareness and acknowledgement of the erasure, misogyny, transphobia, and homophobia that women and gender expansive people face when accessing harm reduction services is needed. It is also imperative that service providers acknowledge how other forms of oppression, such as racism and poverty, intersect with these issues to create barriers to access.

The WGEP Working Group provides the following recommendations:

- Have gender-affirming signage (e.g., degendered washrooms, art from queer/trans community members).
- Have staff discreetly ask about and respect pronouns and gender identities.
- Provide spaces for pronouns and gender identities on all forms and documentation. Minimize documentation for all service users.
- Build partnerships with health care providers who can support the needs of pregnant individuals in accessing midwives and other pre- and postnatal care.
- Ensure gender expansive populations have support in gaining access to trans-affirming care.
- Provide equipment for different types of injections (e.g., hormone replacement therapy).
- Build the capacity of service providers to act as a connection point for system navigation to increase access to essential resources and supports such as: medical benefits and gender affirming programs, including clothing closets and counselling supports for gender expansive populations.
- Provide spaces that are accessible and private for individuals who need to undress for injections.
- Supply educational support materials for risk reduction and access to supports for sex workers.
- Maintain service hours that reflect when people who do sex work are not working and can use the service — i.e., be open early in the morning and late at night.
- Establish clear policies and procedures that outline steps and good practices around staff's responsibility to intervene in cases of gender-based harassment (e.g., transphobia,

homophobia), as well as racial discrimination within the site. This includes establishing the role of other staff when their co-workers are responding to incidents (e.g., crowd control).

SCS/OPS should be spaces that nurture feelings of safety. The policies above are crucial indicators for someone new to a space on whether they are welcome and will feel safe. Staff in these spaces should offer kindness, compassion, and provide support and access to care for individuals transitioning, and broader acceptance of people's appearances and pronouns. Interactions that are transphobic and violent, perpetrated by staff or other community members, are particularly harmful and uncomfortable when they occur in these spaces, and should be immediately addressed.

Instances of the following should never be excused or permitted:

- misgendering (intentional or unintentional use of incorrect pronouns)
- deadnaming (using the incorrect name and/or the name a person used before social transition)
- commenting on or questioning a person's appearance on the basis of social norms and notions of what is deemed feminine or masculine

Instead, practices should be established early on to address how these interactions will be dealt with.

An appropriate response could look like this:

- Stop the interaction
- Address the misuse of a person's name and/or pronouns by providing the correct name and/or pronouns
- Repeat the sentence/interaction to reflect the correct name/pronouns
- Do not allow the person who caused harm to give excuses or justifications for why the mistake occurred and/or to ask for forgiveness in a way that forces the person being targeted to accept the explanation being given
- Simply correct and move on; a "sorry" and correction will suffice

Modeling these practices shows trans and gender expansive people that their identities are respected when seeking services and support. Also, how these instances are addressed is often an indicator of whether an organization upholds trans rights in other regards, as it relates to bodily autonomy, trans health, and trans people's access to other resources such as shelter and housing.

It's important to recognize that queer and gender diverse people, particularly trans women of colour, have long been leaders in harm reduction. Notable activists such as Marsha P. Johnson and Sylvia Rivera come to mind. Learning the history of both drug use and sexual health harm reduction during the HIV/AIDS epidemic is crucial for understanding and serving QTBIPOC (queer and trans Black and Indigenous people of colour) community members. If you access, work in, or in any way benefit from harm reduction services, you have queer people of colour to thank for that.

Services should be accessible to not only queer, trans, and gender diverse people, but these populations should be meaningfully represented in the development of programming and delivery of services. This requires having queer people in positions of leadership and paying queer people who use drugs for their time and expertise. It's also imperative to understand and commit to always learning more about how factors such as race, income, and disability status intersect with gender for people in our communities who are accessing services. Prioritizing space for queer people of colour in leadership roles is essential for upholding an environment that meets the minimum standard of safety. The goal is to create a welcoming space for people who may have experienced trauma, have done or do sex work, and/or are at risk of experiencing gender-based violence.

Hours of operation should be flexible to accommodate the needs and schedules of sex workers. Staff should be able to connect sex workers to broader services as needed, as it is not uncommon for women, queer and trans people who use drugs to do sex work. Supporting the safety of sex workers requires considerations for incidences of gender-based violence, for example, providing "bad date reporting."**— HEATH D'ALESSIO (THEY/THEM), WGEP LIVED EXPERTISE LEADERSHIP GROUP MEMBER**

When responding to an overdose, you need to be mindful to ensure a person's safety and dignity. Not only are you responding to the overdose, but attention must be paid to the words being used. Hearing is often the last sense to go and the first to return when a person passes in and out of consciousness, so using respectful language when a person is so vulnerable is an intrinsic part of care. There is the potential for oppressive dynamics such as transphobia to arise in these moments, particularly when there isn't much time to reflect and one must think and act quickly. This is why it's crucial to have a really solid grounding in understanding gender identities, and anti-oppressive principles and practices, ahead of time. This will allow you to be prepared to deal with complex issues while navigating the realities of people's daily lives.

— EM CARL (THEY/THEM), WGEP CO- LEAD

Pregnancy, parenting, and caregiving

Many parents use drugs to maintain their wellness, for pleasure, and as a support while they care for their children and maintain the family unit. Studies show that punitive approaches operating from the perspective that substance use alone is grounds for child custody removal deter help-seeking and access to life-saving harm reduction services (Malinowska-Sempruch, 2015; Pinkham, Stoicescu, & Myers, 2012; Poole & Urquhart, 2010). Therefore, it is essential to provide an environment wherein parents and caregivers feel safe in approaching and using the service. This can be supported in the following ways:

- Develop anonymized and collaborative safety and wellness plans for parents. This supports agency and self-determination when it comes to decision-making. A key element of this is relationship- and trust-building between staff and service users. It can include these steps:
    - Navigate service users through the site
    - Clearly explain the overdose response protocols to ensure there is an understanding about the limitation of anonymity once transferred to EMS care (this is especially important for parents who may be in danger of being reported to child protective agencies once transferred during a medical crises due to institutional understandings of "duty to report")
    - Outline various scenarios and steps to be taken in the event of emergencies:

    - Identify a contact person
    - Determine where the child(ren) will go
    - Determine who will be minding the child(ren) after services close, if a parent is unrousable or needs to be hospitalized

- Establish referral pathways to safe non-stigmatizing pre- and postnatal health care providers such as fertility clinics, abortion clinics, high-risk pregnancy clinics, midwives, OBGYNs and family doctors.

- Provide support for and/or referrals to safe and welcoming child-minding spaces, services and or supports (at least in physically adjacent services; or access to benefits such as subsidized child care, free children's programming and/or connecting parents to each other to create networks of support; building community capacity to implement community care models and foster autonomy to create safety plans around their substance use as parents).

    - Provide access to technology (e.g., via tablets or laptops) for parents to remotely monitor their children while using.
    - Provide access to technology to support parents in connecting to their children in care and/or to child welfare workers.
    - Provide support for people whose children are currently in care (for example, who are in foster care, with kin, or as wards of the state) or who have lost parental rights (adoption), ensuring that their needs as individuals and as parents are being met and considered.

It is important to acknowledge the intersectional experiences of parents who use substances, child welfare/protection/surveillance systems, and the generational trauma racialized communities face. Far too often, parents are threatened with statements such as "I'll call CAS," or, "Your children will be taken away." This results in less disclosures of use by parents due to the fear of losing their child(ren). The constant threat is all too familiar within Black and Indigenous communities, where it has been found that their children are disproportionately apprehended and separated from their families. The child protection system is meant for the safeguarding of children from violence, exploitation, abuse, and neglect. The same system has dismantled generations of families and exposed children to abuse and neglect by their adoptive or foster families, under the guise of prioritizing the needs and safety

of all children. Research suggests that professionals in the community — such as school and medical staff — over-report racialized families to child welfare authorities and that this may be linked to bias. These disparities/disproportionalities need to be acknowledged along with the potential impacts on the trust and confidence within these communities (Ontario Human Rights Commission, 2018).

The Motherisk scandal highlights the problems with the monitoring and surveillance of parents who use drugs. Motherisk was a testing program at the hospital for sick children in Toronto, in which parents who used drugs had to participate to maintain access to their children. Tests in this program were proven to be flawed only after children had been apprehended for decades. Little has been done to restore and rebuild trust. Given this history, parents who use substances are less likely to access SCS and even less likely to bring their children to the site — their safety being the foremost concern, as well as avoiding potential calls to child welfare agencies. Ultimately, these parents are at an increased risk of overdosing because they will use alone and isolate themselves to keep their use private and their families safe. Overdose prevention methods — such as virtual spotting with a trusted friend or family member — are the safest option. This presents compounding challenges, because women and gender diverse people are a demographic of substance users who face increased threats of violence, especially when their children are present. In addition, if someone witnesses their use when their child is present, they can use this information against the parent in future conflicts.

The impacts of the harms of the child protection system have lasted generations. In identifying areas where substance users have been criminalized, we must also acknowledge the surveillance of parents/caregivers in the maternity ward, their homes, their children's schools, daycares, and other spaces where they are observed or monitored. The psychological trauma these interactions cause also need to be acknowledged. The history of Black and Indigenous children being taken from their parents during slavery and in the residential school era, and how the apprehension of racialized children has continued through the same systems people are told to report to and rely on, need to be acknowledged. We may be far from being able to ensure safety for parents to use drugs within an SCS/OPS, but by learning about and sharing the histories of families and the child protection/surveillance/welfare system, we can raise awareness of these issues and demand that these systems change.

— CASSANDRA SMITH (SHE/HER),
WGEP LIVED EXPERTISE LEADERSHIP GROUP

Indigenous Peoples have a history of trauma and medical violence when it comes to pregnancy and parenting – even birth control – as well as the systems that control these things, like healthcare and child welfare. Therefore, when an Indigenous person who is pregnant or has children comes into a space, the first thought should not be which of those controlling systems are, or should be, involved. Indigenous parents or soon-to-be parents need to know they have a safe space where they will not be judged, because we are judged everyday as parents. That is amplified 10 fold when you are a parent who uses drugs. We need specialized care models that include childcare and freedom from violence, criminalization, and having our children apprehended just for being who we are and coping how we have been conditioned to.

— ASHLEY SMOKE (THEY/THEM),
WGEP LIVED EXPERTISE LEADERSHIP GROUP

Trauma-informed conflict and violence intervention and prevention

Conflict is a normal and expected part of human interaction. For people who use drugs, tensions can be exacerbated by the stresses of criminalization, stigma, and scrutiny. People who are deprived of housing are more vulnerable to violence and victimization. Likewise, women and gender expansive populations face oppressive dynamics such as sexism, transphobia, and transmisogyny, as well as racism; which can compound experiences of conflict. All of these factors intersect and can contribute to a turbulent existence, and some of these dynamics will play out within the walls of SCS/OPS.

In our study, a significant number of participants reported past experiences of discrimination in the form of erasure, transphobia, and misogyny at SCS/OPS. They indicated that successful conflict resolution occurred when the issue was addressed immediately, everyone involved was consulted, and there was communication prior to deciding on potential outcomes. Participants recommended that staff must be prepared and supported to respond so that safety and access are prioritized. SCS/OPS are life-saving services and restricted access can potentially be fatal to community members. Thus, approaching conflict and violence prevention with compassion, empathy, and intuition is key. Some ways of doing this include the following:

- Hire people who have experience with and are dedicated to using transformative and restorative conflict resolution practices.

- Create trauma-informed protocols for risk assessment and conflict resolution.

- Ensure that there are enough staff members to operate the space and be clear on their roles (e.g., primary responder, backup, crowd control, and continued functioning of services).

- Engage an advisory board made up of members from the community. They will be able to make a valuable contribution to risk assessment by bringing an understanding of what is normal within that community's culture, and they will have a clearer idea of the community's needs.

- Provide staff with training opportunities on topics related to trauma-informed care, conflict resolution, and gender-affirming practices.

- Schedule time for staff to check in at the beginning and at the end of every shift to pass on vital information about any ongoing or new conflicts that arose, and the decisions made on handling or resolving those conflicts.

- Develop strong relationships with community members so that their help can be sought in deciding whether to get involved when resolving a conflict.

- Support and equip staff to be thoughtful and intentional if they choose to intervene in a conflict because they could disrupt or change the culture of the space. Policies and practices should reflect community values to foster a sense of connection and ownership in the space for the people who use the services.

- Develop clear procedures for each type of conflict (e.g., verbal harassment, friends fighting, gang fighting, debt collecting) and ways to triage incidents that can have varying degrees of harm. Policies for dealing with different levels of conflict should be communicated to all clients accessing the space, thus ensuring that outcomes will be fair and equal for all.

- Use the least punitive and most supportive approach possible when dealing with individuals who are engaged in conflict and/or violence in the space (e.g., consider the use of warnings or a break over bans or prolonged suspensions when possible).

- Considering that many clients of SCS/OPS have experiences of incarceration and/or being oppressively controlled, staff should support and encourage informal resolution between the parties within the space, rather than starting a formal process and bringing in authority figures (e.g., managers, site supervisors, security, police), which could heighten tensions.

- Make sure that all parties in the conflict have a chance to be heard before the resolution is decided.

- Invite clients to take accountability after an instance of conflict, so they can reach a resolution and remain connected to the space, rather than treating them punitively.

- Develop safety plans with clients of SCS/OPS, especially ones that take into consideration the dynamics of couples. Each partner needs to be respected individually, especially in cases of overdose, while recognizing the support a partner can give as aftercare. Offering support to each partner can be a means of checking in with each of them in case some level of safety planning is needed, both within and outside of the site.

- Offer ways of temporarily securing people's property in the case of overdose, to avoid theft or loss of personal items.

Many members of the Lived Expertise Leadership Group have frontline experience. Therefore, we recognize when a staff member's attitudes and actions show a need for training on how to properly address conflict versus when they indicate that they need continued support to avoid burnout. We acknowledge that what could be perceived as negative attitudes or less-than-compassionate practices on the part of staff are often the result of burnout and/or a lack of support. It is the responsibility of the organization to provide training and to provide the necessary resources to ensure that staff are well equipped to provide care.

Practices that may be perceived as harmful or punitive by community members are often dictated by organizational policies. When staff are determining a course of action to address conflict, there are the choices that reflect the values and practices of the community, and there are the choices that are in line with the formalized practices of the organization. Calling the police, banning people, or involving authority are examples of these formalized practices, each of which should be a last resort after all other options have been exhausted. The quickness with which staff members take these routes reflects their organization's regard for people who use drugs and shows whether service users are viewed as people to be collaborated with or controlled. If solutions to conflict are too heavy-handed, community members will notice and feel harmed or alienated, and it will affect whether they engage with services.

Furthermore, people who use drugs are very often surveilled, overpoliced and feared. Stereotypes such as the "meth monster," "immoral junkie," and "manipulative drug addict" are prevalent. When staff step into a conflict situation, they may have these fears in mind. These internalized judgments and biases do not reflect the best interests of the community, and they contribute to staff's fears that a situation will spin out into a violent, "drug-fueled" fight. In reality, people who are

in conflict have the ability to address their own issues, often without interference. The best course of action may be for staff to ask, "Can you work this out among yourselves to prevent it from affecting the rest of the folks here, and us from having to get involved?"

Strong relationships with community members can inform staff decision-making in conflict and will give context to a situation that may not be immediately apparent to outsiders. Staff should get involved in a conflict when it is discernible that harm is occurring, when they have been asked, or when the conflict begins to interfere with others in the room.

Moss Park - A Vignette

The unsanctioned overdose prevention site that was started in Moss Park in Toronto in August 2017 was a grassroots pop-up. It served as a response to a need that is present everywhere but was especially dire in this location, while the city dragged their heels in opening a city-run site. When the original group of organizers first showed up on August 12th and put up tents, folks who were already in the park encouraged their efforts. The welcome that the OPS received was due in part to pre-existing relationships with those involved, and the shared belief that people should not be left to die. The organizers knew that they were guests in the park, and that they could not intrude or interfere, but that their role was one of support. At any time, the people of Moss Park could have asked the organizers to leave, but they didn't. There was also a lot of overlap between roles, in terms of people who used and operated the site, which is what led to its success. The majority of people who organized, operated and volunteered at the site were women and gender expansive people. Our approach was by the people, for the people, and our priority was meeting the needs of the community. Creating a site also allowed for us to be responsive to the needs of the people using it outside of the jurisdictions imposed on legally sanctioned sites. There was space for community practices like assisted injection, splitting and sharing, and there was a tent for inhalation. We understood the importance of meeting these needs from a gendered lens, too.

When we moved indoors a year later with government funding, we took up residence in a nondescript brick building around the corner from the park. We were a standalone site in contrast with most other sites, which are co-located in community health centres. In this new space, we were mindful of the importance of keeping the service as low-barrier as possible, especially given our origins as an unsanctioned outdoor

site. We wanted to maintain continuity in our services and approaches to keep people coming back, because it is a life-saving service. There was also an understanding that people who were banned from other services would often end up at Moss Park because we recognized their need for ongoing care. We would go to great lengths to resolve conflict and to avoid permanently banning anybody. The embedding of anti-punitive, anti-carceral ideals and restorative justice practices helped us to maintain accessibility.

The culture of a service is shaped as much by its management as it is by its front-line workers and the community accessing it. The folks who managed Moss Park's daily operations tried to foster a collaborative work environment that lent itself to the culture of the site as a whole. They made efforts to hire folks who had their fingers on the pulse of the community, with recognition given to the insight and skills that they brought to the table. Each of the coordinators, and later the managers, had the skills, capacity, and willingness to step into any role, which fostered my trust in them. This confidence facilitated honesty, which is necessary for equity. This is especially true when addressing the needs of community and front-line workers; otherwise, the service runs the risk of becoming dictatorial in nature. For example, we would hold daily pre-brief and debrief meetings, wherein we all spoke freely; these sessions were an opportunity for our input to be heard and potentially implemented. I was called on to offer my skills as an educator and facilitator, as were other staff members, to provide training to coworkers and management, with recognition given to the knowledge that our team held. All of this was fundamental in offering services with a foundation in competence, collaboration, and compassion.

These considerations also gave me the foundation to do what I needed to do on a daily basis. My usual role at Moss Park was as an overdose response worker — that means I was usually stationed on what we referred to as the "injection side." In this role, I was often hanging out with people and building relationships — checking in with them and dealing with conflict whenever it would arise. Having positive rapports and solid interpersonal relationships with people was very important, especially when I was trying to de-escalate complex situations. Our calls to police were minimal because we were doing a good job with handling conflict ourselves. Owing to our strong connections with community members, they were collaborative when we attempted to resolve issues, and we as providers of a life-saving service could avoid criminalizing vulnerable people.

If people didn't have a great relationship with me, they usually had a good relationship with the space. They felt invested in it; it was a community; it felt like a home to them. They were showing up in whatever mood and state they were in that day. For the folks who use(d) our services, they often deal(t) with control and condescension in their daily lives, which can lead to tension. It was helpful to remember not to personalize a person's behaviour and to understand that sometimes people just need an outlet. Operating with healthy emotional boundaries and empathy allows for greater discretion in determining when and how to address a person's behaviour. These approaches are examples of trauma-informed care, by responding with empathy and intuition to meet folks where they are at.

One thing I tried to uphold — and one of the principles we operated on in Moss Park — was fairness. When a conflict occurred, we would speak to everyone involved and decide if a break was needed. I would convey to them that "we want you to be here, I want you to be here," and let them know that they themselves were appreciated but what they were doing was not. We would hear people out, try to model healthy boundaries, and strive to be as consistent and reliable as possible. Once folks returned, we would check in to see where they were at, and if each person could take accountability then they could come back to the space. People picked up on and responded to kindness and trust, and this positive regard shaped outcomes and relationships. Demonstrating consistent care was a way that we would put our principles of fairness into practice. Many people expressed that they felt a sense of family at Moss Park, and that they felt a sense of ownership in the space.

For folks to be forthcoming about their needs, community members needed to feel safe in being vulnerable enough to share them. This is especially important for folks who face intersecting oppressions such as transphobia, misogyny, and racism. If people are met with care and consistency, the hope is that they will feel a sense of safety and belonging. This sense of connection can help to move folks out of survival care and into holistic care, and fosters a sense of reciprocity. People deserve to be given what they need, instead of what a service deigns to provide, with consideration given to what they go through on a day-to-day basis. A service is only as strong as its connection to community, and this idea was foundational to Moss Park. Although I no longer work at the site, I still carry with me the values and principles that I learned there.

— EM CARL (THEY/THEM), WGEP CO-LEAD

Hiring and representation

Harm reduction programs provide services to drug users, so it makes sense that operators would benefit from hiring people from the populations they seek to serve. It is a documented best practice that people who use drugs need to be included in all stages of program delivery: organizations must create hiring practices and employment policies and procedures that not only support the inclusion of people who use drugs in programming and service delivery, but also ensure people who use drugs are represented at all levels of leadership. Tokenism often supports pigeonholing people who use drugs in "peer" roles with few intersectionalities represented in the "peer" group. Representation is important. Communities of people who use drugs are diverse, and the people that services employ should reflect this. People who use drugs want to see themselves mirrored in the service leadership and staffing. It delivers the message that the service is a space where they are welcome and where they can trust they will be treated with dignity and respect. This message is conveyed by the presence of their peers working in the space: clients assume the organization has done the work needed to make the space safe both for their peers working there and for those utilizing the service. Here are some specific suggestions:

- Provide comprehensive training during the onboarding of any and all staff to ensure employees understand how to work with members of the community they are now colleagues with and may end up supporting within the service.
- Provide ongoing support and professional development/ training, based on individual need.
- Offer adequate compensation and benefits equal to other types of employees.
- Provide flexibility and accommodation if needed and whenever possible.
- Hire people with ongoing drug use experience and not only "good drug users" or people who used in the past.
- Ensure that people who use drugs are not harmed as a result of the role as a "peer worker."
- Discuss which aspects of the work they might or do find challenging. Do not restrict their access to the service itself or to other services at your agency, including the SCS/OPS.

As someone who embodies multiple intersecting identities — being Black, a person with a past of drug use, a mother, a woman and more — re-entering the workforce has been an eye-opening experience. Particularly when collaborating with organizations where decision-making tables are often devoid of individuals who reflect my own experience and appearance. It is critically important for organizations, especially those engaged in research that impacts communities like mine, to empower those with lived and living experience to lead and contribute in a substantial way.

Reflecting on my personal journey, I've participated in numerous research interviews and surveys, sharing sensitive information, and recounting traumatic events in the hope that my insights would foster change and yield benefits for my community. Unfortunately, I have frequently been left in the dark, with no indication that the narratives I've shared have been used constructively or have had any positive return for the people and the places I represent. All too often, I am met with silence — a silence that speaks volumes about the disconnect between the data collected and the action taken by said organizations.

Individuals from marginalized communities often grapple with more severe societal challenges, including disproportionate criminalization, unstable housing, poverty, mental health issues and much more. These difficulties are not sporadic misfortunes; they stem from deep-rooted systemic biases that have historically favored the majority while sidelining "othered" groups, such as people of colour, 2SLGBTQ+ folks, women, and those with disabilities.

Organizations that aim to mitigate these challenges must actively involve those with firsthand experience. By hiring individuals who have navigated these adversities, organizations gain crucial insights and the ability to pinpoint deficiencies in their services that might otherwise go unnoticed. This practice elevates the level of service, fosters trust with service users, and is essential for creating meaningful change. Adopting an anti-oppressive, anti-racist, and feminist framework reinforces the principle that those who live with these realities should be at the forefront of crafting solutions. "*Nothing about us, without us*" should be a guiding maxim, ensuring that change is not only proposed but led by those who understand the nuances of marginalization most intimately.

When integrating folks with lived and living experience into your organization, consider the following additional strategies to create a supportive and inclusive work environment:

1. Ensure robust support systems are in place, offering regular check-ins to understand and meet their professional needs, while also providing professional development opportunities that respect their background and foster career advancement.

2. Approach working relationships with empathy and adaptability, creating an environment where open communication and grievance redress mechanisms are standard, allowing for concerns and suggestions to be raised without fear.

3. Move beyond tokenistic inclusion by offering meaningful roles with comprehensive contracts that include fair compensation, benefits, leave for grief, ample paid time off, and equitable advancement opportunities.

4. For employees who use drugs, ensure there are appropriate supports available to maintain wellbeing during work hours, which may include protocols for safe drug use.

5. Proactively meet and adapt to accessibility needs, while also engaging in regular policy reviews to ensure ongoing relevance and responsiveness to employees' needs.

6. Discard outdated notions of workplace decorum that may be exclusionary, such as strict punctuality requirements, in favor of practices like flexible scheduling, and promote a culture that values diverse perspectives and shared decision-making.

7. Offer mental health support tailored to their experiences and compensate for the emotional labor that comes with sharing their personal stories for organizational growth or advocacy.

8. Cultivate an organizational culture that educates all staff about systemic barriers, equity, and justice, ensuring that the entire workforce is committed to a supportive and inclusive environment.

9. By integrating these practices, organizations can create a work atmosphere that not only values the unique contributions of individuals with lived experience but also actively supports their personal and professional growth.

— AKOSUA GYAN-MANTE (SHE/HER),
WGEP LIVED EXPERTISE LEADERSHIP GROUP

"It is important that any organization hiring under-represented and often marginalized communities ensures they have the appropriate policies and practices in place to support staff from varying identities before employing them. Just having a training or certificate in gender equity or cultural competency or Anti-Racism Anti-Oppression (ARAO) isn't enough. Make sure there are policies in place that have been created in collaboration with the communities impacted by them to create inclusive, safe, and equitable environments for staff and service users to thrive in – it's not just about there being representation." **– NAT KAMINSKI (THEY/THEM), WGEP CO-LEAD**

The Nameless – A Vignette

The Nameless (a peer-led harm reduction outreach service in St. Thomas, Ontario) comes from the understanding that people have worth by virtue of just being. We see the value in the way that we operate and we see the pride that each person holds when in the space, around the space, in public, and with their peers. Offering equal opportunities for everybody to be involved creates a ripple effect of self-worth, self-realization, the ability to give back, trust to be built, networks to be made, and voices to be heard.

When we look at people who use drugs as knowledgeable, talented, strong, capable people, we make our city better, as they are often denied opportunities to advance because of their past. We understand that many of these choices were made because there weren't many other options on the table, or that they stem from living in the cycle of poverty, and that being in a rural city offers little chance to get out. At The Nameless, we have kept people from incarceration and offered them a place where they feel comfortable, valued, trusted, and included.

- The time that we operate is a good time for many (6:30pm–9:30pm, 7 days a week).
- There are many roles to be filled.
- We have heard feedback that the freedom, trust, belonging, and vibe in our space make people want to come in and complete their hours.
- People can swear, use, and eat.
- People are surrounded by their peers when doing the work as a collective, and they are able to make changes and offer suggestions to the organization.
- We don't require background checks, which reduces the social, emotional, and financial barriers to employment.
- We require very little training because we know that people with lived/living experience are champions in their own life experiences and have a wealth of knowledge to offer.

Our payment model involves offering a cash honorarium at the end of the day. By offering above living wage in cash directly after the work, people do not have to wait to get paid and they do not have to claim payment anywhere, making it more accessible to those on assistance.

We have a conversation and safety plan with individuals who self-identify as needing accommodations. This could look like ensuring that folks know this is a safe place to consume substances, so they don't have to hide their substance use, putting them at risk of harm. It could look like a code word that would prompt a private conversation with the team on shift when someone arrives and is not able to complete the duties required. We would ask that individual what they see their role as that day and go with their lead, as long as the safety of others is not compromised. If an individual self-identifies as someone actively using substances, we will ask that the individual be well enough (not too intoxicated, and not unwell (in withdrawals)) to navigate the space. We do not expect people to overextend themselves or feel pressured to perform. If we observe that any teammate is struggling, we will have an honest conversation about it and actively seek recommendations and solutions that they create. By opening the door for honest conversations, we remain flexible and ready in case of emergency and we support workers to tailor their duties to their needs at the moment.

We do not ask for disclosure, but we do ask for radical honesty; this involves discussing behaviour and offering observational feedback so that people can grow and learn together. We communicate our expectations and hold each other accountable to them because in the end, we are a team of neighbours who see value in each other's lives. Many face barriers to belonging, to giving back, and to participating, and we have learned that we can lessen those barriers by tailoring the services to meet people where they are at and celebrate them.

Recommendations for employing people with living/lived experience:

- Hold space for hard conversations.
- Do not expect abstinence.
- Safety plan for onsite use, or coming in too intoxicated to perform the necessary duties.
- Hold space for reciprocal feedback.
- Ensure that the space is welcoming, non-judgmental, and flexible.
- Ask the individual what their strengths are and work with those strengths.
- Ensure that timelines are not rigid and celebrate attendance.
- Remain secular.
- Lead with implicit trust in all who come.
- Debrief after shifts and maintain open lines of communication 24 hours after.
- Provide access to supplies to meet basic needs to ensure wellness on shift, especially food and harm reduction supplies.
- Hold conversations when an individual departs from the organization to ensure the individual can still access services without stigma or judgment.
- Understand that people need time off when there is a loss or a struggle in the community.

— LETICIA MIZON (SHE/HER), FOUNDER OF THE NAMELESS, WGEP LIVED EXPERTISE LEADERSHIP GROUP

Data collection and service expansion

While acknowledging that funding and regulatory bodies often require reporting on service utilization and aggregate demographic information on participants, it is important to balance service accessibility with data collection in a way that does not impede service delivery by triggering fears of surveillance. It is also important to note that these system interactions can create harm and often have a deeper impact than just in the immediate moment. There becomes a real potential to create cultural/service norms where certain communities of people become unwelcomed because instances of harm are deemed individual or interpersonal. If policies and procedures do not take into account systemic oppressions and how to address them, these harms will be embedded into the framework of an organization, and people will not be kept safe.

Needs of women and gender expansive people are not being met in supervised consumption spaces. Sixty-nine percent (n=61) of survey participants reported inhaling their drugs and overdose deaths are now related primarily to this method of drug use. Despite the fact that a federal exemption can be sought to implement safer inhalation services, seeking adequate funding, navigating municipal WorkSafe and Smoke Free bylaws, provincial and territorial exemptions, and obtaining support with engineering for adequate ventilation still pose significant barriers to the implementation of supervised inhalation services, and as such very few exist nationally. The lack of accommodation for safer inhalation is both discriminatory and a safety risk as national drug poisoning data indicates an increase in fatalities linked to inhalation of poisoned drugs. Services and responses to the toxic drug death crisis need to incorporate data-driven strategies.

- Data collection should be done in such a way as to minimize intrusion and singling people out, and should not exacerbate systemic harms (eg., surveillance of parents, subpoena of service records).

- Sites need to be expanded/created to accommodate indoor and outdoor inhalation with considerations for women and gender expansive people as part of implementation and planning. There are only two sites for women in all of Canada, only one of these offers supervised inhalation.

When developing or updating policies and procedures, it is important to include a diverse range of voices, including all the people who may be affected (i.e., employees, volunteers, clients, partners, etc.). This should also include a strong Indigenous and African, Caribbean, Black presence, which should increase the level of trust with those populations; when done right. When tokenism is avoided — healing and reconciliation can begin. Having these folks involved in all steps of developing, writing, implementing, reviewing, and evaluating programs is key for transparency and equity, and can lessen the risk of oppressive power dynamics. PWUD should be hired as consultants when doing this work, so there is no oversight by a manager who may be able to negatively affect their job or service access. This practice addresses the "peer"-employer power imbalance that often silences the true feelings of PWUD who fear losing their position.

PWUD need to have agency over their views and should not be ignored or forced out because their views do not coincide with current organizational policies and procedures. Policies and procedures should be amended to align with the views of the people for which the service is funded to support, for without PWUD, these agencies would not exist.

— ASHLEY SMOKE (THEY/THEM),
WGEP LIVED EXPERTISE LEADERSHIP GROUP

LIMITATIONS

Throughout the process, we identified a number of limitations to the WGEP survey. A primarily online survey posed accessibility barriers to people without access to technology or people with less practice with digital literacy. Although we achieved representation from many different ethnicities and cultures, the vast majority of the participants were white, cisgender women. As this was an online survey distributed during COVID 19 to CAPUD members, the participants were representative of members with Internet access who were comfortable offering their input and experiences. The survey was then made available only to WGEP team members who then intentionally sought to hear from people whose voices and identities were not well-represented. In particular, we reached out to Indigenous; African, Caribbean, and Black people; and Two-Spirit, trans, and gender non-conforming

people. Despite conducting in-person outreach, we concluded that, in the future, we will need to create a more robust system to reach participants who do not have access to the Internet.

At the midway point of the data collection phase, the survey was hacked by an individual by way of a bot. Not only did this delay project progress, but also the responses from the bot were misogynistic and transphobic. It is not lost on the entire project team that a survey developed to explore barriers and inequities for vulnerable people that experience heightened violence was targeted by this intentional and hateful act.

As mentioned in the Findings section, some questions may have caused confusion due to lack of specificity. In our survey, we asked participants if they had ever overdosed, but what constitutes an overdose was not well-defined. We acknowledge that an overdose response — as defined in many SCS/OPS medical directives — can encompass a range of interventions, including verbally addressing someone or physical stimulation (as simple as resting a hand on someone's shoulder). A common misconception is that overdose response requires the administration of naloxone or oxygen; this is not always the case, as sometimes repeated stimulation is all that is necessary to carry someone through an overdose. There are also different presentations of overdoses, which can be referred to as atypical overdoses, such as "flailing," where a person involuntarily moves around or vocalizes and doesn't have control over these actions (Kinshella, Gauthier, & Lysyshyn, 2018). This is still a form of overdose and intervention is still necessary to keep a person safe, but these reactions are not commonly acknowledged as being a form of overdose. We also wish to acknowledge the reality that someone may not remember that they have overdosed. For these reasons, the responses received may not be fully representative of how many participants have actually overdosed at an SCS/OPS.

CONCLUSION

Supervised consumption and overdose prevention sites are vital, life-saving services for people who use drugs, however, more can and must be done to ensure and to work toward the improved accessibility of these services for women and gender expansive populations. Despite the gendered make up of the workforce, specific services and support for women and gender expansive people are extremely limited. There is an urgent need for dedicated resources, specifically funding, that needs to be directed to the creation of new sites and services for women and gender expansive people

with overlapping marginalized identities. Many of the above recommendations can be implemented within existing site structures and resources. Some will require advocacy by site operators in solidarity with women and gender expansive populations of people who use drugs to change systemic barriers and save lives.

"I think about the big wins that come for free, like making a space feel comfortable rather than clinical, and designing the space, policies, and procedures with a social justice and accessibility lens. These considerations send the message that we have been thought about. They don't require a major funding source, just a conscious operator who understands that our needs are different." **– NAT KAMINSKI (THEY/THEM), WGEP CO-LEAD**

To support the implementation of safe and accessible harm reduction spaces for women and gender expansive populations, the WGEP Advisory Committee will:

1. Develop an assessment and reflection tool for SCS/OPS operators to identify access barriers for women and gender diverse people at their sites.
2. Develop corresponding resource guides for SCS/OPS operators to address identified barriers.
3. Work with operators to further develop and support implementation of recommendations.
4. Work with all levels of government to identify and address barriers to gender inclusive/affirming spaces.

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APPENDIX A

Annotated bibliography

Gender Identity

- Collins, A. B., Bardwell, G., McNeil, R., & Boyd, J. (2019). Gender and the overdose crisis in North America: Moving past gender-neutral approaches in the public health response. *International Journal of Drug Policy*, 69, 43–45. https://doi.org/10.1016/j.drugpo.2019.05.002

This commentary describes how the overdose crisis has been characterized as a men's health crisis, which obscures the diverse experiences of women, transgender, Two Spirit, and non-binary persons, who are differentially impacted by drug-related harms. Drug policies are often "gender neutral" or reinforce gender inequities by seeking to exert control over the bodies of cisgender women and gender expansive persons, as seen through punitive approaches to pregnant people who use drugs. Current overdose surveillance data maintain the use of a gender binary, thereby failing to capture the various experiences of gender expansive persons. More nuanced data collection and reporting are thus required to ensure that the differential impacts of the overdose crisis on transgender, Two Spirit, and non-binary persons are understood and can be addressed.

- HIV Legal Network. (2020). *Gendering the scene: Women, gender-diverse people, and harm reduction in Canada*.

This summary report explores how women and gender diverse people who use drugs are differentially/ disproportionately affected by stigma, racism, colonialism, homophobia, transphobia, poverty, housing insecurity, and violence in Canada. The authors cite a "troubling lack of data" on gender diverse people who use drugs and list as a limitation, the paucity of discussion of gender diverse people in the majority of the research consulted for the report. The authors recommend clear policies prohibiting sexual harassment, including gender-based, homophobic, or transphobic language and staff education on gender-based violence.

- International AIDS Society. (2019). *Women who inject drugs: overlooked, yet visible.*

This discussion paper notes the lack of data on transgender and gender expansive people who use drugs and advocates

for gender-affirming health care for transgender women who inject drugs.

- Nathoo, T., Poole, N., & Schmidt, R. (2018). *Trauma-informed practice and the opioid crisis: a discussion guide for health care and social service providers.* Vancouver, BC: Centre of Excellence for Women's Health. Available at: https://cewh.ca/wp-content/uploads/2018/06/Opioid-TIP-Guide_May-2018.pdf

This guide contains a section entitled Trauma, Gender and Opioid Use, which describes how the specific experience of trauma due to transphobia, erasure, and sexual violence intersects with opioid use. The authors recommend learning about the unique harm reduction and pain care needs of trans and non-binary people, as well as using inclusive language, providing gender-neutral washrooms, and allowing people to use services consistent with their gender identity.

- Women and Harm Reduction International Network. (2021). Global mapping of harm reduction services for women who use drugs. International Drug Policy Consortium. Available at: https://whrin.site/ourpublication/global-mapping-of-harm-reduction-services-for-women-who-use-drugs-english/

This report calls for harm reduction services to "see and meet the harm reduction (HR) needs of women... in all countries." The authors advocate for the use of a gendered lens in harm reduction service delivery and provide a global account of successful harm reduction services for women. The report also includes "a 'living' listing by Regions of services with a brief description and links." In the section on North America, the authors report that services for women are nearly non-existent in rural areas and on reserves. Survey participants consistently identified 1) lack of childcare, 2) fear of child apprehension, 3) stigma, and 4) a general lack of women-specific services as key gaps in harm reduction services. Participants also noted the need for more trans-inclusive services, as well as services for women who are unhoused, have mental health issues, and engage in sex work. The authors note, "[t]here is also an urgent need to provide peer-led women specific harm reduction services as a safe and non-judgemental space for WUD including those with children."

- Xavier, J., Lowe, L., & Rodrigues, S. (2021). *Access to and safety for women at supervised consumption services. Findings from a community-based research project.* Canadian Mental Health Association. Available at: https://cmha.ca/wp-content/uploads/2021/04/Women-and-SCS-Report_FINAL-April-2021.pdf

This report briefly discusses transphobia and the ways in

which transphobia can be curbed or wrongfully upheld by staff at an SCS.

Pregnancy and Parenting

- Boyd, S. (2019). Gendered drug policy: Motherisk and the regulation of mothering in Canada. *International Journal of Drug Policy*, 68, 109–116. https://doi.org/10.1016/j.drugpo.2018.10.007

This paper provides an analysis of the effect of child protection policies and practices on pregnant women and mothers suspected of using drugs, with a focus on the Motherisk drug testing tragedy in Ontario. Through critical analysis of the 2015 Report of the Motherisk Hair Analysis Independent Review" and the 2018 report of the Motherisk Commission, "Harmful Impacts: The Reliance on Hair Testing in Child Protection," the author concludes that drug testing — and thus drug use — is not only an inadequate measure of parenting capacity but also an incident along a continuum of state and gendered violence against poor, Indigenous, and Black women in Canada. The author argues that prohibitionist discourse and current policies around drug use and parenting perpetuate institutional violence and the fracturing of families.

- HIV Legal Network. (2020). *Gendering the scene: Women, gender-diverse people, and harm reduction in Canada*.

The summary describes how laws relating to drug use and child welfare affect women and gender diverse people who use drugs. The authors state, "although most provincial/territorial child protection laws and policies do not make specific reference to drug use as a ground of intervention, child protection services have conflated maternal drug use with neglect or mistreatment rather than determining whether drug use has affected parenting or child welfare." The authors recommend that services be friendly to pregnant and parenting people, ensuring that drug use alone will not trigger child protection involvement.

- International Network of People who Use Drugs. (2016). *Practical guide for service providers on gender-responsive HIV services.*

This practical guide is intended for harm reduction service providers, managers, health care workers, and outreach workers who work directly with women who inject drugs. Key considerations for making sites more accessible for parents who use drugs include service delivery integration (e.g., with family planning) and parenting support(s) (e.g., childcare). The guide suggests dates that pregnant clients should not be barred from accessing services. The authors comment on

how laws and practices that indicate drug use and sex work as a criterion for child custody loss and the lack of providers trained to address gender-based violence deter women from accessing services. The guide advocates for allowing children to be with their parents while they access services and creating child-friendly spaces.

- Kenny, K. S., Barrington, C, & Green. S. L. (2015). "I felt for a long time like everything beautiful in me had been taken out": Women's suffering, remembering, and survival following the loss of child custody. I*nternational Journal of Drug Policy, 26*(11), 1158–1166.

This narrative analysis explores the impact of child custody loss on 19 women who use drugs in Toronto, Ontario, as well as how child protective services disproportionately impact poor and racialized families. The authors underscore the need for strategies to address women's health and structural vulnerability prior to and following custody loss and advocate for community-based alternatives to parent–child separation.

- Lamonica, A. K., Boeri, M., & Turner, J. (2021). Circumstances of overdose among suburban women who use opioids: Extending an urban analysis informed by drug, set, and setting. *International Journal of Drug Policy, 90,* 103082. https://doi.org/10.1016/j.drugpo.2020.103082

This mixed-methods study aimed to elucidate the circumstances surrounding overdose of street-involved suburban women in Philadelphia. Eleven out of 32 women linked underlying influences and life experiences to their overdose experiences, one key experience being child custody issues.

- Malinowska-Sempruch, K. (2015). What interventions are needed for women and girls who use drugs? A global perspective. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, 69(Supplement 2), S96–S97. https://doi.org/10.1097/qai.0000000000000621

This supplemental article describes the increased vulnerability of women who use drugs due to social, economic, and cultural power imbalances and details best practices for addressing these socio-structural vulnerabilities. The authors describe how mothers who use drugs are highly villainized and readily separated from their children via unjust loss of custody based on misguided beliefs about their parenting abilities. Pregnant women face an even higher degree of shame and stigmatization by family, health care workers, and other people who use substances. The article lists the following effective harm reduction strategies to mitigate these barriers: offering safe, clean spaces where children can stay while their parents receive care; mobile and take-home dosing services; and legal literacy services

that empower people who use drugs to challenge systemic discrimination and abuse.

- Nathoo, T., Poole, N., & Schmidt, R. (2018). *Trauma-informed practice and the opioid crisis: a discussion guide for health care and social service providers.* Vancouver, BC: Centre of Excellence for Women's Health.

This discussion guide on trauma-informed care for health and social service providers focuses on addressing trauma and violence in the context of the opioid crisis, especially as it relates to the experiences of trauma among women, transgender, and gender-expansive people. The authors recommend use of strengths-based language that emphasizes clients' choice, control, and collaboration. In acknowledgement of parents who use drugs, the authors advise that providers avoid using terms like "addicted babies" or "born addicted to heroin" and instead use phrases like "exposed to substances in utero" or "experiencing withdrawal."

- Pinkham, S., Stoicescu, C., & Myers, B. (2012). Developing effective health interventions for women who inject drugs: key areas and recommendations for program development and policy. *Advances in Preventive Medicine, 2012*, 1–10. https://doi.org/10.1155/2012/269123

This review article describes the harms experienced by women who inject drugs, and women's access to harm reduction and health services. It includes a section about the Sheway project in Vancouver, a service that provides education, referrals, and support to help women access prenatal care, while prioritizing choice. Recommended services and practices listed in the article include the following: the inclusion of specific items to basic harm reduction kits (period care materials, pregnancy tests, diapers); addition of services such as short-term childcare; development of relationships with trusted gynecologists and obstetricians for referrals; staff training on drug use during pregnancy; multidisciplinary case management for women (pregnant or parenting) and their children; and comprehensive maternity and post-natal services for pregnant women who use drugs. The authors also advocate for the elimination of laws that make drug use alone grounds for the removal of parental rights, as this is a strong deterrent to help-seeking.

- Poole, N., & Urquhart, C. (2010). *Mothering and substance use: Approaches to prevention, harm reduction and treatment, gendering the national framework series* (Vol. 3). Vancouver, BC: British Columbia Centre of Excellence for Women's Health. Available at: https://bccewh.bc.ca/wp-content/uploads/2012/05/2010_GenderingNatFrameworkMotheringandSubstanceUse.pdf

This discussion guide provides an overview of four topics related to mothers and pregnant people who use substances: 1) stigma and public discourse, 2) barriers to treatment, 3) a guiding framework for practice, and 4) examples of Canadian mother-centred programming. The guide discusses how mothers and pregnant women who use drugs face stigma and judgment from the public discourse, health care workers, and even their support networks. The authors note that Indigenous women who use drugs lose their children at a rate far higher than non-Indigenous women. The guide also cites punitive policies around mothering and substance use as a significant barrier to service: "[w]omen repeatedly report that fear of losing their children is one of the most significant barriers to treatment." The authors recommend a shift away from a child- or fetus-centered approach toward a paradigm of care that is focused on the parent–child unit, that is harm reduction-oriented and collaborative, and that assists parents in dealing with stigma, judgment, and blame.

- Thumath, M., Humphreys, D., Barlow, J., Duff, P., Braschel, M., Bingham, B., Pierre, S., & Shannon, K. (2020). Overdose among mothers: The association between child removal and unintentional drug overdose in a longitudinal cohort of marginalised women in Canada. *International Journal of Drug Policy,* 102977. https://doi.org/10.1016/j.drugpo.2020.102977

This study examines the prevalence of overdose and its association with child removal among a cohort of marginalized women (sex workers and women living with HIV) (n=696) over an eight-year period. It also explores the effects of child removal on recent unintentional, non-fatal overdose among Indigenous women. The authors hypothesize that the correlation between unintended, non-fatal overdose among mothers who have recently experienced child removal is probably a result of substance use due to grief, post-traumatic stress disorder, and feelings of inadequacy and guilt. The authors discuss the role of "prohibitionist drug policies, together with the child welfare system, in exacerbating the risks of child custody loss and subsequent potential for maternal overdose." The authors advocate for gender-responsive linkages to harm reduction, substance use treatment, and safe drug supply for women who have experienced child removal, as well as the integration of overdose prevention and management, drug checking, and mental health supports into maternal health services for women. They also advocate for culturally appropriate social services and family liaisons.

- Wolfson, L., Schmidt, R. A., Stinson, J., & Poole, N. (2021). Examining barriers to harm reduction and child welfare services for pregnant women and mothers who use substances using a stigma action framework. *Health & Social Care in the Community, 29*(3), 589–601. https://doi.org/10.1111/hsc.13335

This scoping review examines how stigma and related health system barriers impact access to, retention in, and outcomes of harm reduction and child welfare services for pregnant women and mothers who use substances at the individual, interpersonal, institutional, and population levels. The review identifies opportunities for service providers and policy-makers to better support pregnant people and parents who use substances.

- Värmå Falk, M., Strömdahl, S., Ekström, A. M., Kåberg, M., Karlsson, N., Dahlborn, H., & Hammarberg, A. (2020). A qualitative study of facilitators and barriers to participate in a needle exchange program for women who inject drugs. *Harm Reduction Journal, 17*(1). https://doi.org/10.1186/s12954-020-00425-9

One major barrier to accessing needle exchange programs in this study was the fear of child custody loss. The authors stress the importance of integrating family support programs into harm reduction services, as well as helping to reduce knowledge gaps among mothers about the legal processes of child custody loss, which may, in some cases, alleviate concerns.

Racial Considerations and Cultural Safety

- Bardwell, G., Austin, T., Maher, L., & Boyd, J. (2021). Hoots and harm reduction: a qualitative study identifying gaps in overdose prevention among women who smoke drugs. *Harm Reduction Journal, 18*(1). https://doi.org/10.1186/s12954-021-00479-3

This paper qualitatively examines the experiences of 32 women and gender diverse people in smoking drugs and utilizing a women-only (transgender, Two-Spirit, and non-binary inclusive) supervised inhalation site. Participants expressed the need for services that attend to women's specific experiences of gendered, race-based, and structural violence faced within and outside a mixed-gender social service setting. Findings demonstrate the need for culturally appropriate interventions that recognize diverse modes of consumption while attending to overdose and violence.

- Boyd, S. (2019). Gendered drug policy: Motherisk and the regulation of mothering in Canada. *International Journal of Drug Policy, 68*, 109–116. https://doi.org/10.1016/j.drugpo.2018.10.007

This paper provides an analysis of the effect of child protection policies and practices on pregnant women and mothers suspected of using drugs, with a focus on the Motherisk drug testing tragedy in Ontario. The paper describes Motherisk as "part of a continuum of state and gendered violence against poor, Indigenous and Black women of Canada," and provides evidence of the disproportionate harms of such programs and child welfare services on Black and Indigenous families.

- Marshall, S. G. (2015). Canadian drug policy and the reproduction of Indigenous inequities. International Indigenous Policy Journal, 6(1). Available at: http://ir.lib.uwo.ca/iipj/vol6/iss1/7

This study describes how Canadian drug policies during the Conservative Harper administration exacerbated the systemic health inequities between Indigenous people and non-Indigenous people who use drugs.

- Thumath, M., Humphreys, D., Barlow, J., Duff, P., Braschel, M., Bingham, B., Pierre, S., & Shannon, K. (2020). Overdose among mothers: The association between child removal and unintentional drug overdose in a longitudinal cohort of marginalised women in Canada. *International Journal of Drug Policy*, 102977. https://doi.org/10.1016/j.drugpo.2020.102977

This study examines the prevalence of overdose and its association with child removal among a cohort of women (sex workers and women living with HIV) (n=696) over an eight-year period. It also explores the effects of child removal on recent unintentional, non-fatal overdoses among Indigenous women. The authors advocate for gender-responsive linkages to harm reduction, substance use treatment, and safe drug supply for women who have experienced child removal, as well as the integration of overdose prevention and management, drug checking, and mental health supports into maternal health services for women. They also advocate for culturally appropriate social services and family liaisons.

Physical Space and Surrounding Environments

Space Design and Police Presence

- Bardwell, G., Austin, T., Maher, L., & Boyd, J. (2021). Hoots and harm

This study describes the various ways in which police presence outside of SCS impacts access for people who use drugs.

- Centre for Addiction and Mental Health. (2007). *Asking the right questions 2: Talking with clients about sexual orientation and gender identity in mental health, counselling, and addiction settings.*

The goal of this manual is to help service providers create an environment wherein lesbian, gay, bisexual, transgendered, transsexual, Two-Spirit, intersex, and queer clients feel comfortable identifying themselves as such and discussing their identities in the context of their service needs. It provides an intake questionnaire that is inclusive of multiple gender identities and sexual orientations. The entire manual can serve as a language guide for operators.

- Goldenberg, S., Watt, S., Braschel, M., Hayashi, K., Moreheart, S., & Shannon, K. (2020). Police-related barriers to harm reduction linked to non-fatal overdose amongst sex workers who use drugs: Results of a community-based cohort in Metro Vancouver, Canada. *International Journal of Drug Policy, 76*, 102618. https://doi.org/10.1016/j.drugpo.2019.102618

This longitudinal study explores how experiencing police-related barriers to accessing harm reduction services increases non-fatal overdose risk among women sex workers who use drugs. Adversarial policing practices identified in the study include police harassment (physical and emotional abuse), surveillance, arrest, displacement from areas where harm-reduction services are concentrated, barriers, apprehension, destruction of harm reduction materials by police, and workplace inspections. The authors advocate for the scaling up of sex worker-friendly harm reduction services that are gender sensitive, trauma-informed and led by people with living/lived experience.

- Kolla, G., Penn, R., & Long. C. (2019). *Evaluation of the overdose prevention sites at Street Health and St. Stephen's Community House.* Toronto: Street Health and St. Stephen's Community House.

This evaluation examines the provision of services at Street Health and St. Stephen's Community House in Ontario.

Women and members of the 2SLGBTQIA+ community expressed a strong preference for a small, quiet OPS, noting that loud environments dissuade them from using spaces. Women participants credited the non-clinical character of the Street Health OPS — replete with magazines, plants, and art — as contributing to its welcoming feeling.

- Nathoo, T., Poole, N., & Schmidt, R. (2018). *Trauma-informed practice and the opioid crisis: a discussion guide for health care and social service providers.* Vancouver, BC: Centre of Excellence for Women's Health.

This discussion guide on trauma-informed care for health and social service providers focuses on addressing trauma and violence in the context of the opioid crisis, especially as it relates to the experiences of trauma among women, transgender, and gender diverse people. The authors highlight some people's preference for spaces that look less medicalized, which can be accomplished by adding plants, couches, warm colours, and art that reflects the community.

- Rouhani, S., White, R. H., Park, J. N., & Sherman, S. G. (2020). High willingness to use overdose prevention sites among female sex workers in Baltimore, Maryland. *Drug and Alcohol Dependence, 212*, 108042. https://doi.org/10.1016/j.drugalcdep.2020.108042

This study examines the self-reported willingness, barriers and conditions of hypothetical use of overdose prevention sites among street-based sex workers in Baltimore, Maryland. Barriers to use included transportation, fear of arrest, and concerns about confidentiality and privacy. Concerns about cleanliness were also noted. The authors cite that, "studies have shown PWUD... feel that OPS can be a refuge from robbery, violence and gendered power relationships surrounding drug consumption". The authors thus advocate for negotiations with law enforcement to provide immunity for drug use on and around the premises.

- Xavier, J., Lowe, L., & Rodrigues, S. (2021). *Access to and safety for women at supervised consumption services. Findings from a community-based research project.* Canadian Mental Health Association.

In this report, women who use drugs discussed security and privacy as key factors for ensuring safety in supervised consumption sites. Participants identified 24/7 services or extended hours as critical for reducing exposure to violence. Overnight services were deemed especially important for sex workers. Other facilitators of safety included layout and design features that allow for privacy when using drugs. Participants preferred private injection spaces and "expressed that having the choice to remove oneself from the male gaze could increase feelings of safety."

- Värmå Falk, M., Strömdahl, S., Ekström, A. M., Kåberg, M., Karlsson, N., Dahlborn, H., & Hammarberg, A. (2020). A qualitative study of facilitators and barriers to participate in a needle exchange program for women who inject drugs. *Harm Reduction Journal, 17*(1). https://doi.org/10.1186/s12954-020-00425-9

In this study, women participants described the waiting room of a needle exchange site as a barrier to access — women reported concerns about being harassed or threatened by men. Other concerns that were raised were anxiety associated with crowding in the waiting area and the fear of being registered into a system, thus losing anonymity.

- Rouhani, S., White, R. H., Park, J. N., & Sherman, S. G. (2020). High willingness to use overdose prevention sites among female sex workers in Baltimore, Maryland. *Drug and Alcohol Dependence, 212,* 108042. https://doi.org/10.1016/j.drugalcdep.2020.108042

Among this study population, many reported transportation concerns, which prompted the authors to suggest interventions such as offering mobile sites or integrating OPS into multi-service centres. Fear of police was also high; the authors suggest that service providers negotiate with law enforcement to allow service users to be provided immunity for drug use while on the premises.

Programming and Practical Considerations

Operating hours, supplies, resources, and integrated services

- AIDS Vancouver Island & the Women and HIV/AIDS Initiative. (2019). Safer spaces: feedback from women about overdose prevention sites.

This project examined how women use OPS and what makes them more or less accessible. Surveys conducted at five OPS in British Columbia and Ontario found that women value sites that are trustworthy, offer community support, provide food and basic needs, and hire well-trained, non-judgmental staff. Survey participants also highlighted the importance of privacy, less-crowded spaces, clean spaces, “chill out” spaces, sight lines to exits, and women-only programming, inclusive of trans women and non-binary folks.

- Boyd, J., Collins, A. B., Mayer, S., Maher, L., Kerr, T., & McNeil, R. (2018). Gendered violence and overdose prevention sites: a rapid ethnographic study during an overdose epidemic in Vancouver, Canada. *Addiction, 113*(12), 2261–2270. https://doi.org/10.1111/add.14417

This paper explores how the overlapping epidemics of overdose and gendered and racialized violence impact the experience of women who use drugs at five OPS in Vancouver's Downtown Eastside. Participants characterized accommodation of assisted injections and injecting partnerships as critical to increasing their OPS access. Peer-administered injections disrupted gendered power relations to allow women increased control over their drug use; however, participants indicated that gendered and racialized violence extended into OPS spaces, experienced at times as "masculine," that jeopardized some women's access.

- Boyd, J., Lavalley, J., Czechaczek, S., Mayer, S., Kerr, T., Maher, L., & McNeil, R. (2020). "Bed bugs and beyond": An ethnographic analysis of North America's first women-only supervised drug consumption site. *International Journal of Drug Policy, 78,* 102733. https://doi.org/10.1016/j.drugpo.2020.102733

This paper draws on observation and 45 qualitative interviews with women accessing SisterSpace, North America's first low-threshold supervised consumption site exclusively for women (transgender and non-binary inclusive) in Vancouver, Canada. The setting (non-institutional and de-medicalized), operational policies (no men; inclusive; offering of basics such as food), and environment (diversity of structurally vulnerable women who use drugs), afforded some participants a temporary reprieve from some forms of stigma and discrimination, gendered and social violence, and drug-related harms. It enables knowledge-sharing (about a range of topics including avoiding bad dates, drug toxicity, access to housing, and navigation of child protection services).

- Canadian Institute of Health Research & British Columbia Centre of Excellence for Women's Health. (n.d.). *Intersections of mental health perspectives in addictions research training. Gender-informed prevention & harm reduction for substance use.* Available at: https://bccewh.bc.ca/wp-content/uploads/2019/10/infosheet-Gender-based-prevention03.pdf

This factsheet details examples of effective harm reduction strategies that are responsive to the intersecting and gender-based factors affecting substance use. "Examples of successful, women-centered harm reduction programs include: peer-led mobile outreach services for women involved in street-level sex work, which provide education, harm reduction materials and support services, and

specialized maternity programs that provide parenting and child development support, access to basic necessities (e.g., food, housing, transportation) ..."

- Gagnon, M. (2017). It's time to allow assisted injection in supervised injection sites. *Canadian Medical Association Journal, 189*(34), E1083–E1084. https://doi.org/10.1503/cmaj.170659

This commentary explores the importance of removing the restrictions on assisted injection in Canada to increase access to supervised injection services, improve health, and reduce overdose risk for people who need assistance with injecting substances. The author states that women are more likely to require or prefer assisted injection, usually from intimate partners and that, overall, studies show that requiring injection assistance is associated with an increased risk of injection-related injury or infection and overdose, as well as street- and partner-related violence and exploitation.

- International Network of People who Use Drugs (2016). *Practical guide for service providers on gender-responsive HIV services.*

This guide provides multiple practical suggestions for harm reduction service providers to improve and implement gender-responsive services for women who use drugs.

- Malinowska-Sempruch, K. (2015). What interventions are needed for women and girls who use drugs? A global perspective. *JAIDS Journal of Acquired Immune Deficiency Syndromes, 69*(Supplement 2), S96–S97. https://doi.org/10.1097/qai.0000000000000621

This supplemental article describes the increased vulnerability of women who use drugs owing to social, economic, and cultural power imbalances and details best practices for addressing these socio-structural vulnerabilities. The author recommends that harm reduction services include the following: centres only for women or that have women-only hours that are located in safe and convenient neighbourhoods; mobile dosing services and take-home dosing; integrated services that incorporate sexual and reproductive; health education and services that network with women's shelters and domestic and sexual violence prevention services; sex-worker specific programming; programing for queer, trans, two-spirit, and non-binary people; legal literacy services; and sensitization of local law enforcement to reduce stigma, discrimination, and abuse.

- Neal, N., Schrader, T., Hyndman, J., Boyce, B., Phillips, D., Smith, R., Sushi, Genovese, F., Ricciardi, J., MacVicar, M.K. & Mukkath, S. (2014). Street-based sex workers needs assessment. Available at: https://www.streethealth.ca/downloads/sex-workers-needs-assessment.pdf

This needs assessment of street-based sex workers (n=100) in Ontario was conducted to understand the demographic profile of street-based sex workers in the Greater Toronto region. Many participants mentioned the need for services at nighttime, especially to address safety concerns. Participants reported the need for compassionate, non-judgmental service providers (including peer workers), as well as safe drop-in spaces. Participants also reported wanting more after-hours childcare services. The authors suggest that services provide harm reduction outreach to sex workers (including education and supplies).

- Schäffer, D., Stoever, H., & Weichert, L. (2014). *Drug consumption rooms in Europe: Models, best practice and challenges.* Amsterdam: European Harm Reduction Network. 10.13140/RG.2.1.2730.0960

This report by the European Harm Reduction Network outlines challenges and best practices in the implementation of drug consumption rooms. The report includes a section on a woman-only drug consumption room in Hamburg, Germany, that is staffed by social workers, doctors, lawyers, nurses, and cultural mediators, all of whom are women. In a survey, 80% of participants reported feeling more comfortable and safe in the women-only space than in mix-gender spaces.

- Värmå Falk, M., Strömdahl, S., Ekström, A. M., Kåberg, M., Karlsson, N., Dahlborn, H., & Hammarberg, A. (2020). A qualitative study of facilitators and barriers to participate in a needle exchange program for women who inject drugs. *Harm Reduction Journal, 17*(1). https://doi.org/10.1186/s12954-020-00425-9

This study explores the reasons for, and barriers to, participation in needle exchange programs among women who use injection drugs in Sweden (n=20) and identifies measures to strengthen the program and increase participation among women. The most valued service was the sexual and reproductive health service, which provides access to contraceptives, cervical cancer screening, and testing for sexually transmitted infections. Barriers included fear of child custody loss, unwillingness to spend time in the waiting area because of overcrowding and fear of harassment and sexual violence by men, limited operating hours, and travel distance. Most participants proposed “women only” access to the needle exchange program, to enhance feelings of safety.

- Women and Harm Reduction (2020). Women and Harm Reduction Assessment Tool. Available at: http://sagecollection.ca/en/system/files/6_-_whai_harm_reduction_toolkit_-_assessment_tool.pdf

This resource is part of WHAI's Women and Harm Reduction in Ontario: A Capacity Building Toolkit, which was created to strengthen the efforts of harm reduction programs to improve harm reduction for women who use drugs. The tool includes questions related to peer employment, provision of basic needs and harm reduction supplies, cultural wellness, and women-only times and spaces.

- Xavier, J., Lowe, L., & Rodrigues, S. (2021). *Access to and safety for women at supervised consumption services. Findings from a community-based research project.* Canadian Mental Health Association.

In this report, women who use drugs discussed security and privacy as key factors for ensuring safety in SCS. Participants identified 24/7 services or extended hours as critical for reducing exposure to violence. Overnight services were deemed especially important for sex workers. Other facilitators of safety included layout and design features that allow for privacy when using drugs. Participants preferred private injection spaces and "expressed that having the choice to remove oneself from the male gaze could increase feelings of safety."

Staff Training, Competency, and Representation

- AIDS Vancouver Island & the Women and HIV/AIDS Initiative. (2019). *Safer spaces: Feedback from women about overdose prevention Sites.*

The presence of women staff with living/lived experience of substance use was considered a positive and enabling factor by study participants.

- International Network of People who Use Drugs (2016). *Practical guide for service providers on gender-responsive HIV services.* Available at: https://www.unodc.org/documents/hiv-aids/2016/Addressing_the_specific_needs_of_women_who_inject_drugs_Practical_guide_for_service_providers_on_gender-responsive_HIV_services.pdf

This practical guide provides multiple suggestions on how to integrate people with lived/ living expertise into harm reduction programming.

- Kolla, G., Penn, R., & Long. C. (2019). *Evaluation of the overdose prevention sites at Street Health and St. Stephen's Community House.* Toronto: Street Health and St. Stephen's Community House.

This evaluation examines the provision of services at Street Health and St. Stephen's Community House in Ontario. Participants highlighted that many of the OPS staff team are women with living/lived experience of drug use, which increased their desire to use the site. The paper includes a section called "Employment of people with lived experience of drug use." Women participants noted the importance of disallowing gendered comments and insults in OPS (including sexist, homophobic, and transphobic comments). The authors recommend establishing spaces or hours for women and transgender people and providing training to ensure all staff members are equipped to respond to gendered homophobic and/or transphobic comments and are well versed in trauma-informed care, conflict resolution, and restorative justice.

- Nathoo, T., Poole, N., & Schmidt, R. (2018). *Trauma-informed practice and the opioid crisis: A discussion guide for health care and social service providers.* Vancouver, BC: Centre of Excellence for Women's Health.

This discussion guide on trauma-informed care for health and social service providers focuses on addressing trauma and violence in the context of the opioid crisis, especially as it relates to the experiences of trauma among women, transgender, and gender-diverse people. The guide has four sections that each address a principle of trauma-informed practice: Trauma-Awareness; Safety & Trustworthiness; Choice, Collaboration & Connection; and Strengths Based and Skill Building. The authors recommend service providers learn the signs of burnout, vicarious trauma, and compassion fatigue and create policies that support staff well-being.

- Women and Harm Reduction. (2020). Women and Harm Reduction Assessment Tool [PDF]. Available at: https://whai.ca/resource/women-and-harm-reduction-in-ontario-a-capacity-building-toolkit/

This resource is part of WHAI's Women and Harm Reduction in Ontario: A Capacity Building Toolkit, which was created to strengthen the efforts of harm reduction programs to improve harm reduction for women who use drugs. The tool includes questions related to peer employment.

Trauma-Informed Gender-Based Violence Prevention and Intervention

- Boyd, J., Collins, A. B., Mayer, S., Maher, L., Kerr, T., & McNeil, R. (2018). Gendered violence and overdose prevention sites: a rapid ethnographic study during an overdose epidemic in Vancouver, Canada. *Addiction, 113*(12), 2261–2270. https://doi.org/10.1111/add.14417

This paper explores how the overlapping epidemics of overdose and gendered and racialized violence impact the experience of women who use drugs at five OPS in Vancouver's Downtown Eastside. The article discusses myriad ways in which OPS can prevent gender-based violence, including assisted injection and zero-tolerance policies around violence.

- Goldenberg, S. M. (2020). Addressing violence and overdose among women who use drugs—need for structural interventions. *JAMA Network Open, 3*(10), e2021066. https://doi.org/10.1001/jamanetworkopen.2020.21066

This commentary explores the need for structural interventions, research, and policy to address gender-based violence and overdose among women and gender diverse individuals who use drugs. The author advocates for the decriminalization of individual drug possession and use and sex work, as well as sex-worker-specific supports, such as trauma-informed, gender-specific, and integrated harm reduction and health services.

- Harris, M. T. H., Bagley, S. M., Maschke, A., Schoenberger, S. F., Sampath, S., Walley, A. Y., & Gunn, C. M. (2021). Competing risks of women and men who use fentanyl: "The number one thing I worry about would be my safety and number two would be overdose." *Journal of Substance Abuse Treatment, 125*, 108313. https://doi.org/10.1016/j.jsat.2021.108313

This study used a quantitative approach of in-depth interviews with women and men aged 18–25 years or 35+ years who use fentanyl. The study found that women disproportionately feared physical and sexual violence and prioritized caring for children and maintaining relations with child protective services, and only women reported that the omnipresent fear of violence interfered with their utilization of harm reduction services. The authors thus advocate for women-only spaces and gender-responsive harm reduction programming that includes childcare provision.

- HIV Legal Network. (2020). Gendering the scene: Women, gender-diverse people, and harm reduction in Canada. Available at: http://www.hivlegalnetwork.ca/site/gendering-the-scene-women-gender-diverse-people-and-harm-reduction-in-canada-summary-report/?lang=en

This summary report explores how women and gender-diverse people who use drugs are differentially and disproportionately affected by stigma, racism, colonialism, homophobia, transphobia, poverty, housing insecurity, and violence in Canada. The report describes how women who inject drugs are more likely to be dependent on a sexual partner for help acquiring and injecting, increasing their risk of infection, overdose, and violence. The authors note how power imbalances and the threat of violence in intimate relationships disproportionately hinder women's access to harm reduction services and safer drug use practices, stating that, "[g]gender-based violence has been linked to elevated rates of syringe sharing, inconsistent condom use, and accidental overdoses." The authors provide the following recommendations for SCS: women-only operating times/services; clear policies prohibiting sexual harassment, including gender-based, homophobic, or transphobic language; and staff educated on gender-based violence.

- International Network of People who Use Drugs (2016). *Practical guide for service providers on gender-responsive HIV services.* Available at: https://www.unodc.org/documents/hiv-aids/2016/Addressing_the_specific_needs_of_women_who_inject_drugs_Practical_guide_for_service_providers_on_gender-responsive_HIV_services.pdf

This practical guide includes a section entitled "Gender-Based Violence and Related Services," which provides strategies and suggestions to help service providers respond to gender-based violence in harm reduction settings.

- Kennedy, M. C., Hayashi, K., Milloy, M.-J., Boyd, J., Wood, E., & Kerr, T. (2020). Supervised injection facility use and exposure to violence among a cohort of people who inject drugs: A gender-based analysis. *International Journal of Drug Policy, 78*, 102692. https://doi.org/10.1016/j.drugpo.2020.102692

This prospective cohort study examines the gender-specific relationship between the use of supervised injection facilities and exposure to violence among people who use drugs. Notably, after multivariable analysis, site use was associated with decreased odds of experiencing violence among men, but not among women. The authors describe how supervised injection facilities tend to be male-dominated spaces and how women's common experience of harassment by men can deter access. "Women were significantly more likely than men

to report that perpetrators were current or former partners, sex work clients, and sex workers." The authors advocate for the implementation of anti-violence programming at sites, like violence prevention resources and counselling, as well as the implementation of peer-assisted injection.

- Kolla, G., Penn, R., & Long. C. (2019). *Evaluation of the overdose prevention sites at Street Health and St. Stephen's Community House.* Toronto: Street Health and St. Stephen's Community House.

This evaluation report includes a section called "Staffing an Overdose Prevention Site," which includes a subsection called "Training for Frontline OPS Staff"; this section provides topics that frontline harm reduction staff should be well versed in, including violence prevention.

- Malinowska-Sempruch, K. (2015). What interventions are needed for women and girls who use drugs? A global perspective. *JAIDS Journal of Acquired Immune Deficiency Syndromes, 69*(Supplement 2), S96–S97. https://doi.org/10.1097/qai.0000000000000621

This supplemental article describes the increased vulnerability of women who use drugs due to social, economic, and cultural power imbalances and details best practices for addressing these socio-structural vulnerabilities. The authors describe how women are at greater risk of violence, coercion, stigma, and infection (due to their often being "second on the needle"). The article lists the following trauma-informed harm reduction strategies to mitigate these barriers: women-only centres or hours; sites in safe, convenient neighbourhoods; services that integrate sexual and reproductive health education and services and that network with women's shelters and domestic violence and rape prevention services; and legal literacy services that empower people who use drugs to challenge discrimination and abuse.

Nathoo, T., Poole, N., & Schmidt, R. (2018). *Trauma-informed practice and the opioid crisis: A discussion guide for health care and social service providers.* Vancouver, BC: Centre of Excellence for Women's Health.

This discussion guide on trauma-informed care for health and social service providers focuses on addressing trauma and violence in the context of the opioid crisis, especially as it relates to the experiences of trauma among women, transgender, and gender-diverse people. The guide has four sections that each address a principle of trauma-informed practice: Trauma-Awareness; Safety & Trustworthiness; Choice, Collaboration & Connection; and Strengths Based and Skill Building.

- Xavier, J., Lowe, L., & Rodrigues, S. (2021). *Access to and safety for women at supervised consumption services. Findings from a community-based research project.* Canadian Mental Health Association. Available at: https://cmha.ca/wp-content/uploads/2021/04/Women-and-SCS-Report_FINAL-April-2021.pdf

This report examines the barriers and facilitators that impact women's access to SCS and related health care services connected to these sites. This research reports on seven focus groups (n=33) with women who use drugs and seven interviews with frontline staff at SCS in Ontario to explore factors that contribute to, mitigate, or prevent gender-based violence, discrimination, and/or aggression at SCS and identify suggestions for increased safety and access. Four main themes were identified around barriers and facilitators to accessing SCS: 1) safety from violence, discrimination, and coercion; 2) SCS as a unique point of access for women; 3) SCS as spaces that challenge marginalization; and 4) an unmet need for gender-responsive protocols and frameworks (including the need for women-only SCS and/or women-only hours).

APPENDIX B

WGDP Survey Questions

Note: "Prefer not to answer" was an option for every question, as well as "Other", where applicable.

1. **What is your age?**
   Under 18
   18-24
   25-44
   45-54
   55-64
   65+

2. **The purpose of this survey is to gather the experiences of people who use/used drugs. Are you someone who uses/used drugs?**
   Yes
   No

3. **Do you or don't you use an SCS/OPS?**
   I do
   I don't
   I don't have an SCS/OPS in my community
   I have considered using drugs in an SCS/OPS but have not yet

4. **What kind of drugs do you use? (Select all that apply)**
   Prescribed Opioids (Dilauded, oxycodone, etc.)
   Non-prescribed opioids (Fentanyl, heroin, etc.)
   Methamphetamine/Amphetamine
   Cocaine
   Benzodiazepines (Ativan, Valium, etc.)
   GHB
   Alcohol

5. **How do you use your drugs?**
   Oral
   Smoking
   Snorting
   IV Injection
   Muscling
   Skin popping
   Boofing

6. **Gender identity - I identify as... (Select all that apply)**
   Cisgender woman (you identify with your designated gender at birth)
   Transgender woman (you identify with a gender other

than what was designated at birth)
Transgender man
Two-Spirit
Non-binary
Gender-fluid
Gender-queer
Agender
Intersex

7. **We are sharing this survey to determine accessibility needs also for people who are pregnant, parenting with or without custody, or acting as a caregiver for someone else's children. Are you...**
Pregnant
A parent with custody
A parent without custody
A caregiver for someone else's child
None of the above

8. **Where are you located?**
[All provinces and territories listed]

9. **How would you describe where you live? (Select all that apply).**
Urban
Suburban
Rural
Remote
On reserve
Off reserve

10. **In our society, people are often described by their race or racial background. For example, some people are considered White Black, or East/Southeast Asian, etc. Which race category best describes you? (Select all that apply).**
Black (African, Afro-Caribbean, African Canadian descent)
East Asian (Chinese, Korean, Japanese, Taiwanese descent)
Southeast Asian (Filipino, Vietnamese, Cambodian, Thai, Indonesian, other Southeast Asian descent)
Latino (Latin American, Hispanic descent)
Indigenous (First Nations, Métis, Inuk/Inuit)
Middle Eastern (Arab, Persian, West Asian descent, e.g., Afghan, Egyptian, Iranian, Lebanese, Turkish, Kurdish, etc.South Asian (South Asian descent, e.g., Indian, Pakistani, Bangladeshi, Sri Lankan, Indo - Caribbean, etc.)
White (European descent)

11. **How did you hear about the SCS/OPS?**
Friend
Partner

Community member(s)
In the neighborhood
Health care provider
News/media
Outreach teams
Police/security
Other

12. Is the SCS/OPS low barrier or high barrier?
Yes
No

13. What makes the SCS/OPS low barrier or high barrier?

14. What about the exterior of the SCS/OPS might deter you from accessing the site?
Crowded/busy
Police presence nearby
Staff doing outreach/attending outside SCS/OPS
Excessive noise

15. Who did you see when you first went into the SCS/OPS?

16. Would you say that the staff were representative of women and gender diverse people, BIPOC, and/or PWUD?
Yes
No

17. How did staff at the SCS/OPS greet you? (Select all that apply)
Told me where to sit
Asked me what my equipment preferences were
Asked me what pronouns I use
Completed a registration form with me
Oriented me to the site
Showed me where the washrooms were

18. Was it explained to you why you were asked demographic questions and what would be done with that information?
Yes
No

19. Did you feel like you could trust your personal information with SCS/OPS staff when asked?
Yes
No

20. **Were you allowed to implement your own safety protocols at the SCS/OPS? For example, peer-assisted injection, splitting and sharing, sitting with a partner/ friend.**
Yes
No

21. **Did you feel comfortable asking staff for information/ resources/support?**
Yes
No
Maybe

22. **How would you rate the level of knowledge of staff related to gender inclusivity, issues around substance use, issues around race and racialized populations?**
(No Knowledge - 1 - 2 - 3 - 4 - 5 - Very Knowledgeable)

23. **Were/are you comfortable using drugs at the SCS/OPS?**
Yes
No

24. **Have you experienced the following at an SCS/OPS? (Select all that apply).**
Misogyny
Transphobia
Erasure

25. **Have you witnessed violence at an SCS/OPS?**
Yes
No
a. If you answered yes to the question about witnessing violence, how was that addressed by staff at the OPS/ SCS?

26. **Do you feel comfortable approaching staff if you are in a harmful situation with a partner?**
Yes
No

27. **Have you had negative or uncomfortable experiences where staff have intervened? If yes, please specify. If no, leave blank.**

28. **How was behavior of other clients responded to by staff?**

29. **Have you overdosed at an SCS/OPS?**
Yes
No

30. **If you were pregnant or parenting, did you feel comfortable disclosing that to staff at the SCS/OPS?**
Yes
No
Not applicable

31. **Do you feel that your external appearance impacts how you are treated in the SCS/OPS? If yes, why/how?**

32. **Were you given an opportunity to inform staff of your gender and pronouns?**
Yes
No

33. **Did you feel safe informing staff of your gender and pronouns?**
Yes
No

34. **What makes you feel welcome at an SCS/OPS?**
Comfortable waiting space
Visual cues/messaging/posters
Being orientated to the space
Staff with lived/living experience
Drop-in space/chill space
Options for childcare

35. **What makes you comfortable or uncomfortable using the SCS/OPS?**

36. **What do you feel staff can do to better address conflict or violence in SCS/OPS?**

37. **If you were allowed to split and share your drugs, would that encourage you to use at an SCS/OPS?**
Yes
No

38. **What values are crucial for creating a more gender-safe space? (Select all the apply).**
Anti-racist
Anti-colonialist
Sex-worker inclusive
Queer and trans-friendly

39. **How do you think your gender/identities affect(s) your experience in an OPS/SCS?**

40. **How can SCS/OPS be more gender-safe/relevant for you?**

Holding and Untangling - A Lived Experience Lens: Women & Gender Expansive Populations' Access to Supervised Consumption/Overdose Prevention Sites: NATIONAL SURVEY REPORT