Access to and Safety for Women at Supervised Consumption Services

Findings from a community-based research project

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INTRODUCTION

The opioid poisoning crisis in Canada continues unabated. In the six months (April to September 2020) following the public order to stay at home due to the COVID-19 pandemic, 3,351 lives were lost to opioid toxicity, which marks a 74% increase from October 2019 to March 2020.[1] Injection drug use, an increasingly toxic drug supply, and the criminalization of substance use are associated with multiple harms. These include opioid poisonings, health issues, elevated risk of contracting HIV or other infections, increased risk of contact with police and the legal system, and experiences of stigma, marginalization, and discrimination.[2] In response to these issues, community health services are increasingly adopting harm reduction approaches.[3]

Harm reduction approaches include supervised consumption services (SCS) and overdose prevention sites (OPS). SCS are facilities that promote safer and more hygienic drug use by providing sterile equipment and a space to use pre-obtained drugs under the supervision of specially trained staff.[4] SCS encompass policies, services and frameworks that aim to minimize the harms associated with drug use, provide access to services that do not require a commitment to abstinence and recognize the rights and agency of people who use drugs.[5] OPS are similar to SCS; however, they are temporary low-barrier services that are primarily staffed by people who use drugs (PWUD) or have lived experience of drug use. OPS are urgent-need services and, as such, may not offer the range of the services that SCS provide. In 2018, the Government of Ontario undertook a review of the evidence of SCS and subsequently combined and restructured SCS and OPS into a new model known as Consumption and Treatment Services (CTS).[6]

As an increasing number of municipalities across Canada implement SCS, there is a need to assess facilitators and barriers to access that are experienced by different groups of people who use drugs. Studies of SCS/OPS demonstrate that these interventions are effective in promoting public health and reducing opioid-toxicity deaths.[7]

Women's access to SCS is an important consideration given that they are more likely to experience gender-based discrimination, aggression, and violence, which may also be linked to race, socio-economic status, colonialism, gender identity, sexuality, and ability. Many WWUD are also criminalized for their participation in sex work and/or drug use, and women who are pregnant and using drugs may also face considerable stigma that limits their access to SCS.[8] 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.

Despite the fact that drug use is gendered and WWUD are exposed to greater risks and harms compared to men who use drugs, the needs of WWUD have not figured prominently in harm reduction research and policy making. Historically, WWUD have been made invisible in the research on drug use, which has been narrated through men's perspectives,[9] and as some researchers have pointed out more recently, the drug policies and harm reduction services developed in response to the opioid poisoning crisis in Canada have been "gender neutral."[10] The reporting on the opioid poisoning crisis in Canada also erases WWUD from the narrative. Public Health Agency of Canada (PHAC) statistics reveal year-upon-year that up to three quarters of opioid poisonings affect men. In turn, many Canadian news outlets have suggested that the opioid poisoning crisis in Canada is a men's health crisis.[11] The limited evidence that

exists on women's access to SCS suggests that WWUD visit SCS/OPS at lower rates than men and are less likely to express willingness to use these services.[12] WWUD who are parents also have a high involvement with child protection services and research suggests that a significant number of child welfare reports against WWUD are filed when they access health services, which may deter women from accessing services they need and contributes to the marginalization and stigmatization experienced by this group.[13]

As the health and safety of WWUD is increasingly at stake in this worsening poisoning crisis, intersectional gender approaches and policies are needed more than ever to facilitate women's access to SCS/OPS. The objective of this project was to determine the barriers, including structural barriers, and facilitators that inform women's access to SCS and, by extension, other health-care services connected to these sites. Through a series of focus groups and interviews with WWUD and frontline staff at SCS in Ontario, we sought to understand what factors contribute to, mitigate, or prevent gender-based violence, discrimination and/or aggression at the services, and we draw on these findings to identify potential directions for increased safety and access.

In pursuing this research, we were mindful that there are important structural barriers associated with the SCS/OPS/CTS models that affect how agencies organize and deliver services. These barriers include chronic underfunding and short funding cycles, operational rules and regulations set by Health Canada and by the provinces and territories, and a vulnerability to changes in government and policy priorities. Because the unauthorized possession of a controlled substance is illegal in Canada, in order for SCS to operate they must be granted a federal exemption under the Controlled and Substances Act (CDSA) and adhere to Health Canada operating regulations. Examples of such guidelines include the prohibition of staff supplying drugs to clients at SCS and drug sharing among clients, both of which are activities that could be classified as trafficking.[14] Historically, assisted injections were not permitted in SCS but were common practice at OPS.[15] At the time of this writing, Health Canada now allows peer assistance at SCS in the course of preparing and consuming drugs, but staff, including registered nurses, are not permitted to administer drugs.[16] Regulations prohibiting assisted injections have been criticized by the harm reduction community given that there are important health benefits associated with the practice, particularly for women. Assisted injections have been shown to minimize HIV transmission, injection-related infections, and exposure to violence while also reducing the possibility of toxicity and death.[17] Research with WWUD has shown that women require assisted injections more often than men and, as such, where the practice is prohibited, they are more vulnerable to violence and coercion.[18]

Furthermore, the shift to the CTS model in Ontario, which occurred as we were beginning this research, introduced new regulations that have created barriers to the rapid scale-up of these much-needed services, given that the new model eliminated the low-threshold OPS model, capped the number of allowable sites in Ontario to 21, and imposed greater reporting requirements and audit protocols.[19]

Keeping in mind that these government regulations create structural barriers in the operation of SCS/OPS, this study explores the facilitators and barriers to service access experienced by WWUD. This report delineates the challenges and opportunities for improving access to the services and contributes to existing research about the experiences and specific needs of WWUD. It also builds on CMHA's recent policy work on the opioid poisoning crisis in Canada.[20]

METHODS

In Fall 2019, a research coordinator from the Canadian Mental Health Association (CMHA) and an OPS staff member with lived experience facilitated seven focus groups with WWUD (n=33), six of which took place at SCS/OPS and one at a drop-in centre, and seven one-on-one interviews with frontline SCS/OPS staff.[21]

To be eligible to participate in a focus group, participants had to identify as women,[22] be at least 18 years old, self-report as having injected drugs once or more in the past six months and have accessed an SCS/OPS at least once in the past. Recruitment followed a convenience sampling methodology, and was facilitated by SCS staff, who assessed eligibility, recruited women who were visiting their site and showed interested in the research, and introduced those willing to participate to the research coordinator.

Before each focus group, participants voluntarily and anonymously filled out a questionnaire, which invited them to share their gender identity, race, education level, employment status, income, housing and SCS access. From there, focus groups were co-facilitated by either the research coordinator or both the research coordinator and a person with lived experience, who was also frontline staff at an SCS. Using a trauma-informed lens,[23] the co-facilitators asked WWUD about a range of topics in relation to accessibility of SCS: design and layout, site rules, staff characteristics and approaches, sex work, mothering and pregnancy, relationship dynamics, and their thoughts on women-only services and women-only hours (see Appendix A for focus group questions). Participants had control and authority over what they felt comfortable discussing and sharing.[24]

To be eligible to participate in a one-on-one interview, participants had to be a frontline staff member at one of the SCS/OPS included in the study.[25] Staff were recruited at the SCS by the research coordinator via convenience sampling. Interviews lasted approximately 1 hour. Topics were similar to those discussed with WWUD (see Appendix B).

To analyze the data, the research team familiarized themselves with the transcripts and collaboratively and iteratively conducted an inductive thematic analysis. Glaser & Strauss's grounded theory supported the development of conceptual categories, and was a guide for iteratively refining these categories as we immersed ourselves in the data as well as the existing research.[26] The research team identified key themes and discussed and distilled them with a Community Advisory Board comprised of people with lived experience, frontline SCS staff, and subject matter experts, whose expertise was invaluable in assessing the appropriateness and relevance of the findings.

FINDINGS

In the small sample of WWUD who participated in this study (n=33), 28 women completed the pre-interview questionnaire. The majority of these women identified as White (71%), with a smaller number identified as Indigenous (11%), Black (7%), mixed race (7%), and Indigenous/White (4%). One woman identified as Trans, while the majority who responded identified as cisgender (86%). A significant number of the participants indicated that they experienced housing insecurity in that they were living on the streets or residing in a shelter (61%) or staying with friends or family members (4%).

Several themes arose in relation to women's experiences of drug use and opioid poisonings, and the barriers and facilitators to accessing SCS. These themes are:

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.

Safety from violence, discrimination & coercion

Many WWUD experience barriers to staying physically and emotionally safe. The majority of participants indicated that they access SCS because the services promote and prioritize their safety. For WWUD, the SCS is a "safe haven" that is "non-judgmental."

> "They were like, you know, just supportive and they weren't like, 'Oh you're doing drugs and you inject yourself, you're a bad person.' But like, I find, this place is one of the most supportive – it's kind of like a home, like a family. And you feel like you're safe, supported, no judgment…"

> "It's like a little space of comfort, surrounded by chaos and stigma and hiding and paranoia."

> "It's like a home away from home."

Many WWUD in our sample were also experiencing homelessness and/or insecure housing and spoke about the association between drug use, inadequate housing and vulnerability to physical and sexual violence. For example, participants shared that they were often subject to and made uncomfortable by some men's predatory behaviour:

> "Yeah it's like every single man takes advantage of the female…I'm disgusted by men, I'm disgusted with sex, I'm just so creeped-out that I'm about to snap."

> "Women have expressed like nodding off in alleyways and waking up to men like, pulling their clothes off and stuff."

In addition, intimate-partner violence was a common experience among WWUD in our sample. They and frontline staff identified physical and psychological abuse as factors that influenced women's access to SCS, motivating them to visit the site. One participant underlines the role SCS played when she was in an abusive relationship:

> "…I would just come here, and I didn't even care. But it was the factor of getting away from him and getting able to be able to get here, right? And, like, I knew once I got here, I was safe."

Yet, the exposure of WWUD to violence and predation sometimes extended to their experience at SCS. When participants were asked what would make them hesitant to go to SCS, many of them identified predatory male behaviour as a factor.

> "A lot of [men] get perverted when they get high, so..."
>
> "…They [men] think that they come here to target some women. You know, 'Oh, maybe I can get them [women] working for me for drugs or whatever'."

Experience with intimate-partner violence also complicates women's access to SCS. While in some instances, SCS provide a safer space for women who are in controlling/abusive relationships to escape and seek support, their partners often limited access or dissuaded them from visiting. One participant's abusive husband, from whom she had recently separated, disparaged SCS and tried to discourage her from accessing the site.

> "I can't see him ever understanding what this place does for me…He would just look down at it and be like, 'Why would you want to go there? You just want to go there if you want to get high and get dope,' like he wouldn't see the positive supports."

Frontline staff indicated that they take into consideration the complex dynamics of abusive relationships and emphasized the need to create individual safety plans and strategies to support women's unique needs and safety. For example, staff and WWUD emphasized the practicality of having a second and more discreet exit from the SCS, allowing women to be accompanied out of SCS should their controlling or abusive partner come looking for them, as well as having a gate or layout that would allow staff to regulate or deny access. As one staff member indicated:

> "We have a back alley exit right out of the injection room that goes into the alleyway so that if someone shows up at the front and…someone is feeling unsafe with that person, they can sneak out the back."

The theme of safety was also connected to verbal violence, discrimination, and oppression at SCS. Consistent oversight of verbal violence was underscored as a unique focus at SCS that helps to increase safety for people or communities who may otherwise be subject to oppressive language or actions. Staff underlined that it was critical to monitor for discriminatory language and behaviour and to be proactive about implementing a zero-tolerance approach to oppression directed at women and other marginalized groups.

WWUD agreed that they could rely on staff to shut down aggression rooted in sexism, transphobia, and homophobia. However, one participant indicated that the staff's approach to curbing violence directed at Trans women inside the SCS undermined what she herself did for self-preservation and safety:

> Staff have told me, 'Keep your head down. Don't talk to anybody,' when I'm all dolled up and everything. So, when I'm all done up and have a facial, you can't tell that I'm Trans…people hit on me, like I get cat-called, whatever. And then I speak and I tell them, 'no, I'm not interested,' and that's when I'm getting attacked. I shouldn't have to come in and be told by staff…'Don't let anybody know that you're Trans. Just keep to yourself.' I get it, but I also shouldn't have to.

WWUD also discussed security and privacy as key factors for ensuring and preserving safety. This was especially the case for WWUD who experience multiple forms of marginalization and vulnerability. For example, participants identified 24/7 services or extended hours as critical to

not only increasing their access to harm reduction services but also as an avenue for increasing safety by reducing exposure to violence. For WWUD, overnight services were deemed important because many other services do not operate at night and because WWUD, particularly those who do sex work, can be exposed to unsafe situations during these hours.

Other facilitators of safety included layout and design features that allow for privacy when using drugs, as WWUD may be uncomfortable with using drugs with others close by. WWUD who preferred more private injection spaces expressed that having the choice to remove oneself from the male gaze could increase feelings of safety.

One participant, who injects into her femoral vein, noted that:

> "I have to generally undo my pants and pull them down…so being a woman, having no space to privately do that, is an issue."

Many women who identified as sex workers also mentioned the discomfort and/or fear of harassment they felt when having to use drugs at the SCS in proximity to sex work clients. Several WWUD shared that they inject in private areas but currently lack options to perform these injections in privacy.

The theme of safety also arose when participants discussed SCS rules that enabled or limited access. WWUD agreed that permitting assisted injections at SCS would make the space accessible to women who cannot inject themselves. Their experiences indicate that assisted injections are a key component of harm reduction:

> "I have to hit myself at least 30 times before I can even get a vein. And I start crying. Like it's hurting me."

Frontline staff also signalled that some of the physical harms could be reduced if assisted injection was permitted.

> Some really struggle with injecting themselves…It would be great if even a nurse could or like a medical staff would be able to find the vein and actually like assist with guiding the injection into the vein but not necessarily plunging. Even if something like that could happen, I think that that would definitely help with to mitigate abscesses [and] bacterial infections from misses.

A debate emerged about safety and site rules against sharing drugs. For some WWUD, rules prohibiting drug sharing allowed them to retain agency over their finances and their supply. If sharing were permitted, WWUD could be coerced or even forced to share with others. Importantly, WWUD were not unanimously supportive of a "no sharing drugs on-site" rule. In fact, many participants advocated for abolishing this rule and for allowing drug sharing on-site while supporting continued efforts to prevent drug dealing on-site.

WWUD who also do sex work shared that because drugs are a frequent form of payment, harm reduction in sex work and in injection drug use were interconnected. WWUD who do sex work said information and education was critical for them as a form of harm reduction and protection. Specifically, WWUD discussed the many tactics they have developed to ensure their safety from clients who are violent, who violate boundaries or who refuse to pay, and said they would

welcome overnight SCS hours, mental health support at SCS, education and strategies for safer sex work distributed by SCS, and having SCS located in the areas where they work.

> "Yeah like I'm either losing jobs or putting myself in dark places that prove to be higher risk because then I don't have a safe place to go for that [drug use]."

> "I don't – yeah maybe just information again, and maybe learning about other harm reduction things like…always know where your exits are, these things."

Safety also featured prominently in discussions about how to improve access for pregnant women and mothers who use drugs. WWUD and frontline staff underlined the importance of ensuring that polices impacting parents or guardians be rooted in the safety of parent and child. However, WWUD had differing ideas about what guidelines support safety.

Some WWUD saw access for pregnant women and mothers who use drugs as a way to increase safety. They shared that allowing access to the site would reduce children's exposure to potentially unsafe or unhygienic drug use environments, reduce the likelihood that children are left without supervision and ensure that a child's guardian is safer from health complications and harms associated with injection drug use.

One participant referred to the SCS as reducing her child's exposure to her drug use:

> "I don't want, you know, like what if he was walking outside and saw me doing that [using drugs]. I don't want that."

In contrast, others felt that allowing guardians to access SCS with their children was problematic and expressed concerns about exposing children to concentrated drug use.

Within this discussion, participants identified that access for pregnant women and mothers could support safety from stigma and discrimination. While frontline staff were in agreement that access would increase safety for WWUD and their child, clients were divided on this topic. Many recognized that clients and communities of people who use drugs, in addition to society as a whole, judge pregnant women and mothers who use drugs, and that this can be a source of stigma and shame:

> "Oh God, [being pregnant] was awful. I had no one to talk to about it because no one wants to hear that I'm pregnant and want to get high. You just keep it quiet. I go to work, I don't talk about it, I keep my mouth shut because no one wants to hear that."

Many agreed with the sentiment that they would avoid SCS if they were pregnant to prevent being "hounded" by judgment and advice. Others suggested that pregnant WWUD would hide their pregnancies.

One participant highlighted that pregnant women and mothers who use drugs may experience discrimination in the form of judgemental comments or threats of violence:

> "Well, it would affect their decision in coming because [of] other people's judgmental thought of someone being pregnant and using…they would feel threatened. Some individuals may be like disagreeing on that and may be wanting to kill them."

In addition, WWUD and staff members reported that the fear of losing custody of a child as a result of visiting SCS/OPS was itself a barrier to access for parenting women:

> "I think a lot of women won't [visit the site] because they'll be afraid about judgment, let alone having maybe FACS [Family and Children's Services] called on them because they're pregnant and using. I think a lot of them would hide it."

> "Another woman who came in who was pregnant, she was speaking on the phone with her CAS worker at that time and she had stated that one of the reasons why she wasn't coming was because she thought that she would have a call to CAS or somebody would be watching her, following her, into the site."

The challenge of access to SCS for pregnant WWUD or mothers who use drugs was also seen as an opportunity for education and awareness. Both WWUD who were supportive of access for pregnant women and those who were opposed agreed that design changes such as a separate section for pregnant women would increase their safety and reduce their exposure to stigma and possibly violence.

In addition to SCS supporting a safer environment before and during drug use, WWUD and frontline staff indicated that SCS also ensure women's safety after they use because they protect women from vulnerability to violence and theft after they have used drugs in an open-air setting. One participant noted that, in open-air settings, others can observe one's supply and target them for theft:

> "And, when you're out in the open inside there, I mean, again, when you're pulling your drugs out, they see how much you have. So, I think it should be a little more private that way, as well. They can see exactly how much you have so they go, "Oh, she's got a ball, let's get her when she goes outside, and she's fried."

Frontline staff echoed this, suggesting that their SCS encourages clients to stay longer at the site after using in order to mitigate risk:

> "If they are vulnerable and if they don't stay, we would encourage clients, especially if they're having like a heavy nod, I guess is the phrasing that we use, we would ask them to stay longer. But if they don't want to stay that can make them more vulnerable to the community so I can see that being…you know, if somebody sees someone and they're having a hard time in the room and they leave then they might, I don't know, see that they're more vulnerable, if that makes sense?"

Staff suggested that women are at-risk of being preyed upon and that, given this, it is imperative that SCS not only increase access for WWUD but also ensure that WWUD feel comfortable enough to remain at the SCS for a period of time after they use drugs.

SCS as a Unique Point of Access for WWUD

In addition to SCS promoting safety, participants also recognized that SCS have features that support inclusivity for women from marginalized communities and help build relationships between clients and staff. When discussing the experiences of subgroups of WWUD, such as pregnant women, women experiencing homelessness, women experiencing intimate-partner violence and women who do sex work, SCS were seen as a "door in" for women who may experience barriers to complementary services or supports because they are marginalized.

WWUD described how staff and peers at the SCS/OPS helped them get onto wait lists for housing, connected them with nurses and physicians, and linked them to sexual health services, sexual assault supports, and women's peer support groups. They also provided referrals to drug treatment services, counseling and mental health services, and to other wrap-around supports.

Participants emphasized that SCS are much more than supervised injection services, sharing that they have built meaningful relationships and support systems there. SCS build awareness about services and healthcare and connect WWUD to them:

> "They're always making sure that you're okay and like you know putting you in contact with services…that you didn't even know you had an option to contact, maybe."

For WWUD who are in abusive relationships, staff and WWUD spoke about how the access offered by SCS was unique in comparison to other services. Participants indicated that, while controlling or abusive partners often barred or limited their access to other social services, they could still access SCS. This made it possible for WWUD to build relationships with staff, disclose their situation and seek help.

Some frontline staff shared that it was important to welcome abusive partners into the space and to build trust with them with the objective of building a bridge to women experiencing intimate-partner violence. This approach was understood to be an effective way of connecting a group of vulnerable women to care and supports.

In addition, there was a sense that SCS encourage long-term access to adjacent services and supports and follow-up with staff. One participant described the broader scope of care frontline staff had given her:

> They will definitely double-check the next time they see you to see how things are going and make sure things are cleaning up okay, you know health-wise or [otherwise]. I just resigned and ended up back on the street so they're always double-checking to see where I'm staying, you know, and if I need help with whatever.

The conduct and approach of frontline staff were other factors that made SCS unique. For instance, when discussing their relationships with frontline staff, WWUD shared that staff took a non-judgmental approach to service delivery that promoted anti-oppressive practice, boundary setting, trustworthiness, and relatability. Even WWUD who did not regularly access SCS and preferred to use drugs elsewhere saw SCS staff as one of the most positive aspects of these services. WWUD shared the following experiences with and impressions of staff:

> “I feel like I’ve had a therapy session by the time I leave because I’m multi-tasking all the staff here [getting support for a number of different things].”

> “I have trouble remembering that it’s their job. I mean, it’s like, you know coming in to see friends and family and like you know they’re, as I said, overly dedicated to us as clients and they don’t treat us as clients, they treat us as friends. If we’re hurting they’re hurting for us and they genuinely care about what’s going on, they genuinely understand.”

> “They drive me home and that way I'm safe. There was an incident where my partner and I were attacked outside of an OPS and it was a homophobic attack…Yeah. And the staff were just amazing, like they jumped right on it, they got me the camera footage, they got everything that we needed.”

At the same time as participants considered SCS to be unique points of access to safer injection and additional services and supports, WWUD also experienced barriers to access there. These barriers included a lack of physically separate space between people who were using and people who were not, inconsistent access to a peer or staff member to provide assistance with injections, and imposed time limits for injections.

Several participants shared their perspective on the importance of allowing assisted injections at SCS:

> “I don’t have anybody in my life that would be able to [assist], so, that’s about the only place that, if I couldn’t hit…I could go to have somebody else there to do it.”

> “I also wouldn’t go…if I didn’t know that there was going to be somebody. Think if I knew like ‘Oh, we have a group of staff members who can help you,’ yeah, maybe I would go…but I wouldn’t go if I had no idea whether or not there wasn’t going to be someone there to help.”

Sites that impose a time limit for injection posed a particularly serious barrier for WWUD. Women who use drugs sometimes experience shame about difficulties injecting themselves and a sense of being rushed when time limits are imposed. Some shared that SCS could enhance accessibility by allowing assisted injections so that WWUD would not have to register multiple times to extend their time at the site.

Further, participants mentioned that the absence of supervised smoking services at the majority of SCS was a significant and potentially lethal gap. One participant suggested that the focus on injections meant that there were still risk for people who smoke drugs:

> What doesn’t make sense to me is like…they don’t all have to have available smoking sections and I don’t mean cigarettes. Because people want to smoke crack and like people overdose when they smoke heroin, people overdose when they smoke fentanyl. But they’re getting in shit for sitting in the back yard of the OPS to smoke up.

Participants also identified information gaps at SCS regarding harm reduction and pregnancy. One participant shared:

> "When I first started doing drugs and then becoming pregnant, I was like, 'Oh, why didn't I know this before?' Like certain tips about being safe with your drugs and being pregnant. Like, what could happen, what effects could happen to you and your baby?"

The distribution of supplies at SCS motivated WWUD to visit. Many felt that gender-specific essentials, like menstrual supplies, birth control, and self-defence kits, as well as personal hygiene kits and a place to securely store belongings would increase access. WWUD shared that when these supplies were offered, quantities were insufficient. This was especially a concern for WWUD who do sex work:

> "They give you three condoms if you ask for them, right? Well, if you're a working girl and you're using, you're going to need a little more than three, probably."

Although some WWUD and staff shared suggestions for what measures would enhance access to SCS for parents, such as transparency about staff's duty to report, and on-site childcare, this was a challenging line of inquiry because SCS operate within a system that enforces the removal of children from WWUD.

SCS as Spaces that Challenge Marginalization

WWUD and frontline staff emphasized the importance of challenging marginalization by reducing hierarchies between staff and clients and between women and men. This, they indicated, could cultivate stronger relationships, and increase the effectiveness of the care provided. They shared that disrupting power imbalances and hierarchies ought to be a guiding principle for the design and operation of SCS.

When discussing power and hierarchy at SCS, focus group participants emphasized that the lived experience of staff members was a factor that, if and when present, challenged marginalization by enhancing inclusivity and reducing inequity. Typically, they noted, hiring practices tend to prefer service providers with clinical training over peers with lived experience. WWUD and frontline staff shared that having SCS staffed by people with lived experience could increase access. Participants shared that interactions with staff who do not have lived experience created a sense of discomfort, because they could not relate to those staff members.

> "I would rather have someone that's more well seasoned and well versed rather than someone that's just studied it. Because it's like you don't fully understand what it's like."

> "But, I mean, sometimes you feel misunderstood by people, like, who don't use. And you are. If you weren't, it wouldn't be normal."

For WWUD in our sample, the presence of staff who identify as people with lived experience created a space where there were more opportunities to connect, relate and build relationships with people who have had similar experiences. In addition, WWUD suggested that the presence of staff with lived experience allowed clients to be more open and honest, because they felt less judgment and/or discomfort when interacting with their peers at the SCS:

> "I don't feel uncomfortable to talk to them because they know where we've been."

While WWUD and frontline staff emphasized the importance of having staff with lived experience, WWUD had a unique perspective about this. WWUD created a further distinction between staff with lived experience who no longer used drugs and those staff who use drugs. Some focus group participants emphasized that it was important for SCS to have a complement of staff with lived *and* living experience of drug use. As one participant put it:

> "Because we, as addicts, have a better understanding of how it all works, how to get through it, and that's why I think it's really important to not only have people who have lived the experience, but people who are also going through it."

Many participants saw the staffing of SCS by persons with lived experience as motivating and inspirational. It was, for them, a practice that disrupted power imbalances and indicated that lived experience of drug use was a valuable skillset for agencies and organizations providing services to PWUD. It was also seen as a way to destigmatize drug use within the culture of those agencies and organizations.

Still, some participants shared that although many SCS employ staff with lived experience, much work remains to be done to ensure that trained professionals are not positioned as more valuable than peers, that staffing models are not tokenistic, and that hiring practices for persons with lived experience are equitable. In this regard, one frontline staff member shared the following insight:

> I think it's really important to have people with lived experience on staff and I don't like the whole peer models because what you're really doing, a lot of the time, is tokenistic. It's hiring people with lived experience but not giving them any real responsibility or ability to move up through the ranks and they can see [that] because you don't value their skills in the same way. I just think lived experience should be a valued part of all the job postings. And the way that you post for requirements for a job, should take that into account...And [even] creating those peer positions, it's creating dichotomy, like there's only two things – you're either a worker or you're a drug user. Whereas we know that there are lots of workers who are also people with lived experience.

Discussions of how staffing might create access or barriers for PWUD included staff's approach to de-escalating conflict and ensuring site rules were followed. Sometimes, these approaches reproduced rather than disrupted power dynamics. Frontline staff and WWUD said that this expressed itself in how rules and regulations were sometimes reinforced, and not necessarily in the rules or regulations themselves. For example, some WWUD shared that when staff leveraged their authority to enforce rule following, it could aggravate pre-existing sensitivities to authority and did not always support compliance with rules. In fact, some indicated that such an approach might deter PWUD from accessing SCS and others suggested it might lead to deliberate rule breaking. One participant stated:

> "Being told what to do, usually as an addict [can aggravate the person] because we're – now, we're going to be like, 'Oh, yeah? Watch this.' If they were able to say it in a way that didn't sound like they were telling you you had to, it'd be so much easier."

With regard to power dynamics at SCS, participants also shared their experiences with and views of uniformed professionals at SCS. While some WWUD were not opposed to the presence of paramedics and/or security personnel at SCS, others expressed discomfort with

this. Because many WWUD have had negative experiences with paramedics, healthcare and law enforcement professionals, their presence was seen as potentially triggering and a possible deterrent or barrier to access for WWUD. One focus group participant summarized her negative experience with a uniformed police officer at an SCS:

> The police asked me if their presence was intimidating me and I said, 'Very much so.' And the male officer was like, 'We just saved your life' and he was pissed off at me. I have PTSD and you're [the officer] in-between me and the door buddy, but I didn't say that, but you don't know that just your presence – like I'm not allowed to be intimidated?

Across the focus groups, discussions about assisted injections also touched on power dynamics and power differences. In one focus group, a minority of WWUD opposed allowing staff to assist with injections as they felt it would violate WWUD's autonomy and choice to use drugs and would cross an ethical line for staff who were in positions of power relative to WWUD. However, WWUD and staff who were proponents of assisted injection did not perceive this. Our study also found that WWUD and staff disagreed with existing research that suggests that women, on average, require more assistance with injections than their male counterparts. In our study, WWUD and SCS staff encountered relatively equal numbers of men and women who require assistance with injections; however, in one focus group, the gender dynamic between men and women who require assistance was perceived as a factor compounding the vulnerability of those who require assistance. Specifically, participants often spoke about the ways in which men use a woman's need for assisted injection as a tool for control and/or abuse:

> "I know there's the guys [who] hit them [inject women] so they can't even hit themselves. So, they control them like that."

> I could see it being a very good aspect in terms of being able to get out of a situation where your significant other's the only person who scores for you and hits [injects] you and all that kind of stuff. 'Cause then you're just completely reliant on them and you don't have any other way to get high, way to not be sick. So, having this safe site is at least one aspect. I mean, it would be better if they had people who could hit you, but there's usually at least a couple of other users that will.

Participants also highlighted that assisted injections at SCS were an avenue for women's empowerment, autonomy and protection from control and/or abuse.

Gender-Inclusive and Gender-Responsive Protocols

Our interviews with frontline staff and focus groups with WWUD revealed the importance of "gendering" site protocols to recognize women's unique challenges and needs. Participants shared that overarching guidelines and frameworks do guide SCS staff and SCS operations towards the creation of more inclusive spaces, and could further address the presence of common barriers, such as site features that put women at risk of greater marginalization, exclusion or violence.

Many staff highlighted the importance of training in anti-oppression, crisis intervention, anti-racism, and trauma-informed practice to facilitate women's access to SCS/OPS. They cited

trauma-informed practice as an especially important framework for working with WWUD. Trauma-informed practice is an approach used in some health-care settings that understands that people impacted by violence and trauma could experience re-traumatization at the point of service access, and therefore to promote healing, the services should strive to support women's safety, choice and control.[27] As one staff member explained,

> Staff need to be trauma informed when working with women in this community because so many of them have experienced some trauma…it's just so pervasive. And I think there's a statistic about women who use drugs, like something like 90% of them have experienced violence.

Serving WWUD in a manner that is trauma informed can mean different things. Staff described situations where, at the request of WWUD, they refrained from contacting police and paramedics when the women needed help, opting instead to connect them to alternative health-care services such as supports for sex workers. In other instances, having women on staff who could respond in a crisis helps reduce the risk of re-traumatization, as does paying careful attention to the language they use in speaking with WWUD. Staff noted that trainings on anti-oppression and trauma-informed practice were not always available through the SCS/OPS, in some cases due to budgetary constraints. They reported that SCS/OPS managers would often hire staff members who already had requisite skills in these areas, but that not all staff necessarily had a grasp on what trauma-informed practice constitutes, thus highlighting a need to have training for all staff members.

Participants shared that, in addition to being gender-responsive, a person-centered approach should also apply. This would signal that SCS recognize that because the challenges and barriers WWUD face are not homogenous, the approach to responding to them should not be, either. Specifically, even though WWUD may experience similar barriers to accessing SCS, they may require different forms of support. A person-centered approach is especially critical given the intersecting forms of vulnerability many WWUD experience. If staff and SCS follow general protocols to meet the needs of clients without carefully considering the client's unique situation, invisible consequences can occur for WWUD – such as exposure to violence and reduced access to resources. An "unseen/invisible consequences" that can result from failing to apply person-centered approaches, is articulated by a participant who explained how her situation impacted the kind of support she might need:

> I've talked to them too and, like, they were like, 'Well, is there anything that I can do? Like, would you like me to call some shelters?' or, you know, that kind of stuff. But, again, like, even though if you call a shelter and you get me into a shelter, I'm still going to have [to] deal with the situation because now that person [the abusive partner] is going to end up wanting to come to a shelter or try to find you. And then, it just makes it a lot worse for you because now you talk and you know our business.

Staff and WWUD also discussed the appropriate time/context warranting "banning" clients, underlining the importance of approaching situations at SCS case-by-case. There was no set of circumstances that participants agreed should warrant prohibiting clients, but rather they called for staff to take a person-centered approach that would take into consideration the incident, the client, the client's history and the impact the incident has on female clients.

WWUD shared that there is a delicate balance between promoting access to SCS for all and preventing access to keep SCS as safe as possible. Here, two participants underscore the complexities:

> If they see a man being perverted, you know, more than once, and if they do it again, [they] remove them. Because, I mean, it's extremely uncomfortable and with me, I have high anxiety because of things. So, I'll be sitting there, and I'll be twitching and they're thinking I'm ODing but it's not that at all.

> I mean, I know it's supposed to be a safe place to do it, but if they can't follow the rules, if they let one person get away with it, then everyone else is going to push those limits and they're going to do it, and then it's not going to be a comfortable, safe place anymore. Right?... Everywhere has to have some sort of rules, otherwise everyone would just do what they want.

Finally, through implementing a gendered protocol and being attentive to clients' individual and unique needs, SCS can become more inclusive of WWUD and sub-groups of WWUD such as sex workers, Transwomen, pregnant women, parents, and WWUD in controlling/abusive relationships – groups that were identified by staff as having limited and/or reduced access due to experiences of discrimination, violence and marginalization.

Women-only SCS and Women-only Hours

Focus group and interview participants were also asked about their preference for SCS that were exclusive to women (women-only SCS) or for women-only hours at mixed-gender SCS. While participants did not have a unanimous preference, WWUD recognized the importance of a women-only option because they understood that many WWUD have lived experiences of trauma with men, which impacts their access to mixed-gender services.

Participants who were proponents of women-only SCS expressed that a women-only space could encourage clients to be more open and supportive with each other, given their shared experiences and challenges. Participants also shared this would enable WWUD to share resources and support.

> "I think that we share similar experiences and we'll be more open and supportive that way."

> "You can find people that have similar needs that can help you find what you need."

Some WWUD also associated women-only SCS or women-only hours with increased access for women whose access at a mixed gender site would be impacted by their relationship dynamics with a male partner. For example, WWUD spoke about reduced access for one partner after a break-up and how a women-only SCS or women-only hours could encourage the female partner to continue to access SCS without having to encounter their male ex-partner.

Others saw a women's only space as a way to increase access to women who might be in controlling or abusive relationships, because they would not arouse the suspicion of their partners. As one participant expressed:

> "He doesn't think that you're cheating or with some other guy because he knows it's only a woman thing. So, you could have that time away from them, because you need that, trust me. And, you wouldn't have the headaches after, right?"

There was a consensus among WWUD and staff that a women-only SCS would be more accessible and beneficial than women-only hours at an existing mixed gender SCS. Some participants shared that if the objective is to attract WWUD who face multiple barriers including gender-based violence, and fear of men, then a space that is women-only is necessary. Otherwise, the most marginalized WWUD may continue to be excluded. On the other hand, women who were apprehensive about women-only SCS and women-only hours worried about reduced or interrupted access for women who use drugs with their male partners as well as women who are in controlling relationships with a male partner.

Some WWUD thought that women-only SCS would reassure controlling partners, while others saw the potential for women-only SCS to escalate controlling or abusive behaviour. As one participant put it:

> A lot of times, I just stay home with him and we don't go at all, because it saves the argument. Well, it doesn't save the argument, we still argue, but…at least I'm not being blamed for anything. Like, me hanging out with any of these girls right here, like, he'd be, like, 'Well, you know, where'd they bring you? Or who are they setting you up with?'

Although many women found mixed gender staff to be acceptable, some noted that their access depends on having supportive female staff working at the site. Some WWUD expressed that they were more comfortable debriefing with a woman after a traumatic experience. This highlights the nuanced benefits of having women staff and the potential for more openness between WWUD and women staff. Although there was considerable support for women-only services, resource constraints among OPS/SCS could make this difficult to achieve; integrating women-only hours into SCS that already serve WWUD could reduce barriers for women's access in instances where there are resource constraints.

CONCLUSION

Supervised consumption services are a vital health-care resource for improving the health and well-being of WWUD. The present study provides insights from WWUD and frontline staff regarding the interaction between gender and SCS access. The experiences shared here outline the ways in which SCS are currently providing access to WWUD, and how service users and staff feel SCS might become more accessible. This evidence can inform the development of recommendations that make sense to those with lived experience and expertise in creating and sustaining SCS.

Overall, the WWUD who participated in this study felt that their experience with SCS reflected the staff's commitment to their safety and dignity, but that they experienced some gendered barriers due to the limited resources and limited privacy at the services. Rules around assisted injections and drug sharing were contested, though not unilaterally rejected, as placing some WWUD at disadvantage or risk. SCS and staff acted as an important temporary haven from intimate-partner violence in which control over drug use could be weaponized as part of abuse.

Although many SCS/OPS staff fostered spaces that were supportive environments for pregnant and parenting WWUD, participants relayed the considerable discrimination that this group of WWUD faces and how their access to SCS is hampered by the fear that staff or others connected with SCS/OPS might report them to child protective services.

The discussion of women-only services and women-only hours brought out contrasting views, although participating WWUD felt that women-only services were more likely to protect vulnerable women service users than women-only hours. Having staff with lived experience in positions of responsibility was also identified as an important way to ensure inclusion and dignity.

Although WWUD and frontline staff recognized that SCS connected women with a continuum of wrap-around supports, they noted some gaps. Participants identified a range of supports and services that SCS could integrate or make referrals to, including mental health services, education sessions about drug use and supply, the relationship between pregnancy, parenting and drug use, other forms and options for harm reduction, protocols and navigation associated with the child protective services system, and education to promote safer sex work.

Gender-responsive policies and services in SCS represent an important ongoing area of program development; in the Southern Ontario region, a basis of trust exists that can be built upon. Participating WWUD see the potential in SCS and OPS to holistically meet their needs and act as spaces that counter marginalization and foster dignity, autonomy and freedom from violence. As frontline staff and WWUD continue the conversations typified here, we hope that this report can help inform discussions about and plans to enhance inclusivity and access.

About the Canadian Mental Health Association

Founded in 1918, the Canadian Mental Health Association (CMHA) is the most established, most extensive community mental health organization in Canada. Through a presence in more than 330 communities across every province and one territory, CMHA provides advocacy, programs and resources that help to prevent mental health problems and illnesses, support recovery and resilience, and enable all Canadians to flourish and thrive.

Appendix A. Focus Group questions

Main Questions	Prompt Questions
Introductory	
Why do you use OPSs/SCSs/CTSs or harm reduction services?	
Key	
People have different comfort levels with different spaces. What sort of things would make an SCS/OPS/harm reduction space more or less comfortable?	• Do you have a preference in terms of the physical size of the SCS or the number of people? Why is that? • Are there other things you look for in a space to feel safe or welcome? (ex: door in sight, privacy) • What is the general vibe of [specific site] in your opinion? • What are some of the things you've heard people say when it comes to differences/advantages/disadvantages between sites? Did that influence your decision about which SCS to access? • Does the location of the SCS/OPS affect your decision to come? • Do the hours of the SCS/OPS affect your decision to come? • What are some good parts about coming to or being in SCSs/OPSs? What are some difficult parts about coming to or being in SCSs/OPSs? • When it comes to accessing SCSs/OPSs and its services, are there things that you think would make women decide not to use the services? (ex: personal information collection, costs for other services, involvement with legal system, stigma, distance/commute)
Can you tell me a little bit about your experience with the SCS staff?	• Can you tell me about a great experience you've had with staff? Can you tell me about a not so great experience you've had with staff? • What kind of things do you feel contribute to a great staff member? What characteristics? • How do you feel about the way staff greet you or talk with you? • What kind of behaviors or comments do you think staff should be preventing? Why do you think this is important? • What are your thoughts and preferences when it comes to the gender of the staff? Why is that? • What are your thoughts and preferences when it comes to staff having lived experience? Why is that?
What are some of the rules that SCSs have that you agree with? What are some of the rules that they have that you don't agree with? How would you like to see the rule change?	• Can you list 3 positives about having an SCS that allows assisted injections? What about 3 negatives? • How do you think allowing assisted injection in SCSs would affect women's lives? How do you think it would affect how often they visit SCSs? • Would you be interested in accessing a site that offers assisted injections? Why or why not?

	• What are your thoughts on rules when it comes to splitting or sharing drugs? • What are your feelings about how the SCS handles a situation when someone is dealing drugs in or around the SCS? • In your opinion what is the best style or way for rules to be enforced? Is it verbally or is there another way you think could work? Are there things you think staff should avoid saying when they are enforcing a rule?
Can you tell me about how safe or how unsafe you've felt coming to an SCS?	• Are there behaviors or language you've witnessed or experienced at the SCS that affected your feelings of safety? Was the issue dealt with well? If not, how would you prefer to see a situation like that dealt with? What resources or services would be helpful in a scenario like that? • What are some things you do to ensure you are safe at the SCS? Can you tell me about settings you avoid using around (whether that's times, groups of people..)? • Would you consider reporting something that made you feel unsafe to staff or to someone else? Why or why not?
What are your thoughts on women's only hours at SCSs? What about women's only SCSs?	• Would specialized hours impact your decision of when to access the SCS? • If you've never accessed women's only hours at an SCS is this something you'd be interested in? Why's that or why not? • What do you think would be some advantages or disadvantages to a women's only SCS? • Would you be interested in accessing a women's only SCS? Why's that or why not?
! Trigger warning !: In the next part of this focus group discussion we'll be opening up a space to hear about your perspectives when it comes to topics such as pregnancy, parenting, domestic violence and sex work, to get a better understanding about how these issues may affect women's access to SCS/OPS. You are in no way required to talk about the experiences you may have personally had with these issues and the questions are asked in a way that do not ask you about your experiences but instead we ask for your general input. Conversations about these topics and drug use can be triggering, especially if there are strong and opposing opinions and personal experiences at play. We ask, as we did at the start of the discussion, that everyone be respectful of different viewpoints. If you feel as though it's something you'd rather not talk about or hear about for any reason at all, this is just us letting you know that it's totally okay for you to step out of the room at this moment or at any moment over the course of the conversation. It is also completely acceptable for you to stay in the room and not engage if you would prefer that.	
How do you think being pregnant or being a parent affects a woman's decision to come to an SCS?	• How do you think people coming to the SCS/OPS can do differently to support pregnant women and parents who would like to come to the SCS? • What do you think SCSs/OPSs can do differently to better support pregnant women and parents who would like to come to the SCS?
How do you think relationships with a partner may affect women's access to SCSs/OPSs?	• Have you ever heard of someone's partner not allowing them to go to an SCS/OPS or controlling how/when they go?

	• In your opinion, does having a partner who uses drugs affect woman's access to SCSs? How? Have you ever heard of fights with a partner affecting someone's access? • What do you think SCSs/OPSs could do differently when it comes to trying to help women with an abusive partner?
What are some things you think women who exchange sex for drugs or sex for money think about when they are inside or around an SCS?	• Can you think of specific needs women who exchange sex for drug or money may have for them to have better access to SCSs? • Are there things about the SCS that you think need to change to better support women who exchange sex for money or drugs? • Can you think of resources or supplies that would be important for SCSs to provide to better support them?
How do you feel about having a space where you can talk to or hangout with other WWUD? Do you consider this an advantage of SCSs/OPSs?	• How have you noticed or experienced women supporting each other? • In your experience, do women share information among each other to help each other out? • How do you think women can do things differently to better support each other?
Closing	
If you were in charge of SCSs, what changes would you make that haven't already been discussed?	

Appendix B. Questions for one-on-one interviews

Main Questions	Prompt Questions
Introductory	
What have you noticed when it comes to women accessing SCSs/OPSs?	• How many women come to the site? • Have women shared any experiences of overdose in community? • Have women shared any gender specific issues when it comes to SCSs/OPSs?
Key	
People have different comfort levels with different spaces. What sort of things do you think are important when it comes to making a SCS/OPS space more comfortable and accessible for women?	• What are some of the things you've heard people say when it comes to differences/advantages/disadvantages between sites? • Do the majority of people who come to the SCS/OPS come regularly? Is there a demographic that's over-represented or under-represented? • Have you noticed differences in the SCS/OPS before and after the Ontario government approval of the SCS model – change to CTS model?
Are there services or referrals you believe would be important for SCSs to have for women, that SCSs currently do not have access to?	• In your experience what are the services most often used? Why do you think that is? • What are your thoughts around services that may be especially important to encourage access for women? In your experience are these services something women express interest in or use? • When it comes to accessing external services through the SCS, what are some things that you may have noticed make women hesitate or decide not to use them? (ex: personal information collection, cost, involvement with legal systems, stigma, distance/commute) What about things that make women hesitate or decide not to use internal services? • If you could change anything about the services or referrals offered, what would you change?
Can you tell me a little bit about what you spend your time doing as a staff member at the SCS and what your experience has been like?	• Did you receive any specific training around gender, sexual diversity, anti-racism, working with Indigenous women, and women's safety? • Can you tell me about any conflicts or difficulties you've experienced as a staff member at the SCS? What would you suggest to help avoid those kinds of issues? • What sorts of policies or procedures do you try your best to make sure are followed? • How do you think staff contribute to people feeling more or less comfortable coming to an SCS/OPS?
Are there rules you think are important for SCSs to have in	• Can you list 3 positives about having an SCS that allows assisted injections? What about 3 negatives?

place to improve access for women? Are there any rules you think negatively impact access for women at this SCS or others? How would you like to see the rule change?	• What are some challenges you anticipate if assisted injections were allowed at SCSs? • What are your thoughts about rules around splitting or sharing drugs? • What are your thoughts about rules around dealing drugs and how that may impact access to the SCS? • In your experience, what have you found to be the best way to enforce rules? Are there things you avoid saying to avoid conflict? What kind of messaging do you think is the most effective?
Can you tell me, from your experience as a staff member, about violence and its presence at SCSs? [Here, violence can be anything from physical violence, to threats, to verbal violence in the form of aggressive language…]	• Have you experienced or witnessed language or behaviors at the SCS that affected your feelings of safety and/or others' feelings of safety? How did staff respond? • Are there any protocols staff are asked to follow when they witness, or someone reports physical, emotional, sexual or verbal violence? • What are your thoughts about involving police or some form of security when it comes to these incidents? • What are some ways in which you think SCSs can work to prevent or diminish violence, specifically against people who identify as women?
What stands out to you as potential barriers for pregnant women or parents accessing an SCS?	• How does stigma impact access for parents or pregnant women? How have you seen stigma play out in or around the SCS/OPS space? • What are some fears that exist when it comes to SCSs/OPSs and the child welfare system? • What happens when a visibly pregnant woman comes to use the site? How are staff asked to respond? • What happens if parents bring children? How are staff asked to respond? • How do you think SCSs/OPSs can evolve to better support pregnant women and parents?
How do you think relationships with a partner may affect women's access to SCSs/OPSs?	• Have you ever heard of someone's partner not allowing them to go to an SCS/OPS or controlling how/when they go? • In your opinion, does having a partner who uses drugs affect woman's access to SCSs? How? • How have you noticed staff respond to situations involving a partner affecting someone's access to the SCS? • In your opinion, what are some important points to consider for staff aiming to help women who's access is being affected by their partner? What can SCSs do differently to reduce barriers that may exist due to partner dynamics?
What are some things you think women who exchange sex for drugs or sex for money think about when they are inside or around an SCS?	• Are there things about the SCS that you think need to change to better support women who exchange sex for money or drugs? • Are there resources or supplies that would be important for SCSs to provide to better support them?

How do SCSs benefit women and support their unique experience of drug use and overdose?	• Have you heard about specific issues women who use drugs face that have been alleviated through SCSs? • In your opinion, does the SCS create a space for women to support each other and share information with each other? Do you consider this an advantage of SCSs?
What are your thoughts on women's only hours at SCSs? What about women's only SCSs?	• Do you see women's only hours as an effective approach for reducing barriers for women and transwomen? • Can you share some of your thoughts around women's only spaces and the gender of staff, and whether or not you think that would be important to consider? • Can you talk a little bit about whether you think all SCSs should adopt women's only hours? Do you believe women's only hours are sufficient? • What are your thoughts on a women's only SCS/OPS?
Closing	
If tomorrow you were in charge of decision making for all SCSs, what changes would you make that haven't already been discussed?	

NOTES

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[3] *Ibid.*
[4] Stone et al., 2018.
[5] Stone et al., 2018.
[6] For the purposes of this research, we retain the language of "SCS" and "OPS" rather than "CTS" to recognize that there are still sites that operate as OPS without support, including funding support, from the Government of Ontario. Furthermore, the language of SCS and OPS is consistent with that used by Health Canada as well as all other provinces and territories where these services exist.
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[13] Olsen, Anna. "Punishing Parents: Child Removal in the Context of Drug Use" in *Drug and Alcohol Review* 34.1 (2015): 2.
[14] Foreman-Mackey, Annie and Cecile Kazatchkine. (2019). Canadian HIV/AIDS Legal Network. *Overdue for a Change: Scaling up Supervised Consumption Services in Canada.* Toronto, Ontario.
[15] This was because OPS were "unsanctioned" pop-up services when they first appeared, in that they were established and operated without applying for an exemption through Health Canada or from any level of government. They were therefore not constrained by federal rules that prohibit assisted injection.
[16] Government of Canada. "Supervised Consumption Sites: Status of Applications," https://www.canada.ca/en/health-canada/services/substance-use/supervised-consumption-sites/status-application.html
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[19] HIV & AIDS Legal Clinic Ontario (HALCO). "Ontario's New "Consumption and Treatment Services" Plan – Open Letter from HALCO and Other Organizations, 13 November 2018, https://www.halco.org/2018/news/cts-ont-plan; South Riverdale Community Health Centre, "Consumption Treatment Services at SRCHC: Frequently Asked Questions," 4 January 2019, https://www.srchc.ca/news/consumption-treatment-services-at-srchc-frequently-asked-questions/
[20] Canadian Mental Health Association. (2018). *Care Not Corrections: Relieving the Opioid Crisis in Canada*. Toronto, ON: CMHA.
[21] Each focus group participant and interviewee provided their voluntary and written informed consent to participate. All focus group participants received $30 in gratitude for their time; refreshments and travel/transit reimbursements were provided. One of the focus groups was conducted at a drop-in centre, in order to help us solicit and centre the experiences of WWUD but who may not be accessing SCS, and to ensure any barriers they face were represented in our findings. Ethics approval was granted by the Community Research Ethics Board. Focus groups and one-on-one interviews were recorded with participants' permission and subsequently transcribed by a third-party transcriber.

[22] This included ciswomen, transwomen, people who identify as gender fluid, and people who identify as two-spirit.
[23] Trauma-informed practice is an approach used in some health-care settings that understands that people impacted by violence and trauma could experience re-traumatization at the point of service access, and therefore to promote healing, the services should strive to support women's safety, choice and control. See Nathoo, T., Poole, N. and 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.

[24] Focus groups lasted 1-2 hours, with a break to check-in with participants and assess interest in and ability to continue the discussion. Participants were provided a cash honorarium and refreshments as an expression of gratitude for their time and stories.

[25] We thank our site partners for their participation and support: Street Health Toronto, StreetWorks St. Catharines, Regional HIV/AIDS Connection (RHAC) London.

[26] Glaser, Barney G., and Anselm L. Strauss. (2017). *Discovery of grounded theory: Strategies for qualitative research.* London: Routledge.

[27] Nathoo, T., Poole, N. and 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.