Community Drug Checking and Substance Use Stigma:

An Analysis of Stigma-Related Barriers and Potential Responses

by

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We acknowledge and respect the lək’ʷəŋən peoples on whose traditional territory the university stands and the Songhees, Esquimalt and W̱SÁNEĆ peoples whose historical relationships with the land continue to this day.

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Abstract

The illicit drug overdose crisis is an ongoing epidemic that continues to take lives at unprecedented rates and British Columbia, Canada has been identified as the epicenter in Canada, where approximately five deaths per day are linked to unregulated substances most often including fentanyl (Service, 2022). In Victoria, British Columbia, community drug checking sites have been implemented as a public health response to the ongoing overdose crisis and the unregulated illicit drug market through a community-based research project called the Vancouver Island Drug Checking Project. In addition to providing anonymous, confidential, and non-judgmental drug checking services with rapid results, the project has conducted qualitative research aimed to better understand drug checking as a potential harm reduction response to the illicit drug overdose crisis and the unregulated illicit drug market (Wallace et al., 2021; Wallace et al., 2020).

An analytical framework was utilized to understand the impact substance use stigma has on those accessing drug checking services, as well as those who avoid accessing these services as a direct result of substance use stigma. This study found that the risk of criminalization and the anticipation of being poorly treated appear to be the most significant barriers related to stigma, rather than actually experiencing stigma. Further, it appears the implementation of community drug checking creates tensions that need to be navigated as sites and services balance a hierarchy of substances and stigma; differing definitions of peers; public yet private locations; and, normalization within criminalization. The findings suggest the solution to substance use stigma and drug checking will not come from continuing as we are, but through making changes at all levels (individual, interpersonal, and structural) and thus for all people who access community drug checking.

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Dedication

This is for those who have been and continue to be harmed by substance use stigma and those who have lost their lives to the unpredictable drug supply and illicit drug overdose crisis.

This thesis was written with every youth in my heart and mind in hopes of creating access to community drug checking, no matter your age, your identity, or where you live. CA, CP, and DW, this is for you.

Introduction

The illicit drug overdose crisis is an ongoing epidemic that continues to take lives at unprecedented rates and British Columbia, Canada has been identified as the epicenter in Canada, where approximately five deaths per day are linked to unregulated substances most often including fentanyl (Service, 2022). Drug checking is a harm reduction response that provides a chemical analysis of substances to inform individuals about the contents. Increasingly drug checking is being pursued as a potential response to the rapid emergence of synthetic opioids including fentanyl and the high rates of overdose related to the unpredictably of the unregulated drug market (Barratt et al., 2018; Green et al., 2020; Laing et al., 2018; Measham, 2020). In Victoria, British Columbia, community drug checking sites have been implemented as a public health response to the ongoing overdose crisis and the unregulated illicit drug market through a community-based research project called the Vancouver Island Drug Checking Project. In addition to providing anonymous, confidential, and non-judgmental drug checking services with rapid results, the project has conducted qualitative research aimed to better understand drug checking as a potential harm reduction response to the illicit drug overdose crisis and the unregulated illicit drug market (Wallace et al., 2021; Wallace et al., 2020).The goal of the research is to hear from people's experiences with drug checking, including people who use drugs, their family, friends, peers, and/or people who make or distribute substances (Wallace et al., 2021; Wallace et al., 2020). The central intention of these studies were to gain a well-informed understanding of how people think about drug checking from a range of social locations, with the goal of making drug checking widely accessible, safe, and effective for all.

I approached this research with a critical harm reduction and social justice approach that seeks to transcend neoliberal perspectives of harm reduction, which often emphasizes placing

responsibility on the individual and maintains abstinence values (Pauly, 2008; Rhodes, 2009; B. Wallace et al., 2021; Wallace et al., 2021). Stigma related to substance use emerged as a dominant theme in our research project, which initially aimed to explore how to implement drug checking as an overdose response. Substance use stigma (SUS) is generally defined as the stigmatization of people who use drugs (PWUD) for using illicit substances (EQUIP, n.d.).There is overall recognition of the need to address substance use stigma as integral to responses to the illicit drug overdose crisis (Allen et al., 2020; McGinty et al., 2018; Tsai et al., 2019) and this paper specifically explores substance use stigma (SUS) as it relates to community drug checking from the perspectives of people who use and/or sell drugs and others impacted by the illicit drug market. The purpose of the research is to understand how these experiences and knowledge can inform the implementation and scale-up of drug checking in the context of unprecedented overdose rates.

In his early and well-known work on stigma, Goffman (1963) identified stigma as a relationship where stigmatized qualities or stereotypes are applied to some by others, resulting in the stigmatized person being viewed as "tainted" or "discounted". Understandings of stigma have shifted from Goffman's interpretations of stigma as static, and on to thinking of stigma as an ever evolving social phenomenon (Parker & Aggleton, 2003). According to Tsai et al. (2019, p. 2), stigma is defined as a "process wherein people with a particular social identity are labeled, stereotyped, and devalued, unfolding within the context of unequal and often pre-existing power-relations, leading to discriminatory behaviour against people with the stigmatized identity". According to Tyler (2020) the most common form of violence in democratic societies is stigma, despite rarely being considered a form of violence or abuse of power. Therefore, stigmatization

can have serious impacts on social and physical health outcomes, especially in the context of substance use stigma.

As stigma operates at these different levels, it can function as a tool to control and oppress (Link & Phelan, 2014). This has been referred to as "stigma-power" and is typically theorized as the stigmatizer having motivations to maintain status, wealth, and power, enforce social norms, and marginalize those viewed as unfit for society and as such employs stigma processes that are easily, effectively, and indirectly accepted and enacted in society (Link & Phelan, 2014, p.25). Based on this interpretation of stigma-power, the stigmatizer is not necessarily limited to a powerful individual or group, but also permeates the general public and the individual, therefore it can exist at the individual, interpersonal, and structural level.

Research Epistemology

As described by (Wallace et al., 2021) drug checking cannot be guided with a focus on abstinence, rather it focusses on improving health outcomes for PWUD, increasing accountability within the illicit drug market, encouraging and proving the effectiveness of a safe supply and decriminalization, and mitigating the harms of criminalization of certain substance. In alignment with (Wallace et al., 2021) my research will avoid a neoliberal focus on harm reduction by respecting a basic right to use drugs and access to harm reduction services. Wallace et al. (2021) also identify that evaluating drug checking seeks to address structural and systemic issues related to the opioid epidemic, rather than individual responsibility in substance use. As both a researcher on this project and someone with my own worldview, I align with these focuses and intentions and will engage with these perspectives throughout my research.

The methodological framework that will align with these views and allow me to effectively answer the research questions is a critical emancipatory approach informed by critical

epistemologies and emancipatory methodologies inspired by Pease (2010) and MacAdams (2020). MacAdams (2020, p. 45) explains how "critical epistemologies view knowledge as socially constructed and are critical of how knowledge regimes premised on universal truths are used to establish the dominance of some groups of people over others" and "emancipatory research approaches enable social change to be embedded into the research process and intentions". It is imperative that we understand how we know what we know about stigma related to drug checking to change normative perceptions of what it means to use drugs safely and I believe this framework will make this possible. Engaging with this framework will allow me to highlight how stigma and perceptions of substance use and drug checking are socially constructed and can be shifted to emancipate PWUD and drug checking sites.

Emancipatory research aims to break down "unacknowledged constraints, relations of domination, and conditions of distorted communication and understanding that deny humans the capacity to make their future through full will" (Devetak, 2005, p.170). According to Humphries (2008), Pease (2010), and MacAdams (2020), emancipatory research can be accomplished by centering the voices and experiences of communities experiencing oppression and following through with the actions required to incite change.

A key aspect of my methodology is constant reflexivity that engages with and is influenced by teachings from Indigenous community members, scholars and anti-racist and anti-oppressive epistemologies. I am approaching my research carrying with me experiences and stories of people I have worked alongside and learned from. Wilson (2013, p. 313) talks about going beyond being in relationship with participants by fully emerging oneself in the relationship as he says, "I am these relationships". My approach will be to come into relation with each story presented in the data holding close the person who shared them and caring for them and their

lives the same way I do for the youth who inspired me to take on this research. Throughout the writing process, I will check in with myself to ensure accountability and that I am engaging in anti-oppressive practice through my writing. Holding the dignity of the participants and sharing their stories in a meaningful and appropriate way will be at the forefront of my writing.

Theoretical Framework

For our analysis, we drew heavily on Tsai et al's (2019) typology of stigma related to substance use to guide our analysis. Tsai et al. (2019) highlight that stigma influences several facets of our lives, including societal attitudes, policies, and political agendas—directly impacting how resources are funded, access to care, and media portrayals of people who use drugs. To inform our analysis, we developed a substance use stigma framework (Table #1) by adapting general literature and theories on stigma and applications of those theories specifically to substance use. It has been identified that attention is often focused on stigma at the individual level, which overlooks realities of social, political and cultural contexts (Link & Phelan, 2001; Pescosolido et al., 2008). Therefore, our framework considers substance use stigma at three levels; individual, interpersonal, and structural. Within these levels we considered two types of SUS at each level. At the individual level, we looked at anticipated stigma and internalized stigma; at the interpersonal level, we looked at enacted stigma and episodic stigma; and at the structural level we looked at criminalization stigma and systemic stigma.

Broadening the analysis of stigma at each level allows us to consider how difference and power are created and maintained, as well as tangible ways to challenge existing norms, cultures, and structures that sustain SUS. While the framework presents each level of stigma as distinct levels for our analysis, we recognize the complexity of SUS and the significant intersections of each level which we also explore. The framework intentionally avoids a hierarchical approach as

a strategy to acknowledge the creation and maintenance of SUS at each level, but also highlights that each level is not mutually exclusive and cannot exist without the others. As discussed by Parker & Aggleton (2003) stigma and stigmatization "function… at the point of intersection between culture, power, and difference" and therefore, we must explore the interactions between these levels at which stigma exist to better understand how they are sewn into the social fabric of our society.

Researcher Positionality

I spent much of my life insulated by the comforts of my freedoms and advantages that I have as a white, heterosexual, cisgender, and able-bodied woman. I grew up in a safe neighbourhood and in a stable home with the heteronormative nuclear family. For a long time, I lacked a critical analysis of what it means to walk through the world from my social location. My position in society will be ever present in the work I do as a researcher and I need to recognize its implications. I am in a position of significant power and influence as someone who is engaging in meaning making around substance use and drug checking as someone who has no experience with using illicit substances or drug checking sites. It is because of my social location that I must engage constantly with self-reflexivity, anti-oppressive frameworks, and the demands and worldviews of those with lived experience in this realm. I cannot identify with the ontologies of Indigenous peoples, Black people, or other racialized individuals, LGBTQIA2S+ people, people experiencing homelessness, those who are living on welfare, or engaging in substance use, although I seek to understand these communities of people by learning from the accounts and stories they share. I acknowledge this to identify that I am not an "all-knower" and to make clear that I am not an expert in anyone else's life other than my own.

My current and evolving approach to decolonization and anti-racism is influenced by and drawn from scholars including Eve Tuck and K Wayne Yang (2012), Raven Sinclair (2004), and many others. I want to complicate the term "decolonizing" as I understand this term to be contentious. Tuck and Yang (2012) identify how decolonial desires of white people can become a disguised means to further settler colonial agendas. This is shown in a discussion of metaphorization of decolonization, where it becomes a term that is not backed by action or fulfilment of what it calls for and, rather, allows for settlers to "move to innocence" (Tuck and Yang, 2012). Decolonization thus becomes a means to an end that eases settler guilt, complicity, and protects colonialism for the benefit of the settler (Tuck and Yang, 2012; Snelgrove et al., 2014). Over the two years, I have worked to uncover the many moves to innocence I have engaged with in my adult life. I acknowledge the many times I have taken advantage of my whiteness to benefit myself, especially when I have not been aware it. I have reframed how I use this term by employing a reflexive practice each time I use it, to ensure that I am not using it metaphorically, and that there is action taken alongside its use.

Elder Vera Martin says, "You cannot take anyone any further than you yourself have gone" (as cited in Baskin, 2016, p. 39). I have carried this quote alongside me for many months now. It has taught me that I must deeply know and understand what shapes my reality because my subjectivities directly impact how I am in practice. This is particularly important because my subjectivity (or perceived reality) is a product of government structures designed to benefit me and that I spent a lot of my life trusting and believing in (Pon et al., 2011). Practicing routine reflexivity, identifying where, and how I am benefitting and actively breaking that down is key in decolonial practice. This can prevent being complicit in the harms caused by social workers (Baskin, 2016). In a podcast with Dr. Billie Allan and Corinna Sparrow, Sparrow described the role of a social

worker to be a conduit or a connecting piece (Personal communication, October 21, 2020). Understanding myself as a conduit will hold me accountable to my responsibilities and makes it impossible to centre myself. I constantly return to the notion that the only life I am an "expert" in is my own and therefore, I only know what is best for myself—no one else. This is especially important given that Eurocentric/western/colonial knowledge has been deemed superior to Indigenous knowledge, a designation I have benefitted from my entire life (Hart, 2009). My role as a conduit, then, is to research, learn about, and offer connections/supports/networks to those I work alongside without ever forcing anyone into a decision.

Between my undergraduate degree and my MSW, I was a youth worker working alongside Indigenous youth in group homes in East Vancouver. Many Indigenous youth were using substances and experiencing addiction. Much of the knowledge, experience, and perceptions I have of substance use come from the youth I worked alongside and the institutional violence they faced as young people who use drugs in an opioid crisis. Through this work, I was developing my non-judgemental, critical harm reduction worldview that moved away from what was once an individualized approach to substance use to one that understands the implications of trauma, the pleasure of substance use, institutional barriers, oppression, stigma, and so much more.

In 2019, one of the youth, a 17 year old girl, accidently overdosed after leaving a treatment program. A few weeks later, I responded to an accidental overdose of a 16 year old boy, outside of the group home. These two young people are the reason I am doing this research. I have witnessed the horrific realities of the opioid epidemic and lost people I love because of the inaction of the government, a lack of sensible policy, and the stigma that surrounds drug use and harm reduction practices. Thomas King (2003) says that we live in and by stories—and we do. We live by the stories we tell ourselves and that others tell about us. There is both beauty and pain in story-

telling where lies and misconceptions can emerge, but also where deep lessons in love and life can live on through us. I have learned that it is my responsibility to ensure that the stories I tell about people, especially Indigenous peoples, are stories they would tell about themselves. The perceptions we hold can often be informed by untrue and misinformed stories we are told. I would have given anything to have the resources to check the substances the youth used for fentanyl and for these youth to exist outside of the harms of stigmatization and institutional violence. I am doing this research for them and others with shared experiences.

Further, the research I am conducting is based on data gathered at the Vancouver Island Drug Checking Project VIDCP during drug checking. Because I am physically located on the traditional lands of the Tsleil-Waututh, Squamish, and Musqueam First Nations (colonially known as Vancouver), I am unable to partake in the drug checking process at the VIDCP. This means everything I know about drug checking is learned from the previously conducted interviews in this study, my colleagues who work at the drug checking sites, the project's social media, and the articles I have read. I view this distance from drug checking as a potential limitation because it could lead to assumptions or inaccurate meaning making of the lived experiences of those who participated in the study. This is something I am aware of and will address.

My intentions in taking up this research are to be in relation to those who have graciously contributed to the study and to honour what they have shared of their personal experiences. My motivations are to work towards breaking down the stigma around substance use and drug checking, to influence decriminalization and a safer drug supply, and to make it possible for anyone to access drug checking without fear or shame.

Chapter One – Literature Review

This research is guided by an anti-racist, anti-oppressive, and decolonial framework and an intersectional analysis of power to understand stigma and Community Drug Checking. I began by searching for articles based on research from the Vancouver Island Drug Checking Project. From there I expanded my search on Google Scholar, PubMed, and Summons using key words like: stigma*, drug use, drug checking technologies, harm reduction, illegal and/or illicit drug use, drug checking, drug testing, overdose, Indigenous Harm Reduction, intersection*, race, gender/sex, and class, and criminalization. Within each article, I searched for discussions of race, sex/gender, culture, socioeconomic status, and stigma. Not all of the literature I am presenting explicitly connects drug use and stigma, so I have decided to bring these two bodies of literature into conversation with each other to better contextualize drug checking. Finally, I have intentionally included sources dating prior to 2011 as I have identified them as essential to illustrating knowledge around drug checking and stigma.

This thesis will address a gap in the existing literature by exploring drug-related stigma and how it impacts the use and universality of drug checking sites. The ultimate goal of this research is to break down stigma around substance use and drug checking to allow for more widely accessible, safe, and dignified harm reduction practices.

Conceptualizing Stigma

According to Erving Goffman (1963), the term 'stigma' originated in Greek culture, where it was used to expose individuals as slaves, criminals, or traitors by burning symbols into their bodies. This signaled to others to avoid those people. Christians expanded this understanding of stigma to include physical disorders in addition to imposed blemishes (Goffman, 1963). There was a shift from specific markings inciting stigma to the entire individual being considered a disgrace

(Goffman, 1963). In 1863, the word “stigmata” was used in newspapers to describe markings on runaway slaves during the American civil war (Tyler, 2020). The advertisements were meant to inform the public that someone had runaway and to look for certain markings and brandings on their body to identify them (Tyler, 2020). It was not only common to burn and whip people during this time, but legislated in various codes and acts giving rights to English colonialists to own other humans and to burn them if they display any violence (Tyler, 2020).

Tyler (2020) looks at the Oxford English Dictionary definition of stigma, which is a "distinguishing mark or characteristic (of a bad or objectionable kind) and a "mark of disgrace or infamy, a sign of severe censure of condemnation, regarded as impressed on a person or thing". This definition was composed in 1916 and while it continues to be applicable today, it does not encompass the experiential aspect of stigma (Tyler, 2020). It is key to understand that stigmatization is deeply a colonial and racially-based process that continues to be deeply entrenched in societal practices and norms today.

In his early work on Stigma, Goffman (1963) effectively identifies the importance of understanding the general assumptions and definitions that existed at the time of writing and that I have found in my research, continues today. For example, Goffman (1963) illustrates how stigma is at play when we go from viewing a person as a whole person to a "tainted discounted" person (p. 257) with “undesired differentness” (p.258). This is evident in how we view people who are stigmatized as less valuable in society. It is key to think of "stigma" not as an attribute but as a relationship—including that of stereotypes, concealing or not concealing things about ourselves. Goffman (1963) describes the impact of stigma as being so significant that one characteristic of an individual can sever the claim the "good" or non-stigmatized traits has on normative society,

resulting in non-acceptance (p. 258). We can deduce from this that acceptance is a central tenant of stigma and is a key element of the relationship between stigma and people.

Goffman's (1963) work is undoubtedly well cited because it is viewed as the beginning of stigma theory and draws on early theories of stigma that are rarely discussed elsewhere. I take issue with much of the language used by Goffman (1963) in this work as it perpetuates stigma. For example, the term "cripple" or "normals" are used frequently. "Cripple" is a term often used as a pejorative and is considered inappropriate and offensive by people who have a disability. Using this term without at least mentioning the intention behind its use has potentially further stigmatized people who have a disability (or diverse abilities). "Normals" is a loaded term, which encompasses those with abled bodies, white skin, wealth, cis-gender, and heterosexual preferences. It also calls on people who engage with normative practices of the global north, including people who have jobs, homes, pay taxes, do not engage in drug use (excluding party drugs and alcohol), and more.

Another critique of Goffman (1963) is that his presentation of people impacted by stigma make them appear helpless and lacking agency (Carnevale, 2007). This critique is supported by Scrambler (2004) who argues Goffman's (1963) stigma theory fails to adequately address social structures and power by taking an individualistic approach. This individualistic approach also results in an unhelpful focus on physical issues of individuals (e.g. illness or bodily characteristics) as opposed to social phenomena (Carnevale, 2007).

Conceptualizing Substance Use Stigma

Substance use stigma (SUS) is generally defined as the stigmatization of people who use drugs (PWUD) for using illicit substances (EQUIP, n.d.). Substance use stigma prevents people from engaging in harm reduction practices (Corrigan & Nieweglowski, 2018; Tsai et al., 2019; Wallace et al., 2020). Further, Corrigan and Nieweglowski (2018) and Tsai et al. (2019) identify

stigma as a main hindrance in adequately responding to the opioid crisis through harm reduction practices. There are many ways of thinking of and conceptualizing both stigma and substance use stigma in the existing literature. The purpose of this subsection is to explore the various ways stigma is theorized and how it interacts with substance use stigma. The substance use stigma framework from which this thesis will draw includes some of the most common definitions of stigma.

Tsai et al. (2019) identify 6 types of stigma: structural, public, enacted, courtesy, internalized, and anticipated. Additionally, Corrigan and Nieweglowski (2018) identify three types of stigma: label avoidance, public stigma, and self-stigma. Earnshaw & Chaudoir (2009) identify internalized, anticipated, and enacted stigma. Other scholars discuss structural stigma, which often includes discussions around laws and regulations. There is a general theme of substance use stigma existing at three levels: an individual level where stigma exists within individuals, an interpersonal level where stigma exists within interactions between people, and a structural level where stigma exists at a policy level. I will now present the literature findings based on common iterations of substance use stigma.

According to Earnshaw & Chaudoir (2009), internalized stigma refers to the process of believing in the negative feelings imposed on those who use substances and an internalization of negative beliefs and feelings associated with substance use. Tsai et al. (2019) explain internalizing stigma can result in maladaptive behaviour, such as withdrawing from care or resources. This can lead to the belief that one's status in society is less valuable than others (Tsai et al., 2019, p.3). As part of internalized stigma, those who are stigmatized likely feel "normal" when alone and abnormal around those perceived as "normal" (Carnevale, 2007). Seeking the sense of being "normal" can lead to the pursuit of being alone in private spaces where an individual facing

stigmatization is not being watched or approached (Carnevale, 2007). A sense of "normal" can also be sought in social groups with members who share similarities and can reduce isolation and loneliness (Carnevale, 2007), which may look like associating with those who share similar behaviours.

The expectation that one will experience prejudice, discrimination, or judgement in the future is considered anticipated stigma, as defined by Earnshaw & Chaudoiur (2009). It is common for an individual who anticipates stigmatization to adapt their behaviours out of fear of rejection by others and avoid services or means of care that could be beneficial to their well-being (Tsai et al., 2019). For example, one might avoid a community drug checking service, which could lead to negative impacts for that individual, such as consuming unknown or fatal substances. Anticipated substance use stigma requires the individual to be subjectively aware of the negative attitudes commonly attributed to their consumption of substances (Tsai et al, 2019). Status loss and social rejection has been identified as a key attribute related to anticipated substance use stigma Yang et al. (2017) and Phelan et al. (2014). These phenomena are considered mechanisms which create social ordering and hierarchies that can lead to unequal outcomes for stigmatized individuals, both setting them below and apart from the non-stigmatized group. Phelan et al. (2014), suggest stigmatized individuals may encounter interactions where they expect to be rejected and treated as "less-than", while the non-stigmatized individual may approach that same interaction with the sense they are superior to their counterpart and thus justify the imposition of social rejection or distancing.

According to Earnshaw & Chaudoir (2009), enacted stigma is to experience stigma from others in an individual's community. It is demonstrated when others behave in a way that communicates judgement, prejudice, or disapproval (and stigmatization) of a stigmatized

individual through actions such as social distancing or avoidance (Earnshaw & Chaudoir, 2009). This often takes place when the public perceives a stigmatized individual as dangerous or to have moral failings (often based on stereotypes) and discriminates against or avoids that individual for that reason (Tsai et al., 2019). Enacted stigma also means the individual who has been stigmatized believes they have been treated in a way that is discriminatory and/or prejudiced (Earnshaw & Chaudoir, 2009). Enacted stigma becomes structural when the attitudes and beliefs are merged with cultural norms, laws, and policies.

Episodic stigma refers to isolated events where stigmatization occurs over time, rather than on a consistent basis (Gagnon, 2015). Often, individuals experiencing this type of stigma express they are generally "well treated" (Gagnon, 2015). For example, if an individual experiences substance use stigma as they enter a safe consumption site or a community drug checking site at least once, but not constantly, they would be experiencing episodic stigma.

Systemic stigma is enacted and enforced by agencies, institutions, and influential individuals within groups of people and targets those who are stigmatized by attempting to manage risk and govern their interactions (Gagnon, 2015). The act of using stigma as a resource to oppress has been identified as stigma power (Link & Phelan, 2014). Link & Phelan (2014) describe the relationship between systemic stigma and stigma power as a means to oppress or maintain the oppression of stigmatized groups and to reinforce stigmatized identities in society. An important factor of systemic stigma is it protects the stigmatizer from repercussions of discrimination, because the stigmatization is embedded in norms, policies, or resources and the goals of stigmatization are achieved at the macro level Tsai et al. (2019) and Link & Phelan (2014).

Criminalization is a form of stigma that is closely related to substance use and is a common and effective way for governments to "control and exclude persons who are defined as threatening

to an existing social order" (Dollar, 2019, pg. 306). It is often enacted through street policing and can result in reduced access to harm reduction services, rushed injection, increase in disease transmission, and increased risk of overdose (Collins et al., 2019). Criminalization can be more common for people who use substances and who are experiencing poverty and/or are racialized or experiencing other intersecting identities (Dollar, 2019). It is an effective tool to "other" PWUD and maintain existing hierarchies in society and is considered a way to shift public attention from systemic inequalities (Dollar, 2019). One example of criminalization stigma is policing around community resources like safe consumption sites, needle exchanges, or community drug checking, often leading to fear of arrest, mistrust in a service and decreased access (Collins et al., 2019).

Presenting intersectionality

Turan et al. (2019) discuss how Erving Goffman defined stigma theory and how intersectionality is intertwined in how stigma is conceptualized within these intersections. This article will be useful in presenting a historical account of where stigma theories began and how it exists in contemporary contexts with a more critical lens applied. These sources will allow me to consider how different types of stigma influence the behaviours of PWUD and their peers.

Medina-Perucha et al. (2019, p. 316) and Turan et al. (2019, p. 1) discuss "intersectional stigma", which is prevalence of multiple stigmatizations in social identities and structural inequities that interact with one another to shape one's existence and how they experience the world. These social identities include race, gender, sex, and class that can intersect with one another, as well as other factors like trauma, social status, peer pressure, and more. These authors identify how the intersection of stigmas "creates unique experiences of social exclusion and marginalization" and "increase social invisibilities" (Medina-Perucha, et al., 2019, p. 320). These

sources will help identify the many stigmas people who use drug checking sites face and how they interact with one another.

In her book, Tyler (2020) identifies stigma as the most common form of violence utilized by democratic societies, despite rarely being theorized as a violent practice or form of power. This source will be valuable in presenting a critical power analysis of the role stigma plays in the lives of PWUD and their interactions with drug checking sites, especially in terms of criminalization. This will be particularly important when analyzing power dynamics alongside issues of racism, transphobia, and classicism, and other harmful prejudices related to stigma and drug checking.

Collins et al. (2019) present a relational intersectional lens when engaging with research related to PWUD. This lens can also be applied to understanding realities for PWUD and drug checking as it supports the researcher in analyzing all social locations to understand their complexities and interconnections and how they shape existence, as well as how they shift and change over time (Collins et al., 2019). With particular attention to social-structural inequities, this source will support an analysis of harmful and ineffective drug policies and other risk environments created by oppressive structures.

Morality, the law, and substance use

Nieweglowski et al. (2018) discuss the nuances of substance use stigma as it relates to the law and morality, which I will present here. They discuss how substance use disorder and/or opioid use disorder are both legally and socially sanctioned in that these disorders are not only punishable by law and by society more broadly. The legalistic aspects of this mental illness set it apart from others in that addiction is often closely tied to felonious behaviour. For example, in some places in the world people who use drugs can face summary execution. Stigma related to drug use is used strategically to discourage and stop drug use. For example, campaigns will say “drugs are bad” or

“hugs not drugs” to discourage taking up drug use. In some cases, drug use will be presented as a health concern and in others as a criminal issue. Some literature argues that helping people who are struggling with substance misuse can be perceived as supporting someone using drugs, which is largely considered a wrongful act.

Based on my search, there is a significant gap in substance use stigma in the literature. A significant portion of the literature I reviewed lacked a fulsome intersectional analysis which is key to understanding/addressing stigma, as it is founded on racial, ability, economic, and gender-based discrimination and prejudice (Goffman, 1963; Tyler, 2020). This will be an important gap to address in my thesis work.

Conceptualizing Drug Checking

In its simplest form, drug checking is the process in which drugs are tested for components that are not expected in a supply and/or that could cause overdose or otherwise undesirable reactions (Brunt, 2017; Kriener et al., 2001; Spruit, 1999; Spruit, 2001). Drug checking is a harm reduction response to help prevent PWUD from consuming substances they did not intend to purchase and to provide the opportunity to make informed decisions about drug use (Bardwell et al., 2019; Wallace et al, 2020). This approach has been adopted across European countries and in some cities in North America, which accept illicit drug use will continue despite prohibitions and opt to offer special services to drug users (Brunt, 2017; Marlatt et al., 2012).

Understanding how drug checking practices began and continue to evolve in Europe could be helpful to the implementation of sites across Turtle Island. Brunt (2017) provides a useful and detailed account of the history of harm reduction practices across Europe, beginning with the first clean needle harm reduction program in Amsterdam in 1984. In the 1990s, an increased uptake in party drugs prompted drug checking practices to become more widely spread (Brunt, 2017).

Dancesafe, an American drug checking organization, was founded in 1998 in response to the risks posed by adulterants (harmful additives) being found in ecstasy (Dancesafe.org). This response to party drug related overdoses was largely mirrored across Europe and America (McRae et al., 2020). Dancesafe takes the stance that they neither condemn nor condone drug use, rather they provide non-judgmental support to PWUD. This shows that the drug checking movement began in response to young people who used party drugs, such as Ecstasy, in recreational setting likes raves and who were not being reached by existing prevention programs and supports for PWUD (Brunt, 2017).

We have reached the sixth year of the publicly declared overdose crisis in British Columbia and there is no sign of improvements (Lardner and Burek, 2021). Bardwell and Kerr (2018) and Kerr and Tupper (2017) suggested drug checking may be an effective response to the opioid overdose epidemic. Fentanyl is portrayed as the main culprit of this crisis, but Lardner and Burek (2021) and Wallace et al. (2020) state it is the uncertainty of the drug supply and the failed drug policies that are responsible for thousands of overdose related deaths. The literature illustrates that drug policy is not likely to change as quickly and effectively as is necessary for lives to be saved, thus highlighting the need for drug checking as a means of harm reduction in the meantime. Existing research has not found that the presence of drug checking sites has resulted in an increase in PWUD, nor has it found that individuals who use drug checking services use more drugs than those who do not (Brunt, 2017).

What is a drug checking site?

Here, I draw heavily on Brunt (2017) as it provides a thorough and clear explanation of different drug checking sites across Europe. According to my research there are at least two types of drug checking sites as identified by Brunt (2017): mobile and stationary. Importantly, all drug

checking sites/technologies have different levels of accuracy, usability, and cost (Brunt, 2017; Harper, Powell, & Pijl, 2017; Kerr & Tupper, 2017; Bardwell et al., 2018).

Some drug checking sites publish their results for policy or surveillance purposes and others alert the media with warnings for potential risk (Brunt, 2017). In particular, the VIDCP publishes monthly blog posts on their website with detailed accounts of components found in samples (https://substance.uvic.ca/blog/tag/report/). The project also informs the Island Health Authority and will post on Twitter when risk of overdose is recognized as particularly high (Personal communication, March 2, 2021). According to Brunt (2017) and Spruit (2001), some drug checking programs will provide emergency alerts and information on boards at events, community websites, or to national/international organizations to deter dealers from selling the hazardous products and to have the bad supply removed (Spruit, 2001; Brunt, 2017).

How does stigma relate to drug checking?

Because of longstanding stigma related to drugs and drug use, the practice of drug checking necessarily invites judgement and stigma. In their historical account of drug checking, Brunt (2017) shows how harm reduction practices were developed to address "problematic" and marginalized PWUD. In the 1990s, the harm reduction focus shifted to include people engaging in non-addictive party drugs recreationally and who were typically people with higher incomes, higher education, and housing (Brunt, 2017; Orsolini et al., 2015). We are seeing a refocusing of drug checking practices towards people who are using opioids and methamphetamines in the context of the opioid crisis. These individuals are often stereotyped as homeless, unemployed, and people who inject drugs (PWID). Importantly, McRae et al., (2020) identify a heightened stigma attached to people who inject drugs (PWID) and that there is very little research on this issue.

Unfortunately, McRae et al. (2020) do not go into detail about why stigma is heightened for PWID and their experiences accessing drug checking, so a need for this research is identified.

In a study conducted by Wallace et al., (2020) a participant states that people of all positionalities use drugs, including lawyers, youth, people experiencing homelessness, stay-at-home moms, and so on. There is a fear for many people that participating in drug checking as it (and drug use) is currently viewed, will result in being stigmatized and labelled as an addict (Measham, 2020; Wallace et al., 2020). This clearly illustrates how stigma prevents people from safely engaging in drug use by utilizing drug checking sites (Bardwell et al, 2019). I was unable to locate literature breaking down why this stigma exists or the implications of intersecting identities. It is imperative that we understand how accessing drug checking is impacted by racism, sexism, and other intersecting risk factors such as criminalization.

Dundes (2003) raises an important point that needs to be explored: it is very common, especially in Europe, to have drug checking programs available for people who use party drugs, but not to have drug checking sites that largely support people who use opioids or methamphetamines. I will use this source to discuss how certain groups are permitted and even encouraged to utilize harm reduction resources (rich young people vs. people living in poverty, for example) and the tendency of authorities to allow substances to be tested at raves, but not in a city centre (Dundes, 2003). This source, therefore, will support me in highlighting how certain bodies are policed more than others.

A significant barrier to accessing drug checking sites is the infrequency of locations (Bardwell et al., 2019). While this can be attributed to lack of resources (e.g. funding), the core reason for few locations is the stigma and criminalization attached to providing any sort of support for people who use drugs. For example, the VIDCP is an example of stationary community drug

checking sites, with three permanent locations that are determined by the law requiring drug checking to take place in designated safe consumption sites. Where a drug checking site at inner city locations may be expected (Bardwell et al., 2019), a site at a local pharmacy in an upscale neighbourhood may cause alarm for people who have deeply internalized stigma around drug use as inherently bad. Community drug checking will only succeed if we address criminalization and stigmatization around drug use, especially safe drug use (Wallace et al., 2020). Without these changes, PWUD will continue to consume substances that are unpredictable because accessing community drug checking sites remain unsafe spaces to access.

My research will need to explore how intersectional stigma shapes access to drug checking. My goal is to look for literature on how stigma and structural violence shape access to health care. One potential avenue for this analysis is to engage with the Indigenous Harm Reduction Policy Brief (Interagency Coalition on AIDS and Development, 2019). Another important source for this is Medley et al.'s (2021) recent work addressing how to implement Indigenous harm reduction to work. It discusses the "Not Just Naloxone" program which engaged with holistic, culturally safe approaches to harm reduction to the impacts of the opioid crisis in First Nations communities (Medley et al., 2021). This article, alongside the policy brief, will be a strong starting point in addressing the inequities BIPOC communities face in accessing drug checking, as well as the universality of drug checking.

Universality of Drug Checking

The final section will briefly consider what universality is and might look like for drug checking. The intention is to theorize how to make drug checking sites more accessible, widely available, and de-stigmatized for people who use drugs (PWUD) and their peers.

The ultimate goal of my thesis research is to understand how stigma is implicated in drug use and drug checking in order to identify how said stigma can be challenged and broken down, allowing for drug checking sites to be widely available to all PWUD and their peers. To understand what this might look like, I will draw on literature that explores how drug checking sites have become more widespread in places outside of Turtle Island. In witnessing how accessibility to drug checking has been cultivated, we can better understand how to universalize drug checking here.

In interviews conducted by the Vancouver Island Drug Checking Project, participants clearly state that drug checking services are needed in a multitude of locations that expand beyond inner-city spaces where drug use is overtly concentrated (Wallace et al., 2020). A need for diverse and tailored services was identified, as well (Wallace et al., 2020).

A key challenge for implementing drug checking is the requirement of an exemption to handle illicit drugs as many countries do not view drug checking as a justified reason (Brunt, 2017). This challenge directly connects to the issue of universalization, especially given that drug checking is often forced to take place within safe consumption sites (SCS). Importantly, this has begun to shift in Victoria, B.C. where the first drug checking store front has opened and allows for drug checking outside of a SCS (Wallace, B., Personal communication, March 4, 2021). Despite these positive changes, I continue to wonder: do we need to start by changing laws around drugs to break down drug related stigma or do we need to start by normalizing the realities of drug use and drug checking?

Wallace et al. (2020) identify it is imperative that drug checking sites must attend to the risks of criminalization and stigmatization that can impact participants. Some participants in the Wallace et al. (2020) study said that guaranteed anonymity would increase uptake in drug checking

services, again highlighting the pervasive impacts of stigma. Further, drug checking sites need to be trauma-informed and careful not to reinforce stigma unintentionally (Wallace et al., 2020). For example, Wallace et al. (2020) and Bardwell et al. (2019) identify the decision a participant makes after receiving sample results must remain non-judgmental between the worker and participant. Because throwing away a supply may not be an option, or alternatively, a participant may be seeking to use a harmful substance, such as fentanyl.

Conclusion

This literature review has made clear the gap in research on stigma related to drug checking, especially in the context of the ongoing opioid crisis. As Bardwell et al. (2019), Bardwell & Kerr (2018), and McCrae et al. (2020) acknowledge, a significant percentage of drug checking research has been about party drugs (e.g. MDMA) and the music scene. In my search, I found stigma is not adequately addressed in the context of drug checking. In literature that does address stigma, I found the discussion to be very limited and often only acknowledging stigma once or twice, without providing an in depth analysis.

In my search, I identified few pieces of literature on drug use/checking and stigma that take an intersectional approach. This is problematic as stigma is deeply entrenched in racism, gender/sex inequality, and discrimination based on sexual orientation, culture, and other identities (Goffman, 1963; Tyler, 2020). Drug checking does not exist in a vacuum and is impacted by racism, sexism, colonialism, and other risk factors. It is unacceptable that these issues are not taken into consideration when discussing drug checking and stigma, especially if the goal is to make it more widely acceptable. I am moving forward with a stigma-focused analysis that hypothesizes that the cultivation, maintenance, and nurturing of stigma related to drug use is a means to maintain

white supremacy, colonialism, and the oppression of BIPOC communities by discouraging and preventing the utilization of drug-checking sites and others means of harm reduction.

Chapter Two – A Methodology for Substance Use Stigma

Research Purpose

In the ongoing context of the illicit drug overdose crisis and continued criminalization of certain substances, the implementation of drug checking sites is becoming more necessary across differences of identities and communities. It is key that we understand existing barriers, such as substance use stigma, that prevent individuals from accessing this harm reduction and educational service. The purpose of my research was to address a gap in existing drug checking literature by applying a substance use stigma framework as a secondary analysis of a qualitative study. My aim was to highlight perspectives of service users as they identified potential barriers to accessing drug checking that are rooted in substance use stigma and some potential solutions to those barriers.

Research Question

My research was guided by the question: “Does substance use stigma create barriers to accessing drug checking?” My secondary research question was: “What are possible responses to the barriers substance use stigma poses to access drug checking services?”

As part of developing a substance use stigma framework, which functioned as an analytical tool throughout this research, I asked: “How is stigma/substance use stigma defined and theorized in existing literature?” and “How is substance use stigma discussed in relation to community drug checking?”

Critical Emancipatory Research Paradigm

As described by Wallace et al. (2021), drug checking cannot be guided with a focus on abstinence, rather it focusses on improving health outcomes for PWUD, increasing accountability within the illicit drug market, encouraging and proving the effectiveness of a safe supply and decriminalization, and mitigating the harms of criminalization of certain substance. In alignment with Wallace et al. (2021), my research will avoid a neoliberal focus on harm reduction by respecting a basic right to use drugs and access to harm reduction services. Wallace et al. (2021) also identify that evaluating drug checking seeks to address structural and systemic issues related to the opioid epidemic, rather than individual responsibility in substance use. As both a researcher on this project and someone with my own worldview, I align with these focuses and intentions and will engage with these perspectives throughout my research.

Therefore, the methodological framework that will align with these views and allow me to effectively answer the research questions is a critical emancipatory approach informed by critical epistemologies and emancipatory methodologies inspired by (Pease, 2010) and utilized by MacAdams (2020). MacAdams (2020) explains how "critical epistemologies view knowledge as socially constructed and are critical of how knowledge regimes premised on universal truths are used to establish the dominance of some groups of people over others" and "emancipatory research approaches enable social change to be embedded into the research process and intentions" (p.45). It is imperative that we understand how we know what we know about stigma related to drug checking to change normative perceptions of what it means to use drugs safely and I believe this framework will make this possible. Engaging with this framework will allow me to highlight how stigma and perceptions of substance use and drug checking are socially constructed and can be shifted to emancipate PWUD and drug checking sites.

Emancipatory research aims to break down "unacknowledged constraints, relations of domination, and conditions of distorted communication and understanding that deny humans the capacity to make their future through full will" (Devetak, 2005, p.170). According to Humphries (2008), Pease (2010) and MacAdams (2020) emancipatory research can be accomplished by centering the voices and experiences of communities experiencing oppression and following through with the actions required to incite change.

Decolonizing Research Methodology

Research is inherently implicated in both historical and ongoing European imperialism and colonization (Smith, 2021). In part, this is a result of horrific research studies imposed on Indigenous, Black, and other racialized communities throughout time, but discourse around European/Western researchers and intellectuals as "experts" in groups outside of their own (Smith, 2021). This research is part of a university-based project made up of academics from various disciplines and backgrounds. Therefore, the nature of this project is undeniably connected to colonial methods of research and requires diligence in decolonial efforts to prevent perpetuating or causing further harm to Indigenous, Black, and other racialized communities.

A key aspect of my methodology will be constant reflexivity that engages with and is influenced by teachings from Indigenous community members and scholars and anti-racist and anti-oppressive epistemologies**.** I am approaching my research carrying with me the experiences and stories of people I have worked alongside and learned from as a guide through this work. Smith (2021) speaks to story-telling as a decolonial research methodology. It is a goal of this to bring in the voices, experiences, and stories of those who were interviewed to inform how to think about and approach substance use stigma and its relationship to drug checking. This is brought

forward in my research by centering the opinions and thoughts of those interviewed by sharing direct quotes of stories they have shared.

As shown in my Research Epistemology, Wilson (2008, p. 313) talks about not just being in relationship with participations, but to fully emerge oneself in the relationship as he says, “I am these relationships”. An important way to ensure this is happening is to constantly engage with self-reflexivity throughout the research, checking in with myself to ensure I am being accountable to worldviews other than my own, to the people who offered their thoughts and experiences, and to reflect on dominant practices that are engrained in my ontologies (Gooden & Hackett, 2012; Strega & Brown, 2015).

Methods

Victoria, British Columbia, Canada is one city that has been greatly impacted by the illicit drug overdose crisis. This qualitative study was part of a community-based research project in that city that implements and operates community drug checking sites as a harm reduction approach to the illicit drug overdose crisis and the unregulated illicit drug market. Ethical approval was provided from the Human Research Ethics Board at the Island Health Authority (J2018-069). This research project was a collaborative inquiry with both university (BW and DH) and community researchers. The intention of the research team was to include perspectives and experiences from individuals with academic training and skills, research experience and skills, and established trusted relationships with potential participants.

Sampling

Because an earlier study (Wallace et al., 2020) primarily reached individuals who utilize inner-city resources, like harm reduction and health services, the objective of this research was to both include and expand beyond this demographic to reach individuals who are less likely to

utilize inner-city resources, as well as people who make or distribute substances. While the objective was to reach beyond inner-city service users, everyone who expressed interest was interviewed. Handbills, posters, and emails to local services were utilized to recruit participants because it allowed for third-party recruitment and increased potential to reach a wider audience. Word-of-mouth also functioned as a significant recruitment strategy. Participants were provided with a CDN$20 honorarium.

A total of twenty-six interviews were conducted, eleven of which were lead by the lead researcher, eight by interviewers with the drug user organization, and seven by the partnering harm reduction organization. The average interview was about thirty minutes in duration, with some interviews exceeding an hour and others lasting closer to fifteen minutes. Graduate research assistants from the University of Victoria transcribed recorded interviews verbatim with coding using NVivo 11 (led by TvR). The researchers chose to end data collection as COVID-19 created challenges in continuing research activities.

Data Analysis

This secondary analysis of the data was conducted with a focus on substance use stigma, particularly how it creates barriers to accessing drug checking services and any solutions participants could identify. Data analysis began with SD reading the transcribed interviews. We reviewed existing literature considering how stigma is currently discussed and theorized across disciplines and within the substance use and drug checking context. Thoroughly researching key literature on stigma theories allowed SD and BW to engage in an iterative process in identifying key themes in stigma theory that are applicable to drug checking and substance use stigma. Because a consistent framework from which substance use stigma is typically analyzed did not

exist, we developed a framework based on some of the most commonly referenced methods of thought on this topic.

The key types of stigma function as the parent nodes and two child nodes concluding of "stigma barrier" and "possible solutions". The transcripts were coded in NVivo 11 after SD and BW coded two transcripts separately and then compared and confirmed coding framework before proceeding with the analysis. Upon completing the coding, it was determined that for the purposes of this article, we would move forward with the levels at which stigma can occur, rather than discussing each type of stigma separately. This was determined because it was more efficient and meaningful and because in each level, one type of stigma was less frequent in the data.

For our analysis, we drew heavily on Tsai et al. (2019) typology of stigma related to substance use to guide our analysis. Tsai et al. (2019) highlight that stigma influences several facets of our lives, including societal attitudes, policies, and political agendas—directly impacting how resources are funded, access to care, and media portrayals of people who use drugs. It has been identified that attention is often focused on stigma at the individual level, which overlooks the realities of social, political and cultural contexts (Link & Phelan, 2001; Pescosolido et al., 2008). The analytical framework considered three levels at which stigma can take place: individual level, interpersonal level, and structural level. Each level included detailed explanations and examples of substance use stigma drawn directly from the literature. The individual level included anticipated stigma and internalized stigma, the interpersonal level included episodic and enacted stigma, and the structural level stigma included criminalization stigma and systemic stigma. A description of the framework and associated definitions and supporting references is given in Table 1.

As stigma operates at these different levels, it can function as a tool to control and oppress (Link & Phelan, 2014). This has been referred to as "stigma-power" and is typically theorized as the stigmatizer having motivations to maintain status, wealth, and power, enforce social norms, and marginalize those viewed as unfit for society and as such employs stigma processes that are easily, effectively, and indirectly accepted and enacted in society (Link & Phelan, 2014, p. 25). Based on this interpretation of stigma-power, the stigmatizer is not necessarily limited to a powerful individual or group, but also permeates the general public and the individual, therefore it can exist at the individual, interpersonal, and structural level.

Broadening the analysis of stigma at each level allows us to consider how difference and power are created and maintained, as well as tangible ways to challenge existing norms, cultures, and structures that sustain SUS. While the framework presents each level of stigma as distinct levels for our analysis, we recognize the complexity of SUS and the significant intersections of each level which we also explore. The framework intentionally avoids a hierarchical approach as a strategy to acknowledge the creation and maintenance of SUS at each level, but also highlights that each level is not mutually exclusive and cannot exist without the others. As discussed by Parker & Aggleton (2003) stigma and stigmatization "function… at the point of intersection between culture, power, and difference" and therefore, we must explore the interactions between these levels at which stigma exist to better understand how they are sewn into the social fabric of our society.

Ethical Considerations

During data collection, people utilizing the drug checking sites were offered the opportunity to participate in the study. There was no obligation to participate and they could continue to receive confidential non-judgmental drug checking services if they stopped

participating. Participants were given $20 cash as compensation. Participation remained confidential and participants were advised to only share what they were comfortable with and to refuse any questions they did not want to answer. These ethical considerations aimed to ensure the dignity and respect of those who chose to participate, as well as those who did not. During the interview process, participants were asked about their experiences with substances and their thoughts on drug checking services. The aim of this research is not simply to come to conclusions about how people feel about drug checking and substance use, but to take the knowledge that has been shared to create change in how and where drug checking is implemented and practiced in community. An important ethical consideration is that the data that has been collected is used to create tangible change that will directly impact and improve the well-being of those who participated in our study, their peers in the community, and all people who are impacted by the opioid crisis, drug checking, and substance use.

An ethical consideration relating to both data collection and data analysis is that I was not involved in the data collection process. This is a key consideration because I am receiving data from people with who I was not able to interact. It is important to consider how it may feel for someone who has engaged in research to not know the person who is analyzing and writing about their experiences. While the consent form states that only research staff will have access to this data, and I am part of the research staff, it continues to feel unsettling despite there being no deception in the consent given. One way of mitigating this ethical consideration is to access the audio recordings of the interviews, so I can hear the voices of the participants. This is a humanizing process that will allow for more relationality in the process of analyzing the data**.**

Research Limitations

A strength of this study is that it seeks the perspectives of people who use substances to understand the impacts substance use stigma has on accessing community drug checking. This study was conducted by a research team consisting of community partners from local harm reduction and drug user organizations in Victoria, BC, Canada. Overall, the researchers were successful in reaching people who sell substances and saw less success in expanding to people who use substances and do not generally access inner-city harm reduction services.

A limitation of this study is that it was not originally intended to focus on substance use stigma as it relates to drug checking, therefore answers are not as fulsome as they could be when talking about substance use stigma as a barrier to access. This research study was impacted by the COVID-19 pandemic, which resulted in the research team ending interviews earlier than initially intended. Further research needs to focus directly on community drug checking and substance use stigma to reach groups of people outside of urban centres, including people in rural or reserve communities, to determine how community drug checking can best meet their needs. It is imperative that participants are asked questions relating to the different levels of stigma discussed earlier, if they have experience with substance use stigma, and how they see substance use stigma being broken down. Future research is also needed at a structural level to understand the level of acceptability of community drug checking moving into new spaces, such as pharmacies, medical buildings, and more.

Chapter Three – Results: Identified Barriers and Potential Responses to Substance Use Stigma in Community Drug Checking

The interviews included demographic questions related to substance use and overdose, with specific inquiries into location of residence, common locations for consumption, and the prevalence of harm reduction services for participants. There were 26 people who participated in interviews and 24 interviews in total (with three participants taking part in one interview). Of

those interviewed, 17 identified as female, 8 as male with one participant choosing not to disclose. For the purposes of this study, we identified Victoria, Oak Bay, Saanich, and Esquimalt as "Urban" and Langford, Sooke, Central Saanich as "Suburban/rural" with 21 participants living in urban areas and 5 living in suburban/rural areas. 9 participants identified they are wage earners and 6 identified they are on disability benefits, with some (n = 2) participants income coming from a wage and disability benefits. Some participants (n=7) selected "other" for their form of income. Of those 7, 6 participants have multiple forms of income, including disability and wage. 3 participants identified informal means of income as binning and the drug trade.

Of the 26 participants, 22 reported as people who regularly consume illicit drugs, with about half (n=11) using drugs daily. Of the 22 participants who use illicit drugs, 4 identified as having overdosed in the last 6 months. Nearly all of the participants who use illicit drugs (n=22) identified they never use a safe consumption site. Some participants (n=6) identified they never carry naloxone kits and often do not use near naloxone (n=7). In terms of accessing harm reduction tools, 2 participants have used a needle distribution program, 6 have used methodone, suboxone, or an opioid substitution therapy, and 3 have participated in treatment services. About half (n=10) of the participants who identified as using illicit drugs identified they usually use alone and 20 of those participants identified that one of the common locations for consumption is their own home. Characteristics of the sample are given in Table 2.

Here we present the results according to the substance use stigma framework's three levels with six domains with the findings for stigma barriers and potential responses described for each level. We first present experiences of substance use stigma, then potential barriers it may cause, and finally potential responses or solutions to these barriers.

Individual Level: Anticipated and Internalized Substance Use Stigma

For substance use stigma at the individual level, including anticipated and internalized substance use stigma, we heard that participants both felt too embarrassed or afraid to access drug checking due to a fear of being seen and expected others to feel similarly. Accessing downtown resources was described as intimidating and a barrier to drug checking if located and designed as an inner-city service. For example, participants stated "stigma, others seeing you." was a significant barrier to access [P14] and another said they are "always conscious of who could see them" [P20]. For participants with intersecting identities, in particular sex work, the anticipation of additional stigmas were a serious barrier to access and would lead to avoidance of accessing drug checking services. One participant said, "You know, as a sex worker, having been so deeply stigmatized and still stigmatized for that, I'm hypersensitive to any additional stigmas, so, yeah, downtown doesn't really work for me in that regard, and in the meeting last week it was clear that the participants, many of the participants don't want to come downtown" [P15].

Participants with higher paying jobs or normative careers also identified anticipated stigma as a serious barrier because they do not want to be seen as associating with substance use and those appearing to be poor or experiencing homelessness. For example, one participant said, "Yeah, people don't want to get seen by people like their customers, their clients, or co-workers." and "I think people who live in the suburbs and have real jobs are less likely to be OK with it. Or to be seen as being associated with it." [P18]. Another participant said, "I'm sure there's so many people out there using, that are working, or, and their family doesn't know" [P13].

One participant identified the exponential stigma barrier to accessing drug checking services in small towns or on reserve as there is little opportunity to remain anonymous. Accessing non-profits was identified as a significant barrier for some people, as they do not want to be seen utilizing those services. One participant identified that some people do not feel

comfortable standing outside of a drop-in centre, while another said they would not access a safe injection site for any reason because they would not want to be seen in that space. One participant interviewed in a downtown harm reduction site said, “But even just walking in here, today, I was just like was layered with stigma and shame, and you know, all of that and I kind of had to say to the security guard, which was quite honest … to make him very aware that I’ve never been here before and I don’t belong here.” [P15].

Some examples we heard of shifts in behaviour of people who experience internalized substance use stigma and the resulting barriers include; feeling like they have to justify their substance use with a reason like trauma or self-deficiency, viewing themselves as “at risk” or “an addict” if they used a safe injection site, and feeling concerned about looking like those around them in a drug checking site or not [P8]. At the same time, some participants expressed pride at not having internalized nor anticipated stigma as a person who uses drugs and accessing harm reduction services. One participant expressed how they have “been in that world for a long time” [P22] and are pretty open about substance use, but they recognize this is not the case for most other people who use drugs. They said that people are not always open about their substance use because of how others feel about it. Another participant said they do not feel like they are doing anything wrong because substance use, harm reduction, and accessing drug checking is so normal for them. We also heard participants mention a hierarchy of substance use, where using opioids, for example, is viewed as “pretty bad”, but doing MDMA, “that’s fine” [P8]. This internalized SUS could prevent some people from accessing spaces that serve individuals who use those substances due to how it is perceived.

Internalized stigma was attributed to public health messaging, like “don’t use alone” which was described as not realistic and has just led people to a place where they do not want to

tell people they are using alone. The suggestion we heard was to open up conversations to: how are you using safely? Who are you calling? One participant said, “So, I've had so many conversations with people where like if you’re using alone how are we doing that safely? Who are you calling? Like what does that look like? Like, this is what I do when I use alone. Like having those conversations with people has been super important because I think people feel really ashamed to be like “Oh, I use alone” [P22].

Potential responses to individual level SUS focused on more general public and less stigmatized locations and respectful staff at the sites as well as promotional campaigns to get your drugs checked. For example, some suggested drug checking be completely separate from needle exchanges. Less stigmatizing locations that were suggested including public settings such as pharmacies, medical clinics and community labs, grocery stores and gas stations and recreation centres. Specifically, pharmacies were described as public sites but private enough a space for drug checking to take place as you maintain a level of anonymity and suggested a private booth to sit in during the checking process. Participants also suggested putting drug checking in public bathrooms in libraries, cafes, night clubs like condom machines. One participant expressed a common recommendation to “let’s broaden” access because it is not just happening in downtown centres [P14].

Another solution identified by participants was to implement drug checking services that do not require the physical presence of another person. For example, a mail in or online services, drug checking kits in dispensers in public bathrooms, a drop off service, and personal testing kits that can be disposed of after use. Others recommended more confidential service options such as outreach and mobile and mail-in service options.

Interpersonal Level: Episodic and Enacted Substance Use Stigma

Fewer participants identified specific examples of personal experiences with enacted and episodic stigma. It was more common for participants to identify what enacted and episodic stigma would look like to them, including judgement, rudeness, blaming, and a lack of professionalism or how they have witnessed others being stigmatized. For example, enacted stigma was described as "somebody being rude or being judged for being a junky" [P33]. There were also instances of enacted stigma being reproduced in the interviews, for example, some language that was used by participants to describe different groups of people was both stigmatizing and stereotyping.

Conversely, some participants stated they had not experienced enacted or episodic stigma, especially when accessing community drug checking, where they feel welcome and safe [Q2 13] and while some people may feel unsafe disclosing substance use to their family doctor, registered nurse, or drop in clinic doctor, some participants identified drug checking sites as hopefully different. "Anybody but The Man" should be running drug checking, such as "people that care; harm reduction workers, support workers, people that have compassion for the safety and viability of others but still have no opinion about drug use one way or another. People that accept, acceptance, people that accept drugs as part of their community." [P 26] A recurring finding in the interviews was to normalize drug checking, either by promoting it by word of mouth, advertising it like designated driver programs, and putting drug checking sites in common spaces "where normal people go all the time" or in spaces where people already feel safe [P3].

Some recommended responses to enacted and episodic stigma included hiring staff who are either former substance users or who are committed to harm reduction for people who use substances, viewing them as equally deserving of respect and kindness. Overall, participants felt

people with lived experience would be more accepting of people who use drugs and that substance use is part of their community. However, the definition of and portrayal of a "peer" varies, and throughout the interviews, two levels of substance users were typically identified. One level are those who use street drugs, more commonly thought of as heroin/opioids or meth. The other level being so-called recreational substances, like MDMA or cocaine. Some participants thought it was important to tailor drug checking sites to both groups of people using substances, for example having "hipster" drug checking in a storefront for the recreational group and then continuing to have drug checking in harm reduction spaces in urban or downtown areas [P8].

Structural Level Analysis: Criminalization and Systemic Substance Use Stigma

Structural stigma included mentions of stigma systemically produced and maintained in societal institutions and includes criminalization stigma, usually identified as fear of police and authorities relating to the illegality of certain substances. We heard the multiple barriers to accessing drug checking as it relates to police presence and criminalization; the presence of police, stigma and illegality because you fear who is watching you and fear of being targeted by police, and drug checking being hard to access because you are hiding from police. One participant stated, "police presence isn't causing harm reduction. Police presence is causing death." [P24] and drug checking needed to ensure police would not be on or outside of sites. We heard that the focus of drug checking being on something that is illegal makes service users very aware that what you are doing is illegal when you go to get your drugs checked. It was clear in the interviews that any association with police would discourage accessing community drug checking and breakdown and prevent any opportunity for trust.

In particular, those distributing drugs are likely to avoid drug checking because of risk of criminalization and police getting information about them. A fear of an internet trail that could identify substance use or distribution is also a barrier to accessing services. A key finding relating to systemic SUS was promotion in the media and general public of certain areas in a city as ridden with people "shooting up" and stigmatizing entire areas because of substance use [P4] (in particular, areas with harm reduction sites), as well as stigma attached to non-profits which discourages some people from accessing them. When harm reduction sites were initially implemented in BC, some residents were concerned: "People were like "oh my god, they're going to be sitting there just shooting up." Well, what do you think they are doing anyways, right? I just, it was just so shocking. I lived on [the mainland] at that time, and it was just, the news and everything is like "this horrible place where people are just sitting around shooting up", it's like what do you think they're doing in the [area of city]? They're not having a tea party, you know. [P4].

A number of participants identified a fear of getting caught because they have a high paying stable job that they don't want to jeopardize. Tragically, we heard that people are afraid of going to jail but also don't want to die but they end up dying because they are scared of getting caught, and scared of risk exposure.

One suggestion for addressing SUS at the structural level is to promote harm reduction in schools, and talk about how to use drugs safely and how to access drug checking, and shifting the messaging to younger people from abstinence to safe use of drugs as it is a more realistic approach. One participant suggested nurses in schools could talk about drug checking described as an "invitation to drug checking through education" by one participant [P21]. While another participant suggested simply creating more sites and normalizing the existence of drug checking

to make it the norm over time as a means to mainstream drug checking. Other options for normalizing drug checking mentioned included promoting it on billboards and public campaigns around drug checking and positive drug culture so people can see themselves inside of drug checking. This could increase feelings of belonging and trust in drug checking spaces if they are being promoted as spaces for anyone to utilize.

We heard several participants call for decriminalization and the regulation of the drug supply to make it a safer supply, as well as institutionalizing drug checking, developing more treatment centres, and shifting to treating addiction as a medical problem. One participant suggested copying the aesthetic of cannabis shops that were hip and trendy for drug checking locations. Professional storefronts were suggested so it feels like there are no consequences.

Chapter Four – Discussion: Connecting the Results

This study explores how substance use stigma may impact community drug checking and potential responses from perspective potential service users. Substance use stigma is analyzed at the individual, interpersonal and structural levels to identify how community drug checking can navigate these barriers and mitigate their impacts. It is important to note, interviews did not directly or indirectly ask participants about substance use stigma. Rather, stigma was a major theme of interviews upon reviewing the transcripts and an analysis of impacts of stigma was determined necessary.

This chapter begins by considering the most pervasive types of stigma and how they relate to each other. It then introduces five key themes found in the results including, a hierarchy of substance use, differing definitions of peers, the normalization of substance use and harm reduction through exposure, a public yet private approach, and normalization within criminalization.

Pervasive Stigma Types

Of the six types of stigma identified in the substance use stigma framework it was evident that some forms of stigma were more likely to be identified and/or experienced by participants. The pervasiveness of some stigmas versus others is an important consideration because it highlights the nuanced interactions between levels of stigma and how these interactions may impact which forms of stigma are either more identifiable or more prevalent for those experiencing them. It also suggests which levels of SUS may require more analysis in future research.

The least pervasive form of stigma was at the interpersonal level as fewer participants identified specific examples of personal experiences with enacted and episodic stigma. In fact, it was more common for participants to identify what enacted and episodic stigma would look like to them, including judgement, rudeness, blaming, and a lack of professionalism or how they have witnessed others being stigmatized. In instances where participants did identify experiencing enacted or episodic stigma, they were often in specific settings such as hospitals or spaces outside of harm reduction sites. These participants often stated they were otherwise treated well or did not feel as though they experienced stigma often. This phenomenon aligns with (Gagnon, 2015)'s finding in a study on HIV-related stigma in health care settings where participants more commonly stated they felt they were generally treated well and did not feel stigmatized except for a few isolated events. Often, isolated events took place outside of the HIV network and in spaces where they were particularly vulnerable or unwell, such as in a hospital setting. Gagnon (2015) identifies this as an important finding as this nuance indicates spaces with power imbalances and a lack of harm reduction workers can increase the risk of interpersonal substance use stigma, such as episodic or enacted stigma.

Earnshaw & Chaudoir (2009) discuss how enacted stigma is often demonstrated when others behave in ways that communicate to the stigmatized individual that they are dangerous or have moral failings through judgement, prejudice, and disapproval. These behaviours may include social distancing, avoidance, or speaking ill of the individual either directly or indirectly (Earnshaw & Chaudoir, 2009). In a study on HIV related stigma, Earnshaw & Chaudoir (2009) found that enacted stigma is related to lower mental health and lower social support. It is possible that participants in our study identified fewer instances of enacted stigma because they feel supported by their social surroundings, especially given their connection with existing drug checking and harm reduction sites, such as VIDCP, and generally experience fewer cases of enacted stigma due to the nature of these sites.

It is important to mention that a possible explanation for the lack of identifying examples of episodic and enacted stigma is that the interview questions did not directly ask participants to identify examples, rather, any mention of stigma came up naturally in the interviews. It is also important to acknowledge the ease with which participants could identify what they would perceive as enacted and episodic stigma, even if they did not say or believe they had experienced it themselves. A potential explanation for this is pervasiveness of other forms of stigma at the individual and structural levels which are so deeply entrenched in participants that they focus more on those forms of stigma rather than the actual events that have taken place that lead them to think this way.

A more pervasive stigma-type was found at the first level of the SUS framework, anticipated and internalized SUS. A key finding of this study was that many participants stated they were less likely to access drug checking services and other health related supports because of internalized and/or anticipated stigma. Nearly identical findings were reported by various

studies summarized by Tsai et al. (2019), which also found that participants were less likely to access harm reduction sites, health care centres, opioid replacement therapy programs, and other services. Tsai et al. (2019) also discuss the additional barriers people in small communities face when accessing services as many health care and treatment providers have overlapping roles in the lives of service users which can compromise confidentiality and boundaries. This was also a concern identified in the study, where participants identified the challenges posed by living on reserve and in other smaller communities where it is common for everyone to be interconnected. A similar concern was that community members would witness service users accessing sites like Alcoholics Anonymous or other spaces, which posed the concern that community members would share with others an individual's attendance in these spaces.

When individuals begin to identify with or adopt the negative attitudes directed towards their substance use, accessing drug checking, or the like, they are experiencing internalized stigma. In these scenarios, the individual believes they are less valuable (Tsai et al., 2019). Some participants identified feelings of shame and unworthiness when faced with public messaging calling for people to avoid using alone. The internalization of these messages left participants feeling like they could not be honest about using alone and further retracted themselves from engaging with social interactions and harm reduction services.

In this study, some participants identified a hierarchy in substance use in that some substances, like MDMA are considered more morally acceptable than other substances such as heroin or meth. It is possible this categorization of substance use could impact whether people who use heroin or meth access drug checking sites in areas where this sort of substance use may be less obvious or expected, such as a more residential area. Further it could impact whether people who use substances like MDMA access drug checking sites in areas where other

substances are stereotypically more common, such as urban areas and downtown centres. Avoidance of these areas could suggest individuals have internalized the stigmatization around certain substances and do not feel they deserve access to services as a result. Further, it could mean they are anticipating experiencing the stigmatization that stems from other substances if they are scene in a space that is more likely to associating with a different form of substance than the one with which they typically engage.

When an individual is experiencing anticipated stigma, they are aware of the potential negative attitudes people may express or feel towards them and come to expect negative interactions as a result (Tsai et al., 2019). Many of the participants were individuals who felt comfortable disclosing their substance use and accessing drug checking and suggested that people who do not access drug checking sites avoid them because of a fear of being seen or being in a position where they have to disclose their substance use in some way. This example of anticipated stigma is supported by findings from Earnshaw & Chaudoir (2009) where individuals with HIV were less likely to disclose their HIV status out of fear of being socially rejected.

The anticipation of being stigmatized by colleagues or peers if they were to witness an individual accessing drug checking was common in this study. These findings are supported by Measham (2020) where nearly identical sentiments were shared by individuals who feared or refrained from accessing drug checking sites. A suggested response to this concern was to mask that individuals are accessing drug checking by putting drug checking sites in spaces that people could access for other reasons (Measham, 2020).

Interestingly, structural stigma, particularly criminalization, was also pervasive in the experiences of participants. The results suggest there is a link between interpersonal and systemic stigma in that systemic stigma may be a significant contributing factor to both

anticipated and internalized stigma. This is interesting for at least two reasons: first, the literature suggests there are fewer analyses on systemic stigma, including substance use stigma with a more common focus on the impact of SUS at the individual level and (Gagnon, 2015; Tsai et al., 2019). It also suggests there is a significant impact that systemic development and reproduction of SUS has on how individuals perceive themselves in relation to substance use and SUS.

An analysis of power is necessary here to better understand the implications of systemic SUS on the individual accessing drug checking. Parker & Aggleton (2003) say stigma is integral to our social order as it exists at the centre of culture, power, and difference. Further, stigma is considered a tool to maintain inequities between those who have stigmatized identities and those who do not (Earnshaw & Chaudoir, 2009; Parker & Aggleton, 2003). While the studies conducted by Earnshaw & Chaudoir (2009) and Parker & Aggleton (2003) both discuss HIV-related stigma, their conceptualizations of stigma and power are applicable and related to SUS, particularly in terms of how stigma is developed and maintained and functions to oppress those with stigmatized identities.

SUS at the systemic level has at least two significant aspects: first, it can be so explicit that it influences the behaviours and beliefs of individuals who may become stigmatizers. It can also disguise the harms caused by stigmatizers because they do not necessarily have to directly engage in enacted or episodic acts of stigmatization for their means to be achieved at the systemic level (Link & Phelan, 2014). This suggests the systemic forms of SUS are so pervasive that they are dominant and affective at the individual and interpersonal levels.

Link & Phelan (2014) suggest that stigmatization more broadly (and presumably at all three levels) is less commonly expressed in overt and direct actions and is more likely to be achieved through covert and indirect actions. This is based on their findings that stigma power

can be enacted when the stigmatized individual understands how their identity is perceived and inadvertently acts in accordance with the interests of the stigmatizer, which according to Link & Phelan (2014) is to marginalize, oppress, and silence stigmatized individuals. This may support our finding that fewer participants identified instances of interpersonal stigma due to the avoidance of circumstances where such treatment could arise, including avoiding accessing spaces like drug checking sites.

Turan et al. (2019) discusses the rise of the term "intersectional stigma" which builds on Crenshaw's (1989) work on intersectionality. Tsai et al. (2019) discuss how each existing type of SUS intersect with one another and serve to reinforce the harms of each type, at each level. Thinking about the intersection of SUS with other factors in peoples lives allows for a holistic approach to understanding the issues SUS can cause for those impacted by it. This intersection of each type of SUS and the diverse identities of those who are stigmatized creates a complex and nuanced circumstance that inevitably reproduces more extreme cases of marginalization and oppression. For example, the impact that SUS has on a middle class, middle aged white male is significantly different than that of the impact SUS may have on a Black woman experiencing poverty or an Indigenous non-binary person living in a rural area. The interaction of SUS with privilege is an important nuance to understand and a particular focus needs to be given to the role SUS has in reproducing other structural barriers.

A Hierarchy of Substances and Substance Use Stigma

At the individual level, participants identified feelings of fear and embarrassment when accessing or considering accessing drug checking sites, especially where community drug checking is viewed as an inner-city service within a non-governmental organization serving a clientele assumed to use drugs. Fear of association with these types of services may be rooted in

the hierarchy of substances identified by some of the participants. For example, there was a clear distinction between substances typically viewed as “street drugs” versus “party drugs”. The implications of SUS in this form could result in shame for those using substances that are considered more harmful and the avoidance of drug checking services if the site does not seem safe or relevant for them.

Enacted stigma is defined as engaging in behavioural manifestations, including discrimination and social distancing, based on views of social and cultural unacceptability (Scambler, 2004; Tsai et al., 2019). It was made clear in the interviews that enacted stigma exists amongst substance users and is therefore not limited to non-substance users enacting SUS. The focus on challenging enacted stigma should include PWUD and those who do not. It is possible the anticipation of stigma while accessing drug checking sites could be linked to this hierarchy of substance use as some identified the avoidance of accessing drug checking sites and non-governmental organizations as they did not feel they “belonged” in those spaces.

Some participants identified the avoidance of downtown areas and resistance/hesitation towards accessing non-profits for services. Why do people want to avoid these spaces? Do they fear being grouped with people who are not living in traditional housing or are otherwise unhoused? There were also instances of enacted stigma being reproduced in the interviews, for example, some language that was used by participants to describe different groups of people was both stigmatizing and stereotyping. These findings highlight that hierarchies exist in substance use stigma not only for those who do not use substance, but also for those who do. It was clear in the interviews that some participants view some substance use as superior or “better” (like MDMA or cocaine), and others as more concerning or “bad” (like meth or heroin). It is clear that

SUS is not independent from substance use, but inextricably linked to different types of substance use within the user community.

Differing Definitions of Peers

Peers as service providers in drug checking was consistently identified as facilitating trust and reducing stigma while there was also trust in having professionals to be able to operate the technologies and accurately analyze and report the findings. The definition of peer varied as much as the respondents did and typically the peer was hoped to reflect their social location and also to be knowledgeable about their substance whether that be an opioid, stimulant or psychedelic. We heard specifically that peer knowledge about drugs need to be inclusive of the range of substances and not limited to street drugs linked to overdose. PWUD bring a unique perspective to harm reduction services and have a personal understanding of how to implement effective client-centred services, policies, and programs (Marshall et al., 2015). The suggestion to pair peer workers with professionals, like pharmacists and chemists, in the drug checking setting would not be unique, either. Supervised consumption sites (drug consumption rooms) frequently feature peer workers alongside non-peer harm reduction staff and may include nurses as well (Watson et al., 2020).

Several participants sought to have professionals and peers present in community drug checking sites, both parties being “anti-stigma” and “non-judgemental”. The interest in peer to peer service was very common and could be viewed as a response to stigma at the interpersonal level in that lived experience may reduce the chance of the judgment or stigmatization when it is someone who understands substance use in some capacity. With this unique perspective, there is opportunity for compassion and empathy around barriers that substance use stigma can cause for people who use drugs and the courage it may take for some to access drug checking services.

Trust was a common concern within this theme, with some participants stating they trust medical professionals and others stating they would not feel safe with those same professionals. It was clear in the interviews that any association with police would discourage accessing community drug checking and breakdown and prevent any opportunity for trust. A lack of trust in professionals, particularly in medical professional and law enforcement, is not a new phenomenon and is certainly a pervasive one. As we know, racism and discrimination are deeply entrenched in the function of these professions and often result in the mistreatment of Black, Indigenous and all racialized communities (Hardeman et al., 2016). The expectation or fear of mistreatment could result in a lack of trust in medical professionals presence in drug checking sites.

Normalization of Substance Use and Harm Reduction through Exposure

Normalization of substance use and harm reduction has been approached through an exposure-method by some groups and organizations in British Columbia (Bardwell et al., 2018). In one study, peer-based supervised injection sites were implemented in an emergency shelter in Vancouver, British Columbia (Bardwell et al., 2018). The findings suggested that both supervision of substance use and substance use were normalized through the implementation of these practices. While the context of this study took place within shelters, the impact of normalization through exposure proved effective and aligns with suggestions from participants in our study, who believe creating more spaces for drug checking will inevitably normalize it as the public gets used to seeing it.

Another common example of normalization through exposure is dance and music festivals. We know that dance and music festival are spaces where drug checking is normalized, accepted, and even popular (Betzler et al., 2021). These services are viewed as key spaces for

individual harm reduction (Betzler et al., 2021; Larnder et al., 2021). From my perspective, these spaces exhibit the normalization of substance use and drug checking largely as a result of a lack of police presence. While substance use may not be encouraged, it is accepted and expected in dance and music festivals and the goal is to keep everyone safe and informed on the substances they are consuming. This normalization is also likely impacted by the demographic that typically attends dance and music festivals. For example, attendees are more likely to have access to disposable income (they can afford tickets), they are often younger adults, and they are more likely to be taking substances, like MDMA, that are considered "more acceptable" or "better", which is a finding supported by the data in this study. While it is important that these practices continue in these spaces, the normalization of substance use and drug checking has to move beyond the barriers of dance and music festivals and permeate all forms of substance use, no matter the location or individual.

Public yet Private

Expanding drug checking with a public yet private approach has the potential to normalize the existence of drug checking and act of accessing it in a way that reduces and eventually eradicates substance use stigma. Over 50% of participants identified the need to expand drug checking locations to other public and commonly accessed spaces, like pharmacies, grocery stores, gas stations, and medical offices. General public locations were perceived as less stigmatizing than public health or harm reduction sites. At the same time, privacy is essential and ensuring privacy in these public settings is necessary due to the stigma related to drugs. Indeed, participants frequently described drug checking be openly public yet still anonymous. Integrating drug checking within services accessed by the general public was viewed as normalizing what is deemed illicit and needing to be hidden which in turn may enhance the trustworthiness of the

drug checking service for some. I think creating spaces for anyone to access for any reason will increase access to drug checking significantly because the fear of being identified for accessing that service will be reduced. Privacy is an important part of our lives and not everyone will be comfortable accessing drug checking publicly.

The space that was most commonly suggested for public yet private drug checking was pharmacies. The adoption of pharmacy-based drug checking into pharmacies in rural, suburban, and inner-city communities has the potential to make drug checking more accessible by reducing stigma related to substance use and harm reduction. Pharmacies achieve a public yet private approach in that they are spaces open to the public and which anyone could access for any reason. They offer privacy in that it is common for pharmacies to have private rooms for clients to access for modesty and/or privacy when receiving a shot or sensitive information. A similar practice could be utilized with drug checking, where a client may indicate at a pharmacy window that they are there for drug checking. One option may be for the client to enter a private booth or room with a pharmacist and/or peer worker to have their sample checked or to provide the sample to the pharmacist through the window and receive results in the private space. Alternatively, clients could provide the sample to the pharmacist and receive the results in a discreet envelope or bag, similar to what one is provided when picking up a prescription. A public yet private approach will create opportunities for anyone to walk into a space, like a pharmacy, to have their drugs checked, to get a shot, or to have a conversation about their prescriptions without anyone knowing why they are truly in that space.

Another benefit to pharmacy-based drug checking is increasing accessibility for those engaging in third party drug checking. Based on the findings from (Larnder et al., 2021), drug checking is frequently accessed by someone other than the person who will be using a substance

– this is known as “third party drug checking”. Pharmacy-based drug checking could support third parties accessing these services on behalf of others because pharmacies are a familiar and wide-spread resource that may be more accessible for friends, peers, workers, or family members engaging in third party drug checking.

While creating accessibility for some people who use drugs, these more public and sometimes more professional spaces, like pharmacies, are recognized to being inaccessible and unsafe for others including racialized folks, women, and trans*, non-binary, and gender diverse folks and people living in poverty (Urbanoski et al., 2020). Further, medical professionals and spaces have been found to have negative attitudes towards people who use substances and often lack adequate training and education around substance use and critical harm reduction approaches (van Boekel et al., 2013). At the same time, locating drug checking within an overdose prevention site or within a shelter for people who are homeless obviously also limits its reach and relevance to the overall population of people who use drugs and who could benefit from drug checking. Therefore, it is not only important to implement drug checking sites into pharmacies but to continue to offer these services in a variety of spaces that are accessible to all service users. A one size fits all approach inevitably excludes peoples from access and expanding services into pharmacies could contribute to closing the existing gap in access to community drug checking.

Finally, for this approach to be effective, it is imperative that police presence and surveillance is prohibited. In a study on safe consumption sites, Bardwell et al. (2018) discuss how participants felt more comfortable and less worried about consuming substances in a public (visible to others) yet private (within a shelter) space because there was no fear of police intervention. While these findings apply to peer witnessed substance use, the principle of

providing a private yet public space for people to have their drugs checked without fear of criminalization can be applied here. Bardwell et al. (2018) suggest that normalization has the power to reduce drug-related risk and to increase agency among people engaging in harm reductionist practices.

Normalization within Criminalization

The normalization of drug checking was a recurring theme to addressing substance use stigma while the ongoing criminalization of drugs and people who use drugs hinders such efforts. Recommendations to normalize drug checking included health promotion campaigns similar to designated driver campaigns, implementing drug checking within common spaces where people already go or where people already feel safe, and promoting the positive benefits of drug checking more than the harms and risks of drug use. Unfortunately, participants in this research related how public health promotion campaigns and even anti-stigma campaigns directed at substance use and people who use drugs too often reinforce SUS and cautioned on how such campaigns could help or hinder drug checking. For example, Just Say No to Drugs may be an obvious anti-drug campaign, but more recent messages of Don't Use Alone also convey blame and shame while Support Don't Punish and I Love Someone Who Uses Drugs are more normalizing. Care needs to be taken to think about whether these campaigns can operate to reinforce SUS for those with the most structural disadvantage and reinforce processes of internalized stigma related to the hierarchy of substance use

Being criminalized is clearly stigmatizing and the presence of police erodes safety and trust for people who use drugs and are in need to access drug checking and other harm reduction services and sites services (Collins et al., 2019; Mercer et al., 2021; Wallace et al., 2020). Furthermore, criminalization disproportionately impacts Indigenous, Black and other racialized

groups, expectant birth-givers, trans and gender diverse folks, sex workers, and others who face oppression in daily life (Collins et al., 2019; Dollar, 2019; Perritt, 2020). A clear theme from this research was having access to drug checking in spaces that are not currently stigmatized was suggested to ease the anticipation of being stigmatized while accessing a drug checking site. And yet, cultural safety for people who use drugs varies and accessibility for some may be inaccessibility for others (Urbanoski et al., 2020).

Decriminalization has the potential to greatly reduce substance use stigma both by normalizing substance use and removing the morality, the view that something is either right or wrong, from our perception of people accessing drug checking sites. Drug checking and decriminalization are well-aligned and arguably instrumental to each other in the absence of widely available regulated drug supply.

Often, we assume that change comes from a top-down hierarchical approach, where laws and/or policies and media campaigns have to change in order to create change at the individual and interpersonal level. Our findings challenge this assumption in that the importance of normalizing substance use, shifting the discourse on addiction from a deficit to a medical condition, and accepting our neighbours and peers for who they are is highlighted as a strong solution/option. This being said, decriminalization, legalization, and regulation of the drug supply is also viewed as necessary to combat SUS when accessing community drug checking sites.

Chapter Five –Conclusion

"Without community, there is no liberation" – Audre Lorde

This research study engages in a critical analysis of the barriers substance use stigma creates for those accessing community drug checking, as well as suggestions to increase or

facilitate stigma-free access. An analytical framework was utilized to understand the impact substance use stigma has on those accessing drug checking services, as well as those who avoid accessing these services as a direct result of substance use stigma. This analytical framework examined substance use stigma at three levels: individual, interpersonal, and structural.

Because community drug checking is becoming more widely accepted and viewed as a response to the illicit drug overdose crisis, it is important to understand what barriers and facilitators exist to best implement these services. Community drug checking is not limited to responding to the overdose crisis, but also addresses the unpredictable drug supply and provides data that can inform substance use. Anyone can access drug checking services and each person who chooses to should have the opportunity to do so without fear or risk of adverse treatment. This study found that the risk of criminalization and the anticipation of being poorly treated appear to be the most significant barriers related to stigma, rather than actually experiencing stigma. Further, it appears the implementation of community drug checking creates tensions that need to be navigated as sites and services balance a hierarchy of substances and stigma; differing definitions of peers; public yet private locations; and, normalization within criminalization.

The findings suggest the solution to substance use stigma and drug checking will not come from continuing as we are, but through making changes at all levels (individual, interpersonal, and structural) and thus for all people who access community drug checking. It is imperative that changes are implemented at each level that substance use stigma functions. As discussed in earlier chapters, stigma does not exist in a vacuum at each level, but interacts with and impacts stigma at other levels. This complexity suggests that creating shifts at each level will have an impact on others. For example, if public media campaigns shift negative to positive

language when discussing substance use and drug checking, media consumers may be influenced to expand how they think about and treat those impacts by substance use stigma.

While the findings of this study confirm the substance use stigma as a barrier, they also suggest ways to challenge and reduce substance use stigma in drug checking settings. For example, pharmacy-based drug checking could increase access to drug checking and normalize safe and informed substance use. Further studies reaching rural communities, people who distribute substances, and people who live in suburban areas are necessary to better understand how the implementation of pharmacy-based drug checking would impact different communities and support informed substance use. These findings should, however, influence drug checking services and policy makers to expand drug checking into pharmacy settings.

I make the following recommendations based on the research findings which make clear that substance use stigma is a pervasive and harmful phenomenon that requires a shift in policy and practice. First, community drug checking be implemented in pharmacy settings to increase access and reduce stigma by utilizing a public yet private approach. This should take place in addition to drug checking in store fronts and harm reduction services. It is imperative that drug checking sites are located in spaces that anyone would feel comfortable accessing, especially because substance use stigma will not end overnight and will likely continue to be pervasive in society for some time. Creating and maintaining spaces for those in inner city areas, on reserve, in remote communities, and in suburban areas all need access to drug checking. Pharmacy-based drug checking creates opportunities for increased access in areas expanding beyond inner city spaces.

My second recommendation is a shift in media messaging from public health from negative narratives using language like “stop using drugs” or “don’t use alone” to positive

language that encourages accessing harm reduction tools and other services, like drug checking. It is important that we acknowledge that substance use is going to continue regardless of laws and public opinion, so shifting how we talk about substance use and accessing services can positively reinforce taking the steps to engage in informed and safe substance use. If we promote drug checking services on bus stops, posters, and billboards, it will provide opportunities for more people to learn about the positive impact drug checking has on the lives of so many people who engage with substances themselves or who's loved ones and community members do. This could be a significant step towards normalizing drug checking and reducing substance use stigma.

I also recommend discussions in school-age settings that engage in factual and stigma-free conversations around substances and how to use them in an informed way. For example, shifting the narrative away from abstaining from substance use to informing children and youth on ways to access drug checking and other harm reduction materials could reduce the stigma presented if they choose to engage in substance use in their lives. Removing shame and being informative could have huge impacts on how we think about drug checking and substance use stigma because it normalizes informed use and harm reduction tools.

Decriminalization of substances currently classified as illicit is a largely controversial issue, although a common one in harm reduction discourse. It is probable that removing the criminality attached to substances could decrease the stigma often associated with them and thus, reducing substance use stigma. Decriminalization could remove the fear of police intervention, loss of career or family, and other factors that contribute to substance use stigma at all levels. The need for drug checking would continue and a society where service users could access drug checking sites without hesitation could exist.

My final recommendation is for an increase in research that focuses specifically on the intersection of substance use stigma and community drug checking. It would be beneficial to ask participants direct questions about substance use stigma at the individual, interpersonal, and systemic level. In particular, it would be helpful to know more about enacted and episodic stigma and how it impacts internalized and anticipated stigma at the individual level. This understanding would offer more insight into tangible ways of addressing and challenges substance use stigma in drug checking services.

Working together, in community, is the only way we will fight back against substance use stigma.

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APPENDIX A

Table 1: Analytical Framework			
Substance Use Stigma	Individual Level	Internalized	According to (Earnshaw & Chaudoir, 2009) internalized stigma refers to the process of believing in the negative feelings imposed on those who use substances, it is the internalization of negative beliefs and feelings associated with substance use. (Tsai et al., 2019) explain internalizing stigma can result in maladaptive behaviours, such as withdrawing from care or resources. This can lead to the belief that one's status in society is less valuable than others (Tsai et al., 2019).
		Anticipated	The expectation that one will experience prejudice, discrimination, or judgement is considered anticipated stigma, as defined by (Earnshaw & Chaudoir, 2009). It is common for an individual who anticipates stigmatization to adapt their behaviours out of fear of rejection by others and avoid services or means of care that could be beneficial to their well-being (Tsai et al., 2019). For example, one might avoid a community drug checking service, which could lead to negative impacts for that individual, such as consuming unknown or fatal substances.
	Interpersonal Level	Episodic	Episodic stigma refers to isolated events where stigmatization occurs over time, rather than on a consistent basis (Gagnon, 2015). For example, if an individual experiences substance use stigma as they enter a safe consumption site or a community drug checking site at least once, but not constantly, they would be experiencing episodic stigma.

		Enacted	Enacted stigma is demonstrated when others behave in a way that communicates judgement, prejudice, or disapproval (and stigmatization) of a stigmatized individual through actions such as social distancing or avoidance (Earnshaw & Chaudoir, 2009). This often takes place when the public perceives a stigmatized individual as dangerous or to have moral failings (often based on stereotypes) and discriminates against or avoids that individual for that reason (Tsai et al., 2019). Enacted stigma also means the individual who has been stigmatized believes they have been treated in a way that is discriminatory and/or prejudiced (Earnshaw & Chaudoir, 2009). Enacted stigma becomes structural when the

			attitudes and beliefs are merged with cultural norms, laws, and policies.
	Structural Level	Systemic	Systemic stigma is enacted and enforced by agencies, institutions, and influential individuals within groups of people and targets those who are stigmatized by attempting to manage risk and govern their interactions (Gagnon, 2015). The act of using stigma as a resource to oppress has been identified as stigma power (Link & Phelan, 2014). (Link & Phelan, 2014) describe the relationship between systemic stigma and stigma power as a means to oppress or maintain the oppression of stigmatized groups and to reinforce stigmatized identities in society. An important factor of systemic stigma is it protects the stigmatizer from repercussions of discrimination, because the stigmatization is embedded in norms, policies, or resources and the goals of stigmatization are achieved at the macro level (Tsai et al., 2019) and (Link & Phelan, 2014).
		Criminalization	Criminalization is a form of stigma that is closely related to substance use and is a common and effective way for governments to "control and exclude persons who are defined as threatening to an existing social order" (Dollar, 2019) pg. 306). Criminalization can be more common for people who use substances and who are experiencing poverty and/or are racialized or experiencing other intersecting identities (Dollar, 2019). It is an effective tool to "other" PWUD and maintain existing hierarchies in society (Dollar, 2019) . One example of criminalization stigma is policing around community resources like safe consumption sites, needle exchanges, or community drug checking, often leading to mistrust in a service and decreased access (Collins et al., 2019).

Board of Record

Island Health
Health Research Ethics Board (HREB)
2400 Arbutus Road, Room 205
2nd Floor
Queen Alexandra Centre
Victoria, BC V8R 4A9

Certificate of Ethical Approval for Harmonized Minimal Risk Health Study

Also reviewed and approved by:
University of Victoria

Principal Investigator:	Primary Appointment:	Board of Record Approval Reference #:
Dr. Bruce Wallace	**University of Victoria**	**File No. J2018-069**

Study Title: Implementing Innovations in Drug Checking: A Harm Reduction Pilot in Response to Illicit Drug Overdose

Study Approved: 31 August 2018 Expiry Date: 30 August 2019

Research Team Members: Dr. Bernadette Pauly, Dr. Dennis Hore, Dr. Richard Stanwick

Sponsoring Agencies: **N/A**

Documents included in this approval:

- Study Protocol, Version 3, Dated, 31 August 2018
- Participant Consent, Version 2, Dated, 22 August 2018
- Interview Consent, Version 2, Dated, 22 August 2018
- Interview Recruitment Poster, Version 2, Dated 22 August 2018
- Recruitment Poster Version 6, Dated, 31 August 2018
- Recruitment Handout, Version 2, Dated, 31 August 2018
- Interview Guide, Version 2, Dated, 22 August 2018
- Survey Instrument, Version 2, Dated, 22 August 2018

This ethics approval applies to research ethics issues only and does not include provision for any administrative approvals required from individual institutions before research activities can commence.

The Board of Record (as noted above) has reviewed and approved this study in accordance with the requirements of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2, 2014).

The "Board of Record" is the Research Ethics board designated on behalf of the participating REBs involved in a harmonized study to facilitate the ethics review and approval process. In the event that there are any changes or amendments to this approved protocol, please notify the Board of Record.

Board of Record Research Ethics Board Representatives

Name: Ms. Sherri Pooyak, MSW
Title: Co-Chair, Island Health HREB
Date: 31 August 2018
Signature:

Name: Ms. Crystal White, MA
Title: Co-Chair, Island Health HREB
Date: 31 August 2018
Signature:

Invitation to participate in an interview about drug checking services

Drug checking typically uses multiple instruments to determine the active ingredients, fillers, cutting agents, and any unexpected drugs, in samples of substances.

You will be offered $20 to take part in the face-to-face interview which will last less than an hour.

The interview will be scheduled at a time and place that is convenient and confidential for you and the interviewer.

You will be asked for your thoughts about drug checking services as well as your experiences with substances.

You will be advised to only share what you are comfortable with sharing and you have the right to refuse to answer any question(s) you do not want to answer, and/or to withdraw from the study at any time. We'll keep your identity confidential.

Being interviewed is voluntary and you are under no obligation to participate.

If interested, please contact the researcher and leave a confidential message:

[redacted]

Name of Research Project: *Implementing Innovations in Drug Checking: A Harm Reduction Pilot in Response to Illicit Drug Overdose*

Email invitation to Recruiters

We are part of a University of Victoria study evaluating drug checking services. Drug checking typically uses multiple instruments to determine the active ingredients, fillers, cutting agents, and any unexpected drugs, in samples of substances. **We are seeking to hear from people about their thoughts on drug checking.**

Interviews are open to anyone 19 years of age or older, including people who use or used to use substances, their family or friends, and/or people who make or distribute substances. We are hoping to connect, in particular, with people who do not typically access downtown health and social services and who live outside of the downtown core.

Participants will be offered $20 to take part in a face-to-face interview which will last less than an hour.

Participants will be asked about their thoughts on drug checking services as well as their experiences with substances. Participants will be advised to only share what they are comfortable sharing and have the right to refuse any question(s) they do not want to answer, and/or to withdraw from the study at any time. Participation is confidential.

Being interviewed is voluntary and there is no obligation to participate.

We have attached a recruitment poster and handbills which you can display and distribute to interested participants. **Interested participants can contact the researchers directly via information provided on the handbill and poster**.

If you have any questions, please get in touch with [redacted]

Implementing Innovations in Drug Checking: A Harm Reduction Pilot in Response to Illicit Drug Overdose

PARTICIPANT INFORMATION & CONSENT FORM

PRINCIPAL INVESTIGATOR AND STUDY TEAM:
Bruce Wallace, (UVIC Social Work & Canadian Institute of Substance Use Research)
[redacted]

Dennis Hore, (UVIC Chemistry)
[redacted]

Dr. Richard Stanwick, (Island Health)
[redacted]

Background and Purpose of the Study

The purpose of this study, a drug checking pilot project, is to better understand drug checking as a potential harm reduction response to the overdose crisis. You are being asked to participate because you have expressed interest in discussing drug checking, and are over 19 years of age. If you are interested, we now invite you to participate in an interview about your views on drug checking. Your participation must be free and voluntary. You are free to stop at any time.

Location of Research

This research study will be done at the pilot project sites in Victoria and other communities on Vancouver Island.

Number of Participants

While the study will provide hundreds of drug tests the project also includes more detailed interviews with about 100 interested individuals.

Project Funding

This project is being funded by Health Canada's Substance Use and Addictions Program as well as the Vancouver Foundation.

What is Required if I Participate?

If you decide to participate in this part of the study, you will be interviewed by the researcher about your views on drug checking. The interview is expected to take less than an hour.

What are the Possible Risks or Inconveniences of Participating?

Due to the nature of the interview, there is potential for participation to cause you emotional discomfort, stress, or social risks such as loss of status or reputation. To prevent or to address these risks, you will be advised to only share what you are comfortable with sharing; you have the right to refuse to answer any question you do not want to answer without consequence.

What are the Possible Benefits of Participating?

We cannot promise any personal benefits. However, you may feel satisfied because you are taking part in research that will inform responses to overdoses and other harm reduction services.

Do I Have to Take Part?

You are free to choose to participate or not. If you decide not to participate, your access to the drug checking pilot project and any other services will not be affected in any way. By consenting, you have not waived any rights to legal recourse connected to research-related harm. If you decide to participate but change your mind during or after the interview, you can let the research team know. We will stop and you can withdraw without any consequences or explanation. If you do withdraw either during or after the interview, we will stop the interview and ask what you would like us to do with the information you shared, either 1) using what we already collected or 2) destroying what we collected.

Will I be Paid for Taking Part?

As a way to thank you for your time and participation, you will be given $20 as a thank you.This is not meant to influence your decision to participate.

Confidentiality & How my Personal Information will be Used

In order to protect your privacy, your name will not appear in any documents that come out of this research. Any potentially identifying features will be removed prior to data analysis. With your permission the interview will be audio-recorded and hand-written notes will be taken. These recordings and the information you share with us will be kept confidential. Only the research staff will have access to this information. You should only share whatever information you are comfortable sharing. Your data will be safely stored in a locked cabinet at the University of Victoria for five years following the study after which any consent forms and data will be destroyed. Data from this study can be used in journal articles, reports and presentations. Your consent to collect your information for the purpose of this research project will expire when you complete the study.

Disposal of Data

Your data from this study will be disposed of in the following manner:

Data Source	How Destroyed	When Destroyed
Interview Audiofiles	Deleted	Immediately following transcription.
Transcript files	Deleted	These will be retained for 5 years after study completion. This is required by my funding agency.

Sharing of Study Results

A summary of the study results will be provided to you upon request.

Who Should I Contact if I Need More Information or Help?

The contact information for the Principal Investigators is provided on the first page of this Informed Consent Form. For questions or concerns about your rights as a research participant, please contact the Island Health Research Ethics Office in Victoria at (250) 370-8620 or email: researchethics@viha.ca.

CONSENT

Your signature below indicates that:

1. All sections of this Consent form have been explained to your satisfaction
2. You understand the requirements, risks, potential and responsibilities of participating in the research project, and;
3. You understand how your information will be accessed, collected and used.
4. All of your questions have been fully answered by the researchers.

Name of Participant (print)	Signature	Date
Name of Person Administering Informed Consent	Signature	Date

Role of Person Administering Informed Consent

***A copy of this consent form will be given to you, and a copy will be kept by the researcher*.**

Implementing Innovations in Drug Checking: A Harm Reduction Pilot in Response to Illicit Drug Overdose: **Interview Cover Sheet (January 20, 2020)**

Code # Date: Site:

This section has some demographic questions. You can skip any question.

What is your age? _____
Skip

What gender do you identify with?
Male
Female
Non-binary
Transgender
Other: (_____)
Don't know
Skip

What ethnic group or family background do you identify with? (Check all that apply)
Indigenous (that is, First Nations, Métis or Inuk (Inuit)?)
White
South Asian (e.g., East Indian, Pakistani, Sri Lankan, etc.)
Chinese
Black
Filipino
Latin American
Arab
Southeast Asian (e.g., Vietnamese, Cambodian, Laotian, Thai, etc.)
West Asian (e.g., Iranian, Afghan, etc.)
Korean
Japanese
Other — specify
Don't know
Skip

Do you consider yourself to be…?
Lesbian or gay
Bisexual
Two spirit
Heterosexual or Straight
Other:_____
Don't know
Skip

Have you completed any of these? (check all that apply)
High school diploma
High school equivalency
Registered Apprenticeship, trades certificate or diploma
College, CEGEP or other non-university certificate or diploma
University certificate, diploma or degree
Currently a student (enrolled in a training, certificate, diploma, or degree program)
Other
Don't know
Skip

What city are you living in?
Victoria
Esquimalt
View Royal
Oak Bay
Saanich
Central Saanich
North Saanich
Sidney
Colwood
Highlands
Langford
Metchosin
Sooke
Salt Spring Island
Other Gulf Island
First Nations Reserve
Other: (_____)
Don't know
Skip

Are you currently living alone?
Yes
No
Don’t know
Skip

What best describes where you live?
Supportive or subsidized housing
Own house/condo/townhouse
Rent apartment/house/townhouse
Family or friend’s place
Hotel/motel
Rooming house or SRO (e.g., single room occupancy)
Shelter or hostel
Drug treatment facility
Public place, street, park etc.
Other: (_____)
Don’t know
Skip

What is your main source of income?
Wages or Salary including from own business
Disability Benefits
Welfare/Income Assistance
Employment insurance, worker’s compensation
Pension, old age security or guaranteed income supplement
Investments including retirement funds
Informal employment (e.g., drug trade, panhandling, binning, etc.)
No Income
Other: (_____)
Don’t know
Skip

What was your total <u>personal</u> income last year? Please give your best guess.
Less than $5000
$5,000 to less than $10,000
$10,000 to less than $15,000
$15,000 to less than $20,000
$20,000 to less than $40,000
$40,000 to less than $60,000
$60,000 to less than $80,000
$80,000 to less than $100,000
$100,000 and over
Don't know
Skip

These questions are about drug use. You can skip any question.
How often do you use *illicit* drugs?
Daily (How many times per day usually?:_____)
Three or more times per week
Once or twice per week
Once in a while, not every week
Occasionally, not every month
Rarely, not every year
Never
Don't know
Skip
If never, enter does not apply for questions on use

Do you have a drug of choice? (check all that apply)
-No
-Tobacco
-Alcohol
-Cannabis (including shatter or extracts)
-Crystal Meth ("Jib" "Side")
-Heroin
-Fentanyl
-Pharmaceutical opioids (Dilaudid (dillies), Oxycodone/Percocet, Morphine/MS, Contin, Codeine / T3's / T4's)
-Cocaine (powder) or crack (Rock)
-Prescription amphetamines (Dexedrine, Vyvanse, Ritalin etc)
-Ecstasy (MDMA/MDA/MDEA, "Molly" "M")
-GHB
-Psychedelics (LSD ["acid"], magic mushrooms, 2C-x)

-Dissociatives (ketamine, PCP)
-Solvents (sniffed glue, gasoline, etc)
-Methadone
-Benzos (eg. Xanax, Valium, Ativan, etizolam "Tizz", zopiclone)
-Other: (_____)
-Don't Know
-Does not apply
-Skip

Where do you usually use drugs? (Check all that apply)
Own home (apartment or house)
Dealer's place
Someone else's place (friend's or family etc.)
Vehicle
Parties
Music festivals/concerts
Public places; including outside, washrooms, etc.
At work
Supervised consumptions/overdose prevention sites
Other
Don't know
Does not apply
Skip

How often do you use alone?
Never
Sometimes
Usually
Always
Don't know
Does not apply
Skip

Have you used any of these *in the past 12 months?* (Check all that apply)
-Needle distribution program
-Methadone, suboxone, or other opioid substitution therapy
-Supervised injection or consumption site
-Treatment services for drug or alcohol use, such as long or short-term live-in treatment, outpatient treatment, group counselling, traditional healer or elder counselling.
Other:_____
None
Don't know

Does not apply
Skip

How often do you do these things when using drugs?

	Never	Not very often	About half of the time	Most of the time	Always	Don't know	Skip
Use in a supervised consumption site or overdose prevention site							
Use where naloxone and a person to help is nearby							
Carry naloxone yourself							
Test dose before using, or use less, when unsure							
Switch to different drug choice or method (e.g., smoke not inject) you feel is safer for you							
Use a drug checking service before using							
Check for Drug Alerts for possible warnings							
Other: _____							
Does not apply							
Skip							

Have you had an overdose *in the past six months?*
Yes, once
Yes, more than once
No
Don't Know
Skip
If no answer does not apply to following questions on overdose

What drugs were you on when you overdosed? Check all the drugs for anytime you overdosed *in the past six months.*

-Tobacco
-Alcohol
-Cannabis (including shatter or extracts)
-Crystal Meth ("Jib" "Side")
-Heroin
-Fentanyl
-Pharmaceutical opioids (Dilaudid (dillies), Oxycodone/Percocet, Morphine/MS, Contin, Codeine / T3's / T4's)
-Cocaine (powder) or crack (Rock)
-Prescription amphetamines (Dexedrine, Vyvanse, Ritalin etc)
-Ecstasy (MDMA/MDA/MDEA, "Molly" "M")
-GHB
-Psychedelics (LSD ["acid"], magic mushrooms, 2C-x)
-Dissociatives (ketamine, PCP)
-Solvents (sniffed glue, gasoline, etc)
-Methadone
-Benzos (eg. Xanax, Valium, Ativan, etizolam "Tizz", zopiclone)
-Other: (_____)
-Don't Know
-Does not apply
-Skip

Where were you when you overdosed? Check all the places this happened *in the past six months.*

Own home (apartment or house)
Dealer's place
Someone else's place (friend's or family etc.)
Vehicle
Parties
Music festivals/concerts
Public places; including outside, washrooms, etc.
At work
Supervised consumptions/overdose prevention sites
Other
Don't know
Does not apply

Skip

Why do you think you overdosed? Check all the reasons for any time you overdosed *in the past six months.*

Fentanyl in drugs
Other potent cut or additive
Drugs not what you thought
High purity
Used too much
Low tolerance
Used multiple drugs
Changed drug use method (i.e., injected not smoked, etc.)
Was rushing when using
Other:_____
Don't know
Does not apply
Skip

APPENDIX G

Implementing Innovations in Drug Checking: A Harm Reduction Pilot in Response to Illicit Drug Overdose
Qualitative 2.0 Interview Guide

We're going to ask you some questions about how and why people would use a drug checking service, and how a drug checking service should be set up.

1. [**Only ask this one if interviewing at a servicesite**]: To start, can you tell me about how you have been accessing this service?

   ➥ What do you access it for?

2. Do you have previous experience with drug checking?

   ➥ Have you heard about it or accessed it before? What forms of drug checking?

3. How would you describe drug checking to someone who has never heard of it?

4. What do you think about drug checking?

5. What would you hope for in a drug checking service?

6. If you could design a perfect drug checking service, how would it operate?

7. Drug checking is being offered in downtown locations and inside services such as AVI and SOLID. Does that fit for you and others you know, or can you suggest alternatives?

   ➥ When services are offered in social or health services, who is being reached and who could be missing out?

   ➥ *Possible PROMPTS*

   What about:

   - People who own homes and live more in the suburbs
   - People who live in more rural areas
   - People who live on reserve
   - People who don't necessarily identify as a person who uses drugs
   - People who may use drugs more recreationally
   - People with more stable jobs and higher incomes
   - Youth who are living at home (not youth on the streets)

8. How would a service fail to meet your expectations? Can you give some examples?

9. What barriers do you face to accessing a drug checking service?

10. What would make you never want to come to a drug checking service? Or never come back to one?

11. What barriers do you face accessing harm reduction services/services for people who use drugs?

12. We're interested about how/if a drug checking service would impact you. Can you tell us a bit about things you do to stay as safe as possible?

13. Would a drug checking service change your actions around how you use drugs, purchase drugs, or sell them? Could you give an example?

14. What would be the most significant impact of a drug checking service?

15. Is drug checking useful when certain drugs are still criminalized?

    ➥ How can drug checking work if people have to hide their drug use?

16. Thinking through some practicalities, where should a drug checking service be located? Why?

    ➥ *Possible PROMPTS:*

    Drug stores
    Other stores/services
    Health care settings like medical clinics, public health units, hospitals
    Events (what types, music festivals or sporting events, etc)
    Mobile
    Where people buy their drugs (can you give an example?)
    Where people use their drugs (can you give an example?)

    ➥ Who would be reached there and who would miss out?

17. In order for a drug checking program to be a good one, what matters about how it set up and operates?

    ➥ Do you think your idea of a good service could be different from other people? How?

18. Who are the people that should be involved in a drug checking service?

19. When we plan and set up drug checking services, what else should we consider?

    ➥ Are there things we should specifically consider if we want to reach new people, such as people who may not usually access a service like this?

20. What else do you think we need to know, to really understand how a drug checking service should work?

    ➥ Is there anything else we haven't covered that you want to get across?