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ADDING WOMEN TO THE CONVERSATION ON SAFE CONSUMPTION SITES: A QUALITATIVE INTERVIEW STUDY WITH POOR AND MARGINALIZED WOMEN WHO USE ILLICIT SUBSTANCES

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by

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Abstract

Women's erasure from discourses pertaining to substance use and safe consumption sites (SCSs) means harm reduction efforts are developed through the male lens. This research seeks to discover why women do (or do not) access SCSs so as to determine if and how SCSs address the unique gendered needs of women who use illicit substances. Semi-structured qualitative interviews were conducted with 14 women-identified individuals who use illicit substances. Participants were recruited from a non-profit organization that offers harm reduction, but is not itself a SCS in order to capture a full range of perspectives on the SCS in their community. Interviews were transcribed verbatim and analyzed thematically using a grounded theory approach. The analytic insights were divided into two overarching themes. I examine the structural factors which sustain gender inequity - including the feminization of poverty, violence against women, and structural stigma – and heavily impact the daily experiences of poor and marginalized women who use illicit substances, so as to grasp a thorough understanding of the broader gendered issues encompassing the lives of women who use illicit substances. These insights provided context to analyze the SCS to determine if women's needs were being met. Several policies impede women's access to SCSs as well as diminish the site's appeal, such as the hours of operation, prohibiting inhalation and assisted injections, and a lack of peer workers. Findings from this research indicate that women-identified people desire policy and program changes that provide a more inclusive space to better meet their gendered needs. Until a widely accessible safe supply is available, SCSs remain the foremost solution to the opioid crisis and thus must strive to meet the needs of women who use illicit substances.

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Chapter One: Introduction

1.1 Introduction

Overdose deaths from illicit opioid use has been on the rise since 2012 and prior to the COVID-19 pandemic were said to have reached epidemic proportions in Canada in 2019, when over 9,000 more people died by overdose than in the previous three years (Government of Canada, 2019). Then the COVID-19 pandemic exacerbated already rampant overdose rates. Within the first two years of the COVID-19 pandemic in Canada, opioid deaths rose by 91%, to approximately 21 people dying a day (Government of Canada, 2022a). Consequently, many advocates are pushing for harm reduction strategies such as a safe supply of opioid medications, including fentanyl, and an increase in the number of safe consumption site (SCS) locations throughout the country.

Prior to beginning this research project, I worked alongside women who use illicit substances in the emergency shelter system and I saw firsthand the negative impact of an unregulated supply and lack of safe spaces to use. I often found myself attempting to console women, while grieving alongside them, as they learned of yet another friend's fatal overdose. I was and remain outraged at the deficiency of widespread and easily accessible strategies to prevent fatal overdose deaths. I am cautiously optimistic that the implementation of additional SCSs across Canada will increase safety for women who use illicit substances.

SCSs are designed to prevent overdose deaths by providing clean supplies, testing illicit substances, and allowing people to use illicit drugs under the supervision of medical professionals who are trained to respond to overdoses, offer advice to users on best practices for safe use, and work to break down barriers and build trusting relationships between drug-users

and health care system providers (Bayoumi et al., 2012; Green et al., 2004; Ivsins & Marsh, 2018; McCoy et al., 2001). As the number of SCSs increases across Canada to 39 sites in operation as of the end of 2022 (Government of Canada, 2022b), it is important to explore how these spaces address the needs of women-identified people who use substances. Research shows that women who use illicit drugs tend to have poor mental health and are highly vulnerable to health and social harms such as violence, poverty, and criminalization (Boyd et al., 2018; Collins et al., 2020; Medina-Perucha et al., 2019; Thomas & Bull, 2018).

To be most beneficial to women, harm reduction policies and programs need to address women's unique needs. Harm reduction models, such as SCSs, are predominantly 'gender-neutral' but often male-oriented evidence-based approaches that seek to minimize health risks and social harms associated with drug use. The growing research on women's use of SCSs demonstrates that women use these spaces to access clean supplies and because the presence of staff members may temporarily prevent incidents of predatory behaviour and intimate partner violence (Bardwell et al., 2021; Bayoumi et al., 2012; Boyd et al., 2018; Fairbairn et al., 2008; McNeil et al., 2014). The present research project seeks to add to the research on the nature of women's utilization of SCSs.

1.2 Research Objective

Research on SCSs is a rapidly burgeoning area of study that remains largely male-focused. The current study seeks to expand on women's experiences to this important conversation. Identifying barriers and incentives of SCS use acknowledged by women who use illicit drugs will inform how women decide to participate in harm reduction. My research question is: Why do women access SCSs (or not)? This question will help me determine if and

how SCSs address the unique gendered needs of women who use illicit substances. The sub-questions I seek to answer with this study are:

1. How do women perceive the accessibility of SCSs?
2. How, if at all, do women feel SCSs are meeting their needs?
3. How, if at all, do women feel that SCSs could be improved to better meet their needs?

It is important to determine if and how women's needs are being met within SCSs. Women-identified perspectives of SCSs can lead to policy and program changes that provide a more inclusive space that can meet women's needs. The findings from this research will be instrumental in assessing the service design of SCSs and will provide insight into the ways SCSs' policies and practices impact women.

1.3 Terminology

1.3.1 People who use drugs

The term 'drug user' is often used by community members when referencing people who use illicit drugs. This terminology can perpetuate negative stereotypes about people who use substances. Additionally, referring to an individual as a 'drug user' labels that person and implies that this is the only characteristic of the person that matters. For these reasons, I use the terminology 'people who use drugs' to refer to individuals who use illicit substances. Person-first language encourages the individual to be at the forefront of the conversation instead of the attribute being referenced and aids in the reduction of stigma (Colleen et al., 2018).

1.3.2 Women-identified people

I use the term 'women' to refer to all women-identified people for the purposes of this research. Women-identified people self-identify as female, and may include cisgender – people whose gender identity corresponds with the sex registered for them at birth; transgender – people

whose gender identity does not correspond with the sex registered for them at birth; genderqueer – people whose gender identity does not correspond to conventional binary gender distinctions; and gender non-conforming – people whose appearance and/or behaviour does not conform to dominant social expectations of one's gender. My research is inclusive of all individuals who self-identify as women.

1.3.3 Safe consumption sites

SCSs have been known by a variety of names. Safe injection facilities (SIF) existed prior to SCSs. The primary difference between the two is that SIFs supported injection drug use only, while SCSs permit a wider range of consumption methods, including snorting, swallowing, and inhalation. For the purposes of this project, I will refer to all of the sites as SCSs, unless it is pertinent to the discussion that they be differentiated.

In the last five years the terminology on SCSs changed in Ontario from safe consumption sites to "consumption and treatment services". The premise for the change, according to the Ford government, is that the previous government-directed initiatives focused too much on overdose prevention and not enough on providing services to stop people from using drugs (Toronto Sun, 2018). However, the services and pathways provided through consumption and treatment services have always been available through safe consumption sites (SRCHC, 2019). I have chosen to use the term safe consumption sites because people are more familiar with this terminology and it is used internationally.

1.4 Thesis Overview

In this thesis, I argue that while the increasingly toxic drug supply remains, SCSs are an effective way to prevent overdose death, and as such those entrusted with creating and implementing policies for SCSs must ensure the sites are accessible and usable for women-

identifying people. To make this claim, I first ground my research in the existing literature, providing an overview of illicit drugs within a Canadian context. In chapter three I examine two theoretical frameworks - critical feminist and stigma theory - to analyze the perceptions of SCSs from women who use drugs. These theories provide frameworks through which I interpret and gain insights into data collected for this study, enabling me to decipher the findings. Then in chapter four I provide an outline of the methods I used to develop my study, obtain ethics approval, conduct semi-structured interviews, code, and analyze my data set. Chapter five and six delve into the findings from this research project. Specifically, in chapter five, I explore gendered structural factors including the feminization of poverty, violence against women, and structural stigma that influence poor and marginalized women's experiences within their community. From there, in chapter six I consider how gendered structural factors impact women's use of SCSs. Specifically, how the operational management fails to account for women's gendered needs, as well as how the interactions among both staff and guests can impact the accessibility of SCSs for women. Lastly, chapter seven provides recommendations based on my research.

Chapter Two: Literature Review

2.1 Introduction

There is an abundance of research on illicit substance use, including women's use of substances and the positive impact of harm reduction. While SCSs remain controversial within the general public, male-oriented research demonstrates ample beneficial effects including prevention of overdose deaths (Kerr et al., 2007; Boyd et al., 2018). Newly emerging women-centric research on SCSs replicates this finding of overdose prevention, yet notably finds avoiding omnipresent threats of gender violence superseded concerns of overdosing (Boyd et al., 2020; Harris et al., 2021; Kennedy et al., 2020). Within the literature review I begin by examining the onset and racist origins of Canadian drug laws. Next, I follow the progression and expansion of harm reduction efforts from grassroots movements and in policy. I demonstrate the partial shift that has occurred in the response to illicit substance use from one of solely punitiveness to including health, albeit in a restricted way. I then focus on women's drug use specifically and the factors that uniquely impact women including how their use of SCSs and substances is influenced by gender-specific factors.

2.2 Prohibition: Criminalization of Drugs

Historically, the criminalization of certain drugs stems from "moral crusades" targeted against particular groups of people who are then controlled, denied, deported, and imprisoned due to cultural practices involving opium (Solomon & Usprich 1991). Alcohol, tobacco, and opium were all campaigned against by moral crusaders in the early 1900s, yet alcohol and tobacco – the substances of choice among white, middle- and upper-class individuals – have

mostly remained legal. Opium, however, most commonly used by Chinese immigrants, was criminalized in 1908 (Solomon & Usprich 1991).

Prior to the 1880s Chinese immigrants were welcomed in Canada as cheap labour to build the railways (Solomon & Usprich 1991). During this time, people legally operating opium dens were required to pay annual licensing fees (Boyd, 1983). Opium use by Chinese immigrants was largely accepted but not its use by white people, as inter-racial fraternization was highly disapproved of, especially among young white women (Solomon & Usprich, 1991). Once the need for labourers declined and unemployment began to climb, resentment towards Chinese immigrants intensified amongst white Canadians and led to policies and civil uprisings to discourage immigration from Asia, examples being an increased 'head-tax' on new immigrants beginning in 1885, and an anti-Asian labour demonstration in Vancouver in 1907 (Solomon & Usprich, 1991).

In 1907, following a violent anti-Asian riot in Vancouver, Mackenzie King, then Canada's Deputy Minister of Labour, strongly recommended eradicating the "evil" that was opium and that white people were increasingly using (Solomon & Usprich, 1991). Within a year of the anti-Asian riot, Canada passed its first drug prohibition – the *Opium Act* 1908, which carries a legacy that has expanded and continues to seriously harm people who use drugs. Proponents of drug prohibition purport the intent of drug criminalization is to prevent people from using substances. They contend the potential negative physical and/or psychological health outcomes of using illicit substances, as well as a multitude of societal harms including violence and vandalism, can be curtailed with prohibition (Husak & de Marneffe, 2005). Reducing the availability of drugs inhibits those without connections from gaining access thereby lessening the number of people who use illicit substances and the harms associated with substance abuse

(Smith, 2002). Aligned with the proponents of drug prohibition, the Government of Canada proposes to address substance use first as a health issue while balancing public safety (Government of Canada, 2023).

Conversely, I suggest that the criminalization of substances is in direct opposition to these stated objectives. The prohibition of a substance results in increased potency, and thus increases health risks for the people who do use the substance (PHS Community Services Society, 2021). Drug criminalization removes the regulated supply of the substance and compels people to participate in the black market. While the risk of adverse health effects is high among people who use illicit substances (Olding et al., 2018), harm reduction efforts including providing safer drug use supplies (i.e., unused needles and pipes, sterile water, alcohol swabs, etc.), non-judgemental information on best practices, and prescription heroin treatments demonstrate the ability to curtail these adverse effects (Bayoumi et al., 2012; Hunt et al., 2007; NAOMI Study Team, 2008; Oviedo-Joekes et al., 2008). Notably, it is a small minority of individuals, disproportionally society's most marginalized people, whose substance use is detected and punished, whereas a large majority of people are able to use recreationally, avoid detection, and are not criminalized (Askew & Salinas, 2019).

The criminalization of drugs, both historically and presently, further marginalizes already stigmatized groups. Unlike in other countries, including the U.K., Canadian criminalization legislation removed the right for physicians to prescribe opium to patients (Boyd, 2014; Carstairs, 2006). Thus, opium previously used by law-abiding citizens became illegal without providing any maintenance or alternatives. Likewise, no treatment options were made available to deal with the inevitable withdrawal effects following the loss of a safe and reliable opium supply due to prohibition. The RCMP promoted the idea that addiction was secondary to

criminal lifestyles and should be punished (Alexander, 1990; Boyd & Naomi Patients Association, 2013; Kandall, 1996; Well & Rosen, 1990).

Criminalization forces substance use underground and thus increases the potential harm due to unsafe consumption practices, unregulated dosages leading to overdose, and re-using dirty needles resulting in abscesses and transmitting communicable disease (Boyd, 2018). Criminalizing substance use means that marginalized people who use illicit substances are forced to seek out hidden locations and to rush their drug use so as to not be charged - making it less safe (Small et al., 2006). Additionally, people who use drugs are often hesitant to call emergency services for fear that police will be summoned, and they will be charged with drug possession, resulting in more overdose deaths. Notably, the most severe harms caused by illicit substances result not from the pharmacological composition but instead from the effects of criminalization (Moore, 2007).[1] The next section will discuss Canadian grassroot efforts aimed at reducing the harm caused by criminalizing substances.

2.3 Harm Reduction in Canada: A Timeline

Vancouver's Downtown Eastside has been the epicentre of Canada's harm reduction advocacy over the last three decades, beginning in earnest when Vancouver declared a public health emergency in the mid 1990s following a spike in drug-related deaths. The Provincial

[1] There is contention within the literature as to whether criminalization affects the general public's use of illicit substances. Contrary to predictions that decriminalization within Portugal would increase rates of drug use, this has not occurred (Hughes & Stevens, 2010). Notably, in 2019, the EU's (excluding Portugal) drug deaths averaged 23 per million, whereas Portugal's were significantly lower at a rate of 6 per million (Slade, 2021), demonstrating increased harm under a criminalized approach. Conversely, research on the use of cannabis in Canada diverges from findings in Portugal and indicates a slight increase in the percentage of individuals who use following legalization (Rotermann, 2020). More research should be conducted to determine how criminalization, decriminalization, and legalization impact an individual's decision to use substances.

Chief Coroner of BC formed a task force that produced the *Cain Report,* which recommended opening a SCS (Kerr et al., 2017). Following the report, but prior to any official response, an unsanctioned, grassroots operated overdose prevention site (OPS) opened in 1995. Nurses frequented the OPS to provide medical support and several police officers referred individuals who used drugs to the facility. Although some police officers supported the OPS, within a year the Vancouver Police Department closed the unsanctioned, illegal OPS (Kerr et al., 2017).

As the drug scene worsened and overdose deaths continued to escalate, the City of Vancouver referenced provincial powers to challenge federal drug policies. They looked to Western European drug policies that use the Four Pillar Drug Strategy, which looks to balance prevention, enforcement, treatment, and harm reduction (Cain, 1994). As such, the *Cain Report* recommended opening SCSs in the City of Vancouver (Kerr et al., 2017). Vancouver was able to enact policies regarding substance use as drug policies fall under provincial jurisdiction around healthcare. In contrast, the criminalization of drugs falls within federal jurisdiction and thus there is a disconnect between healthcare and criminalization policies legislated to manage substance use.

Canada's drug framework has a long history. However, the recent illicitly manufactured fentanyl crisis is an unprecedented threat to the lives of people who use drugs. Fentanyl is a highly addictive synthetic opioid, 100 times more potent than morphine and is commonly prescribed to treat severe pain often in cancer patients and others in the end-stages of life-threatening diseases (Suzuki & El-Haddad, 2016). Fentanyl became prevalent on the illicit-market following efforts to prevent prescribed OxyContin (a synthetic opioid) misuse by manufacturing tablets to be uncrushable (Aquina et al., 2009).

As fentanyl increasingly penetrated the global illicit drug supply beginning in 2016, overdose deaths rose. In British Columbia, overdose deaths increased by 80% in 2016 from the previous year due to the fentanyl crisis (Thomson et al., 2017). The rapid increase in overdose deaths led credence to the necessity for more SCS locations. Most recently, the effect of lockdowns and social distancing during COVID-19 intensified the negative consequences of the opioid epidemic, including overdose deaths (Holloway et al., 2020). The first 15 weeks of the COVID-19 pandemic, declared in Ontario March 17, 2020, saw a 38% increase in overdose deaths compared to the 15 weeks immediately preceding to the pandemic, with over 40% of these overdose deaths occurring in neighbourhoods with the highest material deprivations (Ontario Drug Policy Research Network et al., 2020). This escalation of overdose deaths while people were being advised to isolate to prevent the spread of COVID-19 – a recommendation in direct contrast to harm reduction messaging to never use alone – increased the calls for a widespread and easily accessible regulated supply of drugs (Glegg et al., 2022; Tyndall, 2020).

2.4 Shifting from Punitive to Health Response

In the past 25 years Canada has made some headway in shifting from a punitive to health response to drug use (Hathaway & Tousaw, 2008). Examples of initiatives include: access to safer supplies including sanitized water, filters, pipes, and needles; access to Naloxone kits; methadone maintenance programs; heroin-assisted treatment (HAT) studies; the *Good Samaritan Drug Overdose Act;*[2] and provision of SCSs. While many harmful substances remain illicit, Canadian drug policies have shifted to incorporate a health strategy.

[2]The *Good Samaritan Drug Overdose Act* became law across the Nation in April 2017 and provides immunity from simple drug possession for individuals who call emergency services when they witness an overdose. The Act was

Prior to criminalization in 1908, substances containing opium and heroin were common within households and were largely advertised to middle- and upper-class white women as a necessary remedy every caregiver required to adequately care for their families. Likewise, physicians could freely prescribe narcotics for a wide range of ailments. Following the criminalization of narcotics classes in Canada, individuals who were using these substances legally suddenly became entangled in a criminalized practice (Boyd & NAOMI Patients Association, 2013). Given drug tolerance and the difficulty in cessation of use, this imprudent approach to drug criminalization failed to account for the very real health complications of removing supply and meant that people turned to the illegal market.

In the 1940s the RCMP vehemently insisted that people who were addicted to illegal drugs were first and foremost criminals (Boyd & Naomi Patients Association, 2013). Thus, abstinence and prison sentences were deemed the appropriate solution to manage addiction. An addiction specialist at the time noted that the "absence of community treatment facilities must be directly related to the social concept of the addict as criminal first, and a sick person second" (Halliday, 1963, p. 413). In the 1950s, grassroots movements in Vancouver consisting of doctors, social workers, politicians, and citizens disputed the notion that people who use illicit substances should be treated as criminals and rallied for change with some success. A few small programs stemmed from these movements including methadone maintenance and drug treatment programs in prisons. It was not until the late 1960s – early 1970s that publicly funded methadone maintenance and drug treatment programs came into effect sparingly across Canada (Boyd, 2014). In 2005 the first North American Opiate Medication Initiative (NAOMI) trial and Study

enacted as apprehensions encompassing seeking help have contributed to the high number of overdose related deaths (Barry & Chris, 2018).

to Assess Longer-term Opiate Medication Effectiveness (SALOME) in 2011, sought to discover whether chronic, opioid dependent, daily injection drug users would benefit from heroin-assisted treatment (HAT) (Oviedo-Joekes et al., 2008). The findings from the trials overwhelmingly confirmed that HAT is an effective form of treatment for chronic opioid use which improves physical and psychological health amongst individuals who have not benefited from other drug treatments (NAOMI Study Team, 2008).

InSite, Canada's first SCS opened in Vancouver in 2003 and lead the way for future SCSs. Nonetheless political resistance resulted in onerous applications and a refusal to provide exemptions to subsequent sites. The second SCS also located in Vancouver, Canada was granted an exemption in 2017, fourteen years after InSite opened, following a change in political leadership (Kerr et al., 2017). The changing political landscape coincided with the rapid surge in opioid-related overdose deaths and prompted the request and approval for new SCSs. As of the end 2022, there were 39 SCSs across Canada currently operating (Government of Canada, 2022b). The increase in the number of SCSs can also be seen as part of the shift from a punitive response to drug use to a health response. In communities that have adopted SCSs, people who use drugs are expected to use safely (Moore, 2004). While SCSs are designed to reduce the risks associated with drug use, including but not limited to transmission of diseases and overdose deaths, the sites also function as a tool for socio-spatial regulation (Fischer et al., 2004).

Restrictive policies, such as the inability to have assistance with injections, prohibited groin and neck injections, as well as excluding inhalation as an accepted form of consumption, demonstrate a disconnect between ideal and actual drug use practices (Bayoumi et al., 2012; Fischer et al., 2004; Small et al., 2011). These policies ensure compliance with the law, safety, and meet the demands of the space. Many people who use drugs claim to desire access to SCSs;

however, polices such as these are barriers which make the site unusable for some people (Bardwell et al., 2021; Butler et al., 2018; Duncan et al., 2017). For example, groin and neck injections, which notably are risky sites to inject, are often the last locations remaining for someone to inject when other veins have collapsed. Therefore, prohibiting injections in these locations essentially prohibits some of the most vulnerable individuals from accessing SCSs (Butler et al., 2018).

People who are unable to inject themselves, for example, due to disability, inexperience, or withdrawal were and in some places are still unable to use SCSs services (Small et al., 2011). The ability to take one's time while preparing, particularly for assisted injections, without fear of experiencing social stigma or detection by police is cited as an advantage of utilizing SCSs (Duncan et al., 2017; Oudshoorn et al., 2021; Urbanik et al., 2022). Conversely, long wait times to access a SCS are a primary concern and can result in people choosing to use elsewhere (Bardwell et al., 2021; McNeil et al., 2015; Small et al., 2011). If people who use drugs find that SCSs do not allow them to use in the ways they need to, they may avoid the site. With the implementation of a SCS, people who use drugs are expected to access the site instead of using their drugs elsewhere (Collins et al., 2019; McNeil et al., 2014). This expectation fails to consider how some SCSs policies limit their accessibility.

While the needs of drug users are at the forefront of SCSs, there are competing interests and power differentials between various stakeholders that can negatively influence one's inclination to utilize this life-saving resource. Failure to take into account the realities of drug use practices such as the necessity for help with injections and varied methods of consumption including inhalation can reduce demand to access SCSs (Collins et al., 2020; Fischer et al., 2004; Pijl et al., 2021). In their research on intoxication and pleasure within SCSs, Duncan et al. (2017)

found that SCSs are primarily designed to take into account the needs of the neighbouring community members and SCS staff; further they argue that concentrating on these stakeholders instead of prioritizing the needs of the people who access SCSs can reduce the appeal of SCSs for people who use drugs and ultimately result in the decision to avoid the sites. While substances remain criminalized, there also remains a punitive response to the people who engage in substance use.

2.5 Women and Illicit Substance Use

Among people who experience a punitive response are women who use illicit substances. Women use substances for a number of reasons, including a strong positive correlational relationship with trauma and victimization (Logan et al., 2003; Moses et al., 2004; Poole, 2004). Research on women's drug use has repeatedly found that gendered violence dominates how and why women use drugs (Boyd et al., 2018, 2020; Campbell et al., 2012; Kennedy et al., 2020; McNeil & Small, 2014). Violence against women, child sexual abuse, and accessing inadequate social support systems are strong predictors of illicit substance use (Cormier et al., 2001). People who experience multiple and overlapping systemic adversities are at a heightened risk of abusing substances.

Women who use drugs are at a higher risk than men of experiencing mental health problems, are more likely to have histories of abuse and sexual assault, and have a greater vulnerability to health and social harms (Boyd et al., 2018; Medina-Perucha et al., 2019). The two most common harms women who use drugs face are infection and violence (Boyd et al., 2018). Many street-involved women who inject drugs perceive infections and gendered violence as the "natural, inevitable order of things" (Bourgois et al., 2004, p. 262). They are resigned to

the fact that experiencing health problems and violence is part of illicit substance use. As I explore in the following sub-section, an effect of the overlapping risk factors is that women use SCSs primarily for their ability to avoid violence (Boyd et al., 2018).

Goode and Maskovy (2001) claim that the state regulates the poor not with supportive services, but instead through surveillance and incarceration. Governmental services often come with intrusive regulation and tracking. Deviations from accepted norms can then be documented and reprimanded which in turn lend legitimacy to other repressive practices against women, including social assistance cutbacks, child apprehension, arrest, and imprisonment. Poor, racialized women are most vulnerable to drug arrests and convictions (Boyd, 2015).

Women from equity-deserving groups face additional scrutiny and are at increased risk of incarceration and drug charges. Indigenous women make up only 4% of the Canadian population yet represent nearly 50% of federally incarcerated women; a rapid increase from 41.4% in 2018 (Office of the Correctional Investigator, 2021; Zinger, 2019). This disproportionate increase of federally incarcerated Indigenous women has led Canada's Correctional Investigator Dr. Zinger to declare the over-representation of Indigenous peoples in correctional faculties as "one of Canada's most pressing human rights issues" (Office of the Correctional Investigator, 2021, par. 2). Notably, 92% of all federally sentenced Indigenous women have substance abuse needs (Zinger, 2019). Women who are incarcerated express a desire for increased programming and services, particularly surrounding mental health and substance use, however, programming is sparsely implemented and largely ignores racial and gender differences (van der Meulen et al., 2018).

2.5.1 How Women's Use of SCS is Influenced by Gender

Using at a SCS gives women some security knowing that staff are present to provide lifesaving treatment in the case of an overdose or to intervene in interpersonal disputes, if necessary, thereby reducing their chances of experiencing violence (Fairbairn et al., 2008; Ivsins & Marsh, 2018; Oudshoorn et al., 2021). Research on SCS use demonstrates that many of the women who access the space are homeless (Boyd et al., 2018; Collins et al., 2019; Kerman et al., 2020; Oudshoorn et al., 2021). Women's survival on the streets is linked to avoiding violence. Women's accounts of drug use reveal that they or a close female friend have used in a public space and were victims of predatory violence while they were incapacitated. Other women explain that they will no longer use at someone else's home as they cannot guarantee how people they use with will act once under the influence, and they have concerns regarding their personal safety (Boyd et al., 2018; Collins et al., 2020). These same concerns of exposure to gender violence and harassment while under the influence deter some women from accessing SCSs (Harris et al., 2021; Kennedy et al., 2021).

Women who use drugs with their partner have also explained that their partner can be unpredictable while high, leaving them at risk of violence (Campbell et al., 2012). Notably, Boyd et al. (2018) found that although deaths due to overdose are soaring, women continue to link their safety when using illicit substances not in terms of preventing overdoses, but instead to avoiding violence. Participants explained that fentanyl's potency compromised their ability to escape violence, especially when they are using in public spaces, given that some men prey on women who have overdosed or lost consciousness.

SCSs have regulations that govern behaviour that occurs at the site. These policies are in place to ensure compliance with the law, as the section 56 exemption of the CDSA needed for

SCSs to legally operate only removes the illegality of simple possession. These policies, while complying with the law, do not align with the needs of some drug users, and therefore restrict access to only those who fit within the regulations (Moore, 2004). A common regulation is that injections must be unassisted by SCS staff, nurses, or others who visit the site to ensure the sites remain legal. The self-administration requirement within SCSs creates a barrier for some people who are injection users from accessing the sites (Pijl et al., 2021). Groups experiencing this barrier include: women who do not know how to inject themselves, or whose partners insist on injecting them; people who are in withdrawal, are already intoxicated, or are sleep deprived; people with certain disabilities; or people with vascular problems.

When someone in a SCS repeatedly fails to properly inject themselves, they usually leave the site and seek assistance elsewhere, thus making people who are arguably the most in need of harm reduction spaces unable to benefit from them (Small et al., 2011). The Vancouver Area Network of Drug Users (VANDU) recognized the unmet needs of people who require assistance with their injection and began surreptitiously allowing assisted injections to occur within their offices. The program promoted harm reduction and allowed people who require assistance to have an unsanctioned safer place to use. Although this program provided harm reduction to individuals who were neglected by other SCSs, it was terminated as the program's funders threatened to pull their support unless assisted injections were prohibited in accordance with the law (Kerr et al., 2017).

The rule prohibiting assisted injections disproportionately affects women because they often are unable to inject themselves (Epele, 2002; Small et al., 2011). Women are typically introduced to injection drug use by a man, and it is common for men to maintain control over the injection process. Sharing needles has negative health impacts including increased risk of

contracting diseases, yet refusing to share needles with a partner can threaten the relationship status quo (Bryant et al., 2010). In Bourgois et al.'s (2004) research in San Francisco, a woman explained that old men often seek out young women for sexual, romantic, and income-generating partners, expressing that: "I see a lot of guys getting young girls loaded so they can have sex with them. The guys like it when the girls can't fix [inject] themselves. It's power; the guys have power over the girls" (p. 255). Drug using men seek relationships that provide them with power and assisted injections allow men to dominate women and make it more difficult for women to leave the relationship (Bourgois et al., 2004; Boyd et al., 2018). This unequal power dynamic affords men the opportunity to engage in sexual violence and force their partner to participate in sex work to use the profits for their personal drug use (Medina-Perucha et al., 2019). The prohibition of assisted injections within SCSs is beginning to change due to the acknowledgement of these issues (discussed further in chapter 6).

Gender-based violence is rooted in an unequal power dynamic (Epele, 2002). While intimate partner violence is not limited to drug-using couples, violence in these relationships can be more volatile (Bourgois et al, 2004). Many women who use drugs seek men out to act as a form of protection from theft and violence at the hands of strangers, yet in the process get trapped in abusive relationships (Bourgois et al., 2004; Bryant et al., 2010). A small minority of drug using women resist finding a partner because they do not want to be controlled by a man and do not want to be forced into sharing their money or drugs (Epele, 2002). Avoiding the potential for intimate partner violence, however, puts them in a more vulnerable position regarding predatory violence, especially if they are using in a public location.

Many women actively pursue SCSs predominantly because of the diminished threats of violence (Fairbairn et al., 2008). SCSs have the potential to help reduce both predatory and

partner violence while at the SCS, as workers and other guests of the SCS are present and can provide guardianship while one is intoxicated. Conversely, Harris et al. (2021) found a lack of protective association between SCS use and exposure to violence for women. Gender-responsive programs, such as women's only SCSs, may promote service engagement and mitigate omnipresent threats of violence (Boyd et al., 2020; Kennedy et al., 2021). Research has yet to conclusively discover whether gender-neutral SCSs mitigate women's susceptibility to gendered violence, thus, more research examining the relationship between women's use of SCSs and their exposure to violence is required.

2.5.2 Health Concerns

People who use illicit drugs can have complex health care needs. These needs are often related to their substance use and can include co-occurring infectious diseases (Olding et al., 2018). Often, women turn to illegal drugs as a form of pain management, or because they form an addiction to the substance that was legally prescribed but is eventually cut off (Khobzi et al., 2009). Abscesses are one of the most common infectious complications of injection drug use, and injections done by someone else increases the risk of abscesses by 50-100%, usually because the needle is used and therefore duller and injures the skin and/or veins (Wurcel et al., 2018). Given that women are more likely than men to require assistance with their injection and therefore have less control over how the injection is prepared, women are at risk of being injected with used needles, increasing the chances of contracting diseases and developing abscesses (Epele, 2002; Small, 2011).

Many women who use illicit drugs also engage in survival sex work (Krüsi et al., 2016). Oftentimes a cycle develops where someone uses substances to numb their emotional and/or

physical pain when engaging in sex work, which paradoxically increases their susceptibility to robbery, violence, and inability to insist on the use of condoms leading to the contraction of sexually transmitted diseases, as well as a hesitancy to report incidences to police due to their engagement with illegal substances (Bungay et al., 2010). Risk of violence from a client is the primary concern for women who engage in sex work and the risk of transmitting or contracting a sexually transmitted disease becomes secondary (Campbell et al., 2012). Women are 50% more likely than men to contract Hepatitis C through a combination of both substance use and sexual transmission (Bourgois et al., 2004). Fortunately, the evidence is clear that SCSs drastically reduce the risk of illness through preventative measures such as providing ample harm reduction supplies to reduce transmission, promoting best use practices, and improving access to health and social services enabling prompt medical treatment (Bayoumi et al., 2012; Hunt et al., 2007).

Without treatment, the health care needs of people who suffer from substance use disorders become exacerbated; however, there are multiple systematic and interpersonal barriers to accessing care. A common concern among people who use drugs is fear of stigmatization (Kosteniuk et al., 2021; Olding et al., 2018; Pauly et al., 2020). Finnell (2018) found that healthcare professionals have negative attitudes towards providing general healthcare to individuals with substance use disorders. Health care professionals exhibit apathy towards people with substance use disorders by making shorter visits, showing less empathy, and lacking personal engagement. The stigmatization people experience when accessing healthcare becomes an obstacle to using services, often resulting in a worsening of the medical condition, until it becomes a critical condition that requires emergency care. Preventative and outpatient care are much more cost effective for taxpayers and less traumatic for patients (McCoy et al., 2001).

Another barrier for people who use drugs to access medical services is the inability to use substances while in the hospital (Kosteniuk et al., 2021). This barrier could be responsible for the high number of discharges against medical advice (Kerr et al., 2017). Another reason people who use drugs avoid seeking medical treatment, or leave against medical advice, is being cut off of pain medication while still in pain or being refused pain medicine altogether (Olding et al., 2018). Health care professionals' refusal to provide pain medication to people who use substances can be indictive of concerns regarding an increased likelihood of overdose, but can also send a message that neither their pain, nor the individual is worthy of care; leaving people who use substances to seek out alternative, illegal forms of pain management. When people are not treated fairly and do not have their needs met whilst accessing health care services, it is not surprising that they will avoid accessing it, and thus have diminished health outcomes.

2.5.3 Motherhood & Pregnancy

Drug policy often ignores the complexities of women's unique needs, especially women's risks regarding escaping violence and avoiding or managing infection, with the exception of pregnancy. Thomas and Bull (2018) examined policies and guidelines from various countries that covered drug strategies, women's health policies, treatment guidelines/principles and gender-responsive treatment or interventions. They found that these policies claimed to attempt to balance the needs of the mother and the needs of the fetus, while stressing the need for the mother to act in a caring manner towards the child. Government guidelines specifically outline how pregnant women's drug use should be managed, creating a shift from the 'care of the self' to the 'care of the (foetal) other' (Thomas & Bull, 2018).

Women's capacity to conceive has long resulted in governance over their bodies by other actors. Pregnant women face considerable judgement when using substances such as caffeine, alcohol, or tobacco. Stigmatic assumptions surrounding someone's (in)ability to suitably care for children is amplified for pregnant women who use illicit substances. Therefore, it is not surprising that pregnant women who use illicit substances may attempt to hide their pregnancy and/or stop accessing harm reduction services altogether (Xavier et al., 2021). While the idea of promoting SCS use among pregnant women is highly controversial, the alternative includes alienation and the removal of low barrier access to social and health supports (Olsen, 2015).

Women are often reluctant to seek harm reduction or treatment for their drug use when they are fearful that they will lose custody of their children (Armstrong, 2017). In their research on the barriers to substance use treatment for women with children, Brogly and colleagues noted that almost 60% of respondents expressed a desire to attend treatment if they could bring their children (2018). Additionally, fear of losing their children and a lack of childcare were the top two reasons why women with substance use disorders did not attend treatment programs, despite a desire to do so. It is important to implement harm reduction and treatment services that address women's unique responsibility to care for children.

2.6 Conclusion

This literature review has examined the criminalization of drugs within Canada and the history and subsequent Supreme Court case that ensured Canada's first SCS – InSite – and all SCSs that followed would receive an exemption from section 56 of the CDSA. SCSs provide people who use drugs a location that is hygienic, away from police surveillance, and has a reduced risk of infection and death from overdose. Some of the policies within SCSs fail to take

into consideration the realities of drug use and may result in a decision by people who use substances to avoid the site. Evidence reveals that regardless of the awareness of different needs between men and women, SCSs along with other harm reduction services, are often designed primarily for white men (Boyd et al., 2018), with minimal attention to women-identified drug-users' perceptions of these sites. Newly emerging research on the gendered dynamics of SCSs have pointed to the desire for women-only and culturally sensitive sites (Bardwell et al., 2021; Boyd et al., 2018; Collins et al., 2020; Kerman et al., 2020).

Women's accounts of illicit drug use revealed that both predatory and partner violence are common, and that SCSs are one strategy to try and avoid that violence. People who use illicit substances commonly have complex health needs and women have increased risks. Research has repeatedly shown that women who use drugs have a variety of risk factors (Ivsins et al., 2023; Kennedy et al., 2020; McNeil et al., 2014). Creating policies and programming within SCSs that are gender-sensitive could drastically reduce these risk factors for women (Thomas & Bull, 2018). Since research on women's unique experiences with SCSs is a newly emerging field of study, it is not yet clear how policies and programs should respond to women who use drugs. My research aims to determine if and why women access SCSs (or not) to better understand whether SCSs address the unique gendered needs of women who use illicit substances.

Chapter Three: Theoretical Framework

3.1 Introduction

To make sense of how women who use illicit substances utilize SCSs, I grounded my analysis in two theoretical frameworks: critical feminism and stigma. Using these theories allows me to focus on the lived realities of the women I spoke to. In the first section I explore critical feminist theory. Women have largely been excluded from research and gender-neutral theories are predominantly male-orientated (Steffensmeier & Allan, 1996). While 'gender-neutral' theories can provide explanations of general patterns of delinquency, feminist researchers find it problematic to explain women's conformity and deviance through male-oriented theories, as both subtle and profound differences may be missed (Chesney-Lind, 1989; Hannah-Moffat, 2010; Steffensmeier & Allan, 1996). Critical feminist theory challenges the masculine nature of criminological theories by conveying the absence and misrepresentation of women within these theories (Chesney-Lind, 2006).

In the second section of this chapter, I consider stigma theory. People who use illicit substances are continually confronted with stigmatizing assumptions from those without the 'drug user' stigma. Stigma theory elucidates how policies and social norms generate discrimination for people who use illicit substances and illuminates the negative effects of this discrimination on their lives (Goffman, 1963; Hannem, 2012; Link & Phelan, 2014). People who use illicit substances are constructed as blameworthy and therefore deserving of social exclusion and avoidance (Hatzenbuehler & Link, 2014). For women, this discrimination is intensified as they are held to specific gendered standards (Davis, 2003).

3.2 Feminist theory

3.2.1 What is Critical Feminist Theory?

Feminist theories posit that within patriarchal society women have historically been deprived of public status, punished for deviancy, and for straying from gender norms (Davis, 2003). The historical plight of women who resisted the inequities of the patriarchy led to large feminist organized movements. While the various waves of feminism have ranged in terms of their objective, tactics, and inclusiveness, the fundamental motive across movements has been gender equality/equity. Unfortunately, constructs around gender, race, sexuality, and class make women vulnerable to surveillance, control, and punitiveness (Evans & Chamberlain, 2014; Johnson, 2005). Women who resist sexism, racism, colonialism, and ablism are denounced and/or punished through discrimination and/or criminalization (Crenshaw, 2012).

Critical feminist theory explores how women's needs and experiences are positioned within a patriarchal society thus resulting in gendered disparities and the systematic repression of women, girls, and gender diverse people. The patriarchy is a male-dominated structure of social stratification and social control that values masculinity over femininity (Chesney-Lind, 2006). A patriarchal society provides (CIS, white, wealthy, heteronormative) men power and privilege that reinforce their higher position within society. Critical feminist theory recognizes that women exist within a social world that creates gendered patterns of poverty, unemployment, and abuse that subjugates women and adds undue afflictions (Smith, 2008). It is important to examine existing gendered social relations to better understand and ultimately remedy these inequities.

Women centered research is still an emerging field. Prior to the last few decades women have been a neglected population within criminological research. Classical criminological theories are often presented as gender-neutral and ignore the influence of gender on the motives,

severity, and frequency of criminal activity. Adler's seminal article, *Sisters in Crime* (1975), made the case for the existence of the gender gap within criminological research and advanced our understanding of how women's experience of poverty, unemployment, and victimization intensifies their risk of engaging in criminal behaviour. Following Adler's work there was an increase in critical feminist criminological research seeking to understand the factors that shape women's criminality. Much of this research finds that structural inequity, including the feminization of poverty, which refers to the social and economic consequences of being a woman including their over-representation in part-time and low wage jobs that lead to higher rates of poverty, is highly associated with women's subordinate position within society (Agnew, 2009; Chesney-Lind, 1989; De Coster et al., 2013; Pearce, 1978). Further, critical feminist criminological theory touts that without an appreciation of how gendered social experiences shape women's criminality, crime cannot be fully understood. This is because crime is shaped by a person's experiences and gender greatly influences a person's life experiences (Adler, 1975). Critical feminist theory explores the link between women's, girls', and gender-diverse individuals' subordinate position and their engagement with crime (Chesney-Lind, 1989).

When women do engage in crime or delinquency they are frequently constructed as problematic and personally responsible for their 'moral failure' (Boyd, 2015). Women who commit crime are positioned as doubly deviant for not only having committed a crime, but also of having "transgressed fundamental moral principles of womanhood" (Davis, 2003, p.70). Women's crime directly diverges from socially constructed expectations that women are good, demure, and passive (Boyd, 2015). Women's subordinate position in society and their engagement in crime are highly interconnected and as such policies and procedures meant to eliminate women's inequity need to be attuned to this reality (Hannah-Moffat, 2010). When the

criminal justice system treats groups of people as interchangeable it effectively disregards the unique challenges they face within society, further cementing unequal gendered structures (Davis, 2003).

3.2.2 'Add Women and Stir'

Women's sustained systemic inequities and subordination are associated in part with the way women's unique circumstances and positionality are simply added to the male-oriented public sphere (Chesney-Lind & Eliason, 2016). Feminist theorists claim that ignoring the influence of gender inequity on women's lives when implementing policy does a disservice to all women, and women facing multiple layers of oppression more-so. Women have historically, and in many cases continue to be subject to systems designed for men in an 'add women and stir' method, including within the workforce and corrections (Balfour, 2006; Chesney-Lind, 1989; Davis, 2003). Simply adding women into male-oriented spaces or using program models on women and gender diverse people when they are designed for men "leaves the deeper structures of oppression and exclusion untouched" (Johnson, 2005, p. 26). Crenshaw (1991; 2012) argues that by excluding women and girls from various public discourses, especially within the area of social supports, the criminalization, victimization, and systematic oppression that shapes their lives is perpetuated and remains largely unacknowledged.

One significant structural effect of simply adding women to spaces and systems designed for men is women's heightened risk of experiencing interpersonal, structural, and symbolic violence. *Interpersonal violence* refers to violence perpetrated by an individual against another. Examples of interpersonal violence include physical and sexual assault. Interpersonal violence is shaped in part by *structural violence,* which describes violence perpetrated by institutions against

an individual or group of people resulting in health, economic, racial and gender inequities (Montesanti & Thurston, 2015). Structural violence occurs when this violence becomes internalized and accepted as inevitable. *Symbolic violence* takes place when people who have been systematically ensnared in subordinate positions blame themselves, rather than inequitable social structures, for their position in society (Krüsi et al., 2016). Violence against women occurs within each of these forms of violence, and their intersection perpetuates inequality and further violence (Montesanti & Thurston, 2015).

Women experience the dominance described above through pervasive gender-based violence including physical, emotional, and financial abuse, sexual assault, and sexual harassment. Historically, gender-based violence, particularly intimate partner violence, was ignored or trivialized as women were seen as her husband's property. Although intimate partner violence is illegal, the home remains one of the most dangerous places for women. For the past four decades in Canada, a woman or girl is killed from acts of violence every 2.5 days, of which 66% are perpetrated by male partners or other male family members (Canadian Femicide Observatory for Justice and Accountability, 2019). Gendered violence is amplified in racialized communities, with Indigenous women being significantly more likely to be killed by an intimate partner than non-indigenous women (Legal Strategy Coalition on Violence Against Indigenous Women, 2018). In 2018, 36 percent of the women and girls killed by violence in Canada were Indigenous despite only accounting for five percent of the Canadian population (Canadian Femicide Observatory for Justice and Accountability, 2019).

Marginalized women and women living in poverty are relegated by social structures into positions of relative powerlessness, and are at increased risk of discrimination, stigmatization, criminalization, and pathologization (Boyd & Norton, 2019). Crenshaw (1991) coined the term

intersectionality to express how multiple oppressing characteristics co-exist within harmful societal reactions, resulting in additional hardships for people across social locations. Crenshaw explains how the intersection of sexism and racism in Black women's lives cannot be fully understood by looking at either factor separately. Although poverty and the adverse effects of systemic gender inequality increases poor, racialized, and Indigenous women's marginalization, they have largely been excluded from feminist movements (Carbado et al., 2013; Collins, 2000; Crenshaw & Allen, 2014). This is especially concerning because poor and marginalized women face intersecting vulnerabilities. Women's systemic oppression makes it difficult for women, especially marginalized women, to become financially independent and puts them at increased risk of experiencing interpersonal, structural, and symbolic violence.

3.2.3 Women's Criminalization

Various policies within the criminal justice system reinforce women's subordinate position within society. Examining women's experiences with the criminal justice system fosters a nuanced comprehension of women's broader criminalization. Women's circumstances within the penal system replicate those within larger society and result in women's continued oppression and victimization (Chesney-Lind, 1989). Critical feminist theory recognizes that women's experiences of subordination and structural violence is crucial to understanding their lived realities, as well as their involvement in crime. Women are criminalized for the coping mechanisms they employ to manage trauma, including substance use (Boyd, 2015). While the feminist movement has been somewhat effective in revealing the extent of women's victimization, the relationship between women's victimization and their criminalization has been

systematically ignored by lawmakers, the criminal justice system, and some feminist advocates (Boyd et al., 2018).

Social inequity and the subordination that accompanies discrimination is largely experienced by poor, and racialized women and results in increased reliance on social supports. Pate notes how cuts to social supports correlate with women's increased imprisonment in Canada, as "social assistance payments are so inadequate that, women end up criminalized for doing what they must do to support themselves and their children" (Pate, n.d., p.1). Women's systematic punishment and oppression can best be understood by examining the prison system.

Although women's crime is often directly related to their subordinate position within society, women's vulnerabilities are perpetually defined as risk factors within the penal system (Hannah-Moffat, 1999). Within federal corrections, Correctional Service of Canada (CSC) conducts an assessment to determine a prisoner's security classification. While this assessment has predictive validity among men, its validity has not yet been proven effective in predicting women's risk levels, and its continued use indicates that there is a failure within corrections to acknowledge that women's crime is influenced by gender-specific factors (Hannah-Moffat, 2009). Assessment tools individualize structural inequities which are then used as a rationale for increased punishment (Hannah-Moffat, 2016; van Eijk, 2017). Women's vulnerabilities and needs are thus transformed into risk factors that result in a higher security level and thus a harsher prison sentence (Hannah-Moffat, 2010).

Mental health and drug treatment tend to work similarly as women's criminalization, in that it focuses on women taking responsibility for their decisions rather than recognizing the inequitable social structures that keep them within their position in society (Boyd, 2015). Social support services and the criminal justice system expect women to make responsible choices and

are seen as incapable of doing so when they are mired in systemic inequity and discrimination (Hannah-Moffat, 2010). The penal system is a technology of structural violence that effectively ensnares poor and marginalized individuals – particularly women – in vulnerable positions. Women's engagement in activities, legal or not, that transgresses gender norms irrespective of the systemic inequality and discrimination that influences those decisions is met with stigmatization. It therefore is important to examine women's use of SCSs through a framework that recognizes the profound inequalities and adverse consequences including increased responsibilization that result when gender differences are overlooked in service provision. The second half of this chapter investigates stigma and the subsequent impact amongst women who use illicit substances.

3.3 Theorizing Stigma

3.3.1 What is Stigma?

Stigma is the relationship between an attribute and a negative stereotype used to disgrace someone, commonly based on preliminary conceptions of a person or group's social identity. Stigma transforms an individual, "from a whole and usual person to a tainted, discounted one" (Goffman, 1963, p.3). Every individual has their own conceptualization of themselves that makes up their unique personal identity. This personal identity is closely influenced by their social identity. A person's social identity is constructed through the presentation of self to others, which is heavily influenced by the societal expectations imparted upon them due to our personal characteristics (Goffman, 1963). Whereas structural attributes – the characteristics that make up groups' social identity – are decontextualized from personal identity, people assume these attributes relate to all individuals within a particular group (Hannem, 2012). The implication here

is that individuals may be stigmatized for a trait they do not personally possess because they are recognized as part of a group.

Stigmatized individuals' perceptions of their stigma, as well as their understanding of how others view their stigma, may be influenced by their own perception of the shame associated with the characteristic. While there is nothing inherently stigmatizing about any particular attribute, social interactions and assumptions can lead to stigmatization (Hannem, 2012). These attributes are defined by 'normals' or those without a particular stigma, as undesirable and therefore deserving of discrimination (Bruckert & Hannem, 2013). Croker et al. (1998) assert that stigma is a deeply "devaluing social identity" (p. 505) that profoundly influences the stigmatized individual's life outcomes, including their socio-economic status, health and wellbeing, as well as safety from violence. Intersectional stigmas refer to the convergence of multiple stigmatic attributes, which amplifies its negative effect (Krüsi et al., 2016).

Stigmas are established through preliminary conceptions between stigmatized individuals and 'normals' within society. As stigmatizing assumptions are constructed through social interactions, the stigmatized individual is often aware of their denounced attribute (May, 2000). The validity of stigmas is rarely challenged, resulting in false or incomplete depictions of groups who are stigmatized. Cases that challenge stigmatized assumptions are seen as exceptions, whereas actions that reinforce stigma fuel the perpetuation of the stigma (Link & Phelan, 2014).

Discrimination is the "observable evidence of stigma" (Hannem, 2012, p.7). The magnitude of this discrimination is at its most extreme with stigmas that become an individual's master status. Master statuses "obliterate other dimensions of social identity" (May, 2000, p.202), and are the main characteristic that others assign to an individual. People who are severely stigmatized are sometimes regarded as less than human, which in turn leads to

discrimination and “reduces [their] life chances” (Goffman, 1963 p. 5). For poor and marginalized individuals who use illicit substances the label of ‘illicit drug user’ may exceed all other characteristics to become their master status. This status profoundly affects their interactions with members of the public (McCoy et al., 2001), health care professionals (Finnell, 2018; Kosteniuk et al., 2021), and police (Small et al., 2006; Watson et al., 2021).

People with stigmatizing characteristic(s) sometimes internalize the stigma, potentially leading to feelings of inadequacy and shame (Goffman, 1963). Some people engage in stigma management strategies to minimize the effects of the stigma such as managing spaces, information and self-presentation, through passing, selective disclosure, and advocacy (Goffman, 1963). Depending on the type and degree of stigma, an individual may experience or perceive social exclusion and rejection from others that results in avoidance techniques to minimize further discrimination. Many people who use illicit substances are familiar with carefully managing stigmatizing attributes. For example, Radcliffe and Stevens (2008) found that individuals seeking drug treatment, such as methadone, perceived one of the major barriers to recovery to be the unavoidable disclosure of their identity to anyone who witnessed them using treatment services.

For individuals who ‘pass’ as someone without a particular stigma, there is a constant threat of being ‘outed’ and subsequently discredited should someone learn of its existence. Disclosing a stigmatized attribute is one way to remove the discreditable potential (Goffman, 1963), however there are risks associated with disclosure. When people who were previously unaware of an individual’s stigmatized attribute learn of its presence, there may be a negative effect on the relationship due to a sense of betrayal for having hidden the stigmatized attribute (Hannem, 2012). Alternatively, stigmatized individuals may attempt to reduce their stigmatized

status through advocacy to deconstruct incorrect stigmatizing assumptions, and create systemic change within social, economic, and political institutions that produce structural stigma.

3.3.2 Structural Stigma

Structural stigma derives from the institutional and social regulation of stigmatized groups based on the assumption that they are inherently risky to themselves and/or the larger community (Hannem, 2012). Link and Phelan (2001) explain that structural stigma is constructed through social, economic, and political realms that work in tandem to restrict the life-outcomes of people who are a part of a stigmatized group. Structural power, such as creating laws and policies, can produce the very social circumstances that are stigmatizing, such as poverty. A fulsome understanding of stigma requires we examine stigma beyond the personal experience to focus on the macro-level factors that limit life outcomes for members of stigmatized groups (Hatzenbuehler & Link, 2014).

The perpetuation of stigmas originating within or reinforced by social, economic, and political fields is well concealed and therefore incredibly difficult to change (Das et al., 2001; van Olphen et al., 2009; Yang et al., 2007). Social norms and institutional policies strengthen structural stigma and generate broader structural issues that benefit non-stigmatized people, reinforcing dominant discourse about what constitutes ‘normal’ or ‘stigmatizing’ (Hannem, 2012; Hatzenbuehler & Link, 2014; Link & Phelan, 2014).

Stigma and the subsequent discrimination of some groups of people perpetuates social inequality. People belonging to highly stigmatized groups can be subjected to increased surveillance, which creates suspicion and criminalizes behaviours that would likely go unnoticed if not for amplified surveillance. For example, when someone accesses governmental supports,

such as employment or disability insurance, homeless shelters, hospitals, or becomes involved with the criminal justice system or child protective services, they are placed in an environment where observation and scrutiny are normalised. Surveillance and incarceration are tools for generating false depictions of an 'other' and demonstrating the need for state regulation of stigmatized groups, including marginalized women (Boyd et al., 2018).

Howard Becker, arguably the most prominent labeling theorist, asserts that "social groups create deviance by making the rules whose infraction constitutes deviance, and by applying those rules to particular people and labeling them as outsiders" (1963, p. 9). Different group will have varied standards of what constitutes deviance and thus who is an outsider, as "deviant behaviour is behaviour that people so label" (Becker, 1963, p. 9). The perceptions of people who are labeled an outsider are likely to clash with the labeller, and demonstrate that what an individual defines as deviant varies and is reinforced by their group identity.

While group identities are influential in shaping attitudes and actions, individuals belonging to a particular group may have never engaged in activities presumed to be associated with their group. Becker describes how people who have been labeled 'drug user' – in particular people who use opioids – also carry the label of 'deviant' or 'criminal' and that combined, these labels indicate to others that the individual possesses dangerous traits. There is also a belief held by a majority of community members that because an individual has engaged in a criminal act that they will violate other laws. This assumption leaves people suspicious of the individual and restricts legitimate opportunities, thus resulting in continued deviant behaviour. Becker (1963) refers to this phenomenon as secondary deviance and is a, "consequence of the public reaction to the deviance rather than a consequence of the inherent qualities of the deviant act" (p. 34-35).

3.3.3 Stigma and Illicit Substance Use

Illicit substance use has long been considered a criminal matter and has only begun to be recognized as a medical concern within the last 20 years, and continues to be a highly stigmatizing issue (Hathaway & Tousaw, 2008). People who use illicit substances have acknowledged that fear of arrest for drug possession following an overdose call is a deterrent from calling for help in the future (Barry & Chris, 2018). As a result, the federal government passed the *Good Samaritan Overdose Act* in 2017. The *Act* provides immunity from simple drug possession in instances of overdose to encourage calling for help. In practice, its effectiveness is limited by a lack of awareness about the *Act* by police and people who use illicit substances. Even when people who use illicit substances are aware of the *Act,* they still hesitate to call for help given their history of stigmatization, harassment, and arrest on different charges, effectively nullifying the principle of the *Act* (Moallef & Hayashi, 2020).

Health professionals, like everyone else, have their own set of biases that negatively impact stigmatized individuals. A systematic review of the effects of health professionals' attitudes towards people with substance use disorders and the treatment they receive provide evidence that people who use drugs receive less thorough care by medical professionals who have negative attitudes towards the population (van Boekel et al., 2013). This phenomenon is described as 'avoidance', whereby a healthcare professional makes fewer visits to check in, shows less empathy, and does not personally engage with patients known to use illicit substances (van Boekel et al., 2013). Inadequate and discriminatory health care is similarly experienced by Black, Indigenous, and racialized populations (Matthew, 2016). This inferior treatment is directly associated with drug users' reluctancy to seek medical care. Despite their increased need, stigma is correlated to reduced access to health care (Krüsi et al., 2016) and mental health

services (Hatzenbuehler & Link, 2014). The long-term impact of subpar medical treatment is reduced health outcomes for stigmatized people.

Women who are stigmatized because of their drug use by medical staff find that being treated as inferior worsens pre-existing mental and emotional problems, which can contribute to their continued or relapsed drug use (van Olphen et al., 2009). SCSs were developed specifically to address these negative and untrusting relationships with medical professionals. SCSs provide people who use drugs a safe and non-judgemental connection to medical staff, with the aim to reduce stigmatization in a healthcare setting and bolster a willingness to access services. Medical staff are trained to respond to overdoses, can teach users best practices for safer drug use, and can help to decrease barriers and build trusting relationships between drug-users and the health care system (Bayoumi et al., 2012; Pauly et al., 2020). This philosophy can improve health outcomes for people who use drugs while simultaneously functioning to build non-stigmatizing relationships with healthcare professionals (Parkes et al., 2019). Key to SCSs success in reducing stigma is people's willingness and ability to use these spaces, which as Chapters five and six reveal, is not always the case for women.

3.4 Conclusion

I began this chapter by examining the ways in which women are excluded from the patriarchal society, and how this exclusion constructs and maintains systemic gender-based inequities. A contributing reason for women's sustained inequity is the way in which women are simply "added and stirred" to systems that were designed for men (Davis, 2003). This results in gender differences being overlooked and disregarded, creating further hardships for women. One of the most profound adverse consequences of ignoring gender differences is the impact of

interpersonal, structural, and symbolic violence in women's lives. In the second half of the chapter, I examined the influence of stigma on people who use drugs. Structural stigma moves beyond the individual and focuses on larger, social strategies that reinforce the stigmatization of particular groups. Stigmatized groups, in particular people who use illicit substances, have inadequate access to supports including health care, and are criminalized for their perceived riskiness, as indicated by their additional needs. Broad socially-based assumptions about people who use drugs often ignore larger systemic inequities that further perpetuate stigma.

The remainder of this thesis will be informed by the frameworks of critical feminist and stigma theories. Both theories provide me with a lens through which I designed the study, collect, code, and analyze the data set. Using these theories, I am able to move beyond simply describing the data collected to interpreting and understanding the stories women shared with me, and connect it to the larger body of research of the lived realities of women who use illicit substances.

Chapter Four: Research Methodology

4.1 Introduction

Previous research on SCSs established that women's voices on harm reduction service has not yet been thoroughly evaluated (Boyd et al., 2018). I responded to this gap by designing a study which focuses on women who use illicit substances. This research project was designed using qualitative methodologies and constructivist grounded theory. I used semi-structured interviews to create a directed but flexible interview process (Charmaz, 2014). It was important to provide participants flexibility within the interview so that the data reflected their true convictions. Likewise, flexibility ensured participants were able to explain their thoughts and introduce topics that may not be covered in theoretical and empirical research (van den Hoonaard, 2019). While I was unable to include all of the quotes in this thesis, I chose quotes that captured the essence of the stories that emerged throughout the interviews. This chapter will cover the study design and safeguards in place to obtain ethics approval. I will then explain how I gained access to my research participants and the steps I took during recruitment, and ultimately the interview process. Next, I explain how I coded and analyzed the data set. Finally, I position myself and my own experiences that contribute to my findings.

4.2 Study Design and Procedure

By using constructivist grounded theory, I remained true to the data as an inductive approach is used to generate a new theory from information gathered during data collection (Charmaz, 2014). While I had ideas of what data I might collect due to reading previous research as well as past experiences with the population, embedding my work within a constructivist grounded theory framework ensured that I analyzed the actual data and the trends that exist

within the data set, instead of the data I believed I would collect. Semi-structured interviews suited this research as participants were able to share relevant information that I may have overlooked while designing the interview guide (van den Hoonaard, 2019).

Ethical considerations were very important while designing this study as it involves vulnerable human participants (van den Hoonard, 2019). I received ethics approval for my study from Laurier's Research Ethic Board (REB #6224). I anticipated that participants may discuss issues surrounding trauma and victimization; however, the interview guide (see Appendix 1) was written with a focus on the policies and practices adopted by SCSs. Every effort was made to ensure that partaking in this research did not make women feel unsafe in any way.

4.3 Access and Recruitment

As my research includes a very specific population I decided to engage in purposive sampling. Purposive sampling is a non-probability method whereby recruitment efforts target a small selective subset of the wider population based on the presence of certain attributes or the ability to elucidate on a specific concept or phenomenon (Maxfield & Babbie, 2008). I recruited participants in February 2020, from a non-profit organization that offers harm reduction supplies within an Ontario city located within the Greater Toronto and Hamilton Area, with a population approaching 800,000 that had recently opened their first SCS. In June of 2018, the city opened their first SCS. This meant that the SCS was relatively new, however it had been in operation for long enough that people who chose to access harm reduction services had ample time to both become aware of and access the site, if they desired. It was important to recruit participants from a location that offers harm reduction services but I did not want to recruit participants from the SCS directly as I would then be excluding people who do not access the site as well as people

who have accessed the site and decided they would not return, or had been barred. I wanted to ensure that the participants felt free to answer questions about the SCS honestly, and had I recruited from the SCS, some participants may have felt uneasy about providing honest responses.

Relationships with gatekeepers are key to accessing and conducting research with a vulnerable population such as people who use illicit substances (Van den Hoonard, 2019). In this research, I initially met with two staff members working at the non-profit organization and explained my research and answered questions. The gatekeepers informed me they wanted to first get consent from the women who attend the weekly Women's Harm Reduction meeting prior to allowing me to attend. I provided the gatekeepers with copies of my poster to hand out at the meeting and to be posted within the organization. I did this so that regardless of whether I was permitted to attend a meeting, potential participants would have my contact information and so that those who did not attend the meeting would also have an opportunity to participate in the research. The following week I received an email informing me I could attend the next meeting.

I attended the Women's Harm Reduction meeting in person and had the opportunity to present myself and my research to the group. I made recruitment posters (see Appendix 2) that were readily available to anyone wishing to partake so that they had easy access to my contact information and could connect with me privately, in a time that worked best for them. I ensured these paper posters were available for women to take so that they could contact me if they were interested in connecting with me at a later time, or if they knew of anyone who might be interested. The poster was also displayed at the organization, so that my contact information was readily available to anyone who wished to partake in the research but did not want anyone at the

organization to be aware. I was invited to stay and partake in their activity, which allowed me to develop rapport.

The following day, a potential participant reached out to set up a time and location to do an interview. At their request, the interview took place at the non-profit organization. Following interview preparations in a private room, I waited for my first participant. She did not arrive. I began talking to the individual working the front desk, who had led the meeting two nights prior. She suggested I stay there for the day and see if anyone who drops by the organization was interested in partaking in my research. When women came into the organization - mostly to obtain harm reduction supplies - myself or my new gatekeeper informed them about my research and asked if they wanted to participate, and many did. Gatekeepers are able to make connections and increase the researcher's legitimacy and trustworthiness among potential participants, particularly important when the population being researched is hard to reach (Charmaz, 2014). I cannot overstate the importance of the gatekeeper in aiding me with recruitment. While I am grateful for all her assistance, once I had nearly completed all of my interviews, I overheard her informing a potential participant she was recruiting that the interview was short. I am uncertain how many of my participants were told the interview was brief, and believe this may have contributed to my interviews being shorter than I had anticipated.

4.4 Interview Process

I conducted 14 semi-structured interviews that lasted approximately 35 minutes with women-identified drug users over the age of 18. One participant had never been to a SCS, while the remainder said they have accessed the SCS multiple times. All but one interview took place within private rooms within the non-profit organization where I actively recruited participants.

The sole interview that took place outside of the organization occurred at a coffee shop, as per the interviewee's request, because the organization was closing. I conducted all the interviews, which took place over the span of four days. Interviews were conducted in such a short time span, because frequently when I had finished an interview, there was already someone waiting at the front desk, hoping to be able to partake in the research. On the second day, I had to tell multiple people that I could not conduct their interview that day, as I had only brought enough packages for seven people that day. I told everyone who I was unable to interview that day that I would come back the following day, and that they could also schedule a different place or time with me – two returned. All but one of the interview participants consented to being audio-recorded. For the participant who did not consent, I took detailed handwritten notes.

I was cognizant going into the interviews that I was asking participants to discuss illegal and stigmatized activity, and that participants may rightfully have some hesitancy around discussing these topics. I spent time prior to the interview process engaging in rapport building to help the participant feel at ease. Once the participant appeared comfortable enough to begin, I thanked them for their involvement in this study and I gave them a copy of the consent form (see Appendix 3) and we went over it together. I explained to participants they may skip any question they do not want to answer, take a break at any point if they choose, ask for the recorder to be turned off, or end the interview entirely with no questions asked. The participants had the opportunity to ask any questions they may have had. Participants received remuneration immediately following signing the consent form ($20). I explained that this means the participant will receive the full remuneration, regardless of the quality and quantity of their participation and that pausing or stopping the interview completely will have no effect on their remuneration. I also provided a list of local resources (not included in keeping with anonymity) that outlined 24

hour supports with which they could connect with if needed, and mentioned that I was available following the interview to debrief if desired.

Once they signed the consent form and I received permission, I turned on the recorder and began to ask my questions. In designing my interview guide, I was careful to make my questions broad, open-ended, and non-judgemental to foster detailed discussions most important to my participants. For example, I began by asking participants to walk me through what a typical day looks like for them. I started the interviews in this way to facilitate conversation and allow participants the freedom to provide me with any information they deemed important. I probed and asked clarifying questions and jotted down points they had mentioned that I wanted to return to. In one instance, a participant seemed to be putting a lot of effort into crafting her responses. I had tried to put her at ease using nonverbal cues and reiterating that I wanted to hear her story. It was not until she swore in a response and quickly apologized that I realized where her hesitation was likely coming from. I made the decision to swear while telling her she could use any language she wanted to tell her story. She laughed and immediately seemed more comfortable. From that point forward her replies appeared more natural and had more detail. At the completion of each interview, I chatted with the participant to ensure they were okay before they left.

Following each interview after the participant had left, I wrote memos on my reflections about the interview and the project at large. While I tried to ensure I had enough time to write a memo after each interview, in most cases there was someone waiting who had seen the last participant leave; this resulted in me also trying to get my thoughts down quickly, without providing as much detail as I would have liked. I made further memos at the end of each day of interviewing.

Once I had completed the interview process, I transcribed the interviews verbatim, memoing as I went. Following transcription, I deleted the audio-recordings in keeping with REB requirements. Identifiable information such as people's names, places, specific events, and dates were anonymized at the point of transcription. The master list that connects the pseudonym[3] to the participant, as well as all signed consent forms were to be kept in a locked cabinet within Dr. Dej's office, however the COVID-19 lockdown prevented this from happening. Therefore, the consent forms and master list were stored in a locked bag within my apartment. Transcriptions were kept on a password protected computer.

4.5 Coding

Following a constructivist grounded theory approach, I coded the project in two phases (Charmaz, 2014). Coding involves creating conceptual categories to sort raw data into to be further analyzed (Maxfield & Babbie, 2008). In creating my code book, I utilized deductive codes based on the literature and theories applied in this research project and added inductive codes as they emerged in the data set. The initial coding was open coding, where I engaged in line-by-line coding as well as story chunking. This helped me to select, separate and sort my data. These initial open codes enabled me to brainstorm and explore multiple possible meanings prior to applying a conceptual label (Maxfield & Babbie, 2008). Further, initial coding provided me the opportunity to define what was happening within the data and allowed me to begin to grapple with what the data was truly indicating (Charmaz, 2014). It was important that during initial coding I remained open to exploring whatever theoretical possibilities arose within the

[3] Participants were asked if there was a pseudonym they wanted to use. Only one person answered in the affirmative and provided the name they wanted to be assigned to them. For all other participants I selected the pseudonyms.

data. I did this by staying close to the data, and keeping codes short and precise (Charmaz, 2014).

Line-by-line coding the first few interviews helped me to build the code book I used for future interviews. At times this coding process felt tedious and unproductive as the codes I produced lacked clarity. I grappled with how I would be able to turn these low-level concepts that I could see little analysis through, into codes that would enable me to deeply identify the trends within my data set. I updated my code book when new codes emerged through the analysis of additional interviews and made sure to re-examine the interviews I had already coded, to ensure I was not overlooking the newly emerging codes within previously coded data. Repeatedly going over the data allowed me to gain new analytical insights. For example, when going back to recode one of the earlier interviews I was able to see the progress I was making as I generated new ideas and fresh codes emerged from data where I had previously only seen one code.

By studying and comparing my initial codes I developed new focused codes that enabled me to better examine the raw data and create more analytical codes. Through the process of aggregating codes to create overarching parent codes I was able to interpret the data in new ways. Coding rich data requires multiple layers of interpretation (Braun & Clarke, 2013). While searching for various significances within the construction of participant's story and then again reading over the data looking for different themes, new codes and understandings of the data emerged. Focused coding enabled me to compare and contrast stories told by different participants to derive the core themes that exist within my data set (Charmaz, 2014). Delving into the data repeatedly aiming to derive a fresh interpretation allowed me to see the larger story

that was being told by my participants, as well as the higher-level societal story happening alongside personal narratives.

4.6 Analysis

Throughout the coding process I began to recognize patterns within the data set and was able to create themes. My continued engagement with the data set during focused coding enabled me to see the core themes. Becoming aware of the volume of codes possible within the data allowed me to better engage in a thematic analysis. Thematic analysis is a flexible and interpretative approach to analyze qualitative data; it is a process of identifying patterns and themes while looking for underlying explanations and assumptions (Braun & Clarke, 2013). The analysis process occurs during and after data collection and transcription as contemplation of the specifics within the data trigger further analysis (Maxfield & Babbie, 2008).

When analyzing using a constructivist grounded theory, it is important to seek out the multitude of perspectives within the data, systemically organize the shared and varied meanings, compare and contrast between participants' narratives, follow leads, and look for alternative explanations (Charmaz, 2014). Engaging in thematic analysis enhanced my understanding of the concepts within my data by adding precision and clarity, making my analysis coherent and comprehensible (Charmaz, 2014). By utilizing a thematic analysis, I was encouraged to become familiar with the data while looking for underlying explanations within emerging patterns in the data (Braun & Clarke, 2013). It was not until I had the chance to engage with the data repeatedly seeking alternative interpretations through coding that I was able to expand beyond a purely descriptive account of the data and begin to assign higher-level meaning to it.

It is important to note that my research is influenced by my positionality. I am a middle-class, Caucasian, CIS-gender female, who has not used illicit substances, but has worked closely alongside women who do. I thus came to this research able to relate on gendered factors and cognizant of the daily struggles women who use illicit substances encounter, but as someone who has not personally experienced the discrimination that poor and marginalized women who use substances experience. I am also a staunch supporter of harm reduction efforts and believe that society has a moral obligation to support all of its members. My decision to return to studies and conduct this research project was influenced by my previous experiences working alongside women who use illicit substances within a harm reduction emergency homeless shelter and soup kitchens.

While working in these roles I saw firsthand the impact of a toxic supply of substances alongside an absence of anywhere safe to use. I witnessed women's endeavors to increase their safety during a time of unprecedented overdose deaths, when no safe options were provided to people who use illicit substances. I personally responded to overdoses in locations often cited as safe by research participants, including individuals' room and bathrooms where I sincerely thought I had reached them too late. Fortunately, I was able to reverse all of the overdoses I responded to and unlike many others did not have to bear witness to someone's death. My experiences made me realize women's incredible efforts to improve their safety were assiduous but executed alongside a socio-political climate reluctant to implement widespread and comprehensive initiatives designed to remove harm – namely safe supply and 24-hour access to SCSs.

Daily conversations with women who used illicit substances augmented my understanding of the constant struggle to maintain safety while using a toxic supply and

amplified my enquiry into the ways in which women are included or not in harm reduction efforts. These experiences provided me with insight that made me privy to insider "lingo" and perceptive to persistent structural barriers. I was cognizant of my status as an outsider while conducting research and reiterated to participants that they were under no obligation to share anything they felt uncomfortable sharing. I believe that my understanding of daily struggles faced by poor and marginalized women who use illicit substances gained through my previous experiences with the population increased participants comfort and augmented the information they were willing to share with me.

4.7 Summary

This research project was designed using constructivist grounded theory and thematic analysis. I used semi-structured interviews as my method to ensure that participants were able to provide the information they thought relevant thus resulting in the data set being aligned with their genuine views. I took every precaution to ensure that ethical considerations remained top priority throughout the duration of this project. Following transcription of the interviews, I familiarized myself with the data set as I developed my code book. Repeated coding efforts facilitated further interpretation and analysis. By meticulously utilizing constructivist grounded theory and thematic analysis I was provided the methodical process to construct this research project and analyze the collected data, which enabled me to gain valuable insights laid out in the next two chapters.

Chapter Five: Structural Struggles

5.1 Introduction

In this chapter I examine women's drug use and the structural factors that influence the experiences of poor and marginalized women, including the feminization of poverty, violence against women, and structural stigma. This chapter lays the groundwork for the subsequent analysis of the gendered experiences of SCSs described in chapter 6 by providing a nuanced understanding of the broader issues at play for women who use illicit substances including: stigma, overdose risk and the overdose death of friends and family, criminalization, intimate partner violence, and losing custody of children. We must first understand the gendered needs of women who use illicit substances to determine whether SCSs meet those needs.

I first address structural issues that sustain systematic inequity and lead members of the public and policy makers to hold prejudiced views against individuals experiencing poverty and/or marginalization and perceive poor and marginalized women who use illicit substances as inherently risky and 'othered' (Hannah-Moffat, 2016; Hannem, 2012). I examine how the depiction of otherness negatively affects women's ability to meet their basic needs. I next examine the criminalization of poor and marginalized women who use illicit substances. In order to understand the impact of criminalization of selected drugs and people who use them, I explore the dangers of an unsafe illicit-market supply (Tyndall, 2018). I then consider how relationships, particularly with intimate partners and children, influence women's wellbeing and effect their drug use (Covington & Bloom, 2006).

5.2 Structural issues

5.2.1 *Persistent Stigma and Its Consequences*

Stigma typically focuses on the micro, interpersonal connections between individuals; however, the stigma experienced by poor and marginalized women who use illicit substances are frequently based on structural attributes that are assumed to relate to all poor and marginalized women who use drugs (Hannem, 2012). In addition, women who use illicit substances are often discriminated against through structural and systemic policies. The structural stigma experienced by poor and marginalized women who use illicit substances negatively impacts their socio-economic status, health and wellbeing, and safety (Link & Phelan, 2001). It is therefore important to focus on the stigma experienced by poor and marginalized women who use illicit substances through a structural lens. All of the participants in this research were living in poverty as indicated by their disclosure of homelessness, unemployment, and/or food insecurity. Twelve of 14 participants discussed the incessant impact of structural stigma on their lives due to their status as poor and marginalized women who use illicit substances.

Poor and marginalized women who uses illicit substances are often depicted as deserving their circumstances of poverty and social exclusion. Katz (2013) explores what differentiates the deserving from the undeserving poor. Individuals who are constructed by members of the general public and policy makers as undeserving are thought to have brought about the circumstances of their poverty on themselves. Policies are designed to restrict services and supports from individuals seen as blameworthy for their circumstances. Conversely, individuals who are thought to have little culpability over their circumstances, mothers living in poverty, for example, are more likely to be imbued with the victim identity and thus constructed as deserving of assistance. However, women who use illicit substances are often constructed as blameworthy

for their drug use as well as any obstacles that seemingly arise as a consequence of drug use, due to their perceived poor judgement (Finnell, 2018). This characterization fails to consider how being a victim of violence and historical and ongoing trauma can be a cause of illicit substance use.

The construction of the undeserving poor fails to incorporate the struggles that lead to the decision to use drugs. To escape a violent relationship, Susan, a 49-year-old mother who had housing explained to me that she agreed to move to Vancouver in 2014 with her mother from Ontario, but six weeks prior to their move her mother passed away,

> I only went because I promised my mom I'd go to get away from a bad relationship. It was very lonely, and it's horrible actually. And I went right downtown to find drugs, to try and mask my pain. I wish I'd never went.

Susan began using drugs to mask her pain and loneliness caused by the abusive relationship she had just escaped as well as her mother's recent death. Susan revealed she experienced abuse throughout her entire life and that she used to think she had a "shitty childhood" but that she "had the life of a princess compared to some of these kids." Susan provided multiple examples of friends' and acquaintances' experiences of horrific child abuse. Susan, like many others, has faced numerous challenges related to her drug use and expressed exasperation at being treated as lesser because of her marginalized status, "they judge you by looking at you, and it's terrible. You have no idea what that person has gone through". Many participants discussed how they experienced judgement from others who have no knowledge of their reality.

The absence of understanding on the part of the general public leads people who hold prejudiced views against individuals experiencing poverty and/or marginalization to justify treating them with stigma and discrimination (Bruckert & Hannem, 2013). Examples of discriminatory actions include offensive remarks, intense scrutiny, avoidant behaviour or

assumed culpability from members of the public (McCoy et al., 2001), health care professionals (Finnell, 2018; Kosteniuk et al., 2021), and police (Small et al., 2006; Watson et al., 2021). Ettorre (2015) explains that women who use illicit substances are "positioned as deserving the very social exclusions that exacerbate their otherness" (p. 795) because they are constructed within public discourses as willfully deviating from gender norms. There is ample research demonstrating that stigmas produce discrimination, such as in employment and housing, which drastically reduces the health and wellbeing of people who are already disadvantaged (Finnell, 2018; Goffman, 1963; Hatzenbuehler & Link, 2014; Lloyd, 2012; McCoy et al., 2001; Small et al., 2006).

5.2.2 Health and Unmet Basic Needs

The persistent stigma and discrimination that poor and marginalized women who use illicit substances experience negatively affects their health and wellbeing (Finnell, 2018; Hatzenbuehler & Link, 2014; Lloyd, 2012). All of the participants mentioned how difficult it is to meet their basic needs and many linked their drug use to masking various forms of pain. Jessica, a 30-year-old woman experiencing homelessness, communicated to me that she felt her mental and physical health was "deteriorating" in what she calls "everyday struggles." She described the benefits of using opioids,

> So fentanyl, it's on a freezing cold winter day, it's like a giant teddy bear coming and hugging you and he's like a warmed up heated teddy bear, like a heated blanket, being wrapped around you, and you get this warm ecstasy feeling down the back of your neck through your shoulders and then you just ahhhh relax and the world is amazing at that point in time, and everything's just great and your body just feels awesome…It like quiets everything, you're no longer thinking about crap, you're just thinking about enjoying the way your body feels…Blocks it all I'd say. People say it numbs the pain, literally and physically and emotionally and yeah it's true. Just shuts it all down.

Understanding what someone gets out of using drugs allows us to empathize with the struggles they face. Jessica, who spoke at length about the loss of custody of her son, various abusive relationships, and the struggles of living in poverty, illustrated how drug use "quiets everything" and "blocks it all." Jessica's description speaks to the adversities facing poor and marginalized women (Boyd et al., 2018) including experiencing the feminization of poverty (Pearce, 1978; Ruppanner et al., 2019), pervasive interpersonal, structural and systemic violence (Crenshaw, 2012; Krüsi et al., 2016), and a lack of affordable housing (Suttor, 2016). For Jessica, fentanyl provides temporary relief from the daily and sustained challenges she encounters. This finding is consistent with available evidence that some women use drugs to cope with trauma (Boyd et al, 2018). Further, Jessica's description of how fentanyl "numbs the pain, literally and physically and emotionally" exemplifies the kinds of physical and emotional trauma that is common among women who use drugs, are living in poverty, and/or who are homeless or precariously housed (Canadian Femicide Observatory for Justice and Accountability, 2019).

The adversities, including unmet basic needs, poor and marginalized women experience can lead to increased drug use and correspondingly amplified stigma. Jessica described her life as full of mental and physical chaos because she has inadequate income to cover the costs of her needs including shelter and food and thus identifies herself as, "one of those scroungers, I guess you could call it, in the city that utilize every factor and every outlet and just juice it until its un-juiceable". Stigma and the resulting discrimination are well documented as both the cause and result of social disadvantage, which in turn reproduces negative outcomes (Hatzenbuehler & Link, 2014). These overlapping disadvantages of poverty and persistent stigma make it difficult for poor and marginalized people to meet their most basic needs, including accessing food and shelter. The participants in this research project all struggled to meet their basic needs, which in

turn creates instability and uncertainty about how they will meet these needs each day. All of the women in this study expressed gratitude for the supplies I brought to the interviews, such as water bottles, meal replacement bars, and gum, mentioning that these items are extremely helpful and often difficult to access. This struggle to survive means that women are incredibly resourceful and find creative ways to meet their needs, or as Jessica's describes "juice it until its un-juiceable."

Jessica uses dumpster diving, selling clothes, and repurposing people's garbage as a way to meet her daily needs, including the cost of accessing drugs. For Jessica, the city offers various outlets that she has figured out how to use to survive, such as finding scrap metal in dumpster bins throughout the city and knowing where the clothing drives are that she can turn around and sell to others. Without this detailed knowledge of how to make the most of what the city has to offer, she would be unable to meet her needs. Jessica's resourcefulness speaks to the lack of official resources available to adequately meet the needs of all who require them.

5.2.3 Generating Income

The depiction of people who use drugs as risky and likely to engage in further criminal activities impacts drug users' legitimate means for generating income (DeBeck et al., 2007; Ti et al., 2014). Becker (1963) warned that engaging in illegal acts and being assigned the 'drug user' and thus 'criminal' labels leads to secondary deviance (p. 32). Many women described how stigmatization contributes to difficulties obtaining formal employment. Kaileigh, a 22-year-old who is living on the streets, communicated her irritation at being unable to attain a job, remarking, "good luck getting a job, okay. I'd love to have a job. I'd love to have a place to live. I'd love to have all these things. I've had them before, but, umm, I'm at ground zero". Obtaining

the income necessary for someone to meet their basic needs as well as to access drugs becomes problematic when there are no legitimate opportunities. None of the women I interviewed noted being legally employed, which is consistent with research describing the significant barriers to employment for women who use illicit substances (Richardson et al., 2010). Kaileigh said she is always looking for a way to make money, explaining that one of the best ways is a "copper score,"

> where we collect scrap metal. So, we're going into abandoned buildings to get scrap metal. It's good money, right? ... I'm not like a prostitute or anything like that. So, I have to make like a means to get money and stuff, that seems like the most probable solution.

While Kaileigh expressed a desire for legal work, she must ensure her needs are met irrespective of whether legal work is available to her. While selling copper provides Kaileigh some informal employment, it also puts her at risk of harm (DeBeck et al., 2007). Multiple women told me they knew of someone who accidently cut a live wire during a 'copper score' resulting in the loss of one full arm and the other hand. While Kaileigh believes that a 'copper score' is one of the only viable ways for her to earn some income, she is also putting herself in an incredibly dangerous situation.

When I asked what she does if she is unable to obtain enough money to buy her drugs for the day, Kaileigh assured me she always finds a way,

> I make sure, you know what I mean? If I'm not making money, I'm selling other people's dope for them and I'm getting a little bit off of that. It helps. It helps that I've been out here for so long because I know everyone.

Kaileigh occasionally works as a 'user-dealer,' otherwise known as selling small quantities of drugs to support their own habit (Moyle & Coomber, 2015). Larger-scale dealers use user-dealers to shield themselves from criminal charges (Small et al., 2013). Poor and racialized women are "the most vulnerable to arrest and conviction and are often situated at the lowest level

of the drug economy, mirroring their status in society" (Boyd, 2015, p. 225). Although there are risks associated with dealing, including increased exposure to police and violence, women also see dealing as an effective means of generating income while allowing them to avoid or reduce their involvement in actions deemed riskier, such as sex work (Moyle & Coomber, 2015).

Alex is a 34-year-old woman who is homeless, has used drugs for 19 years and is anxious about her increasing inability to inject herself because of scarring and collapsing veins. She was also the only woman to disclose to me her occupation as a sex worker. Alex spoke about survival sex work as a "never-ending cycle" and explained how she works to support both her and her boyfriend's drug use regardless of his disdain for her occupation,

> I'm a working girl right so, I pretty much wake up at 4am. Go to work. Before I do, I do, like, a smash. Like, I do heroin right. So, or fentanyl, whatever. And then I go to work, and then I come home. Or I go to my dealers and get it. It's just the same. It's repeated every day. Right? And then I'll go back out again. Same thing. Right. But I have a boyfriend too right, so he also doesn't like that too much (laughs). Yeah, but he's a user too right. So, although he doesn't want me to go out, you know, he doesn't work neither right, so. Right now, we're both homeless, we're sleeping outside so it's been pretty rough.

Following a discussion of how she accesses the SCS hoping for assistance with her injection, she then links her inability to receive help with an increased need to work. Alex adds,

> It is very frustrating. Like sometimes I'm there [at the SCS] for a couple hours trying to hit [inject] myself. Right. And like I'll buy enough for say, until tomorrow morning, right, and then I'll end up doing it all, because I'm missing it, right. So, then I'll make another shot up, and then I'll miss that one, and then, and then I have to go back to work (laughs). And then I get really mad at him [her boyfriend] because you know it's like, you're getting it every time and I'm not, and I'm working for it. I'm the one that has to go out and suck dick for it, and not you, and you're high and you're falling asleep, and I'm fucking still sober. Like what the fuck is that and then he gets mad because I'm going back out and then it's just like, it's a never-ending cycle.

Alex is the primary breadwinner, and supports both her and her boyfriend's substance use. She is irritated that he expresses a distain for her work while he benefits from her labour while she

often does not. Due to scarring and collapsing veins Alex often "misses" injecting into her vein, meaning she unintentionally injects subcutaneously – into the skin and/or muscle – and thus she has to repeat the process several times as her supply diminishes. Subcutaneous injections provide a slower absorption method thereby reducing risk of overdose, but pose a significant risk of skin infections (Saporito et al., 2017). Due to the gradual absorption Alex does not experience the euphoria and considers the injection missed. Because Alex often fails to inject her drugs intravenously, she must go back to work to buy more in the hopes that she can successfully use. The loss of accessible veins is a common problem among women who inject drugs (Fairbairn et al., 2010).

Deering et al. (2011) found that the safety of women who engage in survival sex work and use drugs can be negatively impacted by peripheral factors. Rising drug prices, often from police crackdowns, and more recently as an effect of lockdowns during COVID-19 (Holloway et al., 2020; Ontario Drug Policy Research Network et al., 2020), results in riskier behaviours to be able to afford the drugs (Deering et al., 2011). Alex and other women in similar situations use up more drugs than they ingest because of their problems injecting. This means that they have to purchase more drugs than they would if they had assistance injecting - a practice prohibited at the time of interviews and that I describe in detail in chapter 6 - costing more money and leading to riskier behaviour to make enough money to support their use.

Pollack (2000) found that among criminalized women the "primary motivation for breaking the law was money" (p. 7). Kaileigh noted that finding formal employment was incredibly difficult and was why she turned to informal employment. Abby, a 30-year-old woman who recently reduced her usage in the hopes of being able to become sober, admits that she used to steal in order to meet her basic needs. However, because of her reluctancy to engage

in illegal activities she now exclusively panhandles or borrows money from friends. Like Abby, Melissa, a 23-year-old Eurasian trans-woman who was experiencing homelessness and had been using drugs for ten years, told me she panhandles all day. While Abby and Melissa both try not to engage in illegal activities, others cannot survive without doing so.

Poor and marginalized women are repeatedly denied employment or adequate income assistance, requiring them to find alternative forms of financial gain. Without techniques for income equity, such as a guaranteed basic income or adequate social assistance, people living in poverty are unable to meet their needs, even if employed in low paying, unstable jobs (Hamilton & Mulvale, 2019). Although drug use can limit someone's ability to successfully maintain employment, it is not always the case. Discrimination in the form of an unwillingness to hire people with criminal records, including individuals who use drugs, leave no alternative but to turn to illegal income generating activities (Becker, 1963; Pager, 2007). People with criminal records are often denied legal employment as many job applications require people to disclose their criminal status at the first stage of the process. Answering these questions in the affirmative significantly reduces the chances of obtaining an interview and thus the position (Agan, 2017). The refusal to hire someone with a previous criminal conviction is a form of discrimination. Furthermore, there is no place in record checks to describe the nature of the criminal record and no nuance to address how the majority of women's crimes are directly tied to their position of poverty (Hannah-Moffat, 2010). This lack of context and structurally-embedded form of discrimination can be seen as yet another punishment for women's poverty as well as a hinderance to improving their economic position.

5.2.4 Criminalization of Drugs

The criminalization of drugs ensures that the supply remains unregulated and therefore often hazardous (Boyd, 2015; Small et al, 2006; Tyndall, 2020). The harms associated with an unregulated and unsafe supply of drugs were never more apparent than in the midst of an opioid epidemic that has resulted in over 29,000 opioid-related deaths in Canada between 2016-2021, most of which were accidental (Government of Canada, 2022a).

Bettie is a 48-year-old woman who was first prescribed opioids following a medical procedure, and became addicted to her prescription drugs, which provided her relief of chronic pain caused by her ex-husband's physical assault. She subsequently lost custody of her children to her ex-husband because of her opioid use. Bettie described her desire to make drug use safer for people who use illicit substances,

> We're not gonna cure drug addiction. We're not gonna make it go away. But were gonna try and make it manageable. And have survival. I don't know how many people we've buried, ah it's got to be every day. At least once a month we were losing somebody. Overdose awareness day is in June. At Victoria Park we had the overdose prevention day. On the bus, I started writing the names of everybody I lost. Just myself, and my two arms were full in the span of 7 city blocks. Names, names, names, names, names, names. I couldn't believe it…Somebody had asked "oh that's awfully colourful, what are you here representing?" I said "all my dead people. These are all the lives of people I've lost" and it was a husband and a wife, their son had fallen to overdose and passed away. And his face, the father's face, I think what I saw was him envisioning every name, losing his child over and over and over again.

During the timeframe Bettie is referring to, on average eleven people were dying from opioid overdoses per day in Canada (Public Health Agency of Canada, 2020). Most of these deaths could have been prevented. Canada has rapidly expanded their harm reduction strategies by increasing the number of SCSs across the country and making Naloxone more readily available in an attempt to reduce the number of fatalities (Fairbairn et al., 2017; Karamouzian et al., 2018; Skolnick, 2018; Wallace et al., 2019). These strategies have shown some success (Irvine et al.,

2019). Yet, as rates of overdose deaths continue to rise, it is evident that more strategies are required to effectively reduce opioid-related deaths.

One of the central tenets of harm reduction as it relates to drug use is to never use alone. The presence of others decreases the probability of an overdose resulting in death, as Naloxone can be administered and/or paramedics can be called (Moore, 2004). Despite these warnings, Cassie, a 30-year-old who has been using illicit substances for a year and a half, expressed her reluctancy to access the SCS, "well, they say not to use alone, but I always do. I mean I guess when I'm feeling more sociable or what not then I'll go to these places [SCSs] and use, but otherwise umm no". Like Cassie, Tiffany, an Indigenous presenting woman who has used drugs for eight years, is not concerned about overdosing because, "I know my limit. I take it easy too." This confidence fails to account for inconsistent potency, and leads to increased drug use in locations other than supervised sites (Ivsins et al., 2020; McNeil et al., 2014).

Rachel, a 27-year-old who normally only accesses the SCS to pick up supplies, stated her confidence that using in a public washroom or at home with her boyfriend was safe because he has instructed her to "just do as much as you can handle" and told her that "you can't OD [overdose] on crystal but you can OD on fentanyl." The belief that overdose is not possible while using crystal methamphetamine is simply untrue. Prior to the saturation of fentanyl within the drug supply, Fairbairn et al. (2008) found crystal methamphetamine was the drug most commonly associated with overdose. Although Rachel asserted that she uses safely, she was quick to point out how fentanyl is increasingly being found in the drugs she and her friends buy. Despite the unsafe supply, participants in this research project were confident that they could use safely; notably no woman interviewed used exclusively at the SCS.

Although all participants disclosed that they use outside of the SCS, many noted that they feel safer at the site due to the presence of others to aid in the case of an overdose. Bettie told me she always uses the same amount of drugs whether using alone or not but that because of an inconsistent supply she cannot be sure how much she is actually getting,

> Even the pros can still go down, that's what I learned when I overdosed. Nothing had changed, I didn't increase my amount. But it's just, that's the thing with man-made drugs, you don't know. And that's the scary part, that's the scary thing 'cause you don't know. Yeah, that was scary and that's what made me stop.

Bettie overdosed while using fentanyl and described the experience as terrifying, especially because it required four doses of Narcan to revive her. Following Bettie's overdose, she informed her doctor that she was worried it would happen again but could not stop using because of her need for "pain control, pain management" resulting from her chronic pain (Volkow & McLellan, 2016). Bettie received a prescription for Dilaudid 8s – hydromorphone, an opioid used to treat chronic pain – and explained,

> Three years ago, what I was shooting in my arms, to what I'm shooting in my arms today, everything is the exact same, except one is legal and one is not. But the routine is the same, everything is still the same.

While Bettie explained that she can use her prescription with the same routine as she used illicit substances, her life has completely changed because she now has access to a clean and consistent drug supply. Previously homeless, Bettie is now housed and has been working on repairing her relationship with her children. She also explained that since obtaining her prescription she has been able to take better care of herself and feels more stable.

In lieu of a widespread legal supply, individual prescriptions are occasionally made available to individuals who can demonstrate chronic pain or acute substance use disorder. Several physicians in Ontario and British Columbia prescribe hydromorphone tablets to

individuals at high risk of overdosing, as was the case for Bettie (Browne, 2019). Prescriptions of safe supply for 'risk mitigation' increased to ameliorate COVID-19 related harms (Glegg et al., 2022). The rapid, albeit disproportionate, implementation of safer use programs throughout the provinces demonstrates the feasibility of providing low-barrier safe supply (Ivsins et al., 2020). While some may question whether prescribing opioids is the proper solution to the opioid crisis, especially given that the origin of the opioid crisis began with the over-prescription of opioids, the devastating rise in overdose deaths is currently a result of the unregulated and hazardous supply (Tyndall, 2018; 2020). Illicit market supply in congruence with pandemic related worldwide supply-route delays has created an increasingly volatile and potent drug market and supply (Ivsins et al., 2020).

Bettie and Olive are the only two participants who had an opioid prescription to aid with their illicit substance use. Both women asserted that having a prescription has allowed them to improve their wellness by enabling them to avoid withdrawal symptoms, have better physical health, and eliminate many of the harms associated with illicit substance use, such as a potentially lethal dose (Tyndall, 2018) and risk of violence to access drugs (Ivsins et al., 2020). Prescriptions provided both women increased confidence that they would not overdose, yet both conveyed that risks are omnipresent while using substances. Notably, having a prescription did not change either's use of the SCS. Bettie expressed that similarly as prior to obtaining her prescription, she sometimes uses at the site and sometimes uses elsewhere. While Olive has never been to a SCS, she nonetheless repeatedly expressed appreciation for their existence.

Olive explained the struggle of withdrawal she used to experience from opioids, "you're almost dead if you don't have it" adding that "I can't even go see my son or grandchildren if I don't have anything." Olive credits her prescription with allowing her to have an improved

relationship with her children and grandchildren. Olive described how her prescription is crucial given that finding prescription drugs on the street has become increasingly difficult as fentanyl has taken over the market. She was fearful that due to a lack of available illicit prescriptions she would end up trying fentanyl. Olive's fear is precisely what happened to Cassie. Cassie, who disclosed that she uses alone despite warnings of the risk of doing so, explained that because she was unable to purchase prescriptions, and with the saturation of fentanyl within the drug market, she decided to try it. Cassie calls this decision her "stupidest mistake ever." Many of the women I interviewed expressed that they do not want to use fentanyl but lack alternatives.

This section has illuminated the intersectional structural adversities that poor and marginalized women who use illicit substances repeatedly encounter that negatively impact their lives (Link & Phelan, 2014). The struggles they face are intimately connected to their personal relationships. In the next section I examine the influence of relationships on women's wellbeing and their drug use.

5.3 Relationships

Gender informed policies commonly draw on relational theory, which posits that the "primary motivation for women throughout their life is the establishment of a strong sense of connection with others" (Covington & Bloom, 2006, p.16). Positive relationships of all kinds are influential to women's wellbeing as they contribute to a sense of community, support, and connection. Poor and marginalized women who use illicit substances are among the most marginalized groups in society and accordingly experience multiple forms of exclusion and limited social support (Neale & Brown, 2016).

Claire, a 36-year-old who has been using drugs for 10 years and has just recently secured an apartment after years of homelessness, finds respite from discrimination and loneliness by accessing the SCS. She described SCSs as providing her the benefit of, "just like seeing a smiling face…it's kinda lonely out there. Right? So yeah, it's just good for human interaction you know. Cause you're alone a lot of the time". Claire spoke of isolation and loneliness, a common finding among poor and marginalized homeless women who use substances (Neale & Brown, 2016; Oudshoorn et al., 2021; Rokach, 2005). Women who use illicit substances cite negative relationships and isolation as a source of anguish. Conversely, positive intimate relationships can provide women an amplified sense of self-esteem and confidence (Covington & Bloom, 2006).

Research participants repeatedly emphasized that positive relationships are a source of non-judgemental support in an otherwise ostracising world. This is especially true within groups of similarly stigmatized individuals (Goffman, 1963). When reinforcing her feelings of safety and the safety of her drug supply, Kaileigh explained that she feels protected by her fellow drug users and because, "they're family, you know what I mean? When I say community, I mean community." In addition to providing solace from loneliness, positive relationships act as a support system (Oudshoorn et al., 2021). Within these groups it is common for individuals to trust and support each other (Neale & Brown, 2016). For Kaileigh this translates into having people she trusts watching out for her wellbeing by being there to talk, but also to warn her about "bad dope." Kolla and Strike (2020) found that people who use drugs are likely to consider buying from a trusted source as a form of harm reduction that reduces their chance of overdose.

Relationships are incredibly valuable to women and can provide numerous benefits including a sense of safety. The most influential relationships that participants described were

those with intimate partners and children. When these relationships are positive, they can provide women with a sense of self-worth (Kilty & Dej, 2012; Stevenson & Neale, 2012).

5.3.1 Romantic Partners

Intimate partner relationships provide both benefits and additional struggles to women who use illicit substances. Among the participants, five were currently in a relationship, and an additional three referred to past abusive relationships; two identified as bi-sexual, however all romantic relationships discussed were heterosexual, and all but two relationships were with men who also use drugs. The relationships ranged from incredibly positive and supportive to extremely abusive. In this section I examine how relationships can both positively and negatively impact the wellbeing of women who use illicit substances.

The support, closeness, and acceptance provided within intimate relationships can have a positive impact on wellbeing and reduce levels of stress, especially among people who face severe disadvantage and adversity (Stevenson & Neale, 2012). Abby, who was staying in a homeless shelter following her husband's recent overdose death, jokingly informed me he was "such a cry baby" while suffering through "dope sickness," saying she would frequently inform him "you make me stronger, `cause at least I'm not that bad." While it is likely that Abby had to take on additional responsibilities to care for her husband while they were both suffering through withdrawal, she stressed the advantages provided from her relationship with her husband. Opioid withdrawal symptoms vary, but often include severe pain, and in extreme instances can even result in death (Kosten & Baxter, 2019). Abby maintained that withdrawal can be made a little easier when experienced with someone who understands the struggles. Loving intimate partner relationships can render obstacles a little easier to manage as having someone to go through

struggles with can make them seem less daunting (Simmons & Singer, 2006). While having a partner who also uses illicit substances would seem like an additional burden, Abby was clear that her relationship with her husband helped her with things she considered essential, such as a caring connection with someone who genuinely accepted her for who she is.

Following her husband's death, Abby's grief led her to transition from smoking to injecting fentanyl,

> After my husband passed away, I started injecting fentanyl and I remember one day I was sitting there and I was like, it hit me, he would kill me if he knew what I was doing. So, I've taken a step back from that and I still, I still do it a little bit, but not anywhere near as much as I was. And I'm trying to get off of doing that, fentanyl all together.

Abby uses her memories of her husband's desire to keep her safe to strengthen her resolve to stop using fentanyl. Relationships between drug-using couples share many of the same aspects as relationships among non-drug-using couples, with caring for one another as a pivotal feature (Simmons & Singer, 2006). Intimate partner relationships can alleviate or worsen existing struggles, and lead to changes in one's method of consumption and the quantity of drugs used. Supportive intimate partner relationships can have a positive effect on the wellbeing of the individuals within the relationship by supporting a reduction in levels of drug consumption (Stevenson & Neale, 2012). Yet, if their partner is using, drug use will continue to be reinforced within the relationship.

Although intimate relationships can be beneficial for some women, they can also create additional struggles. Intimate partner violence (IPV) is a formidable social problem encompassing all segments of society (Balfour, 2006). Structural and systemic failures experienced by poor and marginalized women who use illicit substances requires them to develop strategies to reduce their risk of potential victimization. Thus, intimate relationships with

men are mobilized as a form of physical protection from unknown violence. Although these relationships can themselves be violent, they are often framed as providing safety from external violence (Watson, 2016). While I did not inquire about abuse in the interview guide, six participants voluntarily disclosed that they have experienced violence, four of whom mentioned that the violence they experienced was from an intimate partner, while the other two did not want to discuss it. Resko (2010) asserts that research has repeatedly demonstrated that IPV between heterosexual couples is highly related to low-income and poverty. While violence against women transcends class boundaries, poor and marginalized women who use illicit substances face unique challenges because they do not always have the necessary resources to successfully exit an abusive relationship and support themselves and their child(ren) (Montesanti & Thurston, 2015).

Multiple women described being a victim of IPV as their own fault. IPV survivors commonly have reduced levels of self-esteem as part of the emotional abuse inflicted by their abusers to keep them in the relationship and to ensure they do not report the violence to others (Reich et al., 2015). Additionally, women who are victims of IPV often blame themselves for their own victimization. Claire described the last time she used and subsequently lost consciousness with her boyfriend,

> He thought I took some of his medication, and he got upset and like, I woke up the next morning, and it looked like I had gotten hit by a fucking truck. It was insane. And the place was trashed. I had no recollection of that happening. The cops even took me to the hospital, I don't remember that, like wow. It's crazy, I can't do benzos, it's just wow. Bad, bad for me.

Benzodiazepine or "benzos" have a strong sedating effect, which explains why Claire had no recollection of the night (Bachhuber et al., 2016; Collins et al., 2020). Whether she took his medication or not, his response to the conflict was one of extreme violence. Survivors of IPV

regularly condemn and attribute their victimization to their own actions and assume responsibility for the violence (Reich et al., 2015). Koss et al. (2002) found that women who blame themselves for the violence they face report less distress than women who blame the individual enacting the violence against them. Blaming themselves for the violence they endure is a coping strategy used by many women to make the violence seem manageable and thus preventable.

Women who have experienced violence are at an increased risk of abusing prescription medication as a form of pain management (Hemsing et al., 2016), as exemplified in Bettie's story described above. Bettie said she had never used a drug in her life, but following knee surgery she was prescribed an opioid and, "realized what it was like with these pills, not having pain, what the big hoopla was about. That scared me, because I enjoyed it". In addition to treating the pain from her surgery, her prescription also treated the chronic pain she suffered due to the violent victimization she regularly experienced from her husband. Illicit substance use is common among women who have been abused (Campbell, 2002; Collins et al., 2020; Kennedy et al., 2020). Bettie did not realize how much she was suffering until she found some relief from the pain. It is not at all surprising that following years of victimization, Bettie enjoyed having her pain managed through pharmaceuticals. Bettie's doctor was aware she was a victim of IPV and therefore highly likely to know about her chronic pain, but had not provided any treatment, as evidenced by Bettie when she questioned whether she could have avoided her addiction had her pain been treated. Doctors are often incredibly hesitant to prescribe opioids because of their addictive quality that can lead to illicit-market use (Volkow & McLellan, 2016). This follows research that revealed that the majority of people experiencing opioid addiction were introduced to opioids through a prescription (Tyndall, 2018). As described in chapter three, the link between

violence and substance abuse is well established, yet more attention needs to be given to effective and safe pain management strategies for women (Hemsing et al., 2016; Volkow & McLellan, 2016).

5.3.2 Motherhood: "I Didn't Even Get a Chance"

The other relationship that participants spoke about most was with their children. Gendered expectations imply that women are caretakers and thus desire and inherently know how to be good mothers. The classification of a 'good mother' is based on white middle-class understandings of motherhood that fails to consider the structural barriers poor and marginalized women may face in raising their children (Kilty & Dej, 2012). Women who use drugs are rarely constructed as 'good mothers', given that breaking the law and transgressing gendered norms are diametrically opposed to the expectations of womenhood (Boyd, 2015; Davis, 2003). 'Good mothers' are meant to put their children's needs ahead of their own and engaging in substance use is seen as contradictory to this objective (Couvrette et al., 2016). Women who use drugs and also have custody of their children are stigmatized and viewed by others as inadequate mothers.

Many women who use illicit substances go to a great deal of effort to demonstrate that they still exemplify the tenets of good motherhood. Substance use does not inherently equate with poor parenting yet for women who use illicit substances maintaining custody of their children is difficult (Taplin & Mattick, 2015). As Susan highlights, "every single one of the girls that I know [at the SCS], they don't have custody of their children, they have children, but they don't have them'. Bettie echoes this reality, "we all have young children, but don't have young children. They're with other people. Responsible people, I guess is how society deems it". When Bettie says that the children are with "responsible people" she questions the societal belief that

women who use illicit substances are inherently irresponsible and unable to fulfill their parental responsibilities. The betrayal felt by women following the loss of custody of their children results in increased levels of depression, anxiety, and suicidal idealization (Janzen & Melrose, 2017; Nixon et al., 2013). Whether custody was voluntarily relinquished or compulsory removed, many mothers experience long lasting grief that often exacerbates illicit substance use (Askren & Bloom, 1999). Although substance use does not inevitably remove someone's ability to properly care for their children, mothers who use illicit substances are positioned as engaging in a "direct form of child maltreatment" (Boyd, 2015, p.10).

Of the women I interviewed, eight mentioned that they were mothers. Two women did not express any custody concerns, however they both explained that their children are grown and they did not use drugs when their children were in their care. Susan, who began using drugs following her move to Vancouver, expressed gratitude that, "I didn't even drink until my son was 16 years old…So, fortunately I was very lucky; I was able to raise him before it became, you know, a fall down or whatever". Susan refers to herself as lucky because her drug use did not interfere with her ability to raise her son in a way that she believes a 'good mother' should. Susan also mentioned that her son is now a doctor adding, "I did something right." Susan indicates she does not believe she could have given her son the attention he deserved if she was using drugs. When Susan refers to her drug use as a "fall down" it is clear that her perception of her self-identity has suffered. Similarly, Olive expressed that she stopped using drugs while raising her children:

> I've been using [drugs] all my life … But I wasn't using while I had my pregnancy or have the kids. Just like I'm saying, basically I started using at a young age, it's always been a part of my life. But the kids, after they got to an age and I just sorta fell back into it. It was like a pattern; I just fell back into it.

The responsibilities of motherhood can motivate women to reduce their drug use or stop it all together (Boyd, 1999). Olive revealed that she began using drugs again once her children had grown, but also expressed that it is very important to her that she is drug free around her children and grandson, "because I like to just enjoy them." Both Susan and Olive described themselves as grateful for being able to raise their children while they were not using illicit substances. Mothers who use illicit substances commonly use the 'good mother' narrative and implement strategies to diminish negative consequences for their children (Couvrette et al., 2016). These approaches include but are not limited to: only using while their children are not around, only using while another adult who is abstaining is present, using a limited amount while with their children, or abstaining from drug use altogether. While Olive was able to discontinue her drug use while raising her children, this is not a realistic option for everyone.

Mothers who do not stop using drugs often still embrace the 'good mother' narrative and do not want their children to be negatively affected by their drug use. Alex demonstrates her desire to keep her children away from the struggles related to illicit substance use, "I would not want to use around my kids…Well that's why I gave my kids up, right…'Cause I don't want to use around them. It's not fair to them". Alex, like many other women who use illicit substances, attempted to shield her children from her drug use (Taplin & Mattick, 2015). Alex made the decision she felt was best for her children and entrusted her mother with custody of her children. Following the above passage Alex requested we stop talking about her children and told me that talking about them was making her anxious. Alex's response demonstrates the weight of her sacrifice for what she views as the best option for her children. Women who sacrifice custody for the benefit of their children commonly position their decision as an act of motherhood (Boyd,

2015). While these mothers view the decision to put their children's needs before their own as altruistic, this decision is often depicted by others as selfish (Kilty & Dej, 2012).

While Alex alluded to the personal struggles she experiences due to the loss of her children, the other mothers who discussed losing custody of their children directly linked their lack of connection with their children with their declining wellbeing. Jessica described how her "mental state is a constant battle, and deteriorating slowly," saying she never used to think she'd consider suicide because,

> I thought life was just too precious…But with this, addiction and losing everything I love. My son…I had my son his whole life, he's 10. I lost him [two years ago] and I haven't been the same since, and I wake up every day and I don't really want to be here. I hate to say that, but uh yeah there's times where I wake up and I kinda wish I didn't.

Jessica explains that she lost custody of her son while she was incarcerated for attempting to cash a faulty cheque and how much the loss has changed her. She used to believe that there was no obstacle she could not overcome, but without her son she contemplates suicide. Women who have had a child apprehended are 1.5 times more likely to experience an overdose than women who have not had a child apprehended (Nixon et al., 2013). The grief mothers who have lost custody of their children suffer can result in intensifying drug use, suicide attempts, and/or overdose (Thumath et al., 2020). Both of the mothers who talked in detail about losing custody of their children also revealed they often had suicidal thoughts.

Like Jessica, Claire connects her depression and anxiety along with feeling lonely and isolated with the loss of her son, yet refers to herself as "lucky" since, "my boyfriend's parents took him. Because they wanted to do Crown ward, no access. Which I probably would have killed myself if that happened". Although Claire counts herself among the fortunate ones whose children are still in her life, she admits:

> I feel guilty, yeah. I don't even like really consider myself a mom to be honest with you. Cause, like I had him the first time I went to jail, and I didn't even get a chance to bring him home, like they took him away right away, so. I didn't even like consider myself a mother. Yeah, it sucks. Yeah, I hate myself for it. I just don't want him to be mad at me when he grows up, you know. Thinking that I did it on purpose or something. You know, that I bailed on him…I feel like a piece of shit pretty much. And I see like some other people on the street who do have their kids and it's just like wow, I didn't think I was that bad of a person. It's not like I took him home and neglected him, and then they took him away. I didn't even get the chance to show them my parenting skills or anything like that, you know.

Claire explains the grief that accompanies the loss of the mother-child relationship and expresses how significantly her wellbeing has been negatively impacted, a common finding among women who have lost custody of their children (Janzen & Melrose, 2017; Nixon et al., 2013). Claire exhibits a loss of her mother identity when she says "I don't even like really consider myself a mom." It is clear that Claire is suffering from the loss of her child and the loss of her mother-identity; nevertheless, her focus remains on how her child will view their relationship when he is old enough to understand her absence. Her biggest fear is that he will be mad at her and think she willingly relinquished custody.

Claire, like many other women who have lost custody of their children, is critical of other substance-using mothers who still have custody of their children, perceiving them as neglecting their children's needs (Couvrette et al., 2016). This reaction is reminiscent of Goffman's (1963) "deviators", members of a stigmatized group who fail to adhere to group norms and are consequently further stigmatized by those within the original stigmatized group (p. 141). Claire views these mothers as 'deviators' to the 'good mother' identity, and simultaneously stigmatizes substance using mothers who have custody, while also questioning her own mothering abilities and personal identity when she says, "I didn't think I was that bad of a person."

These excerpts demonstrate the anguish women experience when they lose custody of their children. Regardless of the way in which mothers lost custody of their children, it is clear that it can have detrimental effects on women's wellbeing and exacerbate drug use. Women are socialized to highly value personal relationships and fear the loss of these connections (Steffensmeier & Allan, 1996). Where safe, an ongoing relationship between mothers and their children is crucial. Women living in poverty are less likely to be reunified with their children than people who do not struggle to meet their and their children's needs, not because they are bad or neglectful parents but because of their poverty (Esposito et al., 2017). The feminization of poverty and violence against women are highly correlated with the loss of custody and therefore it is vital to address these structural issues.

5.4 Conclusion

Poor and marginalized women who use illicit substances confront complex and intersectional hardships. Participants in this research expressed how their membership in a marginalized group led to unremitting experiences of stigma and how their inability to obtain formal employment or adequate income was a significant barrier to their wellbeing and led to their engagement in risky behaviours to generate income, such as survival sex work, that further perpetuates women's oppression and victimization (Chesney-Lind, 1989). Illicit substances continue to be criminalized despite evidence demonstrating that a safe supply would remove many of the problems associated with illicit substance use including overdose and withdrawal, which often results in riskier drug use (Ivsins et al., 2020). A nationally available safe supply is desperately needed to prevent the rising number of overdose deaths. This argument is in keeping with previous research demonstrating that providing individuals with a clean and legal supply of

drugs removes the obstacles caused by criminalization and allows for improved life outcomes (Tyndall, 2018).

The women in this study repeatedly demonstrated that relationships with their partner and children are influential in their overall wellbeing. Positive intimate partner relationships provide support and can ease struggles associated with poverty and stigmatization, while abusive relationships often lead to increased drug usage. Mothers who use illicit substances face intense scrutiny and are positioned as always and already unfit to parent (Boyd, 2015). Women who no longer had custody of their children connected this loss with their diminished wellbeing; in some cases, women willingly relinquish custody because they do not want their children to be adversely affected by their drug use, and when they are forcibly removed due to a belief that substance using women cannot properly care for children (Couvrette et al., 2016). For many mothers who do not have custody of their children, their self-esteem and identity are negatively affected (Kilty & Dej, 2012).

The discrimination women who use drugs illicitly experience, caused by interpersonal and structural stigma stemming from using criminalized drugs, has a negative effect on their overall wellbeing. These interconnected and overlapping circumstances of violence, poverty, stigma, and addiction are well established and shown to drastically reduce physical and mental health (Krüsi et al., 2016; Link and Phelan, 2001; Vahid et al., 2019). Stigmatizing assumptions that are embedded within social discourses about women who use drugs illicitly do not capture this interconnected labyrinth of structural struggles. It is necessary to understand the structural hurtles faced by poor and marginalized women who use illicit substances to fully comprehend how SCSs address women's unique needs.

Chapter Six: Regulating Poor and Marginalized Women's Drug Use within SCSs

6.1 Introduction

As discussed in chapter three, gender-neutral policies and practices are most often male-oriented, thus overlooking the unique gendered needs of women. For this reason, understanding the gendered needs of women is crucial in developing SCSs that meet the needs of everyone who accesses the sites. Research shows that marginalized women who use illicit substances face unique challenges accessing SCSs (see Boyd et al., 2020; Kennnedy et al., 2021; Resko, 2010; Thumath et al., 2020). It is imperative that SCSs, which are spaces designed to reduce drug-related harms, address the multiple harms experienced by women. As the number of SCSs within Canada grows and the opioid crisis persists, it is vital to ensure these spaces address the needs of all who access them, including individuals most vulnerable to harms.

In this chapter I explore the gendered experiences of using SCSs and uncover policies and practices that do not account for women's unique context and needs, with the potential effect of undermining harm reduction efforts. I first analyze how the rules and regulations within SCSs impact women's illicit substance use through 'gender neutral' policies that are not favourable for women (Boyd et al., 2018). I focus on the harms exacerbated by prohibiting assisted injections, excluding inhalation, and through the daily operational management of the site. I next explore how the interactions with staff and other people who access the space can influence the harm reduction potential of the site. It is important to examine the relationships and interactions experienced by the diverse groups of people who frequent SCSs as adverse relations may limit the site's appeal for women.

6.2 Operational policies within SCSs and their effect on accessibility

In this section I discuss how, despite the intention to make SCSs spaces of inclusion for people who use drugs, the rules that govern their operation leads to the exclusion of some women who use drugs. I analyze three policies that disproportionately negatively impact women who use illicit substances: the prohibition of assisted injections within SCSs; the omission of inhalation; and the operational management of the sites.

6.2.1 Injection Assistance

Injection is the riskiest method of drug consumption (Speed et al., 2020). It is even riskier to rely on another individual to inject and increases the risk of sharing syringes, infection and abscesses, overdose, and violence (McNeil et al., 2015). Notably, women are over-represented among people who require assistance injecting (Collins et al., 2020; Wood et al., 2003). There are two main reasons women commonly require assistance. First, women tend to have smaller surface veins resulting in poor vein access that makes injection difficult (Collins et al., 2020; Evans et al., 2003). Second, women are typically initiated into drug use by a male partner who subsequently controls resources and forbids women from injecting themselves or getting help from anyone else under the threat of violence (Epele, 2002; Kennedy et al., 2020; McNeil et al., 2014). These factors lead women to be dependent on men for injections (Fairbairn et al., 2010). The restriction on assisted injections within SCSs negatively impacts poor and marginalized women who wish to consume substances in a supervised location (Bardwell et al., 2021).

Since conducting my interviews, the federal government has lifted the ban on peer injections. One month after I conducted interviews, on March 1, 2020 the federal government

revised the guidelines to allow SCSs to apply for exemptions to accommodate peer-to-peer injections (Kennedy et al., 2020). Although peer injections have received federal approval, they are not permitted within all SCSs across the country. As the time of writing, 28 of 39 SCSs in Canada, and 19 of 24 which are located in Ontario, allow peer-to-peer injections (Government of Canada, 2022b).

All but one participant in this research project cited injection as the only or one of a few ways they consume substances. Abby and Claire expressed that they have never let another person inject them. While Cassie and Kaileigh required assistance when learning how to inject, they expressed that it was important to them that they be in control of their injections. Cassie informed me that the person who taught her how to inject instilled in her the importance of self-injection,

> They pretty much schooled me before they even tried injecting me…literally the person, I went to their place every other day for like a week straight they schooled me on how to use it or you know like practicing using a needle with a cup of water and also told me 'Never, never do a shot that you didn't make, and if you aren't making it, watch the person that makes it for you.' The person you know just schooled me pretty much and maybe like the first or second time I needed their help but I practiced.

All four women expressed that they only trust themselves and want to avoid the dangers associated with assisted injections. People who require assistance with their injection are almost twice as likely to contract HIV and Hepatitis C than people who can self-inject because they are using used needles (Fairbairn et al., 2010). Additionally, individuals who depend on someone else for their injection experience elevated rates of injection-related infections (including abscesses), syringe-sharing, vein damage, violence, and overdose (McNeil et al., 2014; Pijl et al., 2021). These four women expressed that while they were not willing to accept the risks associated with assisted injections, and regardless of the prohibition on assisted injections within

SCSs, they help inject others. They added that anyone who requires assistance will find someone to help them, be it against the rules at the SCS or elsewhere.

All other participants (9/14) who inject indicated that they know how to inject themselves but have varying degrees of difficulty doing so. The struggle to inject themselves is amplified when they are in withdrawal, grieving, or when their veins have collapsed (Pijl et al., 2021). These nine women communicated their aggravation and dissatisfaction that when they require assistance, they are unable to legitimately obtain it within SCSs. Kathryn, a 27-year-old woman who is homeless and has been using drugs for three years, mentions that for the most part she can inject herself, but notes that when she is in withdrawal she requires assistance, "if I'm dope sick, and I'm really shaky and I can't do it myself, then I'll get somebody else to do it for me. But most of the time I do it myself." Kathryn, along with many other women, requires assistance with her injection especially while she is in withdrawal. Withdrawal limits one's ability to function, elicits agitation, insomnia, shakiness, diarrhea, nausea, and in extreme cases can result in death (Kosten & Baxter, 2019). Therefore, it is of no surprise that people who are in withdrawal may need assistance with their injection.

Peers will commonly provide assisted injections for individuals who require help. While the federal government has only recently lifted the ban on peer injections, the prohibition did not previously deter individuals from providing assistance (Boyd et al., 2018; McNeil et al., 2014). Bettie used to be a peer worker at the unsanctioned peer-run overdose prevention site and admitted that she would provide injections to people who needed them. Bettie informed me at the time of the interview – when assisted injections were not legally permitted –she frequently provided injections for individuals who required assistance within the sanctioned SCS. She added that one woman would pay for Bettie's cab to and from the SCS so that she could benefit

from Bettie giving her an assisted injection outside of the site. This demonstrates both that there is a desire to use at or near the SCS and that assisted injections are needed. Likewise, this example establishes that access to harm reduction is unevenly distributed among people who access SCSs as additional resources may be required to get assistance, and individuals who are unable to afford the additional costs such as cab fare are unable to use the site.

Bettie struggles to balance her desire to aid people in need and the very real risk should the individual receiving an assisted injection overdose,

> If you're gonna be one to administer, you need to be aware that there is a chance that that person is not going to survive…Umm, the impact of thinking that you have taken someone's life, I've seen it first hand, and you know it's scary… that impacted him… he went through counselling. It was scary for this guy. I said to him I said, 'you did what I would have done, any other day, because you were helping him because he couldn't help himself'.

Bettie expressed the emotional toll people have to grapple with if someone they assisted dies. In addition to the emotional toll, the individual who provided help with the injection could encounter potential legal repercussions. While there does not appear to be precedence for charging someone who provided peer assistance with injections, according to the *Criminal Code of Canada*, "Every person who administers or causes to be administered to any other person or causes any other person to take poison or any other destructive or noxious thing is guilty" (1985, s 245(1)). Should someone die as the result of an overdose following an assisted injection, it is conceivable that the person assisting with the injection could be charged with manslaughter. I was unable to locate any research on the repercussions should the individual receiving an assisted injection experience a fatal overdose.

Participants in this study who obtain and/or provide assisted injections are well aware of the dangers associated with assisted injections, especially the risk of overdose. They see this risk

as unavoidable when using illicit market supply, which is only partially mitigated when using in the SCS. The reality of what it means to access, or not be able to access SCSs is disconnected from SCSs' stated objectives to "save lives and benefit communities" (Government of Canada, 2021).

Collapsed veins are a common occurrence among many people who inject drugs, resulting in pain and frustration due to an exacerbation of injection issues (Fairbairn et al., 2010; Harris & Rhodes, 2012; Kennedy et al., 2020). Alex informed me she can rarely inject herself and relies on her boyfriend to help her with her injections, but recently he has been having difficulty and is often unsuccessful due to her collapsing veins. Further, Alex describes the chronic pain she lives with due to her collapsed veins,

> I've found that my hands go numb now, like when I wake up my hands are numb, and they're sore. I'll wake up out of a dead sleep crying, `cause they're so sore, because of the veins collapsing right. I've been using for a long time. I've used my legs; I've used my stomach. See? My stomach is all bruised. See like I have too, this is both my arms, I can't, tons of scars. I have no veins left. Anywhere. And the thing is this arm is the same as this arm. And I'm having to hit my stomach. It's pretty bad, if you miss it a lot. I've got lumps in my belly now, and they aren't going away, so I don't know. I just found out that I have HIV as well.

Alex's explanation of how her body is declining from sustained drug use demonstrates the pain and health issues associated with collapsing veins. As veins collapse, injection risks intensify as people use new locations including the jugular and muscles (Ciccarone & Harris, 2015). Alex has long experienced collapsing veins causing her to inject into muscle; she worries that she will soon have no remaining options for injection.

Alex explained that particularly due to her difficulty injecting caused by her collapsed veins, she goes to the SCS in the hopes that she will get assistance from nurses and expressed

frustration that they are never able to help her with her injection. She wants medical professionals to be able to inject her as she believes they will have a better chance of success,

> The nurses can only assist you with the veins [pointing out viable veins to inject into], they can't actually help you [by providing an assisted injection]. I never found it to work. Personally. Umm, I need someone to hit [inject] me, that's my problem. Right? Because where my veins are, I can't hit them myself. You know what I mean, so yeah, they don't help with that.

Alex is exasperated that she cannot receive help from the medical professionals at the SCS because she feels this is her only realistic option. Nurses on site are able to provide education and guidance on injection, oversee peer-assisted injections, and help locate viable veins, but are not able to provide hands-on assistance (Kennedy et al., 2020; Pijl et al., 2021). In the previous chapter Alex described that her boyfriend has begun having difficulty injecting her, and thus she requires assistance from someone with medical training.

The recent federal approval of peer-to-peer injections – injections administered by another individual who also uses substances - means that people requiring an assisted injection can officially receive help within SCSs. Interestingly, in the recent federal change to allow peer assistance the directive listed women among those who are most vulnerable to harms associated with requiring assistance (Government of Canada, 2022a). As these injections are provided on a voluntary basis, it is conceivable that some individuals for any number of reasons will not have anyone agree to provide them with assistance. This requirement means that the benefits of assisted injection may be unevenly distributed. Further, the need to have someone agree to provide the injection could maintain gender violence that exists for women who may want to leave an abusive relationship, but depend on their partner for injections.

The recent federal approval of peer-to-peer injections within SCSs is a significant advancement, and will surely improve access to harm reduction for many individuals who are

unable to inject themselves, especially women (McNeil et al., 2014; Pijl et al., 2021; Small et al., 2011). While the significance of this advancement cannot be understated, a closer inspection of the policy change reveals that the federal government approved allocating the risks associated with injections on to peers instead of trained medical professionals. As Alex's story exemplifies, there are instances where peers are not able to assist and medical assistance is necessary.

Given that medical staff are already present within SCSs, and as research show that relying on someone for help with injection increases a person's susceptibility to harms including gendered violence, abscesses, and infectious diseases, allowing trained staff to assist with injections may be the best way to reduce these harms (Bourgois et al., 2004; Boyd et al., 2018). While the decision to only allow peers to inject is arguably due to the illegality of handling illicit substances, exemptions under section 56.1 of the *Controlled Drugs and Substances Act* already exist to sanction SCSs (Government of Canada, 2022a). Thus, it is conceivable that another exemption could be made to offer safer assisted injections at SCSs administered by trained medical professionals, or preferably, safe supply would remove the need for an exemption.

6.2.2 Excluded Forms of Consumption

SCSs allow various forms of drug use including snorting, swallowing, and injecting, but at the time of writing only two SCSs in Canada located in Saskatoon, Saskatchewan, and Toronto, Ontario allow inhalation (Government of Canada, 2022b). The provision of inhalation had been entirely prohibited within sanctioned SCSs in Canada until 2017. In 2017, North America's first safe inhalation site opened in Lethbridge, Alberta. The organization, ARCHES received approval from Health Canada to permit inhalation but unfortunately closed in September 2020, due to false allegations of misuse of funds (Dryden, 2021; Kamran & Fleming,

2020). At the time, the approval allowed for inhalation in its own room with separate ventilation systems and advocates hoped it created the precedence for future inhalation sites (Bourque et al., 2019). Although smoking has fewer health risk factors than injection, inhalation is not without risk (Bardwell et al., 2021). The toxic illicit-market supply of drugs means that regardless of the form of consumption there is risk of overdosing (Tyndall, 2018). Further, women who inhale drugs are still at risk of predatory and intimate partner violence; as Boyd et al. (2018) found, women who use drugs overwhelmingly cite their safety from violence as a primary reason for accessing SCSs.

Injection and inhalation were the primary drug consumption methods among participants in this study. McNeil et al. (2015) found that people who smoke want to have access to a supervised location to use drugs. My research corroborates this finding. Kaileigh, who primarily injects drugs, questions whether the lack of options provided to smokers results in more people injecting, and highlights how safer supplies fails to mitigate the risk of an illicit-market drug,

> A lot of people smoke. They don't know where to go right? It makes sense, I guess. I guess it's not fair. They're like 'What, I don't use needles so I can't safely use my drugs as well?' I wonder if that would push people to use needles. 'Here, we'll give you tinfoil and a tube but good luck'.

Kaileigh speaks to the gap in service provision for people who inhale substances. She finds it unreasonable that people who inject are provided a safe space, yet individuals who inhale are merely provided clean supplies and sent away, which does nothing to combat the health risks associated with overdose (Bardwell et al., 2021; Small et al., 2011). The federal government has turned down many proposals to accommodate safer smoking options within SCSs, irrespective of Lethbridge's safe inhalation site demonstrating the feasibility of extending harm reduction to individuals who inhale their substances (McNeil et al., 2015). Partial harm reduction efforts such

as providing supplies, while restricting access to a safe location to use, fails to address overdose risks (Pauly et al., 2018). While Kaileigh wonders whether the absence of a safe space for people who inhale substances leads to an increase in the number of people injecting, Kerr et al. (2007; 2017) has not found the presence of SCSs to be linked to an increase in the number of people who inject. However, amongst individuals who both inhale and inject substances, limited access to safer smoking environments may encourage injection despite a preference for inhalation (Pijl et al., 2021). Kaileigh ultimately recognizes the discrepancy in harm reduction efforts for people who inhale substances, which results in further exclusion among people who use illicit substances.

Jessica, the only participant who exclusively smokes her drugs, expressed irritation that she was excluded from the harm reduction services offered to people who consume substances in methods permitted within SCSs, saying,

> It's the same thing. We're ducking in and out of alleyways and like, you know, putting ourselves at risk to take a puff, and [people who inject substances] are allowed to go in and inject, and I've always not found that fair.

Jessica was frustrated from being left out of harm reduction supports, claiming that "it's the same thing" while referring to her risk of overdose from inhalation. Failing to provide a safe space for people who inhale substances leaves them susceptible to intersecting forms of violence (McNeil et al., 2015; Boyd et al., 2018). Strategies such as concealing drug use by smoking in alleyways and public washrooms, implemented by poor and marginalized women to limit their exposure to stigma and criminalization, may actually function to increase their vulnerability to theft, violence, and overdose (Bardwell et al., 2021; Collins et al., 2020; McNeil et al., 2014). Research repeatedly shows that SCSs at least temporarily shield individuals who use illicit substances from structural, symbolic, and gendered violence (Boyd et al., 2018; Fairbairn et al.,

2008; McNeil et al., 2014). As demonstrated above, the risk of overdosing and being victimized is present regardless of the form of consumption, but people who inhale substances are left out of harm reduction benefits provided by SCSs.

Jessica's desire to access harm reduction services and have the peace of mind that someone is around to intervene if she overdoses has led her to smoking inside the SCS. She admitted that this puts other people at risk and is apologetic but asserted her need for safety as well,

> I've used drugs in the washroom. Which you're not supposed to use in the washroom. But uh. Yeah, I've used in the washroom and I've actually sat there not giving a shit and smoked right in the middle of the hallway that's there, which obviously is dangerous. So, I try to kinda keep to myself but in the same aspect let someone know I'm doing it.

Jessica is desperate for a safe space to use where she knows she will receive medical assistance should she overdose. It is common for poor and marginalized people who use illicit substances to use within washrooms of organizations that provide harm reduction as a safer alternative to using outside when they are not provided a medically supervised location to use (McNeil et al., 2015; TOSCA, 2012). Jessica is well aware of the opioid epidemic and knows that unsafe supply has contributed to many people's death, leading her to pursue a supervised environment where one has been officially denied to her.

6.2.3 Regulations of Site Operation as Barriers to Access

The women who participated in my study made it clear that they want to use at the SCS and noted that they appreciate having a space "where if you use drugs, you're not gonna die necessarily" (Cassie). All 14 participants spoke positively about having a SCS in their city, however, no one used drugs exclusively at the site. Within this section I examine the operational

regulations of the SCS, including the hours of operation, capacity limits and subsequent wait times which the participants of this study claimed impeded their access to the site. [4]

6.3.1 Operating Hours

An important factor in determining the accessibility of SCSs is the hours of operation and the consistency of these hours. The hours of operation were the most common grievance participants had about the SCS. A majority of participants (12/14) mentioned they wished the SCS had longer hours, with Kaileigh noting "we're drug addicts all the time." Participants informed me that when the SCS in their city first opened the hours frequently changed and it was incredibly frustrating because they never knew if it would be open. Multiple women told me what the hours at the SCS used to be; notably none of their responses were consistent. Additionally, I searched the hours of the SCS throughout the duration of this project and noticed changes in the operating hours. This indicates that the hours repeatedly change leading individuals accessing the SCS to be unaware of when they could use the service.

When the SCS is closed it means individuals use in alternate locations, including public washrooms and alleyways (Bardwell et al., 2020; McNeil et al., 2014). Susan disclosed that she will use at home if the SCS is closed, but that she prefers using in a location where she can get help, "if I'm doing it [using drugs] at home it's usually because the [SCS] is closed, because I will go there first, because they have nurses that can help me". Susan, along with nine other participants expressed that they prefer to use at the SCS over any other location and wished the

[4] It is important to note that this research was conducted prior to the onset of the global COVID-19 pandemic, and therefore will not explore how well-intentioned policies put in place to curb COVID-19 from spreading may have exacerbated issues already existing within SCSs.

SCS was open 24/7. Conversely, two women mentioned that they do not think the SCS needs to be open 24/7; however, they would like the site to have extended hours.

Kaileigh revealed that she and her friends want constant access,

> There's been a lot of talk of 'why isn't it a 24-hour service'. I think that makes sense right, I mean, I know it doesn't matter what time of the day it is I'm probably using. People are using all the time there. It doesn't matter what time it is.

Kaileigh articulates the need for SCSs to be open 24/7. One of the main objectives of SCSs is to allow people who use drugs to do so in a way that reduces their risk of harm (Bardwell et al., 2020; Kerr et al., 2017). If the SCS is not open when people need it, the harm reduction potential of the site is minimized.

SCSs have proven effective in preventing overdose deaths (Kerr et al., 2017), and participants appreciated that they had access to the life-saving interventions provided by staff but this benefit can only be realized while the site is in operation. Participants who partook in this research project were disheartened at the obvious disconnect between the operating hours and the hours they use substances. The efficacy of SCSs could be improved by increasing the hours of operation to better align with the needs of individuals who access the site, and to keep consistent and dependable hours.

6.3.2 Wait Times

As demonstrated in the previous section, the ability of SCSs to provide effective harm reduction is influenced by its accessibility, and the ease in which individuals can use the site. Long wait times make it difficult for the SCS to meet people's needs and increases the likelihood that people will use just outside the SCS (Kerr et al., 2017; McNeil et al., 2015). When individuals use outside of the SCS, it conceivably demonstrates that they want to use somewhere

safe, where they can receive lifesaving medical attention if they overdose, but that the wait to get inside is simply too long. When people arrive at a SCS they typically want to use as soon as possible (Small et al., 2011). The majority of participants in this research expressed frustration that the capacity of the SCS was so limited – there are only three seats – and mentioned that there is almost always a line to get into the site.

Three participants – Jessica, Kathryn, and Melissa – explained that for them wait times are not an issue. Kathryn was the only participant who expressed she has never had to wait. Kathryn's experience with not having to wait was unique, and may be indicative of her knowing and avoiding the busiest hours at the SCS. Even Melissa, who found the services generally worked for her, explained that she sometimes has to wait. Remarking, "wait times range from quick to 30 minutes. More often it is quick." Melissa, however, did not use the SCS very often.

The much more common experience was long wait times. Participants talked of the high demand to use at the SCS and were critical that the sole SCS in the city can only accommodate three people at a time. Alex explains how she always has to wait to access the SCS due to the limited capacity,

> It's bullshit there. It takes people 45 minutes to an hour, and there's a huge line up there. That's why I stopped going there. I was like screw this shit. Every time. Every time when I went, I've had to wait. Every time. I've never gotten in there fast.

Although it is clear that Alex wants to use at the SCS, she sees the wait as prohibitive. When wait times to access the SCS are long, people do not see the SCS as a viable option. Kaileigh reiterates the drawback of long waits,

> Wait times are ridiculous. That's why I end up just using outside. Half the people leave all the time right. Like, 'Oh, are you kidding me, ten minutes, fuck that.' They're sweating profusely.

Kaileigh's narrative reveals one significant reason individuals may choose to use outside of the site rather than waiting – withdrawal (Kerr et al., 2017; Small et al., 2011). The agony of withdrawal can make lengthy wait times unbearable, and result in people opting to use elsewhere (Pijl et al., 2021; Urbanik & Greene, 2021). Long and unpredictable wait times at the SCS may hinder an individual's ability to meet other obligations, including accessing time sensitive services such as meal programs or shelters that require checking-in in time to obtain a bed. For individuals who depend on these services waiting to use at the SCS may result in the loss of other necessities.

6.3 Interactions Among Other People at the SCS

As discussed in the previous chapter, relationships are instrumental to women's wellbeing and sense of self (Covington & Bloom, 2006). It is therefore reasonable that women's perceptions of SCSs are influenced by the social interactions and relationships they have with other people at the site. In this section I explore the complex interactions and relationships women have with non-peer staff, peer staff, and male guests who access the site, and how these dynamics influence women's use of the SCS.

6.3.1 Non-Peer Staff: A Source of Support and Frustration

People who use drugs face public discrimination and stigma due to their identity as a 'drug user' (Lloyd, 2012). As such, SCSs are intended to be safe spaces free from judgement. In addition to the ability to receive medical attention should somebody overdose, participants in this study cited the inclusive language and actions at the SCS as the best aspect of the site. When asked about their perspective on SCS staff, the majority (11/14) of participants replied with

neutrality or explained that generally staff are reasonable and respectful. The remaining three women, Abby, Rachel, and Amanda had very strong views about the staff.

For Abby, the staff at the SCS are exceptional and she considers them good friends. She credited their non-judgemental support and understanding with helping her grieve the loss of both her father and husband. Abby expressed appreciation for being able to talk about any issue she has without concern of being judged,

> It doesn't matter what you have to talk about, you can talk to them and you don't feel any kind of, nothing bad, nothing negative, nothing, you know, like they're up here and you're down here. You're just, you're a person, they're a person, and they're listening to you and they give a shit about what you're going through. There needs to be more people like that in the world.

Abby has built trusting relationships with non-judgemental SCS staff members. Trusting relationships between staff and people accessing social services are critical to sustaining engagement, improving self-esteem, and in some instances can facilitate a desire to reduce usage and/or a willingness to engage in ancillary services (Kerman et al., 2020; Oudshoorn et al., 2021; Parkes et al., 2019). Within these caring and responsive relationships Abby feels seen as a person and appreciates that she can discuss any topic without fear of being judged. Harm reduction research has repeatedly demonstrated the necessity that people accessing services are treated like human beings with dignity (Collins et al., 2015; Pauly et al., 2016; van Boekel et al., 2013). These non-judgemental relationships are critical to the wellbeing and future outcomes of people accessing harm reduction services (Neale & Stevenson, 2015; Parkes et al., 2019).

Unlike Abby, Rachel and Amanda emphasized that they experienced judgement and viewed staff as yet another obstacle to harm reduction. Negative accounts of staff interactions repeatedly stem from a disconnect between staff and the lived realities of poor and marginalized women who use illicit substances (Bardwell et al., 2018; Kennedy et al., 2019). This experience

of punitive scrutiny and discrimination by staff can result in avoiding harm reduction services (Wilson et al., 2014).

Amanda was frustrated with non-peer staff and expressed that the most marginalized individuals who access the SCS face discrimination. She remarked,

> I've had them not talk to me for like a week, just shun me completely. It's very ridiculously unprofessional. Ridiculously. They have favouritism, it's really bad. Like a couple people that you can tell are a little dirtier, they live on the streets and stuff, they treat them like shit. Like absolute shit, they get them going and will piss them off when they're going down just so they can fight with them. It's not okay. Even when it comes to concerns of our safety, they get their backs up. They don't want to be questioned. And it's always, "We can be closed soon. Guys, you're gonna get us shut down." We hear that every day.

Amanda does not believe that staff makes service users a priority. Rather, she saw an uneven power dynamic between individuals accessing the SCS and non-peer staff members, with staff members dominating the most marginalized people. This discrimination can lead people to avoiding SCSs (Bardwell et al., 2018; Collins et al., 2020; Wilson et al., 2014). At the same time, Amanda's comments of staff informing service users that problematic behaviour could lead to the SCS losing their government-issued exemption and be shut down speaks to the uncertainty of the longevity of SCSs. SCSs remain controversial and complaints from the public due to safety or public disorder concerns may jeopardize the future of sites. The SCS closures in Calgary, Lethbridge, and Edmonton demonstrate the legitimate threat to these sites (Dryden, 2021; Gibson, 2021; Pearson & Gilligan, 2021). SCSs closures would remove the benefits provided for everyone who depend on SCSs to mitigate the risk of overdose, which is rampant due to a dangerous illicit-market supply. To ensure SCSs remain operational, staff must navigate the tension between providing care and managing public perception of the SCS by being strict towards individuals whose actions endanger the future of the site.

6.3.2 Peer Workers: Someone Who Understands

Peer workers are employees who have or currently use substances, and thus are able to relate better to individuals accessing harm reduction services. Peer workers offer numerous benefits to people accessing harm reduction services, including SCSs. Although including peer workers in drug use settings is relatively recent (Greer et al., 2016), studies demonstrate that service users have an overwhelming preference for peer workers (Bardwell et al., 2019; Kennedy et al., 2019). Service users favour peer workers compared to non-peer staff because of a break down in power differentials as well as prior negative experiences with non-peer staff (Bardwell et al., 2018). Further, peer workers enhance feelings of comfort due to shared experiences, which facilitates relationship building and trust (Kennedy et al., 2019; Pauly et al., 2020). Peer workers have relevant drug knowledge and understand the complex experiences people face (Klein, 2020) and can encourage individuals who might not typically engage with harm reduction services to do so (Ashford et al., 2019; Chang et al., 2021).

There was an overwhelming desire among participants for workers who could better relate to the daily struggles they experience. Many participants felt the SCS could be improved by employing additional peer staff. At the time of interviews, there were two peer workers employed at the SCS, which meant that there was not always a peer worker available. While talking about the staff at the SCS Amanda exhaustedly exclaimed, "there's no one to relate to there. Nobody." Claire echoed Amanda's yearning for staff who understand what it means to be a poor and marginalized woman who uses illicit substances,

> It would be cool if [the SCS] had maybe an addict who was sober. Other addicts to talk to, you know, girls right. Not like, you guys [people without personal drug experience] are great too, but just people who have actually experienced it, kinda thing. You can just relate a little bit better. You learn a lot more information. You'd probably feel more comfortable opening up about certain things, right.

> Sometimes you do some shady shit and like I don't know like to a normal person you'd be like 'oh my god, I could never tell somebody like that', you know. So, if someone has lived it, you're like 'okay, I can feel a little more comfortable, you know, saying whatever.'

Claire illuminated the shortcomings within the SCS when there are not enough peer staff members. Peer workers, and as Claire specifies, women peer workers, can relate to the women accessing SCSs and simultaneously provide overdose prevention strategies and non-judgemental support (Boyd et al., 2020). When women peer workers are employed within SCSs there are positive effects for women accessing the site including promoting autonomy, self-esteem and safety (Boyd et al., 2018). Gender-specific experiences including women's relationships as partners, their role as caretakers, and pervasive exposure to stigma and violence can be best understood by women who have likewise encountered similar pressures. Women have disclosed that they are more likely to openly and accurately discuss hardships and insecurities with other women who have undergone similar events compared to men or women without those same experiences (Greenfield et al., 2013).

Women who used the services at SisterSpace – Canada's sole women's only SCS in Vancouver – unequivocally expressed an appreciation for the focus on gender, where peer workers fostered inclusivity and safety (Boyd et al., 2020). In one study just prior to the opening of SisterSpace, researchers concluded that women's involvement as peer workers and site operators was "critical to ensuring women's safety from overdose death and violence" as peers increased the desirability and thus utilization of the site (Boyd et al., 2018 p.5). Peer workers are particularly effective at developing positive relationships with service users (Bardwell et al., 2018; Pauly et al., 2020; Parkes et al., 2019). These relationships are built not only with an

understanding of drug culture and drug use, but also in relation to other concerns including family, financial, and everyday life difficulties (Chang et al., 2021).

Most participants expressed that they had no issues with staff, yet still demonstrated a preference for the overdose prevention site (OPS) – the unofficial peer run site – that existed prior to the implementation of the SCS. While participants were unable to express exactly why they preferred the OPS, they alluded to the fact that the unofficial sites did not have to follow strict rules and regulations to maintain their exemption to the *Controlled Drugs and Substances Act* the way SCSs are required. Additionally, the OPS was peer run and therefore there was likely less judgement and had fewer regulations (Pauly et al., 2020). Bettie asserted that the sites used to be purely about "saving lives" whereas now there is "red tape." While the increase in the number of SCSs across the country demonstrates a commitment to reducing the harms associated with opioid use, it has also increased the cumbersome bureaucratic and administrative requirements (Fischer et al., 2004; Pauly et al., 2020; Russel at al., 2020). While these additional governmental obligations are important for data collection and governmental funding, they have been interpreted by individuals accessing the SCS to mean that "saving lives" is no longer the only, or even the top priority. OPSs originated as a grassroots and peer run service aimed at preventing overdose deaths (Kennedy et al., 2019). While they were often temporary and constantly at risk of being shut down, they also excelled at creating spaces free from discrimination in a way that is not reflected in the sanctioned sites.

6.3.3 "What If He Snaps Today": Male Guests as Obstacles to Feeling Safe

Gender-based violence and discrimination disproportionately affects poor and marginalized women who use illicit substances (Montesanti & Thurston, 2015). SCSs have

proven effective in reducing opioid related harms; however, there is not a consensus within research on the role of SCSs in reducing women's experiences to gender-based violence (Boyd et al., 2018, 2020; Harris et al., 2021; Kennedy et al., 2021; Oudshoorn et al., 2021). Boyd et al. (2018; 2020) found that women primarily cite their use of SCSs as a means to avoid gender-based violence, which speaks to the severity of violence in the lives of women who use illicit substances, as even while the risk of overdose is high, they perceive violence as an even greater threat. Yet, SCSs can reproduce socio-structural violence and unequal power relations that disproportionately impact women, potentially jeopardizing women's access to these life-saving spaces (Bardwell et al., 2021; Collins et al., 2020; Harris et al., 2021).

Ten women discussed instances of gender-based violence perpetrated against themselves and/or other women, both within the community and at the SCS. Participants repeatedly described how they are uncomfortable using drugs around men, and how this discomfort can result in them avoiding the SCS. Tiffany clarified that she typically does not access the SCS as she is apprehensive about using drugs around men she does not know, stating, "I just don't trust them." Similar to Tiffany, Rachel disclosed that she dislikes the atmosphere of the SCS and tries to avoid the site due to potential conflicts that may occur. Susan agreed, noting, "Men become, can become, very aggressive. And its, its those guys that make it tough for ya. Because of the men. They're just, they're thinking that they're superior to us". Women tend to avoid areas they perceive to be dangerous and locations where they have previously experienced violence (Bardwell et al., 2021; Shannon et al., 2008). Fear of violence can lead women to use alone in environments where they have a sense of relative safety, such as public washrooms (McNeil et al., 2014). Unfortunately, their perceptions may be misguided as these alternate locations are linked to an increased susceptibility to violence and overdose (Kennedy et al., 2020).

Cassie stated that she generally feels safe using around men, however she expressed concern regarding the ever-present potential to be victimized within SCSs,

> I've had some altercations with males. Mainly just guys being like perverted or derogatory towards women…There's been a few guys though that I didn't feel safe using around them, just because, like I wasn't scared they're like gonna hurt me, but like you know, what if, what if he snaps today.

Cassie emphasized that men's presence at the SCS does not impede her feeling of safety, yet they also expressed apprehension deriving from the potential actions of men accessing the SCS based on their previous victimization. This finding is consistent with research demonstrating that poor and marginalized women who use illicit substances experience disproportionately high levels of gender-based violence and harassment (Boyd et al., 2018; Harris et al., 2021; Kennedy et al., 2020; McNeil et al., 2014).

Cassie stated that she most often feels safe using around men but provided multiple instances of physical and verbal violence she experienced while under the influence of drugs. On one occasion she was verbally abused by a male guest also accessing the SCS. SCS staff subsequently banned him for a few days and took steps to ensure her safety. Cassie pointed out that while these efforts provide her with immediate safety, it does little to fix the systemic and unremitting nature of gender-based violence,

> And they [SCS staff] had asked if I felt safe leaving, even if he was out there, and they went and checked and made sure he was off property. It was nice of them to do, but I mean, at the same time like, when they're not open like what if I run into him, you know.

Cassie's story illustrates the ever-present threat of gender-based violence. SCSs staff can intervene when they witness or are made aware of instances of inappropriate behaviour. Although staff attempt to intervene and stop further harassment, they are not able to prevent violence at the SCS or once women leave the site (Fairbairn et al., 2008).

Alex disclosed that as a sex worker she feels judged and is treated offensively by the men at the site due to her occupation. She told me she is not comfortable using around men and clarified that women and men should have access to separate SCS spaces. When asked if she thought a women's only site would be used, Alex answered in the positive. Claire similarly expressed a desire for a women's only SCS,

> Yeah, I'd probably use one of those places, over a place that was co-ed, probably. Yeah. Just cause I would feel just more comfortable, and like probably be like able to open up more, to like a girl, you know what I mean. I just find like, I don't know, it seems like men always have an alternative motive, or something else. You know what I mean? So, I'd prefer just to talk to, get help, like you know from women. Yeah. yeah, so I'd definitely use one of those compared to the co-ed ones for sure.

It is evident that gender-based violence shapes the experiences of marginalized women who use illicit substances, and that these women desire a space away from having to keep their guard up (McNeil et al., 2014). The stories from participants in this research illustrate the pervasive and inescapable nature of gender-based violence in society. Multiple women expressed that the actions of other guests of the site, particularly men, make them uncomfortable and less likely to access the SCS. Research conducted on women's only SCSs in North America demonstrates that women-only spaces can help to mitigate harm (Bardwell et al., 2021; Boyd et al., 2020).

6.4 Conclusion

In this chapter I explored how the operational management of SCSs and the interactions among staff and guests influences the accessibility among women who use illicit substances. The participants in this research had positive views about SCSs, yet identified many obstacles to using the harm reduction services. Participants described deliberately ignoring the prohibition of assisted injections and inhalation at the site as these rules are incompatible with their drug use

practices. This restriction results in inequitable service provision and consequentially individuals who require assistance injecting or inhale substances remain in a precarious situation where they must either break the rules or have no safe location to use (Bardwell et al., 2021; McNeil et al., 2015). Likewise, participants were explicit that too often factors concerning time restraints, including the site being closed and long wait times negatively interfered with their ability to access the SCS.

The relationships women had with staff members and men accessing the SCS were influential in determining the site's perceived accessibility (Boyd et al., 2018, 2020; Harris et al., 2021). Trusting and compassionate relationships with staff members enhanced participants' assessment of the SCS, whereas stigmatizing interactions often led to avoidance of the site (Parkes et al., 2019; Pauly et al., 2020). The women in this research expressed a longing for women-identifying peer staff members who can relate to their experiences, a theme consistent within existing research (Boyd et al., 2018; Kennedy et al., 2019; Klein, 2020). Interactions between guests could impede the desirability of the site. Participants repeatedly cited gender-based violence as an omnipresent concern that was intensified while they or the men around them were under the influence (Harris et al., 2021). The women who partook in this research were adamant about their efforts to engage in harm reduction but found that ineffective operational policies and undesirable interactions between both staff and clients impeded their ability to access the SCS.

Chapter Seven: Conclusion

In this thesis I have methodically examined women's decisions to use or not access SCSs to determine if and how SCSs address the unique gendered needs of women who use illicit substances. The majority of research on women's use of SCSs is primarily located in Vancouver, whose social and political context regarding substance use does not mirror most other parts of the country. I addressed this gap by conducting qualitative interviews in an Ontario city with women who use illicit substances to determine how they perceive the accessibility of SCSs, if they feel their needs were being met within SCSs, and the ways SCSs could be improved to better meet their needs. In what follows, I summarize the main findings from this research project and provide recommendations of how SCSs could be altered to better meet women's needs. I will then address the limitations of this study and provide suggestions for future research.

7.1 SCSs: Lifesaving! But Do Not Align with the Realities of Drug Use

Women are an under-served population within harm reduction efforts. It is important that they be included in harm reduction research so that their unique use of SCSs can be addressed (Bardwell et al., 2021; Boyd et al., 2020). Women who use illicit substances face many systemic and socio-structural hardships that negatively impact their socio-economic status, health and wellbeing, and safety (Link & Phelan, 2001). Throughout the analysis it was evident that all participants were grateful for the presence of a SCS within their city, and were appreciative that in a time with so many overdoses they had somewhere they could go and receive life-saving intervention should they overdose.

The women interviewed conveyed the severity of not having somewhere supervised to use, and provided examples of both predatory and interpersonal violence they experienced when using elsewhere. The majority experienced SCSs as a judgement-free zone where they were treated with dignity, respect, and could avoid violence and death. Notably, not a single woman interviewed used exclusively at the SCS. They mentioned that there could be improvements to increase the accessibility of the SCS. They cited barriers caused by policies that simply did not align with the realities of drug use practices, often expressing frustration that these policies hampered their access to effective harm reduction. This is indicative of the need for policy changes that could lead to increased access to SCSs among women who use illicit substances. In what follows, I provide seven recommendations based on my analysis that would ameliorate SCSs for women and improve their access to safety.

7.2 Recommendations

Recommendation 1: Increase the Hours of Operation

One of the primary reasons why the women I interviewed used in locations other than the SCS was that it was not open during the times they used substances. SCSs have proven effective, but the harm reduction benefits generated by a SCS can only be realized while the site is open (Bardwell et al., 2020; McNeil et al., 2015). When SCSs are closed, people find alternate, less safe locations to use and as a result are more likely to experience a multitude of harms including overdose and violence (McNeil et al., 2014; Pijl et al., 2021). People use substances at all times of day and thus require access to safety through SCSs with operating hours that reflect that reality.

Recommendation 2: Permit Inhalation

Inhalation is a form of consumption with fewer health risks than injection, however, the magnitude of the opioid crisis and the toxic supply of substances means they are still susceptible to overdose and death (Bardwell et al., 2021; Tyndall, 2018). Therefore, people who inhale substances require lifesaving harm reduction services. The participants found it unfair that people who inhale their substances were excluded from SCSs and the safety that comes from using in a location with medical professionals who are trained to provide lifesaving treatment in case of an overdose. When inhalation is prohibited, people use alternative spaces and thus are omitted from the harm reduction potential of SCSs (Collins et al., 2020; McNeil et al., 2014). Although severely limited, there are SCSs in Canada that permit inhalation as an acceptable consumption method, thus demonstrating the feasibility of constructing SCSs equipped with inhalation rooms (Government of Canada, 2022b). It is also conceivable that outdoor locations, which would not require ventilation, could be added to pre-existing SCSs. Permitting inhalation at SCSs would facilitate safer use and access to medical intervention amongst people who choose to smoke substances.

Recommendation 3: Employ More Peer Workers

Women who use illicit substances face intense stigma and discrimination and peer workers are able to relate to these complex experiences (Chang et al., 2021; Oudshoorn et al., 2021). The participants who partook in this research emphasised their preference towards peer workers at the SCS, noting that shared experiences make it easier to build trusting relationships where they do not have to sensor their comments and can discuss drug culture, drug use, and everyday struggles. Individuals accessing SCSs may be more likely to utilize advice about safer

use practices from peers who understand the intricacies of substance use practices. In short, peers are more likely to create a safe space than non-peer workers. I contend that employing more peer workers within SCSs will increase women's feelings of comfort, reliability, and trust consequently improving their access and thus increasing their safety.

Recommendation 4a: Allow Peer Assistance with Injections

Participants were adamant that they or others they know sometimes require assistance with their injection, and that whether or not it was permitted by SCSs they would find this assistance, even if it required leaving the SCS. When an individual relies on another for their injection their susceptibility to violence and coercion increases, and women disproportionately require assistance with their injection (Small et al., 2011). It is safer for people to use illicit substances at a SCS due to the ample supply of unused injection equipment, the presence of trained medical professionals who can provide life-saving treatment should someone overdose, and the protective effect from violence and intimidation caused by the presence of other people accessing and working at the service. Therefore every effort should be made to ensure all SCSs meet the needs of the people who want to use them. For individuals who require assistance with injections, allowing peers to provide assistance at the SCS will improve accessibility and prevent the necessity to look elsewhere for help (Bardwell et al., 2021; Collins et al., 2020).

Recommendation 4b: Allow Medical Staff to Assist with Injections

Relying on peers for assistance with injections increases someone's risk to infection, overdose, and violence (McNeil et al., 2015). I thus contend that it is unreasonable that the federal government allocate the provision of injection assistance to peers alone (Government of

Canada, 2022b), particularly when medical staff who are trained in providing injections are onsite. It is easy to understand why medical staff would have concerns regarding injecting potentially toxic substances and thus lends credence to the need for a safe supply in addition to permitting assisted injections.

Recommendation 5: Provide Widespread and Easily Accessible Safe Supply – Without Criminalizing Low Level User-Dealers

My research adds to the literature on the need for a safe supply by demonstrating how many of the harms related to the illicit-market drug supply, most notably overdose, can be mitigated by providing a safe and reliable supply to women. A regulated supply of substances would support safer and informed decisions surrounding substance use as potency would be consistent. Unknowingly consuming extremely potent substances can result in women unexpectedly becoming unconscious increasing their risk of victimization. Findings from this project align with a bourgeoning body of research which shows that providing individuals who use illicit drugs with a safe supply drastically reduces the negative effects of illicit drug use, including a reduction in overdose and death (Browne, 2019; Ivsins et al., 2020; Olding et al., 2020; Thomson, 2017; Tyndall, 2018). Most of the harms from drug use are caused not from drugs themselves, but from the criminalization and subsequent stigmatization of people who live in poverty (Butler et al., 2022). A new approach to substances that does not rely on the criminal justice system is necessary. Correspondingly, any plan for safe supply must allow adequate quantities that align with the realities of drug use practices. Insufficient quantity limits could result in people being charged with dealing.

Recommendation 6: Implement Universal Basic Income

Given that women who use illicit substances face significant barriers to employment, universal basic income would facilitate safer access to one's basic needs. When denied formal access to employment, women who use illicit substances find informal ways to generate income., including sex work, 'copper scores,' and selling substances on behalf of a dealer. These unregulated means of generating income put women's safety at risk (DeBeck et al., 2007; Deering et al., 2011). Notably, acquiring income is the primary motivation for women engaging in criminal activity (Pollack, 2000). Universal basic income provides all inhabitants of an area with a set amount of income to be used as the individual decides. By providing universal basic income, women would have the freedom to make financial choices that meet their needs. Universal basic income would remove the necessity for women to engage in precarious work and increase their safety.

Recommendation 7: Open Women's Only SCSs

The protective association between women's use of mixed-gendered SCSs and diminished threats of gendered violence are inconclusive (Harris et al., 2021). While some women use SCSs to reduce their chance of experiencing violence due to the presence of staff and other service users, others avoid accessing services due to the potential for violence (Boyd et al., 2018; Kennedy et al., 2021; Oudshoorn et al., 2021). The presence of intoxicated men at the SCS deterred some women from using the space, while others claimed they at times felt unsafe. Women's only SCSs can provide a temporary reprieve from violence (Boyd et al., 2020; Oudshoorn et al., 2021). Providing women separate SCSs (or different times of use, or different

spaces) could help alleviate these concerns, and enable the creation of spaces that can evolve to provide harm reduction based in an understanding of gendered struggles. SisterSpace - Canada's sole women's only SCS – has proven effective in providing gendered harm reduction and should be used as a model for future sites across Canada.

7.3 Limitations

Although this study provides an in-depth analysis of women's perceptions of how SCSs are meeting their needs, there are several limitations to the research. First, my sample size was small, consisting of 14 women and thus cannot be said to be representative of all women accessing SCSs in Ontario. The small sample size allowed for in-depth data collection that aligned with the timeframe and scope of a Master's research project. While this data is limited in its generalizability qualitative research is designed to permit comprehensive and detailed accounts that accurately convey people's experiences (Charmaz, 2014).

Secondly, participants were recruited for this research from a 'Women and Harm Reduction' weekly meeting that occurs within a non-profit organization located in a mid-sized city that has one SCS. Therefore, I was recruiting participants who were actively engaged in harm reduction efforts. Thus, my findings should be used to enhance one's understandings of women who engage in harm reduction within similarly sized cities within Ontario that have a single SCS and cannot be said to be generalizable to other locations.

It is also important to note that my interviews took place prior to the COVID-19 pandemic, and accordingly are unable to address changes in accessibility due to policy changes in place to curb the spread of COVID-19. Although the findings may not be transferable to all settings and cannot be generalized with certainty, the insights gained on women's perceptions of

SCSs are invaluable. These findings can provide insight into future SCSs policies and practices that may garner a more inclusive space for women.

7.4 Future Research

It is important that SCSs function to meet the needs of all people who desire a safe, supervised location to use substances. Research and program development focusing on women's perspectives of SCSs is a quickly emerging field yet more research is necessary to expand on how social and structural inequalities impact poor and marginalized women who use illicit substances decision to utilize SCSs. Further studies should be conducted in other Ontario cities, as well as other provinces/territories. The services offered and policies regulating SCS use vary from one place to another. Therefore, comparing women's interpretations on how well SCSs meet their unique gendered needs in different locations will enable a more comprehensive understanding of policies that are favourable for women. Similarly, there is a need for further research to examine gender-diverse people's use of SCSs.

Additional research should also examine how COVID-19 related policy changes have altered the accessibility of SCSs for women. The policies in place to curb the spread of COVID-19 are contradictory to guidelines provided for safer use amidst the opioid epidemic. For example, one of the primary strategies for reducing the spread of COVID-19 was to isolate and limit contact with others, whereas, a key harm reduction principle is to not use alone. Researchers should look into how women are managing these conflicting messages surrounding their safety.

SCSs are an effective form of harm reduction against opioid related overdoses while toxic supply remains. Despite the effectiveness of SCSs in preventing overdose deaths, there are

policy changes that could potentially make SCSs more inclusive for women and women-identifying people and thus increase their actual and perceived benefits.

Appendices

Appendix 1: Interview Guide

Use if the participants say they have been to a SCS

Introductory questions

1. Can you walk me through what a typical day looks like for you?

Drug Use Questions

As you know, I'm interested in hearing about your experiences using drugs both in and/or outside of SCSs. Do you mind if I ask you a few questions about your experiences with drugs?

2. Can you tell me about what types of drugs do you use? (licit and illicit)
3. How long have you been using drugs for?
4. How often do you use drugs?
5. How do you typically consume your drugs? (i.e. smoke, swallow, snort, inject).
6. Do you ever need help using drugs?
7. Do you ever go to a Safe Consumption Site? If so, how long/often have you used SCSs?

Thank you for sharing that information with me. Now, if it's ok with you, I would like to shift gears a little bit and hear more about your thoughts on times when you've accessed/used SCS.

SCS Questions

8. Can you tell me about why you use SCSs?
9. What things do you like about SCSs?
10. Can you tell me about any problems you've had accessing SCSs (if at all)?
11. Can you tell me about any problems you've had using SCSs (if at all)?
12. How has using SCSs affected your feelings of safety while you use drugs?
13. Can you tell me about how using SCSs might have affected your feelings of safety in other parts of your life?
14. Would you say that using SCSs has changed your well-being (health, mental health, etc.)? If so, how?
15. What things about SCSs do you think can be improved?
16. In this research project I'm only talking to women (people who identify as women). Do you have any thoughts on how being a woman affects your experience with SCSs?
    a. Do you feel comfortable using drugs around men? Do SCSs make you more or less comfortable using drugs around men?
    b. If it is relevant to your situation, does caring for your children affect your ability to use SCSs?
    c. Do you have any suggestions on how SCSs could be changed to work better for women?

17. Is there anything we haven't talked about that you'd like to discuss?

Demographic questions

18. How old are you?
19. What race/ethnicity do you identify as?
20. What gender do you identify with?
21. How would you describe your sexual orientation?
22. What is your current housing situation?
23. Are you currently employed?

Use if the participants say they have never been to a SCS

Introductory questions

1. Can you walk me through what a typical day looks like for you?

Drug Use Questions

As you know, I'm interested in hearing about your experiences using drugs both in and/or outside of SCSs. Do you mind if I ask you a few questions about your experiences with drugs?

2. Can you tell me about what types of drugs do you use? (licit and illicit)
3. How long have you been using drugs for?
4. How often do you use drugs?
5. How do you typically consume your drugs? (i.e. smoke, swallow, snort, inject).
6. Do you ever need help using drugs?
7. Do you ever go to a Safe Consumption Site? If so, how long/often have you used SCSs?

Thanks for sharing that information with me. Now I want to shift gears a little bit and hear more about your thoughts on SCSs.

SCS Questions

8. Are you familiar with SCS? What do you think of SCS sites?
9. Can you tell me about some of the reasons why you haven't gone to a SCS?
10. Where do you prefer to use drugs?
11. How would you describe your well-being? (health, mental health, etc.)? Do you think accessing a SCS would impact this in any way?
12. From what you know of SCSs, what are the best aspects of the site?
13. From what you know of SCSs, what are the worst aspects of the site?
14. Is there anything about SCS that could change that would lead you to start using them?
15. In this research project I'm only talking to women (people who identify as women). Do you have any thoughts on how being a woman affects your experience with SCSs?

    a. Do you feel comfortable using drugs around men? Have you noticed any changes in the last 1.5-2 years (since the SCSs opened) that make you more or less comfortable using drugs around men?
    b. If it is relevant to your situation, does caring for your children affect your ability to use SCSs?
    c. Do you have any suggestions on how SCSs could be changed to work better for women?
16. Is there anything else you think I should know that we have not discussed?

Demographic questions

17. How old are you?
18. What race/ethnicity do you identify as?
19. What gender do you identify with?
20. How would you describe your sexual orientation?
21. What is your current housing situation?
22. Are you currently employed?

Appendix 2: Research Poster

PARTICIPANTS NEEDED FOR RESEARCH PROJECT

"Women's Opinions on Safe Consumption Sites"

Eligibility:

- 18+ years of age
- Currently using drugs
- Identify as a woman
- Willing to participate in a confidential interview lasting approximately 1 hour

The goal of this study is to determine if safe consumption sites are meeting women's needs

In appreciation of your time, you will receive $20 cash.
Participation in this research will in no way affect your access to any services.
This research is completely independent of all services.

For more information or to volunteer to participate in this study, please contact:

Kaitlin Waechter, MA student, Wilfrid Laurier University
(613) 859-7691 waec8110@mylaurier.ca

Appendix 3: Informed Consent Form

WILFRID LAURIER UNIVERSITY INFORMED CONSENT STATEMENT

Women's Opinions on Safe Consumption Sites
Researcher: Kaitlin Waechter, Graduate Candidate, Department of Criminology
Supervisor: Dr. Erin Dej, Assistant Professor, Department of Criminology

Who are we looking to talk to?

We are looking to talk to people who identify as women, 18 years of age or older, who use illicit substances.

Why are we doing this study?

We are conducting this study to get a better understanding of what women think of safe consumption sites. The study hopes to discover what women like and don't like about safe consumption sites, if women feel safe at safe consumption sites, and women's overall experiences with safe consumption sites.

What will happen during the study?

You will be asked to participate in an interview lasting approximately 1 hour. With your permission the interview will be audio-recorded. During this interview you will be asked to talk about your opinions of safe consumption sites.

Potential harms, risks or discomfort

Some of the questions asked during the interview may make you uncomfortable. You do not have to answer these questions if you don't want to. You can skip any question you don't want to answer. You can also ask for the recording to be turned off, ask to take a break, or end the interview entirely.

You will be provided a list of resources that offer 24-hour phone-supports as well as walk in supports. The interviewer will also be available, should you want to talk after the interview.

Potential benefit

Participating in this research project will allow you to talk about your experiences in safe consumption sites. Your opinions could help to redesign the ways safe consumption sites operate for women.

Confidentiality

All of your information will be kept secure. No one will be told that you participated in this interview. Participation in this research will in no way effect your access to services at the AIDS Network, any safe consumption site, or any other services.

A pseudonym will be used for all of your information. The pseudonym will also be used for any quotes that are used from your interview.

As the interviews will be discussing illegal activity, there is a possibility that the interviewer will be court ordered to release information. Unless court ordered, your personal information will not be shared with anyone.

Study results

The interviewer will be writing an analysis that will show common themes between all of the interviews. If you want a copy of this summary, it will be made available to you by May 2020. If you want a copy of the summary, please provide a mailing address or an email address to which Kaitlin Waechter can send the summary. The summary can also be hand delivered at an agreed upon time and location. If you decide later you want a copy of the summary, you can contact Kaitlin at any time (waec8110@mylaurier.ca or 613-859-7691).

The information provided in the interviews will be used to complete the interviewer's thesis. It will also be published in a journal and presented at conferences by the interviewer.

Can I decide if I want to be in this study?

You do not have to answer any questions that you do not want to. You can also take a break or end the interview at any time for any reason, without explanation. There is no consequence to withdrawing your participation in this study. You will still receive $20 if you choose to withdraw from the study.

Compensation

You will receive $20 before the interview starts. If you end the interview early, you will not lose this money. If the interview takes place at a location where refreshments are sold, I will purchase one non-alcoholic beverage.

Rights of research participants

If you have questions at any time about the study you may contact the researcher, *Kaitlin Waechter*, at *waec8110@mylaurier.ca* or *613-859-7691*.

This project has been reviewed and approved by the University Research Ethics Board (REB# *6224*), which receives funding from the Research Support Fund. If you feel you have not been

treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact Jayne Kalmar, PhD, Chair, University Research Ethics Board, Wilfrid Laurier University, (519) 884-1970, extension 3131 or REBChair@wlu.ca

Consent

	YES	NO
I have read and understand the above information. I have received a copy of this form. I agree to participate in this study in accordance with the terms set out above.		
I agree to have the interview digitally recorded.		
I understand that I can request to review the interview transcript and add, delete, or change it to ensure accuracy and comfort level for one month following the interview.		
I agree to allow the use of quotes from my interview in publications.		
I would like a copy of the summary of the interviews.		

Participant's signature _____ ___ Date _____

Researcher's signature _____ Date _____

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