Gender Gaps in Harm Reduction Services: Understanding Women’s Experiences with Supervised Consumption Sites

by

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Abstract

In Canada, the opioid overdose crisis continues to have significantly adverse impacts on people who use drugs, their loved ones, and their communities. Increasingly, understanding the impacts of this crisis, as well as the impacts of supports and services aimed at reducing these harms, through a gendered lens has become the focus of researchers and public health officials alike. In line with this, the objective of the current research was to interrogate women’s experiences with one particular substance use intervention, supervised consumption sites, particularly barriers to accessing, experiences within, and outcomes of these sites. During Phase 1, nine women attending a supervised consumption site in Ottawa, Ontario provided feedback on the proposed methods for the second phase of this research. This phase concluded with minor revisions being made to the methodology for the second phase of the research as a result of the feedback solicited from participants. During Phase 2, seven women from the same supervised consumption site completed a brief survey, which collected socio-demographic and health information, as well as information related to their substance use and use of supervised consumption sites. Participants also engaged in a semi-structured interview that asked questions related to barriers to accessing the site, their experiences within the site (e.g., relationships with staff and peers, feelings of safety), as well as the impacts of the site on their drug use and other aspects of their lives. Findings from this second phase highlight the critical role of connection within these spaces, particularly connection to staff, peers, and various supports, including support to engage in safer drug use, as well as health and community resources. Although participants generally had positive relationships with site staff and peers, and overall, felt safe within the site, some participants also highlighted the violence and harassment present both within and outside of the facility. From a psychological perspective, these findings highlight the
role supervised consumption sites play in providing much-needed support to women who use
drugs, and, concurrently, the importance of ensuring these spaces are free of violence.
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Dedication

To the women who shared their experiences with me: quite simply and sincerely, thank you. This research is not just about you – it is for you.
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Gender Gaps in Harm Reduction Services: Understanding Women’s Experiences with Supervised Consumption Sites

Issues related to substance use have increasingly become the topic of societal and political discourses in recent years, due in large part to the burgeoning opioid overdose crisis that is permeating and devastating communities, both in Canada and abroad. Yet, until more recently, there has been a paucity of attention given to understanding both the gendered nature of this crisis, as well as the differential impact of interventions. In view of this, the research described hereafter, which departs from a feminist psychological perspective, aims to understand women’s experiences with a particular substance use intervention – supervised consumption sites.

In order to situate the ensuing discussion in the context of Canada’s opioid overdose crisis, it is necessary to first examine the plethora of harms experienced by individuals who use opioids, including apparent opioid toxicity deaths, opioid poisoning hospitalizations, and suspected opioid-related overdoses, as well as responses to opioid-related harms. This is subsequently followed by a discussion of a feminist psychological perspective of substance use and harm reduction interventions.

The Opioid Overdose Crisis in Canada

Opioids are a class of drugs with analgesic (i.e., pain-relieving) properties. This class of drugs includes codeine, fentanyl, morphine, oxycodone, hydromorphone, and heroin, among other drugs. Opioids, although often prescribed by physicians to treat pain, are also used illicitly for a myriad of reasons, including to experience a sense of euphoria, as well as to “numb” both physical and emotional pain. In recent years, the prevalence and severity of harms caused by opioid use has escalated in Canada. This trend has been attributed to physicians’ prescribing practices (i.e., a tendency to over-prescribe opioids), as well as the increasingly toxic illegal drug
supply in Canada, among other things. In response to the significant rise in opioid-related harms, there has been a tendency to refer to and approach the harms associated with opioid use in Canada as a “crisis.” Indeed, the federal government’s response to this issue has integrated the notion that substance-related harms are very much a public health crisis (Public Health Agency of Canada, 2022).

Opioid poisoning and mortality exemplify the immense harms associated with opioid use. To illustrate the magnitude of these harms in Canada, data on apparent opioid toxicity deaths, as well as opioid poisoning hospitalizations, are provided below. Additionally, data related to suspected opioid-related overdoses based on emergency medical services are highlighted. Where possible, data are disaggregated by sex and age to demonstrate the extent to which opioid-related harms vary among women and men of different ages in Canada.¹

**Apparent Opioid Toxicity Deaths**

Apparent opioid toxicity deaths are defined as deaths “caused by intoxication/toxicity (poisoning) resulting from substance use, where one or more of the substances is an opioid, regardless of how it was obtained (e.g., illegally or through personal prescription; Federal, Provincial, and Territorial Special Advisory Committee on the Epidemic of Opioid Overdoses [Special Advisory Committee], 2022).” Recent research illustrates the extraordinary prevalence of apparent opioid toxicity deaths in Canada. Given that the current research takes place in Ontario, statistics presented below are provided both at the national level and for the province.

¹ These data were not disaggregated by other characteristics (e.g., race, Indigenous identity, immigrant status).
Between January 2016 and June 2022, there were 32,632 apparent opioid toxicity deaths in Canada, with 11,844 (36.3%) of these deaths taking place in Ontario. During the first half of 2022 (i.e., between January and June), 3,556 apparent opioid toxicity deaths occurred in Canada (1,278 in Ontario), which corresponds to approximately 20 deaths per day (and about seven deaths per day in Ontario). In comparison, in 2016, there were about eight apparent opioid toxicity deaths per day in Canada (and about two deaths per day in Ontario). The age-adjusted rate of apparent opioid toxicity deaths in Canada in the first half of 2022 was almost triple that of the rate in 2016 (19.3 vs. 7.8, respectively). In Ontario, the age-adjusted rate of apparent opioid toxicity deaths was 17.1 per 100,000 population during the first half of 2022 (vs. 6.3 per 100,000 population in 2016). The vast majority (89.7%) of apparent opioid toxicity deaths in Canada took place in three provinces between January and June 2022: British Columbia, Alberta, and Ontario (Special Advisory Committee, 2022).

The overwhelming majority of apparent opioid toxicity deaths at both the national level (96.8%) and in Ontario (96.4%) were accidental in nature during the first half of 2022. Notably, there has been a gradual increase in the proportion of apparent opioid toxicity deaths that were deemed accidental in nature at the national level since 2016, at which point 87% of these deaths were classified as accidental (Special Advisory Committee, 2022).

At the national level, about three-quarters (76%) of accidental apparent opioid toxicity deaths in the first half of 2022 were among men, while 24% were among women—a pattern that

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2 This includes deaths from British Columbia (2019 to June 2022) related to all licit drugs and Quebec (2021 to June 2022) related to drug or opioid-related intoxication.

3 It should be noted that all data presented in this section related to apparent opioid toxicity deaths, opioid poisoning hospitalizations, and emergency medical services responses to suspected opioid-related overdoses use the sex variable, and therefore use the terms “male” and “female.” For consistency with the terminology used throughout the rest of this dissertation, the terms “women” and “men” are used in this section instead.
has been relatively consistent since 2016. In Ontario, just under one-quarter (23%) of all accidental apparent opioid toxicity deaths between January and June 2022 were among women, which was lower than the proportion of such deaths that were among women in 2016 (29%). The crude rate of accidental apparent opioid toxicity deaths among men in Canada during the first half of 2022 was more than three times greater than the rate observed among women (20.2 per 100,000 population vs. 6.3 per 100,000 population, respectively). In Ontario, it was about 3.5 times greater for men (25.5 per 100,000 population) than women (7.3 per 100,000 population; Special Advisory Committee, 2022).

In Canada, most accidental apparent opioid toxicity deaths between January and June 2022 occurred among those aged 20 to 59 years: 15% were among those aged 20 to 29, 28% among those aged 30 to 39, 25% among those aged 40 to 49, and 20% among those aged 50 to 59. Another ten percent of accidental apparent opioid toxicity deaths occurred among people aged 60 years and older (Special Advisory Committee, 2022).

Three-quarters (76%) of accidental apparent opioid toxicity deaths in Canada during the first half of 2022 involved fentanyl, while 14% involved fentanyl analogues and 25% involved non-fentanyl opioids. In Ontario, 87% of all accidental apparent opioid deaths between January and June 2022 involved fentanyl, while about one-quarter (24%) of these deaths involved non-fentanyl opioids, and 5% involved fentanyl analogues. About 7 in 10 (72%) accidental opioid toxicity deaths in Canada during the first half of 2022 among women involved opioids that were only non-pharmaceutical (vs. 81% among men), 15% involved opioids that were pharmaceutical.

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4 Age-adjusted data were not provided.
5 The distribution of accidental apparent opioid toxicity deaths between January and June 2022 across age groups was virtually identical in Ontario.
6 According to the Special Advisory Committee (2022), “Opioids with a pharmaceutical origin refer to opioids that were manufactured by a pharmaceutical company and approved for medical
only (vs. 9% among men), and 8% involved opioids that were both pharmaceutical and non-
pharmaceutical (vs. 7% among men).\(^7\)\(^8\) Almost half of apparent opioid toxicity deaths in Canada 
between January and June 2022 involved a stimulant (47%), whereas this was the case for about 
3 in 5 (61%) of these deaths in Ontario. Further, 48% of accidental apparent opioid toxicity 
deaths during this time period involved other psychoactive substances (compared to 36% in 
Ontario; Special Advisory Committee, 2022).

**Opioid-Related Poisoning Hospitalizations**

In addition to death caused by apparent opioid poisoning, it is important to also consider 
the magnitude and impacts of other opioid-related harms, including non-fatal opioid poisonings. 
According to the Canadian Institute for Health Information (CIHI), opioid poisoning can occur 
when an individual uses an opioid incorrectly, such as taking the wrong dosage, using opioids in 
combination with another prescribed substance or alcohol, or not taking the opioid as 
recommended (CIHI, 2018). Certainly, opioid poisonings can also be intentional, as will be 
evidenced below.

Between January 2016 and June 2022, there were 33,493 opioid-related poisoning 
hospitalizations in Canada.\(^9\) During the first half of 2022, 2,524 opioid-related poisoning 
hospitalizations occurred in Canada, corresponding to 14 hospitalizations per day, which is 
comparable to the number of hospitalizations per day (\(n = 13\)) in 2016. In Ontario, there were 
975 total opioid-related poisoning hospitalizations between January and June 2022,

\(^7\) The origin of opioid(s) involved in 5% and 4% of accidental opioid toxicity deaths among 
women and men, respectively, was ‘undetermined.’

\(^8\) Similar patterns were observed in Ontario.

\(^9\) Excluding Quebec.
corresponding to an age-adjusted rate of 12.6 per 100,000 population. At the national level, the age-adjusted rate of opioid-related poisoning hospitalizations was 16.6 per 100,000 in the first half of 2022, while it was 12.6 per 100,000 in Ontario. Like apparent opioid toxicity deaths, the majority (88.2%) of opioid-related poisoning hospitalizations that took place during the first half of 2022 occurred in British Columbia, Alberta, and Ontario (Special Advisory Committee, 2022).

About 7 in 10 (71.6%) opioid-related poisoning hospitalizations between January and June 2022 in Canada were accidental in nature, whereas 18.7% were intentional. Of note, the proportion of opioid-related poisoning hospitalizations that were deemed accidental in nature has increased since 2016, at which point over half (55.4%) of all such hospitalizations were accidental, while the number of intentional opioid-related poisoning hospitalizations has decreased from 29.2%. In Ontario, two-thirds (66.2%) of opioid-related poisoning hospitalizations were deemed accidental in nature between January and June 2022 (Special Advisory Committee, 2022).

Men comprised the majority (62%) of all opioid-related poisoning hospitalizations at the national level during the first half of 2022, although to a lesser extent than their representation among apparent opioid toxicity deaths. Notably, women’s representation among opioid-related poisoning hospitalizations in Canada has decreased since 2016: whereas women accounted for half (50%) of all opioid-related poisoning hospitalizations in 2016, they represented less than 2 in 5 (38%) of such hospitalizations during the first half of 2022. However, women accounted for more than half (54%) of all intentional opioid-related poisoning hospitalizations, while about

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10 The intention behind 10% of opioid-related hospitalizations was unknown.
one-third (34%) of all accidental opioid-related poisoning hospitalizations were among women (Special Advisory Committee, 2022).\footnote{Similarly, 36% of all accidental opioid-related poisoning hospitalizations in Ontario between January and June 2022 were among women.}

Women’s representation among opioid-related poisoning hospitalizations in Canada during the first half of 2022 was greater among certain age groups than others. Specifically, women accounted for almost 3 in 5 (57.3%) opioid-related poisoning hospitalizations among those aged 0 to 19 and about half (48.6%) of those aged 60 years and over. Among the other age groups, the proportion of total opioid-related poisoning hospitalizations that occurred among women ranged from 30.0% to 37.0%. A similar pattern was observed when examining only accidental opioid-related poisoning hospitalizations: women accounted for 43.0% and 46.6% of people aged 0 to 19 years and 60 years and older, respectively, who were hospitalized for accidental opioid-related poisoning during the first half of 2022, compared to between 26.0% and 33.0% in the other age groups. In contrast, the representation of women among people aged 0 to 19 years who were hospitalized for intentional opioid-related poisoning hospitalizations was particularly high, with 4 in 5 (80.9%) occurring among women. In the other age groups, women represented between 46% and 56% of those hospitalized for intentional opioid-related poisoning (Special Advisory Committee, 2022).

Almost one-third (32%) of accidental opioid-related poisoning hospitalizations in Canada between January and June 2022 involved fentanyl or fentanyl analogues, compared to 19% in 2018. About one-quarter (24%) of accidental opioid-related poisoning hospitalizations during the first half of 2022 involved co-occurring non-opioid poisonings, 16% involved co-occurring stimulant poisonings, and 14% involved co-occurring non-stimulant/non-opioid poisonings. In
contrast, almost half (46%) of intentional opioid-related poisoning hospitalizations involved a co-occurring non-opioid substance (Special Advisory Committee, 2022).

**Emergency Medical Services Responses to Suspected Opioid-Related Overdoses**

In addition to hospitalization, a number of individuals seek care from emergency medical services (EMS) in the wake of an opioid-related poisoning. Between January and June 2022, there were 18,287 EMS responses to suspected opioid-related overdoses, corresponding to slightly more than 100 responses per day. In Ontario specifically, there was close to 1,000 such responses during the first half of 2022 (or about 6 responses per day). At both the national level and in Ontario, the majority (73%) of EMS responses for suspected opioid-related overdoses between January and June 2022 were among men. However, further disaggregation by age revealed that the proportions of women among EMS responses to suspected opioid-related overdoses in Ontario between January and June 2022 were slightly higher in the younger age groups, as well as the oldest age group. Specifically, women accounted for about 3 in 10 EMS responses to suspected opioid-related overdoses among those aged 0 to 19 years, 20 to 29 years, and 60 years and over, compared to about one-quarter among the other age groups (Special Advisory Committee, 2022).

Although the trends highlighted above suggest that men are disproportionately impacted by the significant harms associated with opioid use, women, too, have been – and continue to be – impacted by the opioid overdose crisis. Quite arguably, the over-representation of men among apparent opioid toxicity deaths, opioid-related poisoning hospitalizations, and EMS responses to suspected opioid-related overdoses obscures how women are experiencing and navigating this crisis. Indeed, the tendency for societal discourse and empirical research to focus on men may

12 These data are based on available data from eight provinces and territories.
render opioid-related harms (including harms that extend beyond fatalities and poisonings) experienced by women, as well as their unique treatment needs, invisible. While sensitive to the undeniable need to continue investigating how the opioid overdose crisis has, and continues to, impact men (and non-binary people) in Canada, women must continue to be the focus of empirical research on this topic in order to more effectively understand the gendered nature of the current opioid overdose crisis. In this regard, this research focuses on women’s unique experiences in the context of this crisis, particularly their experiences with substance use interventions.

Responses to Opioid-Related Harms

Societal and political discourses, as well as efforts to understand and address substance use, have traditionally been aligned with one of two models: the disease model and the moral model. The former perspective views addiction as an issue extending beyond the control of people who use drugs (Marlatt & Witkiewitz, 2010). According to the disease model, factors such as family history and genetics contribute to an individual’s likelihood of developing an addiction (Marlatt & Witkiewitz, 2010). The latter is a prohibitive perspective that condemns – and even punishes – people who use drugs for their behaviour. This model, in essence, regards substance use as an immoral behaviour. Dialogues stemming from this belief tend to incite shame, guilt, and stigma around and among people who use drugs (Marlatt & Witkiewitz, 2010).

The moral approach to substance use is reflected in Canada’s current drug policies, the foundation for which was laid in the early twentieth century. Indeed, the origins of Canada’s drug laws can be traced back to the Opium Act of 1908 (followed shortly thereafter by the Opium and Drug Act of 1911), which prohibited, and imposed criminal penalties on, the importation,
manufacturing, sale, and use of opium for non-medical purposes (Mackay, 2018; Malleck, 2015). With this Act, “… the Government of Canada had achieved the legal prohibition of drugs that were considered to be physically, morally, economically, and socially debilitating to the body of the individual and to the body of the nation” (Malleck, 2015, p. 245). This prohibitive approach to drug use continued through to the 1960s, at which point pressures against this approach resulted in some amendments to drug policies in Canada, and, ultimately, a lessening of such a prohibitive approach (e.g., less severe sentences; Erickson, 1992). However, Canada witnessed a resurgence of this prohibitionist approach to drugs in the 1980s (Erickson, 1992). The current federal drug control statute, the Controlled Drugs and Substances Act (CDSA), enacted in 1996, departs from this prohibitionist perspective.

Harm reduction represents another approach to discussing, understanding, and addressing issues related to substance use. Conceptually, harm reduction encompasses interventions intended to reduce the negative consequences of behaviours (Marlatt, 1988). For example, the provision of clean razors for individuals who engage in self-harm behaviours (i.e., cutting) constitutes an effort intended to reduce the harms associated with cutting behaviour (Logan & Marlatt, 2010). Similarly, condoms serve to reduce the potential harms (e.g., transmission of sexual infections) associated with sexual behaviour and, instead, encourage safer sex (Logan & Marlatt, 2010).

In the context of substance use, harm reduction proposes an alternative approach to traditional substance use prevention and treatment modalities than what is offered by the moral and disease models. Interventions that depart from the moral model endorse the use of various forms of punishment, including incarceration, in an effort to eliminate substance use, while interventions based on the disease model focus on achieving complete abstinence from drugs
Harm reduction interventions recognize that, for some people who use drugs, they may be unable or unwilling to abstain from substance use. Accordingly, harm reduction interventions attempt to meet people who use drugs where they are, rather than impose upon them the (often unrealistic) requirement of total abstinence (Marlatt & Witkiewitz, 2010). In essence, then, harm reduction interventions, recognizing that abstinence may not be possible, endeavour to minimize the risks associated with substance use (Marlatt & Witkiewitz, 2010).

Over the last several decades, Canada has experienced an emergence and uptake of various harm reduction approaches to substance use. Needle exchange programs are one such approach. These programs aim to reduce the transmission of blood-borne diseases, such as the human immunodeficiency virus (HIV) and hepatitis, among individuals who engage in injection drug use (Logan & Marlatt, 2010). This is achieved through the provision of clean, sterile injection equipment. In addition to needle exchange programs, opioid substitution therapy is another prominent harm reduction approach to substance use. Opioid substitution therapy involves the replacement of both prescription and illicit opioids with other opioids (e.g., methadone) or opioid-receptor agonists (e.g., buprenorphine) under the supervision and management of medical practitioners (Marlatt & Witkiewitz, 2010).

A third harm reduction intervention intended to reduce the harms associated with substance use, especially intravenous use, is supervised consumption sites. The purpose of these sites is (at least) three-fold. First, supervised consumption sites aim to reduce the harms linked to illicit drug use, particularly the risk of overdose and the transmission of blood-borne diseases (Kennedy et al., 2017). A second purpose of these sites is to facilitate connections between people who use drugs and substance use treatment and/or other health and social services (Kennedy et al., 2017). Third, the implementation of supervised consumption sites is intended to
diminish the extent to which illicit drug use infringes upon public order and safety (Kennedy et al., 2017).

In Canada, supervised consumption sites are authorized to exist through an exemption under section 56.1 of the CDSA. The first federally-sanctioned supervised consumption site, Insite, opened in Vancouver in 2003. Located in Vancouver’s Downtown Eastside, the site was created in response to the opioid epidemic in the area. Until 2017, Insite was the sole federally-sanctioned supervised consumption site in Canada. Since this time, however, there has been a marked increase in the number of sites that have been granted an exemption under the CDSA. Presently, there are 38 supervised consumption sites in Canada, located in Alberta, British Columbia, Ontario, Quebec, and Saskatchewan that hold a valid exemption from Health Canada and are offering services to the public (Government of Canada, 2023).

Systematic reviews have sought to understand the effects of supervised consumption sites on health and community outcomes. These reviews have demonstrated the efficacy of supervised consumption sites in achieving their intended purposes. Indeed, these sites reduce the harms associated with the injection of illicit drugs, including mortality and risky behaviours associated with the transmission of blood-borne diseases (i.e., the sharing of injecting equipment; Kennedy et al., 2017; Potier et al., 2014). Further, supervised consumption sites provide people who use drugs with access to substance use treatment and other health and social services (Kennedy et al., 2017; Potier et al., 2014). Moreover, these sites are associated with a reduction in threats to public order and safety (e.g., drug use in public spaces; Kennedy et al., 2017; Potier et al., 2014).
Understanding Substance Use and Harm Reduction Interventions through a Feminist Psychological Lens

Much like other issues that have been the focus of psychological inquiry, substance use, including interventions to address substance use, is an area of investigation that psychologists have traditionally examined largely through an androcentric (i.e., male-centered) lens. Feminist psychology offers a unique way of understanding the issue of substance use and challenges the gendered biases that permeate the field, as it does with other topics of interest to psychologists. Accordingly, it is worth briefly describing this field of study, as well as the ways in which it contributes to the larger field of psychology.

Feminist psychology is defined as “the search for knowledge that could direct us to sociopolitical and personal change congruent with feminist goals” (Mednick, 1991, p. 612). In essence, research and theory in the field of feminist psychology can help achieve the feminist goal of eliminating sexism in our relationships with others, as well as in our social institutions (Yoder, 1989). As the women’s movement of the late 1960s drew attention to injustices experienced by women, both natural sciences and social sciences, including the field of psychology, also became the target of criticism (Crawford & Marecek, 1989; Crawford & Unger, 2004). These criticisms largely focused on the androcentric nature of psychological knowledge (Crawford & Unger, 2004). Indeed, subjects of relevance to women (e.g., rape) were considered trivial or taboo, and, thus, were not the focus of psychological inquiry (Riger, 2000). Further, women were often excluded from research samples in psychological research (Riger, 2000). Psychological research on women has also been critiqued for failing to adequately consider the influence of social contexts on behaviour (Riger, 2000).
Feminist psychology is, in large part, a response to the aforementioned criticisms of the field of psychology. Feminist psychological research (as well as feminist research in other fields) attempts to rectify these limitations by: challenging traditional scientific inquiry; focusing on the experience and lives of women; regarding power relations as the basis of asymmetrical political and social arrangements; recognizing gender as an essential category of analysis; paying attention to the use of language and the power to “name;” and promoting social activism with the goal of societal change (Worell & Etaugh, 1994). Accordingly, feminist psychologists have made great strides in transforming the ways in which we understand phenomenon from a psychological perspective. Nonetheless, there is much work to be done to more effectively integrate a feminist psychological perspective into certain areas of study, including substance use, and, thus, reap the positive contributions such a perspective can offer.

Feminist Psychological Perspective of Substance Use

Traditionally, research on substance use has approached the issue, from both a theoretical and methodological standpoint, in a way that is insensitive to the realities of women (Ettore, 1992). Certainly, a great deal of attention in the field of addictions has been devoted to understanding the experiences of men, given that they tend to be the most “visible” members of drug-using culture (Ettore, 1992). Accordingly, this bias toward understanding men’s experiences, much like the bias that has traditionally existed in other arenas of psychological inquiry, upholds traditional understandings and leaves the unique experiences of women largely unacknowledged, both in the realm of treatment and in research (Ettore, 1992). Additionally, women who engage in substance use have traditionally, and often continue to be, studied as a homogenous group without due consideration of how other aspects of their identity (e.g., race, age, disability) influence their experiences (Ettore, 1992). In light of this, a feminist
psychological perspective can provide a valuable lens through which psychologists can examine the experiences of women who engage in substance use, including their experiences with harm reduction interventions.

**Feminist Psychological Perspective of Harm Reduction Interventions**

A feminist psychological perspective of harm reduction interventions considers how gender (and its intersections with other identity characteristics) is implicated in such interventions. More often than not, psychological research on interventions for opioid use has failed to meaningfully consider how gender influences the trajectories of individuals’ experiences with interventions for opioid use. Said differently, psychological research often neglects how gender and its intersections with other identity characteristics may create unique barriers to accessing substance use treatment. Further, not all psychological research disaggregates data related to the outcomes of such interventions by gender and other identity characteristics (although progress continues to be made in this regard). Notably, however, feminist psychologists, and feminist researchers in other fields, have begun to address these limitations and consider how gender is implicated in experiences with harm reduction interventions for opioid use.

**Women’s Experiences with Harm Reduction Interventions**

A growing body of research has explored women’s experiences navigating traditional harm reduction interventions, especially their interactions with methadone maintenance treatment programs. This research has investigated barriers to women’s access to the services offered by these facilities. A significant barrier highlighted in the literature is the (unfortunately) common experience of gender-based violence among women who use drugs. Indeed, violence often impedes women’s entry into methadone maintenance treatment (Kelley et al., 1996).
Further, women who do access these services often experience differential outcomes as a function of their gender. Although, as highlighted above, violence can serve as a barrier to entry, it is also implicated in the retention (or lack thereof) of women in treatment. Violence may contribute to the need to interrupt or delay methadone maintenance treatment (Kelley et al., 1996). For example, for women experiencing intimate partner violence, attempts to find safety may leave little time or energy to fully and successfully engage in treatment (Kelley et al., 1996).

Research that has been undertaken with people who use drugs accessing Insite in Vancouver, as well as low-barrier overdose prevention sites in British Columbia, is an important starting point for understanding women’s experiences with supervised consumption sites, including barriers to accessing, experiences within, and outcomes of these sites. According to this research, women who engage in substance use may experience unique barriers to accessing supervised consumption sites. Much like the research (i.e., Kelley et al., 1996) that has highlighted how gender-based violence may act as an impediment to women’s access to other harm reduction interventions, such as methadone maintenance treatment programs, existing research on supervised consumption sites suggests that violence may also serve as a barrier to accessing the services offered by these facilities. Research conducted with people who use drugs in Vancouver’s Downtown Eastside highlighted that gender-based violence restricted the spatial movements of women and marginalized men within the drug scene, including their access to supervised consumption sites (McNeil et al., 2014). Most of the women sampled in McNeil et al. (2014)’s research indicated that they do not access Insite because the surrounding area is riddled with violence perpetrated by men. In an effort to uphold personal safety, they avoid the area surrounding Insite, even at the expense of not being able to access the services offered through
the site. This research demonstrates that gender-based violence may ultimately serve as a barrier to accessing supervised consumptions sites.

In addition to the apparent influence of gender on access to supervised consumption sites, experiences within these facilities may also be gendered. For example, these facilities have been characterized as “masculine” spaces (Boyd et al., 2018). According to recent research conducted by Boyd et al. (2018), women, particularly Indigenous women, are exposed to routine harassment perpetrated by men within these facilities. The (often) resulting fear that such harassment could lead to physical violence, in turn, serves as an impediment to accessing these services (Boyd et al., 2018). For other women, harassment is tolerated in these spaces, given that the alternative is resorting to using drugs in unsupervised – and potentially dangerous – spaces (Boyd et al., 2018).

Additionally, Boyd et al. (2018)’s research demonstrates the ways in which gendered expectations are enacted and upheld within supervised consumption sites. This is illustrated by women clients’ assertions that they were expected to conform to certain expectations with respect to both their use of the services, as well as their interactions with the men clientele. For example, women indicated that they were expected to tidy up and consume their drugs quickly, whereas these same expectations were not had of the men clients. Additionally, they were expected to assume a caretaker role in their relationships and interactions with the men clients, especially their partners. Taken together, this research suggests that gender-related factors may influence women’s experiences within supervised consumption sites.

Certainly, gender may affect women’s access to and experiences within supervised consumption sites. Despite best efforts to document and understand the outcomes of supervised consumption sites, considerably less is known about the extent to which potential outcomes of
these services – both positive and negative – vary as a function of gender. However, one such consequence that has been explored, to an extent, is how women’s use of supervised consumption sites contributes to their experiences of gender-based violence. Recent research reveals that supervised consumption facilities serve as a safe haven for women who use drugs that experience violence (Boyd et al., 2018; Fairbairn et al., 2008). Specifically, these researchers have suggested that, for women using the services provided through a supervised consumption site, these facilities present a space in which they can use substances without the fear of gendered and racialized violence that riddles the drug scene. Importantly, this seemingly positive consequence of supervised consumption is at odds with the previously discussed notion that violence serves as a barrier to accessing these facilities (e.g., McNeil et al., 2014).

The Current Study

Research Objectives

In an effort to contribute to the growing body of research on interventions for opioid use, particularly supervised consumption sites, the overarching objective of this research is to explore how women who use drugs engage with supervised consumption sites. Specifically, this research intends to provide a more nuanced and comprehensive understanding of women’s experiences with supervised consumption sites. To my knowledge, previous research has not yet explored, in a comprehensive manner, the trajectory of women’s interactions with supervised consumption sites. Although some research has identified gender-related factors, particularly the experience of gender-based violence, as influencing women’s access to, experiences within, and outcomes of supervised consumption sites, these investigations have tended to focus on one such aspect of the trajectory in isolation. Indeed, there has been no comprehensive examination of women’s experiences as they move in and out of these spaces.
Consequently, our understanding of the gendered experiences, particularly gender-based violence, of women who use supervised consumption sites is muddled. On the one hand, experiences of violence may serve as a barrier to accessing supervised consumption sites (McNeil et al., 2014). Further, for some women, their experiences within these sites may be characterized by violence and harassment perpetrated by men clients (Boyd et al., 2018). On the other hand, these facilities may also function as a space wherein women may be reprieved of the potential threat of and harms caused by violence outside of these spaces (Boyd et al., 2018; Fairbairn et al., 2008). Clearly, then, gender-based violence plays a seemingly contradictory role in the experiences of women as they move in and out of supervised consumption sites. This research endeavours to clarify the role of gender-based violence in women’s experiences with these sites by examining the entirety of the trajectory (i.e., access to, experiences within, and outcomes of supervised consumption sites).

It should also be noted that the potential gendered impacts of supervised consumption beyond the walls of the facility have not been extensively explored (Fairbairn et al., 2008). It is unclear, for example, whether the apparent potential of these sites to reduce women’s risk of experiencing violence and exploitation during drug consumption extends beyond women’s experiences within the site. Research that has examined other harm reduction interventions, however, suggests that such positive impacts may not extend outside of the immediate treatment setting. In methadone maintenance treatment, for example, research suggests that, despite providing temporary relief for women experiencing domestic violence, these facilities often fail to equip their women clients with survival tactics that they could employ outside of the clinic (Fraser, 1997).
Given the relative novelty of supervised consumptions in Canada, there is much to be learned about women’s access to, experiences within, and outcomes of these facilities. Certainly, Insite and low-barrier overdose prevention sites in Vancouver have served as a hotbed for a considerable amount of research, including the research that has demonstrated the seemingly positive outcomes of supervised consumption sites. Nonetheless, there remains a paucity of research left to be filled to understand supervised consumption sites in other parts of the country, including how these sites are shaped by the contexts in which they are embedded.

This research will build upon Boyd et al. (2018)’s ethnographic research in a low-barrier overdose prevention site to not only understand how gender influences women’s experiences within federally-sanctioned supervised consumption sites, but also their access to and outcomes of these sites. To this end, the research described hereafter, which departs from a feminist psychological perspective, has four main objectives. First, I endeavour to understand how gender creates unique barriers to accessing supervised consumption sites. Second, I examine how gender influences women’s experiences within these sites. Third, I consider the outcomes of supervised consumption sites for women. I will pay particular attention to responding to Fairbairn et al. (2008)’s call for research to assess how gendered experiences within supervised consumption sites translate into measurable impacts that extend beyond the walls of the facility. A fourth, cross-cutting objective of this research is to interrogate the seemingly contradictory role of gender-based violence in women’s interactions with supervised consumption sites.

Methodology

Phase 1

Participants. Participants were women recruited from a supervised consumption site located in Ottawa, Ontario. In Ottawa, there are currently four federally-sanctioned supervised
consumption sites that are offering services. One such site operates through Ottawa Inner City Health, a local organization that endeavours to improve health care services and access to such services for individuals in the community who experience chronic homelessness. Ottawa Inner City Health operates a host of programs and special projects, the latter of which includes the supervised consumption site.

To be eligible to participate in this research, participants had to identify as a woman, have previously accessed Ottawa Inner City Health’s supervised consumption site (at least once) to use their services, and be able to understand and communicate in English (given that I, as the sole researcher conducting this work, can only speak English). Individuals who were recruited were screened by the site’s staff/peer support workers to ensure that they met the aforementioned inclusion criteria before they could participate in this phase of the research.

A total of nine women participated in this phase of the research. There was no predefined number of participants that were sought for this phase. Rather, I entered this phase of the research with the intention to complete as many interviews as necessary to achieve theoretical saturation (i.e., the concepts that were revealed through the analysis of the data were well-developed and no new concepts emerged; Glaser & Strauss, 1967). Socio-demographic characteristics of the women who participated in this phase of the research were not collected.

Procedure. During this phase, I solicited feedback from participants regarding the proposed research objectives and methods for Phase 2 of this research. Contact was made with staff at the Ottawa Inner City Health’s supervised injection site to solicit their interest in and permission for me to undertake this research in their facility with their clients.

The COVID-19 pandemic interfered with the original intent to collect the data for Phase 1 of this research in person. At the time (i.e., in 2020), the increasing number of COVID-19
cases in the city of Ottawa resulted in the Carleton University Research Ethics Board suspending in-person data collection methods. Given the uncertainty of how long such restrictions would be in place, I decided to switch from in-person data collection to collecting the data through virtual methods. Specifically, rather than conduct the interviews for Phase 1 in a room at the supervised consumption site, the interviews were conducted through Zoom, a videoconferencing platform.

Mutually convenient dates and times were identified for both myself and site staff to undertake Phase 1 of this research. Irrespective of the fact that I was incapable of recruiting participants myself, due to my inability to be onsite for this phase of the research, site staff had previously indicated to me that they would prefer to handle participant recruitment. Given their previous interactions and rapport with individuals accessing the site, they were well positioned to identify women who may be interested in and available to participate in this research, as well as facilitate the logistics of organizing the meetings between myself and the participants. As such, on my behalf, site staff, volunteers, and peer support workers used a recruitment script (Appendix A) to solicit women clients’ interest in completing a short interview. Participants were provided with a brief overview of the purpose of this phase of the research, as well as the study writ large.

At the request of site staff, participants who were recruited to take part in an interview with me were accompanied by a peer support worker during the interview. Peer support workers provide support to others who share a common experience (i.e., have lived or living experience). In the case of Ottawa Inner City Health’s supervised consumption site, these individuals have or continue to use the site’s services themselves. Peer support workers assist site staff by providing varying forms of support (e.g., emotional, social) to their peers accessing the site. Their role in this study was to provide support to participants in both phases of the study. In particular, they
were present to provide support should uncomfortable or distressing discussions arise, as well as to help participants feel more comfortable. Each peer support worker signed a confidentiality agreement (Appendix B) that was submitted to me electronically.

Participants were escorted into a room at the supervised consumption site that had a computer stationed in it. Collecting participants’ names through written consent forms precludes this study being conducted as anonymously as possible. In view of this, after greeting the participant, I sought oral consent to participate in this phase of the research using a script (Appendix C). The information contained in the script provided participants with an overview of the study’s objectives, their role in the research, risks and benefits to participating, as well as information about anonymity, privacy and confidentiality, voluntariness, and remuneration. Participants were subsequently asked to verbally indicate if they consented to participate in this phase of data collection. A consent log (Appendix D) was used to record the date and time that each participant provided consent.

Once oral consent was obtained, I engaged in brief semi-structured interviews with participants. Semi-structured interviews are interviews that use a pre-defined set of open-ended questions as a frame for the interview (Given, 2008). During these interviews, I provided an overview of the proposed research, including the research objectives, a description of each element of the research methodology for Phase 2 (i.e., participant observation, survey, and interview), as well as shared the data collection tools (i.e., the survey and interview guide for Phase 2) with participants. An interview guide (Appendix E) was used to facilitate discussions with participants about each element of the research methodology, and, ultimately, to solicit their feedback on these elements. Handwritten notes were taken to document participants’ feedback. These semi-structured interviews were not audio-recorded.
When the interviews were finished, participants were provided with a debriefing form (Appendix F) that outlined the purpose of this research and contact information for the research team, as well as with a list of community resources (Appendix G). I also allowed time at the end of the interview to respond to any questions participants had. Participants were compensated $15.00 CAD in cash for participating in this phase of this research. The amount and type of compensation is in line with what the staff at Ottawa Inner City Health requested, as well as with recent research that establishes this amount as fair compensation that does not patronize people who use substances.

This phase concluded by reflecting on and incorporating the feedback gained from clients in an effort to enhance both the objectives and methods of Phase 2 of this research. These reflections and revisions are outlined in the results section.

**Measures.** As noted above, an interview guide (Appendix E) was used to facilitate discussions with participants about the proposed elements of the methodology for Phase 2 of this research. The interview guide was comprised of questions I developed to generate feedback on the proposed methodology for Phase 2. There were three sections of the interview guide that corresponded to the three (originally) proposed elements of the methodology for Phase 2: participant observation; survey; and interview. Two other sections of the research guide included questions aimed at soliciting general feedback about the research study. The interview guide consisted of a combination of 16 open- and closed-ended questions. Examples of questions include, “Are there any questions [in the survey] that you think could cause negative thoughts or emotions?” and “Are there any questions [in the interview guide] that do not make sense?”

**Phase 2**
Participants. As in Phase 1, participants were women recruited from a supervised consumption site located in Ottawa, Ontario. The eligibility criteria for participating in Phase 1 of this research also applied to this second phase of data collection. As was the case in Phase 1, there was no predefined number of participants that were sought for this phase. Rather, I completed the number of interviews needed to achieve theoretical saturation.

Going into this research, I was aware that participants may be under the influence of drugs, which may, in turn, impact their ability to provide free and informed consent to participate (i.e., due to any physical or cognitive impairments associated with drug use). My previous experience working directly with individuals who engage in substance use at a local methadone clinic aided in my attentiveness to symptoms suggestive of intoxication (e.g., drowsiness, slurred speech, confusion/disorientation). During one of the interviews, I began to notice signs of intoxication in one of the participants. At this point, the participant had already provided oral consent and had completed the survey. However, once the interview got underway, it became more apparent that the participant was not in a state to provide free and informed consent. As such, I suggested to the site volunteer accompanying the participant and I in the meeting room that the interview be suspended. The participant was still provided with financial compensation, as well as the debriefing form and list of community resources. The data collected from the participant were not retained in the analysis. As such, the final sample for this phase consisted of 7 participants.

Socio-demographic Characteristics. Various socio-demographic characteristics of the participants were collected using a survey (Table 1). All seven women identified as cisgender. That is, none of them identified as transgender. The age range of participants was 21 to 46 years, with a mean age of 34.3 years. Two of the seven women (28.6%) identified as Indigenous. Five
(71.4%) women identified as White. With respect to sexual orientation, five women (71.4%) indicated their sexual orientation was heterosexual, while the other two women (28.6%) indicated that they were bisexual.

When asked their marital status, the majority \( (n = 4; 57.1\%) \) of participants indicated that they were single (never married), while two women (28.6%) reported that they were living common law and one woman (14.3%) reported that she was married. In addition to their marital status, participants were also asked whether they were currently in a dating or other romantic relationship. The majority \( (n = 4; 57.1\%) \) reported that they were currently in a dating or other romantic relationship. Further, more than half \( (n = 4; 57.1\%) \) of the women indicated that they have children.

Most \( (n = 4; 57.1\%) \) women indicated that they have engaged in sex work. Five of the seven women (71.4%) reported having a disability. The most cited type of disability reported by these five women was mental and/or psychological, which was reported by each of the five women. This was followed by pain-related disability \( (n = 4, 80.0\%) \) and memory-related disability \( (n = 3; 60.0\%) \). Other forms of disability reported by participants included seeing-related disability \( (n = 2; 40.0\%) \), mobility-related disability \( (n = 2; 40.0\%) \), and hearing-related disability \( (n = 1; 20.0\%) \).

The majority \( (n = 6; 85.7\%) \) of the women reported having a medical condition. Depression was reported by two women, as was post-traumatic stress disorder (PTSD), when asked to specify which medical conditions they had. Half \( (n = 3; 5.0\%) \) of the six women who reported having a medical condition noted only having one condition, while one woman reported having eight different conditions. Other conditions reported by participants included
psychological disorders, such as anxiety, drug-induced schizophrenia, and bipolar disorder, as well as various physical conditions (e.g., arthritis, asthma, multiple sclerosis).

**Substance Use.** In addition to the socio-demographic characteristics of the participants, information related to participants’ substance use was also collected (Table 2). First, participants were asked to indicate the amount of time they had used prescribed and/or illicit substances. Most \( n = 4; \ 57.1\% \) women reported having used prescribed and/or illicit substances for between one and five years, one woman \( (14.3\%) \) indicated between five and ten years, another woman \( (14.3\%) \) reported between 10 and 20 years, and, finally, two \( (28.6\%) \) reported 20 or more years. Participants reported using a wide range of prescription and illicit substances anywhere in the past year. Each of the seven women reported using fentanyl, while most women reported using cocaine \( n = 6; \ 85.7\% \), dilaudid \( n = 6; \ 85.7\% \), tobacco \( n = 6; \ 75.7\% \), cannabis \( n = 5; \ 71.4\% \), crack cocaine \( n = 5; \ 71.4\% \), or crystal meth \( n = 5; \ 71.4\% \). Three in seven \( (42.9\%) \) women reported using morphine, speedball (i.e., a combination of heroin and cocaine), or Ritalin or Biphentin (i.e., stimulants commonly used in the treatment of Attention-Deficit/Hyperactivity Disorder). Less commonly reported substances included alcohol, tranquilizers or benzodiazepines, heroin, amphetamines, gabapentin, generic oxycodone, methamphetamines, valium, gamma hydroxybutyrate (GHB), and methadone.

All seven women indicated that they had ever injected drugs. With respect to the number of times they inject, on average, on a day when they inject, responses ranged from one time a day to 10 times a day, with a mean of four times a day. Most \( n = 5; \ 71.4\% \) women reported that they had ever injected alone. When asked how often they had injected alone in the past year, two of the five women \( (40.0\%) \) reported “occasionally” (i.e., less than 25% of the time) injecting alone, while three \( (60.0\%) \) reported “sometimes” (i.e., 26-74% of the time) injecting alone.
Participants were also asked if they had ever needed help injecting, to which all the women responded affirmatively. Most of the women reported either “occasionally” (i.e., less than 25% of the time; \( n = 2; 28.6\% \)) or “sometimes” (i.e., 26-74% of the time; \( n = 2; 28.6\% \)) needing help injecting in the past year, while one woman (14.3%) reported “usually” (i.e., more than 75% of the time) needing help. Two women (28.6%) reported that they “always” needed help injecting in the past year.

Participants were also asked questions related to the sharing of drug paraphernalia. The majority (\( n = 6; 85.7\% \)) of women reported that they had ever shared drug paraphernalia. When asked how often they had shared drug paraphernalia in the past year, one (16.7%) of the six women who reported that they had ever shared drug paraphernalia reported “never,” half (\( n = 3; 50.0\% \)) said “occasionally” (i.e., less than 25% of the time), one (16.7%) said “sometimes” (i.e., 26-74% of the time), and one (16.7%) said “usually” (i.e., more than 75% of the time).

The last of the questions related to participants’ substance use pertained to overdoses. Participants were asked if they had ever overdosed by accident anywhere (outside of a supervised consumption site) in their lifetime. All of the women reported having overdosed by accident anywhere in their lifetime. Two (28.6%) women reported that they had overdosed by accident anywhere in the past 30 days, while one woman (14.3%) reported she had accidentally overdosed anywhere between one and six months ago. Three women (42.9%) reported overdosing by accident anywhere more than six months ago. In terms of the number of times they had overdosed by accident anywhere, three women (42.9%) reported overdosing between one and five times, one woman (14.3%) reported between six and 10 times, another woman (14.3%) reported between 11 and 15 times, and two women (28.6%) reported overdosing by accident anywhere 20 or more times.
Use of Supervised Consumption Sites. Finally, participants were asked questions related to their use of supervised consumption sites. When asked to indicate the amount of time they had been using supervised consumption sites, most women reported either between one to two years \((n = 3; 42.9\%)\) or more than two years \((n =1; 14.3\%)\). One woman (14.3\%) reported using supervised consumption sites for between three and six months, while two women (28.6\%) reported between six and twelve months. Each of the seven women reported using supervised consumption sites daily in the past year.

In addition to asking participants to report how many times they had overdosed by accident anywhere in their lifetime, they were also asked to report on accidental overdoses at supervised consumption sites. Almost all \((n = 6; 85.7\%)\) of the women reported that they had accidentally overdosed at a supervised consumption site. Most \((n = 4; 66.7\%)\) of these six women reported they had accidentally overdosed at supervised consumption sites between one and five times. One of these six women (16.7\%) reported accidentally overdosing at supervised consumption sites between 16 and 20 times, while another of these six women (16.7\%) reported 20 or more times.

Procedure. Unlike Phase 1 of this study, I was able to conduct Phase 2 of this research in person (as was originally intended), rather than through virtual means. At the time of completing this phase of the research (late 2021), it was deemed safe enough to interact with participants in person, and, with the permission of the Dean of the Faculty of Arts and Social Sciences, I was authorized by CUREB-B to undertake in-person data collection. Accordingly, all data collection methods described below were conducted between myself and participants in person at Ottawa Inner City Health’s supervised consumption site.
As in Phase 1, at the request of site staff, participant recruitment was performed by site staff for the reasons previously discussed in Phase 1. To this end, site staff, volunteers, and peer support workers engaged in participant recruitment were asked to use a recruitment script (Appendix H) to solicit clients’ interest in participating in this phase of the research. This script provided information about the nature of the study and what would be involved of them if they were to participate.

For each interview, the participant and I were accompanied by a site staff member or volunteer, each of whom signed a confidentiality agreement (Appendix B). Once a participant had been recruited, they were escorted into the meeting room, which was a small medical examination room within the facility. After greeting the participant, I proceeded to seek oral consent. As in Phase 1, a script (Appendix I), which provided participants with a general overview of the research, the requirements of their participation, as well as information about anonymity, privacy, and confidentiality, voluntariness, and remuneration, was used to obtain oral consent. Participants were asked to verbally indicate if they consented to participate, as well as whether they consented to being audio-recorded. A consent log (Appendix D) was used to record the date and time that each participant provided consent. Each participant was asked to provide a pseudonym for the purpose of recording their consent.

Once oral consent was obtained, the research commenced with a short survey (Appendix J). This survey included questions related to participants’ socio-demographic and health information, substance use, and use of supervised consumption sites. The intention was to have participants complete the survey either independently or with the assistance of myself and/or the staff member/volunteer accompanying us (e.g., in cases where illiteracy or eyesight issues posed a challenge). With the exception of the first participant, who completed the survey
independently, the method by which the survey was completed by the other participants differed from what was originally intended. Rather than have participants complete the survey with pen and paper (either by themselves or with assistance), I decided to ask the survey questions verbally, as part of the interview, and record the answers myself. Next, a semi-structured interview was completed. As in Phase 1, an interview guide (Appendix K) was used to facilitate these discussions. These interviews were audio-recorded to facilitate data analysis.

Participants were provided with a debriefing form (Appendix F) and a list of community resources (Appendix G), in the event that they experienced any psychological distress as a result of participating in the study. Each participant was compensated $25.00 CAD in cash, which is in line with what was requested by the staff at Ottawa Inner City Health.

**Measures.** As a result of the feedback garnered during Phase 1, which will subsequently be discussed in detail, the survey (Appendix J) was comprised of 29 questions that were mostly multiple-choice format, with some write-in response questions included as well. There were two main sections of the survey: socio-demographic and health information; and substance use and use of supervised consumption sites. This survey was largely modelled after a survey developed by the British Columbia Centre on Substance Use (2017) that was designed to collect information about the feasibility and potential uptake of supervised injection services among people who use drugs. The survey used in the current research also utilized some questions used by Kerman et al. (2020)’s research, whose survey also drew from questions included in the survey developed by the British Columbia Centre on Substance Use (2017; N. Kerman, personal communication, January 25, 2020). Socio-demographic questions used in the survey in the
current research were modelled after questions used in surveys conducted by Statistics Canada (e.g., Canadian Community Health Survey).

The interview guide (Appendix K) consisted of questions I developed to collect information from participants regarding barriers to accessing, experiences within, and outcomes of supervised consumption sites. As with the survey, modifications to the original interview, presented below, were made to the original interview guide as a result of the feedback that was garnered during Phase 1. The final interview guide consisted of eight open-ended questions. Examples of questions include, “Can you describe anything about this site that is particularly important to or helpful for you?” and “What are your relationships like with staff, volunteers, and peer support workers here? What are your relationships like with other people who come here?”

Results

Phase 1

The results of Phase 1 of this research pertain to the feedback solicited from participants on the proposed methodology for the second phase of this research. As previously discussed, feedback was solicited from participants with respect to their thoughts about the three main elements of the proposed methodology (i.e., participant observation, the survey, and the interview guide), as well as their general thoughts about the research and any remaining suggestions they had to improve the proposed research. The results of this phase of the research are generally organized and presented below to align with the sections of the interview guide for Phase 1.

Participant Observation. At the time of completing Phase 1 of this research, in-person data collection was suspended. It was also not clear at that time whether it would be possible to
undertake the second phase of the research in person, as was originally intended. As such, I did not invest significant time into questioning participants about the proposed methods related to participant observation. Nonetheless, for those I did ask whether they would be comfortable being observed for research purposes, they indicated that they would feel comfortable with this.

**Survey.** Participants were asked to comment on the questions included in the survey that would be administered during Phase 2 of this research. Specifically, they were asked to share whether there were any questions that did not make sense, whether any questions were inappropriate or unnecessary, if there was the potential for any questions to elicit negative thoughts or emotions, and whether any questions should be removed or added. Overall, participants provided positive feedback about the survey, with some minor modifications suggested.

Generally, there were no significant issues raised with any of the socio-demographic questions. Participants generally understood why two separate questions on sex and gender were included (i.e., reflecting the fact that sex and gender are not always aligned, and that it is necessary to have both questions to be able to identify transgender women). Of note, one participant pondered why the sex and gender questions were the first questions to appear in the survey, noting that it felt as though these aspects of a person’s identity were being centered out, when, in their view, questions related to sex and gender are not the most important thing to ask about when completing a survey about health. Another participant suggested asking these two questions after questions about other socio-demographic characteristics. Despite these suggestions, I decided to keep these questions at the start of the survey, given that questions about sex and gender are often featured at the start of other surveys (e.g., Statistics Canada), coupled with the fact that gender is at the fore of this research.
With respect to the question about participants’ sexual orientation, only one participant raised an issue with this question, noting that this question was not relevant, and that it was a “personal question to be asking.” They also indicated that they felt the questions related to sex and gender already captured the information that would be gained by asking this question. Given that this perspective was the minority, and that no other participants conflated sexual orientation with sex or gender, this question was retained in the survey. One other participant noted that it was a good question to ask (although some participants may not want to answer), while another participant commented on the fact that it is okay to ask this question, noting that, “it is asked everywhere now.”

Some participants raised some potential concerns with the question regarding whether participants have children. These concerns centered around the fact that a question of this nature may be sensitive or triggering to some women who have lost their children (e.g., those who do not have custody of their children). Still, some participants indicated that it would be acceptable to ask this question as long as the “prefer not to answer” option was included, as some women may not want to answer. Another participant commented on the fact that this question – and all of the questions in the survey – is a common question to ask. As such, this question was retained in the survey, with the option for participants to not answer this question (or any of the questions) should they so choose.

Particular emphasis was placed during these discussions on the appropriateness of including a question regarding sex work in the survey. One participant noted that it was fair to ask such a question, and two others noted that it was okay to ask this question/that it was a good question to ask. Only one participant explicitly noted that the topic of sex work is “uncomfortable,” and that this question should not be included in the survey. Some participants
were more ambivalent about the inclusion of this question in the survey, recognizing that it may be a triggering question for some people, and that some people may be too embarrassed, potentially resulting in some people not answering this question. However, these same participants noted that there is still value in asking such a question, with one noting that it is better to ask the question outright rather than wait for it to potentially be brought up organically by participants during the interview. Another participant suggested that it was important to retain this question “to keep people safe.” Much like the question related to whether participants have children, one participant recommended that this question also include an option for participants to refuse to answer. In light of these comments, this question was retained (along with the “prefer not to answer” option).

The survey also included two questions related to participants’ disabilities and medical conditions. Participants noted that these questions are fair to ask and relevant, with one participant mentioning that disabilities and medical conditions are “reasons why people come” to the site. Two other participants commented on the fact that asking these questions would potentially generate information that could, in turn, be helpful for the staff and could be used to better support the clients of the trailer.

In addition to socio-demographic and health information, the survey also included questions pertaining to participants’ substance use and use of supervised consumption sites. In its original form, the question, “On average, on a day when you inject, how many times do you usually inject?” was followed by a blank space for participants to indicate the number of times. Two participants noted that it was acceptable to have a blank space for people to fill in their response. One of these participants indicated that people “know” this number, noting that people are either impressed or unimpressed by this number, given that it alludes to their tolerance or
whether or not they have been cutting back – both things this participant noted are things to be proud of. Still, another participant mentioned that it may be difficult for some people to provide a specific number, as there are many factors that could affect the number of times they inject on a day when they inject. This participant recommended that it would be more effective to provide ranges for participants to select from. Ultimately, I decided to act in accordance with this participant’s recommendation for three primary reasons: to reduce any potential issues participants may have answering this question (which could subsequently affect the validity of the results); to align the format of this question with most of the other questions in the survey, which provide ranges rather than blank spaces for participants to fill in their answer; and, to facilitate data analysis.

Some participants also commented on the questions related to overdoses. Two of the original questions asked participants to fill in the number of times they had overdosed anywhere, as well as the number of times they had overdosed at a supervised consumption site, in their lifetime. Three participants noted that most people would likely be able to provide either an exact or approximate number. On the other hand, some participants suggested that memory issues may interfere with participants’ ability to provide a figure. As two participants noted, sometimes people are not even aware that they overdosed. At the same time, another participant commented on the fact that it may be easier for some people to indicate how many times they had overdosed at a supervised consumption site specifically, given that the “excitement” surrounding an overdose within a site contributes to it being easier to remember. Some of the participants suggested, or, when asked, had no objections to, the idea of providing ranges for participants to select from, rather than a blank space for participants to fill in. To mitigate any recall issues, the two questions related to the number of times participants had overdosed anywhere, as well as
within a supervised consumption site, were modified to include response options for participants to choose from, rather than a blank space for them to provide a number for each.

When asked if they had any outstanding feedback after going through the survey questions, three of the participants highlighted the fact that it is important to always provide participants with the option to not answer a particular question, should they so choose.

**Interview Guide.** Participants were asked to share whether they thought the questions in the interview guide for Phase 2 made sense. Generally, there were no significant issues raised by any of the participants in terms of the clarity of the interview guide questions. However, a few minor suggestions were proposed by participants to improve the clarity of some of the questions.

With respect to the request regarding challenges experienced while accessing the site, originally, the question read as, “What sort of challenges have you experienced here?” Some participants suggested that the question was vague and that I might want to consider providing examples or specifying what was meant by “challenges.” One participant questioned whether “challenges” was in reference to challenges accessing the site, challenges with staff, or something else entirely. They also suggested that being specific about what I meant by “challenges” might aid in preventing participants from talking at length in response to this prompt, given that, in their view, many people could likely spend a notable amount of time answering this question. Another participant suggested that “challenges” exist in the space outside of the trailer, and that it might be useful to expand the focus of this question to also include challenges experienced outside of the facility. On the other hand, some participants indicated that the question was simple, straightforward, and that they would have no issue answering the question themselves, with one participant commenting that it was “good to be broad” as “all sorts of women come here.” In an effort to reconcile these different opinions, the
question was modified slightly to, “Can you share any challenges you have experienced while accessing this site?” This modification was made with the goal of more effectively capturing information to respond to one of the main inquiries of this research, that is, barriers to accessing supervised consumption sites experienced by women. At the same time, it was important, in my view, to not be too specific about what sort of challenges I expected participants to cite, as I did not want to bias the sort of responses they might provide.

In a similar vein, one participant suggested that I might consider clarifying the word “impact” in the questions “What impact has this site had on your drug use?” and “Can you share what impact this site has had on other aspects of your life (e.g., social, financial, intimate relationships, health and well-being)?” This participant was, however, the minority, with other participants noting that these questions were straightforward. For the reasons cited above, namely the desire not to bias the sort of responses that participants might give to these questions, as well as the fact that this concern was only cited by one participant, I opted to leave the question in its original form.

Particular effort was given, during Phase 1, to elicit participants’ feedback on whether they felt that some of the questions in the interview guide could cause negative thoughts or emotions. It was especially important for me to ascertain whether the two questions in the original interview guide related to violence and harassment (i.e., “Can you explain whether violence or harassment have made it difficult for you to come here?” and “Can you share whether you have witnessed or experienced violence and harassment here?”) were problematic. In the case of the former of the two questions, most of the participants did not express any concerns about the question eliciting negative thoughts or emotions. One participant noted that they are accustomed to being asked questions of this nature. Three participants did, however,
suggest that the question could be triggering, make some people uncomfortable or upset, or that the question might be “off” to some participants. With respect to the question concerning whether participants had witnessed or experienced violence at the site, only one participant cited concerns that this question may make some participants uncomfortable. For both questions, some participants spoke to the value of asking questions about this topic. For example, one participant indicated that it is important to know what is really going on at the site, as this information could subsequently be used to change things, going so far as to say that “not knowing this information could be dangerous.”

In an effort to heed the calls to ask questions on this topic, while still being mindful of the potential emotional harm that could be elicited by asking such questions, I decided to only ask one question about violence and harassment rather than two separate questions that tackled separate issues, that is, the role of violence and harassment as a barrier to accessing the site, as well as whether they had witnessed or experienced violence and harassment while at the site. Instead, I decided to focus only on experiences of violence and harassment within the site as I anticipated, upon reflection, that the issue of violence and harassment as a barrier to accessing the site could be raised in response to the question, “Can you share whether anyone or anything made it difficult for you get here today?”

In addition to reducing the number of questions about violence and harassment, as well as to focus the question on whether participants had witnessed or experienced violence and harassment within the trailer, some modifications to the question’s wording were made to reflect the feedback garnered from two participants. One participant suggested that, rather than ask about whether participants had witnessed or experienced violence and harassment at the trailer, it may be more appropriate to focus on whether participants feel safe from violence and harassment
while on site. This participant noted that participants might feel more comfortable answering this, as it would not require having to “tell” on someone. Relatedly, another participant suggested adding a question to the interview guide to inquire as to whether women feel comfortable at the site. To this end, the question, “Can you share whether you have witnessed or experienced violence and harassment here?” was modified to say, “Can you share whether you feel comfortable and safe here?,” which captured both of the elements (i.e., comfort and safety) these two participants suggested incorporating into the interview guide.

Participants were also asked to indicate whether they felt that any of the questions in the interview guide for Phase 2 were inappropriate or unnecessary, as well as whether any questions should be removed. None of the participants expressed any concerns with the questions being inappropriate or unnecessary, nor did they indicate that they felt any of the questions should be removed. As such, all of the questions in the original interview guide were retained, either in their original form or with minor modifications made to the wording (e.g., “What sort of challenges have you experienced here” was changed to “Can you share any challenges you have experienced while accessing this site?”).

Participants were also asked to indicate whether there were any other questions not included in the interview guide that should be added. Two participants spoke to the potential utility of asking a question related to women’s relationships with site staff and volunteers, with one of them also recommending that a question be asked about relationships with other clients of the site. I decided to add such a question, as I believed it would help to capture – and understand – women’s experiences within the site. As such, a new question was added to the interview guide, which read as, “What are your relationships like with staff, volunteers, and peer support workers here? What are your relationships like with other people who come here?”
**General Comments.** At the end of each interview, I left space for participants to provide any further suggestions on the proposed research, to ask questions, and to share any outstanding comments about the research. I also used this time as an opportunity to probe questions that arose during the course of these interviews that were not reflected in the interview guide for this phase of the research. One such question was whether the order in which participants would be asked to complete the survey and interview during Phase 2 mattered. Two participants indicated that it would be more effective to complete the survey first, followed by the interview, with one of these participants noting that the results of the survey might provide context for the interview.

A second question that I put forward to some of the participants was whether there would be any benefit to completing the surveys with participants or have them complete it independently. Two participants expressed that they felt it would be better to ask the survey questions to participants verbally rather than have them complete it themselves (with pen and paper or on a computer). The rationale for this perspective that was offered up by one of these participants was that, in doing so, I would elicit more open, honest, and detailed responses from participants, relative to filling in the survey themselves. This participant mentioned that, if they were to fill out the survey themselves, they would likely go through and select answers quickly. The other participant noted that this approach would make it easier for participants to seek clarity if any of the questions were unclear, as well as the fact that participants may be better able to articulate their answers to their questions verbally.

I also used this opportunity to ask some of the participants their thoughts about how participants would react to being audio-recorded during Phase 2. No issues were expressed by these participants about the prospect of being audio-recorded.

**Phase 2**
Thematic analysis was used to analyze the data (i.e., fieldnotes and transcribed interviews) collected during Phase 2. Thematic analysis is a qualitative method of analysis that identifies, analyzes, and reports patterns – or themes – within the data (Braun & Clarke, 2006). There are six phases of conducting a thematic analysis: becoming familiar with the data; generating initial codes (i.e., interesting features of the data); collating codes into potential themes; reviewing themes; defining and naming themes; and writing the report (Braun & Clarke, 2006). NVivo, a qualitative data analysis software, was used to conduct the thematic analysis.

Overall, the themes that emerged from the data centered on the topic of connection. The ways in which connection – to people and to different types of support – featured prominently in participants’ discussions of their experiences with supervised consumption sites. Indeed, participants highlighted a variety of different connections that shaped their experiences with supervised consumption sites, including connections with site staff and peers both within and outside of the site. As will be demonstrated, these different types of connections influenced women’s experiences with supervised consumption sites. In addition to connections with others, participants often spoke about the ways in which the site connected them with various supports, which, as highlighted by many, had a considerable impact on them.

**Connection with Staff.** The most prominent theme that emerged from discussions with participants was related to the significance of their relationships with staff at the supervised consumption site. Indeed, the role of staff in shaping participants’ experiences cannot be overstated, as participants frequently spoke to the ways in which staff shaped their experiences
within the site, as well as the outcomes or impacts of the site on their drug use and other aspects of their lives.

When asked to speak to the positive elements of the site, one participant said, “Um, the staff [giggles]. There’s great staff here. They’re, like, fun to be around. They’re super nice, enjoyable. They make the space, like, happy and overall, it makes it an enjoyable place, right. ‘Cause if you need to talk to somebody, there’s always someone there you can talk to. They’ll help you with resources or they’ll help with the problem. They also save lives here, so it’s actually a great, positive environment most of the time.”

These sentiments were echoed by other participants. For example, when asked what made her feel comfortable at the site, one participant responded by saying, “The people that work here. Just their friendships. Their help. The things they’ve helped us receive or achieve with being here. They’ve helped a lot. I owe everything from here to them.” Another participant explained how the staff had helped her “immensely” with many things. One other woman mentioned that she goes to that particular site because she feels comfortable with the staff.

A particularly striking observation from discussions with participants was their recognition of the extent to which staff have given them a sense of worth. One woman highlighted the ways in which the staff’s support helped her recognize the value of her life: “Well, so, I did get kicked off safe supply for I don’t know what reason. But they, when they had an opening here, they put me, you know, number one for needing to get back on safe supply because I was getting so sick and overdosing all the time. So that, you know, really, really helped. Probably saving my life there. Like I was really surprised and flattered by that, that they put me, you know .. that they actually cared, because when they took me off at the other place, it
made me feel like they don’t care, like my life doesn’t matter, because it’s kind of keeping people alive, you know?”

A second participant shared similar sentiments. When prompted to share the impact of the site on her drug use, she highlighted the impact of site staff on her recognizing her worth: “I was kind of just using, not caring, not thinking about it. And they made me, in a sense … [inaudible] they made me think about my life. Think about, ‘Is it worth it? Should I do something else? Can I achieve other things?’ That kind of shit. They put it as not just an addiction, but like, is there other things you can be doing? You know what I mean?”

**Connections with Peers.** Overall, the nature of participants’ relationships with peers at the site was relatively positive, although some participants shared how this is not always the case. When asked to share how their relationships are with other people who go to the site, one woman indicated that she had “good” relationships, adding that she had a lot of friends [at the site]. Another woman indicated that her relationships with peers were more positive than negative, going on to say that she “always loved it down here.”

Many of the women conveyed that their connections with peers were “mostly good.” According to some of these women, the extent to which these connections were positive depended on the day or the drugs used by their peers. Another woman, somewhat apprehensively, noted that her relationships with other clients accessing the site are “fine.” She explained her stance by saying that, since clients are separated within the site, there is no need to interact with other clients.

**Safety.** Safety emerged as a key sub-theme within the broader themes of connections with peers and staff. Indeed, connection with others is at the crux of one’s sense of safety. Overall, the extent to which people described their experiences at the site as safe varied, with some women
communicating that they felt safe, while others either did not feel safe, or at least not all of the time. As will be demonstrated, perceptions of safety were intimately connected to participants’ connections with their peers, as well as the site’s staff.

Two of the participants were quite certain in sharing that they felt comfortable and safe at the site. When asked what contributes to their sense of safety, both shared that it was the staff that made them feel safe. Still, however, one of these women noted that she did not always feel comfortable and safe. When asked to share any challenges she had experienced when coming to the site, she noted, “Probably the people that use this place. More the users or drug dealers or something, let’s say. Like, that kind of thing, ‘cause Sheps [Shepherds of Good Hope] kind of has a bit of a, what do you call that, like a reputation. It’s a little bit scary. It’s a bit kind of intimidating at the beginning.” As we discussed this further, the participant revealed that the negative reputation of the site served as a barrier to her accessing the site for almost a year. When I asked her what ultimately helped her in deciding to come to the site, she replied by saying, “Just kept sticking to it, knowing that that the people in here are helpful and safe.” She also noted that she is no longer concerned about coming to the site due to its reputation, but added that she is “always on guard.” According to this participant, there is nothing that can be done to address the negative reputation of the site: “It’s just … the people. They use drugs. You know what I mean? And sometimes there are just desperate moments in all of us because we all have addictions. And that alone, you know … someone can be in a really desperate state and they’ll make desperate decisions.”

Many of the other women shared more mixed feelings when describing whether they felt safe at the site. For example, one woman indicated that she felt safe within the actual facility, noting, like two other participants, that the site staff contributed to her sense of safety. As she
explained, “They’re very nice people. And they actually care about us. You know what I mean? Enough to work here and make sure we’re safe, you know?” On the contrary, however, this woman stated that she did not feel this same sense of safety when directly outside of the site. When asked what made her feel unsafe outside, she explained that the primary factor was the people outside: “They get high and then they want to fight or they want to do stupid shit. If you’re sitting there using, you can’t keep an eye on everything that’s going on.” In terms of potential solutions to address this perceived lack of safety outside of the site, the participant said there was nothing that could be done to make her feel safer. As she noted, there are already security guards outside of the site. For her, it was just a matter of “the dumbasses out there that act stupid.”

A second participant also shared more mixed feelings about her sense of safety while on site. For her, she explained that she felt safe “half of the time,” noting that ‘personal anxieties,’ as well as other people, made her feel unsafe sometimes. For her, “getting along socially” with her peers contributed to helping her feel safe.

In addition to both the positive and more mixed sentiments shared by participants about their sense of safety on site, one woman conveyed that she did not feel safe both inside and outside of the site. This participant spoke to the dynamics on the street outside of the facility, and how these dynamics were challenging for her and served as a barrier to accessing the site. When asked to share things that make it difficult for her to come to the site, she said, “It’s just, uh, people. And circumstances and whatnot. A lot of people target me and bully me. And so currently, a few people are doing that to the point where it is physical. Like, you know, I’m being shoved, I’m being assaulted, I’m getting spit on, and I just don’t feel safe because people get other people to gang up and it makes me afraid, you know, that I’m going to get jumped or
whatnot, or this person’s just going to come up and attack me when I’m walking by. And so it’s made me a little more fearful and it makes it harder to come down here because I don’t feel safe even just stepping outside.” When asked to expand on her experiences, she noted that threats to her safety tend to occur more at night.

In terms of her safety inside, this participant explained that she used to feel safe inside, but this was no longer the case. She went on to provide an example of a case wherein she did not feel safe within the facility: “… with people getting away with stuff or being sneaky, I don’t know how to enjoy being inside, like as I said, being spit on, that was the other day. But someone who has beef with me, she doesn’t particularly like me at the moment … the other day I’m standing there talking to her and my friends at her booth and a person walked up and they just fucking spit on me and then left to their own booth.” She went on to explain how this behaviour was not noticed by staff, although she was quick not to assign blame to staff for not intervening: “There’s so many people here who need help and they can’t be there 24/7, right? They have a job. They’re working. Can’t blame them for that.” When asked whether having more staff on site would help to address her concerns, she explained that she does not think the behaviour in question can be controlled all of the time. Instead, she suggested that greater awareness among the staff might help to address the issue so that they could help prevent these behaviours from happening or aid them in intervening before the issue escalates to the point of someone getting hurt.

For this woman, addressing the issue of safety and how it serves as a barrier to her accessing the site would involve greater protection from the staff, potentially even staff outside of the site. As both she and the staff member accompanying us during the interview noted, there
is a security guard outside of the facility, but they are not there 24 hours a day. According to the participant, even with the security guard, “people still act up.”

Another woman also spoke about the fact that there are certain people outside of the facility that she does not get along with and that there is bullying that exists within the “homeless world” (here, the participant was referring to people who stay at Shepherds of Good Hope, a homeless shelter that is adjacent to the supervised consumption site). This participant was quick to assert that, for her, these challenges only exist outside of the facility. According to her, there is never any fighting or issues inside of the trailer, and instead, the trailer is “one of the most positive places for us.” In reference to the bullying that takes place outside, she noted that, “… it’s not a reflection of the trailer. It’s just, you know, the homeless people and whatever, and they hang out there, but it’s not anything that the trailer is doing, you know what I mean? It’s not because of this place. It’s just the homeless community. That’s it.” Still, this participant noted that the people outside of the facility that she does not get along with and the bullying that takes place outside of the facility make it challenging for her to come to the site.

Connections with Support. A third key theme that emerged from discussions with participants was related the ways in which the staff at the supervised consumption site connected them with support – for their drug use, as well as supports and services for issues outside of their drug use.

First, several of the women highlighted the extent to which the site supported them with, and contributed to, safer drug use. When asked how the site had contributed to her drug use, one participant indicated that she “definitely use[s] safer,” attributing this to the fact that the site staff encouraged her to use safer. For another woman, the site had had a “good” impact on her drug use, as she was no longer using outside, adding that she felt safer using at the site than she would
elsewhere. A second participant also mentioned that the site helped her not have to use on the street. She added, “Just knowing that I have the help that I have gets me here.” One woman shared that the site had contributed to her and her husband using safer because they had access to proper supplies all of the time. In addition, two participants mentioned that access to safe supply facilitated them coming to the site or was a particularly important feature for them. Another woman noted that the site had contributed to her using less drugs, estimating that her drug use had lessened from ten points of fentanyl a day to about two points. For her, she indicated that she believes this reduction would not have happened if it were not for coming to the site because of the support being provided to her for other things as well, such as mental health. Only one woman noted that the site had not had an impact on her drug use. For this woman, the impact of the site was most felt in terms of its ability to connect her with other resources.

When asked what impact the site has had on her drug use, one participant (rather emotionally) stated, “I don’t want to do drugs forever. I’m only getting older. And I have kids, so I wanna live.” She continued on to say that attending the site was important in terms of her life, as well as her children’s lives. I then asked her to expand on what she meant by “important for their lives.” In response, she simply said, “Me living.”

Another woman mentioned that an element of the site that had been helpful for her was the fact that staff could help clients with injection (i.e., helping clients find a vein). As the participant and staff member accompanying us during the interview explained, at the time of conducting the interview, nurses were unable to help in this way due to the COVID-19 pandemic. As she explained, because the nurses were unable to assist in helping her find a vein, she needs to be assisted by her husband. She cited one particular occasion where her husband injected himself before injecting her, and he “jammed the needle so far up my neck the white
part was in there and the nurse had to pull it out ‘cause he was on the nod,’” adding that this was “very dangerous.”

Despite these positive impacts on women’s drug use, some features of the site had a more negative impact, namely the demand for resources within the site, including site staff. When asked what makes it helpful in terms of getting her to the site, one participant explained, “I try not to use anywhere but here now. I mean, sometimes when you’re really dopesick and you feel like crap, if it’s too busy or something like that, I might do it just outside here, but like, for the most part, I try to only use here.” Of note, however, when asked if there is anything that makes it challenging for her to go to the site, she said, “Not enough booths or if there’s an OD [overdose] happening, they can’t let people in. Too much going on, back and forth … it’s a lot to handle for the staff here, right? So just that. There’s a lot of commotion that happens sometimes.”

Participants also shared how the site helped connect them with support for issues outside of their drug use. One participant described the impact that the site’s staff has had on helping her and her partner navigate different community resources after moving to the area, such as getting a health card. As she noted, “I mean, with all of the things we had to do, they really held our hand in the sense that they took every step of the way with us. And if we were kind of children about it, or whatever, they didn’t treat us like that. They were just like, ‘Come on!’ and very, almost like they were rooting for us, you know? And when we got something done, they were like, “Yeah you got that [inaudible]!” You know? It’s awesome that someone felt awesome for me. It’s cool.” She also noted that, despite being opposed initially to receiving help connecting with various supports, she eventually accepted this offer, noting it would have been “so stupid” of her not to do so.
When asked to speak to the impacts the site has had on her, one participant commented on how the site supported her in terms of transitioning out of homelessness, while at the same time, highlighting the positive impact of the site on her mental well-being: “I just think it’s a little bit of positivity for me. Like, you know, being out there, it’s like, depressing … it can get depressing and just coming in here is kind of … it’s just good. It’s helped me with the resources and getting away from homelessness and it’s just kind of a positive environment. You know, out of the cold and sitting out there being homeless. It’s good.”

One participant observed that the site helped connect clients with various resources to help with the cessation of substance use. According to her, “They can connect you with all sorts of positive places, like, you know, that actually help you get away from the drugs.” Other participants spoke to the ways in which the site staff had connected them to various community resources. For example, other participant mentioned that a staff member had served as and her husband’s guarantor for their birth certificates. She also noted that staff had helped her get back her identification, as well with probation appointments.

Other participants commented on the ways in which the site facilitated access to medical supports and services. Five women underlined the importance of the site in connecting clients with mental health supports, such as a mental health nurse available on site, as well as the Canadian Mental Health Association. Other women highlighted the fact that the site connected them with support for physical and sexual health supports and services. One woman noted that she appreciated the fact that there is always a nurse available to help with physical issues, noting that she had been treated by the nurse for issues she was having with her finger, leg, and feet, adding that they followed up with her every time she came in to see how she was doing. Another woman mentioned that the staff helped her with some of her medications. This same participant
also mentioned how the site supported her after she had been raped, noting that she had not felt comfortable going to the hospital. Instead, staff at the site were able to support her through that experience, including taking swabs [for the rape kit].

Discussion

The objective of this research was to examine women’s experiences with supervised consumption sites. Specifically, this research endeavoured to understand barriers to accessing, experiences within, and outcomes of supervised consumption sites. To achieve this aim, semi-structured interviews and a survey were used with a small group of women attending a supervised consumption site in Ottawa, Ontario to shed light on their experiences. The discussion that follows uses a psychological lens to reflect upon women’s experiences with supervised consumption sites. Subsequently, I share my reflections on conducting research with women who use drugs.

Women’s Experiences with Supervised Consumption Sites

Connection – with staff, peers, and to various supports – emerged as a fundamental aspect of women’s access to, experiences with, and outcomes of supervised consumption sites. In an effort to understand the pivotal role of connection, it is worth contextualizing these findings with psychological literature on both social support and safety.

Social Support. The importance of women’s relationships with site staff cannot be overstated. Overall, participants held the site staff in high regard, with several of them noting how the staff were an important or helpful element of the site. Some women even commented on how they felt valued and encouraged by the staff. Participants also shared how much they appreciated the staff connecting them with various resources, including health-related supports and services. This latter finding supports the fact that one of the key objectives of supervised
consumption sites is to facilitate connections between people who use drugs and substance use treatment and/or other health and social services (Kennedy et al., 2017). These findings also align with other research that has demonstrated the importance of support within supervised consumption sites for people accessing these sites (Kerman et al., 2020).

It is not uncommon for the social networks of women (and people more broadly) who use drugs to be devoid of, or lacking, social support (Nargiso et al., 2014; Trulsson & Hedin, 2004), which may be due, in part, to the stigma surrounding drug use, particularly for women who use drugs (Meyers et al., 2021). Social support is defined as “a social network’s provision of psychological and material resources intended to benefit an individual’s ability to cope with stress” (Cohen, 2004, p. 676). It should also be noted that social support refers to the social resources given by non-professionals, whether that be in the context of formal support groups or informal helping relationships (Cohen, 2004).

Social support can be divided into three main subtypes, which reflect the type of resources that are provided: emotional, instrumental, and informational (House & Kahn, 1985). Emotional social support can take the form of displays of empathy, providing reassurance, as well as the expression of caring and trust, while instrumental support refers to social support that provides material aid, and, finally, informational support consists of providing relevant information, often in the form of advice or guidance, in an effort to help an individual navigate or cope with difficulties (Cohen, 2004). The need for these types of resources is generally linked to acute or chronic stressful experiences, including addiction (Cohen et al., 2000).

Previous research has demonstrated a link between social support and health and well-being (e.g., Power, 1988; House et al., 1988a; House et al., 1988b), including reduced substance use (e.g., Creswell et al., 2015). One of the main theoretical models related to the relationship
between social support and health is the stress buffering model. According to this model, stress influences health insofar as it promotes certain harmful coping strategies, including substance use (Cohen, 2004). This model posits that social connections provide both psychological and material resources that are necessary to manage stress (Cohen, 2004), meaning, in effect, that social support serves as a stress buffer. A key factor in social support acting as a stress buffer is one’s perception that other people will provide necessary support (Cohen & Wills, 1985). Ultimately, this perceived support can influence the extent to which an individual believes they can cope with demands, which, in turn, can affect their appraisal of the stressor and reduce the stress associated with it (Cohen & Wills, 1985). In addition to perceived social support acting as a stress buffer, some research has elucidated how the actual receipt of social support is implicated in stress buffering. According to Cohen (2004), the receipt of social support may reduce the impact of stress by offering a solution to the problem, diminishing the perceived importance of the problem, or providing a distraction from the problem.

From a psychological perspective, the perceived and actual availability of social support within supervised consumption sites may be beneficial in bridging the gap between the lack of social support experienced by many women who use drugs and the positive benefits afforded by the receipt of social support. Many women (and people more generally) who use drugs experience a plethora of stressors, including homelessness (Torchalla et al., 2011), issues related to child custody (Murnan & Holowacz, 2020), among others. Yet, as previously discussed, they may not have access to social support within their social networks that could support them with managing these stressors. In an effort to fill this void, they may turn to or lean on supports and services within the health care system and/or the community. This may ultimately explain why, in the current research, connection to, and support received from, site staff featured prominently.
in women’s accounts of their experiences with supervised consumption sites. Indeed, women talked about how site staff provided them with various supports, including emotional, instrumental, and information support. Ultimately, these findings suggest that supervised consumption sites, particularly the staff working within them, can play a vital role in supporting women (and people more generally) accessing the site, who may lack social support outside of the facility, which may have implications for their health and well-being.

**Safety.** A second prominent theme that emerged from the interviews was the nature of women’s connections with their peers and staff, including how these relationships influence their perceptions of safety. Overall, participants indicated that their relationships with their peers were mostly positive, or, at the very least, positive with some caveats. Similarly, participants generally indicated that they felt safe within the site. Notably, however, these relatively positive relationships with peers and overall sense of safety within the site juxtaposes with the seemingly fewer positive relationships, and, indeed, violence and harassment, outside of the site. For some women, the violence and harassment permeating the space outside of the facility served as a barrier to accessing the site, which aligns with previous research that has found that the fear related to whether harassment could escalate to physical violence serves as a barrier to accessing supervised consumption services (Boyd et al., 2018). The fact that not all of the women spoke to the apparent violence and harassment within and outside of the site and whether it serves as a barrier to accessing the site could be explained by the fact that they tolerate this violence and harassment, since the alternative would be using in unsupervised spaces, as has been demonstrated by other research (Boyd et al., 2018).

From a psychological perspective, an individual’s need for safety is paramount. According to Maslow’s Hierarchy of Needs (Maslow, 1943), the need for safety is critically
important, so much so that it is second in the hierarchy only after physiological needs. Just as certain aspects of the social environment, such as social support, are beneficial for health and well-being, other aspects may actually be detrimental. According to Cohen (2004), social networks provide “the opportunity for conflict, exploitation, stress transmission, misguided attempts to help, and feelings of loss and loneliness.” These negative elements of social networks can ultimately serve as psychological stressors, and, consequently, affect biological and affective responses that may contribute to an increased risk of poor health (Cohen, 2004).

The application of a psychological lens to the issue of safety, then, helps to explain, at least in part, why violations to one’s sense of safety, or not having these needs met, may be detrimental to one’s motivation, or ability, to seek out or engage with substance use interventions, including supervised consumption sites. This underscores the need for supervised consumption sites to address women’s concerns related to, or violations of, safety both within and outside of their sites to facilitate their (continued) access to these sites. Additionally, in view of Cohen’s (2004) perspective that negative aspects of social networks can act as psychological stressors, and, in turn, affect health and well-being, it is imperative that supervised consumption sites ensure that these spaces are free of violence, should they wish to promote the health and well-being of women (and all of their clients) attending their facility.

To a smaller extent, participants spoke about the ways in which the site facilitated safer drug use. Several of the women highlighted various ways in which the site had impacted their drug use, including no longer having to use outside, the provision of a safe supply of drugs through the site, reduced drug use, and (previously) assisted injection. These findings are in line with the fact that one of the main objectives of supervised consumption sites is to reduce the
harms associated with illicit drug use, especially the risk of overdose and transmission of blood-borne diseases (Kennedy et al., 2017).

To summarize, then, the current research echoes the findings of previous research on women’s use of supervised consumption sites, namely that these sites are often supportive and safe spaces for women, both in terms of the support offered related to safer drug use, as well as other forms of support, such as emotional support and the provision of other resources, due in large part to the staff working within them. Concurrently, these spaces, or, at the very least, the space outside of these facilities, are often characterized by violence and harassment, which, in the case of the current research, can serve as a barrier for some women to accessing the supports and services afforded by these sites.

**Conducting Research with People Who Use Drugs**

Although the primary objective of this research was to explore women’s experiences with supervised consumption sites, two serendipitous lines of inquiry emerged as this research unfolded. As this work progressed, I became increasingly aware of, and interested in, how women’s drug use shaped the course of this current research, and what implications this has for future research on (and with) women who use drugs. Relatedly, a second area of inquiry that emerged from this research is whether, or to what extent, various elements of “traditional” psychological research make sense, or are appropriate, in the context of research on women—and people more generally—who use drugs. Both of these lines of inquiry will be explored in turn.

In my view, the way the research was conducted, and consequently, the findings that emerged from this research, were impacted by women’s drug use. Here, I intentionally refrain from using the word “limitation” to characterize the role of drugs on the research process, as
women’s drug use is an inherent feature of conducting research related to women who use drugs. Indeed, their drug use cannot – and, arguably, should not – be separated from their ability to participate and contribute to research about their drug use.

First, it is worth being mindful, when conducting research with women who use drugs, of how their drug use influences their ability to participate in the research process. In the current research, being under the influence of drugs served as a barrier to recruitment during Phase 1. One of the peer support workers who aided in recruiting participants noted to me that it was becoming increasingly difficult to find women who were “awake.” As a result of this, it is conceivable that the sample of participants I had, for both Phase 1 and Phase 2, necessarily excluded women who may have otherwise wanted to or been able to participate, if not for the physical and cognitive impairments of drug use that essentially limited their ability to participate. This spurs questions regarding what sort of discourse may have unfolded with women who could not participate for this reason. That is, were these women, who were under the influence of drugs to the point that they could not participate in this research, any different than their counterparts who were able to participate, whether that be in terms of the amount of and/or types of drugs they use? Could their experiences with the site, then, have been inherently different than the experiences of their peers who did participate?

Second, in addition to participant recruitment, the influence of drugs was a factor in the extent to which participants were able to fully engage in the interviews. As previously noted, during Phase 2, I had no choice but to suspend an interview with a participant after completing the survey, as it was becoming increasingly apparent that they were under the influence of drugs to the point that they could not fully engage in the interview (e.g., nodding off, slurred speech). Although this was a more extreme case, I observed a few other participants during both phases
who appeared slightly drowsy and who had slightly slurred speech, although they remained fully conscious and coherent during the interviews. It was very much expected, going into this research, that participants may be under the influence of drugs at the time of participation, given the location in which this research was taking place. In other words, I expected that participants would engage in this research after substance consumption within the facility. Nonetheless, it is worth considering how researchers conducting research on women who use drugs can navigate through the challenges associated with participants being under the influence of drugs. Naturalistic observation, which I had intended to incorporate into the research methodology, may be one way to overcome this barrier. Through such methods, the researcher can observe the behaviours and interactions of women who may otherwise not be able to verbalize their experiences through more traditional measures due to drug impairment.

It is also worth reflecting on elements of traditional research and to what extent they have a place in research with women (and people more broadly) who use drugs. One such element is the research materials (e.g., recruitment script, oral consent script) that are used to conduct research with this demographic. Ethically, researchers are bound to certain requirements to ensure that participants are fully informed about the research being undertaken and any risks to their well-being that may ensue through their participation. As a result, participants should be able to provide free and informed consent to participate in the research. Necessarily, then, it is customary for researchers to develop certain materials, including recruitment materials and informed consent forms, to both communicate the research objectives and any risks associated with participating, as well as to ensure their free and informed consent is obtained.

However, one notable observation that arose during the current research is the extent to which such materials were effective in achieving their aims with this particular demographic.
Arguably, one might question the efficacy of these materials in more traditional research settings (e.g., laboratory, online, etc.). That is, it would be fair to assume that not everyone reads or listens to written consent forms or oral consent scripts, respectively, in their entirety. This could be due to a range of factors, such as the fact that these materials are often lengthy, a lack of patience and/or attention, and fatigue, among other things. This was evident in the current research. Specifically, in some cases, it was difficult to follow the oral consent form verbatim, due to its length, as well as the fact that the tone of the form was quite academic in nature and did not lend itself well to the more conversational tone I adopted during the interviews.

Certainly, like any other prospective participant in any other research domain, women who use drugs who are invited to participate in a research project about their drug use must be informed of what their participation will entail, as well as any harms they may incur as a result of participating. What’s more, they should, without question, be able to freely provide consent to participate in that research. The question that remains after undertaking this research, however, is whether there are more effective methods that could be used to recruit them and to obtain their informed consent. It may also be worth considering whether traditional ethical requirements of psychological research could be more flexible, such that the ways in which recruitment takes place and consent is obtained can be adapted to the particular demographic and setting in which the research takes place, thereby striking a balance between upholding tenants of ethical research and, at the same time, meeting participants where they are at.

**Methodological Strengths**

One notable strength of this research is the extent to which women were able to contribute to the design of this research. Indeed, during Phase 1, some of the participants commented on the fact that they appreciated being provided with an opportunity to engage in and
shape the course of this research. The decision to involve women in the design of this research was very much in response to the calls of people with lived and living experience with drug use to be involved in research and decisions that are about them. Further, this decision was also inspired by participatory action research, a process whereby researchers and participants co-create the research (e.g., developing the objectives and methods, data collection, data analysis; Reason, 1994).

**Limitations and Future Directions**

Notwithstanding the key methodological strength of this research noted above, there were notable limitations of this research that should be addressed. Generally, these limitations can be organized under three main areas: the research context; methodology; and analysis.

**Research Context.** The fact that this research occurred in the context of the COVID-19 pandemic cannot be dismissed, nor can its impact on the research be overstated. The measures that were imposed to protect people during the first several waves of the pandemic shaped the research methods that were used, thereby impacting the findings that were generated from this research.

As a result of the physical distancing requirements imposed during the initial stages of the pandemic, all in-person data collection was suspended by the Carleton University Research Ethics Board. Accordingly, I was required to evaluate whether I should adapt my research methods to the virtual ways of communication that were heavily utilized during the first few waves of the pandemic, or, conversely, wait for an undetermined amount of time until it might be safe for me to undertake this research in the way I had originally planned, that is, in person. Ultimately, revising the research methods such that the research could still move forward, albeit via different methods, was the decision that was taken.
Prior to undertaking this research, the intention was that I would commence this research by developing relationships with the site’s clients and staff by engaging in brief, informal interactions with the clients, under the supervision of the site’s staff, as well as the staff themselves. The objective of this was to develop a mutual trust and respect among all involved parties, as well as non-hierarchical, non-judgmental relationships that did not exploit the lived experiences of the community. In addition, I originally intended to begin this work by engaging in participant observation. The goal of this process would have been to bear witness to women’s experiences within the site, paying particular attention to if and how gender-based violence manifests itself in this space and the effects of such violence.

In the end, the research methods were revised such that Phase 1 of the research was conducted exclusively online, thereby precluding the intended period of relationship building that would have set the tone for the rest of the research process. Certainly, the fact that this sort of relationship building with site staff and clients did not get to happen did not, in my view, prevent the development of non-hierarchical, non-judgmental relationships, which, as noted above, was the objective of that relationship building phase. At the same time, it is worth questioning whether the fact that I was not able to get to know the site and its staff and clients, nor were they able to get to know and become familiar with me prior to the start of data collection, influenced the amount and type of information that was divulged to me.

During the second phase of the research, it was deemed safe enough to resume in-person data collection, which allowed me to conduct the interviews in this manner. However, various public health measures (e.g., wearing a mask, maintaining physical distance) were still in place at that time. Due to the close quarters within the facility, as well as the number of people who attend the site, I did not feel comfortable being within the facility for any sustained period of
time, certainly not the amount of time that would have been required for any meaningful observation of clients. This, coupled with the fact that I did not reside in Ottawa at the time this research was being conducted, led to me deciding to forgo this element of the research. The consequence, unfortunately, of this decision, is that I likely cannot fully appreciate and understand the dynamics of the site, particularly how women interact with other people accessing the site, as well as the site’s staff. Certainly, the information shared with me by participants helped to shed light on women’s experiences with supervised consumption sites, and these contributions should not be diminished. However, this information would have been enriched with a first-hand account of the intricacies of the site and the relationships within it, particularly the sort of information that participants may have been reluctant to divulge on their own accord.

Methodology. In addition to the ways in which this research was influenced by the COVID-19 context, other limitations of the research were observed, including limitations related to the research measures. As previously noted, the research paradigm that was utilized was a key strength of this research. Indeed, women were able to contribute to the research methodology in a way that is not typical of more traditional research. Despite seeking participants’ feedback on the methods and measures for Phase 2, however, the feedback garnered was not sufficient in ensuring I was able to fulfill the objectives of this research. Put differently, even with the modifications that were made to the measures as a result of the feedback received from participants to ensure the measures were clear, appropriate, and could ultimately spark meaningful dialogue, there were still limits to the validity of, and in turn, the value of, these measures. Of note, these shortcomings of the measures, which will be outlined and elaborated on below, are not a reflection of the modifications proposed by participants. Rather, other factors
(which will be discussed) very likely contributed to the type of responses that were elicited from participants.

It is good practice, when undertaking qualitative research, to utilize open-ended questions during interviews. In so doing, the researcher does not impose their assumptions about how participants might or should respond. Instead, participants can respond according to how they have interpreted the question. This is not without consequence, however, as it may result in participants not knowing quite how to respond, and, as such, limit the type of response they provide, as well as the amount of information shared. This was evident in both phases of this research, but especially so during Phase 2. Indeed, it was not uncommon for participants in that phase to provide rather short responses to the questions posed to them.

Another limitation of the measures is related to the extent to which the questions were readily understood by participants. In Phase 1, participants suggested that, when asking about challenges experienced at the site during the interview, I should be specific and provide examples of what I meant by “challenges.” As previously discussed, in an effort to strike a balance between participants who suggested modifying the question in this way and participants who indicated that the question was straightforward in its original form, I made a small modification to the question to specify that I was referring specifically to challenges accessing the site. In retrospect, it would have been more effective, in my view, to heed the suggestion of some of the participants to be more specific, or provide concrete examples, of the types of challenges I was referring to when asking this question to participants in Phase 2. In effect, the information garnered from participants when prompted with this question was not as elaborate as I had hoped. Although one of the participants suggested that I specify what sort of “challenges” I was referring to in order to reduce the amount of time participants might take to respond to this
question, paradoxically, I believe that providing more specific examples of what I meant by “challenges” would have spurred greater discussion and, ultimately, resulted in more complex findings.

Likewise, although they were the minority, one participant suggested clarifying what I meant by “impact” in the two questions related to the impact the supervised consumption site has had on their drug use and other aspects of their lives. Although I opted not to clarify the word, in retrospect, I believe modifying the questions to clarify what I meant by “impact” would have yielded more robust findings. Instead, the responses that were generally elicited from these two prompts were not sufficiently elaborate, particularly in the case of the latter question.

To summarize, then, the interview guide for Phase 2 could have been strengthened by heeding the advice of some of the participants to provide examples and be more concrete about the sort of information I was seeking, namely the sort of challenges experienced accessing the site, as well as the impact the site had on their drug use and other elements of their lives. Although participants who were asked these questions in Phase 2 seemingly had no issue with understanding what I meant by “challenges” and “impact,” as evidenced by the fact that they did not seek clarification, providing clarification or examples may have made these questions less abstract which could potentially, in turn, have resulted in more elaborate responses.

Another notable limitation of the research measures is that the questions used in the interview guide for Phase 2, in hindsight, were very “academic” in nature. In other words, they were not very conversational. Although the questions appeared to be relatively sound, especially after having them “screened” by participants during Phase 1 and subsequently revising them as a result of their feedback, it became increasingly evident as I was asking participants the questions during Phase 2 that there was a disconnect between how these questions might perform, and how
they actually performed. This observation reinforces the sentiments previously shared regarding how research should be conducted with women (and people more generally) who use drugs. Specifically, this research undertaking taught me that it is not only important what you ask of participants, but how you ask them. In my view, with this particular demographic, the dynamic should very much shift to one of a conversation, rather than the traditional dynamic of the participant and the researcher. Even despite my efforts to talk to participants in a conversational manner, the participant-researcher dynamic was still present. I believe a different approach, whereby this traditional dynamic was less salient, would have garnered more frank, in-depth discussions, which would have ultimately resulted in more nuanced findings.

In addition to limitations associated with the research measures, a considerable limitation was noted related to the sample that was recruited to participate during Phase 2. One of the key objectives of this research was to examine barriers that limit women’s access to supervised consumption sites. Some barriers (e.g., the dynamics outside of the facility) were noted. Other factors, however, such as childcare and relationships with romantic partners, for example, were not discussed in terms of limiting women’s access to supervised consumption sites. Further, several of the women noted that the location and the hours of the site were convenient, suggesting that neither of these factors served as a barrier to their access. This should not result in one drawing the conclusion that other barriers to women’s access do not exist. On the contrary, features of the study’s methodology, as well as characteristics of the participants, could explain these findings, as will be discussed below.

Perhaps the most notable factor influencing the fact that so few barriers were highlighted is that, presumably, the women experiencing the greatest barriers to accessing the site are, in fact, women who are not clients of the site. Indeed, these women were not able to participate in
this study, given the eligibility criteria (i.e., they had to be attending the supervised consumption site). In retrospect, in order to uncover barriers to accessing the site, it would have been more appropriate to sample women outside of or in the vicinity of the site (or even elsewhere). In so doing, I may have been able to more effectively tap into the barriers women experience, such as gender-based violence perpetrated outside of the site, as McNeil et al. (2014) demonstrated in their study conducted with a broader sample of people who use drugs in Vancouver. Further compounding this issue is the fact that the current research took place during the COVID-19 pandemic. Recent research indicates that people who use drugs with markers of structural vulnerability and drug-related risk were more likely to experience difficulty accessing supervised consumption services during the COVID-19 pandemic (Cassie et al., 2022). Taken together, it is conceivable that the overall lack of barriers to accessing supervised consumption sites unearthed by the current research is a function of who was able to attend the site in the first place, and, thus participate in this research.

It is also worth noting the absence of racially diverse women in this research. Five of the women identified as White, while two identified as Indigenous. One potential explanation for the lack of representation of racialized women in this research could be related to their resistance to participate in psychological research. This may be particularly the case for Black women. As Thomas (2004) notes, “The life experiences of Black women have never fit neatly within the traditional boundaries created within the field of psychology since its emergence as an independent intellectual and academic discipline …” (p. 286). Indeed, traditional psychological theories are limited in the extent to which they are relevant to Black women, given that they were traditionally borne out of a Euro-American context (Thomas, 2004). It is conceivable, then, that this perception of the discipline may deter racialized women, including Black women, from
wanting to participate in psychological research. In order to appropriately interrogate the experiences of Black women with supervised consumption sites, then, a psychology of Black women is needed, which, in essence, “[situates] theory and research authentically in relation to Black women’s own context and background experiences” (Thomas, 2004, p. 290).

Finally, certain factors related to my role in this research are worth reflecting on. One such factor is the manner in which I utilized the research measures. In retrospect, data collection in both phases would have benefited from me probing certain topics further. At times, I moved from question to question somewhat quickly and abruptly, not giving space for participants to elaborate on their responses, nor giving me the space needed to delve further into participants’ responses. Added to this, there were some instances in which I phrased questions during the interviews in a more close-ended way (despite the conscious effort I made to phrase the questions in the interview guides in an open-ended manner), as well as some cases where I asked leading questions, such as, “I assume this is okay, right?” Taken together, the ways in which I asked questions, as well as my failure to sufficiently explore participants’ responses during the interviews, very likely impacted both the breadth and depth of research findings.

In addition to the potential influence of how I employed the research measures, I believe certain personal characteristics of myself may have also shaped, to an extent, this research. Undertaking this research afforded the opportunity to reflect on the ways in which the researcher’s positionality influences how research is undertaken, and, by consequence, the validity of their research findings. In my case, the fact that I am a White, cisgender woman very likely shaped how this work unfolded. Participants, who all identified as cisgender women, and most of whom identified as White, may have been more receptive to sharing their insights with me due to the perceived similarity between us on a number of characteristics, than perhaps they
would have been to a White, older man or even a young, racialized woman. In this sense, it is worth recognizing that my positionality facilitated my ability to not only be welcomed into these women’s space, but for them to open up to me about such personal experiences.

An interesting observation that arose during this research was how I was treated by certain others. More specifically, some participants commented, either directly to me or to the person accompanying us, on my appearance. As a petite woman, it is not uncommon for people to comment on my size, and for my size, coupled with my younger age, to, in my view, influence how people treat me, that is, whether they infantilize me or treat me as an adult or professional, or whether they view me as needing protection. Outside of personal interactions, this phenomenon was also observed in my previous line of employment when I worked with people who use drugs at a local methadone clinic. Nonetheless, it came as somewhat of a surprise to observe this phenomenon with some of the participants and other people in the vicinity of the site. A concrete example of this is that one participant referred to me as a “cutie pie.” In addition, when I arrived outside of the facility to complete the interviews, an older man approached me on the sidewalk, warning me to be careful and to seek him out should I need any help. It was apparent that this man thought I might need protection while at or around the site, although it is unclear whether this perceived need for help was due to my size, gender, my age, a combination of all three, or something else entirely. Although not necessarily a traditional “limitation,” it is worth considering to what extent the ways in which participants responded to me, or took the research seriously, was influenced by certain characteristics of myself.

**Analysis.** A significant limitation of the current research is that the research methodology that was utilized did not permit any strong conclusions to be drawn regarding whether the barriers, experiences, and outcomes of supervised consumption sites reported by the women are
truly gender-based. In other words, it is conceivable that the themes that emerged from this research may also have emerged from similar discussions with men and non-binary persons attending the site. Indeed, recent research conducted by Kerman et al. (2020) with a comparable sample (i.e., people attending a supervised consumption site in Ottawa, Ontario) uncovered similar findings as the current research, that is, the importance of connection to supports, as well as concerns regarding safety. Although Kerman et al. (2020)’s findings were not disaggregated by gender, the fact that the majority of their sample who completed an interview were men suggests that issues related to connection and safety feature prominently in men’s experiences with supervised consumption sites as well. Future research might usefully consider, then, the extent to which both the positive and negative aspects of supervised consumption sites for women are a function of their gender, as well as whether the issues of connection and safety are of greater importance to women than men.

Although research has focused on how gender influences experiences with other harm reduction interventions, as previously noted, a considerable limitation of the current state of the literature is understanding how gender and other identity characteristics intersect to create differential experiences with supervised consumption sites in Canada. Indeed, a scant amount of research has sought to understand diverse groups of women’s access to such services (i.e., barriers preventing them from accessing these sites), their experiences within these sites, as well as the outcomes they experience as a result of attending supervised consumption sites. This research did not yield much in the way of intersectional data, certainly not enough to make any broad claims about diverse groups of women’s experiences. Further, although there were some differences observed among participants on some of the characteristics studied (e.g., age, sexual orientation, Indigenous identity), the sample was largely homogenous. As a result, no notable
trends emerged with respect to the responses shared by participants, thereby precluding any claims to be made about whether women’s experiences with supervised consumption sites vary as a function of the intersections of their gender and other identity characteristics.

**Conclusion**

Overall, this research highlighted that, for many women, supervised consumption sites are generally positive spaces for them – not just for how they influence their substance use, but also the impacts they have on other aspects of their lives. This should not diminish the limitations of the site raised by some of the participants, particularly the issue of safety. Rather, this should reinforce the need to continue investing in these sites and ensuring that they are accessible and beneficial for all women.

Examining these findings through a psychological lens, particularly by contextualizing the findings with previous research on social support and safety, highlights the critical role of connection for women who use drugs (who often lack social support), particularly in substance use treatment and other supportive settings. Ultimately, such a perspective underscores the ways in which supervised consumption sites can fill the void in terms of the lack of support that is sometimes characteristic of the social networks of women who use drugs, and ultimately reinforces the need to do so. At the same time, it supports the notion that these sites should ensure, to the extent possible, that their spaces (and the surrounding area) are free of violence, given the implications that violations to one’s sense of safety can have.

My objective, through this research, was to shed light on women’s experiences with supervised consumptions, including barriers to accessing these sites, their experiences within them, and outcomes of these sites on their drug use and other aspects of their lives. Evidently, several limitations challenged my ability to contribute many novel insights into women’s
experiences in these spaces, particularly the experiences of marginalized groups of women (e.g., Black women, transgender women, or Indigenous women). What emerged from this research instead, though, should not be discounted. Rather, my experience conducting research with women who use drugs – in the context of both an ongoing drug epidemic, coupled with the emergence of the COVID-19 pandemic, no less – afforded me with the opportunity to reflect upon how scientists can most effectively undertake research related to substance use. These observations can usefully inform how future research is conducted on, for, and with women who use drugs in an effort to generate robust findings that can, in turn, be used to support their well-being.
References


https://www.canada.ca/en/health-canada/services/substance-use/supervised-consumption-sites/status-application.html


Table 1. Socio-demographic and Health Characteristics of Phase 2 Participants

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n (%) N = 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Cisgender</td>
<td>7 (100.0%)</td>
</tr>
<tr>
<td>Transgender</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>34.3 years</td>
</tr>
<tr>
<td>Range</td>
<td>21-46 years</td>
</tr>
<tr>
<td>Indigenous identity</td>
<td></td>
</tr>
<tr>
<td>Indigenous</td>
<td>2 (28.6%)</td>
</tr>
<tr>
<td>Non-Indigenous</td>
<td>5 (71.4%)</td>
</tr>
<tr>
<td>Racial group</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>5 (71.4%)</td>
</tr>
<tr>
<td>Other</td>
<td>2 (28.6%)</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td></td>
</tr>
<tr>
<td>Heterosexual</td>
<td>5 (71.4%)</td>
</tr>
<tr>
<td>Bisexual</td>
<td>2 (28.6%)</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>1 (14.3%)</td>
</tr>
<tr>
<td>Living common law</td>
<td>2 (28.6%)</td>
</tr>
<tr>
<td>Single, never married</td>
<td>4 (57.1%)</td>
</tr>
<tr>
<td>Currently in a dating or other romantic relationship</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>4 (57.1%)</td>
</tr>
<tr>
<td>No</td>
<td>3 (42.9%)</td>
</tr>
<tr>
<td>Children</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>Gender Gaps in Harm Reduction Services</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>4 (57.1%)</td>
</tr>
<tr>
<td>No</td>
<td>3 (42.9%)</td>
</tr>
<tr>
<td>Ever engaged in sex work</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>4 (57.1%)</td>
</tr>
<tr>
<td>No</td>
<td>3 (42.9%)</td>
</tr>
<tr>
<td>Disability status</td>
<td></td>
</tr>
<tr>
<td>Has a disability/disabilities</td>
<td>5 (71.4%)</td>
</tr>
<tr>
<td>Does not have a disability/disabilities</td>
<td>2 (28.6%)</td>
</tr>
<tr>
<td>Medical conditions</td>
<td></td>
</tr>
<tr>
<td>Has a medical condition/conditions</td>
<td>6 (85.7%)</td>
</tr>
<tr>
<td>Does not have a medical condition/conditions</td>
<td>1 (14.3%)</td>
</tr>
</tbody>
</table>
Table 2. Characteristics of Phase 2 Participants’ Substance Use

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n (%)</th>
<th>N = 7</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amount of time using prescribed and/or illicit substances</strong>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-5 years</td>
<td>4 (57.1%)</td>
<td></td>
</tr>
<tr>
<td>5-10 years</td>
<td>1 (14.3%)</td>
<td></td>
</tr>
<tr>
<td>10-20 years</td>
<td>1 (14.3%)</td>
<td></td>
</tr>
<tr>
<td>20+ years</td>
<td>2 (28.6%)</td>
<td></td>
</tr>
<tr>
<td><strong>Number of times they inject on an average day</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>3.9</td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>1-10</td>
<td></td>
</tr>
<tr>
<td><strong>Ever injected alone</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>5 (71.4%)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>2 (28.6%)</td>
<td></td>
</tr>
<tr>
<td><strong>How often injected alone (past year)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occasionally (less than 25% of the time)</td>
<td>2 (40.0%)</td>
<td></td>
</tr>
<tr>
<td>Sometimes (26-74% of the time)</td>
<td>3 (60.0%)</td>
<td></td>
</tr>
<tr>
<td><strong>Ever needed help to inject</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>7 (100.0%)</td>
<td></td>
</tr>
<tr>
<td><strong>How often needed help injecting (past year)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occasionally (less than 25% of the time)</td>
<td>2 (28.6%)</td>
<td></td>
</tr>
<tr>
<td>Sometimes (26-74% of the time)</td>
<td>2 (28.6%)</td>
<td></td>
</tr>
<tr>
<td>Usually (more than 75% of the time)</td>
<td>1 (14.3%)</td>
<td></td>
</tr>
<tr>
<td>Always (100% of the time)</td>
<td>2 (28.6%)</td>
<td></td>
</tr>
<tr>
<td><strong>Ever shared drug paraphernalia</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>6 (85.7%)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>1 (14.3%)</td>
<td></td>
</tr>
</tbody>
</table>
How often shared drug paraphernalia (past year)***

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>1 (16.7%)</td>
</tr>
<tr>
<td>Occasionally (less than 25% of the time)</td>
<td>3 (50.0%)</td>
</tr>
<tr>
<td>Sometimes (26-74%)</td>
<td>1 (16.7%)</td>
</tr>
<tr>
<td>Usually (more than 75% of the time)</td>
<td>1 (16.7%)</td>
</tr>
</tbody>
</table>

Overdosed by accident (lifetime)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, in the past 30 days</td>
<td>2 (28.6%)</td>
</tr>
<tr>
<td>Yes, between 1-6 months ago</td>
<td>1 (14.3%)</td>
</tr>
<tr>
<td>Yes, more than 6 months ago</td>
<td>3 (42.9%)</td>
</tr>
</tbody>
</table>

Number of times overdosed by accident anywhere (outside of a supervised consumption site)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-5 times</td>
<td>3 (42.9%)</td>
</tr>
<tr>
<td>6-10 times</td>
<td>1 (14.3%)</td>
</tr>
<tr>
<td>11-15 times</td>
<td>1 (14.3%)</td>
</tr>
<tr>
<td>20+ times</td>
<td>2 (28.6%)</td>
</tr>
</tbody>
</table>

* Does not total 100% as one participant provided two responses: one for ‘harder drugs’ and one pertaining to her marijuana use.

** Excludes 2 participants that responded ‘not applicable.’

*** Excludes 1 participant that responded ‘not applicable.’
Table 3. Characteristics of Phase 2 Participants’ Use of Supervised Consumption Sites

Characteristics of Phase 2 Participants’ Use of Supervised Consumption Sites

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n (%)</th>
<th>N = 7</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Length of time using supervised consumption sites</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than one month</td>
<td>0 (0.0%)</td>
<td></td>
</tr>
<tr>
<td>1-3 months</td>
<td>0 (0.0%)</td>
<td></td>
</tr>
<tr>
<td>3-6 months</td>
<td>1 (14.3%)</td>
<td></td>
</tr>
<tr>
<td>6-12 months</td>
<td>2 (28.6%)</td>
<td></td>
</tr>
<tr>
<td>1-2 years</td>
<td>3 (42.9%)</td>
<td></td>
</tr>
<tr>
<td>More than 2 years</td>
<td>1 (14.3%)</td>
<td></td>
</tr>
<tr>
<td><strong>Amount supervised consumption sites used in past year</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daily</td>
<td>7 (100%)</td>
<td></td>
</tr>
<tr>
<td><strong>Number of accidental overdoses at supervised consumption sites</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-5 times</td>
<td>4 (57.1%)</td>
<td></td>
</tr>
<tr>
<td>16-20 times</td>
<td>1 (14.3%)</td>
<td></td>
</tr>
<tr>
<td>20+ times</td>
<td>1 (14.3%)</td>
<td></td>
</tr>
<tr>
<td>Not applicable</td>
<td>1 (14.3%)</td>
<td></td>
</tr>
</tbody>
</table>
Appendices

Appendix A: Recruitment Script (Phase 1)

I am inviting you, on behalf of the researcher, to participate in a research study being conducted by a Ph.D. student in the Department of Psychology at Carleton University. The goal of this study is to understand women’s and gender minorities’ experiences with supervised consumption sites. You should also know that this study will last several months and will require the researcher to be on site for an extended period of time.

This first phase of the study involves participating in a one-on-one interview, which will last about 30 minutes, with the researcher in a meeting room here. Because of the COVID-19 pandemic, the meeting will take place on Zoom, a videoconferencing platform. One of the peer support workers from the trailer will be in the room during the interview.

The interviews are meant to gather information about the research methods that will be used in the second phase of the study. The researcher wants to make sure that the research methods make sense and are appropriate, and wants to ask clients of the trailer for their feedback. During these interviews, you would be asked to provide feedback on a survey and an interview guide. Both of these tools ask questions about drug use, experiences of violence, sex work, and use of supervised consumption sites. You would not be asked to answer any of these questions yourself. Instead, you would be asked whether certain questions should be added or removed from these tools to improve this research.

All information collected from you would be anonymous and confidential. There would be minimal risk to you for participating. More detailed information about anonymity, confidentiality, about possible risks would be given to you by the researcher before the interview begins. You would be able to withdraw from the study at any time before, during, or after the interview.

Your participation in this part of the research is completely voluntary. Whether or not you participate will not impact your access to or treatment within the trailer by staff and volunteers. As a token of appreciation, you would be given $15.00 in cash.

Would you like to participate?

If the client says yes:

Thank you. I will let the researcher know that you are interested in participating and will follow up with you to figure out a time that you can both meet for the interview.
If the client says no:

That is not a problem. Thank you for taking the time to listen!
Appendix B: Confidentiality Agreement

I, _____________________________, have been asked by staff at Ottawa Inner City Health to support a research study conducted by Tia Carpino of the Department of Psychology at Carleton University. In this role, I will have access to confidential data relating to a research study. Confidential information refers to all information obtained about the participants in the research study that is personal in nature.

I hereby agree to:

1. Keep all of the data shared with me confidential by not divulging information or making it accessible in any form or format with anyone other than the members of the research team. I will exercise caution in ensuring that information is not inadvertently disclosed.

2. Only disclose confidential information when required by law (e.g., there is imminent risk of harm to the participant or to others, including children, as well as cases of child abuse). In such cases, confidentiality will be broken to ensure the safety of those at-risk persons.

Peer Support Worker Name: _____________________________

Peer Support Worker Signature: _____________________________

Date: _____________________________

Principal Investigator Name: _____________________________

Principal Investigator Signature: _____________________________

Date: _____________________________
Appendix C: Oral Consent Script (Phase 1)

Hello, my name is Tia and I am a Ph.D. student in the Department of Psychology at Carleton University. Thank you for agreeing to participate in Phase 1 of a study called *Supervised Consumption Services: Understanding the Experiences of Women and Gender Minorities*. This study has been approved by the Carleton University Research Ethics Board - B. As the title suggests, the goal of this study is to understand women’s and gender minorities’ experiences with supervised consumption sites.

Phase 1 of the study involves completing a short interview with me. The goal of this interview is to make sure that the research methods that will be used in Phase 2 of this study are appropriate and meaningful. During the interview, I will share information about the research methods and data collection tools (i.e., survey and interview guide). Generally speaking, these data collection tools ask questions about drug use, use of supervised consumption sites, experiences of violence, and involvement in sex work. You will not be asked to answer any of these questions yourself. Instead, I will ask for your feedback about the research methods and data collection tools, including whether anything needs to be changed, added, or removed. This interview will take about 30 minutes to complete. A peer support worker will be in the room during the interview to provide support as necessary. They have signed a confidentiality agreement stating that they will not share any of the content of the interviews, unless required by law, like, for example, if there is a risk of harm to the participant or others, including children.

**Do you have any questions so far?**

Some of the questions that will be asked of participants in Phase 2 of this research may cause negative thoughts or emotions, since they are sensitive and personal. Even though I will not be asking you to answer these questions, it is still possible that you might experience negative thoughts or emotions in reaction to hearing these questions. Both myself and the peer support worker will provide you with support if you experience any negative thoughts or emotions during the interview. If you appear to be upset, I will ask you if you want to skip the question, take a break, or stop the interview. If you continue to appear upset, the interview will end. Both myself and the peer support worker will connect you with the appropriate resources if you experience any negative thoughts or emotions during or after the interview. I will also provide you with a list of community resources that provide free mental health, counselling, and support services, either in person or via telephone. I encourage you to contact any of these resources if you experience any negative thoughts or emotions during or after the interview.

You might not directly benefit from this study. However, your answers to the questions I will ask you during the interview will help to make sure that Phase 2 is appropriate and meaningful. The goal of this research is to help researchers, policy makers, and supervised consumption site staff and volunteers, to better understand women’s and gender minorities’ experiences with
supervised consumption services. Also, the information collected through this study may be used to help address and improve women’s and gender minorities’ experiences with Ottawa Inner City Health’s supervised consumption site.

Do you have any questions so far?

I will not be collecting any information that can be used to identify you. I will be assigning you a pseudonym so that data collected from you can be presented in the research findings without it being linked to you. For example, a research report might say something like, “Billy Bob highlighted the importance of …” All of my notes from the interview will be stored electronically on a password-protected USB key. These notes will be kept for 5 years and then destroyed after that. Everything you say during the interview will be treated as confidential.

The results of this study may be published or presented at an academic conference or meeting, and general findings will be shared verbally with participants, staff, peer support workers, and volunteers of the trailer who are interested once the study is complete. Research findings will also be provided to the trailer’s staff in a report and, if of interest, through a presentation to clients, staff, volunteers, and peer support workers of the trailer.

Your participation in this survey is completely voluntary. If you do not want to participate, this will not be used against you in any way and will not affect the services you receive at the trailer. If you do want to participate, you can choose not to answer any of the questions in the questionnaire and interview. You can also withdraw from the study at any time, including before, during or after the interview. During the interview, you can let me or the peer support worker know that you would like to withdraw. After the interview, you can let me know by contacting me at my email address that will be provided to you after the interview. Or, you can let staff or peer support workers at the trailer know that you would like to withdraw, and they will let me know. If you withdraw your consent during or after the interview, all of the information collected from you will be destroyed.

You will be given $15.00 in cash for participating. You will still be compensated if you withdraw your consent during or after the interview.

Do you have any questions about this study or need any clarification?

Do you voluntarily agree to participate in the study?
Appendix D: Oral Consent Log

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Pseudonym</th>
<th>Phase (1 or 2)</th>
<th>Consent Given (Yes/No)</th>
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Appendix E: Interview Guide (Phase 1)

The Lead Researcher will begin by providing an overview of the study objective and research methods. Then, the Lead Researcher will discuss each element of the research methodology (i.e., participant observation, survey, interview) individually in detail. Following the discussion about each individual element, the Lead Researcher will use the following guide to solicit feedback on that particular element. The Lead Researcher will then discuss and solicit feedback on the next two aspects of the research methodology in turn.

**Participant Observation**

1. What are your thoughts about me observing clients within the trailer? Do you think this is appropriate and necessary?
2. Are there certain things I should really pay attention to?
3. How can I make sure that I observe participants in a respectful way?

**Survey**

Thinking about the survey questions:

4. Are there any questions that do not make sense?
5. Are there any questions that are inappropriate or unnecessary?
6. Are there any questions that you think could cause negative thoughts or emotions?
7. Are there any other questions that should be removed?
8. Are there any other questions that should be added?

*If participants answer YES to questions 4-6, they will be asked which questions, why, and how this should be addressed (i.e., either by modifying or removing the question). If participants answer YES to questions 7 or 8, they will be asked to indicate which questions should be removed/added and why.*

**Interview Guide**

Thinking about the interview questions:

9. Are there any questions that do not make sense?
10. Are there any questions that are inappropriate or unnecessary?
11. Are there any questions that you think could cause negative thoughts or emotions?
12. How can I, as the interviewer, help to reduce the chances of a participant experiencing any negative thoughts or emotions?
13. Are there any other questions that should be removed?
14. Are there any other questions that should be added?

*If participants answer YES to questions 9 or 10, they will be asked which questions, why, and how this should be addressed (i.e., either by modifying or removing the question). If participants answer YES to questions 13 or 14, they will be asked to indicate which questions should be removed/added and why.*

**General**

15. Overall, what do you think about this research? Does it make sense? Do you think this research is appropriate and necessary?

**Conclusion**

16. Is there anything else you would like to add to help improve this research?
Appendix F: Debriefing Form

Name and Contact Information of Researchers:

Principal Investigator:
Tia Carpino, Ph.D. Candidate, Carleton University, Department of Psychology
Email: Tia.Carpino@carleton.ca

Supervisors and Contact Information:
Dr. John Weekes, Carleton University, Department of Psychology
Email: John.Weekes@carleton.ca

Dr. Cheryl Harasymchuk, Carleton University, Department of Psychology
Tel.: (613) 520-2600 x 3056
Email: Cheryl.Harasymchuk@carleton.ca

Project Title
Supervised Consumption Services: Understanding the Experiences of Women and Gender Minorities

Carleton University Project Clearance
CUREB-B Clearance #: 112334 Date of Clearance: October 14, 2020

What Are We Trying to Learn in This Research?
This research examines aims to understand women’s and gender minorities’ access to, experiences within, and outcomes of supervised consumption sites.

Why Is This Important?
Given the relative novelty of supervised consumption sites in Canada, as well as their recent establishment in several parts of the country, there is much to be learned about women’s and gender minorities’ access to, experiences within, and outcomes of these facilities. Much of the existing research on supervised consumption sites has not considered how experiences with these sites may differ for women and gender minorities, relative to men. The information gained from this study will fill important knowledge gaps and may facilitate change at supervised consumption sites in order to address the unique needs and experiences of women and gender minorities who access supervised consumption services.

What If I Experienced Psychological Distress?
If you feel any psychological distress (e.g., stress, anxiety, depression) after participating in this study, you are encouraged to contact any of the community resources listed on the document provided to you upon providing signed consent. If you are at risk of imminent harm, please go to your nearest emergency department or call 9-1-1.
**Where Can I Learn More?**

Following the completion of this study, the Principal Investigator will provide Ottawa Inner City Health with a brief report outlining the research findings. The Principal Investigator will also discuss with Ottawa Inner City Health how these findings can be shared with individuals accessing the supervised consumption site.

**What If I Have Questions Later?**

If you have any remaining concerns, questions, or comments about this research, please contact Tia Carpino (Principal Investigator) at Tia.Carpino@carleton.ca.

If you have any ethical concerns with the study, please contact the Carleton University Research Ethics Board-B (by phone at 613-520-2600 ext. 4085 or via email at ethics@carleton.ca).

*Thank you for participating in this research!* 
Appendix G: Community Resources

Should you experience any psychological distress during the course of or after completing this study, you are encouraged to contact any of the community resources listed below.

If you are or someone else is at risk of imminent harm, please go to the nearest emergency department or call 9-1-1.

---

Crisis Lines

Child, Youth and Family Crisis Line of Eastern Ontario: 613-260-2360
Distress Centre of Ottawa: (613) 238-3311
Mental Health Crisis Line: (613) 722-6914
Tel-Aide Outaouais: (613) 741-6433
Telehealth Ontario: 1(866) 797-0000
Trans Lifeline: 1(877) 330-6366

If you have experienced abuse, here are some of your options:

1. Call a crisis line:
   
   **Ontario Assaulted Women’s Helpline** (24 hour): 1(866) 863-0511
   **Ottawa 24 hour Information and Help** (24 hour): (613) 745-4818
   **Ottawa Distress Centre** (24 hour): (613) 238-3311
   **Ottawa Rape Crisis Centre** (24 hour): (613) 562-2333
   **Sexual Assault Support Centre** (24 hour): (613) 234-2266 TTY
   **Fem’aide Crisis Line** (24 hour): 1(877) 336-2433
   **CALACS Francophone d'Ottawa**: (613) 789-8096
   **Francophone Sexual Assault Program**: (613) 233-8478

2. Call the police services:
   
   **Sexual Assault and Child Abuse Unit**: (613) 236-1222 x5944
   **Victim Support Unit**: (613) 236-1222 x2223
   **Partner Assault Unit**: (613) 236-1222 x5407

3. Seek medical attention if needed:
   
   **Ottawa Hospital Civic Campus** (24 hour): (613) 722-7000
   **Lanark County Sexual Assault and Domestic Violence** (24 hour): (613) 283-2330 x1258

4. Call a shelter or Program Against Abuse
Chrysalis House: (613) 591-5901
Evelyn Horne Emergency and Transitional Housing Program for Young Women: (613) 789-8220
Harmony House: (613) 233-3386
Interval House: (613) 234-5181
La Présence: (613) 241-8297
Lanark County Interval House: (613) 257-5960
Maison d’Amitié: (613) 747-0020
Nelson House: (613) 225-3129
Oshki Kizis Lodge: (613) 789-1141

Community Health and Resource Centres

Carlington Community Health Centre
900 Merivale Road, Ottawa, ON
P: (613) 722-4000

Centretown Community Health Centre
420 Cooper Street, Ottawa, ON
P: (613) 233-4443

Eastern Ottawa Resource Centre
215-1980 Ogilvie Road, Gloucester, ON
P: (613) 741-6025

Lowertown Community Resource Centre
40 Cobourg Street, Ottawa, ON
P: (613) 789-3930

Minwaashin Lodge
100-1155 Lola Street, Ottawa, ON
P: (613) 741-5590

Nepean, Rideau and Osgoode Community Resource Centre
1547 Merivale Road, Unit 240, Nepean, ON
P: (613) 596-5626

201-4100 Strandherd Road, Barrhaven, ON
P: (613) 596-5626

Orléans-Cumberland Community Resource Centre
240 Centrum Blvd., Unit 105, Orléans, ON  
P: (613) 830-4357

**Pinecrest-Queensway Community Health Centre**  
1365 Richmond Road, 2nd Floor  
P: (613) 820-4922

**Rideau-Rockcliffe Community Resource Centre**  
P: (613) 745-0073

**Sandy Hill Community Health Centre**  
221 Nelson Street, Ottawa, ON  
P: (613) 789-1500

**Somerset West Community Health Centre**  
55 Eccles St., Ottawa, ON  
P: (613) 238-8210

30 Rosemount Ave., Ottawa, ON  
P: (613) 688-1177

**South East Ottawa Community Health Centre**  
1355 Bank Street, Suite 600, Ottawa, ON  
P: (613) 737-5115

3320 Paul Anka Drive, Ottawa, ON  
P: (613) 247-1600

**Vanier Community Service Centre**  
290 Dupuis St., Ottawa, ON  
P: (613) 744-2892

**Wabano Centre for Aboriginal Health**  
299 Montreal Road, Ottawa, ON  
P: (613) 748-0657

**Western Ottawa Community Resource Centre**  
2 MacNeil Court, Ottawa, ON  
P: (613) 591-3686
Appendix H: Recruitment Script (Phase 2)

I am inviting you, on behalf of the researcher, to participate in a research study being conducted by a Ph.D. student in the Department of Psychology at Carleton University. The goal of this study is to understand women’s and gender minorities’ experiences with supervised consumption sites. You should also know that this study may require the researcher to be on site on multiple occasions over a period of time.

This second phase of the study involves completing a short questionnaire and a one-on-one interview, which will last between 45-60 minutes, with the researcher in a meeting room at Shepherds of Good Hope. One of the peer support workers from the trailer will be in the room during the interview.

The questionnaire and interview are meant to gather information about women’s and gender minorities’ access to, experiences within, and outcomes of supervised consumption sites. Generally speaking, questions asked in the questionnaire will be about your drug use and use of supervised consumption sites. You may also be asked questions about experiences of violence and harassment, as well as engagement in sex work.

All information collected from you would be anonymous and confidential. To help with data analysis, these interviews would be audio recorded. There is a risk that you might feel uncomfortable or upset answering some of the questions in the questionnaire and interview, given their sensitive nature. You would be able to skip any questions you do not feel comfortable answering, and would be able to withdraw from the study at any time before, during, or after the interview. The researcher will also make sure you are supported and connected with resources to reduce the impact of any harm you might experience. More detailed information about anonymity, confidentiality, about possible risks would be given to you by the researcher before the interview begins.

Your participation in this part of the research is completely voluntary. Whether or not you participate will not impact your access to or treatment within the trailer by staff and volunteers. As a token of appreciation, you would be given $25.00 in cash.

Would you like to participate?

If the client says yes:

Thank you. I will let the researcher know that you are interested in participating and will follow up with you to figure out a time that you can both meet for the interview.

If the client says no:
That is not a problem. Thank you for taking the time to listen!
Appendix I: Oral Consent Script (Phase 2)

Hello, my name is Tia and I am a Ph.D student in the Department of Psychology at Carleton University. Thank you for agreeing to participate in Phase 2 of a study called Supervised Consumption Services: Understanding the Experiences of Women and Gender Minorities. This study has been approved by the Carleton University Research Ethics Board - B. As the title suggests, the goal of this study is to understand women’s and gender minorities’ experiences with supervised consumption sites.

You are being invited to participate in Phase 2 of this study, which involves completing a short questionnaire and an interview with me. The goal of this interview is to understand your experiences with supervised consumption sites. Generally speaking, the questions that will be asked of you in the questionnaire and interview will be about your demographics, drug use, use of supervised consumption sites, experiences of violence, and involvement in sex work. A peer support worker will be in the room as you complete the questionnaire and during the interview to provide support as necessary. They have signed a confidentiality agreement stating that they will not share any of the content of the interviews, unless required by law, like, for example, if there is a risk of harm to the participant or others, including children. You will be able to complete the questionnaire by yourself, or with the support of either myself or the peer support worker. The questionnaire and interview will take about 45-60 minutes to complete.

Do you have any questions so far?

Some of the questions that will be asked of you may cause negative thoughts or emotions, since they are sensitive and personal. Both myself and the peer support worker will provide you with support if you experience any negative thoughts or emotions during the interview. If you appear to be upset, I will ask you if you want to skip the question, take a break, or stop the interview. If you continue to appear upset, the interview will end. Both myself and the peer support worker will connect you with the appropriate resources if you experience any negative thoughts or emotions during or after the interview. I will also provide you with a list of community resources that provide free mental health, counselling, and support services, either in person or via telephone. I encourage you to contact any of these resources if you experience any negative thoughts or emotions during or after the interview.

You might not directly benefit from this study. However, your answers to the questions I will ask you during the interview will help to make sure that Phase 2 is appropriate and meaningful. The goal of this research is to help researchers, policy makers, and supervised consumption site staff and volunteers, to better understand women’s and gender minorities’ experiences with supervised consumption services. Also, the information collected through this study may be used
GENDER GAPS IN HARM REDUCTION SERVICES

Do you have any questions so far?

To help me with data analysis, it is necessary and mandatory to audio record our interview. All devices containing research data, such as a laptop or USB key, will be encrypted and password protected. These devices, as well as my notes from the interviews, will be stored securely in a locked filing cabinet in the researcher’s office. All of these materials will be kept for 5 years and then destroyed after that.

The results of this study may be published or presented at an academic conference or meeting, and general findings will be shared verbally with participants, staff, peer support workers, and volunteers of the trailer who are interested once the study is complete. Research findings will also be provided to the trailer’s staff in a report and, if of interest, through a presentation to clients, staff, volunteers, and peer support workers of the trailer. I will be assigning you a pseudonym so that data collected from you can be presented in the research findings without it being linked to you. For example, a research report might say something like, “Billy Bob highlighted the importance of …” Certain aspects of your identity (e.g., age, immigrant status, disability status) may be presented in the research findings and linked to your pseudonym. However, data will be presented so that it will not be possible to identify you. Because of this, certain aspects of your identity will not be presented when doing so would make it possible for you to be identified. If you do not want certain aspects of your identity to be presented in the research findings, you can let me know when I am finished giving these instructions, or at any point while you complete the questionnaire or interview.

Your personal information and responses will be treated as confidential, although absolute privacy cannot be guaranteed. No information that discloses your identity will be released or published without your specific consent. All data will be kept confidential, unless release is required by law (e.g., if there is imminent risk of harm to yourself or to others, including children, as well as cases of child abuse). In these cases, confidentiality will be broken to make sure those who are at risk are safe. Research records may also be accessed by the Carleton University Research Ethics Board in order to ensure continuing ethics compliance.

Your participation in this survey is completely voluntary. If you do not want to participate, this will not be used against you in any way and will not affect the services you receive at the trailer. If you do want to participate, you can choose not to answer any of the questions in the questionnaire and interview. You can also withdraw from the study at any time, including before, during or after the interview. During the interview, you can let me or the peer support worker know that you would like to withdraw. After the interview, you can let me know by contacting
me at my email address that will be provided to you after the interview. Or, you can let staff or peer support workers at the trailer know that you would like to withdraw, and they will let me know. If you withdraw your consent during or after the questionnaire or interview, all of the information collected from you will be destroyed.

You will be given $25.00 in cash for participating. You will still be compensated if you withdraw your consent during or after the questionnaire or interview.

Do you have any questions about this study or need any clarification?

Do you voluntarily agree to participate in the study?

Do you agree to be audio recorded?
Appendix J: Survey

### Administrative Information

**Participant Pseudonym:**

**Instructions:** Please complete this brief survey about your sociodemographic and health information, as well as substance use and use of supervised consumption services. You may choose to complete the survey independently or with the support of the researcher or peer support worker. Your response to each question is optional. Should you choose not to provide an answer, please select the *Prefer not to answer* option.

If you have any questions or concerns about any of the questions, please inform the researcher or the peer support worker at any time.

### Sociodemographic and Health Information

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
</table>
| 1. **What was the sex you were assigned at birth?** | □ Male  
 □ Female  
 □ Prefer not to answer  

*Select one option.* |
| 2. **What is your current gender?** | □ Male  
 □ Female  
 □ Please specify: ________________________  
 □ Prefer not to answer  

*Select one option.* |
| 3. **What is your age?** | Please specify: ________________________  
 □ Prefer not to answer |
| 4. **Are you First Nations, Métis, or Inuk (Inuit)?** | □ Yes, First Nations  
 □ Yes, Métis  
 □ Yes, Inuit  

*Select all that apply.*  

OR  

□ No  
□ Do not know/unsure |
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>
| 5. | Which of the following racial or cultural groups do you belong to?  
*Select all that apply.* |
|   | White  
|   | South Asian  
|   | Chinese  
|   | Black  
|   | Filipino  
|   | Latin American  
|   | Arab  
|   | Southeast Asian  
|   | West Asian  
|   | Korean  
|   | Japanese  
|   | Please specify: ________________________  
|   | Do not know/unsure  
|   | Prefer not to answer |
| 6. | What is your sexual orientation?  
*Select one option.* |
|   | Heterosexual (i.e., straight)  
|   | Homosexual (i.e., lesbian or gay)  
|   | Bisexual  
|   | Please specify: ________________________  
|   | Do not know/unsure  
|   | Prefer not to answer |
| 7. | a) What is your marital status?  
*Select all that apply.*  
|   | Married  
|   | Living common law (i.e., two people who live together as a couple but who are not legally married to each other)  
|   | Widowed  
|   | Separated  
|   | Divorced  
|   | Single, never married  
|   | Prefer not to answer  
|   | b) Are you currently in a dating or other romantic relationship?  
*Select one answer.*  
|   | Yes  
|   | No  
|   | Prefer not to answer |
| 8. | Do you have any children?  
|   | Yes  
<p>|   | No |</p>
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
</table>
| 9. Have you ever engaged in sex work?                                   | □ Yes  
□ No  
□ Prefer not to answer                                               |
| 10. a) Do you have a disability?                                        | □ Yes  
□ No  
□ Prefer not to answer                                               |
| b) If you have a disability, please specify which type(s) of disability/disabilities. | □ Seeing  
□ Hearing  
□ Mobility  
□ Flexibility  
□ Dexterity  
□ Pain  
□ Learning  
□ Memory  
□ Developmental  
□ Mental and/or psychological  
□ Unknown disability type  
□ Do not know/unsure  
□ Not applicable  
□ Prefer not to answer |
| 11. a) Do you have any medical conditions?                               | □ Yes  
□ No  
□ Do not know/unsure  
□ Prefer not to answer                                               |
<p>| b) Please specify which medical conditions you have.                    |<strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong>|
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|                                                                          |______________________________________________________________________|</p>
<table>
<thead>
<tr>
<th>Substance Use and Use of Supervised Consumption Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. How long have you been using prescribed and/or illicit substances?</td>
</tr>
<tr>
<td>Select one answer.</td>
</tr>
<tr>
<td>☐ Less than 1 year</td>
</tr>
<tr>
<td>☐ 1-5 years</td>
</tr>
<tr>
<td>☐ 5-10 years</td>
</tr>
<tr>
<td>☐ 10-20 years</td>
</tr>
<tr>
<td>☐ More than 20 years</td>
</tr>
<tr>
<td>☐ Do not know/unsure</td>
</tr>
<tr>
<td>☐ Prefer not to answer</td>
</tr>
<tr>
<td>13. a) How long have you been using supervised consumption sites?</td>
</tr>
<tr>
<td>Select one answer.</td>
</tr>
<tr>
<td>☐ Less than one month</td>
</tr>
<tr>
<td>☐ 1-3 months</td>
</tr>
<tr>
<td>☐ 3-6 months</td>
</tr>
<tr>
<td>☐ 6-12 months</td>
</tr>
<tr>
<td>☐ 1-2 years</td>
</tr>
<tr>
<td>☐ More than 2 years</td>
</tr>
<tr>
<td>☐ Do not know/unsure</td>
</tr>
<tr>
<td>☐ Prefer not to answer</td>
</tr>
<tr>
<td>b) In the past year, how often have you used supervised consumption sites?</td>
</tr>
<tr>
<td>Select one answer.</td>
</tr>
<tr>
<td>☐ Less than once per month</td>
</tr>
<tr>
<td>☐ 1-3 times per month</td>
</tr>
<tr>
<td>☐ Once per week</td>
</tr>
<tr>
<td>☐ More than once per week but less than daily</td>
</tr>
<tr>
<td>☐ Daily</td>
</tr>
<tr>
<td>☐ Do not know/unsure</td>
</tr>
<tr>
<td>☐ Prefer not to answer</td>
</tr>
</tbody>
</table>
14. a) In the **past year**, what substances (prescription or illicit) have you used **anywhere**?

*Select all that apply.*

- ☐ Alcohol
- ☐ Amphetamines
- ☐ Cannabis
- ☐ Cocaine
- ☐ Crack/cocaine
- ☐ Crystal meth
- ☐ Dilaudid
- ☐ Gabapentin
- ☐ Generic oxycodone
- ☐ Fentanyl
- ☐ Heroin
- ☐ Hydros
- ☐ Lyrica
- ☐ Methamphetamine
- ☐ Morphine
- ☐ Oxy Neo
- ☐ Percocet
- ☐ Dilaudid
- ☐ Gabapentin
- ☐ Generic oxycodone
- ☐ Fentanyl
- ☐ Heroin
- ☐ Hydros
- ☐ Lyrica
- ☐ Speedball
- ☐ Ritalin or biphentin
- ☐ Steroids
- ☐ Tobacco
- ☐ Tranquilizers or benzos
- ☐ Valium
- ☐ Wellbutrin
- ☐ Other:
  
  ____________________________

□ Do not know/unsure
□ Prefer not to answer

b) In the **past year**, what substances (prescription or illicit) have you used at **supervised consumption sites**?

*Select all that apply.*

- ☐ Alcohol
- ☐ Amphetamines
- ☐ Cannabis
- ☐ Cocaine
- ☐ Crack/cocaine
- ☐ Crystal meth
- ☐ Dilaudid
- ☐ Gabapentin
- ☐ Generic oxycodone
- ☐ Fentanyl
- ☐ Heroin
- ☐ Hydros
- ☐ Lyrica
- ☐ Speedball
- ☐ Ritalin or biphentin
- ☐ Steroids
- ☐ Tobacco
- ☐ Tranquilizers or benzos
- ☐ Valium
- ☐ Wellbutrin
- ☐ Other:
  
  ____________________________

□ Do not know/unsure
□ Prefer not to answer
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. a) On average, on a day when you inject, how many times do you usually inject?</td>
<td>Times: __________________________</td>
</tr>
<tr>
<td>b) Have you ever injected alone?</td>
<td>□ Yes □ No □ Do not know/unsure □ Not applicable □ Prefer not to answer</td>
</tr>
<tr>
<td>c) In the past year, how often did you inject alone?</td>
<td>□ Never □ Occasionally (less than 25% of the time) □ Sometimes (26-74% of the time) □ Usually (more than 75% of the time) □ Always (100% of the time) □ Do not know/unsure □ Not applicable □ Prefer not to answer</td>
</tr>
<tr>
<td>d) Have you ever needed help to inject drugs?</td>
<td>□ Yes □ No □ Do not know/unsure □ Not applicable □ Prefer not to answer</td>
</tr>
<tr>
<td>e) In the past year, how often did you need help when injecting?</td>
<td>□ Never □ Occasionally (less than 25% of the time) □ Sometimes (26-74% of the time)</td>
</tr>
</tbody>
</table>
### GENDER GAPS IN HARM REDUCTION SERVICES

| **Select one answer.** | □ Usually (more than 75% of the time)  
□ Always (100% of the time)  
□ Do not know/unsure  
□ Not applicable  
□ Prefer not to answer |
|----------------------|--------------------------------------------------------------------------|
| **f) Have you ever** | □ Yes  
□ No  
□ Do not know/unsure  
□ Not applicable  
□ Prefer not to answer |
| **shared drug** |  
□ Never  
□ Occasionally (less than 25% of the time)  
□ Sometimes (26-74% of the time)  
□ Usually (more than 75% of the time)  
□ Always (100% of the time)  
□ Do not know/unsure  
□ Not applicable  
□ Prefer not to answer |
| **paraphernalia?** |  
□ Never  
□ Occasionally (less than 25% of the time)  
□ Sometimes (26-74% of the time)  
□ Usually (more than 75% of the time)  
□ Always (100% of the time)  
□ Do not know/unsure  
□ Not applicable  
□ Prefer not to answer |
| **g) In the past year,** | □ Yes, in the past 30 days.  
□ Yes, between 1 month and 6 months ago  
□ Yes, more than 6 months ago  
□ No  
□ Do not know/unsure  
□ Prefer not to answer |
| **when you’ve used** |  
□ Yes, in the past 30 days.  
□ Yes, between 1 month and 6 months ago  
□ Yes, more than 6 months ago  
□ No  
□ Do not know/unsure  
□ Prefer not to answer |
| **drugs, how often** |  
□ Yes, in the past 30 days.  
□ Yes, between 1 month and 6 months ago  
□ Yes, more than 6 months ago  
□ No  
□ Do not know/unsure  
□ Prefer not to answer |
| **have you shared drug** | □ Yes, in the past 30 days.  
□ Yes, between 1 month and 6 months ago  
□ Yes, more than 6 months ago  
□ No  
□ Do not know/unsure  
□ Prefer not to answer |
| **paraphernalia?** | □ Yes, in the past 30 days.  
□ Yes, between 1 month and 6 months ago  
□ Yes, more than 6 months ago  
□ No  
□ Do not know/unsure  
□ Prefer not to answer |
| **16. a) In your lifetime,** | □ Yes, in the past 30 days.  
□ Yes, between 1 month and 6 months ago  
□ Yes, more than 6 months ago  
□ No  
□ Do not know/unsure  
□ Prefer not to answer |
| **have you overdosed** | □ Yes, in the past 30 days.  
□ Yes, between 1 month and 6 months ago  
□ Yes, more than 6 months ago  
□ No  
□ Do not know/unsure  
□ Prefer not to answer |
| **by accident?** | □ Yes, in the past 30 days.  
□ Yes, between 1 month and 6 months ago  
□ Yes, more than 6 months ago  
□ No  
□ Do not know/unsure  
□ Prefer not to answer |
| **b) In your lifetime,** | □ 1-5 times  
□ 6-10 times  
□ 11-15 times  
□ 16-20 times  
□ 20+ times  
□ Do not know/unsure  
□ Not applicable  
□ Prefer not to answer |
| **approximately how** | □ 1-5 times  
□ 6-10 times  
□ 11-15 times  
□ 16-20 times  
□ 20+ times  
□ Do not know/unsure  
□ Not applicable  
□ Prefer not to answer |
| **many times have you** | □ 1-5 times  
□ 6-10 times  
□ 11-15 times  
□ 16-20 times  
□ 20+ times  
□ Do not know/unsure  
□ Not applicable  
□ Prefer not to answer |
| **overdosed by accident anywhere** | □ 1-5 times  
□ 6-10 times  
□ 11-15 times  
□ 16-20 times  
□ 20+ times  
□ Do not know/unsure  
□ Not applicable  
□ Prefer not to answer |
| **outside of a supervised consumption site?** | □ 1-5 times  
□ 6-10 times  
□ 11-15 times  
□ 16-20 times  
□ 20+ times  
□ Do not know/unsure  
□ Not applicable  
□ Prefer not to answer |
C) In your **lifetime**, approximately how many times have you overdosed by accident at a [supervised consumption site]?

*Select one answer.*

- [ ] 1-5 times
- [ ] 6-10 times
- [ ] 11-15 times
- [ ] 16-20 times
- [ ] 20+ times
- [ ] Do not know/unsure
- [ ] Not applicable
- [ ] Prefer not to answer
Appendix K: Interview Guide (Phase 2)

1. Can you share whether anyone or anything helped get you here today?

2. Can you share whether anyone or anything made it difficult for you to get here today?

3. Can you share whether you feel comfortable and safe here?

4. What are your relationships like with staff, volunteers, and peer support workers here?
   What are your relationships like with other people who come here?

5. Can you share any challenges you have experienced while accessing this site?

6. Can you describe anything about this site that is particularly important to or helpful for you?

7. What impact has this site had on your drug use?

8. Can you share what impact this site has had on other aspects of your life (e.g., social, financial, intimate relationships, health and well-being)?