"Here, I feel completely whole": Exploring how YWCA Hamilton's Safer Drug Use Space supports women and non-binary people experiencing gender-based homelessness

“HERE, I FEEL COMPLETELY WHOLE”: EXPLORING HOW YWCA HAMILTON’S SAFER DRUG USE SPACE SUPPORTS WOMEN AND NON-BINARY PEOPLE EXPERIENCING GENDER-BASED HOMELESSNESS

By

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A Thesis Submitted to the School of Graduate Studies

In Partial Fulfillment of the Requirements for the Degree

Master of Social Work

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MASTER OF SOCIAL WORK McMaster University

(2023) Hamilton, Ontario

TITLE: “Here, I feel completely whole”: Exploring how YWCA Hamilton’s Safer Drug Use Space supports women and non-binary people experiencing gender-based homelessness

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NUMBER OF PAGES: 89 (133 including additional pages)

Abstract

YWCA Hamilton's Safer Drug Use Space (SUS) is one of only two gender-specific safe consumption spaces in Canada, and the only one integrated into an emergency drop-in program. It is widely acknowledged in both the scholarly literature and by social service and healthcare providers that women and non-binary people are vulnerable to violence and coercion when using substances around men. They also have different needs from harm reduction programs that are not always met in all-gender safe consumption sites. Furthermore, the integration of safe consumption sites in emergency shelters and drop-ins has been found to lower the number of drug poisonings in the area. This study sought to build upon this existing body of literature by speaking with service users from SUS about how they have been supported by the program in its first year of operation, and how it could be improved. Five service users were engaged in individual, qualitative interviews conducted by one of the front-line staff at SUS who is also a student at McMaster University. The "in-between" position of the researcher and previously established rapport with the participants generated nuanced insights to come out of these conversations. Four themes came out of the data: (1) the importance of positive service user/staff relationships; (2) staff knowledge and expertise; (3) SUS being considered a "safe" place and like a "home" to service users; and (4) accessibility of the space for service users being a contributor to why people return to SUS. This study revealed that aligning their harm reduction framework to include safe consumption onsite has meant SUS staff and service users develop more trusting relationships with each other. This allows them cooperate in unique ways to keep the community safe and connect service users to necessary social and healthcare supports.

Keywords: supervised consumption sites (SCS), integrated, drug poisoning, gender-specific, critical feminist theory, women who use drugs (WWUD), qualitative research, dual roles

Acknowledgements

I would like to thank my supervisor, Dr. Jennifer Ma, for all her support this year. Your kind words mean a lot to me! I would also like to thank Dr. Saara Greene, my second reader and future PhD supervisor, and Mary Vaccaro, my friend and mentor. I have learned a lot from both of you, and I am excited to continue working together.

Viv and Jason – thank you for all the pictures and Facetime calls with Hayden. They always came at the right time.

Hilary – thanks for putting up with me during that last month. You're an excellent roommate (and friend).

I would have been lost without my MSW cohort this year! You're all my favourite Fairweather study dates.

To staff and friends at SUS: you inspire me. I'm proud to grow alongside all of you.

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List of Abbreviations

CAP – Carole Anne's Place

CBR – Community-based research

CTS – Consumption and Treatment Services

DTES – Downtown Eastside (Vancouver)

HAMSMaRT – Hamilton Social Medicine Response Team

HRW – Harm reduction worker

K6 – Keeping Six

OPS – Overdose Prevention Site

OUD – Opioid use disorder

PWUD – People who use drugs

SCS – Supervised Consumption Site

SUS – YWCA Hamilton's Safer Drug Use Space (Safe Use Space)

UPHNS – Urgent Public Health Needs Site

WWUD – Women who use drugs

Prologue

I began working with women and non-binary people who use illegal[1] substances[2] during my student placement at Carole Anne's Place (CAP), YWCA Hamilton's low barrier, overnight drop-in program in 2021. Personally, I do not have experience with street-based homelessness or substance use, but something I do have in common with many SUS service users is that I live with chronic pain. I have had rheumatoid arthritis since I was a toddler. This has led to me taking numerous medications and experiencing the side effects that come with them, some of which have generated other long-term health problems for me. People use drugs for various reasons, but a lot of people we work with tell us they started using illegal substances to cope with physical, mental, and emotional pain. I know that some of my empathy for people who use drugs stems from the way I relate to the desire to treat pain that seems to inevitably return.

Currently, I work front-line at YWCA Hamilton's new Safer Drug Use Space (SUS) as a Harm Reduction Worker (HRW). SUS is Hamilton's first overnight safe consumption site (SCS), and is the first site to be integrated into a shelter or drop-in. SUS is the second gender-specific[3] SCS in Canada (YWCA Hamilton, 2022, June 16). While this program is revolutionary, it has a lot of room to grow. For my thesis, I focused my attention on SUS, pursing a project that would be feasible in the short timeframe, and useful to the SUS leadership team for our upcoming Consumption and Treatment Services (CTS) application to Health Canada (Health Canada, 2018, May 30; Ministry of Health and Long-Term Care, 2018, October). SUS is currently designated as an "Urgent Public Health Need Site" (UPHNS) (Collins, 2021, May 6). This means we can

[1] An illegal substance, according to the Government of Canada, is a "controlled substance or precursor that is obtained in a manner not authorized under the CDSA or its regulations" (Government of Canada, n.d., n.p.).
[2] I use the terms "substance" and "drug" interchangeably throughout this thesis.
[3] I use "gender-specific" to signify a program for women (cisgender and transgender inclusive) and non-binary people. A program that does not serve cisgender men.

operate "…pursuant to an agreement with the provincial…Minister of Health in order to address the [urgent public health need], and where a client can bring their own illegal substances for consumption" until September 30, 2025 (Government of Canada, n.d., n.p.). For us to be open permanently and receive government funding, we will need to transition to a CTS sooner rather than later. At this time, SUS relies on grants from organizations like the Hamilton Community Foundation and Women 4 Change (YWCA Hamilton, 2022, June 16).

Working front-line and doing research as a student with the people I work with puts me in an interesting position. I will delve a bit into how my dual roles and "space-between" insider and outsider have informed the overall direction of this project, as well as how my participants and I relate to each other in the theoretical framework section. Often SUS service users comment that they recently did a survey, or helped someone with a project, but have no idea what came out of their contribution. In response, being able to explain why certain change processes are slow while also problem-solving to get people what they need now is how I stay accountable to them (Banks et al., 2013) and make our participation in the process of research meaningful.

Since returning to McMaster University to study social work a few years ago, I have been trying to figure out where I fit into this profession. According to the Canadian Association of Social Work's (CASW) *Code of Ethics*, social workers are obligated to promote "social justice" in our work (CASW, 2005) but what this means in practice is not at all clear. My work experience before, during, and after studying social work has taught me that in most workplaces, we have space to flex our advocacy skills on behalf of service users (and ourselves) only so far before toeing the line again to protect our jobs (Hardina, 2004). Gayatri Spivak coined the term, "affirmative sabotage" to represent the "…deliberate ruining of the master's machine from the inside" (Evans & Spivak, 2019, n.p.). I have chosen to embed myself both in academia and the

social work profession. I am equally committed to "affirmatively sabotage" these two institutions from the inside over the long-term.

The political environment we work and live within often makes it easier for us to access funds for research (that as an aside may offer benefits to the people being researched) than it is to permanently fund social and healthcare programs (Paradis, 2009; Salmon et al., 2010). Funding and accolades tend to stay with the researcher, while the communities who have been mined for their expertise lack the internal capacity to action the changes the research and evaluation activities have recommended (Branom, 2012; Janes, 2016; Salmon et al., 2010). Given that I will be starting my PhD in Social Work in September, I have spent this past year of my MSW program thinking through how I can incorporate as many principles of community-based research (CBR) into my research with women who use drugs (WWUD)[4] while still getting this study completed in time to graduate. I hope this thesis reflects not only my anxieties over "getting it right," but also the genuine affection and protectiveness I feel for the SUS community.

[4] I will use the acronym "WWUD" (women who use drugs) to represent people who self-identify as women and non-binary people who use drugs throughout this thesis.

Introduction

Canada has been going through a drug toxicity crisis over the last decade. Approximately 36,442 drug toxicity deaths occurred between January 2016 and December 2022 across Canada (Government of Canada, 2023, June). In 2022, the average number of deaths per day was 10, and around half of those deaths involved both opiates and stimulants (Government of Canada, 2023, June). In 2021, YWCA Hamilton, in collaboration with Keeping Six (K6) and the Hamilton Social Medicine Response Team (HAMSMaRT), applied for a 56.1 class exemption under the *Controlled Drugs and Substances Act* (Government of Canada, 2023, July 7). Their intention was to operate an Urgent Public Health Need Site (UPHNS) (Collins, 2021, May 6; Government of Canada, n.d.) out of CAP in response to the dramatic increase in drug poisonings/overdoses occurring in and around YWCA Hamilton's MacNab Street location since the beginning of the COVID-19 pandemic (Vaccaro, 2022, August 29).

A UPHNS is an Overdose Prevention Site (OPS), or a temporary SCS established to help communities reduce harms associated with substance use during the drug poisoning crisis (Bardwell et al., 2021). Since late April 2022, WWUD deprived of permanent housing have been able to come to SUS overnight to inject, snort, or consume (self-acquired) illegal drugs while being supervised by trained YWCA and K6 peer support staff. SUS is open every night from 10:00pm to 5:00am and again in the morning from 10:00am to 1:00pm.

For my MSW thesis, I conducted qualitative interviews with five regular SUS service users in order to solicit their perspectives on how they have been supported at SUS over the course of its first year of operation. Based on my observations and conversations with service users, I believe SUS supports people in multiple ways beyond being a program where people are supervised while they use substances; there appears to be great potential for engagement and care

at SUS, too. This is important information for us to share with the community, both to strengthen our CTS application (Ministry of Health and Long-Term Care, 2018, October) and to highlight the potential benefits that this model can bring to other shelters, drop-ins, and housing programs, particularly ones that support women and non-binary individuals experiencing chronic homelessness.[5] Before I go into the details of this study, I will provide some background on CAP, the low-barrier, overnight drop-in program at YWCA Hamilton that SUS operates out of. I will also describe how the SUS program was developed to provide context for why it is important for us to demonstrate to multiple stakeholders how SUS has provided vital support to service users since it opened.

Carole Anne's Place and Safer Drug Use Space Background

CAP is a low-barrier, overnight drop-in program for women and non-binary people that has operated under a harm reduction framework since it opened as an "out of the cold" program seven winters ago (YWCA Hamilton, 2021; The Hamilton Spectator, 2017, March 14). Many CAP program participants are service restricted from higher-barrier drop-ins and shelters in the city due to substance use, accessibility issues, and behaviours related to mental health, so CAP is one of their only options left for a free bed and accessible meals (YWCA Hamilton, 2021). Being low-barrier and using a harm reduction framework means that CAP operates differently than most drop-ins and shelters in Hamilton. We operate from a trauma-informed perspective, understanding that the people who access CAP have likely had experiences which overwhelm their capacity to cope at different times, and they may respond in varied ways, including using substances (Nathoo et al., 2018; Robinson & Ickowicz, 2023). Accordingly, service users can

[5] Chronic homelessness definition: "Chronically homeless individuals tend to be intensive, long-term users of emergency hostel services and to have very high support needs…[in] addition to being compromised by serious physical and mental health conditions, individuals who experience prolonged homelessness are less likely to find sustainable exit routes, particularly with the passing of time" (Mayock et al., 2015, p. 878).

acquire harm reduction supplies from staff, and they are not barred from accessing CAP when they are substance-affected and/or exhibiting behaviours related to their experience of complex mental health challenges (City of Hamilton Community Services Department, 2009; February; Evans, 2011). Lowering barriers to entry and being thoughtful about service restrictions is important because the power difference between staff and service users is vast. Cutting a person off from service often means they get further away from working on things like housing or receiving support for past/current trauma (Rampersad et al., 2021; Robinson & Ickowicz, 2022; YWCA Hamilton, 2021).

Prior to SUS opening last year, a participant's access to CAP would only be limited if they exhibited violence towards other participants, staff, or property, or used drugs onsite. If someone were "caught" by staff using drugs inside the building, they could be service restricted for 24-48 hours. When someone is service restricted, this means they are not allowed onsite for a set period or indefinitely, depending on the offence that precipitated their restriction (Evans, 2011). All Hamilton shelters use service restriction as a consequence for using drugs onsite (City of Hamilton Community Services Department, 2009).

SUS is an SCS, which means it is a "safe, clean space for people to bring their own drugs to use, in the presence of trained staff…[preventing] accidental overdoses and [reducing] the spread of infectious diseases" (Health Canada, 2023, February 8). SCS are also known to help cut down on the amount of drug-related equipment and activity in public spaces, and bring people into increased contact with healthcare and social services (Jesseman & Payer, 2018, June). WWUD accessing CAP's overnight or day program, or living in YWCA Hamilton's Transitional Living program (TLP) can come to SUS to use their substances, procure harm reduction supplies, obtain information about and referrals to other healthcare and social service

supports, and pick up snacks, hygiene, wound care, and reproductive health supplies. Recognizing that using substances is often a coping response to life difficulties such as imprisonment, the stress of life outside, violence, and trauma (Gaetz, 2015; Nathoo et al., 2018; Robinson & Ickowicz, 2022), our service model centres the use of oxygen as our first response to a drug poisoning. This is possible because we operate under a medical directive written by a physician who allows us to work under her license and re-trains us on its application annually.

During our first year, we supported 205 unique WWUD in the community, and reversed 54 drug poisonings (Vaccaro, 2023, April 21). SUS is one of only a small handful of gender-specific programs of this kind in the world, and the only one in Ontario. Canada's first gender-specific OPS is located in Vancouver, British Columbia (BC), beside a women's housing residence (Atira Women's Resource Society, 2021, March 12; Austin et al., 2023; Thulien & Nathoo, 2017).

In alignment with using a critical feminist framework, it is necessary to understand the historical and contemporary contexts for the relationships of power and oppression SUS service users experience to understand what kind of support SUS facilitates for them (Delgado & Stefancic, 2017; Gringeri et al., 2010). I have grounded this research within the current societal and cultural contexts of the drug toxicity and housing crises which were exacerbated/made visible by the COVID-19 pandemic (Canadian Centre for Substance Use and Addiction, 2020), as well as the situational context (Hankivsky et al., 2010) that there do not exist many harm reduction spaces catered to the unique experiences of WWUD.

CAP does not serve cisgender men because it operates from the understanding that women who use drugs and have experienced trauma and/or mental illness are vulnerable to physical and sexual violence on the street and in male-dominated shelters and drop-ins (Bell &

Salmon, 2010; Boyd et al., 2020; Nathoo et al., 2018; Xavier et al., 2021). The risks associated with drug use are different for women than for most men, and they need a space where they can let their guard down (Boyd et al., 2020; Xavier et al., 2021). Research shows that women need more assistance than men to inject drugs, and they are more vulnerable to violence and coercion in that process. Women have also long been criminalized/stigmatized for their participation in sex work or using substances while pregnant, which risks CAS involvement and apprehension of their baby once it is born (Xavier et al., 2021). If women need to remove themselves from the male gaze to do a femoral or jugular "shot" then a program where cisgender men cannot access makes them more comfortable to remove the clothing they need to and have privacy too (Xavier et al., 2021). Above are examples of why we must ground the data and analysis of experiences in this research in context.

Lived Experience and Community-Based Research

Although the number of drug poisoning-related deaths in BC, Alberta, and Ontario are all rising steadily, BC leads the way in taking action to combat the most recent drug toxicity crisis (Gubskaya et al., 2023; Hyshka et al., 2017). BC was the first province to announce that the high rates of overdose deaths across the province was a public health emergency via their Ministry of Health (Boyd, 2017). The first SCS in Canada opened in Vancouver's Downtown Eastside neighbourhood (DTES) in 2003 (Bardwell et al., 2021; Boyd, 2017).

The consequences of dangerous drug policies and negligent supports for people who are unhoused are experienced almost entirely by the people who experience chronic homelessness and use drugs. I feel some of the effects as a SUS staff and as a person who cares about the people who come to SUS (Nathoo et al., 2018), but I go home to my apartment in a different neighbourhood when my shift ends (Janes, 2016). Consequently, it is imperative that PWUD are

meaningfully involved in harm reduction programs and drug policy research (Austin et al., 2023; Blythe et al., 2017; Boilevin et al., 2019; CAPUD et al., 2021). Due to the short timeframe of this project as well as my lack of research funding, I was not able to involve lived/living experience peers in the research process beyond using informally obtained knowledge from SUS service users to inform my overall research question. The fact that WWUD in our community often tell us (staff) how glad they are that SUS exists and how long they have needed this kind of space were reasons for initiating this study in the first place.

WWUD who experience chronic homelessness often need to prioritize spending their energies trying to survive rather than being involved in every aspect of an academic research process (Clover, 2011; Vaccaro, 2020). I have the time and connections to invest in this work that SUS service users do not always have. Moreover, with the resources I had at my disposal, the small investments of time and perspective I asked participants to contribute to this project felt appropriate, especially since I will continue to assist with the CTS application once this is finished. I have been upfront with participants about my perspective and stakes in this project as a student (Coy, 2006). Troublingly, community social service organizations are constantly hustling for funds to operate their programs, and the core funding for these essential services is becoming more and more scarce (Community University Policy Alliance, 2022). An integral part of demonstrating the efficacy and necessity of these services is program evaluation, which is largely done off the side of desks of people who are already over-burdened with work and under-paid. I envision this thesis work and what will follow to function as an evaluation of sorts of SUS for the YWCA, with their approval.

CBR is usually a time-consuming endeavour. Although I could not make this study a true partnership with SUS service users as CBR is meant to do, I did have an agreement with the

YWCA to conduct this study. Because I cannot offer much in the way of funding or prestige, I tried to incorporate as many principles of CBR in this research as I could. I value the knowledge and expertise of SUS service users, and openly communicate with them, as well as YWCA Hamilton leadership about my intentions with this research. The end result of this research will be used by the community to formalize the SUS program as a CTS. Therefore, this written thesis will not be the only product of this study, and I aim for it to benefit more people than just myself. I will highlight the ways I treated this study as the beginning stages of a long-term partnership between myself and this community (Branom, 2012).

Research Question

In this thesis, I endeavour to provide an explanation of how SUS has supported the WWUD who access the program in its first year of operation, as well as what aspects could be changed or enhanced to better support service users. I have collected feedback via qualitative interviews with regular SUS service users regarding how the program has functioned as a support to them, as well as what could be improved upon. I am interested in getting their perspective on the kind of supportive environment SUS functions as on top of being a place where people can use their substances while being supervised by trained staff.

When staff and SUS advocates speak to people outside of the program about the efficacy of this model, they often highlight the number of reversed drug poisonings or unique service users we have served throughout the time we have been open. I did the same at the beginning of this introduction. Social service and healthcare organizations are well aware of the fact that "[long-term] homeless individuals tend to cycle through costly emergency-driven public systems, including emergency shelters, hospital emergency departments, psychiatric departments, detoxification and criminal justice facilities" (Mayock et al., 2015). An intervention

like SUS which provides a relatively inexpensive environment where people can legally use substances indoors while being supervised by people who are trained to intervene if something happens is thus, lauded for its accomplishments by city councillors (Moro, 2023, April 8). All of this is important, but in this thesis, I will delve into the myriad of other ways that SUS benefits and supports service users. SUS is a place where people come to receive a bit of care and sustenance – in multiple forms. We offer emotional support and referrals, snacks, and conversation. We do art together! As will be illustrated my findings, people come to SUS to feel safe and speak openly about their problems with people who care about them. My experiences demonstrate the potential in this sense of security for people to engage in housing discussions, treatment options, and self-advocacy.

I interviewed SUS service users because as program staff, we have our own ideas of how the program benefits service users. While our viewpoints have value, SUS service users who use it as a life-saving service are the real experts on what they need from it. We recognize that a program like SUS, which is designed to respond to an "urgent public health need" will not do this if we are not meeting prospective service users of the program where they are at.

In the remainder of this thesis, I will provide an overarching review of the literature surrounding the impacts felt by PWUD and WWUD more specifically, as a direct result of contemporary Canadian drug policies. I will briefly speak to what a harm reduction framework involves, and how SUS as an integrated SCS fits into this framework. I will demonstrate where there are gaps to be filled in this literature with regard to qualitative research conducted by, with, and for people who work within gender-specific integrated SCS in Canada. I will next provide an overview of the critical feminist theoretical framework which has informed my interest in and

directions for this research (Gringeri et al., 2010; Salmon et al., 2010), as well as the next steps of action that will come after I hand in this paper, because the work is not done!

I will then follow my theoretical framework section with an explanation of my methodology and research methods, and a discussion of the findings that came out of the qualitative interviews I conducted with my participants. I will conclude by discussing some of the overarching themes that came out of the data, and how they fit into existing literature on SCS and gender-specific harm reduction supports. I will then use my critical feminist framework and practical experience to illuminate patterns and surprises that came out of our conversations. Finally, I will talk about what comes next for us and my final thoughts upon finishing this project and how this work will continue beyond it.

Literature Review

In this literature review, I will provide an overview of contemporary Canadian drug policy, harm reduction approaches, and integrated drug consumption spaces in community-based settings and shelters. In alignment with both my commitment to ensuring the process and results of my research is accessible to the community (Boilevin et al., 2019), as well as the reality that PWUD and allies know best how to support PWUD, my literature review contains both academic ("peer reviewed) and non-academic sources. The experts in the drug toxicity crisis are not university researchers; they are the people impacted on the ground (CAPUD et al., 2021). The range of sources I use to tell this story also reflect my dual positions in this research (researcher/front-line worker), which I will talk more about in my methodology section.

Canadian Drug Policy

Before the rise of the pharmaceutical industry in the nineteenth century, there were no regulatory bodies controlling which drugs people could and could not consume. Commodifying these substances and checking their distribution and use was part and parcel of European expansion and colonialism (Boyd, 2017). In this section, I will briefly outline the history behind Canada's contemporary drug policy, explain what a harm reduction framework is, and relate both to our work at SUS and why SCS are necessary community-based interventions in the drug poisoning epidemic today.

Drug prohibition

Alcohol, tobacco, and caffeine are examples of legal drugs we consume every day. We know that people use legal and illegal drugs for all kinds of reasons, including for pleasure (Gaetz, 2015; Zwarenstein, 2022, September 7), but it sometimes feels more acceptable to us if a person uses drugs solely for medicinal or spiritual reasons. One of the reasons this perspective is

so prevalent in our society is because we have gone through an era of heavy drug prohibition and control in Canada for over a century (Boyd, 2017; Godkhindi et al., 2022; Gordon, 2006; HIV Legal Network, 2020). Prohibitive drug policy has mainly relied on the criminal justice system to enforce punishment for those using drugs for reasons deemed inappropriate or “criminal” (Boyd, 2017; Community Opioid/Overdose Capacity Building, 2022, June). The history of our drug policy environment, available interventions, and societal attitudes towards people who use drugs cannot be divorced from the history of drug prohibition in Canada. Canada’s drug laws have long been used to control groups of marginalized people, primarily poor, Indigenous, racialized people (Boyd, 2017; Canadian HIV/AIDS Legal Network & Canadian Aboriginal AIDS Network, 2017; Community Opioid/Overdose Capacity Building, 2022, June; HIV Legal Network, 2020; Salmon et al., 2010; Zwarenstein, 2022, September 7). This is particularly true when it comes to whose activities are regulated and who is criminalized for drug use (Boyd, 2017).

French, British, and American fur traders brought alcohol over to what is now called “Canada” in the seventeenth and eighteenth centuries. For many years, they traded whisky for furs with Indigenous peoples (Boyd, 2017). As legal, political, and social discrimination against Indigenous peoples increased, alcohol was prohibited from being sold to or consumed by Indigenous peoples under the *Indian Act* up until 1955 (Boyd, 2017; Gordon, 2006). Like with PWUD who use opiates and methamphetamine today, this did not stop Indigenous peoples from drinking alcohol; rather, it just encouraged hidden, dangerous drinking practices and “illegal” business. Indigenous peoples endured harsh punishments, including imprisonment under these racialized policies (Boyd, 2017).

In the late 1800s, thousands of Chinese men arrived on Canada's west coast to work on the national railway. They were paid a third of what white labourers were paid, and many Chinese men smoked opium to relax or to relieve pain (Boyd, 2017; Gordon, 2006). Due to pressure from moral reformers who worried Chinese men would corrupt "moral" white people with their opium smoking practices, as well as an economic crash and subsequent riots in Chinese and Japanese neighbourhoods in Vancouver led by racist white labourers, the biggest shift in drug policy, the *Opium Act of 1908,* was enacted. Three years later, the *Opium and Drug Act of 1911* was passed, too. These pieces of legislation expanded police powers and criminalized the possession and sale of opiates and cocaine for non-medical use (Boyd, 2017).

During this time, thousands of immigrants were deported when arrested for possession and sale of illegal drugs. The message that using drugs led to moral depravity, and that anyone experiencing addiction was necessarily a "criminal" was spread by authorities and the media (Boyd, 2017; Gordon, 2006). The demand of Canadian state "success" and growth depended on the labour of racialized immigrants, and at the same time, authorities saw a need to control the activities of these "Others" because they posed a threat to Canada's "white bourgeois moral order" (Gordon, 2006, p. 60). After the second World War, when psychiatrists became more involved in addiction treatment, addiction was not only criminalized, but pathologized (Boyd, 2017). We still see today that the majority of people arrested and imprisoned for drug-related offences are poor, Indigenous, and/or racialized (Canadian HIV/AIDS Legal Network & Canadian Aboriginal AIDS Network, 2017; Salmon et al., 2010).

In the late 1800s, moral reformers insisted that prohibiting the production, sale, and use of drugs and imposing harsh legal penalties for people engaging in these activities, would lower drug consumption, rates of addiction, and trafficking. The series of federal drug policies based

on political and moral interests that have been enacted in Canada since the early twentieth century have not stopped the use of drugs. These prohibitive policies have actually worsened the health and well-being of PWUD and their communities (Boyd, 2017; Gordon, 2006). Drug prohibition has resulted in increased imprisonment of Black and racialized people, child apprehension from Indigenous parents, and human rights violations. Moreover, prohibition undermines health services such as prevention and treatment services for HIV and hepatitis C and leads to people using drugs in riskier ways (Boyd, 2017).

As a consequence of this history and prejudice against PWUD, abstinence from substance use and "recovery" from addiction have been the predominant goals in treatment, healthcare, and criminal justice settings, particularly since the 1970s when American President, Richard Nixon, began the "war on drugs" (Boyd, 2017; Gordon, 2006; Gwadz et al., 2021). Harm reduction approaches started to gain momentum in a few Canadian cities in the 1980s, but once a Conservative government took control federally in 2007, they replaced Canada's Drug Strategy with a National Anti-Drug Strategy which transferred responsibility for drug policy to the Department Justice from the Department of Health. We have been in a better position since the Liberal Party came into power federally in 2015, but harm reduction policy and implementation are mostly under the control of individual provinces and territories (Hyshka et al., 2017).

Morality-driven drug policy today

I have provided this short history of the lead up to Canada's contemporary drug policies which centre criminalization and police surveillance interventions (Gordon, 2006; HIV Legal Network, 2020) because this history of evolving drug prohibition can be directly linked to health and social outcomes experienced by PWUD today. Drug policy in Canada centres "…the state's concerns with disorder and social contamination" (Gordon, 2006, p. 60). This is reflected in the

ways people, particularly Black and Indigenous PWUD, are still watched, fined, and jailed for even mere drug possession. Similarly, this contributes to how severely PWUD are stigmatized for "problematic" drug use that keeps them from being "productive" workers and members of society (Boyd, 2017; Canadian HIV/AIDS Legal Network & Canadian Aboriginal AIDS Network, 2017; Gordon, 2006; Vaccaro, 2020). The answer to the question of why we have arrived at a point now where we need to regulate/get approval for sites where people can use their drugs safely even during a crisis where street-level drugs regularly cause poisonings becomes clear when we look at our history. It also helps contextualize *who* experiences the brunt of drug-related discrimination (historically and now) and risk associated with drug use/sale and why our government and people in positions of power to change these patterns are slow to act.

Morality-driven drug policies and interventions tell people to change their individual behaviour rather than looking at a person's broader circumstances and making changes to the structures and institutions within the context that a person uses drugs (Getting to Tomorrow Hamilton, 2022; Paradis, 2009). In a capitalist society where we are expected to work to survive and our productivity proves our worth as individuals, engaging in activities that compromise that productivity is considered anathema to how a responsible citizen should live (Gaetz, 2015; George et al., 2003; Paradis, 2009). Therefore, overarching ideas of use, consequences, and responses to drug use are highly individualized. It can be difficult for PWUD who experience homelessness to engage in "citizenship practice" or "participate meaningfully in society" (George et al., 2003, p. 83) because their basic human needs are not being met and they do not have a lot of opportunities to exercise agency in their daily lives (Vaccaro, 2020). Compounding on this is the fact that our governments invest a lot of money into policing and corrections

(Gaetz, 2015; Mayock et al., 2015), validating the idea that drug use is a moral issue that should be dealt with through the legal system rather than as a human rights or healthcare issue.

The Opioid Toxicity Crisis

We have been going through a drug toxicity crisis in North America, exacerbated by the increasing availability of fentanyl and fentanyl-contaminated drugs (Bardwell et al., 2018a; Bardwell et al., 2021b; Gubskaya et al., 2023; Nathoo et al., 2018; Rammohad et al., 2022). The vast majority of drug poisoning deaths are accidental, stemming from the toxic, unregulated drug supply (Bardwell et al., 2021; Rammohad et al., 2022; Zwarenstein, 2022, September 7). It is relatively easy to traffic fentanyl because of its potency; it is easier to conceal since you need smaller quantities of it to achieve the same high (Russell et al., 2023).

Fentanyl is now being cut with different products, including sedatives like benzodiazepines and xylazine[6] (Canadian Community Epidemiology Network on Drug Use, 2023, July; Dryden, 2023, June 28; Russell et al., 2023) making the street supply even more dangerous. PWUD have an increasingly difficult time gauging a safe dose for themselves. Opioids and benzodiazepines depress respiration, but Naloxone only works with opiates (CMHA Ontario, 2018; Strike & Watson, 2019). Therefore, people are becoming dually dependent on opioids and benzodiazepines and the number of drug poisonings is continuing to increase (Russell et al., 2023). If your drugs are cut with xylazine, or “tranq” then you are likely to black out, leaving you vulnerable to being taken advantage of (Dryden, 2023, June 8). Xylazine can also cause painful wounds and skin ulcers that are difficult to treat (Canadian Community Epidemiology Network on Drug Use, 2023, July).

[6] Both of these drugs are colloquially known as “benzos” and “tranq.” When they are combined with fentanyl, the combinations are “benzo-dope” and “tranq-dope.”

The number of drug poisoning-related deaths in Ontario accelerated rapidly after the announcement of a state of emergency for the COVID-19 pandemic was declared on March 17, 2020 in Ontario (Gomes et al., 2021). In 2020, 17 people per day were dying across Canada due to drug toxicity, and we saw an 89% increase in drug toxicity deaths between April and December 2020 compared to the same period in 2019 (CATIE, 2021).

COVID-19 and the Housing Crisis

Along with the drug toxicity crisis, there is a massive shortage of affordable and supportive housing in Canada due to factors including unchecked gentrification, rampant commodification of housing, and rising rent prices (Community University Policy Alliance, 2022; Bardwell et al., 2018a; Mayock et al., 2015). The links between housing stability and health are well-documented:

> People who are chronically homeless face substantially higher morbidity in terms of both physical and mental health and of increased mortality. Many people experience traumas on the streets or in shelters, which has long-standing adverse impacts on psychological well-being. These and other challenges can result in persistently high health care expenditures due to emergency department and inpatient hospital use (Taylor, 2018, June 7).

Additionally, at the beginning of the COVID-19 pandemic, everyone was meant to be physically distancing themselves from each other and staying out of public spaces to curb the spread of virus transmission (Canadian Centre for Substance Use and Addiction, 2020; Gubskaya et al., 2023). The reality of who was able to comfortably distance themselves from others "at home" and who could not was made visible on a national scale (Canadian Centre for Substance Use and Addiction, 2020; Galarneau et al., 2021; Gubskaya et al., 2023). When retail and social service organizations shut down to walk-ins and we were told by our governments and public health to "stay at home," already vulnerable populations were affected even more severely by existing systemic and structural inequities (Bryant et al., 2020; Galarneau et al., 2021). This situation

exposed to those unaware that poor and racialized people were experiencing the worst economic and health outcomes at the height of the pandemic without ready supports (Bryant et al., 2020). PWUD experiencing homelessness were among those most alienated from necessary services and supports (Galarneau et al., 2021; Getting to Tomorrow Hamilton, 2022; MacKinnon et al., 2020).

For people deprived of housing, emergency shelters end up being one of their only alternatives for protection from the elements. Besides being unsuitable for everyone's mental health and subsistence needs, emergency shelters and drop-in programs like CAP are overwhelmed by the demand, and chronically underfunded (Getting to Tomorrow Hamilton, 2022; Mayock et al., 2015; Taylor, 2018, June 7). Since I work overnights, I know that CAP turns away between five and seventeen people per night because they reach capacity. Relatedly, the use of stimulants in conjunction with opiates[7] by people experiencing homelessness has increased, especially at night, because people need to stay awake outside to keep themselves and their belongings safe (Gomes et al., 2021).

Harm reduction-centred shelter workers and advocates across Canada recognized that the context surrounding the pandemic was exacerbating the harms created by the drug toxicity crisis. Drug use (and homelessness) are both heavily surveilled and criminalized (Community University Policy Alliance, 2022; Getting to Tomorrow Hamilton, 2022; Mayock et al., 2015; Nathoo et al., 2018), which "…encourages people to consume drugs in less safe ways…and spaces…and discourages calls to 9-1-1 for overdoses" (Strike, 2019, p. 178). Harm reduction researchers assert that the increasing number of fatal drug poisonings and deaths amongst people experiencing homelessness Canada is unacceptable, and the interventions we should be

[7] This is called "concurrent" drug use – when a stimulant and an opiate are used at the same time or one after another. A "speedball" is the combination of crystal meth and fentanyl or heroin (Lukac et al., 2022).

undertaking to slow this pattern involve improving the practice of harm reduction strategies/lenses in emergency shelters (Community University Policy Alliance, 2022; Getting to Tomorrow Hamilton, 2022). As I mentioned earlier, the number of drug poisonings amongst unhoused Hamiltonians increased to a level which prompted housing advocates at the YWCA and research partners at McMaster to apply for permission from the federal government to operate a UPHNS inside CAP.

Harm Reduction Interventions

Harm reduction is a public health and human-rights centred "…set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm reduction is also a movement for social justice built on belief in, and respect for, the rights of people who use drugs" (National Harm Reduction Coalition, 2020). Using a harm reduction framework means recognizing the intrinsic value of all human beings, and centring pragmatism, flexibility and non-judgment in provision of service (CMHA Ontario, 2019; National Harm Reduction Coalition, 2020). PWUD have been fighting for harm reduction interventions which protect the life and dignity of their communities for decades (CATIE, 2021). Grassroots activists, as well as healthcare and community advocates have fought to expand harm reduction interventions over the last few years as the drug toxicity crisis has worsened in Canada (Nathoo et al., 2018). These interventions include, but are not limited to, safe consumption sites, Naloxone distribution, opioid agonist treatment (OAT), safe supply, and drug checking.

Although I focus on supervised consumption in this thesis, I would be remiss if I did not mention other interventions under the harm reduction umbrella, since those work in tandem with supervised consumption to protect life as we go through this drug toxicity crisis. I have already mentioned Naloxone, which we hand out and train people on how to use at SUS. The provision

of Naloxone kits is now quite widespread. With opioid agonist therapy (OAT), a person is treated using an opioid substitute such as buprenorphine or methadone. With a diagnosis of opioid use disorder (OUD), this treatment is effective in reducing risk of fatal drug poisoning but is not always in line with a person's goals (Gomes et al., 2022). Using a safe(r) supply means that a physician has prescribed a person diagnosed with OUD legal, pharmaceutical versions of drugs like methamphetamine or fentanyl (Lew et al., 2022; Zwarenstein, 2022, September 7). At SUS, we work with HAMSMaRT's safe supply program, Support and Safer Supply (SASS) (Vaccaro, 2023, April 1), and several SUS service users now use prescribed hydromorphone or slow-release morphine tablets. Finally, drug checking can include a range of things, but principally we deal with fentanyl-testing "strips"[8] which you can use to test if your substance has fentanyl in it (Strike & Watson, 2019), or laboratory-based analyses, which are yet to be centrally located in infrastructure accessible to the populations of PWUD we work with (Rammohan et al., 2022).

Each of these interventions receives varying levels of political and financial support from federal, provincial, and municipal levels of government across the country, (Strike & Watson, 2019). Chronic underfunding, short funding cycles, as well as social service organizations' vulnerability to changes in government and policy priorities affect what parts of a harm reduction framework are used in healthcare and social services over time (Xavier et al., 2021). One of the aims we have at SUS is to explore how we could replicate our program for people experiencing gender-based homelessness in other shelters/drop-ins that support WWUD in Hamilton. SUS is currently the only shelter or drop-in with an integrated SCS in Hamilton. The reasons for this are

[8] We are not allowed to provide people with fentanyl-testing strips at SUS because our exemption does not include drug-checking. We have noticed that people who use fentanyl-testing strips are usually using "party drugs" like cocaine, and are not unhoused.

complex, but one major barrier is the lack of government funding (Community University Policy Alliance, 2022; Schwan et al., 2021). Another reason is that some shelter providers argue supervised consumption programs are better suited for the healthcare sector, rather than the housing sector because their "focus" is on finding people housing, not addictions (Moro, 2022, December 10). I would argue that we should not silo these two issues – influential stakeholders falsely separating substance use, experiences of trauma, and housing status plays a significant role in why our communities are going through these devastating patterns in the first place.

Under the definition of "safe consumption sites," CTS and OPS are similar but different, legally speaking. Inside both, a person can bring in their own substances and use them while witnessed by trained staff without being arrested for possessing an illegal substance (Gubskaya et al., 2023). A CTS or OPS could be authorized to allow people to inject, inhale, swallow, or snort their substances. Drug checking and peer assistance with injection may also be approved for the site (Government of Canada, 2023). As I mentioned above, a CTS receives provincial funding to operate (Ministry of Health and Long-Term Care, 2018, October), while an OPS is more grassroots, needing the host organization or community to fund it. PWUD have been operating illegal SCS in alleyways, tents, and rooms for decades. OPS started as ad-hoc operations, run by PWUD and allies to respond more quickly than the government allowed to the drug toxicity crisis.

It can take several years to get approval to run a CTS, and the host must go through a time-consuming community consultation process before being approved (Ministry of Health and Long-Term Care, 2018, October). A CTS is more stable than an OPS, but operators of both must regularly apply to get their exemptions renewed. A CTS has the capacity to offer other kinds of health-related services, and they are often more clinical. Most importantly, nobody has died from

a drug poisoning at an OPS or CTS (Pivot Legal Society, 2021, August 25). Hamilton currently has one CTS, which opened with unanimous support from Hamilton's City Council after they conducted a review to determine the need for SCS in the city in 2017 (City of Hamilton, 2017, December). This CTS strives to also provide wraparound support services for PWUD, including support for mental health, addiction, peer programming, and housing.

Since it takes a lot of bureaucratic maneuvering and time to get government approval to operate a CTS (Blythe et al., 2017; Ministry of Health and Long-Term Care, 2018, October), the alternative of operating an OPS is appealing to many groups. An OPS is an inviting, community-based space where people can use drugs while being supervised by their peers, staff, and/or a healthcare provider. OPS have been sanctioned and unsanctioned, self-funded, makeshift, indoors, and integrated into existing community-based organizations and housing configurations, too (Blythe et al., 2017; CATIE, 2021). Most OPS in Canada are in British Columbia (BC), and most research on drug policy and harm reduction also occur in BC, especially in Vancouver's DTES (Hyshka et al., 2017).

Hamilton's Emergency Shelters and Drop-ins

The rate of deaths related to drug toxicity in Hamilton have been consistently higher than the provincial average since 2016 (City of Hamilton, 2023, March 8). As of February 2023, there were almost 1500 people experiencing homelessness in Hamilton, according to city data (Peesker, 2023, April 13). The highest drug poisoning activity in Hamilton occurs in Wards 2 and 3 in the lower city (Polewski, L., 2021, October 18). SUS is in Ward 2. Hamilton City Council voted unanimously to declare a state of emergency related to mental health, homelessness, and the opioid crisis in mid-April of 2023 (Peesker, 2023, April 13). Calling a state of emergency opens a pathway for the city to appeal to the provincial and federal

governments for support, particularly if other municipalities in the province do the same (Peesker, 2023, April 13). With this call, they asked the Ontario government to provide long-term funding for affordable and supportive housing, expand access to OAT, and strike down the funding cap that allows for no more than 21 CTS sites to operate at one time in Ontario (Peesker, 2023, April 13).

Groups like the Hamilton Harm Reduction Working Group (HHRWG) (of which I am a member), have been increasing the public's awareness of how many overdoses occur inside/around emergency shelters and drop-in programs (Getting to Tomorrow Hamilton, 2022). We have also been advocating to open more SCS in both places to improve safety for people experiencing homelessness who use drugs, and to reduce staff turnover due to continuous exposure to trauma from responding to drug poisonings at work without proper training and support (Getting to Tomorrow Hamilton, 2022; Hewitt, 2022, June 28; Guthrie et al., 2020; Moro, 2022, December 10; Nathoo et al., 2018; Robinson & Ickowicz, 2022). This past winter, the HHRWG called for one of the city's men's shelters to open an SCS inside their shelter after four people died in and around the shelter within two months from suspected drug poisonings (Moro, 2022, December 10). Even though this shelter allowed an SCS to operate there temporarily while they had a COVID-19 outbreak in 2021 (Lew et al., 2022) they were not willing to entertain this conversation. During that four-week period of outbreak, the initiative was successful in preventing the men using the shelter from leaving isolation by having healthcare practitioners prescribe addiction medicines onsite in a basement clinic (Lew et al., 2022). HHRWG and other harm reduction advocates use SUS as an example of a positive intervention in the rising number of opioid poisonings in the community. Since SUS opened in April 2023, we have only needed to call EMS and use Naloxone to reverse a drug poisoning

twice each, and both people were revived with Naloxone before EMS arrived. The vast majority of drug poisonings in SUS are addressed with oxygen.

Most Hamilton shelters and drop-ins are run by religious organizations that do not operate from a harm reduction perspective at a front-line level, even if some of them use that language when it is convenient to do so (Getting to Tomorrow Hamilton, 2022; Gaetz, 2015). When an organization says they operate from a harm reduction framework but have abstinence-based policies, it is confusing to both staff and service users (Gaetz, 2015; Guthrie et al., 2021; Nathoo et al., 2018; Wallace et al., 2018). When pressed on these inconsistencies, organizations cite difficulties with providing comprehensive training and education to staff who may be burnt out, underpaid, and traumatized from this work (Getting to Tomorrow Hamilton, 2022; Nathoo et al., 2018; Xavier et al., 2021). At SUS, our staff team is now specially trained to respond to drug poisonings, alleviating stress from the other front-line workers in the MacNab building who used to respond to drug poisonings around the building almost daily.

Wallace et al. (2018) conducted qualitative interviews in the DTES which highlighted the theme that “harm reduction is incomplete when harm reduction mandates [in shelters] are perceived as the distribution of supplies, in the absence of a harm reduction philosophy” (p. 88). From my experience working in a low barrier shelter in Hamilton both before and after it put an SCS in place as part of its harm reduction strategy, a lot of the reflections documented in the results section of Wallace et al.’s (2018) study mirror the tensions we also grappled with. For example, shelter residents told Wallace et al. (2018) that the disconnect between being provided harm reduction supplies at the shelter but being prohibited from using them leaves people feeling like they cannot openly access those supplies because they might be punished. Before we opened SUS, there were several CAP service users who would just go to their “favourite” staff quietly to

ask for supplies on their way out because they did not want other staff to think they might use on-site and restrict them from accessing program. Some people would even ask staff for supplies on behalf of others who do not want staff to know about their substance use. Even though we had clean equipment and Naloxone, this kind of environment does not really do much to "reduce harms" beyond limiting infection because hidden use and using alone increases your risk of fatal drug poisoning and overdose (Wallace et al., 2018). It also does nothing to change the overall context of criminalization, stigmatization, and shame associated with using drugs (Community University Policy Alliance, 2022; Nathoo et al., 2018).

As a worker in this sector, I know how difficult it is for service users who use drugs to establish trusting relationships with staff, service users, and administrators in shelters and drop-in programs. These efforts feel more futile when the messaging around harm reduction is unclear (Nathoo et al., 2018). It is crucial that shelters and drop-ins improve and clarify their harm reduction messaging and interventions because they are primary supports for people experiencing homelessness and poverty who use drugs within most provinces' poverty reduction strategies today (Guthrie et al., 2021; Nathoo et al., 2018; Wallace et al., 2018). Even with all of the evidence and case studies available which suggest that integrating SCS into shelters and drop-ins will save lives and keep substance use out of public spaces, Hamilton's Housing Services Division, which oversees shelters, continues to defer to the shelters themselves to decide whether they will integrate SCS.

The HHRWG has been meeting with city councillors, writing op-eds, and dissecting the upcoming Opioid Response Protocol and Shelter Standards that the city and Hamilton Public Health Services will be releasing in the next couple of months. In June 2023, the city announced an 18-month pilot project to help prevent drug poisoning deaths in the shelter system. They have

offered $667,000 to the three operators of men's shelters in Hamilton to integrate safer use spaces (mirroring YWCA Hamilton's SUS) (Moro, 2023, June 13). As of now, none of these organizations have taken up this call. Without clear, decisive action within the shelter system, we will continue to see people experiencing fatal drug poisonings in and around shelters.

Gender, Homelessness, and Harm Reduction

Hidden homelessness

Our awareness of the "hidden" nature of women's homelessness has increased substantially over the last decade (Mayock et al., 2015; Schwan et al., 2021; Vaccaro, 2020). I know from working at YWCA Hamilton for several years that the number of unhoused women and non-binary individuals in Hamilton is increasing steadily, and the shelter system is not keeping up with the demand for beds. Because it is unsafe for women to sleep outside on their own, a lot of women hide from public view in alleys, partner up with a man who can "protect" them, or couch surf with friends and family until they run out of options (Mayock et al., 2015). The fact that there are more shelter beds and funded programs to support men experiencing homelessness is said to be reflective of the fact that men's homelessness is more visible (Mayock et al., 2015; Vaccaro, 2020).

Shelters for women and children escaping domestic violence are separate from shelters and drop-ins for single women, but at this time, both types of shelters are working above capacity in Hamilton. Single women without children have faced enormous barriers to accessing support within the shelter and housing support services, (Schwan et al., 2021; Vaccaro, 2020), particularly if their experiences of homelessness are chronic, as opposed to episodic. The Community University Policy Alliance (CUPA) aptly describes the situation many of the women we support at SUS as them "[experiencing] multiple, intersecting systemic barriers that prevent

them from attaining, sustaining, and maintaining long-term, safe, and meaningful housing" (Community University Policy Alliance, 2022).

Women who use drugs

WWUD continue to be stigmatized and judged harshly for using illegal substances. In addition, criminalizing drug use can have violent repercussions for WWUD (Argento et al., 2023; Austin et al., 2023). Women and non-binary people are more vulnerable to violence and coercion when they use substances around men or in public places (Argento et al., 2023; Bardwell et al., 2021; Nathoo et al., 2018; Salmon et al., 2010; Xavier et al., 2021). If WWUD do not feel comfortable or safe in an all-gender harm reduction program, this leads to sharing or re-using supplies, and using alone (Austin et al., 2023; Bardwell et al., 2021; Community University Policy Alliance, 2022).

Over the last few years, our awareness of the fact that there need to be more harm reduction spaces created specifically for WWUD's needs has increased significantly. Integrating supports for reproductive health (Owens et al., 2020) and making the environment feel more "homey" have been cited as important features of women's harm reduction spaces (Austin et al., 2023). WWUD need trauma-informed, supportive harm reduction environments where they can let their guard down and connect with their community (Austin et al., 2023; Nathoo et al., 2018; Robinson & Ickowicz, 2022). Unfortunately, there are very few gender-specific harm reduction programs around the world (Nathoo et al., 2018). When they do exist, they are often just limited drop-in hours set within a normally all-gender program (Austin et al., 2023; Community Opioid/Overdose Capacity Building, 2022, October; Xavier et al., 2021).

Some researchers believe the dearth of gender-specific harm reduction programs is related to the fact that men continue to die at higher rates than women as a result of a drug

poisoning (Bardwell et al., 2021; Community Opioid/Overdose Capacity Building, 2022). However, there is evidence that the mortality rate for Indigenous women from drug poisoning is at least eight times the rate for non-Indigenous women in BC (Bardwell et al., 2021); Canadian HIV/AIDS Legal Network and Canadian Aboriginal AIDS Network, 2017; Salmon et al., 2010). This indicates to me that the range of harm reduction services offered in Canada must adapt to respond to the needs of the diverse groups that live here. Furthermore, this reasoning restricts our understanding of the benefits of harm reduction programs to being only about drug poisoning intervention.

Gaps in the literature

Some community-based research has been done around the importance of safe consumption programs being where people "live" and/or sleep (Bardwell et al., 2018a; Collins et al., 2020; Community University Policy Alliance, 2022; Guthrie et al., 2021; MacKinnon et al., 2020; Michaud & Thomas, 2020; Wallace et al., 2018). Overwhelmingly, these studies conclude that SCS in shelters, drop-ins and housing are considered effective interventions if they are well staffed, and offer supports and referrals which acknowledge the interconnected marginalizing structures in people' lives. Gender-specific drop-in programs are also cited to be sites that provide women and non-binary people with essential supports and care (Community University Policy Alliance, 2022; Rampersad et al., 2021). Women rely on drop-ins when they experience homelessness and housing precarity, particularly when these drop-ins operate as community hubs (Rampersad et al., 2021). As I will discuss in my findings, SUS service users are increasingly considering the YWCA MacNab building in the downtown core as a hub and have their own ideas of what services and supports could be added to this hub to make it even more conducive to their needs.

There is also a dearth of qualitative research done on SCS for WWUD that positions their lived experiences at the centre of the research process. Part of the reason for this is the sheer lack of SCS built for WWUD, aside from one in Vancouver's DTES (Atira Women's Resource Sociaty, 2021; Thulien & Nathoo, 2017) and SUS in Hamilton. It is hard to do research with communities of WWUD because the stigmatization of women's drug use and homelessness make it close to impossible for long-term, trusting relationships to be formed between WWUD and researchers. Our history of viewing drug use as a problem in itself rather than an attempt to cope contributes to this paradox (Nathoo et al., 2018). One of the reasons why I have taken up this project is because I sit in an interesting middle ground of front-line worker-researcher who has good rapport with service users at SUS. Having experience with working using a trauma-informed lens in providing service to WWUD, I prioritized transparency and trust-building in this exercise (Nathoo et al., 2018; Robinson & Ickowicz, 2022).

There is also limited data on the benefits of an OPS or CTS integrated into shelter and housing for women and non-binary people (Community University Policy Alliance, 2022). An early program evaluation for Vancouver's gender-specific OPS said that the integrated approach for their gender-specific program has a positive effect on uptake from WWUD (Atira Women's Resource Society, 2021; Thulien & Nathoo, 2017). PWUD and advocates in Hamilton are in the midst of having a lot of high-level conversations with stakeholders and people in positions of power about the severity of the housing and drug toxicity crises. However, because we do not have a lot of Ontario-based data about OPS integrated into shelters and housing, we face resistance from shelter and housing providers to provide these services to their service users/residents.

Opening a gender-specific UPHNS inside of an overnight drop-in program was a revolutionary move. Our UPHNS serves community members who would normally be service restricted for using substances inside the building. As I have explained, WWUD deprived of housing are often restricted from accessing shelters due to their use of drugs and/or their behaviours associated with their experience of trauma and mental health (which can lead to substance use as a coping strategy) (Nathoo et al., 2018). Even staff at CAP, a low-barrier drop-in that handed out harm reduction supplies would be forced to service restrict people who used substances onsite.

I believe that the support we strive to offer at SUS, where people can be assured their disclosures will not lead to denial of service, isolation, or judgment from staff, creates an environment where people can make connections and nourish themselves in a way that provides them the space to imagine what kinds of support they still need. There is evidence that women are apt to access a service where their relational needs are met (Community Opioid/Overdose Capacity Building, 2022, October; Community University Policy Alliance, 2022; Rampersad et al., 2021). Luckily, a key part of the way we offer support at SUS is how staff are carefully hired and trained to offer trauma-informed support which encourages mutual trust. In the remainder of this thesis, I will demonstrate how this research may assist our communities in creating more "hubs" like the one we are cultivating at SUS and YWCA Hamilton.

Theoretical Framework

In this section, I will describe the critical feminist framework I have used, highlighting how this theoretical framework informs the action-orientation of this research. I will illustrate how my understanding that "[people's] diverse experiences with drugs cannot be divorced from historical, social, cultural, psychological, biological, political, legal and environmental contexts" (Boyd, 2017, p. 3) is central to my motivation for using a critical feminist framework to complement my practice experience as a HRW. These principles informed the perspective from which I asked my questions, how I analyzed the data, and my intention to operationalize the results of this project in our CTS community consultation process (Ministry of Health and Long-Term Care, 2018, October). Ultimately, we want SUS to be permanent and government funded. The second section will frame how I reckon with my position in this work and within the SUS community, how I aim to conduct ethical research with PWUD, and my commitment to reciprocity in community-based research.

Feminist Theory

"Feminist theory" describes a broad range of knowledge. What feminism means for people changes based on who is speaking or writing about it (Gringeri et al., 2010; Rottenberg, 2013). Particularly over the last couple of decades, economic, media, and political institutions have instrumentalized narratives of choice. "Western" women are invited to be active agents in this new era of freedom and participation in public life by overcoming "individualized obstacles of race and class through individual ambition, hard work and self-improvement" (Kanai, 2015, p. 327). The most popular discussions in this popular feminism – the "wage gap," women's education, gender-based violence, women's representation in government and in positions of economic power, women's choice, women's reproductive health – are contextualized as

stemming from a desire for women to gain opportunities that men already have (McRobbie, 2009; Rottenberg, 2013).

Furthermore, we generally categorize "research" as feminist when the researcher says they have grounded their research in feminist theory and the research topic is centred on women, gender-related issues, social justice, and/or issues of power (Dominelli, 2002; Gringeri et al., 2010). For these reasons, I must clarify at this juncture that the feminist theoretical framework I have used for this research is not an individualized, "Western" interpretation of feminist theory which aims to improve circumstances of *individual* women (Rottenberg, 2013). I am wholeheartedly critical of a feminism used to emphasize individual choice and increased economic power so they can have more capital to reinvest in our economy (McRobbie, 2009; Paradis, 2009; Rottenberg, 2013). Instead, the feminist perspective I have used for this thesis is explicitly political, critical of our structures of governance and control, and aims to transform our society as a whole (Dominelli, 2002; Freeman & Vasconcelos, 2010; Gringeri et al., 2010; Hesse-Biber, 2014; hooks, 2000; Paradis, 2009). From this viewpoint, I question historical and continuing systemic inequalities that leave certain people more vulnerable to abuse and marginalization than others due to "interwoven practices of sexism, racism, misogyny, and heterosexism [which] are an integral part of our social fabric" (Mohanty, 2003, p. 3).

Feminist theory and women who use drugs

The burdens of our drug toxicity, mental health, and housing crises are being disproportionately felt by the people we support at SUS (Community University Policy Alliance, 2022; Nathoo et al., 2018; Zwarenstein, 2022, September 7). For over a century, women in Canada who use drugs have been perceived as "…more deviant than men…[and] having abandoned gender norms, incapable of being good wives or mothers" (Boyd, 2017, p. 68).

WWUD are judged more harshly than men because this behaviour does not fit the model of how our society expects women to behave (Boyd, 2017; Women and Harm Reduction International Network, 2022). This has led to many devastating patterns, including high numbers of children apprehended from poor, racialized, and Indigenous women, as well as conflicts over reproductive rights (Boyd, 2017; Canadian HIV/AIDS Legal Network & Canadian Aboriginal AIDS Network, 2017; Salmon et al., 2010; Sweet, 2019; Zwarenstein, 2022, September 7).

WWUD are at increased risk of experiencing gender-based violence and are rapidly becoming the demographic facing most frequent imprisonment for drug possession – especially Indigenous women (Canadian HIV/AIDS Legal Network & Canadian Aboriginal AIDS Network, 2017; Salmon et al., 2010). Women and non-binary people who use drugs are not-so-gently encouraged to be "legible" (Sweet, 2019) as people who are motivated to recover from their addictions so they can become productive, autonomous citizens (Butler, 2009; Sweet, 2019). When they do not fit neatly into this narrative, they are deemed undeserving of social support, making it more difficult for them to access resources, including housing and legal protection (Sweet, 2019). One of my long-term goals in research with WWUD is to interrupt this "paradox of legibility" wherein their experiences are hyper-individualized and the structural and systemic oppressions which shape WWUD experiences, as well as their resiliency/coping strategies are erased (Sweet, 2019).

Intersectionality

The lens I have used to analyze this work is heavily influenced by the intersectionality of oppression research paradigm, popularized by Kimberlé Crenshaw (Crenshaw, 1989; Crenshaw, 1993). Intersectionality expands upon standpoint theory, which argues that we should flip whose perspective influences research priorities and policy priorities from those at the "top" of social

hierarchy to those at the "bottom." This is because the (often devalued) experiences/perspectives of those most marginalized can help us work through significant social problems (Harding, 1993; Gringeri et al., 2010; hooks, 2000; Paradis, 2009). We also understand that all knowledge is situated in the subjectivities and knowledges of people, therefore any knowledge uncovered through research processes will not be an objective "truth," it will be an interpreted, partial truth. In line with this thinking, I decided to interview SUS service users for this project to get their viewpoint on how the program has supported them, rather than relying on just our statistics, or the perceptions of the staff and leadership teams (Gringeri et al., 2010). I also do not distance myself at all from this narrative I am creating, exposing my emotions and position throughout so I stay accountable to the story and the SUS community (Collins, 2000).

Importantly, a key assumption of the intersectional theoretical paradigm is that different dimensions of identity and social life cannot be examined individually, and we cannot essentialize the experiences of any group (Crenshaw, 1989; Crenshaw, 1993; Hankivsky et al., 2010; Lorde, 1984; Paradis, 2009). Intersectional analysis compels us to investigate, understand, and respond to the experience "…at the intersection of two or more axes of oppression…[recognizing] the multidimensional and relational nature of social locations and places lived experiences, social forces, and overlapping systems of discrimination and subordination at the centre of analysis" (Hankivsky et al., 2010, p. 3).

As a critical feminist researcher, I understand that different parts of our identities and histories are linked to and affected by power structures in complicated ways (Gringeri et al., 2010). WWUD who experience homelessness are not just making "bad" choices to use drugs and not have housing out of nowhere, or because they are inherently deficient in some way (Paradis, 2009). Without this understanding, I might elide the experiences of some of the WWUD at SUS.

Importantly, this perspective also demonstrates how differences in identity and experience are sites of knowledge. They help us discover creative ways to work in solidarity to create change (Gringeri et al., 2010; Lorde, 1984b) and allow us to extrapolate lessons learned at the level of the "particular" to help understand issues/dynamics at a "global" level (Mohanty, 2003, p. 501-503). Essentially, insights gained through research and advocacy with WWUD at SUS can teach us all lessons we can apply/adapt beyond that context too.

Methodology and Methods

In this section, I will describe my overall methodology as well as the particular research methods I employed in this study. I will explain how both my methodology and methods are informed by critical feminist theory, as well as my position as an "in-between" researcher who works front-line with the people who participated in the project.

Methodology

A qualitative researcher engages in social research analyzing text to understand relationships and meanings in social life, "…and asks open questions about phenomena as they occur in context rather than setting out to test predetermined hypotheses" (Carter & Little, 2007, p. 1316). I came into this project with specific thoughts about how SUS functions as a supportive space for service users from my perspective as a staff who has worked there a minimum of two shifts per week since the program opened. As I have previously mentioned, we do a lot of informal, collaborative reflection within SUS around what service users get out of the space and how they want the program to run.

In line with critical feminist theory, I sought to engage participants in conversations about their experience of receiving support at SUS, with the intention of instrumentalizing these insights from people who are normally marginalized by social services based on their interconnected identities to: (1) enrich our presentations to community partners and Ward 2 residents about the benefits SUS brings to service users during CTS community consultation; (2) contribute to the model-creation activities harm reduction advocates in Hamilton are engaging in right now to integrate more safer drug use spaces in shelters and drop-in programs that support WWUD; and (3) continue adapting our program to meet the needs of the people it serves.

Before I got ethics approval and began my interviews, I sought permission from my department at YWCA Hamilton (Housing and Gender-Based Violence Support Services) for me to undertake this research. I did not have to rely on a referral to speak to service users, but I did have to run the project by my supervisors so we could create a plan to keep us all accountable within our roles at the YWCA. I co-developed a Memorandum of Understanding (MOU) [Appendix A] with a Senior Policy Analyst and the Director of Housing and Gender-Based Violence Support Services at YWCA Hamilton. The organization had not been in a situation like this before, where they had a front-line staff who wanted to do an academic research project with service users of a program they currently work in.

A process for this was piloted by me for this research so the leadership team in my department and I could have an understanding between us of what my intentions were for this work, as well as what plans I had for ensuring I did not put undue pressure on service users who rely on the program. We also agreed that this research and the findings would not just stay with me and the university – I will be submitting a visually appealing plain-language summary of the project and findings to the department which can be disseminated to service users, stakeholders, and posted to the organization’s website after my oral examination so the products of this work are accessible to the people we work with and the broader community (Boilevin et al., 2019; Paradis, 2009).

Researcher reflexivity

Before I delve further into the details of this study, I will situate my position within this research project because unpacking my “conceptual baggage” (Coy, 2006) to illustrate what informs my interest, investment, and perspective on this work, is a central tenet of feminist research. Also, as a graduate student and front-line worker doing research for my education in

my workplace, I occupy a position that requires me to be introspective about my influence on data and service user participation in this research.

A. Insider/outsider or the "space-between"

In the extant literature about occupying the researcher's role in relation to participants in research, authors question whether being an "insider" means that someone is positioned to understand the experiences of research participants better than an "outside" researcher (Kerstetter, 2012). For example, I could be considered an "insider" because I am staff at SUS, whereas one of my classmates who has not been to SUS at all would be considered an "outsider." If one of my classmates decided to do a similar project as mine at SUS, they might not have the understanding I do about what topics to explore because they lack context. Potential participants may also trust them less to represent their story well in the research because they have not seen them in their community, and they may lack familiarity with the community's language or norms. It takes time and considerable effort to develop trusting, collaborative relationships between researchers, community organizations, and service users (Minkler, 2004).

Aside from my employment at SUS making me an insider to the community, I have lived in Hamilton all my life, and am immersed in the study and advocacy related to experiences of gender-based homelessness and substance use. I rent a small apartment with a roommate for way more money than it is worth, and I have seen my grocery bills climb over the last year. I have long-standing connections within the YWCA and have worked with the people who use SUS for several years as a front-line staff and in volunteer roles. This is all to say that I am not a total outsider coming to SUS just to study this community, manufacturing a relationship that did not exist quickly because I want my agenda to align with their interests (or vice-versa) (Janes, 2016).

The differences in power dynamics between "insiders" and "outsiders" as well as the time it takes to develop a collaborative relationship in community-based research are two factors Minkler (2004) mentions that are very relevant to my project. The fact that I work at SUS means I had "access" to participants for this research. Another angle I had to think about is that I have worked at YWCA Hamilton for almost six years, in many departments. I am also a student intern working with YWCA Hamilton through McMaster's Community Research Platform. Even compared to other staff at the organization, I have a heightened ability to initiate any research in this area altogether.

Up to this point, I have stated a few ways I am "inside" the SUS and YWCA Hamilton communities, but there are also a lot of ways in which, to SUS service users, I do not fit as an insider (Kerstetter, 2012). Principally, I can leave work and not be "in" the community, experiencing the barriers and prejudices that people who are unhoused and use substances encounter daily in Hamilton. I am certain that there are a lot of things service users decide not to tell me, not necessarily because they do not trust me, but because I cannot possibly understand everything that they are experiencing, no matter how much I listen and observe. Although I have worked in social services for several years, I have only been employed in the housing sector since 2021. I have multiple postsecondary degrees, do not plan to work front-line in housing support long-term, and I do not have any personal experience with homelessness or illegal drug use. I have long-term ties to a university, and I am embarking on a career in research.

As much as I care about the longevity of SUS and our service users, it remains true that engaging in this project will help me professionally. Aside from the ways my identity and history affect how I come to this work, I will benefit from being able to get this project efficiently due to my connections in the community, allowing me to get my MSW and move on to my PhD. Most

of my education is now in the field of social work, and a lot of SUS service users have had negative encounters with social workers over the course of their lives (Alexander & Grant, 2009; Branom, 2012; Gallop, 2013). These are factors I cannot change about my history, and they inform the lenses I use towards my work and education. They make research seem like a viable option for achieving change and provide me with an avenue to do so. They have also led me to my current frame of mind wherein I think it is worth doing research within the field of social work to improve care and peoples' wellbeing, even though social workers have enforced oppressive systems and policies through their work in the past (and present) (Branom, 2012; Gallop, 2013).

After much consideration, it might not be possible to concretely define anyone strictly as an "insider" or "outsider" (Kerstetter, 2012; Minkler, 2004) to the SUS community. In fact, the "SUS community" does not even exist as a group of people with the same backgrounds, interests, and aspirations for their futures. Our identities are dynamic. SUS service users themselves want some – but not all – of the same things from gender-specific harm reduction supports. Due to their housing status and scarcity of funds, they have some of the same needs for shelter, but overall, their goals for their substance use journeys and lives are diverse (Guthrie et al., 2021).

Kerstetter (2012) tells us how we need to move beyond the insider/outsider dichotomy and instead "…emphasize the relative nature of researchers' identities, depending on the specific research context" (p. 100). While there are some parts of our identities that stay the same (e.g., race, country of origin) even what those parts of our identities *mean* can change depending on the context we are in. Kerstetter (2012) talks about the "space between" being an insider or outsider to research, and our responsibility to understand where we are positioned and

affected in our research process and outcomes. I am more than one Steph when it comes to SUS. For example, when I am at SUS as a staff member, I shift into a position where I use the skills and knowledge imparted to me as being part of my role. I occupy a position of power in relation to SUS service users and am a gatekeeper to the program (Alexander & Grant, 2009; Gallop, 2013). When I am a researcher and student, I am forced to talk about SUS and the people who use our program in a way that is more detached than I would like, but I have access to language and literature that can help further organizational and service user goals. The above description of my "self" in relation to SUS service users and this work is quite simplified, but I hope it helps illustrate how I sit in a "space between" (Kerstetter, 2012) as I move through this project and continue to work with SUS service users as a researcher going forward.

B. Dual roles in research

Another tension I have had to contend with throughout this process is the dual role I play as a front-line staff and a researcher. Coy (2006) discusses the ethical dilemmas she faced while doing her doctoral project with sex workers who she had previously established relationships with through her job as an outreach worker. I conducted interviews with SUS service users who I know through being a staff in the program; the participants in both mine and Coy's (2006) research projects are all users of a healthcare-centred service we help provide. This means we have prior knowledge of participants' histories that could add depth to our interpretations and the project in general, but we act as gatekeepers of sorts and may also be impeded by "…concern for the women as their support provider first and foremost" (Coy, 2006, p. 419). If I were a researcher who had no prior knowledge of our SUS service users, I might have asked different questions of SUS service users or pushed for more detail when they gave me a response because I would not know about triggers or subjects to stay away from that are particular to that person.

Overall, I appreciate having this knowledge because my position as a carer for them should not be deprioritized next to the goal of collecting data for the purpose of this project.

Aside from demonstrating to stakeholders and the Hamilton community all the wonderful ways SUS provides support to service users, the final narratives I am producing for this thesis help shore up my influence in the field of gender-based housing and substance use supports in academia. Anything I produce about this will undoubtedly be mediated through me and my history with this work (Taylor, 2008). Additionally, the practical parts of the research like interviewing and recruiting participants meant that I had to be careful with how I approached people with the project and separated "staff Steph" from "researcher Steph." A couple of ways I have tried to mitigate some of these tensions is by having discussions about my positions with my colleagues at both the university and at work, and by keeping a journal throughout the course of the year to note thoughts about the project as they came up for me.

The way research is usually framed as an intellectual pursuit where we are meant to keep a distance from participants to protect them from influence or coercion is at once good and frustrating. I interact with these folks all the time, and it is crucial that CBR for the purpose of creating change in the institutions that support WWUD be conducted with people service users know and trust (Banks, 2013; Israel, 1998; Paradis, 2009). The trouble is, although I have been cultivating this trust through my work and I can argue that this helps me respond to ethical issues with intention, there is always a chance that I have missed something. Coy (2006), in her dual role as an outreach worker and researcher with women engaged in sex work, says, "…in terms of eliciting information for the research process, my relationship with the women *hindered* some disclosure because of my existing knowledge of their lives" (p. 426). Something like this happened in one of my interviews. The participant referred to a conversation we had the week

before, and I had to awkwardly find a way to ask them to explain what they meant during the interview. Within the parameters I had to work with, I had to be very intentional in my choices and actions for this research to not be a merely extractive thing where I did a project just so I could get my degree (Paradis, 2009).

Kerstetter (2012) mentions a particular perspective that is discussed in CBR literature where outside researchers might be more useful to research projects because of their lack of personal and emotional connections to the community. Presumably, the distance might make the research process more efficient. But then where is the researcher's investment in action coming from? Will the project be followed through to the end? How will we work to ensure that the action informed by the research has a chance of being realized? I am a student intern with the Faculty of Social Sciences' Community Research Platform (CRP), and we have seen this issue come up again and again through the CRP this year. While a lot of the follow through problems after a study are a result of low financial and institutional capacity in the partner organization, some of it may also be due to lack of investment from the researchers who were outsiders and have moved on to other projects and priorities. I do not claim to be the *best* person to lead this kind of research at SUS, but I do have the will and capacity to follow it through and learn from it long-term.

As an intersectional feminist researcher and social worker, I have centred oppressed groups in my analyses, challenging traditional ways of knowledge production and meaning creation (Dominelli, 2002; Hesse-Biber, 2014; Gringeri et al., 2010; hooks, 2000). Lorraine Code (2014) says that proponents of mainstream epistemology still believe "any thought that aspects of a knower's subjectivity or situation could count as conditions for the possibility of knowledge [is] taken as threatening relativism" (p. 150). I keep coming up against issues with me being a

front-line worker doing research with people I work with. I get asked often if there is a conflict of interest there, and some people question if it is ethical to pay people who use drugs to participate in research (Bell & Salmon, 2010). The fact is that as a staff I am regularly around the program's service users, who are the experts on what they need from it (Alook et al., 2020; Boilevin et al., 2019; Dominelli, 2002; Gringeri et al., 2010).

Method

Recruitment

One of the most impacting factors I had to keep in mind as I did this study was the short time-frame I had to get this project done. I had to be thoughtful about how I collected my data with my participants who are often deprived of familial and institutional supports that might keep them grounded in one place for long (Abrams, 2010; Salmon et al., 2010; Vaccaro, 2020). Conducting research with populations of people who are "hard to reach" (Abrams, 2010) is typical in the field of social work. Furthermore, qualitative research, unlike quantitative research, is not meant to be "'representative' in the sense of seeking to approximate known population parameters" (Abrams, 2010, p. 537). For a project like mine, it would not have made sense to randomly sample from SUS service users. The population of people who access SUS sometimes pop in and out of the program depending on where their life is at, and it can be hard to get hold of them even if you schedule an appointment in advance. If I had randomly selected a service user from our pool of people who have accessed SUS over the course of the first year, I might have picked people I could not locate or who accessed the program once to pick up harm reduction supplies. Given my time constraints, and the end goal of using the insights from this study to help with our community consultation activities in the fall, it made sense to interview people who have shown their "commitment" to the space by accessing SUS on a regular basis.

I did not have to create a recruitment poster or go through a screening process because I interviewed five "regular" service users at SUS who I picked based on criteria I deemed to fit the definition of someone who accesses SUS on a regular basis. For the purposes of this study, I have defined this as someone who comes to SUS at least twice per week and stays in the space for a minimum of 30 minutes per visit. I also used my own judgment as a staff who has worked in the program from its inception to choose five participants who reflect the diversity of our service users in terms of identities as well as drug of choice and method of drug consumption. Although researchers who do qualitative sampling usually recruit participants until they reach "theoretical saturation," (Abrams, 2010) rather than predetermining the total number of participants whose insights they want to solicit, I had to limit my number of participants in order to finish this project on time.

I approached the service users I interviewed at SUS directly on days when I was not scheduled to work so there was less pressure on them to agree to participate since they would be around me while they are using their substances. I approached them in person because many SUS service users do not have regular access to phones or internet for me to ask via phone call or e-mail (Paradis, 2009). I used my recruitment script [Appendix B] and provided each participant with a copy of the script, as well as the questions I would ask so they could take time to decide if they wanted to participate on their own time without me standing in front of them. Every participant said "yes" during our first interaction. I strategized with each participant when and where would be best for them to talk to me, and I worked around their schedules. As per the MOU, I made sure that I interviewed participants more than 24 hours after I worked a shift. This was a bit difficult to do because I could not be around the participants to remind them of our appointment time.

Consent

Before beginning the interviews, I went through a letter of consent with each participant [Appendix C]. Some researchers question whether PWUD who are not seeking treatment for their drug use are capable of giving their informed consent to engage in research (Salmon et al., 2010; Bell & Salmon, 2010). I do not agree with this assumption, which I believe infantilizes and takes agency away from PWUD.

Although there are conflicting views in the literature on paying PWUD who experience homelessness to participate in research because of the "exchange" of their experience for money being potentially unethical, as Salmon et al., (2020) point out, "[for] many women surviving in this context, earning money by participating in research is a far safer way of making ends meet than some of the alternatives provided by the…underground economy" (p. 340). Beyond this, I want to value the time and effort my participants bring to the research for the community. According to advocacy organizations run by PWUD, best practices of doing policy and research work with PWUD is that cash is best because a gift card signifies that I might be trying to control what they do with their money (CAPUD et al., 2021; Touesnard et al., 2021). Due to long-standing prejudice in our society against PWUD, it is best to give them cash whenever possible.

I chose $30.00 as the honorarium amount because best practice in payment for a PWUD to participate in a focus group, interview, or meeting is between $25.00 and $30.00 per hour, depending on the living wage of the province you are in (CAPUD et al., 2021; Touesnard et al., 2021). To respect the expertise and time they brought to this research, I went with the highest end of that recommended scale. The $30.00 honorarium was paid for by me out of pocket. While I did receive approximately $250.00 from the Social Work department to help fund my research, I would have needed to give the participants gift cards to be able to claim those

expenses. The $250.00 from the department went towards the snacks and art supplies I brought to each interview instead.

Although I have prior relationships and rapport established with the participants, it was important to me that I be honest about what this project can and cannot do for SUS service users, as well as how it is ultimately a project that could bring benefit to me professionally (Boilevin et al., 2019). I told them about my hopes for the findings to help with the CTS application, as well as the importance of us telling people how necessary programs like this are to our communities. We chatted together about how we already engage in a lot of honest conversations at SUS about what the program does well to support the people who use it, what we could do better, and what barriers exist that might keep us from doing everything we want to (Boilevin, 2019).

Data collection

I engaged in individual, semi-structured, qualitative interviews (Alexander & Grant, 2009; Blakely & Moles, 2017) with the participants I recruited from SUS to uncover themes regarding how they understand SUS to be a supportive space. I made the decision to just do one individual interview per participant for this study because with my short timeline, I did not want to add the pressure of having to try to retain my sample over the course of multiple interviews, or arranging one time for a focus group where people might forget or be unable to attend (Abrams, 2010). The population I work with at SUS is transient, experiences homelessness, and use drugs (Vaccaro, 2020). Many also have experience with institutionalization (mental health and carceral), as well as disabilities and mental health struggles (Abrams, 2010; Paradis, 2009; Salmon et al., 2010; Vaccaro, 2020).

Interviewing can be a site of critique because participants have an avenue to tell their stories (Alexander & Grant, 2009; Blakely & Moles, 2017; Gringeri et al., 2010). However, the

staging/process of an interview can make someone feel vulnerable (Gringeri et al., 2010; Hesse-Biber, 2015), especially people like the participants I interviewed who use substances and have experienced chronic, long-term homelessness (Bell & Salmon, 2010). Both substance use and homelessness are criminalized and stigmatized in our society, particularly for women (Salmon et al., 2010). If participants did not trust me, they would likely (and understandably) not share their experiences accessing support at SUS truthfully. Feminist theorists agree that there is transformative power in storytelling (Clover, 2011; Dominelli, 2002; Gringeri et al., 2010; Hesse-Biber, 2014). However, data collected in an interview, particularly one semi-structured with questions and with direction imposed by me (the researcher) generate partial perspectives that are then interpreted through the researcher (Alexander & Grant, 2009; Hesse-Biber, 2014).

As I have previously stated, being flexible with the timing when doing research with PWUD is important (Salmon et al., 2010). Like Coy (2006), I did not have to negotiate through gatekeepers to “access” SUS service users to set up or conduct interviews since I see them regularly through my job at SUS. Where this can get complicated is that this group moves around a lot out of necessity and have a lot going on in their lives (often related to generating income) that I do not have knowledge of (Clover, 2011; Schwan et al., 2021; Paradis, 2009; Vaccaro, 2020) and which can keep them from accessing SUS for long periods of time. It is in these instances where my “outsider” status is most pronounced.

Even beyond service users at SUS having complicated things happening in their lives that keeps them from coming to SUS regularly at times, their contact information and lack of fixed address just in general means they are hard to locate (Clover, 2011; Vaccaro, 2020). Additionally, a lot of people who use substances in our program usually ask us for reminders for appointments because it is difficult for them to keep track of time. However, since I was only

interviewing five participants, it worked out in the end. Three of the times I came in to do the interviews, the person I had agreed to meet was not around. Eventually, I found everyone, and they said they were happy I had been persistent.

In alignment with critical feminist theory as well as my practical knowledge of the participants, I paid particular attention to the environment I created for the participants to share their perspectives (Gringeri et al., 2010; Hesse-Biber, 2014). This was done in an attempt to mitigate some of the ways a contrived, formal interviewing structure could mirror other interviewing experiences SUS service users engage in where they have to tell their stories “the right way” to access the supports they need in other social service and healthcare contexts (Blakely & Moles, 2017; Sweet, 2019). All the interviews were hosted at SUS after program finished. I provided participants with colouring pages/instruments and snacks, to have conversations that feel organic and like an extension of what we already do at SUS. Snacks and drinks stayed out throughout the interview, so participants were eating as we chatted. Art supplies were available, and if they asked to take the supplies with them, I said they absolutely could. I donated anything left over after each interview to SUS. I will stress here that even though I wanted these conversations to feel “natural,” interviews are not a natural way of talking to people out in the world (Arieli et al., 2009). This is a performed interaction between interviewer and interviewee, not exactly like a chatting we do when someone is preparing their shot or colouring at SUS.

Each participant filled out a demographic questionnaire before we started their interviews [Appendix D]. Following the questionnaire, I asked each interviewee 8 pre-determined questions, along with relevant probes as suited the flow of each conversation. The full list of questions is in Appendix E. The questions I asked in the interview were almost exactly the same

as questions we already ask SUS service users about what they think about how the program is structured and operates. I have a lot of respect for the people who come to SUS again and again, knowing that they rely on someone to help keep them safe when they are using. The fact that I did not ask questions which are too personal to participants helps me justify to myself (a bit) why I did not use a method of data collection that is more intentionally therapy-focused. I hope that by recreating some of the conditions of our program in the interview itself, I provided a bit of a therapeutic element to my research process, or at least did not cause them more anxiety through this experience than they would feel on an average day visiting SUS.

As we went through the questions, I let participants interpret the question however they wanted to. If I thought they might feel like they were repeating themselves with a later question, I would re-word it and use that opportunity to probe a bit more into something they had mentioned earlier that related to that question. These questions were all very open-ended, and through the course of our conversations together we also brought in examples from our shared experiences of the program. There were moments where we were struck by how funny it was for me to ask a question that seemed to have an obvious answer.

Each of the recordings for the five individual interviews lasted between 15 and 40 minutes. I set aside up to one hour for each interview, and that was plenty of time for each participant to review paperwork, fill out the demographic survey prior to the interview, be interviewed, and eat their snacks. I gave each participant their $30.00 honorarium before we began the interview, clearly stating to them that I was grateful for their assistance with this research and that I was giving them their honorarium in advance because they could withdraw at any time without fear of losing out on the money.

To wrap up, I told each participant that they could expect me to not discuss this interview with them the next time they saw me at SUS, as per my MOU agreement with YWCA Hamilton. To help keep my researcher and staff roles explicitly separate, I ensured that we were double-staffed on my next shift at SUS after each interview. This way, if someone needed to bring something related to the research up while I was on shift, I could step away with the participant without neglecting my responsibilities to other SUS service users.

Data analysis

I engaged in a thematic analysis of the data using the process described by Castleberry and Nolen (2018). According to the authors, a thematic analysis generally consists of five steps. In my "compiling" stage, I transcribed the audio recordings of the interviews myself within 24 hours and deleted the recordings upon completing the transcription. I transcribed the interviews by ear rather than hiring a transcriptionist or using software so I could stay "close" to the data and because of my small sample size (Winterberry & Nolen, 2018). As I transcribed the interviews, I remembered thoughts I had while I met with the person, and had a chance to reflect on things I had missed during the interview itself.

I was not able to return to the participants for assistance with data analysis due to time constraints. Still, I gave each participant the opportunity to go through their transcripts once I had transcribed the interviews myself because I am aware of how ongoing consent in this process is essential yet difficult to attain with people who are transient (Abrams, 2010). Only two participants took me up on this offer, and both said they were happy with what they had shared. The other three participants said that they trusted me to know what they meant. While flattering, I knew to take this trust very seriously. I met the two people who elected to review their transcripts at SUS on a day I was not working. I then anonymized the data, and I assigned each

participant a pseudonym based on the names of the five original baby-sitters from the 'Baby-Sitter's Club' book series, since that was brought up during one of the interviews.

After this, I conducted a thematic analysis of the transcripts, which was partially grounded in themes I derived from my literature review, as well as through insights from my critical feminist theoretical framework and my professional experience as a SUS staff member (Ryan & Bernard, 2003). However, I also left myself open to employing an inductive approach to uncovering themes that came out of the interviews in case ideas came out that I had not thought of before (Ryan & Bernard, 2003).

To conduct my thematic analysis of the interview transcripts, I first read through each transcript three times. Next, I consulted my notebook where I had been noting reflections throughout conducting the research, as well as the handwritten notes I had taken during the interviews, and added some reflections post-listening to the transcripts about what themes I could see coming out of the data. In the "disassembling" stage of thematic analysis, I colour-coded direct quotations from the transcripts in their own Word documents to match three dominant themes I had identified, italicizing and bolding some of the quotations to indicate sub-themes. To identify themes and sub-themes, I searched for repeated ideas, phrases, and words. These were all filtered through the lens of my feminist thematic framework. I then identified similes and metaphors being used by participants to describe their relationship to and feelings felt within SUS (Ryan & Bernard, 2003).

Throughout these readings, I underlined any words that indicated "causal" relationships, such as "because" or "since" (Ryan & Bernard, 2003). Next, I took specific, similar lines said by different participants and compared them to each other, asking myself if I could identify similarities and differences between what the participants were saying on a similar theme (Ryan

and Bernard, 2003). Last, I asked myself if I noticed anything "missing" from what had been shared by participants (Ryan & Bernard, 2003). This helped me think through some of my preconceived ideas of what I thought would come out of the data, and highlighted areas for future inquiry.

I "reassembled" the information by putting like with like into context with each other, based on my interpretation of what matched. I copied and pasted each "cut" section into other Word docs where I could analyze similarities and differences between and within participant accounts under preliminarily identified themes and sub-themes. I moved things around a lot and repeatedly compared lines (Tie et al., 2019), eventually narrowing the data to four main themes. I drew on critical feminist theory to inform the connections I made, focusing on mentions of power in relationships and identity differences/similarities as they related to support in harm reduction and safe consumption. Because I also have some "fluency" in the language and context in which the information shared by participants comes from due to my role as a SUS staff (Ryan & Bernard, 2003), I was able to code the data beyond searching for repetitions; I was able to look for metaphors and linguistic connectors and make inferences on what those mean with respect to participants' perspective on the SUS environment. Using a journal to note my reflections during data collection and discussion phases to help me think through the effects I might have on what participants told me, as well as how I would interpret and analyze patterns from the data based on who I am (Clover, 2011).

I did not use any software or solicit assistance to analyze the transcripts. I "eyeballed" the data (Ryan & Bernard, 2003), which took a significant amount of time. However, given my familiarity with the participants and the program, it was not as strenuous a task as it could have been were I a researcher who was more of an "outsider" (Winterberry & Nolen, 2018). Finally, I

"interpreted" the data, analyzing it (Winterberry & Nolen, 2018) with assistance from my critical feminist framework, insights from my literature review and my professional experience. Following this, I "concluded" by tying my analyses back to my original research question (Winterberry & Nolen, 2018) and thinking through the usefulness of this data for the CTS application and our future work at SUS and beyond. I will demonstrate what came out of both of these stages in my findings and discussion sections.

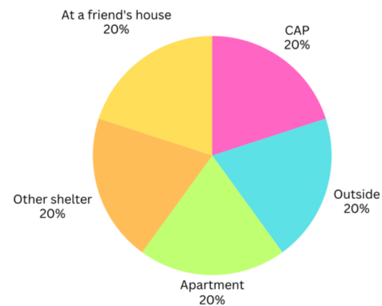
Findings

In this section, I will explore four main themes that emerged from the interviews I conducted with Kristy, Mary-Ann, Claudia, Dawn, and Stacey: (1) caring relationships with SUS staff leading to regular visits, (2) SUS staff knowledge and expertise around harm reduction as a major contributor to trust-building, (3) SUS as a safe place and feeling like "home," and (4) accessibility in terms of hours, location, and services. I will begin with a bit of context around how "well" the participants know SUS. Kristy, Mary-Ann, Claudia, Dawn, and Stacey fit my definition of regular service users at SUS. Kristy told me she comes to SUS "…four times a week, probably? Quite a bit." Mary-Ann comes "all the time," and Stacey said:

> I go to the safe use space every night. Even if I'm not necessarily using right away or anything, or I'm out of stuff, I'm just gonna hang out for a little while. I usually find something throughout the night to do and I just come back, even if it's just something small, I use, I just grab a kit and use.

So even if Stacey does not come to SUS with the specific intention of using, she pops by to "hang out." Claudia comes to SUS "at least once a week" and Dawn told me that when she first learned about SUS, she came about once a week, "and then can came to…over the course of the year, maybe twice a week, then three times a week." The following visuals demonstrate relevant demographic details of the participants in this study:

Age	Gender Identity	Where were you born?	Preferred substance(s)
31	Trans woman	outside Canada	crystal meth
34	Gender Fluid	Canada	crystal meth
38	Cis woman	Canada	crystal meth,
41	Cis woman	Canada	dope, crystal meth
56	Cis woman	Canada	dope, weed



Race/Ethnicity Self-ID	Number of Participants
White European	3
Black Caribbean	1
Indigenous/First Nations	1

Disability/Chronic Health Self-ID (could choose more than 1)	Number of Participants
Deaf/Hard of Hearing	2
Mobility Issues and/or Chronic Pain	3
Psychiatric and Mental Health	2
Addictions	5
Memory Issues	2

I chose these five participants to interview because they voluntarily come back to SUS on a regular basis, and I wanted to speak to people who know the space well. I will bring up how this approach has limitations, however, in my limitations section.

1. Service User/Staff Relationships at SUS

Staff are non-judgmental and accepting

The first, and arguably most discussed theme that came out of these discussions is the positive relationships between the service users and SUS staff being the biggest motivator for people wanting to come visit SUS. All five participants said that staff are non-judgmental in their approach to providing service, and that this made the room, and program in general, feel more comfortable for them to access. Stacey told me, "I never feel judged when I'm in here. And that's super important…so I think that sense of security and confidence is embodied through the employees and just the environment." Furthermore, all participants said that the staff being women and non-binary people is a likely contributor to their understanding of them being non-judgmental; they can empathize with service users on a level they believe cisgender men would not.

Along with staff being non-judgmental, there is a feeling that staff are "always just there to help," as Claudia said. She continued, "…they always keep checking if I need juice and snacks throughout the whole night and everything. If I'm doing more, they just ask how much

and everything." When Claudia says "more," she means using more substances over the course of her visit to SUS. The way she describes the fact that staff "just" ask how much she is going to do, adds to our understanding that the space is non-judgmental for people to use their substances.

Mary-Ann said that one of the main reasons she comes to SUS every day is for the "camaraderie" she gets from hanging out with people who have similar life experiences in a setting where she is not judged. Stacey used the word "camaraderie" in her description of the space as well. She comes to SUS so often because, "I feel there's a sense of camaraderie. It's a good checking point…and connection with people." Participants mentioned the peer led groups that take place on Fridays as well. These activities include harm reduction kit making, art, and other self-care activities (Vaccaro, 2023, April 21). They are hosted in partnership with The AIDS Network and Keeping Six, the organization that trains and supports the peer support staff at SUS. Participants said these creative provide opportune moments for connection-building with other women in the community.

Claudia told me that she intends to apply for a peer position at SUS: "I want to work here someday soon if I can. It would make me feel good to do the things you guys do." I think that seeing us all work together as a team to keep people safe demonstrates to service users at SUS that their knowledge and points of view are valuable and valued by staff employed in a social service organization that would ordinarily be supporting them from a top-down approach.

Stacey explained the SUS staff create an environment where she feels comfortable to get the information she desires to get her needs met throughout the day and where she can unload her problems:

> I can speak about my problems. I can unload, I can unwind. And I can gain, gather knowledge…so I think that's really important is that just to kind of – the, that it's not like, there's no like, necessarily repercussions. Like, it's not, it's not a place used to like, fish for people, like in a negative way. They feel like, they're meeting people, it's actually I

> think, a support, and I think it does save people's lives. And I think it empowers them to just kind of be able to do it without like, without, without feeling judged without feeling any type of like negative consequence. And I think that's really important. Whereas there's other spaces that like, you just feel like…you feel like somebody's getting an idea about about you, but like, here, I feel completely whole.

This sentiment about "feeling whole" at SUS is echoed by the other participants. For example Claudia, who identifies as a trans woman stated that, "…everyone [is] welcome…doesn't matter what your race, sex, sexual orientation or anything. And all that and like, gender identity. It's treated normally here. I love it here." Stacey, who identifies as gender fluid, also spoke about how she feels comfortable expressing their gender identity at SUS sharing: "we're that space of like, freedom and choice." In reference to my question about SUS being gender-specific for women and non-binary people, she joked, "So in terms of that, I do appreciate the gender specificity. And I feel as though like, I have a different comfortability with girls than I do guys. Probably cause I'm not trying to sleep with them." She then continued on a more serious note, sharing how being in an altered state around men affects her sense of safety with them:

> …I think just in terms of like, what I feel like I can share and like, I've always felt more comfortable with girls. And I don't necessarily have the fear or like, discomfort, of really being judged. Like everyone is pretty accepting and understanding. Whereas, guys, for the most part, I certainly have a great time with them. And they're really super cool and super understanding. But obviously, there is hints of like transphobia or people just like not understanding. Sometimes, we just tend to joke, and I think with being in like, an altered state could potentially cause them to be either a little bit more aggressive or just a little bit weird. But yeah, for the most part, I'm more comfortable with the girls.

The other three participants, all of whom identified as cisgender women, stated first that they did not think their sense of comfort in the space was related to the lack of men there, but upon further reflection, all three stated that they did feel more comfortable being there, particularly at night, because cisgender men are not allowed to access the program.

Kristy added a few insights into why SUS service users like programs for women and non-binary people, commenting that SUS is, "a safer place to get away from a man," and that she

knows some people who come because they "…need to be alone, like separated from their boyfriend for a little bit." She continued, "like, there was one girl who came in whose boyfriend had pitched a tent right across the street on the sidewalk and was waiting for her…it is like a safe haven for them to go to, to get away." Dawn and Mary-Ann also hinted that the space being gender-specific is important for other people, rather than themselves, because *they* need the space where they can feel safe.

Kristy also said that she is glad the space is inclusive of diverse gender identities, stating:

> I'm totally comfortable with it. Yeah, yeah. I've noticed that most people are pretty comfortable…and if they aren't comfortable, they're civil about it, and just go about their business…because we need to learn about each other. That's the only way we're going to, like, solve issues and help each other is to is to be open to everyone. And learn.

Hearing about the participants' perceptions of gender identity being "accepted" at SUS was reassuring. However, as I will explain further in my discussion, I have thoughts about how an SCS embedded in the shelter system which operates on strict binary system (The AIDS Network, 2022; Milaney et al., 2022) still may pose similar issues for people who are not cisgender like all-gender SCS with women's drop-in hours do not entirely work for WWUD. Overall, participants' understandings of how the space is used by themselves and others to be supported demonstrates to me that the gender specificity of the space is a key contributor to the space being non-judgmental and accepting for women and non-binary people. This sense of safety is directly connected to the fact that cisgender men are not allowed in the space. The women and non-binary people who access SUS want a place where they can be vulnerable – emotionally, as well as via substances – without the potential for violence or coercion from men.

Staff are friendly confidants

The personality and openness of staff at SUS came up quite a bit in the interviews. Mary-Ann said that her primary reason for coming every day is, "to come see you guys. To spend time

with you guys." Kristy says that beyond grabbing supplies, she mostly comes by every other day for "the support of the people that work there…is my main reason for coming in." She says she comes in to talk, vent, and "just not feeling so alone sometimes, right?" I agreed with her on this – in my experience, it is hard to feel lonely at SUS because someone is always ready to chat.

Dawn says the staff are "nice and outgoing" and she started coming to SUS more frequently "…as I learned to meet everybody, and like, really liked everyone, liked all the workers and everybody, got along with the staff, everybody was so nice." She says she is a private person, but now that she feels comfortable at SUS, "we have the best, deep conversations." Dawn and I have gotten to know each other pretty well at SUS over the past year. At the end of her interview, she told me, "It makes me feel good when I can make you laugh." Over the course of a single day, most of the people who access SUS engage with institutions, stores, and people that do not show them respect. What Dawn said made me think that SUS may function as a space where a person's self-esteem can be boosted through kind interactions and friendship.

I asked Stacey about SUS' vibe, and she said, "I feel like it is - I don't want to say Midnight 'Baby-Sitters Club'…Midnight 'Baby-Sitter's Club' all grown up?" We chatted about our love for the series and the feeling it gave us as youth – the club members were always there for each other, taking care of each other, not unlike the community at SUS. Similarly, Kristy says that stopping by SUS to talk to staff when she does not want to feel alone "….is like a therapy session. It really is." Participants had positive things to say about the staff at the all-gender CTS which is operating temporarily out of a church on James Street South right now, too. Kristy said that when they were still at their Rebecca Street location, she went there almost every day. "And that was for…mainly for the support, to talk to the workers that worked there. Yeah. Because

they were – they were great." Stacey says, "and since they've moved like it's, it's been different but it's great to like reconnect with the staff and stuff like that because they are like family."

2. Staff Knowledge and Expertise

Harm reduction and drug poisoning response knowledge

Another theme that came through the data is the fact that SUS service users come to the program because they rely on and respect the staff's expertise in responding to drug poisonings, as well as safe harm reduction practice. Mary-Ann put it simply when she told me, "there's too many people overdosing. They need to come here to be close to somebody who's going to be able to help them." Claudia recounted an experience from a few weeks prior when she had used a bit more methamphetamine ("jib") than she had meant to, and staff were "right on the ball and everything":

> I've already done too much one night. And had a seizure and everything, but I have a seizure problem…I started seizing for a while but [staff] just apparently sat and watched over me, I was told, until I stopped seizing and calmed down and everything to make sure I was safe. And then they put a blanket over me and let me sleep and then I didn't wake up until like, 3 hours later.

Mary-Ann said having "responsible" women around her in times of vulnerability like this makes her feel more secure about her safety if she has a seizure. She "knows" she will be cared for. The way she conveyed this story showed me she believes women to be "caring" in alignment with normative ideas about gender roles and performance. She also remembered her first night at SUS, when she received helpful advice on what harm reduction equipment she may want to use to do her shot:

> …because like, first night I was there, I was using a short kit. And that's traditionally what I've always used. But um, my veins have gotten pretty bad over the years and everything. I kind of think I use shorts because I have shaky hands. And it's always easier to use a short than a long to not hurt myself or bruise myself. But now it's the opposite of that, which I didn't realize it'd be a good thing to try until [staff] recommended it to me and said, "why don't you try using a long instead since your veins are so deep and

> rolling, it might be easier." And I got it right away on the first try after that. And I've had it first try since, which is great.

Claudia has since witnessed staff give similar advice to other guests at SUS too:

> I see people supported in there just like I was. They're having trouble and suggesting maybe trying a long kit or put some heat on their arm like I do because my veins start to roll a lot. So I always take the portable heater, plug it in, put my arm right in front of it for five minutes. So my veins are brought right to the surface, and like staff are always suggesting to people to get juice first if they can't find their veins, hydrate them and everything.

A core part of our work at SUS is to assist people in using their substances in the safest way possible, and this goes beyond just being a place where you can pick up clean equipment. As Claudia states, staff expertise that they continuously build on, allows them to give people tips of all kinds on how they can use their substances in a way that allows them to enjoy their high rather than feel stressed about it, or sustain an injury or infection.

Dawn brought up the fact that the night before when she had been at SUS, there had been a drug poisoning that staff responded to while she was there. She called their response "professional" and "bang on." Claudia described a similar scenario from a few weeks prior, when "…two staff jumped up right away. And then myself and another girl jumped up and caught back up and everything and helped. It took all four of us to move her over to one of the lounge chairs to stretch her back and for the oxygen." The teamwork aspect of this response to a drug poisoning is something that staff and service users at SUS talk about a lot – even though staff have the official "training" and specialized equipment to respond to drug poisonings, the actual response often necessitates a coordinated effort by everyone in the vicinity.

Other healthcare-related knowledge and support

Participants also noted their reliance on SUS for items such as hygiene, reproductive health, and wound care supplies. Stacey said that SUS is her "favourite stop for razors," while

Dawn said she grabs "shampoos, the soaps, lotions" and Kristy said she sees staff supporting people with dressing their minor wounds. Interestingly, Kristy said she thinks the uptake on reproductive supplies is limited, but that it is good for SUS to have those supplies as an option. I agree with Kristy that we tend to not have a lot of people ask us for reproductive health supplies like pregnancy tests or prenatal vitamins, and this likely points to the increased stigmatization people who are pregnant experience when they use drugs (Owens et al., 2020). In my experience, people who use drugs in SUS are secretive with other service users if they are pregnant because they receive a lot of judgment from their peers for using. Undoubtedly, this judgment is shared by people who work in other healthcare and social services these folks might access as well (Owens et al., 2020). This is one of the reasons we need to offer this support at SUS, which has lower barriers for access and operates from a framework of non-judgment (although I will not claim that SUS staff do not work through judgment in these matters as well).

Referrals to community services

A YWCA blog post interviewed one of our program coordinators, and she told the writer that SUS has "allowed staff to build trust and relationships with CAP patrons, in order to connect them with additional supports" (YWCA Hamilton, 2022, June 16). In Dawn's interview, she told me that we help with "…everything! Helping people with housing. Everything and anything you need is right there. I would call it more…to get more of counseling where I would go to get this help? Or that help?" Her statement indicates to me that she understands we are not housing workers ourselves but that one of the things we do at SUS is resource share, directing people to where they need to go in a way that is accessible and low-pressure. She said, "you guys have supported me through all of my apartment hunting and helped me hold onto hope." Although the

support SUS staff offered was not as workers who could actually secure her the housing she sought, she cited the long talks, internet searches, and help with printing as valuable support.

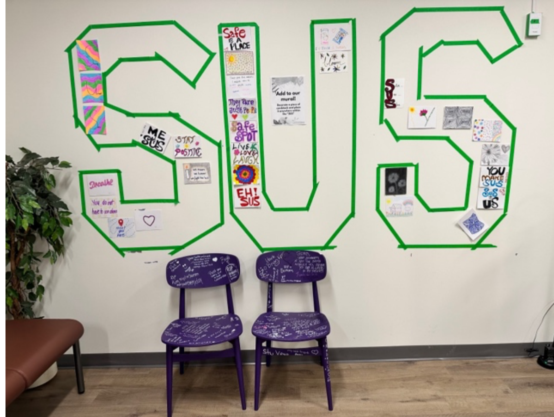
Kristy and Claudia told me that they come to SUS staff if they want to get connected to a doctor, nurse, or detox support. Stacey has gotten referrals to trans friendly and trans oriented community supports like Speqtrum (Speqtrum – YWCA Hamilton, n.d.) and The AIDS Network (The AIDS Network, 2022) and described why getting an appropriate referral for a doctor was important to her:

> Yeah, I'm getting referrals for like, finding doctors down here…you guys explained all about the doctor program that runs through TLP or just through YWCA in general, twice a week on Tuesdays and Thursdays. And I just asked a bunch of questions about like, are they good? Are they knowledgeable on estrogen and hormone therapy? Because like, a lot of doctors aren't.

Staff willingness to brainstorm and research where to get someone what they need was mentioned as a benefit of the program, and so was their banked knowledge about culturally responsive supports that people needed (Community Opioid/Overdose Capacity Building, 2022, June). I will speak more to this in my discussion, because I think this is an area where we can improve.

3. SUS as Safety, SUS as "Home"

The SUS room, although not originally built for the purpose of being a supervised consumption program, was "…designed to feel more like a living room and less like a clinical environment. There are lounge chairs and couches…and the walls have been decorated with colouring pages and art completed by women who have used the program" (YWCA Hamilton, 2022, June 16). Multiple participants pointed at our walls covered in artwork when they spoke about the "feel" of the program.



[A picture of the mural we are collaboratively working on in the SUS room today]

All five participants used the word “safe” to describe the vibe at SUS. Dawn said, “I feel so safe here, especially when it’s me and one of you guys and we can just talk and talk. I remember parts of my life that have been good.” She proceeded to show me one of her possessions that she stuck an “I love SUS” sticker to. I showed her the one I have on my laptop that matches.

To Kristy, SUS is, “…chill. There’s boundaries and you have to follow them. But it’s a space for you to come in and use as you please without feeling judged or looked down upon. And it’s just a safe place. You can say whatever you want.” Claudia said that SUS is a safe place where “people care about you” and Stacey added that she likes to visit often because it “gives a sense of regularity” to her life “…in case anything happens. And a bunch of people that know you. I feel safe here.” Mary-Ann added that SUS feels “homey,” and it is a good place to ground herself when she has a rough day. She says she comes to SUS to “come inside and be safe.” This idea of coming inside was echoed by a couple of other participants too – they come to SUS because it is inside and away from the elements. It is clean and they can stay there for a period of time, which is not the experience they have everywhere in the city. Other comforting touches participants mentioned was that we play music in SUS, there are art supplies, and people can grab snacks.

Dawn, when trying to explain one of the reasons she appreciates me as staff, said, "I trust you enough to leave my stuff here while I go to the bathroom." This may seem like a small thing, especially for those of us who are used to asking a person at the next table at Starbucks to watch your laptop while you run to the washroom. But staff can see how difficult it is for a lot of people who have been unhoused for long periods of time to trust others. Clover (2011) says, "[there] are many aspects of street life that discourage people from trusting one another and others. Street-life can be characterized as 'flight life' – fleeing from a violent or potentially violent situation, the police, or even an angry shopkeeper who finds a woman sleeping in a doorway" (p. 19). We see how this "flight life" affects SUS service users' ability to let their guard down and trust other people to help care for them.

Finally, Stacey compared SUS to other programs in the city that provide service to WWUD:

> There's no sense of hierarchy or classism, because I know that sometimes we're like people are like, they really want to be defining their roles. They're like, "listen, I'm the worker, you're the client." And it's about like, I just feel like here it's women connecting with women. And I think that's really important. I think it's organic. And I think it makes it much more personable and less of like, a clinical trial kind of thing.

With that last comment I got a sense that Stacey was both commenting on the physical layout of the space as not being "clinical" like many other environments that support PWUD, as well as the fact that the people who work at SUS are not healthcare workers, and usually focus on how "well" people are doing in a holistic rather than a precisely medicalized sense.

The limited literature available about these sites online confirms many of the statements the participants in this study made regarding what helped them feel comfortable, safe, and supported at SUS. Layout and "feel" of the space are important to WWUD at an SCS (Boyd et al., 2020; European Harm Reduction Network, 2014). Vancouver's OPS also intentionally has a

"living room" atmosphere, including comfortable chairs, plants, and murals on the walls in the space. They say they work from the knowledge that women are generally more relational than men (Atira Resource Society, 2021; Boyd et al., 2020; Thulien & Nathoo, 2017), which is something we have observed at SUS as well. We have three recliners for people to "chill" post-injection, and the table with chairs in the middle of the room always have some flowers or a fun activity for people to check out. The artwork all over the walls at SUS is intentional, too. It helps people feel a sense of ownership over the program, and showcases the beautiful things they create.

4. Accessibility Matters

The final dominant theme that came out of the interviews was the ways the accessibility of the physical space and hours means the program is supportive to the needs of WWUD.

Location, location, location!

All of the participants said that having SUS be integrated into CAP/YWCA Hamilton's MacNab site is critical to their decision to access the program. Mary-Ann and I chatted about how she likes to drop in frequently at CAP and SUS on her rounds in the area. I asked her if she ever stops at another women's drop-in program in the community and her response highlighted the importance of location. Being close to people in the community is important so people feel less alone, and you can get what you need. These two participants said they wait for SUS to open to grab supplies now, and hang out in the MacNab area because their support systems have centralized there.

Furthermore, location matters a lot to people who are transient and do not have a stable space that is just theirs (Vaccaro, 2020). When a service is located near where the other things they need are, they will access it (Salmon et al., 2010). Mary-Ann told me that she "…used to go

to the Core…at first. And then after they moved, I stopped." Kristy said the same thing about not going to the city's all-gender CTS after it moved: "It was the location. Yeah. Cause it was all of us – that type of people, you know, in that area so you could find your drug of choice, your friends, talk to staff, get food. Like, I met tons of people there and it was literally 'the core.'"

The fact that SUS is located inside a program where people go to sleep at night is important to the service users who come to SUS because being outside at night can be dangerous for women (Milaney et al., 2020). Women's homelessness is often cited as being "invisible" because women tend to couch surf, stay with a partner (even if that partner has demonstrated abusive behaviours), or trade favours rather than sleep rough since these options afford them some more control over where they end up being at night (Milaney et al., 2020). Service users who come to SUS during the night regularly tell staff that the Hamilton streets are even more dangerous at night now than they used to be for women who are unhoused.

Timing

The timing of service provision matters a lot, too. Participants all cited a need for supervised consumption programs to be open 24 hours per day, but aside from this, being open at night is crucial. For example, Dawn uses fentanyl at night, she says, because, "that's when my pain is more aggressive. During the nighttime," demonstrating both how time of day for use is an important factor to consider, as well as an example of how drug use is a coping strategy for people experiencing chronic pain (Nathoo et al., 2018). I am in the same boat as Dawn with my pain – it is worse at night and when I first wake up in the morning, All five participants said that their main source of income is Ontario Disability Support Program (ODSP). They also all self-identified as struggling with mental health and/or physical disabilities. This follows with what the literature says about substance use being linked to experiences of mental health and chronic

pain (Nathoo et al., 2018) and our understanding that "for people dependent on a drug, the drug is essential for their ability to function and be 'well'" (Zwarenstein, 2022, September 7, n.p.). Furthermore, the fact that ODSP rates keep people living below the poverty line demonstrates another way intersecting relations of power in our society force people to live on the margins (Community University Policy Alliance, 2022; Schwan et al., 2021).

With respect to timing, Claudia also told me:

> I'm trying to keep it to the nighttime because I don't want to do it that often anymore, right now…I don't want to go back to what I was doing back when I was in [city] and homeless. Multiple, multiple, lots and lots of multiple shots a day…I'm always a night owl and everything too…so it just kind of makes sense to do it at nighttime because I'm gonna be up anyways. I'm never gonna go to sleep right away.

People experiencing homelessness have a close to impossible time finding somewhere safe to be at night unless they snag a shelter bed in our overburdened shelter system. A safe place to be overnight is something participants in my study as well as Vancouver's gender-specific OPS' service users appreciate about the fact that the programs have evening hours. Vancouver's OPS is open until midnight (Atira Women's Resource Society, 2021; Thulien & Nathoo, 2017), but their associated tent-based OPS a few blocks away is open 24 hours and offers supervised inhalation (Wyton, 2020, May 26). Even though the original location is only open until midnight, that is still some night-time hours where people can be inside and receive care once public spaces are closed.

Mary-Ann compared SUS open hours to the city's all-gender CTS. She said, "on the weekends they're not open but we are." I found it interesting (and sweet) that Mary-Ann used the term "we" to refer to SUS. This reinforces the idea that SUS functions as a hub and home for her. Stacey mentioned the all-gender CTS as well, saying that, "I feel as though, like, it just seems like they're limited sometimes with how often they're open. Like…I know they open. I

know they're functional, but um…it's not always when I go there. But I do enjoy the times I do go." Regarding the CTS' hours, I have a feeling one reason why they are limited is due to their operating out of the church at the moment while their new location is being built. It is very possible that inconsistencies or issues people have with the current CTS model will be ironed out once they are situated in their permanent location.

It was difficult to limit my findings in this section to four themes. The participants and I had excellent conversations, and I learned a lot from them. I was also glad to discover that they appreciate and notice a lot of the things I love about how we operate SUS. In my discussion, I will tease apart some of these themes, relating them back to what came out of my literature review and suggesting a few possible future avenues of inquiry.

Discussion

In this section, I will synthesize the insights that came through in my findings, making connections between what the participants shared and the literature, through my lens as a staff researcher working with a critical feminist framework. In my findings, I expanded on four main themes that came out of the interviews I conducted with my participants relating to how SUS operates as a supportive space: (1) the importance of positive service user/staff relationships; (2) staff knowledge and expertise; (3) SUS being considered a “safe” place and like a “home” to service users; and (4) accessibility of the space for service users being a contributor to why people come to SUS. I will connect these themes to my original research question, which was to understand from SUS service users’ perspectives how our gender-specific program has functioned as a support to service users in its first year of operation. Finally, I will speak to the limitations of this study and posit some possible avenues of research and program development for us (SUS service users, YWCA Hamilton, and myself) to pursue together in the future.

An Overview

SUS service users seek friendly, meaningful social interactions at SUS with staff and their peers. They want to talk about light-hearted topics and have the space to discuss serious things too, including mental health struggles, their histories with substance use, and experiences of violence in their past and present. The specific environment created in a place where, as a woman or non-binary person, you are not judged for using illegal substances in a society where drugs/drug use are criminalized and women who use are perceived as deviant, offers relief to service users. They seek validation for their struggles there, as well as refuge from the isolation and danger they experience outside.

Participants in this study affirmed that it is important to have a place for women and non-binary people to use substances safely away from people who might wish them harm or be in coercive relationships with them (Atira Resource Society, 2021; Thulien & Nathoo, 2017; Xavier et al., 2021). As I mentioned in my literature review, women and non-binary people experiencing homelessness rely on drop-in programs for physical and emotional nourishment (Schwan et al., 2021). Integrating an SCS in a gender-specific drop-in program means we are able to support people more genuinely from a place of non-judgment in an environment catered specifically to the needs of WWUD, which came out in the interviews. Service users do not guard themselves in the same way as they do in all-gender safe consumption spaces because threat from gender-based violence and coercion is minimized in this space. With this threat and judgment for being women who use drugs removed from the equation, service users can connect with each other and staff on a more intimate level (Boyd et al., 2020; Xavier et al., 2021).

The vibe we create together at SUS means we rarely even need to employ intervention methods like Naloxone and oxygen to reverse a drug poisoning. The trusting relationships and calm environment help service users feel safe and cared for. This leads to them often making personal decisions about their drug use to use more safely. For example, they might use smaller amounts when they are taking a different substance than they normally do or because they know that they will be able to do multiple shots at SUS. Not needing to rush or hide their drug use means people space out the timing of their use more, hydrate and feed themselves better, and talk about healthcare, housing, and treatment options with the caring people around them.

The unpredictable drug supply, which is increasingly cut with xylazine, along with unsafe drug practices lead people to experience infections, abscesses, and painful wounds (Canadian Community Epidemiology Network on Drug Use, 2023, July). We can connect people to

healthcare practitioners, SASS, and even perform minor wound care at SUS. People who are unhoused and use substances have historically had fraught relationships with the healthcare system (Lew et al., 2022), but through SUS, people can openly talk about the options with staff and be warmly referred to physicians and nurse practitioners who work with people who use drugs.

Expertise and knowledge about substance use and harm reduction are also key to the success of gender-specific SCS (Boyd et al., 2020; Thulien & Nathoo, 2017). In Vancouver's gender-specific OPS' program evaluation, they speak explicitly about the expertise of their peer workers, and this is true for us at SUS as well (Thulien & Nathoo, 2017). YWCA staff learn a lot from the Keeping Six peer support workers in our program, but there are some things that are not learned from word of mouth. Speaking for myself, there are times when I am not the right person to console a woman who has come to SUS because I do not have a frame of reference to draw from. I have learned about things like heat and fluids being important things to offer people who cannot find a vein from the peer support staff who have lived/living experience of substance use and homelessness.

On one of my shifts, a woman could not hit[9] herself properly for over an hour, and started to cry because she was so frustrated and in so much pain. I had offered water, conversation, snacks, and everything I could think of to make the experience better for her. The peer support staff on shift with me ended up sitting next to her and helping her look all over her body for a good vein. This is something I could never do with the experience and education I have, and I found myself feeling overwhelmed by how grateful I was to have my co-worker with me that night. Having them in the program benefits service users because it increases their feelings of

[9] In this community, to "hit" means to successfully inject a substance.

safety and of being understood by someone who has gone through what they have, too (Bardwell et al., 2018b). I would say that their knowledge and meaningful incorporation into the operations of the program (Bardwell et al., 2018b; Community University Policy Alliance, 2022) have had some of the most influence on the way YWCA staff relate to and offer support to service users at SUS.

Offering people a space where they can pursue leisure activities and art, an important aspect of our program, offers service users humanizing experiences and time to reflect on the harmful systems they engage in every day. When you are outside and having to fight to survive every day, that does not leave you a lot of time to think about the broader societal forces which are contributing to your situation (Clover, 2011; Vaccaro, 2020), or organize yourself with others to combat them. Having a space like SUS which is increasingly being considered a hub, could lead to WWUD engaging in more self-advocacy activities, collective capacity-building, and consciousness-raising (Freire, 1970).

Limitations

There are several limitations to this study. I have mentioned this numerous times already, but the short time-frame I had to get this project done to finish my program within a year meant there were a lot of things I could not do in this project, and I ultimately had the most power over the narrative produced here. If I had more time and resources, I would have engaged in more community consultation with SUS service users around what methods of data collection and dissemination would suit them best (Clover, 2011; Salmon et al., 2010). In the relevant literature, similar studies took anywhere from 18 months to three years to complete, and all had external funding to support research activities and pay community research partners for their expertise (Clover, 2011; Salmon et al., 2010; Vaccaro, 2020). Also, when you take more time to engage in

research, readers of your work tend to trust your results more because you can see more variations in data over time, and they may feel assured you did not come to your conclusions too quickly (Abrams, 2010). I regret the lack of time I had, but I am committed to working with people at SUS long-term to find exciting ways for us all to engage in research.

Honorariums

I know from conversations I have with SUS service users that the time I would take out of a person's day to do an interview would cut into the time they have to earn money. Boilevin et al., (2019) published a manifesto about how to do research with people in Vancouver's DTES. In their manifesto, they say, "hustling for survival takes time, and if you take our time and don't pay us we might need to hustle in ways that put us more at risk" (p. 18). There is also plenty written about the fact that doing research with over-researched groups like people who use drugs requires us to put in the effort to develop trust and pay them for their expertise (Alook et al., 2020; Bell & Salmon, 2010; Boilevin et al., 2019; Touesnard, et al., 2021). Offering a $30.00 honorarium for participation could be considered a limitation because it could have had a deciding influence on the people who ended up participating in the study. Anecdotally, I know that $30.00 can buy someone between one and three "points" of fentanyl on the street, which depending on one's tolerance, could last them the entire day. The honorarium, as well as the fact that I had snacks and art supplies means one could make an argument that the participants were coerced a bit into participating. In my methodology section, I explained my reasoning for offering payment (Boilevin et al., 2019; Touesnard et al., 2020).

Sample size

The fact that I only interviewed five people who were all hand-picked by me is also something I have been upfront about. I have excellent relationships with all of these people, and

"knew" they would be happy to participate in this study. Interviewing such a small pool of people who were all chosen by me because they had proven through their words and behaviour that they have positive feelings about SUS means the positive reflections they provided might not represent the perspective of all SUS service users.

Due to the small sample size of this study and my centring on regular service users at SUS, I have focused mainly on commonalities between the participants' experiences rather than differences for the practical reason that I want to protect the identities of the participants. With a larger sample, I would have made different choices. However, this community is small, and we all know each other pretty well.

Reflecting upon my own positionality in this work through my prologue and laying out of my dual roles and "in-between" position was done with the intention of ensuring that at least I (the researcher and a front-line worker) am fully implicated in this work and am constantly reflecting on the ethics of what I am doing (Gringeri et al., 2010). This choice was purposely made to highlight my responsibility for prioritizing reciprocity and action throughout the course of and after this project. I am not a neutral party, and my commitment to self-reflexivity and disclosure of my viewpoint and position(s) throughout this research is something I have endeavored to make clear (Gringeri et al., 2010; Daftary, 2020). In future studies which incorporate a wider range of participants, I will explicitly focus on the different experiences of support of the people who access SUS.

My prior relationships with participants

Since the participants all knew me, they may have felt some obligation to participate in this study. This was something I discussed at length with the leadership team of my department, and as per the MOU, I attempted to mitigate this pressure by: (1) approaching the participants

outside of program hours; (2) interviewing them 24 hours after one of my shifts; and (3) explicitly explaining that my two roles of researcher and staff were separate (Coy, 2006). I told them they were completely free to decline my invitation to participate with no impact on their access to SUS or YWCA Hamilton in general. However, the fact that they were being interviewed within an institution that supports them but also defines the support they receive, means there could be “silences” in the data reflective of the ways service users modify themselves and their stories to fit within the narrative of a WWUD experiencing homelessness (Paradis, 2009; Sweet, 2019).

Even though my questions were not terribly invasive, I have seen these participants in vulnerable positions many times at SUS in my role as a staff. It is possible that even though I perceive my relationship to them as being reassuring, they could feel some shame or regret about me knowing so much about them while they are helping with this research (Banks et al., 2013). If they are anything like me (and I think we have quite a bit in common), they derive some reassurance and strength from being able to parcel out knowledge and trust to people on their own terms.

In research conducted with communities of highly marginalized women and non-binary people who use drugs and are deprived of housing, it would have been nice to include a therapeutic component to the data collection process, perhaps engaging in a more art-based methodology than interviewing (Clover, 2011; Paradis, 2009). I would have preferred to do this, but in the end, I decided that given my lack of resources and time to do this work properly, ultimately, it would be unfair for me to potentially bring up a lot of feelings in the participants that I would not be able to ethically address within my role as researcher. If we had discussed histories and feelings of the participants in depth, I believe it would have been ethically

necessary for me to provide therapeutic support so they could debrief their experiences (Paradis, 2009). I have time to think about how to do arts-based research with service users at SUS next year. I think, if done well, arts-based data collection and interpretation would be well received by this group. Collaborating in arts-based activities with the proper supports in place could be therapeutic while also providing a space for us to do some of the consciousness-raising (Clover, 2011) I mentioned above.

Integrated SCS do not "fix" shelters or bad drug policies

The whole point of this project is a limitation in itself. Figuring out a way to put more supervised consumption programs inside shelters seems like a solution on the surface, but shelters do not work for many people (Lew et al., 2022). They have a lot of rules, and they are not necessarily "rehabilitative" places – they are just spaces for people to be "put" – another "warehouse [for] people who represent major social problems" (Davis, 2014, p. 25). Due to the fact that there is a shortage of both affordable housing and staff to help people access the supports they need in this sector (Community University Policy Alliance, 2022; Schwan et al., 2021), the shelter becomes a place where people just use a bed (if the shelter is not at capacity). Even making shelters "low-barrier" (Evans, 2011) could be understood as us creating better institutions for people who experience homelessness without changing their actual circumstances and making systemic-level changes (Davis, 2014; Paradis, 2009).

A question I asked myself throughout this process is whether it makes sense to put these programs into shelters for more reasons than merely because we have all made an association in our heads that shelters are "for" people who are unhoused now. Also, would we even need safe consumption sites integrated into shelters and drop-ins if drug use, manufacture, and sale was decriminalized? Delving into the discussion of drug decriminalization was outside the scope of

this thesis. However, if we had a more stable drug supply for people to consume, these sites may not even be necessary in the first place.

A paradox of participation

Finally, the fact that the project organization, data collection, and data analysis could not be done collaboratively with the WWUD at SUS is disappointing. Again, the lack of time and resources I had for this project were the biggest contributors to this decision. It is possible that I have contributed to a paradox of participation (Arieli et al., 2009) because I put parameters around what participants talked about with how my questions were written, and I did not do that "official" community consultation piece which enables people in the community to direct the research priorities (Branom, 2012).

Although I hope this project functions as a form of community consultation or exploratory groundwork setting (Paradis, 2009) for the research I will do in the PhD program, the truth is it is hard for SUS service users to spend lots of energy on advocacy, research, writing, and policy-making because they need to spend those energies on meeting their basic needs (Vaccaro, 2020). They may not even see the point of doing more research when nothing seems to change for them, preferring to discuss action that could be taken immediately, however "unrealistic" those of us who do research think it is without laying groundwork and convincing stakeholders of the benefits so these actions can be financially and infrastructurally supported (Arieli et al., 2009; Banks et al., 2013; Israel et al., 1998). In future phases of this work, I hope to have more opportunity and resources to facilitate research that centres this community's priorities as they themselves articulate them (Arieli et al., 2009).

In our interviews, all five participants said that SCS are necessary investments. Claudia told me that, "everyone should have a safe space to use drugs, or anything of that nature…like

everyone should have a safe space for someone to keep an eye on them." Kristy told me: "I just hope we have more of them open up in the city and everywhere in the world, you know? Yeah, the more people know the better." Their words have reassured me it is a worthwhile endeavour to continue working with the intention of turning SUS into a provincially-funded CTS and advocating for more spaces for people to use safely in our city with the support of these research findings.

Implications and Reflections

Knowledge dissemination

YWCA Hamilton has been expanding their focus beyond front-line social services over the past few years. They are engaging in relationships with researchers at post-secondary institutions like McMaster University who focus on the contextual and structural conditions surrounding YWCA Hamilton's service users. I have been lucky to assist in some of this work in my position as graduate student intern with YWCA Hamilton through the CRP this year. I will be putting together a plain-language, visually appealing summary of the findings from this work to share with YWCA Hamilton and everyone at SUS. YWCA Hamilton is in the process of establishing its own "Centre for Feminist Research and Evaluation" with assistance of the CRP, and this could be posted on the website as an example of the feminist evaluations of their programs.

The summary will also be great to give out to community stakeholders as we do our community consultation this fall for the CTS application. My research question and interview questions were relevant to the community's interests because the answers we got will help us talk to stakeholders and community members about the positive aspects of SUS for the community consultation portion of the CTS application. We need letters of support and a

summary of the people and groups we have engaged in dialogues about the program. Testimony from people who use SUS will help us translate our collective work into action.

Future research: "I wish we played music here all the time" – low-barrier, drop-in, expressive therapies

The fact that SUS is integrated into CAP and the existing YWCA Hamilton MacNab location in the lower city plays a key role in its impact as a supervised consumption site for WWUD. Something we are only just recognizing is that the MacNab building is functioning as a hub for people in Hamilton's lower city. YWCA Hamilton has recently taken over Elizabeth Fry Society's portfolio of supports (O'Reilly, 2023, April 1), as well as some of the services offered by Catholic Family Services (Hewitt, 2023, February 10). As YWCA Hamilton expands its range of offered programs, its location as well as the low thresholds for access will continue to attract diverse populations of marginalized people in Hamilton who need connections to essential services.

Stacey, like Kristy, spoke about what she envisions the MacNab YWCA Hamilton location being for WWUD now that it has integrated SUS into the drop-in. The fact that so much "tea" is dropped at SUS leads her to believe that in a myriad of ways, "we could make change with what we hear." Some of her suggestions reflected the intersected power systems WWUD engage in, such as the criminal justice system, and supports for gender-based violence. Stacey said:

> And especially with like, SACHA[10] being in this building, I would love to partner with them a little bit more. But I feel as though obviously, chances are, there are probably going to be – and that's the thing is, I hate making assumptive statements like this, but, and I'm not looking around my community of girls being like, "Oh, my God, like, this person is a victim, this person is a victim" but like, yeah, the potential for it to happen. It can happen to anybody, and it has happened to people. So I just want people to be able to

[10] SACHA is the Sexual Assault Centre of Hamilton and Area. Their office is located on the third floor of the MacNab building.

> access it. And it's like, I know, we can't change – well, yeah, actually, we are making, we're moving towards change with like, there's gonna be more space and stuff like that. So it's going to get better. And I just want to make sure that everybody can get to where they need to go and get the support that they need. Because I think some people are just, they're afraid to open up. And I think it's really important to have a welcoming space in order for people to do so."

Stacey brought up issues of capacity. She says organizations like ours have to provide crisis support and counselling in ways that meet the needs of WWUD, but because of lack of capacity, we are not able to be immediately responsive. She hopes to see us being part of a "synchronized system" of support for people in the community.

One area that could be explored further is creating a model for providing low-barrier mental health support for WWUD experiencing homelessness with the community at SUS. The contentment that SUS service users feel when we have new colouring pages on the bookcase, or when we host UNSHELTERED[11] art drop-ins, combined with their attachment to SUS for the friendly staff support, tells me that this group might benefit greatly from having low-barrier, expressive arts therapy (Hinz, 2020) or drop-in counselling that incorporates art into it somehow. All the participants mentioned the activities we have going on in the space, and Stacey would like to always have music on at SUS. Kristy said, "as long as you're engaging with them in anything, they'll participate, I find, yeah." People like to *do* things and create things. It helps build self-esteem and fosters connections (Frostig, 2011). But it is difficult for some of the people we support to do things that are pre-scheduled because of the chaos that comes with living unhoused. The trust and camaraderie generated within SUS' nonjudgmental space is something that we could build on for people in the community who have experienced trauma –

[11] UNSHELTERED is an arts-based zine project that I volunteer with. Our third issue is being published this summer (Floren, 2022, February 15).

even the trauma that comes with living on the street – and create a therapeutic program model that meets their needs.

Policy: Supervised inhalation in Hamilton

Another takeaway from these findings is that we should open a space, even outdoors, where people can be supervised as they smoke substances. Hamilton does not have any supervised inhalation programs, which is a huge issue because increasingly, drug poisonings are occurring more with people who smoke their drugs than inject them (Ontario HIV Treatment Network, 2022, July). Women in particular often prefer to smoke their drugs because it is hard for them to inject themselves, and because for a long time, people believed your chances of experiencing a drug poisoning is lower if you smoke your drugs (Ontario HIV Treatment Network, 2022, July). Many of us now know that this is not necessarily true, but not everyone is aware of this.

In terms of recommendations for SUS to improve, three of my participants said that having a supervised smoking area would improve the program. Two of these people mostly smoke methamphetamine as their drug of choice, and with the drug supply being so unstable, they understandably fear their drugs being tainted by fentanyl, benzodiazepine or xylazine when they are expecting meth (Canadian Community Epidemiology Network on Drug Use, 2023, July; Dryden, 2023, June 28). Very few SCS in Canada offer supervised inhalation as of writing this thesis because it is difficult to achieve an exemption for it, and committed host organizations would have to navigate around provincial and municipal bylaws (e.g., the Smoke-Free Ontario Act) to provide this option (Gubskaya et al., 2023; Ontario HIV Treatment Network, 2022, July). I aim to familiarize myself with the local bylaws and organizational barriers to providing space for PWUD to have spaces for supervised inhalation of substances to see how we might be able to

incorporate that into the suite of supports at SUS going forward. Furthermore, I will bring this issue to the HHRWG so we can incorporate this imperative into our short list of immediate issues requiring the city's attention.

Policy and practice: The need for more culturally safe harm reduction spaces

Cultural safety is a vital aspect of trauma-informed practice. A few participants mentioned how the environment of non-judgment at SUS extends to how people of different gender identities, sexualities, and races are welcomed in the space, too. The success of gender-specific SCS like SUS and Vancouver's OPS have made me think a lot about how harm reduction spaces built specifically with a group in mind, catered to their needs, is so important. The housing and homelessness sector "frequently marginalizes, undermines, and discriminates against those who do not adhere to strict binary notions of gender. Gender diverse, Two-Spirit, and trans people face significant, intersecting human rights violations when it comes to housing and accessing emergency shelters" (Nelson et al., 2023). Although the participants I interviewed spoke positively about the environment at SUS, this is largely due to the very intentional actions of staff who have put pride flags up, and gently educate people who use stigmatizing language. This is not the same as the space having been created for the purpose of supporting the harm reduction needs of queer and gender diverse people.

One of the lessons we could take away from how happy WWUD are with how SUS meets their needs and supports them is that there should be more culturally safe spaces for other groups too. Indigenous people in Canada have a harder time accessing quality healthcare and experience higher rates of drug use as a means of coping with trauma related to legacies of colonialism (Canadian HIV/AIDS Legal Network & Canadian Aboriginal AIDS Network, 2017). It would be great if there were SCS in Hamilton which were created for the purpose of

supporting Indigenous people, using a harm reduction lens that also broadly aims to reduce the harms that colonization has caused (Canadian Aboriginal AIDS Network, 2019). Or what if there could be more harm reduction supports specifically integrated into social service organizations that support Black people and racialized people which intentionally address the impact of lived experiences of racism in the conceptualization and delivery of service? (Godkhindi et al., 2022; Milaney et al., 2022). Adjusting a structure or program built for one set of people after the fact to provide service for people with different relationships to power is not effective for supporting everyone the way they deserve to be supported.

Practice: Improving service user-staff dynamics across the housing sector

Lastly, the friendly, positive relationships between staff and service users at SUS is something that I think can and should be replicated in drop-ins and shelters around the city. The way people are able to be open about their lives allows for the dynamic between everyone to be less antagonistic than it is when a staff "knows" someone is hiding their drug use or supplies and it is against the rule of your organization. And when you are the person who is being forced to lie and hide, you will find it harder to trust people in positions of authority in these institutions which are often your last resort for support. This is not an ideal basis for cooperation. Front-line staff in shelters and drop-ins go through burnout and vicarious trauma, and the drug toxicity crisis has intensified the trauma they are exposed to (Nathoo et al., 2018). Shelters are constantly understaffed because the turnover rate is high. I wonder if this might change if the interpersonal dynamics between staff and service users was more open and trusting?

Shelters and supportive housing providers should prioritize clarifying their stance on harm reduction in their organizations. It is okay to have some spaces that are for only for people who are sober or trying to stay that way. But we equally need spaces designed to foster open

dialogues and support around substance use for people experiencing housing insecurity. This will both decrease the number of fatal drug poisonings in our community and encourage positive relationships between service users and staff which I know from experience is the first step to getting a lot of people to seek out help with getting housing, paperwork, or social assistance.

Conclusion

In this thesis, I interviewed SUS participants to explore their perspectives regarding how SUS has supported them in its first year of operation. I came into this project with my own beliefs about what we do at SUS aside from providing a physical space for people to use drugs while being supervised by trained staff to prevent fatal drug poisonings. Many of my thoughts were echoed by the participants, but I learned some surprising things, too. Importantly, a gender-specific SCS for WWUD is a necessary program in our community to nurture relationships between peers and between WWUD and service providers. Using a feminist epistemological framework has helped me contextualize my position as well as the inherent value in lived experience narratives for providing a nuanced narrative of the work we do at SUS and what factors in our approach to service provision and support have helped (or hindered) service users' journeys (Gringeri et al., 2010).

Alexander and Grant (2009) talk about how difficult it is for us to know that the relationships we create and engage in with service users is a crucial contributor to positive changes in their circumstances. Yet we must follow strict rules of professionalism with service users in the workplaces where we meet them. Every time a SUS service user remembers my coffee order or asks me how school is going, I think a lot about reciprocity in work and research. Specifically, I think about how structures of neoliberal workplaces can both help us maintain

healthy boundaries and get in the way of us all engaging in mutually sustaining, reciprocal relationships.

True CBR partnerships require mutual investments from the researchers and the community organization or group (Branom, 2012). I much prefer to work with a team, but earning a degree is a solo endeavour, for the most part. I made a lot of concessions in this community-based project so that the majority of the load would be on me, as it should be. I will pick up where we left off and do better as I learn and grow as a researcher. I have been transparent about my attempts and failures at incorporating principles of CBR into this research within a timeline that does not easily allow for this kind of participative research approach. Being a front-line staff/researcher, existing "in-between" in relation to this study meant that I could read between a lot of lines. I knew how to talk to people about SUS so they did not feel judged, and my follow-ups were relevant. I think the measure of trust that exists between myself and the participants helped them believe there is a purpose to this research since they see me at SUS, working to keep us all safe.

In terms of our success in the first year of operation, I do not think I can put it better than Stacey did:

> Stacey: I love SUS. I love the people. And we just finished our first year?
>
> Me: Yeah, one year!
>
> Stacey: I think it was a pretty successful first year and I think we launched pretty quickly. Everything came together real quick. And I think like, it's a really great thing.

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Appendix A

Memorandum of Understanding (MOU) between YWCA Hamilton and Student Researcher

Purpose:

The purpose of this document is to outline the terms and expectations of the research partnership and collaboration between YWCA Hamilton and the Student Researcher. This MOU complements the terms outlined in Operational Policy OPM007-3 “Research Policy”.

Name of Student Researcher:	Stephanie Milliken
Affiliated Post Secondary Institution:	McMaster University
Project Supervisor’s Name, Title and Contact Information:	Dr. Jennifer Ma, Assistant Professor ma168@mcmaster.ca
Department of YWCA Hamilton involved:	Housing and Gender Based Violence Support Services

Scope of the research project:

This section will outline the objectives, methodology, and timeline of the research project, ensuring that both parties have a clear understanding of what is expected. The research project must be a product to be submitted to a post secondary institution for the partial or full fulfillment of the requirements of a degree, research grant or otherwise specific purpose. This policy applies to all staff members who are involved in conducting research within the YWCA Hamilton, regardless of their job title or role.

What is the purpose of the research project (i.e. Master’s Degree, USRA, etc.)	Master of Social Work Degree
Project Title:	“Here, I feel completely whole”: Exploring how YWCA Hamilton’s Safer Drug Use Space supports women and non-binary people experiencing gender-based homelessness
Project Description (include objectives):	I am hoping to learn, from the perspective of the folks who use the program, what the program has done well and how it could improve in terms of providing supports to clients. I also would like to find out how clients feel about the program being gender-specific, as well as how they perceive it as being different from an all-gender safe consumption service. My hope is that this research can help advocates for/clients of safer consumption spaces in

	shelters and drop-in programs make a strong case to policymakers, social service organizations, and potential funders for supporting these integrated programs financially and at various policy levels. Additionally, I hope that the research done in this area can help us create a model that drop-ins and shelters can follow to operate their own safer use spaces in Hamilton and elsewhere in Canada.
Duration:	4 months (May 2023-August 2023)
Does the study involve human participants or only data?	Yes, it involves human participants.
Is Ethics Clearance required for this study? If so, how and when will you be obtaining it?	Yes – it has been obtained.
What methodology will be used?	Individual qualitative interviews.

What is your relationship with the organization being studied?	I am a Harm Reduction worker with the Safer Drug Use Space at YWCA Hamilton. I have worked at YWCA Hamilton for 5.5 years in a frontline capacity.
How do you think your relationship with the organization could affect your ability to conduct unbiased research?	Since I am invested in the longevity/success of the Safer Drug Use Space, and have worked with YWCA Hamilton for several years, this could affect how I ask questions from clients – I could be biased towards getting positive feedback from participants.
Are there any potential conflicts of interest that could arise from your relationship with the organization?	For participants: the fact that I am a staff in the Safer Drug Use Space means they may feel as though what they say might affect their ability to access the Space as well as other services from YWCA Hamilton. I explicitly say in my LOI that their participation will have no effect on their access to the Space and I will ensure that I state that to them verbally. I will be asking people if they would like to participate and interviewing them outside of SUS hours so I am not "working" and thus in a supervisory role in relation to them in those moments.

How do you plan to mitigate any potential conflicts of interest during the research project?	Before I begin my interview with a participant, I will state clearly that I have to clearly separate my two "staff" and "researcher" roles. After the interview, we will not be able to speak about what was discussed in the interview/I cannot act on any information from the interview unless they give me (and other SUS staff) that information again during a SUS shift when I am in my "staff" role. I will be pre-scheduling the interviews when I am not working as a staff, and the interviews will always be scheduled for the morning after SUS is closed. I will not have worked the night before, and the next shift I am scheduled to work after the interview, I will not work alone.
How will you ensure that your findings are objective and not influenced by your relationship with the organization?	I do not believe that it is possible to be entirely objective in research because all researchers and the institutions they work within have pre-existing frameworks and agendas that inform even their decision to pursue a particular project; that being said, I will be bringing the written transcripts from interviews back to participants so they can have a chance to veto or expand on something they have said, giving them more agency over what will be written based on the study.
Are there any ethical concerns that you have regarding your relationship with the organization and the research project?	I will need to be open and honest about what comes out of this research, even if the data collected indicates that there are ways that the program itself or operations of the organization could be improved. I will be clear with all participants that what is told to me when I am in my "researcher" role cannot transfer over to the "staff" role unless it is discussed in SUS with other staff present. I will explicitly state to all participants at the end of their interviews that the next time they see me after the interview, I will purposefully not mention the research project, and I will act as though we did not have that conversation. I will do this so they are prepared for this separation of my roles.
How will you handle any conflicts that may arise during the research project?	In my LOI, as well as in my script for recruitment which I will go through with every

	participant, I have clearly stated that participation in this study is voluntary and participants can withdraw at any time up until June 30, 2023. There are no consequences for withdrawing, and I am giving participants their honorarium at the time of signing the consent form so they may keep their honorarium even if they withdraw after consenting to participate.
What confidentiality protections will you put in place to ensure the protection of human participants or their data?	Every effort will be made to protect confidentiality and privacy. I will not use names or any information that would allow participants to be identified. However, since folks are often identifiable through the stories we tell., I will ask them this keep this in mind in deciding what to tell me. The information/data provided by participants will be kept on MacDrive and will be protected by a password. Once the study is complete, an archive of the data, without identifying information, will be maintained on MacDrive for potential use in future studies conducted by myself. If legal authorities request the information provided, I will defend its confidentiality.

Responsibilities of YWCA Hamilton:

- Assess all Thesis, Dissertation and Research proposals for minimal risk.
- Provide appropriate access to all necessary data required for the research project. Ensure that all secondary data is depersonalized as needed.
- Provide necessary support and guidance to the Student Researcher throughout the project.
- Ensure that the Student Researcher has access to all necessary facilities to carry out the research project.
- Provide any necessary documentation or information to the Student Researcher related to the research project.
- Ensure successful completion of the administrative and/or ethical review process

Responsibilities of the Student Researcher:

- Shall familiarize themselves with YWCA Hamilton's policies and procedures.
- Ensure successful completion of the administrative and/or ethical review process
- Ensure that proposed research does not carry any potential to harm clients, communities, staff members or the reputation of YWCA Hamilton.

- Conduct the research project in accordance with the agreed-upon research methodology and project timeline.
- Provide regular progress reports to the YWCA Hamilton and respond promptly to any requests for information or clarification.
- Respect the confidentiality of any information obtained during the research project and ensure that the data collected is used solely for the purpose of the research project.
- Acknowledge the YWCA Hamilton in any publications or presentations related to the research project, unless directed otherwise.

(If applicable) Rights of the Research Participants:

All potential research participants must provide informed consent prior to agreeing to participate in any research conducted at YWCA Hamilton. Signed consent must be received prior to participation in any research. All participants (e.g., interviewees, research subjects, community members, etc.) have the right to be informed of:

- The nature of the research (hypotheses, goals and objectives, etc.)
- The research methodology to be used (e.g., questionnaires, participant observation, etc.);
- Any risks or benefits;
- Their right not to participate, not to answer any questions, and/or to terminate participation at any time without prejudice (e.g., without academic penalty, withdrawal of remuneration, etc.);
- Their right to anonymity and confidentiality;
- Any other issues of which the participants should be aware that is relevant to specific protocols and research projects;

Intellectual Property:

Any intellectual property generated during the research project shall be the property of the aforementioned post-secondary research institution and the YWCA Hamilton. The Student Researcher shall acknowledge the YWCA Hamilton in any publications or presentations related to the research project, unless directed otherwise.

Publication and Dissemination:

The Student Researcher shall provide the YWCA Hamilton with a copy of any publications or presentations resulting from the research project. The YWCA Hamilton shall have the right to review and approve any publication or presentation prior to dissemination. The YWCA Hamilton shall have the right to utilize any publication or presentation produced as a by-product of the research.

Suspension of Research:

YWCA Hamilton reserves the right to suspend research in any program area if circumstances no longer allow for its continuation, or if research activities contravene the original agreement between YWCA Hamilton and the researchers involved. Allegations of misconduct during the research process will be taken seriously by YWCA Hamilton. A Senior Analyst will follow up

on any complaints that may come forward about a research project conducted at, or in collaboration with YWCA Hamilton. In the event of suspension, the Student Researcher shall provide the YWCA Hamilton with any data collected up to the date of suspension.

Related Policies/Procedures/Documents:

- YWCA Hamilton Research Policy
- YWCA Hamilton Anti-Racism Anti-Oppression Policy
- YWCA Hamilton Public Relations, Communications and Advocacy Policy

By signing below, the parties agree to the terms and conditions of this MOU and that you have read all related policies/procedures/documents.

YWCA Hamilton:

[Name], [Title]
Date: ________________________

Student Researcher:

Stephanie Milliken
Date: ________________________

Appendix B

Study Title: "Here, I feel completely whole": Exploring how YWCA Hamilton's Safer Drug Use Space supports women and non-binary people experiencing gender-based homelessness

In-class/In-person recruitment script

Hello, my name is Stephanie Milliken and I am a Masters student in the Department of Social Work. I am doing a study about the supports provided by YWCA Hamilton's Safer Drug Use Space under the supervision of Dr. Jennifer Ma.

We are looking for volunteers who self-identify as a woman or non-binary, are 21 years old or older, are currently experiencing homelessness, and have regularly visited YWCA Hamilton's Safer Drug Use Space (average of once per week for the last six months) since it opened in April, 2022.

The study involves a structured interview and short demographic form. The demographic form will be completed by myself (Stephanie) by hand on your behalf before we begin the interview. This will take approximately 30-60 minutes and will involve 1 session. The study will take place at the YWCA Hamilton Safer Drug Use Space.

In appreciation for your time, you will receive $30.00.

There are minimal risks involved in participating in this study. You may feel uncomfortable with (anxious, uneasy about) discussing your opinions about how the Safer Drug Use Space operates because you use the program as a client and I am a staff in the program. You may find it stressful to speak candidly about what folks who use drugs and experience homelessness need from safe consumption programs because of prior/current experiences of stigmatization and prejudice.

Participation in this study is voluntary. If you decide to be part of the study, you can stop (withdraw) from the interview for whatever reason, even after giving consent or part-way through the study or up until June 30, 2023. If you decide to withdraw, there will be no consequences to you, and you may keep the $30.00 honorarium. In cases of withdrawal, any data you have provided will be destroyed unless you indicate otherwise. If you do not want to answer some of the questions you do not have to, but you can still be in the study.

Your decision whether or not to be part of the study will not affect your continuing access to services from YWCA Hamilton's Safer Drug Use Space.

If you are interested in participating:

- Email me (Stephanie Milliken) at milliks@mcmaster.ca, or
- Come see me at YWCA Hamilton's Safer Drug Use Space

Thank you.

This study has been reviewed and received ethics clearance from the McMaster Research Ethics Board.

Appendix C

LETTER OF INFORMATION / CONSENT

"Here, I feel completely whole": Exploring how YWCA Hamilton's Safer Drug Use Space supports women and non-binary people experiencing gender-based homelessness"

Student Investigator: **Faculty Supervisor:** Dr. Jennifer Ma

Stephanie Milliken
Department of Social Work
McMaster University
Hamilton, Ontario, Canada

E-mail: milliks@mcmaster.ca

Dr. Jennifer Ma
Department of Social Work
McMaster University
Hamilton, Ontario, Canada
(905) 525-9140 ext. 21587
E-mail: ma168@mcmaster.ca

What am I trying to discover?

You are invited to take part in this study about YWCA Hamilton's Safer Drug Use Space and how it has supported clients during its first year of operation. I am hoping to learn, from the perspective of the folks who use the program, what the program has done well and how it could improve in terms of providing supports to clients. I also hope to find out how clients feel about the program being gender-specific, as well as how they perceive it as being different from an all-gender safe consumption service.

I am doing this research for a thesis under the supervision of Dr. Jennifer Ma. This is a line of research that I hope to continue in the future and will use your data for this project as well as for future related studies.

What will happen during the study?

In this study, you will meet me in person at YWCA Hamilton's Safer Drug Use Space (75 MacNab St S.) after program ends, at a pre-scheduled time between 9:30am and 12:00pm. You will be provided refreshments and colouring supplies to use during the interview when you arrive and as we go through the consent process. As we go through the consent process, you will be given your honorarium. You will then be asked to answer a short series of questions about your experiences using the Safer Drug Use Space during a 30 to 60 minute-long one-on-one interview. You will be asked the following questions:

1. How often do you come to YWCA's Safer Drug Use Space? Why?
2. We use a harm reduction approach in the delivery of the Safer Drug Use Space program. In what ways do you see this approach prioritized (or not) in our space?
3. Our Safer Drug Use Space is gender-specific – does this affect how comfortable you feel accessing and/or using in the space?

   a. From your perspective, are there benefits to the program being gender-specific?
   b. What is unique about our gender-based approach to harm reduction services?
4. YWCA Hamilton's Safer Drug Use Space is one of two safe consumption programs in Hamilton. Do you use Urban Core's all-gender safe consumption service? Why or why not? How often do you go to Urban Core?
5. What is YWCA's Safer Drug Use Space "like"? How are clients supported through the program?
6. Besides safer consumption, what other supports have you accessed through YWCA's Safer Drug Use Space?
7. What are some important values or "vibes" a space like the Safer Drug Use Space should embody? Do we do embody these values at the Safer Drug Use Space?
8. Do you have any recommendations for how safe consumption sites could improve for folks who use them?

I will also ask you for some demographic/background information like your age and education. With your permission, I would like to type notes on my computer during the interview and supplement my typed notes by audio-recording the interview. If you do not consent to audio-recording, that is okay. You can take a break at any time throughout the interview. You may also withdraw your consent for participation at any time during the interview by telling me you do not wish to continue. After the interview, if you indicate on this form that you would like to review your written transcript, I will contact you to do so in-person at the Safer Drug Use Space before June 30, 2023.

Are there any risks to doing this study?]

There are minimal risks involved in participating in this study. You may feel uncomfortable with (anxious, uneasy about) discussing your opinions about how the Safer Drug Use Space operates because you use the program as a client and I am a staff in the program. You may find it stressful to speak candidly about what folks who use drugs and experience homelessness need from safe consumption programs because of prior/current experiences of stigmatization and prejudice.

You do not need to answer questions that you do not want to answer or that make you feel uncomfortable I will provide you with a document which includes contact information for community support and counselling services if you feel distress as a result of participating in this study. I also describe below the steps I am taking to protect your privacy

Are there any benefits to doing this study?

The research will not benefit you directly. I hope that what is learned as a result of this study will help us better understand what benefits a safer use space in emergency drop-ins and shelters provide for folks who are unhoused and use substances. This could help us both provide a strong a case to policymakers and funders on the importance of these spaces, as well as create a model that drop-ins and shelters can use to open their own safer use spaces in Hamilton and elsewhere in Canada.

Incentive/Payment or Reimbursement

Participants of this study will be compensated $30.00 in cash for their time.

Who will know what I said or did in the study?

I will be recording audio of the interviews using a handheld audio recording device. The only person who will have access to these audio recordings is myself, Stephanie Milliken. I will be transcribing the interviews myself, and recordings will be deleted after they are transcribed. If you would like, you can review a written copy of your interview transcript once I have finished transcribing your interview so you can edit, delete, or add information at that time.

Every effort will be made to protect your confidentiality and privacy. I will not use your name or any information that would allow you to be identified. However, we are often identifiable through the stories we tell. Please keep this in mind in deciding what to tell us.

The information/data you provide will be kept on MacDrive and will be protected by a password. Once the study is complete, an archive of the data, without identifying information, will be maintained on MacDrive for potential use in future studies conducted by myself, Stephanie Milliken.

Legally Required Disclosure:

ii) I will protect your privacy as outlined above. If legal authorities request the information you have provided, I will defend its confidentiality.

What if I change my mind about being in the study?]

Your participation in this study is voluntary. If you decide to be part of the study, you can stop (withdraw) from the interview for whatever reason, even after giving consent or part-way through the study or up until June 30, 2023, because I will submit the first draft of my thesis to my supervisor on July 1, 2023. During the interview, you may withdraw by simply telling me (the interviewer) of your wishes. If you would like to withdraw after the interview, you may do so by emailing me (Stephanie) at milliks@mcmaster.ca and asking me to withdraw your information.

If you decide to withdraw, there will be no consequences to you. In cases of withdrawal, any data you have provided will be destroyed unless you indicate otherwise. If you do not want to answer some of the questions you do not have to, but you can still be in the study.

Your decision whether or not to be part of the study will not affect your continuing access to services from YWCA Hamilton's Safer Drug Use Space.

How do I find out what was learned in this study?

I expect to have this study completed by approximately September 1, 2023. A physical copy summary of the results will be posted at YWCA Hamilton's Safer Drug Use Space, as well as on YWCA Hamilton's website. If you would like to receive the summary personally, please let me know how you would like me to send it to you.

Questions about the Study: If you have questions or need more information about the study itself, please contact me at:

Stephanie Milliken
milliks@mcmaster.ca

This study has been reviewed by the McMaster Research Ethics Board and received ethics clearance. If you have concerns or questions about your rights as a participant or about the way the study is conducted, please contact:

McMaster Research Ethics Board Secretariat
Telephone: (905) 525-9140 ext. 23142

E-mail: ethicsoffice@mcmaster.ca

CONSENT

- I have read the information presented in the information letter about a study being conducted by Stephanie Milliken of McMaster University.
- I have received my honorarium of $30.00 from the researcher (Stephanie Milliken).
- I consent to the researcher (Stephanie Milliken) using direct quotations from the interview in any write ups based on the study as long as my real name is not used and the quotation does not include identifying details.
- I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.
- I understand that if I agree to participate in this study, I may withdraw from the study at any time or up until June 30, 2023.
- I have been given a copy of this form.
- I agree to participate in the study.

Signature: ______________________________________ Date: ________________________

Name of Participant (Printed) ___________________________________

Consent Questions:

1. Would you like a copy of the study results? If yes, where should we send them (email, mailing address)?

   ____

2. Would you like to review a copy of the transcript from this interview? Yes / No

3. Do you agree to audio recording? Yes / No

Appendix D

"Here, I feel completely whole": Exploring how YWCA Hamilton's Safer Drug Use Space supports women and non-binary people experiencing gender-based homelessness"

Demographic Survey

1. What year were you born?

    ____

2. Where were you born?
    - Canada
    - Outside of Canada
    - Not sure
    - Prefer not to answer

    If you were born outside of Canada, where were you born?

    ____

3. How do you identify your gender? Gender refers to your current gender, which may be different from the sex assigned to you at birth and may be different from what is indicated on your identification or legal documents. Select all that apply.

    - Woman (cis or trans)
    - Man (cis or trans)
    - Non-Binary
    - Two-spirit
    - I use another term to describe my gender (genderqueer, non-binary, etc.) (please specify): ______________________
    - Not sure
    - Prefer not to answer

4. Do you identify as trans or non-binary?
    - Yes
    - No
    - Not sure
    - Prefer not to answer

5. How do you identify your race or ethnicity? Select all that apply.

    - East Asian (e.g. Chinese, Japanese, Korean)

- South Asian (e.g. Indian, Pakistani, Sri Lankan)
- South East Asian (e.g. Malaysian, Filipino, Vietnamese)
- Black (African)
- Black (Caribbean)
- Black (North American)
- Latin American (e.g. Argentinean, Brazilian, Salvadoran)
- Middle Eastern (e.g. Egyptian, Iranian, Lebanese)
- White (European)
- White (North American)
- Mixed heritage (please specify): ___________________________
- First Nations
- Mètis
- Inuit
- Do not know
- Prefer not to answer
- I identify as… _______________________________

6. Regarding your relationship status, are you:

- Single
- In a long-term relationship
- Married
- Widowed
- Divorced
- Separated

7. Have you ever experienced an opioid poisoning or an overdose?

8. Have you ever participated in an opioid substitution therapy or Safer Supply program?

9. Do you experience any disabilities or chronic health issues that have an impact on your daily life? Select all that apply.

- Mobility Issues
- Deaf or hard of hearing
- Vision issues

- Environmental sensitivities (e.g. to smoke, perfume)
- Psychiatric or mental health challenges
- Cognitive or intellectual disabilities, learning difficulties
- Brain injury
- Pain-related disabilities
- Problems with substance use, addictions
- Chronic medical issues or major illnesses e.g. cancer, asthma
- Memory issues
- Prefer not to answer
- Do not know
- No disabilities
- I experience… ___________________________

10. Which substances have you historically used most often? (Drug of choice)

11. Where did you stay last night?

- Outside
- CAP
- TLP
- Permanent housing (rented or owned)
- Hospital
- Jail or detention centre
- Couch
- Other Hamilton shelter or drop-in (name is optional): _______________________
- Prefer not to answer
- Do not know
- I stayed… _____________________________

Where have you stayed most nights in the past year? ____________________________

12. What is your primary source of income?

Casual to full-time employment (1 to 40 hours per week minimum)
EI
ODSP
OW
Other (please specify): _____________________

13. Do you have children? If yes, how many?

14. What language(s) do you feel comfortable speaking, reading, and/or writing in?

15. Have you been to/admitted to hospital in the last 5 years? How many times?

16. Have you ever spent time in jail, prison, or in a juvenile detention facility?

Appendix E

Interview Questions

1. How often do you come to YWCA's Safer Drug Use Space? Why?
2. We use a harm reduction approach in the delivery of the Safer Drug Use Space program. In what ways do you see this approach prioritized (or not) in our space?
3. Our Safer Drug Use Space is gender-specific – does this affect how comfortable you feel accessing and/or using in the space?
    a. From your perspective, are there benefits to the program being gender-specific?
    b. What is unique about our gender-based approach to harm reduction services?
4. YWCA Hamilton's Safer Drug Use Space is one of two safe consumption programs in Hamilton. Do you use Urban Core's all-gender safe consumption service? Why or why not? How often do you go to Urban Core?
5. What is YWCA's Safer Drug Use Space "like"? How are clients supported through the program?
6. Besides safer consumption, what other supports have you accessed through YWCA's Safer Drug Use Space?
7. What are some important values or "vibes" a space like the Safer Drug Use Space should embody? Do we do embody these values at the Safer Drug Use Space?
8. Do you have any recommendations for how safe consumption sites could improve for folks who use them?