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# **Introduction**

## **Who is this for?**

* This guide is designed for frontline workers and their managers at:
	+ Consumption and Treatment Sites
	+ Overdose Prevention Sites
	+ Addiction treatment centres
	+ Methadone clinics
	+ Needle distributions
	+ Shelters
	+ Organizations that work with unhoused people
	+ Organizations that work with people who use drugs

## **Why is this helpful?**

* Offers key definitions to complex terms
* Provides information about gender, trauma, and intersectionality
* Introduces gender- and trauma-informed practice
* Suggests values for gender- and trauma-informed frontline work
* Proposes practical tips on what to model, ask, and do
* Identifies key takeaways
* Includes a list of references, to be used as further resources

## **How can this be used?**

* Offer as part of training new staff and volunteers
* Utilize key takeaways page in a staff meeting
* Suggest that staff review after gender- or trauma-related issues arise in the workplace
* Read to deepen understanding of how gender and trauma impact people who use drugs
* Reflect on current practices and how they do or don’t align with recommendations

Gender- and Trauma-Informed Frontline Harm Reduction

A guide for workers at supervised injection sites, needle distributions, and other harm reduction service providers.

Emunah Woolf, 2022

# **Key Definitions**

## **Sex**

* Biological and physiological characteristics such as chromosomes, hormones, and reproductive organs which are often assumes to make somebody male, female, or intersex.

## **Gender**

* Social ideas of what makes somebody a man, woman, or other gender such as roles, norms, and other characteristics.

## **Trans**

* Somebody whose gender does not match the sex characteristics they were born with (e.g. somebody with a penis who is a woman).

## **Gender-informed**

* Programs or services that acknowledge that different genders experience the world differently and actively try to respond to those differences by meeting specific and gendered needs.

## **Trauma-informed**

* Services that are knowledgeable about trauma and actively engage with service users in a way that is respectful of potential traumas.

## **Stigma**

* Negative attitudes toward a group of people merely based on the fact that they are part of that group.

## **Equity**

* A model of creating equality by recognizing that everybody starts at a different place, so we have to provide services differently to get people to the same resources and opportunities.

# **Why is this important?**

## **Women**

* Women and trans people face barriers to accessing multigendered services.
* Gendered factors (social, cultural, economic), relationships, and opportunities impact usage and response to harm reduction services.
* These populations face stigma which can lead to discrimination when trying to access services. This leads to women and trans people avoiding services and/or distrusting service providers.
* When harm reduction programs are built to incorporate sex and gender, we can recognize a range of biological, social, and environmental factors that can be improved to fully respond to substance use.
* Taking a sex and gender informed approach to harm reduction can improve access for all.

## **Intersectionality**

* Social, cultural, and economic factors all impact health.
* This can include experiences and identities surrounding class, disability, housing, violence and trauma, family roles, citizenship, age, power, and others.
* Many of these factors are experienced in gendered ways, meaning they are experienced differently depending on your actual and perceived gender.
	+ For example, Black women experience Blackness differently to Black men, also experience sexism, and experience misogynoir (sexist anti-Black racism).
* The barriers that women face become greater and more complicated when combined with other identities and experiences.

The next couple of sections will explore a few examples of what this looks like.

### **Transgender**

* + The prevalence of opioid use among trans women and girls is higher than for cis (not trans) woman and girls.
	+ Transgender populations experience high rates of physical, sexual violence, discrimination, stigma, poverty, homelessness, and unemployment.
	+ Many do not feel safe accessing often gendered housing and harm reduction services.

### **Non-heterosexual**

* + Non-heterosexual young adults (bisexual women in particular) are more likely to use opioids than women of other sexualities.
	+ Many programs and services surrounding substance use are not experienced as safe for women of all sexualities.
	+ Historically, these have been developed for men with a heteronormative approach.

### **Indigenous**

* + Among Indigenous women and men, colonization and intergenerational trauma are closely linked with substance use.
	+ Understandable distrust of the public health system is a key barrier to accessing services.
	+ Women who are multiply marginalized, such as Indigenous women, are more likely to experience gender-based violence.

### **Sex workers**

* + Sex working women and trans people sometimes experience geographical barriers to accessing services.
	+ Studies have found that some women and trans people who do sex work need to avoid the physical location of harm reduction programs to avoid violence and/or interactions with police.
	+ Sex workers are also more likely to have experienced trauma in the work that they do.

**Trauma**

* It is common for people accessing substance use services to report trauma and violence.
* Some find that substance use helps to cope with these experiences.
* Experiences of trauma can interfere with a person’s sense of safety and lead to feelings of shame, helplessness, and powerlessness.

### **Trauma-Informed Practice**

* + Trauma-informed practice is a harm reduction practice that is sensitive to how trauma may show up in a space.
	+ A key aspect of trauma-informed practice is understanding how trauma can be experienced differently based on intersectional identities and experiences.
	+ Now that we know how sex, gender, and trauma can contribute to risky substance use, we need to implement sex and gender-informed, trauma-informed harm reduction approaches.
	+ This includes creating both physical and emotional safety to combat trauma survivors’ feelings of being unsafe and having boundaries violated.

### **Women and Trauma**

* + Research shows that for women and trans people, substance use and experiences of gender-based trauma and violence are interconnected.
	+ Women and trans people may be coming to a harm reduction service directly after an experience of physical or sexual assault.
	+ Some women report avoiding injection sites because of a need to avoid men who have inflicted violence on them.

### **Examples**

* + The power dynamics and gender relations between a man and woman in an intimate relationship can impact the woman’s health.
		- Having to exchange sex for money to buy drugs for a partner
		- Not being taught how to inject on their own
		- Being “second on the needle” and having to share with a partner

# **Underlying values**

## **Gender responsivity is harm reduction**

* Gender impacts substance use and use of harm reduction services.
* We must not only recognize that gender matters, welcome women into our spaces, and be inclusive to trans folks, ratherwe should actively address gender inequity in harm reduction spaces.
* This includes addressing gender gaps, but also reducing other identity-based inequity (such as around racism, classism, etc.).
* A person of any gender can present with many different physical, biological, and social attributes - every person must be respected in their identities and presentation.

## **Trauma-informed practice is harm reduction**

* Trauma impacts substance use and use of harm reduction services.
* We must be aware of the impact trauma can have and create spaces that minimize triggering or retraumatizing service users.
* Working in a trauma-informed way does not require disclosure of trauma; we try and minimize negative experiences and maximize physical and emotional safety for all.

## **Self-determination is harm reduction**

* All people deserve agency, self-determination, and the ability to make their own informed decisions.
* Women and trans people are experts of their own experiences with regard to gender, trauma, substance use, and all other areas of their lives.
* Harm reduction services should be provided in ways that allow choice and control.

## **What does this mean for frontline staff?**

* In order to do harm reduction work, we must embody these values.
* We must strive to be gender responsive, trauma-informed and allow for self-determination in our interactions with service users.
* We may not have control over structural changes in our agency, but we do have control over how we interact with people.
* Here is where we can make a difference in people’s experiences with harm reduction.

# **Practical tips**

## **Model**

### **Sharing pronouns**

* Some people choose to use pronouns different from what you might expect. Some sets of pronouns include she/her, he/him, and they/them.
* Sharing your pronouns when you introduce yourself can make it feel safer for others to share their own.
* Modeling using the correct pronouns for service users can help create a safer environment for trans people.

### **Avoiding gendered language**

* For some people, being called a woman, man, “ma’am”, “sir”, or other gendered terms can feel uncomfortable and triggering.
* Modeling gender neutral language can help remind others to do similarly, creating a safer environment.
* Gender neutral terms include people, folks, and somebody’s name.

**Body talk**

* In general, avoid comments on others’ bodies and clothing.
* If staff must talk about somebody’s body for healthcare purposes, ask what words they prefer to use to talk about their body.
* These conversations should be had privately to normalize not commenting on others’ bodies in the space.

**Appropriate volume**

* For many trauma survivors, loud noises can be triggering.
* Modeling talking in low, calm volumes and avoiding harsh or violent language can set an example for what is acceptable.

**Modelling** sets the tone of the space and encourages service users to be respectful, maintaining a safer environment.

## **Ask**

**Is that booth okay for you?**

* Be conscious that women and trans people might not want to inject next to men – whether specific men or men in general.
* This allows self-determination - deciding where they feel safest.

**Which washroom are you looking for?**

* Some people’s presentation and gender identity do not align.
* Instead of assuming, ask where they feel the most comfortable.

**Is this topic okay for everybody?**

* Sometimes conversation topics may bring up difficult feelings for some people, especially trauma survivors.
* Keep an ear out and check in to make sure folks are safe
* This also offers an opportunity to steer away from the topic.

**Do you need support getting to that booth? How can I help you with that?**

* Some service users, particularly disabled service users, may require additional accessibility support in the space.
* It is inappropriate to touch somebody or their mobility aid without consent. While they may want support, ensure they have asked for and consented to touch before touching them or their mobility aid.

**Is there anything you need to be able to access our services?**

* This is a good question when somebody first accesses services.
* It identifies staff as somebody who they can ask questions to.
* It may be even more helpful to offer specific accommodations staff can provide (e.g. help physically navigating the room, writing down communication instead of speaking, etc.)

**Asking** questions is better than assuming what we may not know about service users, enabling us to meet their needs.

## **Do**

**Identify yourself as a staff member**

* Orienting people creates predictability and security. This can be helpful for trauma survivors who may dislike the unknown.
* This also presents a chance to let service users know that you can offer support if they feel uncomfortable or need assistance.

**Share information about safety and services**

* This can include a bulletin board where staff and service users can pin information about resources, safety advice, and anything else.
* Information should be clear and staff should be prepared to verbally share this with service users who cannot read.

**Offer extra time to use the space**

* Some people may require extra time to inject or use the space.
* This may be because of disability or mental health concerns that lead to them moving slower than other service users.
* This can also be a way to increase safety and comfort.

**Adhere to privacy and confidentiality**

* Strictly adhering to privacy and confidentiality of all service users can help ensure a feeling of safety when accessing services.
* Being clear about confidentiality processes and limits gives service users agency to determine what they feel comfortable disclosing in the space, given the service’s policies.

**Avoid calling the police when possible**

* Many people who use substances (but especially trans people of colour), have had negative and traumatic experiences with police.
* In general, bringing the police to or near a harm reduction agency can make service users avoid the space and can be retraumatizing.

**Trust women and trans people**

* Many people in these populations have experiences of being distrusted in their relationships and the medical system. Staff can shift this experience within the harm reduction agency.

**Validate, offer support, and present pathways if there is a trauma disclosure**

* You can, and should, present options for treatment, legal aid, peer support, healthcare, and other services.
* It is important to not push in any direction and allow folks agency.
* Offer any helpful information you might have about service referrals (e.g. this is a great service but all the staff are men, this service can support your needs but the police are involved, etc.)

**Take feedback**

* Offer multiple methods of feedback provision – a feedback box, a designated staff member, a text line, etc.
* This ensures that services are being offered in ways the continually respond to shifting needs among service users.

**Doing** simple things can really change a person's experience with harm reduction and encourage them to come back into the space.

# **Key takeaways**

1. Trauma-informed approaches are similar to harm reduction approaches – both focus on safety, self-determination, and offering information without pushing a specific action.
2. Frontline workers do not have control over policy, procedure, or the physical environment but do have control over individual interactions with service users. This is a key space to create safety from a gender- and trauma-informed perspective.
3. Oppression is intersectional – ignoring one area of inequity can impact all other groups.
4. It is important to be both gender- and trauma-informed for everybody, regardless of if they disclose or “look like” a woman, trans person, or trauma survivor. You cannot tell somebody’s identity or experience by looking at them.
5. Creating a safer environment ensures that people take their time to use safely, will consider coming back to the service, and may refer people that they know who also use substances to your service – this is harm reduction.

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