



Walking for Harm Reduction through Street Engagement

WHiSE, 2020



elevate NWO

HIV | AIDS | HCV | HARM REDUCTION

ACKNOWLEDGEMENTS

This research study was conducted in Thunder Bay, Ontario, on the traditional lands of the Fort William First Nation, Signatory to the Robinson Superior Treaty of 1850. The Anishinaabeg include the Ojibwe, Odawa, and Pottawatomi nations, collectively known as the Three Fires Confederacy. Elevate NWO acknowledges the history that many nations hold in the areas around the city, and is committed to a relationship with First Nations, Métis, and Inuit peoples based on the principles of mutual trust, respect, reciprocity, and collaboration in the spirit of reconciliation.

We would like to acknowledge the contributions made by the local First Nations and Métis community members by thanking them for sharing their wisdom on harm reduction and substance use by completing the questionnaire.

Funder and Research Team

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DEFINITIONS



Chippewa Park, Thunder Bay, Ontario

1. Street-affected

Being street-affected describes the situation of an individual or community:

- (1) who do not have stable, permanent, or appropriate housing due to systemic or societal barriers and the individual's financial, mental, cognitive, behavioural or physical challenges, and/or racism and discrimination; and
- (2) who may rely on the streets and an informal economy (e.g., under the table, working for cash, off the books) as well as emergency services (e.g., food banks, soup kitchens, drop-ins) to meet their basic needs.

This definition was taken from the

<https://www.homelesshub.ca/sites/default/files/attachments/Definition%20of%20Homelessness.pdf>

and modified to reflect circumstances for Indigenous people who are street affected and use illicit substances.

HIV AND HCV IN ONTARIO

In Ontario, Indigenous people are almost 2 times more likely to contract HIV than the general population and are disproportionately represented among hepatitis C (HCV) cases¹⁻³. Injection drug use (IDU) has been reported as the primary exposure category for HIV and HCV for Indigenous people in recent years⁴. IDU is responsible for over 30% of new HIV diagnoses among Indigenous people³. HCV infection is also correlated with IDU due to needle and syringe sharing⁵. There is a complex relationship between HIV, HCV, and IDU, with socio-economic challenges, discrimination, marginalization, and criminalization that must be considered when developing harm reduction services^{2,5,6}.

Thunder Bay has a disproportionately large population of people who inject drugs (PWID) facing ongoing challenges related to substance use⁷. According to a recent feasibility study for a supervised injection site (SIS) in Thunder Bay, 19% of PWID shared needles and 36% other equipment such as cookers, filters, swabs, and tourniquets, which can transmit HIV and other blood-borne infections⁷. There was also a high rate of unaddressed and preventable harm among PWID. These alarming statistics suggest that engaging PWID is critical to reversing the trends in HIV transmission. Sixty nine percent of PWID (out of a total of 137) expressed a willingness to use a SIS if one were available with the most common reasons for use being access to sterile injection equipment, preventing overdoses, and injecting indoor. In this study, a high proportion of PWID identified as Indigenous, but Indigenous-specific findings were not released due to concerns of further stigmatizing the Indigenous population in Thunder Bay (personal communications: Elevate NWO, Oahas, and OHTN).

Indigenous peoples have distinct health needs arising from the active suppression of Indigenous-led health services, 'fragmented/inaccessible' health services, discrimination, and a lack of Indigenous health service providers⁶. These factors have contributed to poor health outcomes for Indigenous people while eroding their ability to respond effectively to their health priorities^{6,8,9}. Relatedly, many HIV interventions in Canada target non-Indigenous peoples and are devoid or lacking cultural understandings of health and healing approaches for Indigenous people^{6,8,9}. As a result, engagement rates with HIV services including harm reduction strategies are lower for Indigenous people, exacerbating the problem. To combat this, the capacity of Indigenous communities to design, implement, and evaluate HIV-focused health services and harm reduction services must be increased.

Purpose of Research Study

Our project explored the local needs of street affected Indigenous PWID in Thunder Bay to incorporate this knowledge into Elevate NWO's programming. The previous SIS feasibility study conducted in Thunder Bay explored the potential willingness to use SIS and SIS design preferences among local PWID as well as the acceptability and feasibility of SIS from community stakeholders. We focused on determining the specific harm reduction needs of street-affected Indigenous people who inject, smoke, inhale, or orally consume drugs, and to inform a continuum of harm reduction services that is culturally appropriate. This preliminary evidence may suggest that greater consideration to supervised "consumption" sites are needed in the region.

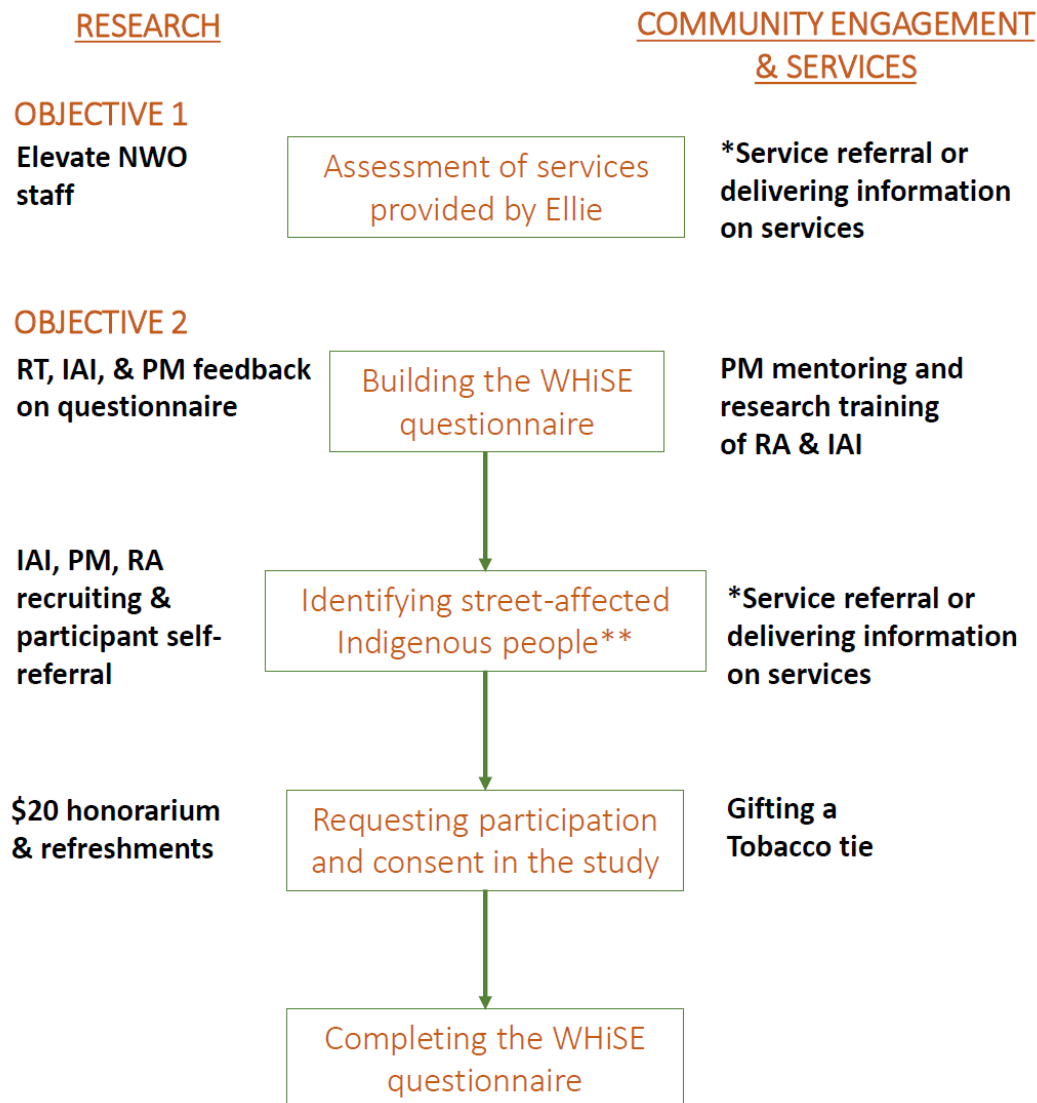
Research study objectives

- (1) Evaluate the impact of Elevate NWO's mobile unit's harm reduction services resources and services on STBBI testing, sexual health literacy, and linkage to treatment and services;
- (2) Determine the demand for and desired characteristics of harm reduction resources and services as well as substance use practices; and
- (3) Develop products to share the findings to Indigenous communities and service providers, and other stakeholders working with Indigenous people consuming drugs.



Thunder Bay Lookout, Thunder Bay, Ontario

RESEARCH PROCESS



Flow chart depicting the assessment of the Ellie van services during 30 trips in the winter and summer (objective 1) and administration of the WHiSE questionnaire (objective 2).

*Service referral includes testing and prevention (HIV, HCV & other STBBIs), treatment and linkage to services, and harm reduction services including naloxone training and information on the Ellie Van.

**Street-affected First Nations and Métis people or the Inuit (Indigenous) aged 16 years or over living in Thunder Bay and using substances (inject, smoke/inhale, oral consumption) within the last 3 months.

Abbreviations: Research Assistant (RA), Indigenous Ambassadors Initiative (IAI), Project Manager (PM), Research Team (RT).

KEY TRENDS

Who completed WHiSE?

- *>99.0% of respondents identified as being **First Nations**.*
- *48.1% of respondents were **women** and 51.4% identified as **men** with the remaining participants being two-spirit.*
- *There was a comparable distribution between **age groups** for women (19-29 years: 37.1%; 30-39 years: 30.3%; ≥40 years: 31.5%) and men (19-29 years: 31.6%; 30-39 years: 33.7%; ≥40 years: 33.7%).*
- *Respondents were from 9 different **Treaties** (Robinson Superior Treaty, Treaties 9, 8, 6, 5, 3, and 1) with the majority from the Robinson Superior Treaty and Treaty 9.*
- *90.8% of respondents preferred speaking **English** and the first language for 95.7% was English.*
- *The top 5 **sleeping** locations (not mutually exclusive) were: apartment that I rent (21.1%), on the street (22.7%), shelter (25.4%), friend's house (29.7%), and couch surfing (33.0%).*
- *The top 5 **sleeping** locations (mutually exclusive) were: single room occupancy unit (10.8%), shelter (12.4%), family member's house (15.1%), friend's house (15.7%), and apartment that I rent (18.9%).*
- *Respondent indicated **spending most of their time** on the street (52.4%).*
- *The top 3 **income** sources for women were: 24.3% selling drugs/24.3% e-transfers, 29.2% middling drugs, and 29.7% selling items; and for men were: 33.0% middling drugs, 31.4% selling drugs and 29.7% selling items.*
- *All participants were impacted by **colonization**. 86.49% were intergenerational school survivors, 66.5% and 53.5% were involved in the child welfare system as a child and parent, respectively.*

Outreach mobile unit

- *Among the WHiSE respondents only 55.7% indicated having used the Ellie Van.*
- *Lower use of the Ellie Van in the winter (147 clients) compared to the summer (273 clients) months and the most frequently accessed service were the harm reduction kits.*

Culture and connection

- *62.7% of respondents were practicing First Nations or Métis ceremonies for healing, celebration or other purposes.*
 - *The top 3 practices (not mutually exclusive) were: 93.1% smudging, 92.2% attending or participating in pow wows, and 76.1% participating in ceremonies. It is noteworthy that between 50-72% of participants indicated learning or speaking their language, attending cultural groups, drumming, hunting, fishing, attending sweats and making Indigenous crafts, for example.*

- *The top 3 reasons for not practicing (not mutually exclusive) were: 54.6% too many competing interests in my life, 38.8% not interested, and 37.3% indicating having no access. Other reasons for not practicing ranged between 13-33%: don't know where to go, clash with beliefs, can't afford it, and can't find the right cultural service providers.*
- *91.9% of respondents saw reflections of Indigenous identity in their community such as: 58.4% advertisements, 61.7% restaurants, 87.6% agencies, and 98.2% peoples.*
- *Respondents found strength in multiple ways: 60.7% connection to culture, and 64.3% creator (tied to culture), and 82.2% family. Religion, god, community/ neighborhood, and connection to the land were also provided as responses (36-63%).*

Drug use history

- *53.5% of respondent indicated injecting drugs, 94.1% smoked drugs (other than marijuana), and 55.7% consumed drugs orally/swallowing in the last 3 months. Drug type and frequency for each form of consumption was determined.*
- *Injecting drugs and consuming alcohol or other concoctions was rarely (2 out of 10 times) reported (29.7%) which was the case for smoking drugs (33.5%) and orally consuming drugs (22.7%).*
- *74.6% of respondents reported using more than one drug at a time.*
- *53.0% of respondents injected when alone, 83.8% smoked drugs alone and 71.4% took drugs orally alone.*

Harm reduction

- *65.4% of respondents knew what harm reduction was and explained it with examples ranging from acquiring unused tools, to helping others stay safe, proper disposal, accessing supervised injection sites, overdose prevention, having a buddy system, having a naloxone kit and safer sex kit, and asking for help.*
- *96.2% of respondent knew where to go for harm reduction services citing Shelter House (97.2%), Elevate NWO (71.4%), and Superior Points (66.3%) as the top 3 locations.*
- *55.7% of respondents indicated having used the Ellie Van, a mobile outreach unit. Several other locations were suggested for the Ellie Van to increase its use.*
- *Respondents wanted more types of services and resources to meet their harm reduction needs such as: information sheets, more unused equipment, safe house/safe sites with longer hours of operation, increased counselling services/workers, food, and first aid kit for example.*
- *For 21.6% of respondents there were things in the way of them accessing harm reduction services such as: 74.4% transportation, 44.7% not knowing location sites, and 42.1% privacy, for example.*
- *For 13.6% of respondents there were things in the way of them practicing harm reduction such as: 60% transportation, 44% confidentiality and 47.8% not knowing location of sites. Privacy was again an important concern (32%) as was being barred (40%) from a location. Other responses included concerns around safety, disliking staff and having another cultural or belief system (24-40%).*

Supervised injection site and supervised consumption site

- *Several reasons were described for not accessing the SIS at NorWest which included: 44.4% I use at my home, 42.0% I go to a friend's place, 22.8% worried about encountering cops, 22.2% I don't want to be seen at a SIS, 22.2% I use on the streets, and 20.5% I can't wait for example.*
- *For 23.4% of respondents there were things that would help them not use where they normally do and instead go to a SIS such as: better trained staff (understand opioids, privacy and confidentiality, Indigenous workers), teaching you how to use safely, help, advice, having a friend accompany them, longer hours, access for mobility issues, snacks, transportation, being able to talk, increased anonymity, counselling, transportation, closer to the street, etc...*
- *80.9% of respondents would go to a supervised consumption site (SCS) if it existed in Thunder Bay for the following reasons: safe place, shelter from the weather, cleanliness, not being bothered, not sharing, obtain help for housing, nurses, support to be alone, and being safe as a woman for example.*
- *Reasons for not going to a SCS included: 22.9% use at my home, 17.1% go to a friend's place, and 11.4% don't want to be seen at a SCS for example. Other reasons for not going to a SCS were similar for not wanting to use a SIS such as worried about encountering cops, can't wait, use on the streets, go to a shooting gallery.*
- *As an Indigenous person, respondents wanted to see or have the following in a SIS/SCS: other Indigenous people, not being bothered, no cameras, art and environment, monitoring for reassurance, native workers, traditional services, culture, friendly staff, and native partnerships for example.*
- *As an Indigenous person, respondents indicated several services needed to be in place to support them to go to a SIS/SCS. The responses were 87% and greater for the following: food, access to Elders, bus tickets, drug testing, Indigenous counselling services, infectious disease clinic, and holistic care for example.*
- *As an Indigenous person, respondents indicated several services needed to be in place to return to a SIS/SCS. Responses were 88% and greater for the following: Indigenous counselling services, family support, holistic care, 'cultural' circles, support groups, and Indigenous healers for example.*
- *As an Indigenous person, a caring staff would look like or do the following at an SIS/SCS: respect privacy, staff that don't make you wait a long time to talk or meet, fight for client rights, know the people they serve, and have lived experience for example. 94% or greater of respondents gave the above answers.*
- *A SIS/SCS inclusive of client needs and values would have the following for example: native staff, food, be open to everyone, not being judged, safe and trusting, humility, be caring not rude, be supportive and not judgemental, respectful and private, listen and be supportive, and care for whole family.*

Testing and overdose prevention

- *41.1% of participants indicated having overdosed at least once.*
- *86.0% of respondents were tested for HIV and 88.6% for hepatitis C.*

- *93.0% of respondents had heard of naloxone and 60% had a naloxone kit. Kits were obtained through the Ellie van, a pharmacy, nurse, through a friend, organizations, and outreach workers for example.*
 - *85.6% were trained on how to use their naloxone kit. 41.6% indicated having used naloxone largely in the spray form (88.3%). 58.4% of those using naloxone called the ambulance/911.*
- *48.6% of respondents were aware of the Good Samaritan Drug Overdose Act and because of this act 91.9% of respondents were more willing to call 911.*
 - *Reasons for not calling 911 were for example: nervous about people around them, cops don't follow the rules, not certain they wouldn't be arrested, racist cops, cops don't care, police violence, they didn't need it, know people that got arrested, no phone, scared, and don't want to be noticed.*

Self-practiced harm reduction

- *Greater than 68% of respondents indicated practicing various harm reduction skills for themselves and others which included: getting safer injection kits for themselves and others, sharing food with someone that is hungry, carrying condoms, disposing needles in sharps container, wearing a seatbelt, walking someone home at night, using the same dealer, calling street outreach services for somebody, and trying a small amount before using the full amount.*

TABLES AND FIGURES

1. Population Description

Table 1.1 Demographic characteristics of participants.

	Gender				
	Woman		Man		Two-Spirit
	N	%	N	%	N
	89	48.1	95	51.4	1
Age median (IQR)	33.5	(27-44)	35	(28-44)	
Age group					
19-29	33	37.1	30	31.6	/
30-39	27	30.3	32	33.7	/
40+	28	31.5	32	33.7	/
Indigenous group					
First Nations	88	98.9	95	100	/
Other	1	1.1	0	0	/
First language					
English	84	94.4	90	94.7	/
French	1	1.1	0	0.0	/
Ojibway	1	1.1	3	3.2	/
Oji-Cree	1	1.1	1	1.1	/
Other	1	1.1	0	0.0	/
Preferred language					
English	83	93.2	84	88.2	/
French	0	0	1	1.1	/
Ojibway	3	3.4	3	3.2	/
Oji-Cree	3	3.4	5	5.3	/
Other	0	0	2	2.1	/

A two-spirit person responded to the geodemographic questions and their responses have been redacted for privacy reasons.

Table 1.2 Geodemographic characteristics of participants.

	Gender				
	Woman		Man		Two-Spirit
	N	%	N	%	N
Total n=185	89	48.1	95	51.4	1
District of Indigenous community of belonging					
<i>Alberta</i>	1	1.1	0	0.0	/
<i>Algoma-ON</i>	2	2.2	0	0.0	/
<i>British Columbia</i>	1	1.1	0	0.0	/
<i>Cochrane-ON</i>	4	4.5	5	5.3	/
<i>Kenora-ON</i>	38	42.7	45	47.4	/
<i>Manitoba</i>	2	2.2	4	4.2	/
<i>Manitoulin-ON</i>	.	0.0	1	1.1	/
<i>Rainy River-ON</i>	6	6.7	5	5.3	/
<i>Thunder Bay-ON</i>	31	34.8	31	32.6	/
<i>Unclear*</i>	3	3.4	3	3.2	/
Treaties from which respondents were from					
<i>Treaty 1</i>	1	1.1	2	2.1	/
<i>Treaty 3</i>	16	18.0	15	15.8	/
<i>Treaty 4</i>	0	0	1	1.1	/
<i>Treaty 5</i>	5	5.6	6	6.3	/
<i>Treaty 6</i>	1	1.1	0	0	/
<i>Treaty 9</i>	41	46.1	45	47.4	/
<i>Robinson**</i>	21	23.6	19	20.0	/
<i>Other***</i>	4	4.5	7	7.4	/

* District was unclear based on text response given. ** Robinson includes Robinson Superior, Robinson Huron, and Saugeen Surrenders. *** Other includes unceded, unaffiliated, non-status, unclear. Respondents were from 57 First Nations communities. A two-spirit person responded to the geodemographic questions and their responses have been redacted for privacy reasons.

Table 1.3 Situational characteristics of participants.

	Gender				Two-Spirit
	Woman		Man		
	N	%	N	%	
	89	48.1	95	51.4	1
Where participants slept the most in the last 3 months					
<i>Couchsurfing</i>	0	0.0	1	1.1	/
<i>Family House</i>	12	13.5	15	15.8	/
<i>House Rent</i>	3	3.4	3	3.2	/
<i>Family Apartment</i>	3	3.4	1	1.1	/
<i>Friend House</i>	15	16.9	13	13.7	/
<i>Weekly Hotel</i>	1	1.1	2	2.1	/
<i>Friend Apartment</i>	1	1.1	0	0.0	/
<i>Street</i>	6	6.7	9	9.5	/
<i>Shelter</i>	10	11.2	13	13.7	/
<i>Rooming</i>	11	12.4	9	9.5	/
<i>Own Apartment</i>	9	10.1	5	5.3	/
<i>Rent Apartment</i>	17	19.1	18	18.9	/
<i>Other</i>	0	0.0	5	5.3	/
Where participants stayed, but not slept, the most in the last 3 months					
<i>Couchsurfing</i>	0	0.0	1	1.1	/
<i>Family House</i>	2	2.2	4	4.2	/
<i>House Rent</i>	2	2.2	0	0.0	/
<i>Family Apartment</i>	1	1.1	2	2.1	/
<i>Friend House</i>	5	5.6	4	4.2	/
<i>Weekly Hotel</i>	1	1.1	1	1.1	/
<i>Street</i>	44	49.4	52	54.7	/
<i>Shelter</i>	1	1.1	3	3.2	/
<i>Rooming</i>	7	7.9	4	4.2	/
<i>Own Apartment</i>	2	2.2	1	1.1	/
<i>Rent Apartment</i>	6	6.7	3	3.2	/
<i>Other</i>	17	19.1	19	20.0	/
Side of Thunder Bay where participants spend most of their time					
<i>Westfort</i>	1	1.1	1	1.1	/
<i>Fort William</i>	60	67.4	54	56.8	/
<i>Intercity</i>	1	1.1	0	0.0	/
<i>Bay & Algoma</i>	1	1.1	0	0.0	/
<i>DT Port Arthur</i>	22	24.7	34	35.8	/
<i>Current River</i>	1	1.1	1	1.1	/
<i>County Park</i>	2	2.2	3	3.2	/
<i>Other</i>	0	0.0	1	1.1	/

Figure 1.1 Current sleeping situation by gender.

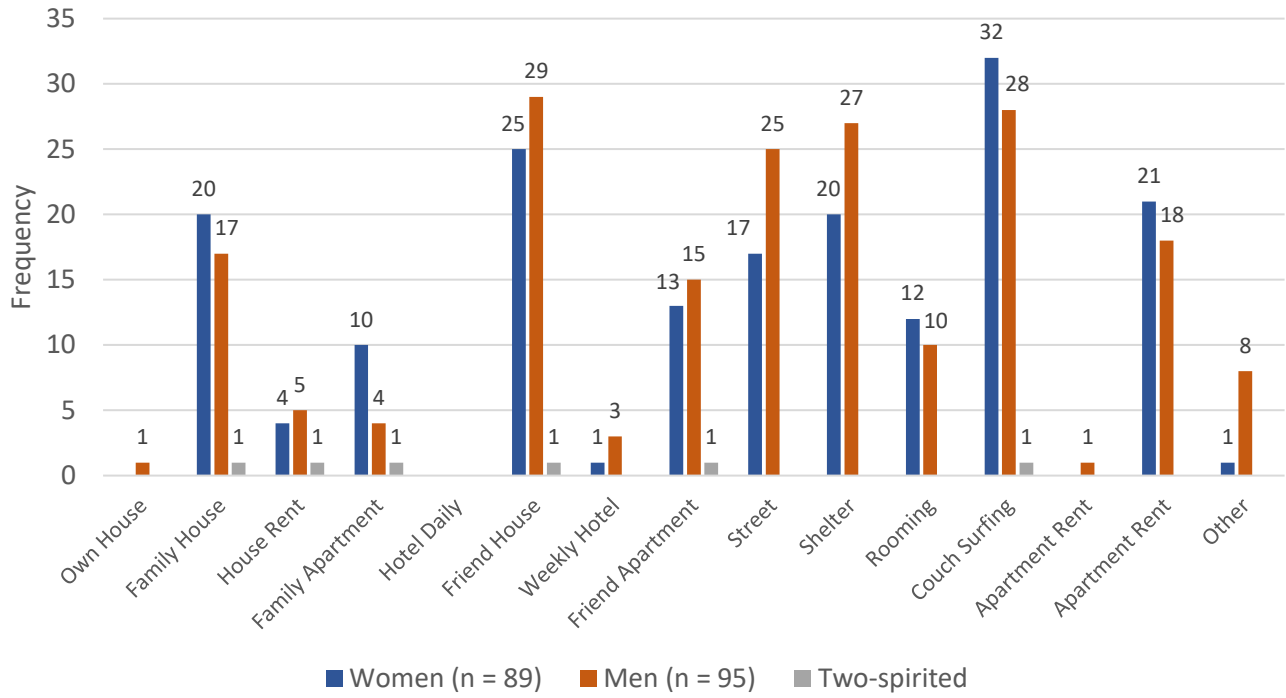
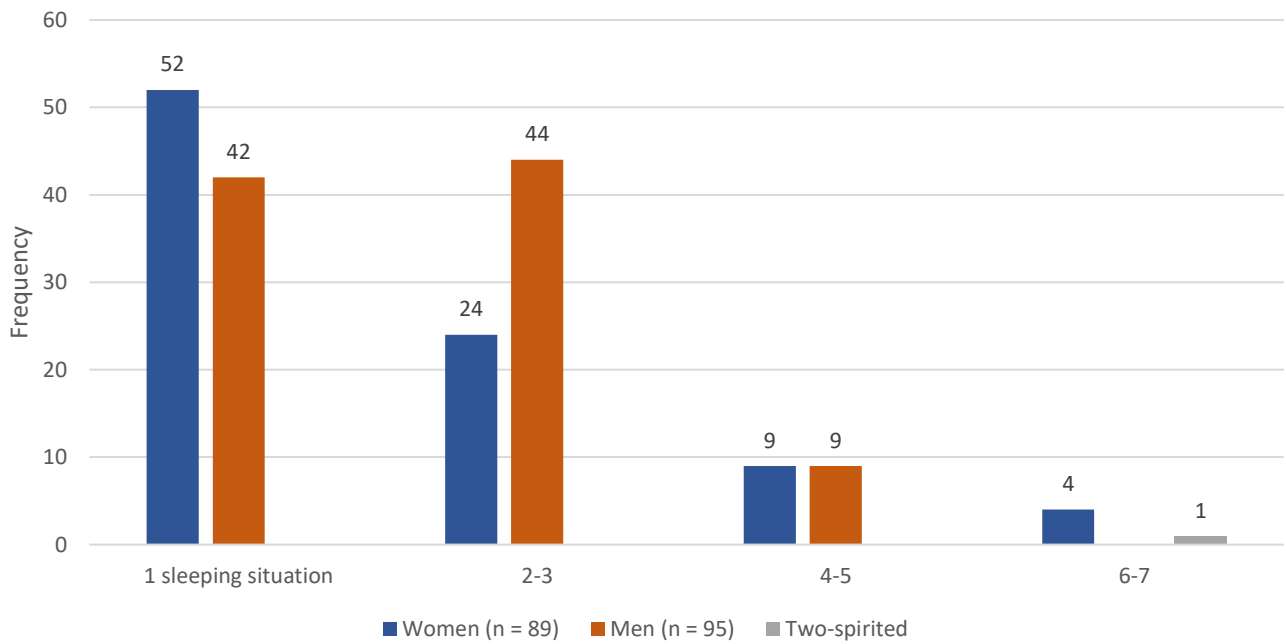


Figure 1.2 Number of current sleeping situations by gender.



185 respondents selected all answers that applied to indicate their current sleeping situations.

Figure 1.3 Sources of income by gender.

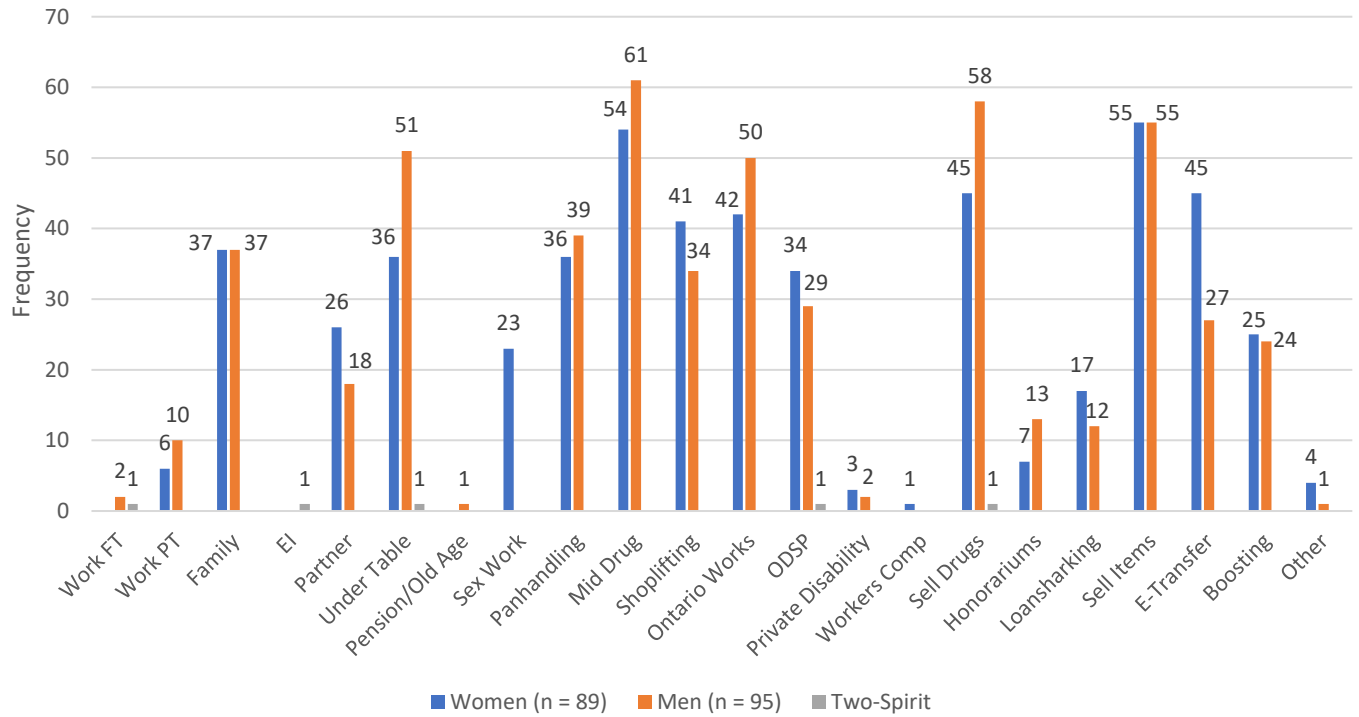
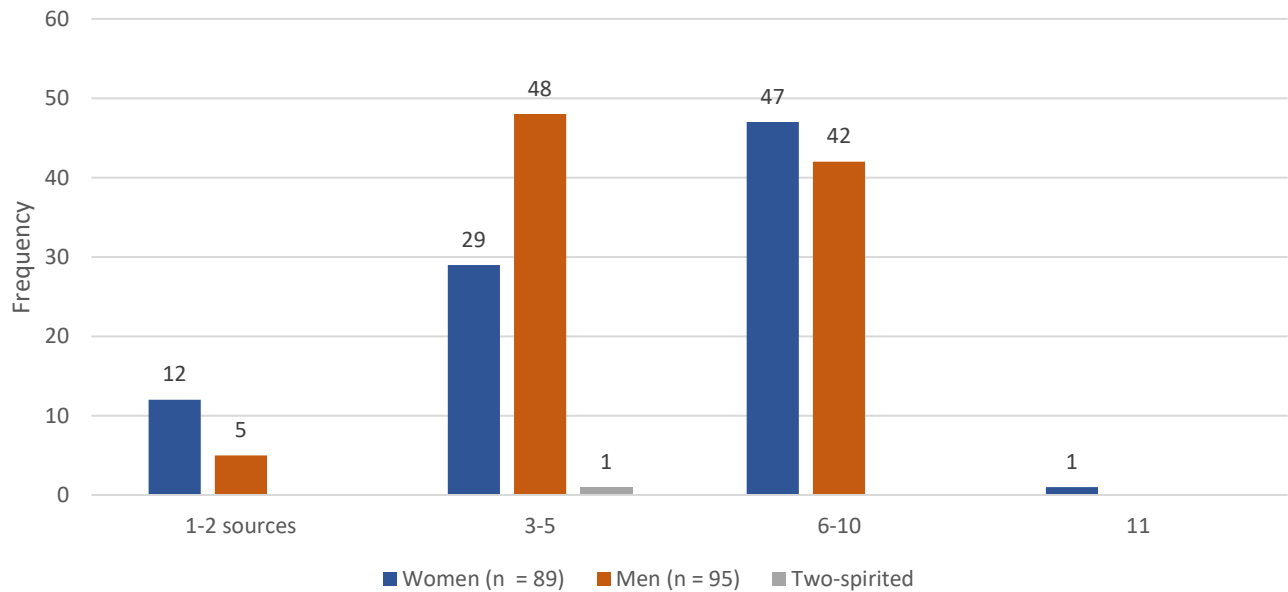


Figure 1.4 Number of sources of income by gender.



185 respondents selected all answers that applied to indicate the different ways they earned money to support themselves. Abbreviations: FT=full-time; PT=part-time; EI=employment insurance; pension/old age=pension/old age security; mid drug=middling drug transactions; ODSP=Ontario Disability Support Program; private disability=private healthcare disability insurance; workers comp=workers compensation; Other=apprenticeship, collecting bottles, prefer not to answer, kindship funds, pawn shop, scamming.

Figure 1.5 Different ways respondents were impacted by colonization by gender.

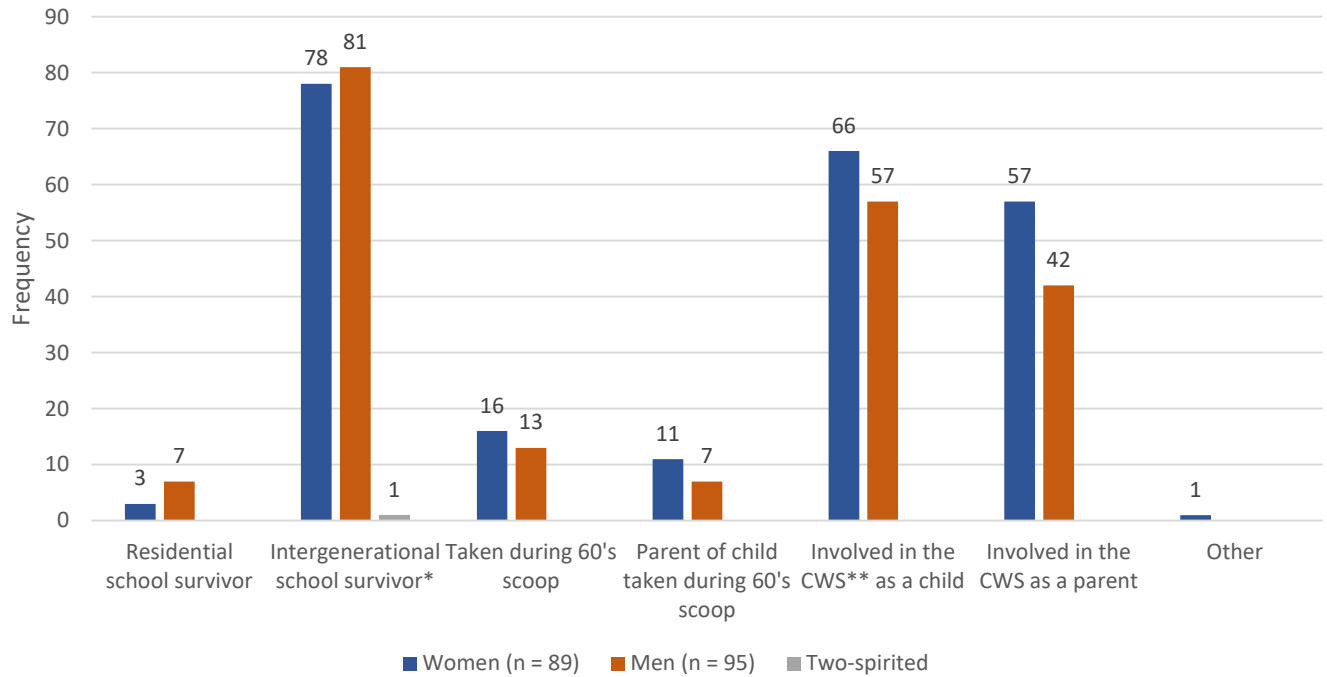
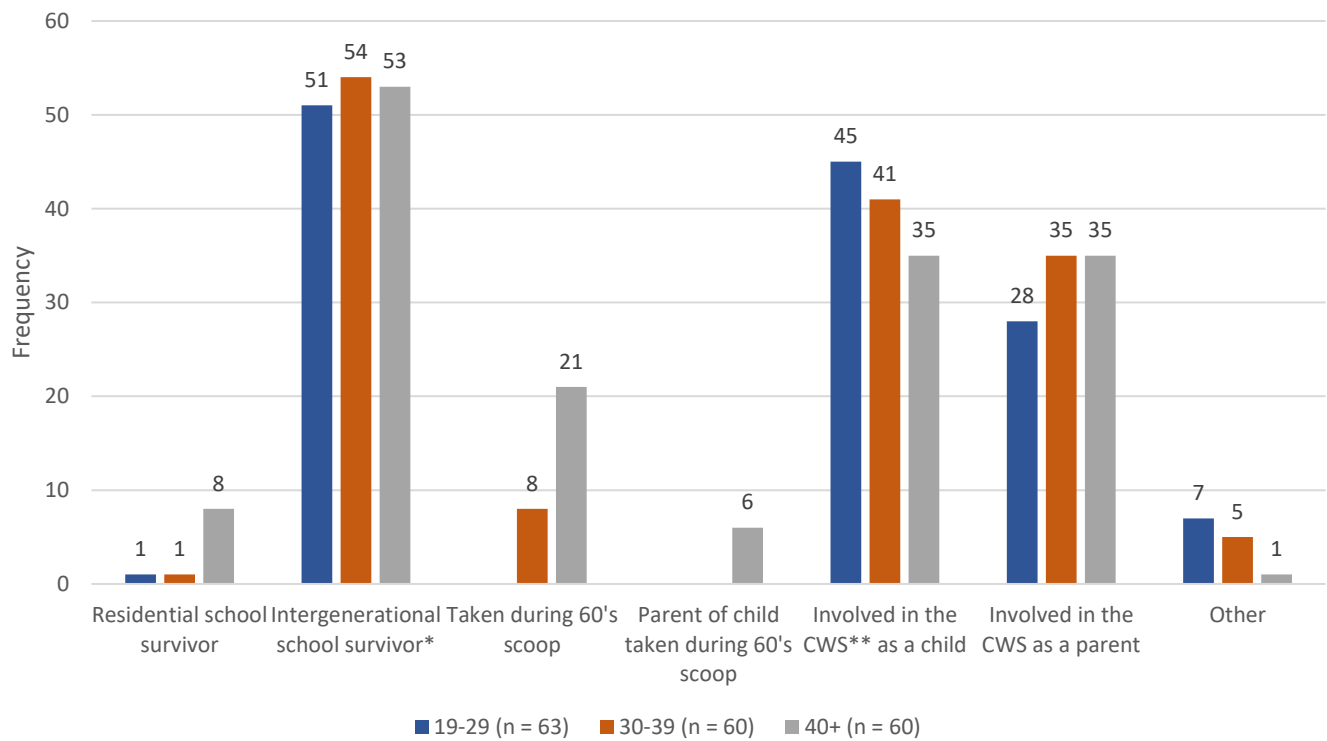


Figure 1.6 Different ways respondents were impacted by colonization by age group.



185 respondents selected all answers that applied, and 2 respondents had missing age. *Parent of grandparent went to residential schools; **Child Welfare System.

2. Outreach Mobile Unit

Among 185 respondents of the WHiSE questionnaire, 55.7% (n=103) used the Ellie Van. A rapid assessment of the outreach services and training by the Ellie Van was recorded from 30 trips between January – March 2019 and 30 trips between June – August 2019 each (Figure 2.1-2.6). Individuals accessed the Ellie Van for several outreach services and may have been counted more than once.

Figure 2.1 Outreach services and training for all genders delivered over 13 trips in January 2019.

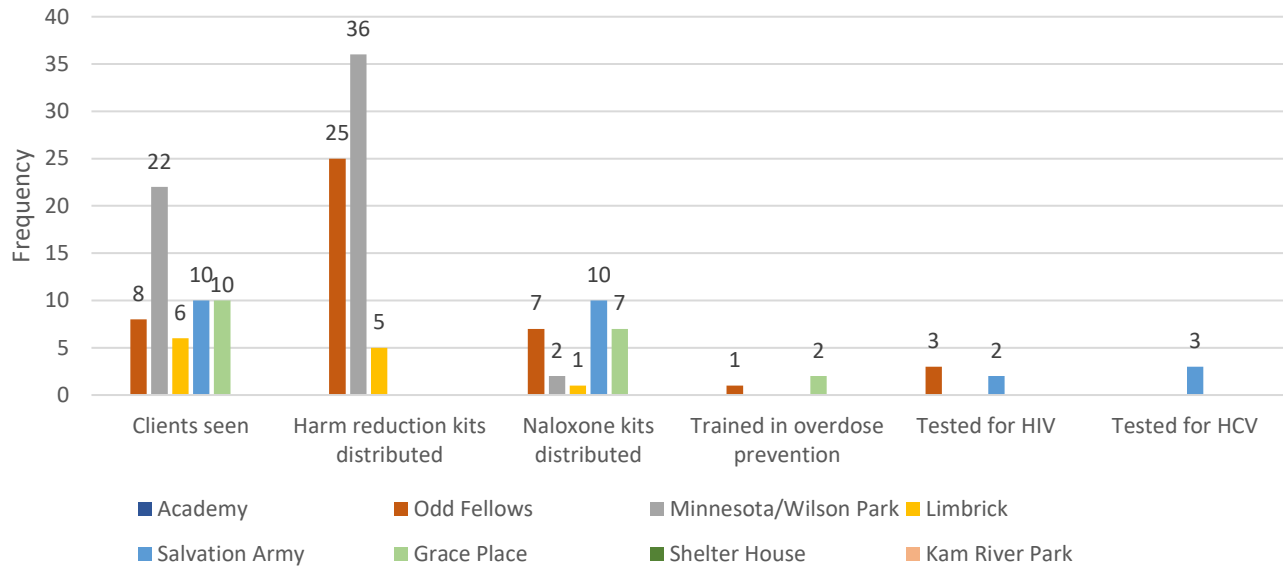


Figure 2.2 Outreach services and training for all genders delivered over 11 trips in February 2019.

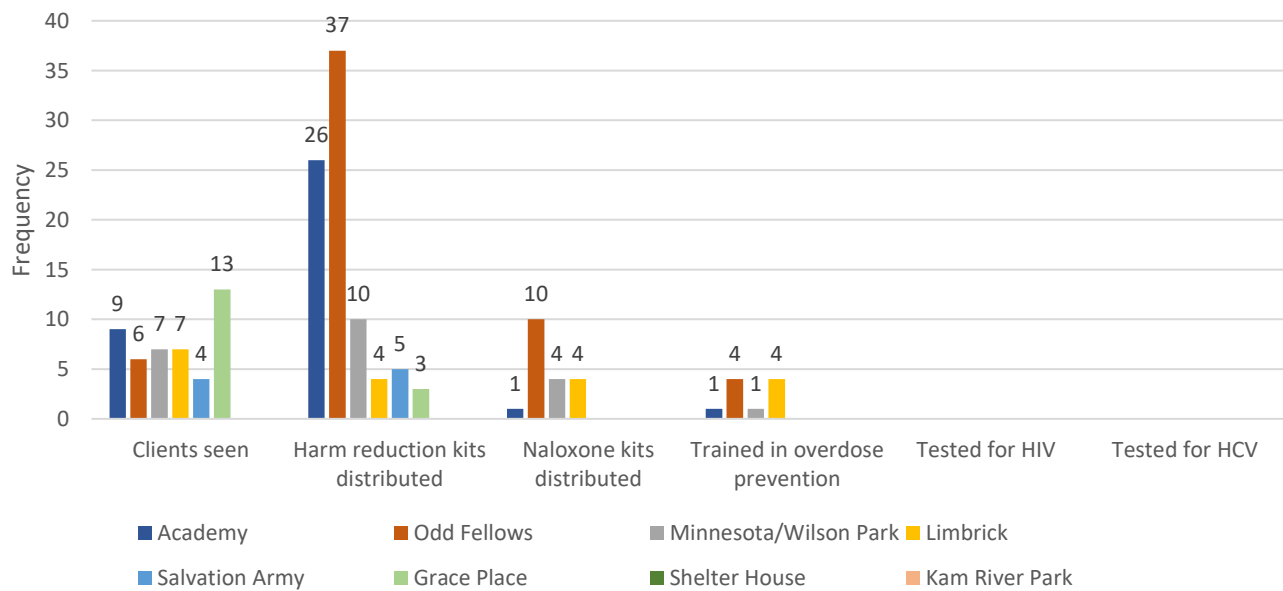


Figure 2.3 Outreach services and training for all genders delivered over 6 trips in March 2019.

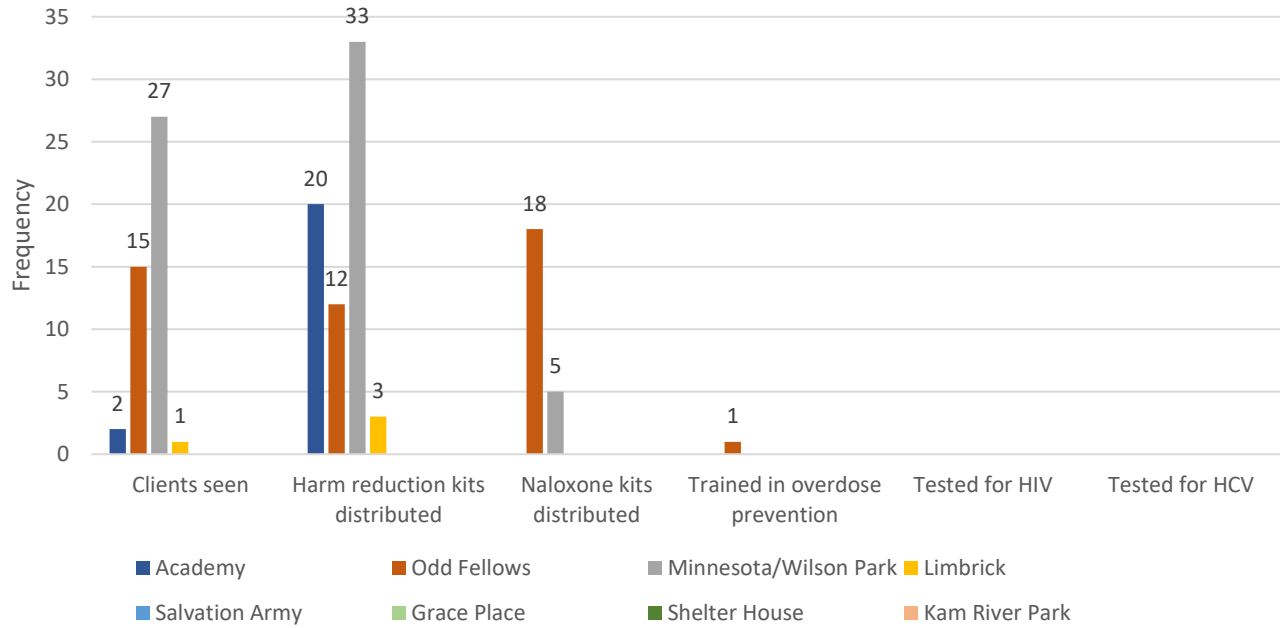


Figure 2.4 Outreach services and training for all genders delivered over 1 trip in June 2019.

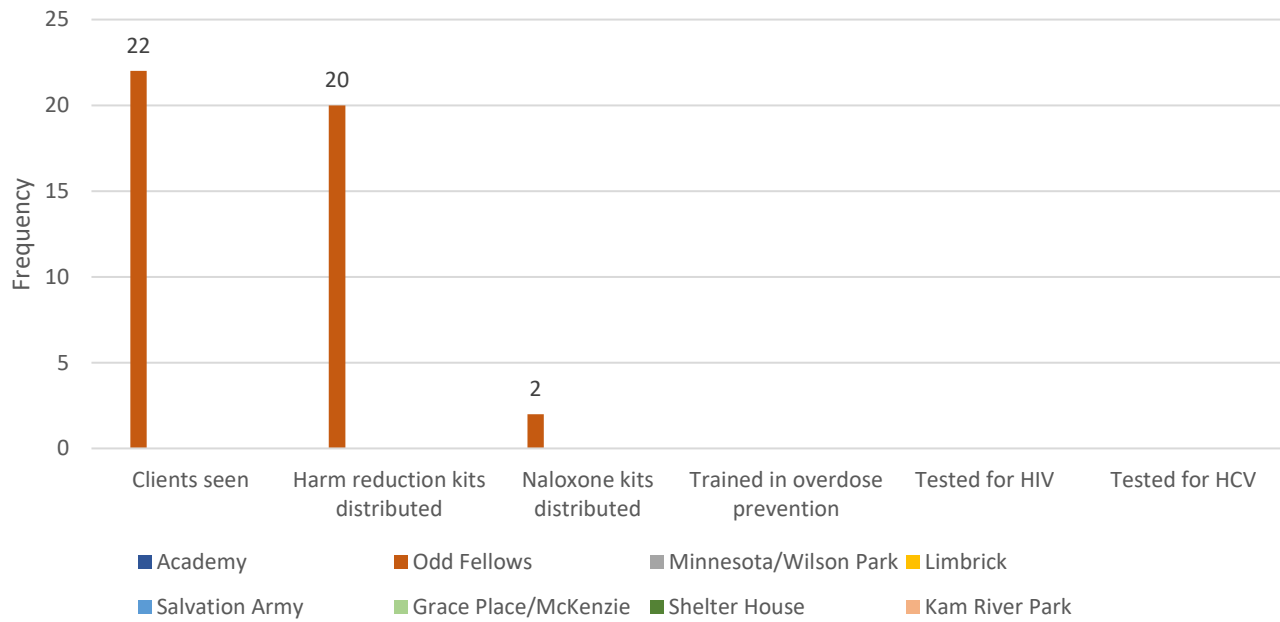


Figure 2.5 Outreach services and training for all genders delivered over 22 trips in July 2019.

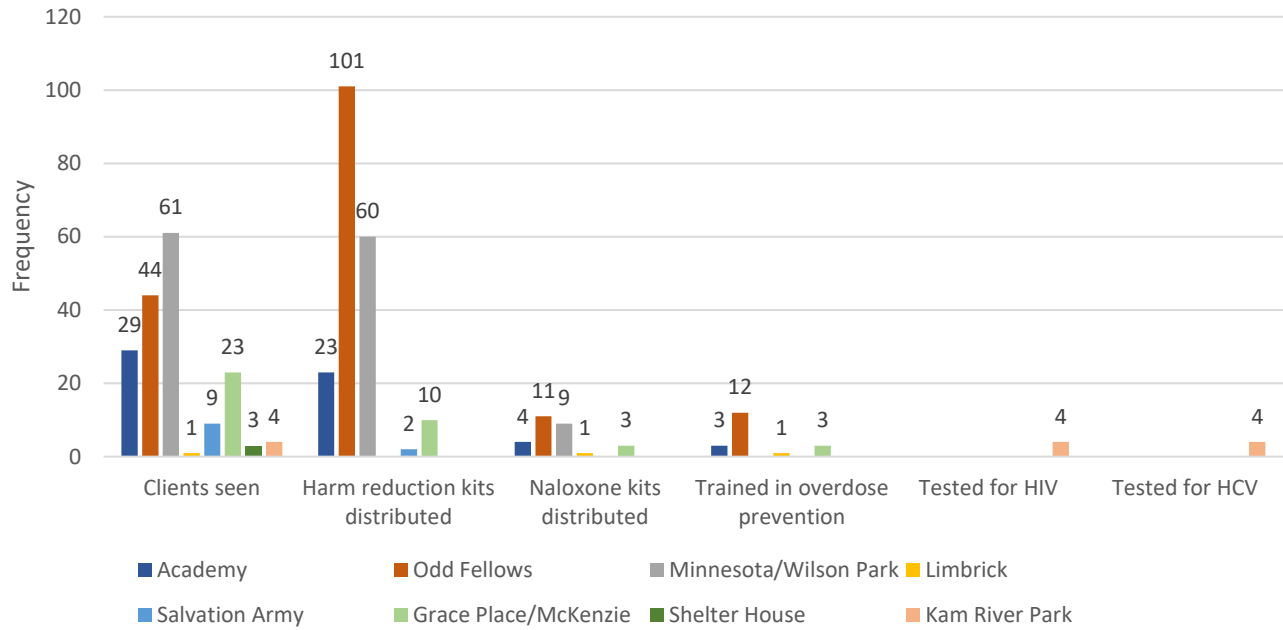


Figure 2.6 Outreach services and training for all genders delivered over 7 trips in August 2019.

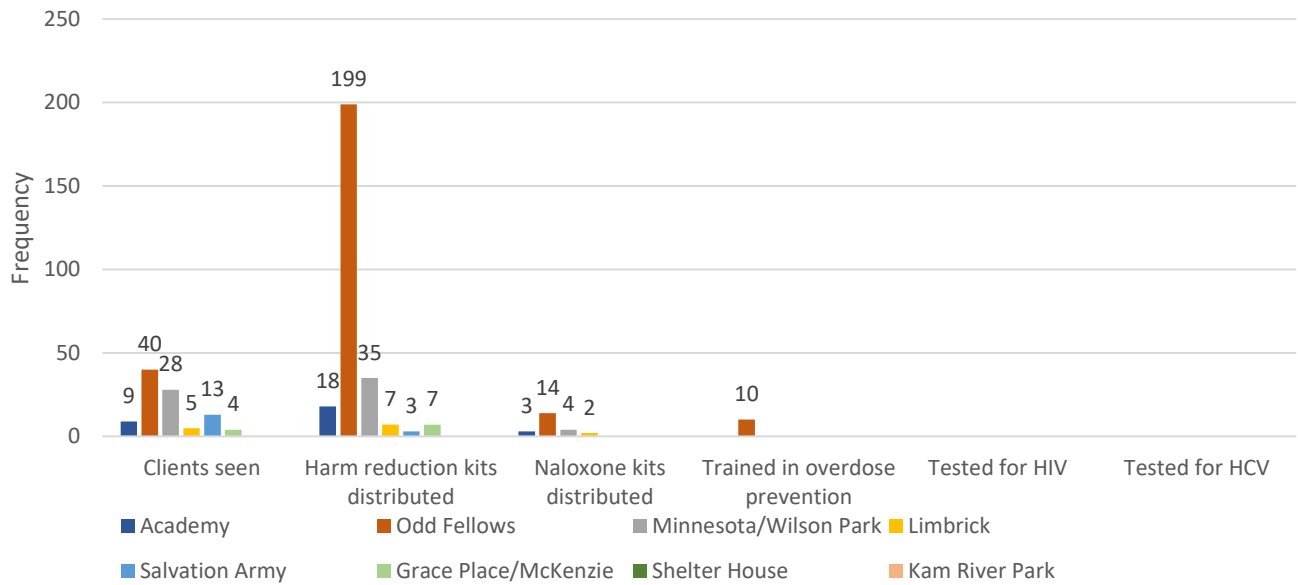
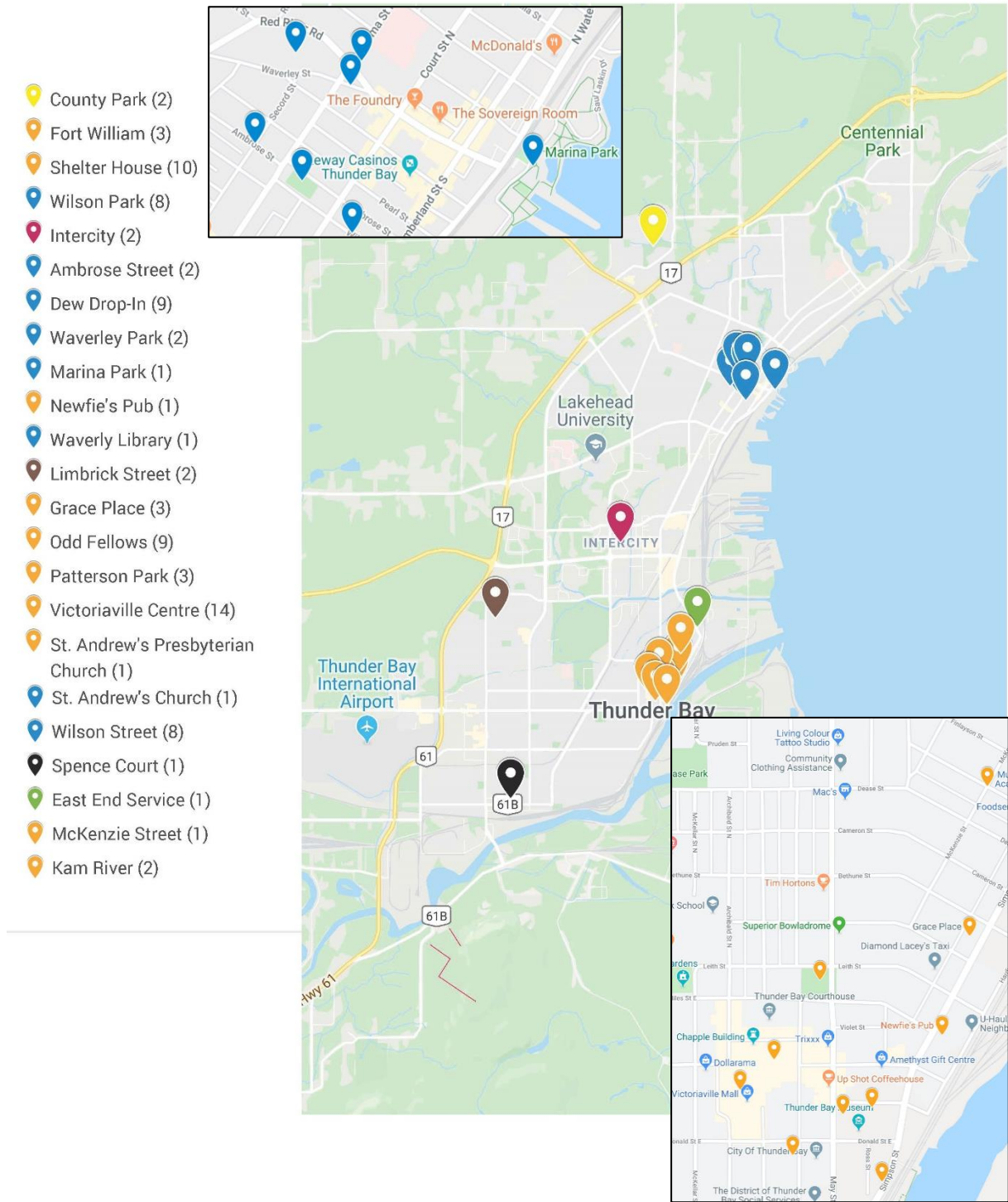
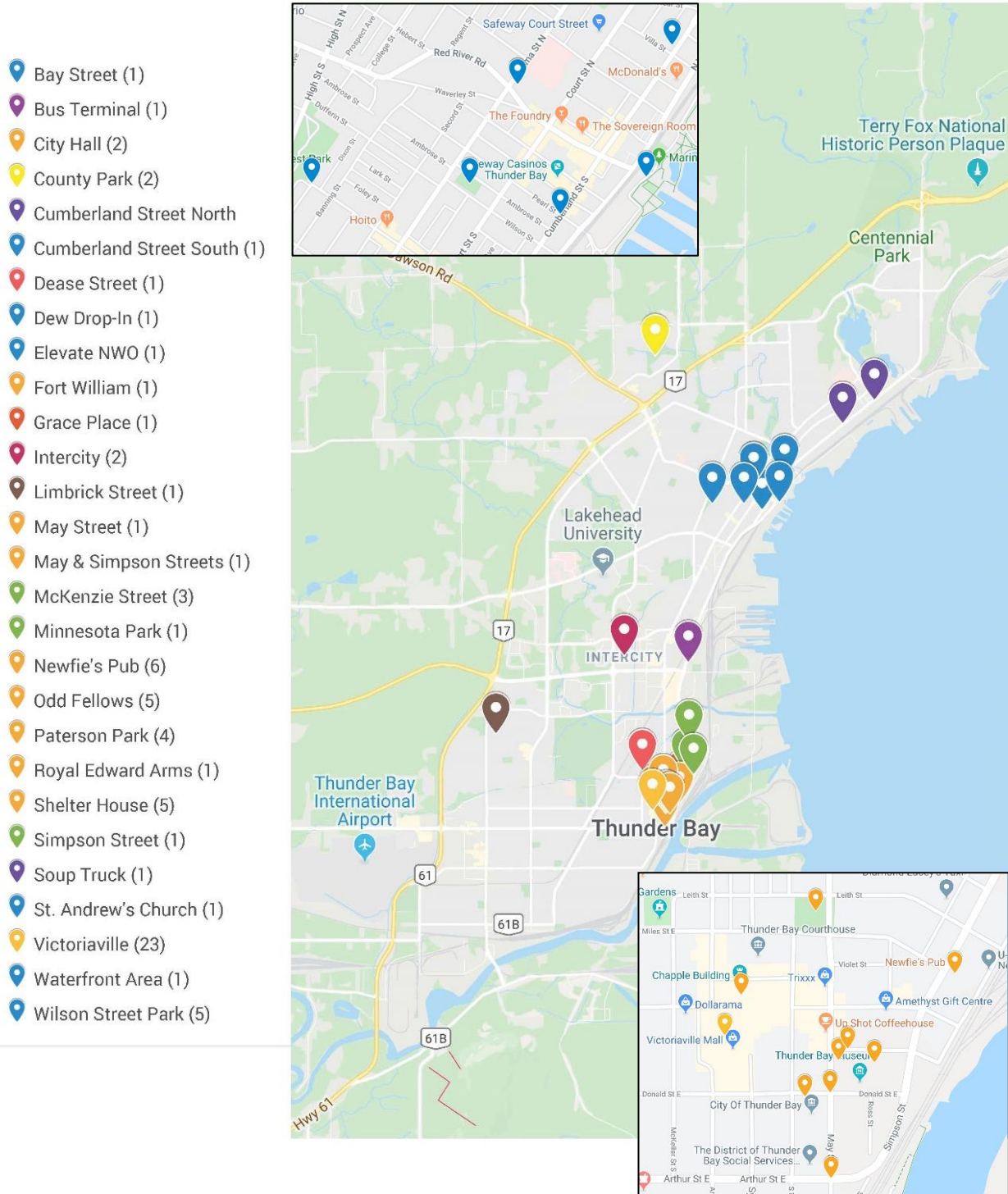


Figure 2.7 Other locations suggested for the Ellie Van to provide outreach services by individuals who have previously used its outreach services.



Numbers in parentheses indicate frequency of responses for that location. Colours indicate clusters within ~500 metres.

Figure 2.8 Locations suggested for the Ellie Van to provide outreach services by individuals who indicated never having used its outreach services.



Numbers in parentheses indicate frequency of responses for that location. Colours indicate clusters within ~500 metres.

3. Culture and Connection

Figure 3.1 Types of First Nations, Inuit or Métis ceremonies for healing, celebration or other purposes by gender.

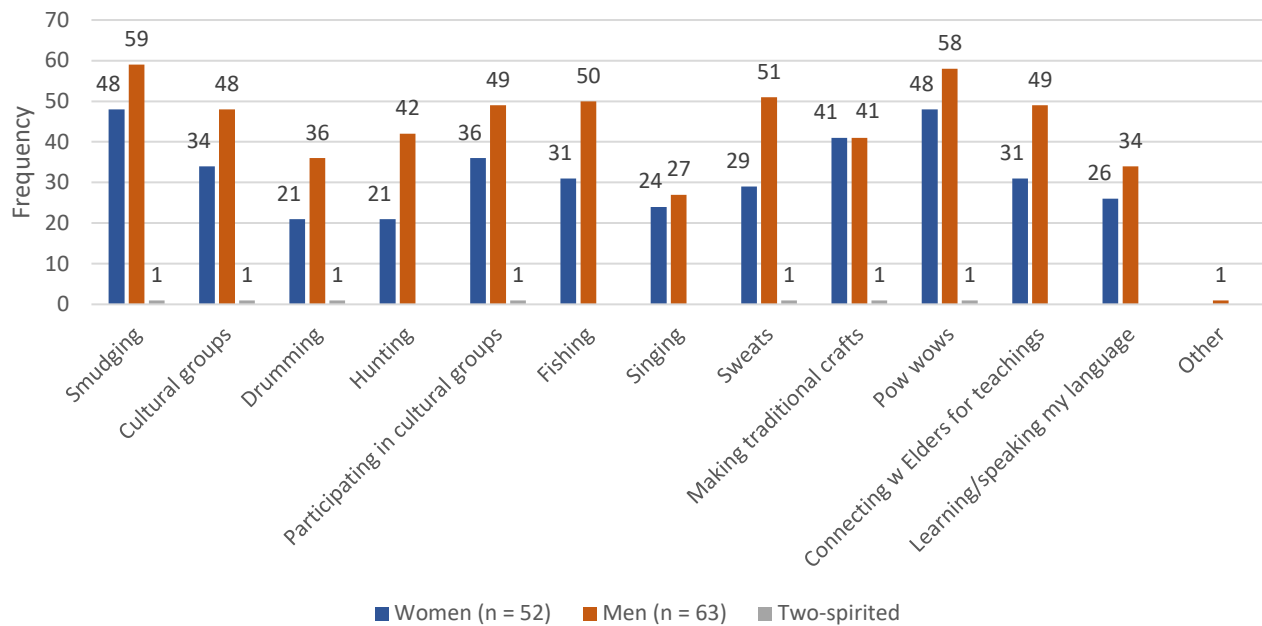
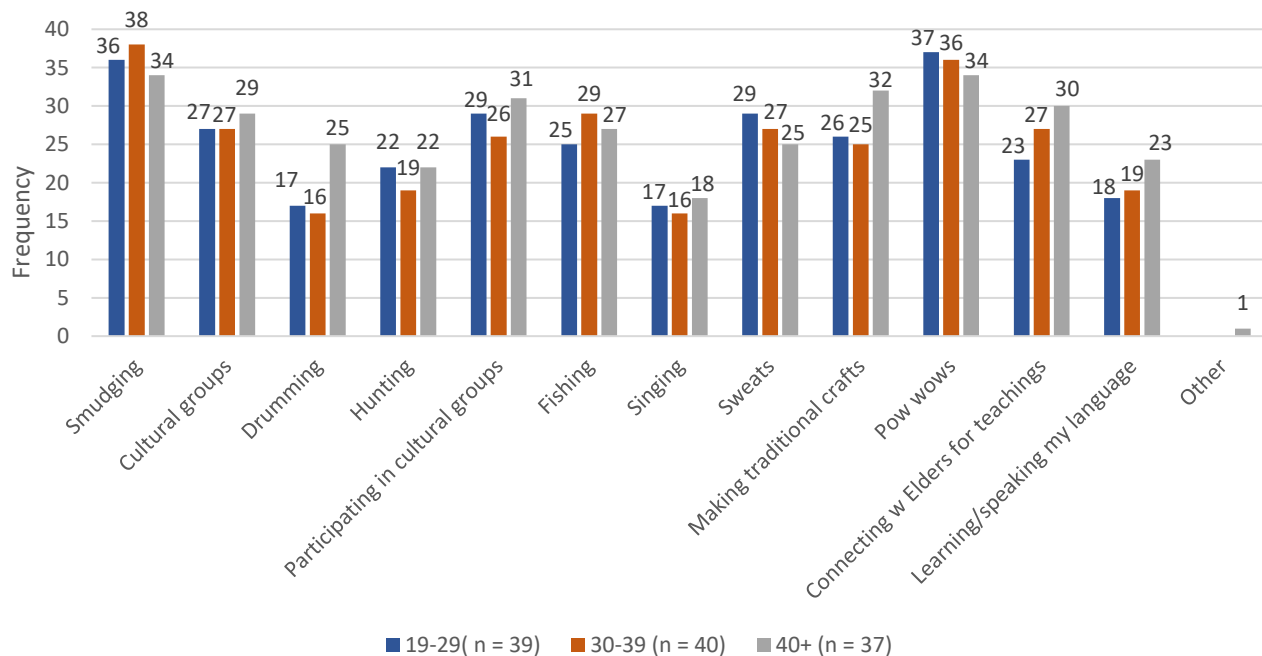


Figure 3.2 Types of First Nations, Inuit or Métis ceremonies for healing, celebration or other purposes by age group.



116 respondents practiced First Nations, Inuit or Métis ceremonies for healing, celebration or other purposes. Respondents selected all answers that applied.

Figure 3.3 Reasons for not practicing First Nations, Inuit or Métis ceremonies for healing, celebration or other purposes by gender.

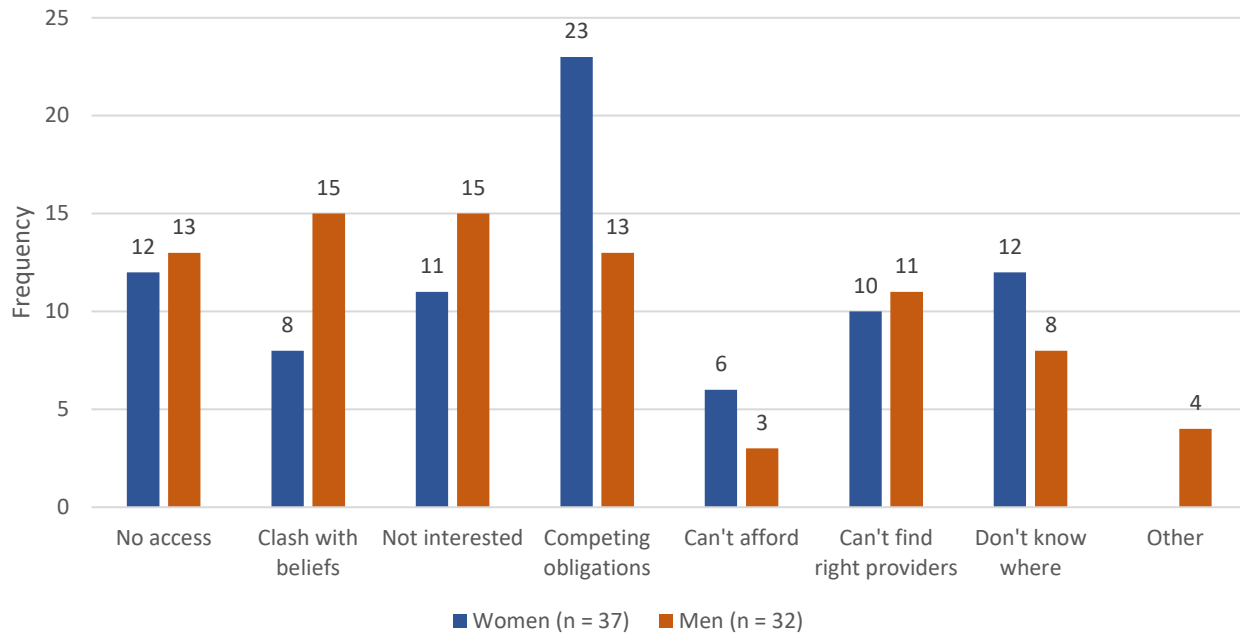
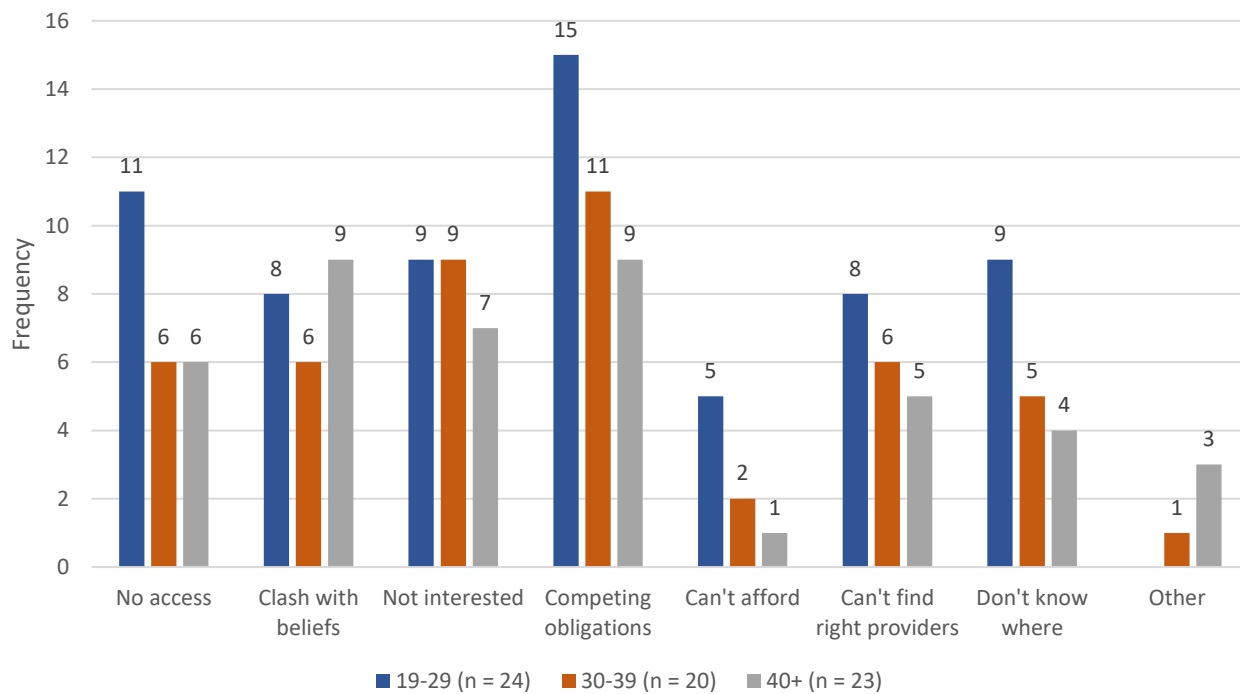
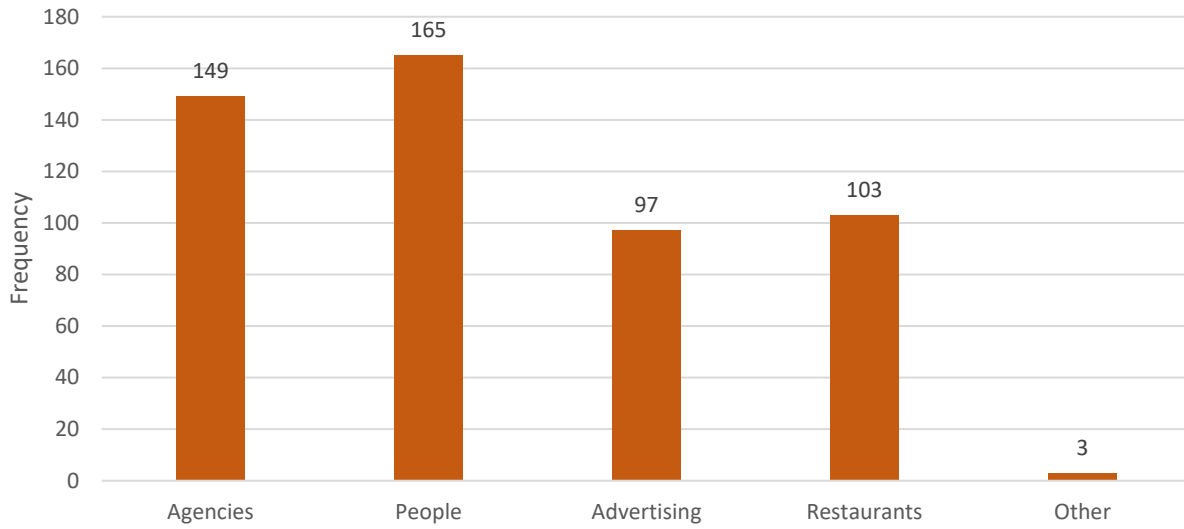


Figure 3.4 Reasons for not practicing First Nations, Inuit or Métis ceremonies for healing, celebration or other purposes by age group



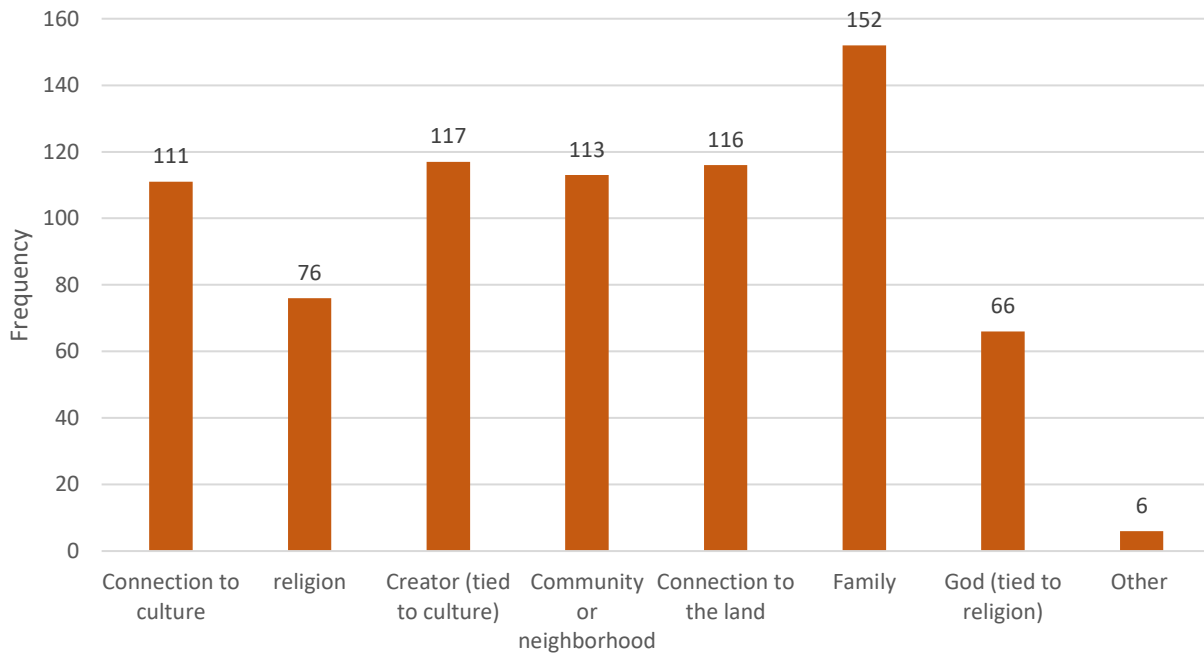
69 respondents selected all answers that applied; 2 respondents were with missing age.

Figure 3.5 Types of reflections of First Nations, Inuit or Métis identity in your community.



Among 185 respondents, 170 (91.9%) individuals answered ‘yes’ they do see reflection(s) of Indigenous identity in their community. Fifteen (8.1%) individuals answered ‘no’. Respondents answering ‘yes’ may have selected multiple answers.

Figure 3.6 Respondents indicated where they found their strength.



185 respondents indicated finding strength through something at least once and selected all answers that applied.

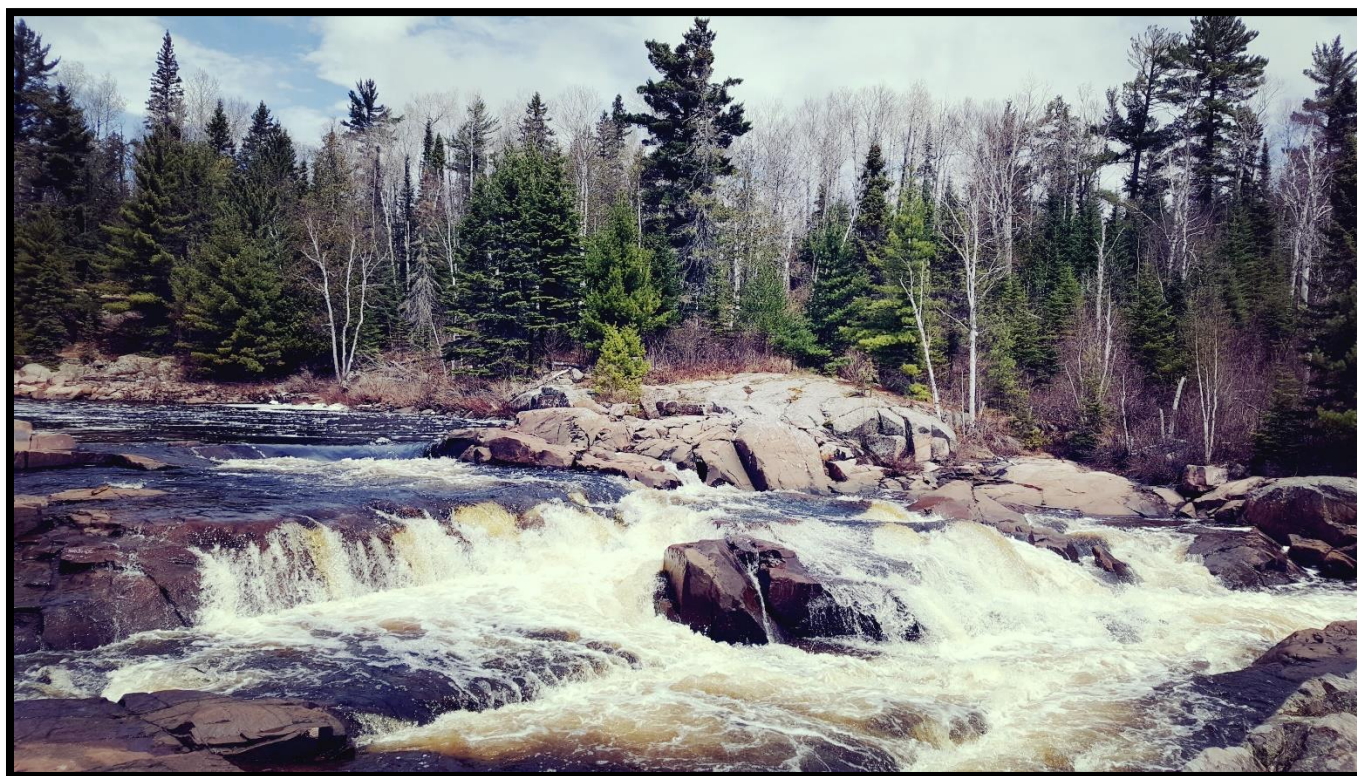
4. Drug Use History

Table 4.1 Injected, smoked (other than marijuana) or taken drugs orally alone and ever used more than one drug at a time by gender.

	Total n=185	Women n (%)	Men n (%)	Two-spirited
Ever used more than one drug at a time	138 (74.6)	62 (69.7)	75 (79.0)	1
Taking drugs alone				
Injected	98 (53.0)	43 (43.9)	54 (56.8)	1
smoked	155 (83.8)	74 (83.2)	80 (84.2)	1
Oral	132 (71.4)	61 (68.5)	70 (73.7)	1

Table 4.2 Injected, smoked (other than marijuana) or taken drugs orally in the last 3 months by gender.

	Total n (%)	Women n (%)	Men n (%)	Two-spirited
Injected	98 (53.0)	49 (55.1)	49 (51.6)	1
Smoked	155 (83.8)	84 (94.4)	89 (93.7)	1
Orally	132 (71.3)	44 (49.4)	58 (61.1)	1



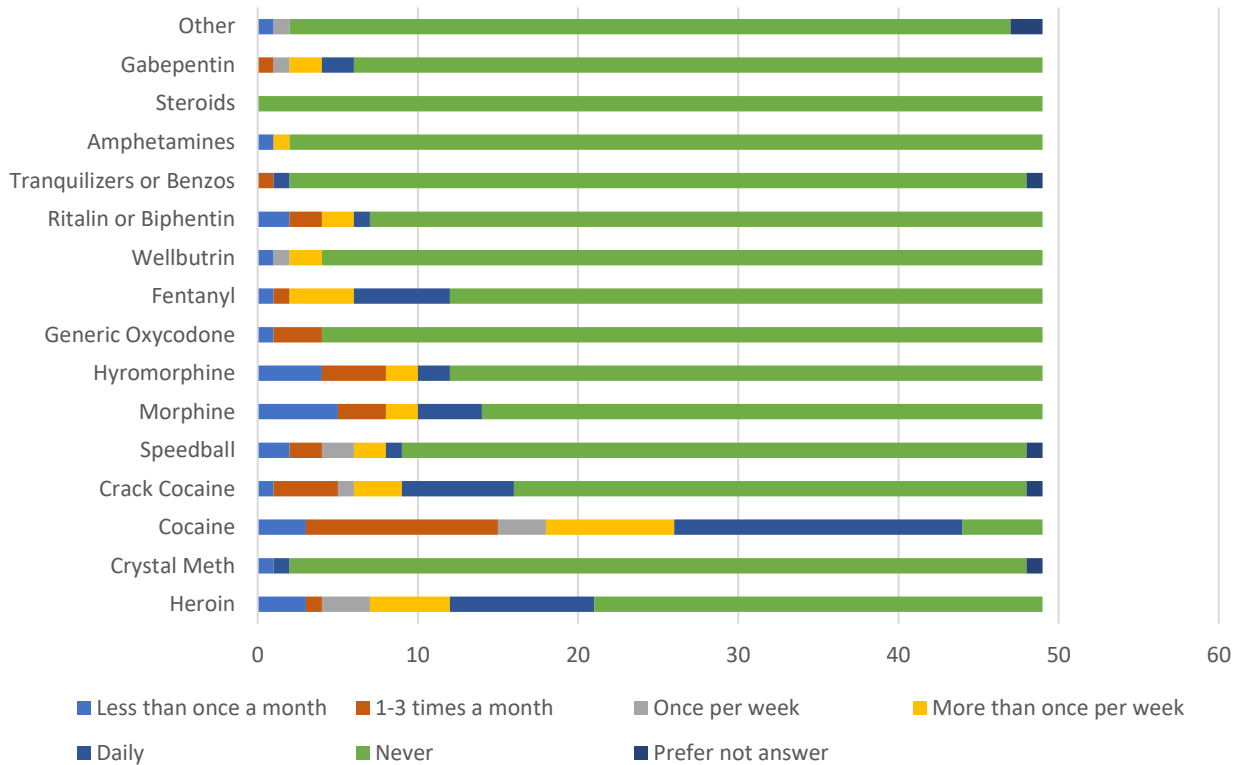
Cascades Conservation Area, Thunder Bay, Ontario

Table 4.3 Frequency of Injected drug use in the last 3 months by gender.

Total n=99	Women n (%)	Men n (%)
Less than once a month	2 (4.1)	7 (14.3)
1-3 times a month	8 (16.3)	5 (10.2)
Once a week	4 (8.2)	6 (12.2)
More than once a week	7 (14.3)	9 (18.4)
Daily	28 (57.1)	22 (44.9)

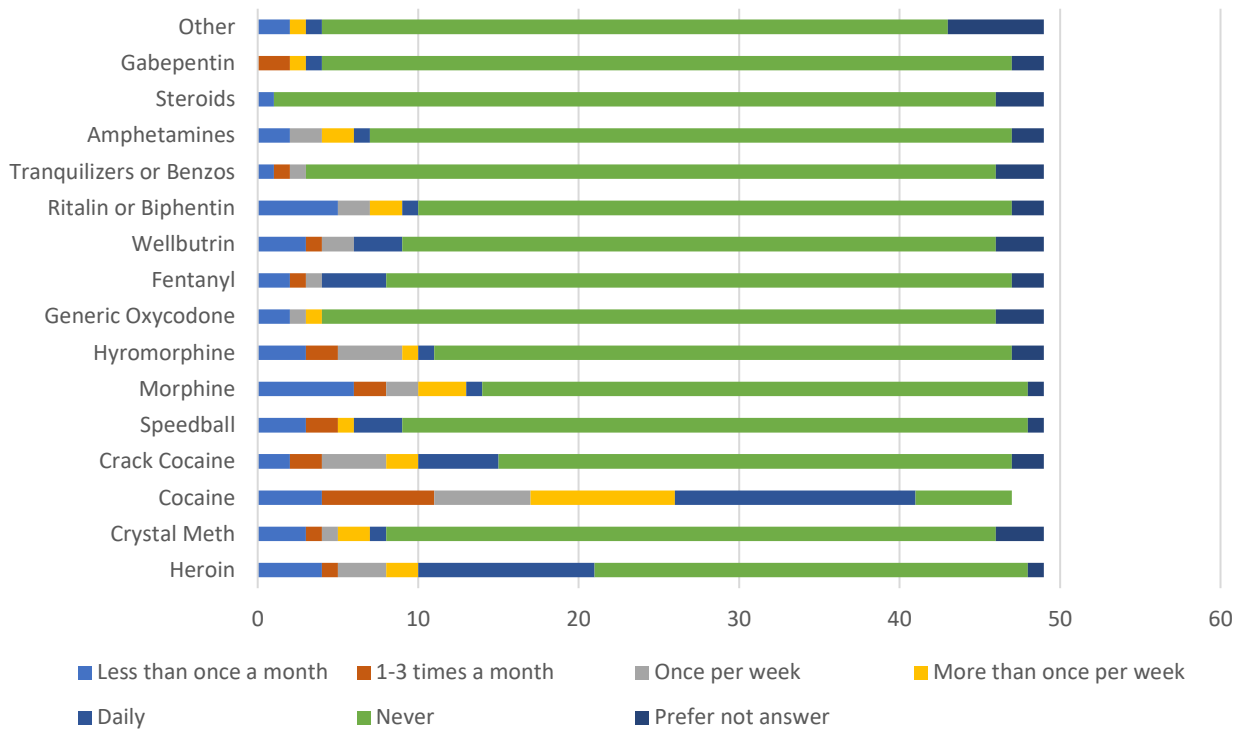
1 two-spirited responded "daily" for injection drug use.

Figure 4.1 Frequency of specific injected drugs used in the last 3 months for women.



Respondents selected all answers that applied.

Figure 4.2 Frequency of specific injected drugs used in the last 3 months for men.



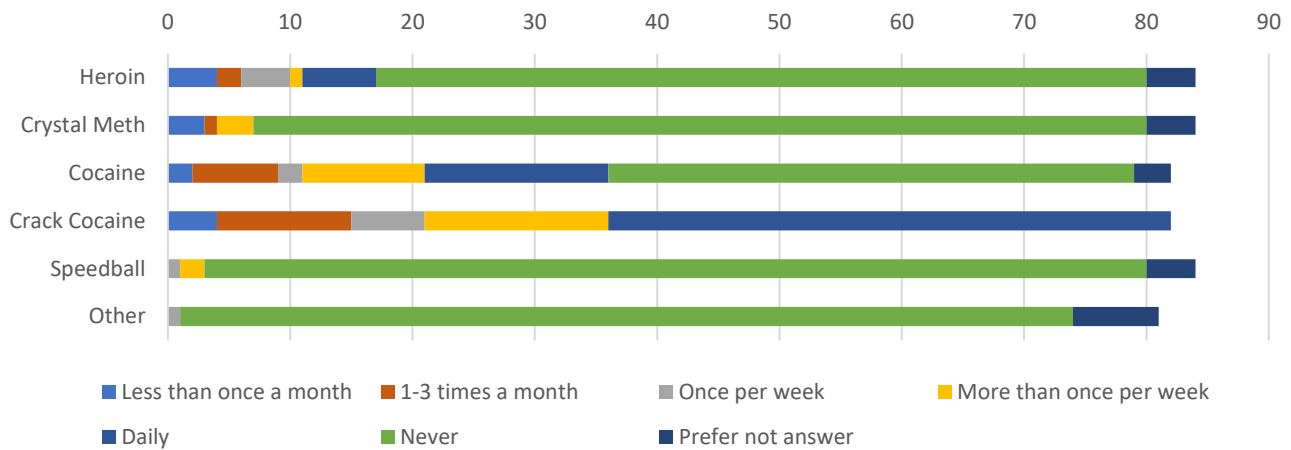
Other responses included 'Alcohol', 'Methadone', 'Suboxone'. Respondents selected all answers that applied.

Table 4.4 Frequency of smoked drug use in the last 3 months by gender.

Total n=175	Women n (%)	Men n (%)
Less than once a month	13 (8.9)	49 (25.7)
1-3 times a month	21 (14.4)	34 (17.8)
Once a week	14 (9.6)	17 (8.9)
More than once a week	31 (21.2)	44 (23.0)
Daily	67 (45.9)	47 (24.6)

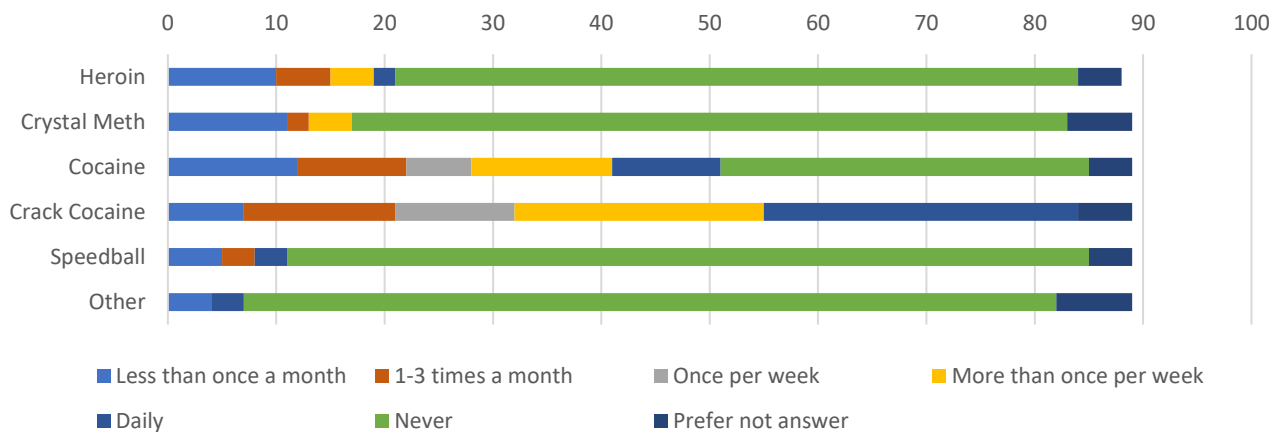
1 two-spirited responded smoking drugs 'more than once a week' and 'daily'.

Figure 4.3 Frequency of specific smoked drugs used in the last 3 months for women.



Other responses included 'Oxy generic brand'. Respondents selected all answers that applied.

Figure 4.4 Frequency of specific smoked drugs used in the last 3 months for men.



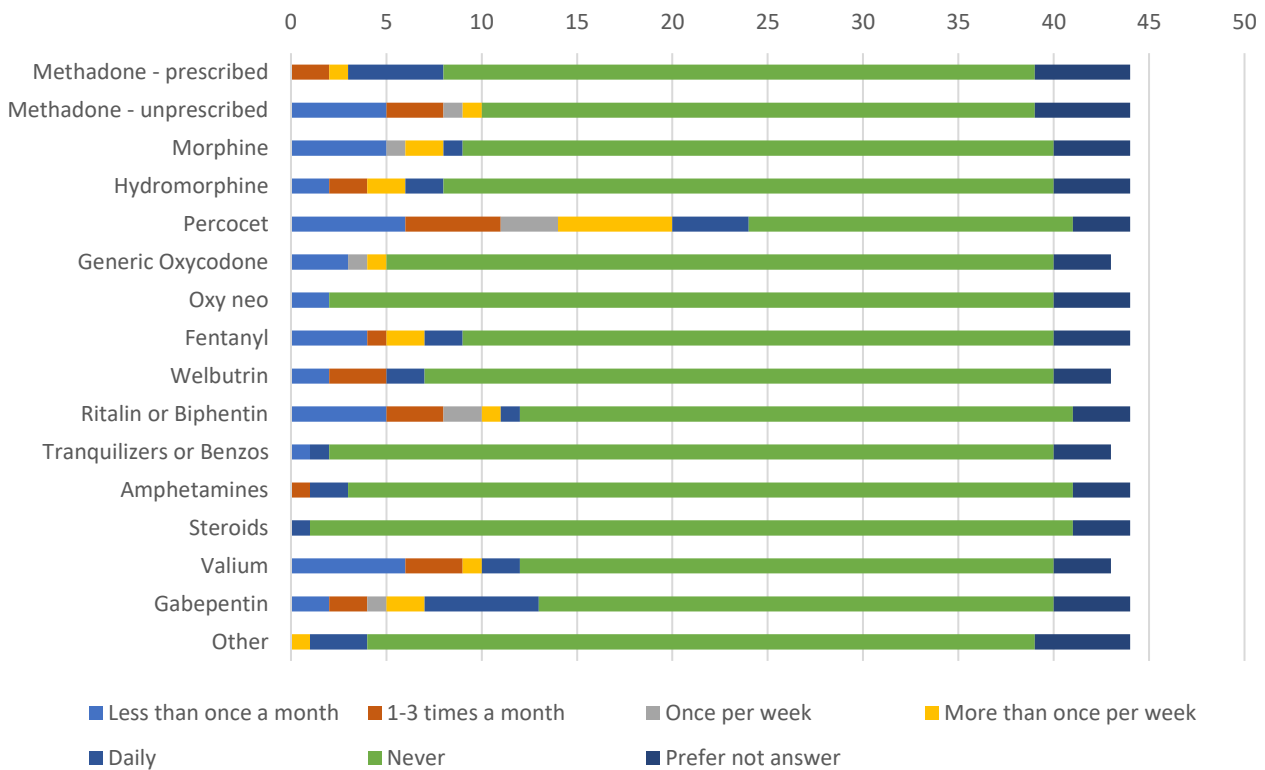
Other responses included 'Alcohol', 'Cocaine and cannabis together', 'Concerta prescribed', 'Morphine'. Respondents selected all answers that applied.

Table 4.5 Frequency of orally taken drugs in the last 3 months by gender.

Total n=103	Women n (%)	Men n (%)
Never	3 (6.8)	3 (5.2)
Less than once a month	3 (6.8)	7 (12.1)
1-3 times a month	6 (13.6)	5 (8.6)
Once a week	4 (9.1)	8 (13.8)
More than once a week	6 (13.6)	12 (20.7)
Daily	22 (50.0)	23 (39.7)

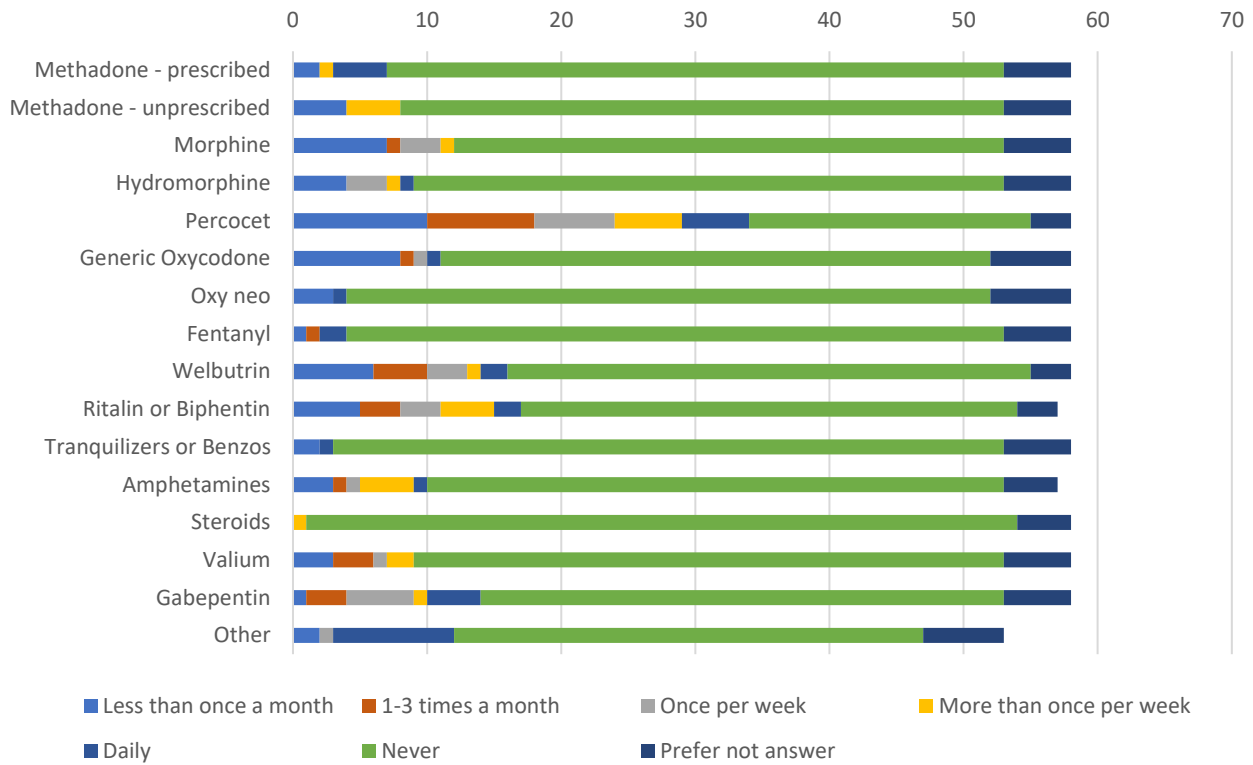
1 two-spirited responded "daily" for oral consumption of drugs. 6 respondents selected yes to taking drugs orally in the last 3 months and did not further characterize their response.

Figure 4.5 Frequency of specific drugs taken orally in the last 3 months for women.



Other responses included 'Suboxone' (5 responses), 'T3s'. Respondents selected all answers that applied.

Figure 4.6 Frequency of specific drugs taken orally in the last 3 months for men.



Other responses included 'Alcohol', 'Concerta', 'Gravol', 'Suboxone' (9 responses), 'T1', 'Codeine'. Respondents selected all answers that applied.

Table 4.6 Frequency of injecting drugs and consuming other substances (alcohol, other products or homemade concoctions) at the same time by gender.

	Women n (%)	Men n (%)
<i>Alcohol (1 preferred not to answer) n=185</i>		
Never	46 (51.7)	48 (51.1)
Rarely (2 of 10 times)	26 (29.2)	29 (30.9)
Some of the time (5 of 10 times)	10 (13.6)	11 (11.7)
Every time or most of the time (7 out of 10 times)	7 (7.9)	6 (6.4)
<i>Other concoctions (2 preferred not to answer) n=184</i>		
Never	81 (92.1)	80 (85.1)
Rarely (2 of 10 times)	6 (6.8)	10 (10.6)
Some of the time (5 of 10 times)	1 (1.1)	3 (3.2)
Every time or most of the time (7 out of 10 times)	0 (0)	1 (1.1)

1 two-spirited responded "never" for alcohol and other concoctions. Any other products or homemade concoctions included babash, hairspray, brew, or hand sanitizer for example.

Table 4.7 Frequency of smoking drugs and consuming other substances (alcohol, other products or homemade concoctions) at the same time by gender.

	Women n (%)	Men n (%)
<i>Alcohol (1 preferred not to answer) n=185</i>		
Never	17 (19.1)	25 (26.6)
Rarely (2 of 10 times)	35 (39.3)	26 (27.7)
Some of the time (5 of 10 times)	26 (29.2)	32 (34.0)
Every time or most of the time (7 out of 10 times)	11 (12.4)	11 (11.7)
<i>Other concoctions (1 preferred not to answer) n=185</i>		
Never	83 (93.3)	78 (83.0)
Rarely (2 of 10 times)	5 (5.6)	10 (10.6)
Some of the time (5 of 10 times)	1 (1.1)	4 (4.3)
Every time or most of the time (7 out of 10 times)	0 (0)	2 (2.1)

1 two-spirited responded "never" for alcohol and other concoctions. Any other products or homemade concoctions included babash, hairspray, brew, or hand sanitizer for example.

Table 4.8 Frequency of orally taken drugs and consuming other substances (alcohol, other products or homemade concoctions) at the same time by gender.

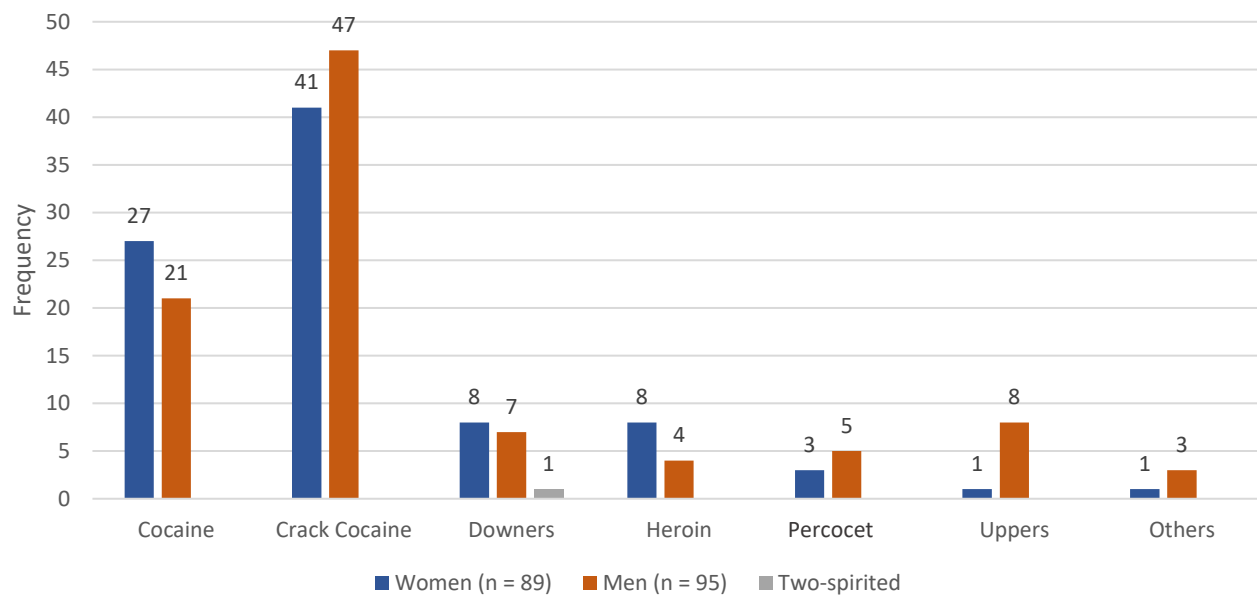
	Women n (%)	Men n (%)
<i>Alcohol (1 preferred not to answer) n=185</i>		
Never	46 (51.7)	48 (51.1)
Rarely (2 of 10 times)	22 (24.7)	20 (21.3)
Some of the time (5 of 10 times)	13 (14.6)	17 (18.1)
Every time or most of the time (7 out of 10 times)	8 (9.0)	9 (9.6)
<i>Other concoctions (5 preferred not to answer) n=181</i>		
Never	81 (92.1)	80 (85.1)
Rarely (2 of 10 times)	5 (5.7)	7 (7.7)
Some of the time (5 of 10 times)	1 (1.1)	2 (2.2)
Every time or most of the time (7 out of 10 times)	1 (1.1)	2 (2.2)

1 two-spirited responded "some of time" for alcohol and "never" for other concoctions. Any other products or homemade concoctions included babash, hairspray, brew, or hand sanitizer for example.

Table 4.9 Preferred drug use based on accessibility represented by gender.

	Total n=185	Women n (%)	Men n (%)	Two-spirited
Available most often	173 (93.5)	87 (97.8)	86 (90.5)	0
Easiest to get	173 (93.5)	85 (95.5)	88 (92.6)	0

Figure 4.7 Preferred drugs used by respondents.

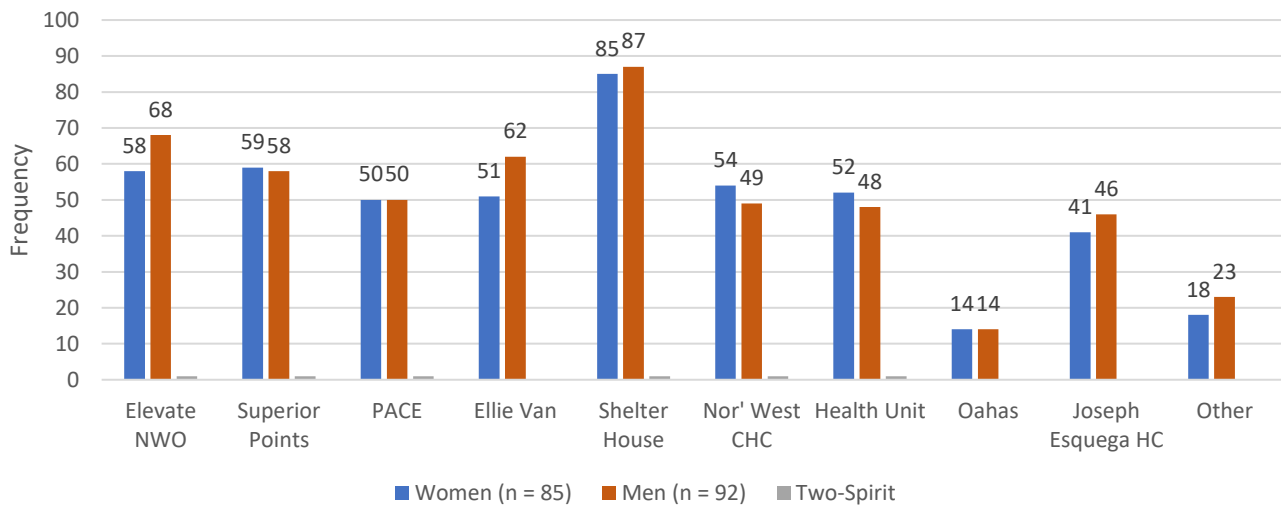


Other responses included suboxone, methadone, all, cannabis.

5. Harm Reduction

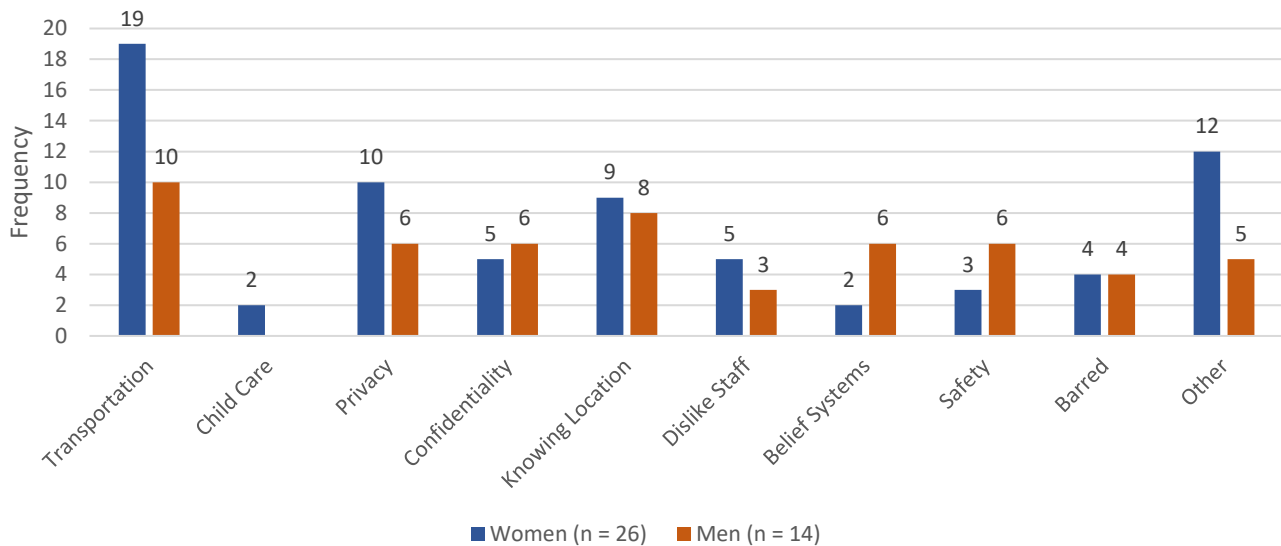
Among 185 respondents, 65.4% (n=121) knew what harm reduction was and defined it as harm reduction kits and safer drug use practices (e.g. not sharing equipment, unused equipment, safe disposal, naloxone kit), increasing education on drugs, safe injection sites and knowing where to obtain equipment for safer sex and drugs, knowing who to go to for help (e.g. counselors, buddy system, health services, outreach workers, drop-in centres), using drugs in moderation, abstinence or replacement activities, and self-care and learning about it.

Figure 5.1 Knowledge of where to go for harm reduction services by gender.



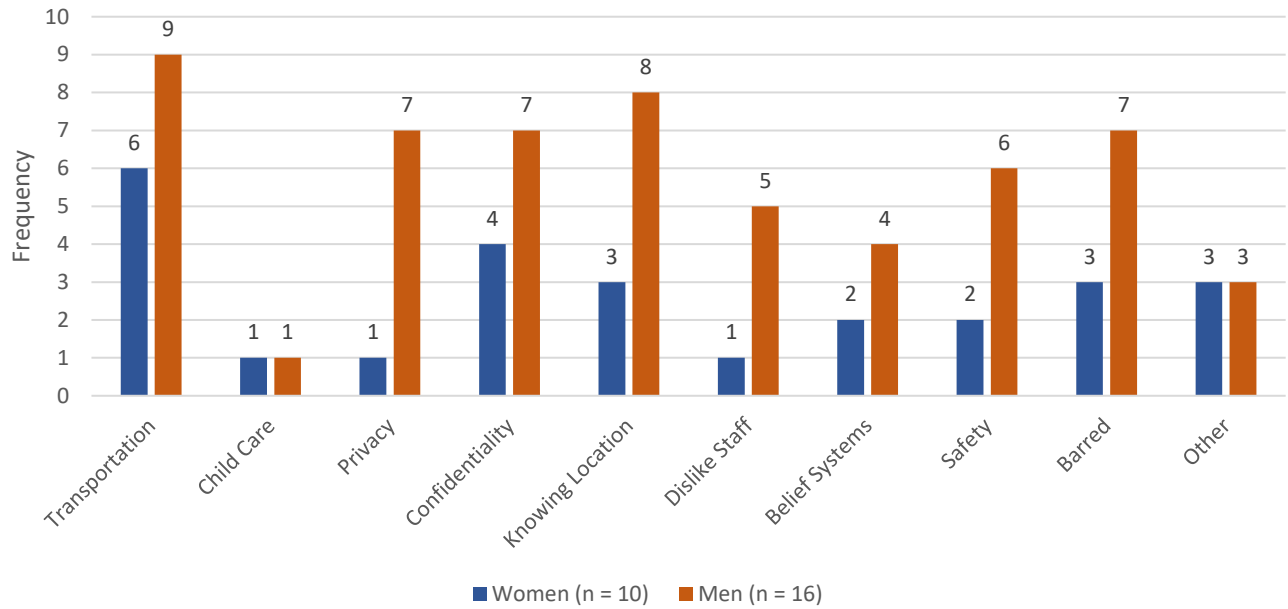
4 women and 3 men responded 'No' to the question "Do you know where to go for harm reduction services and supplies?" and were not prompted to provide responses above. Respondent selected all answers that applied.

Figure 5.2 Barriers or reasons for **not accessing** harm reduction services by gender.



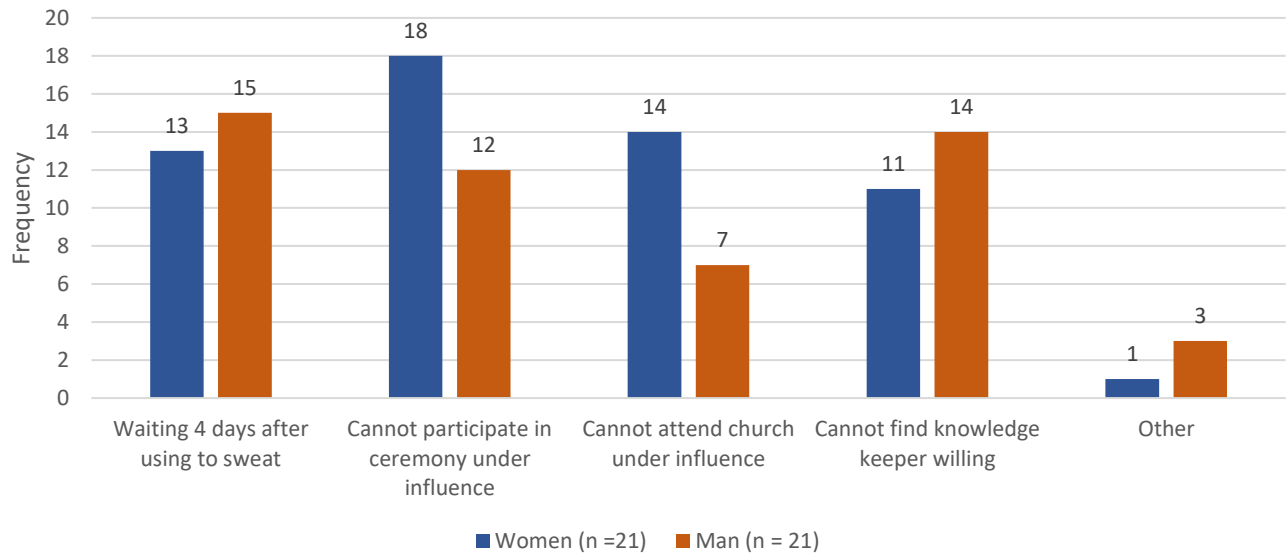
63 women and 81 men and 1 two-spirited answered 'No' to the question "Are there things that get in the way of you accessing harm reduction services and supplies?" and were not prompted to provide answers above.

Figure 5.3 Reasons or barriers for **not practicing** harm reduction by gender.



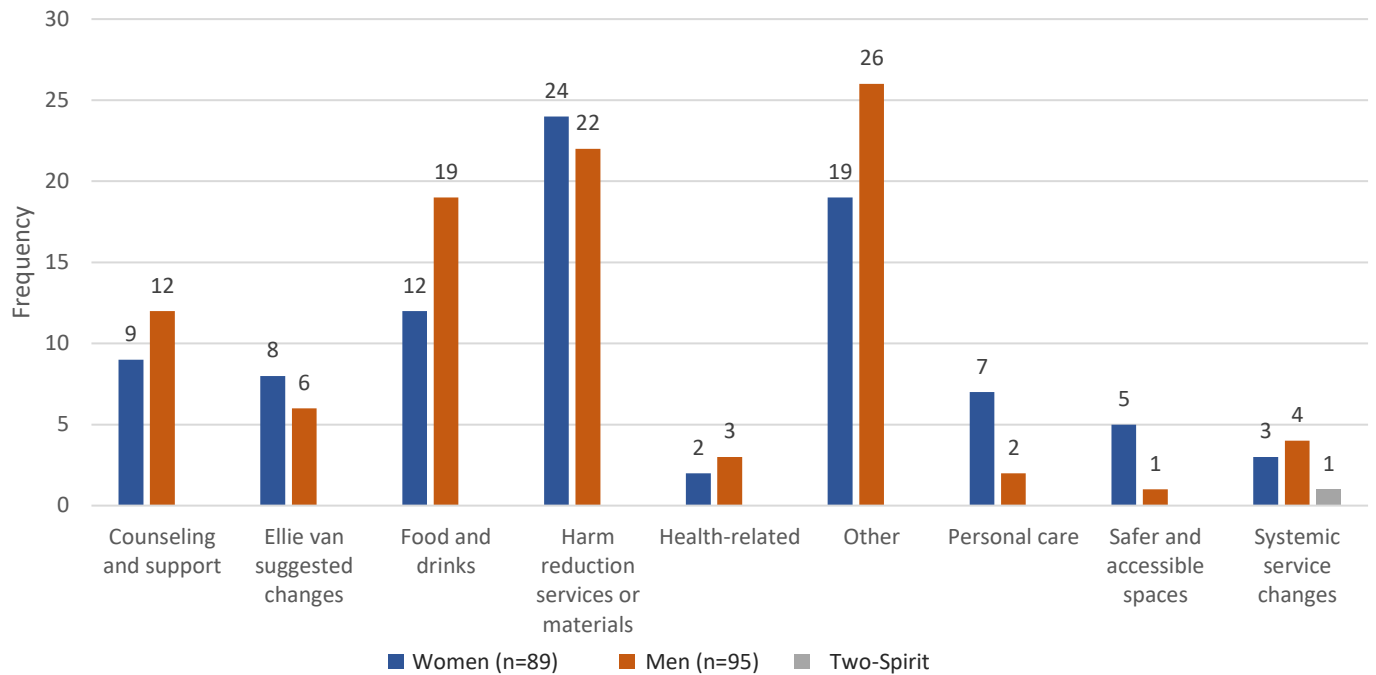
79 women and 79 men and 1 two-spirited answered ‘No’ to the question “Are there things that get in the way of you practicing harm reduction?” and were not prompted to provide answers above. Respondents selected all answers that applied.

Figure 5.4 Reasons for not practicing harm reduction and teachings together by gender.



68 women and 74 men responded ‘No’ to the question “Is there anything about ‘teachings’ that you received from your family, religious groups, or cultural people that affect how you feel about using harm reduction practices?” and were not prompted to provide answers above. Respondents selected all answers that applied.

Figure 5.5 Services or resources respondents would like to see delivered to meet their harm reduction needs.



These are the things I would like to see to have my harm reduction needs met...

SUGGESTED CHANGES TO ELLIE VAN

SAFER AND ACCESSIBLE SPACES
 Accessible and close locations
 More safe spaces for substance use
 Well known safe space
 Safe centres to go to
 Out of sight of children
 Safe spaces to use substances
 Professional and kind outreach workers

More days
 Ellie Van working with Salvation Army Van
 More street outreach services
 Toll-free number for delivery of supplies
More sites
More Ellie Vans
 Longer hour including after hours
 More services like a clinic
 Ellie Van toll-free number
 Increased community presence

SYSTEMIC SERVICE CHANGES
 Call centres for dispatching outreach workers
 Transportation to safe spaces
 Decriminalization of drugs
24-hour harm reduction services
 Drive/walk through spaces
 Mailing harm reduction kits

HARM REDUCTION SERVICES OR MATERIALS

Readily available naloxone kits
 Education on safer drug use
 Access to detox centre
 Option to go to detox
 Harm reduction supplies
 First Aid supplies
 More naloxone kits
Needle exchange
 Clean tools
 Clean needles
 Small needles
 Crack pipes
 Clean pipes
 Education
 Testing drugs
 Meth pipes
 Safe disposal
 Brillo
 Loot bags
Adhesive bandages
 Two pipes per kit
 Polyspout
 Needle disposals
 Pipes
 Handouts
 Creams for rashes
 Medical supplies
Naloxone kits
Alcohol swabs
 Naloxone trained workers
 Clean supplies
 Information sheets
 Kit clean-ups
 More harm reduction awareness
 More beds at detox centre
 Antibiotic cream for track marks
 Safe injection drug education



COUNSELLING AND SUPPORT

Counselling centres
 Peer support groups
 Treatment counselling
 Shelter homes
 Advocacy
 More support
 Support system
 Peers
Counseling
Counselors
Support workers
 People to talk to
 Part-time work
 Safe house
 Story sharing groups
 Housing support

PERSONAL CARE

Cleansing towelettes
 Feminine pads
 Personal hygiene products
 Ibuprofen [Advil or Motrin]
 Shampoo
 Tampons
 Juice boxes
 Towels
Socks
Washing materials
 Adhesive bandages
 Sunscreen
 Sleeping material

FOOD AND DRINKS

Soup vans
 Fruits and vegetables
 Soup
Snacks
Food
Drinks e.g. Juice, water
 Burrito
 Sandwiches

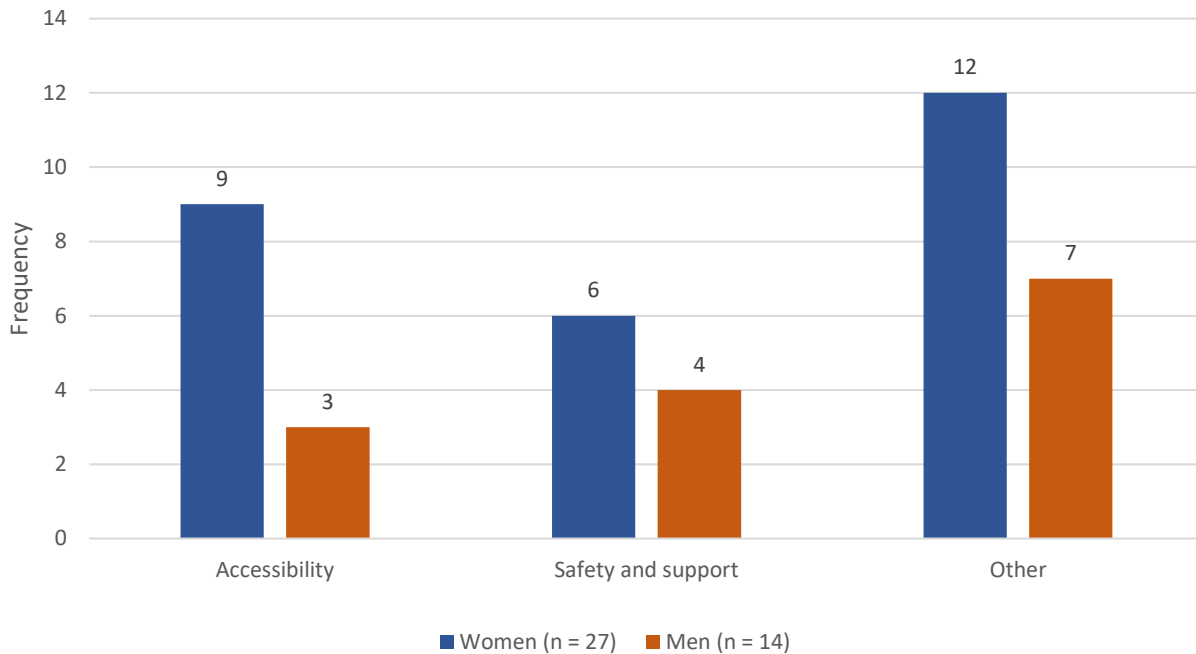
HEALTH-RELATED

Hospital on Fort William side
 Medicine
 Treatment
 Vitamins
 Foot care
 Doctors

6. Supervised Injection Site (SIS) and Supervised Consumption Site (SCS)

Figure 6.1 Things that would **support** holding off on using drugs until reaching a SIS.

Forty-three respondents (out of 184) indicated that there were things that would help them to not use until they get to the SIS. “Other” responses included “Too high”, “Have my own support”, “I don’t use by smoking”, “Other users”, “Ripped off by people”, “Do on own”, and “Anxiety”.



Other responses included unclear, nothing, not sure, not applicable, activities, if I am sick.

To feel supported, we need the following to hold off on using drugs until we can get to a SIS/SCS

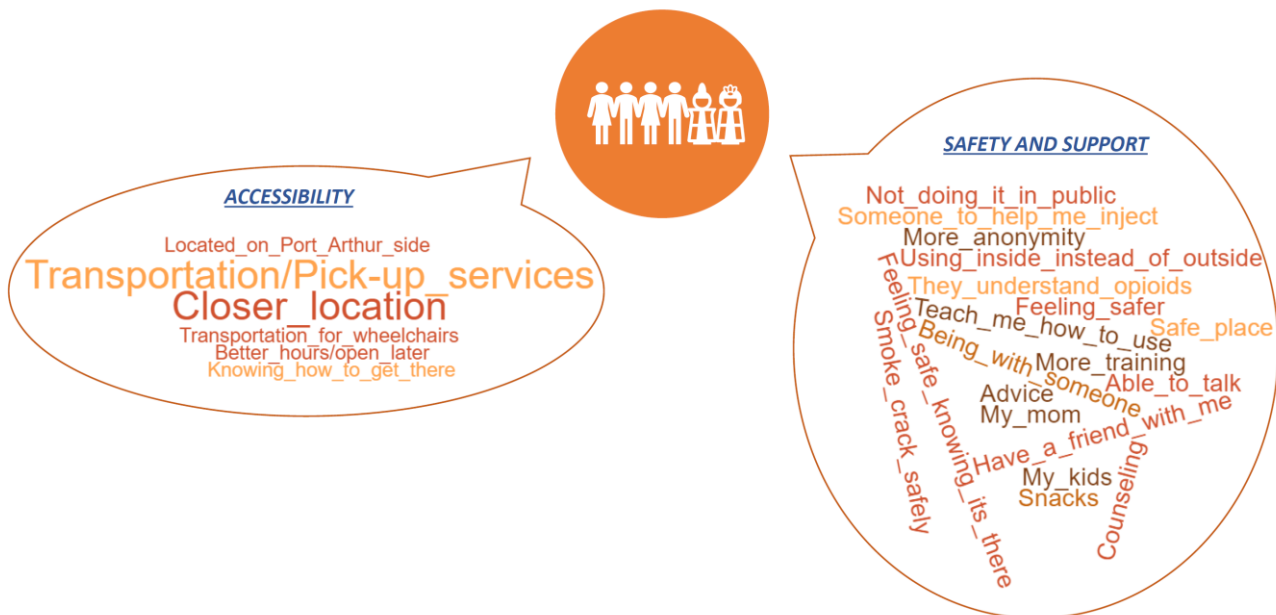
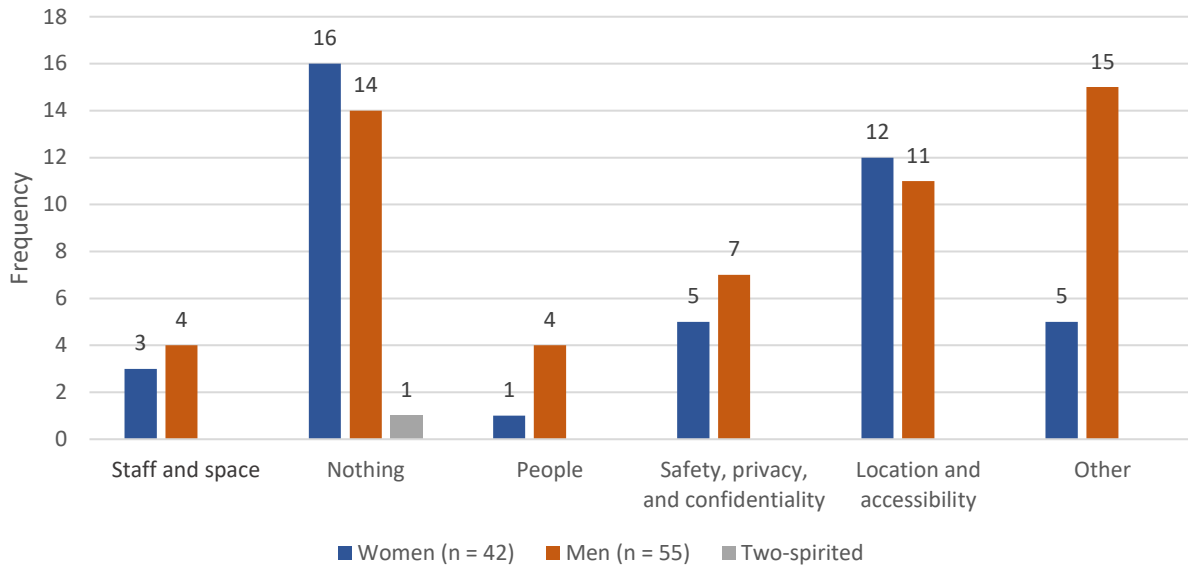


Figure 6.2 Things that would **stop** from holding off on using drugs until reaching a SIS.



Other responses included not sure, did not answer, don't know, free drugs, drinking allowed, knowing about it, let you smoke crack, a bottle, an agreement.

Things that would stop me or another person from holding off on using drugs until I reached a SIS...

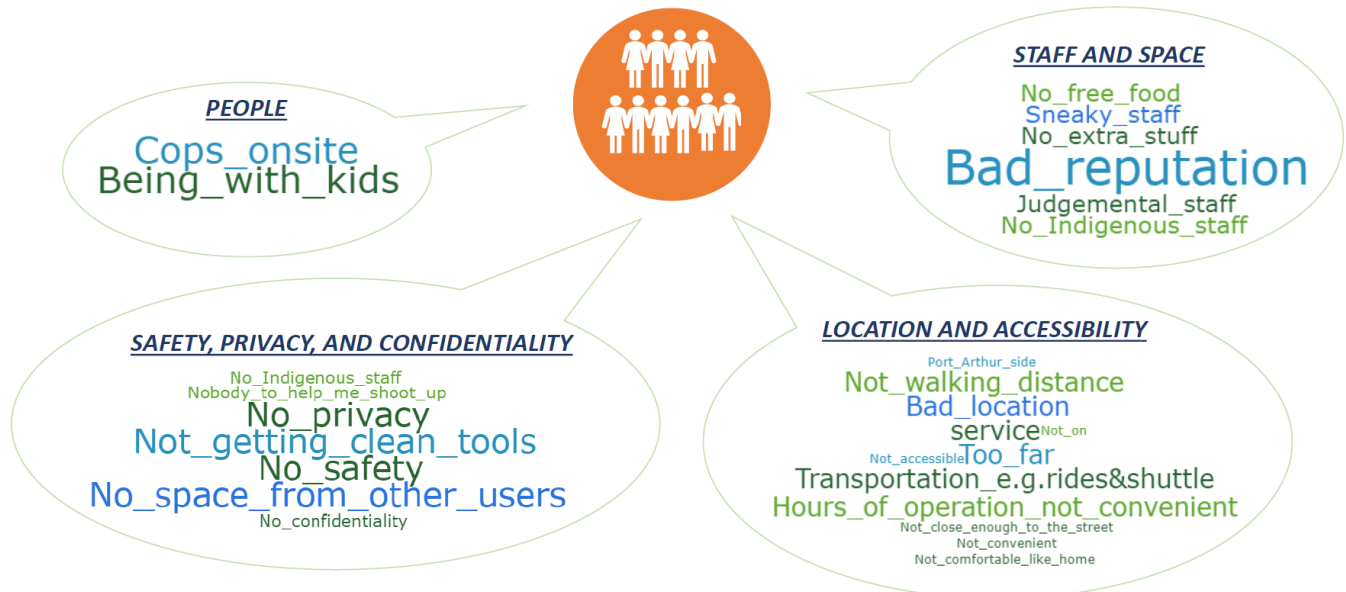
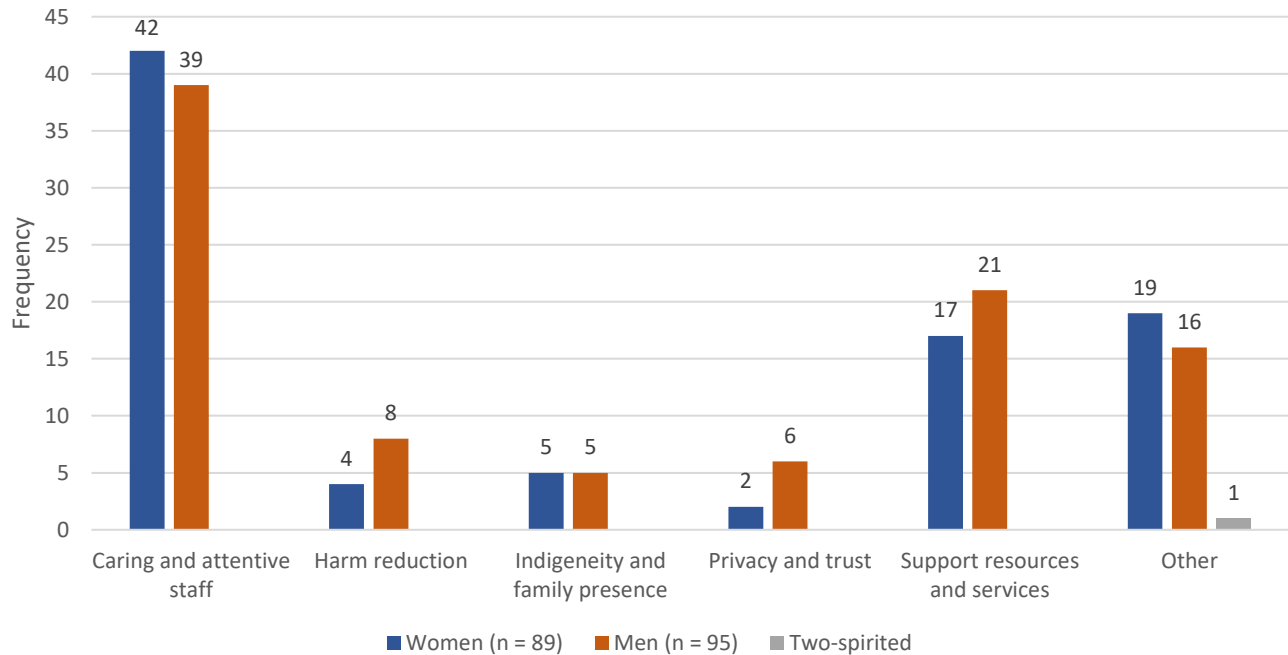


Figure 6.3 Things a SIS and a SCS would have to do to be inclusive of your needs and values.



Other responses included 'Don't know, unclear, been there done that, Na, Yes, be who you are, keep doing what your doing, did not answer'.

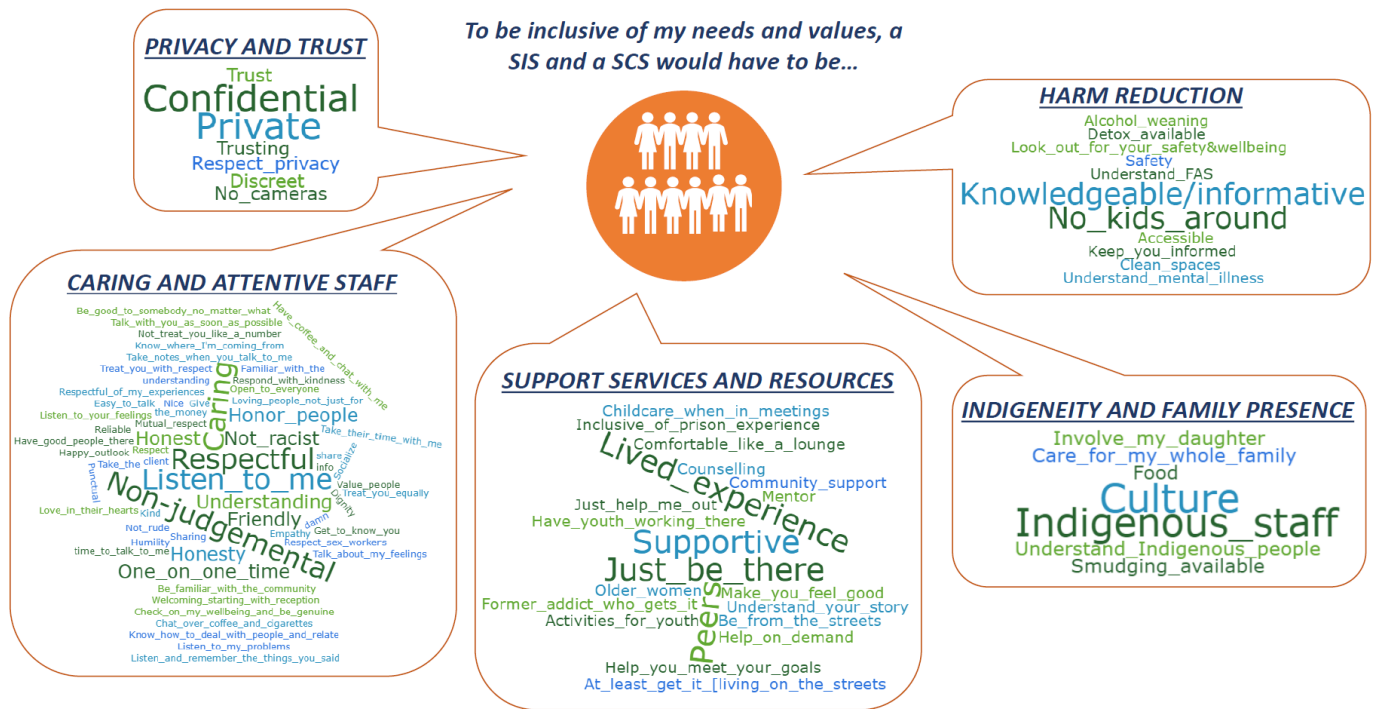
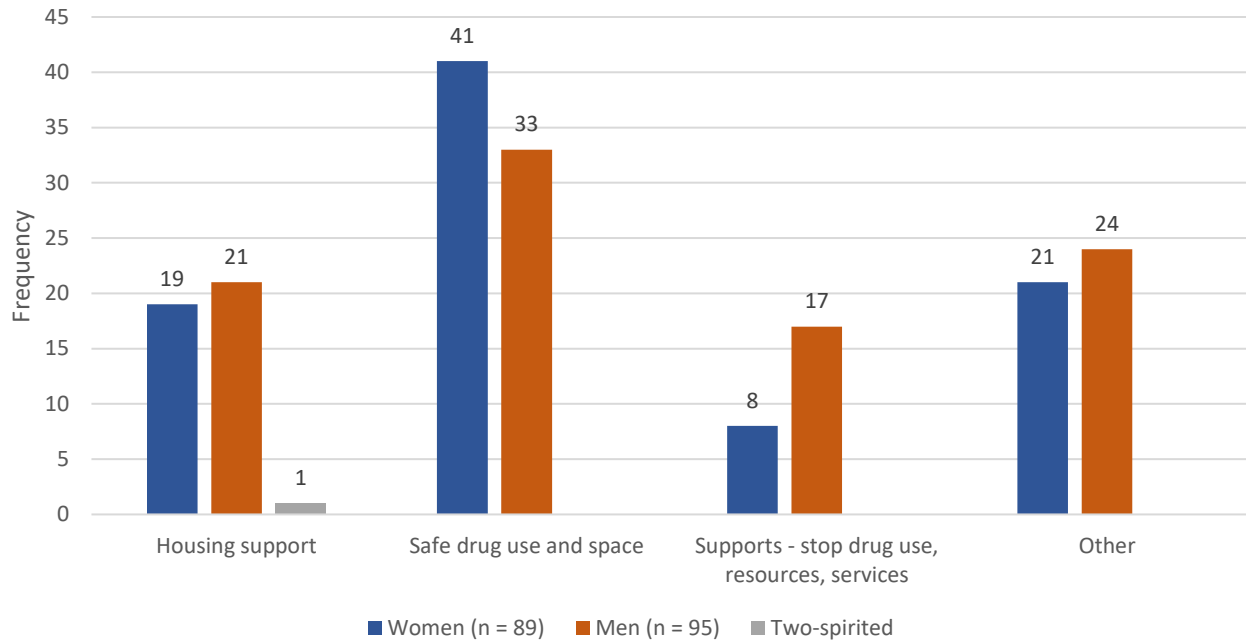


Figure 6.4 Reasons for going to a SCS in Thunder Bay by gender.



Other responses included Don't know, did not answer, unclear, other (other examples: see how it is, how is it managed, last resort).

We would go to a SCS in Thunder Bay for...

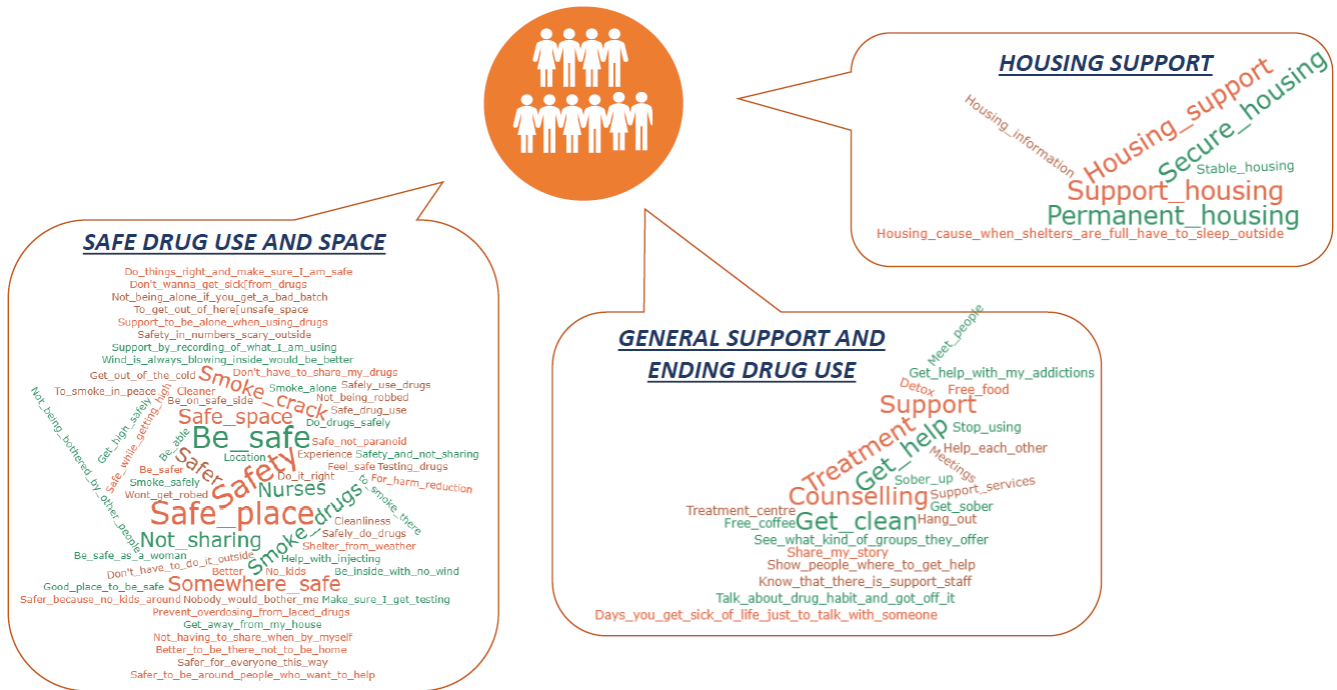
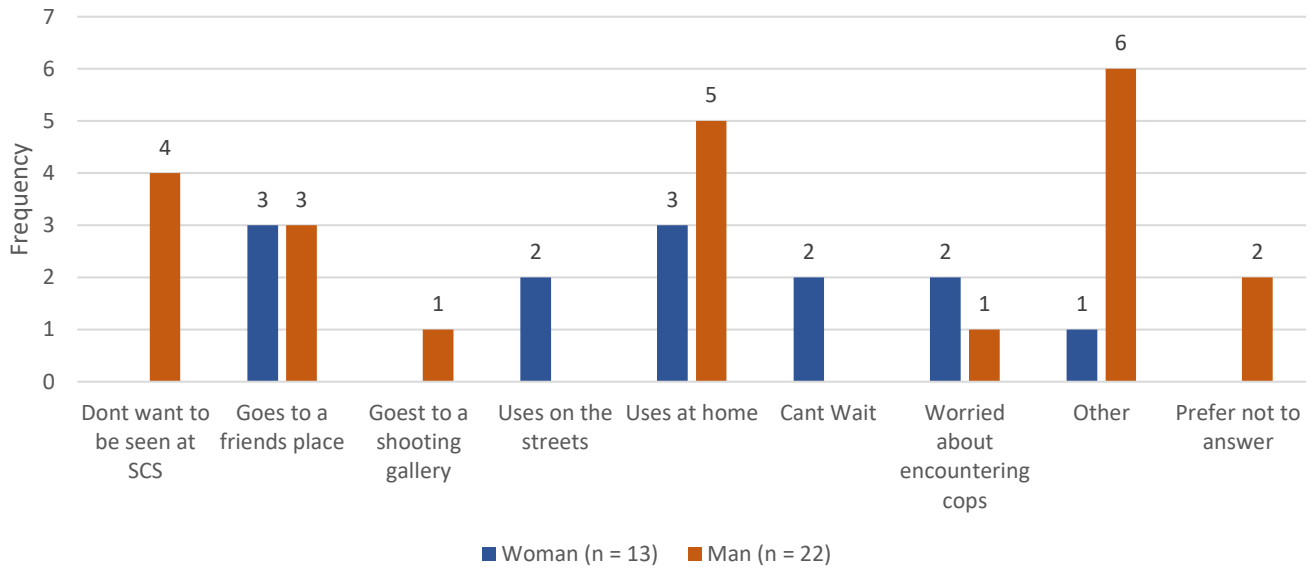
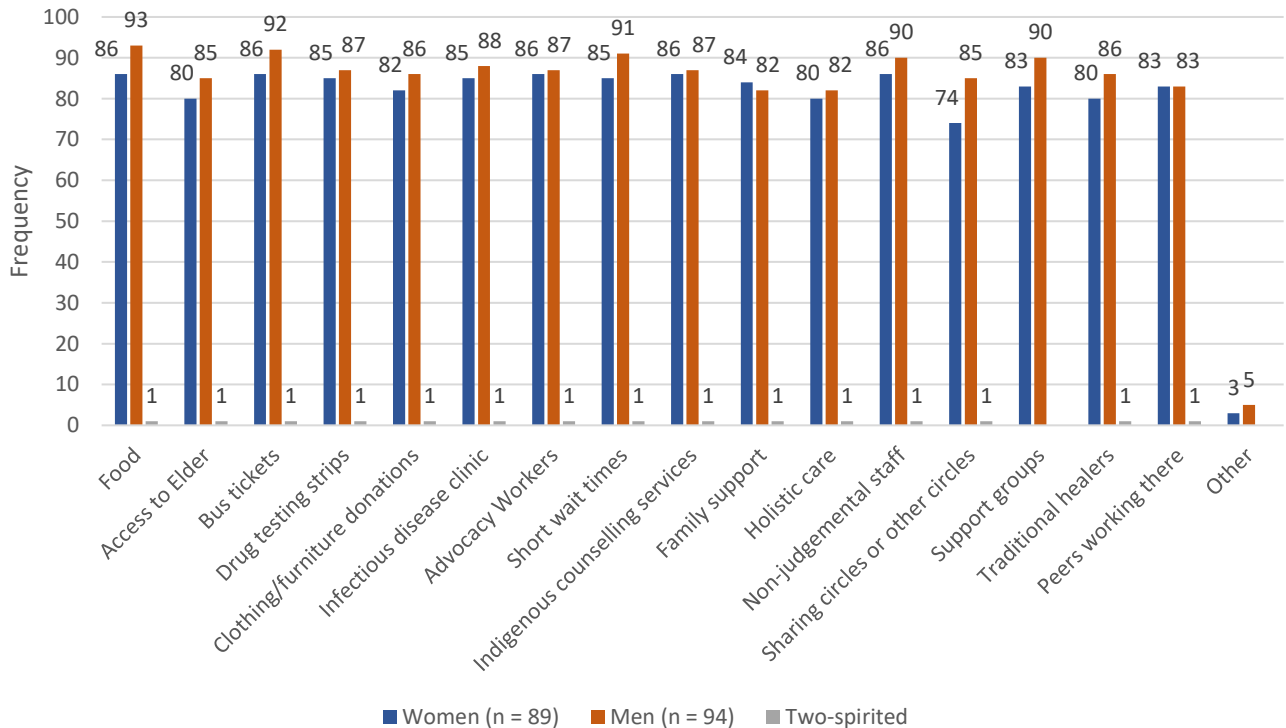


Figure 6.5 Reasons for **not accessing SCS** in Thunder Bay by gender.



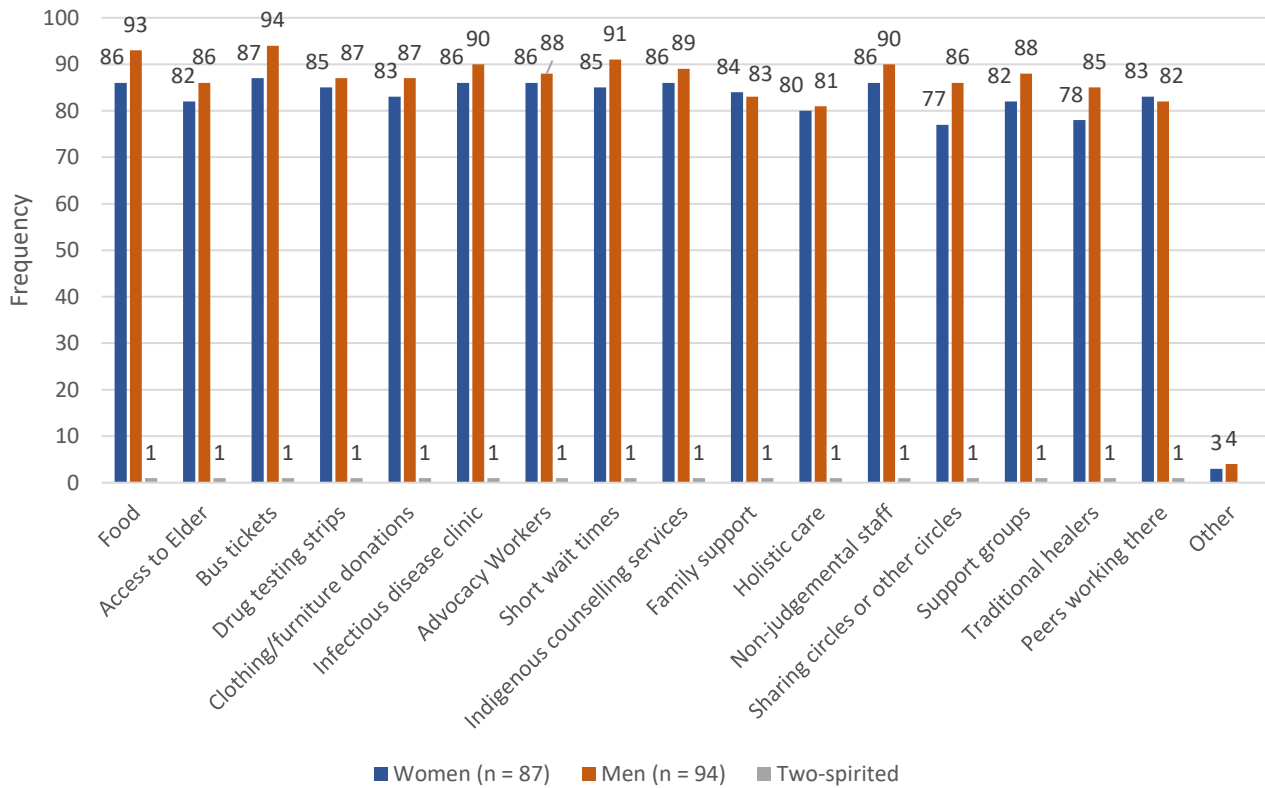
148 respondents out of 183 indicated that they would go to a SCS if one were to exist in Thunder Bay. Respondents selected all answers that applied.

Figure 6.6 Several services needed to be in place to support Indigenous people to come to a SIS/SCS.



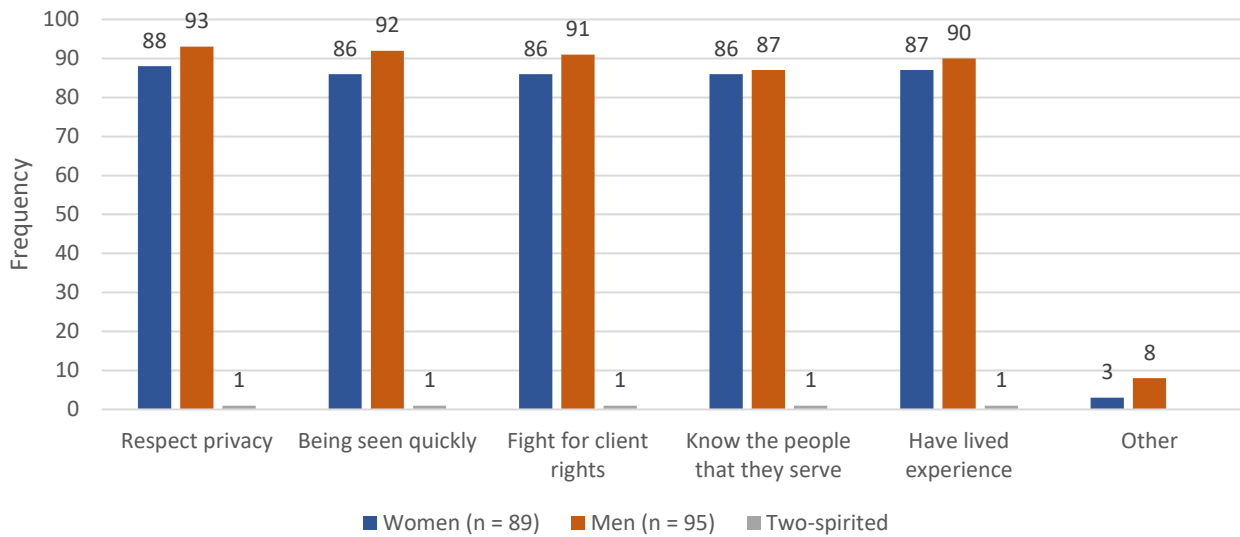
Other responses included 'Do on own', 'More shelters', 'Security', 'Native advocacy workers', 'One on one counselling', 'Rides', 'Just do not like using in the public eye'. Respondents selected all answers that applied.

Figure 6.7 Several services needed to be in place to support Indigenous people to come back again to a SIS/SCS, to become a returning client.



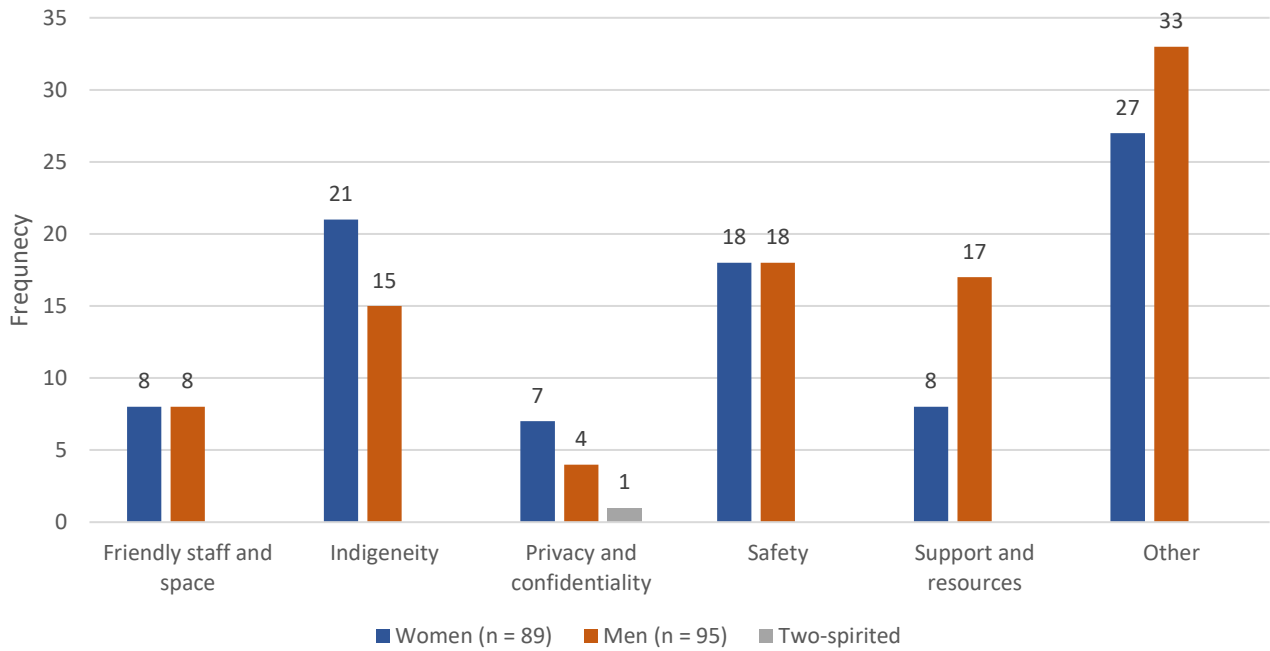
Other responses included ‘Vegan food bike repair kit’, ‘Sweats’, ‘Native advocacy workers’, ‘One on one counselling’, ‘Done way too many programs and would not use in public’, ‘Rides’. Respondents selected all answers that applied.

Figure 6.8 Indigenous people described what a caring staff would look like or do at a SIS/SCS.



Other responses included ‘Show they care’, ‘Uniform’, ‘Friendly’, ‘Patience’, ‘Make clients feel comfortable’, ‘Be polite’, ‘Talk about how their feelings’, ‘Bigger centres’, ‘24-hour grievance counselling’, ‘Native staff’. Respondents selected all answers that applied.

Figure 6.9 Things that Indigenous persons would like to see or have in a SIS/SCS to make them feel safer when accessing it.



Other responses included don't know, not applicable, unclear, nothing, did not answer, doesn't matter, to be alive, not sure, try out services, free beer.

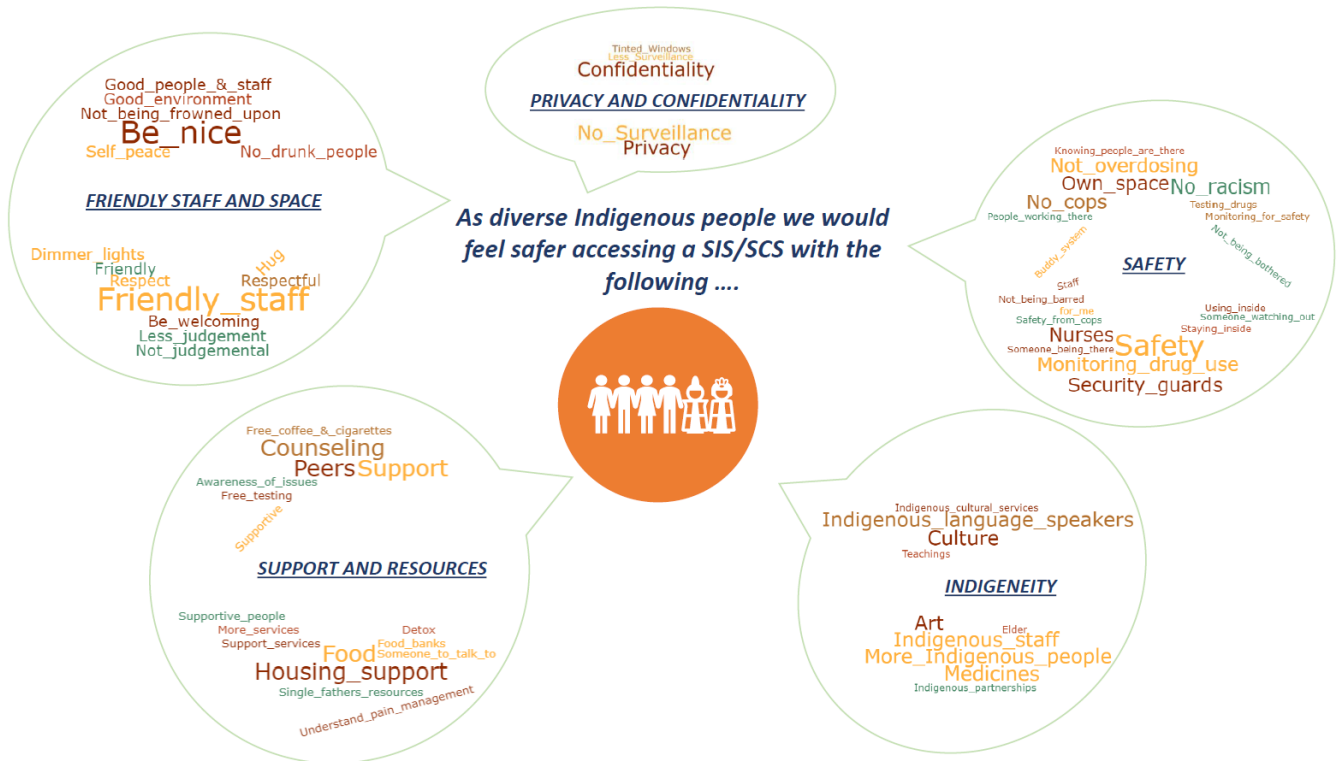
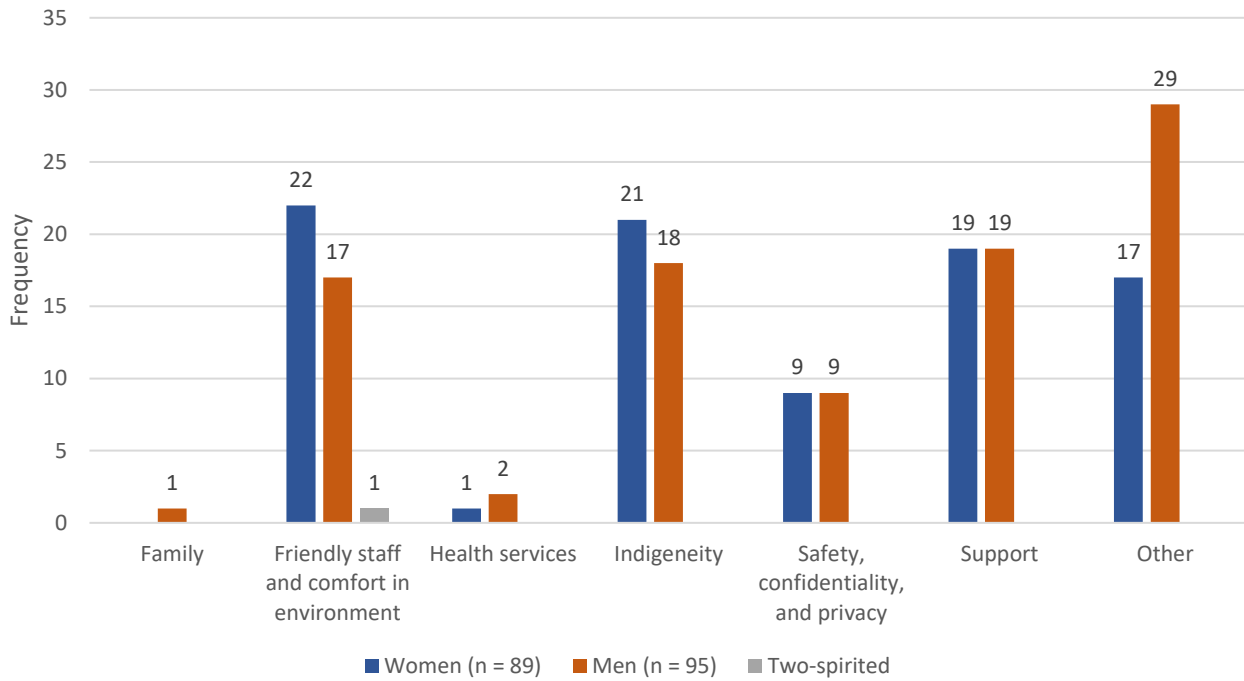
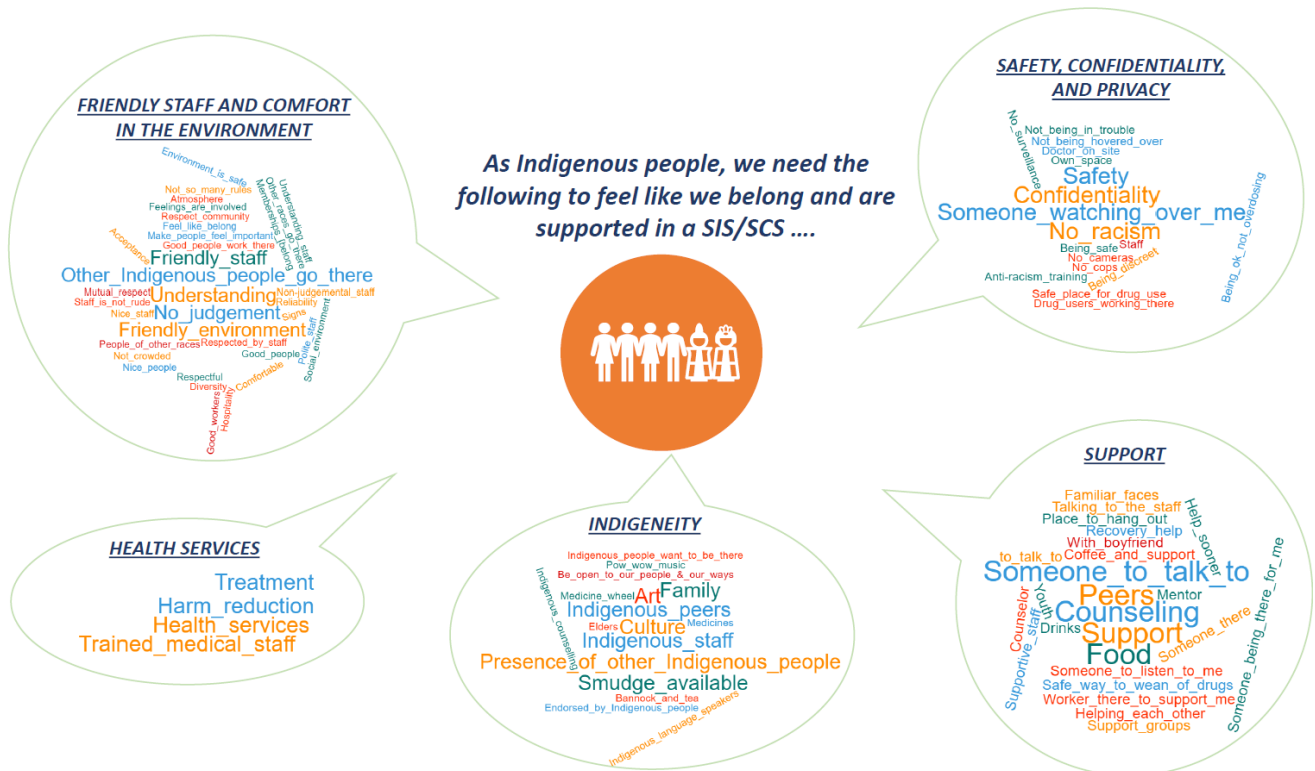


Figure 6.10 Things that would help Indigenous persons feel like they belong and are supported in a SIS/SCS.



Other responses included not applicable, not sure, nothing, did not answer, don't know, unclear, free alcohol.



7. Testing and Overdose Prevention

Table 7.1 HIV and HCV testing by gender and age.

	Women n (%)			Men n (%)			Two-spirited
Tested for HIV (Total n = 159)	Total 81 (91.0)			Total 77 (81.1)			1
	Age group (years)			Age group (years)			
	19-29	30-39	40+	19-29	30-39	40+	
	28 (84.9)	24 (88.9)	28 (100)	24 (80.0)	27 (84.4)	26 (81.2)	
Tested for Hepatitis C (Total n = 164)	Total 84 (94.4)			Total 79 (83.2)			1
	Age group (years)			Age group (years)			
	19-29	30-39	40+	19-29	30-39	40+	
	31 (93.9)	25 (92.6)	27 (96.4)	25 (83.3)	27 (84.4)	27 (84.4)	

Table 7.2 Ever overdosed by gender.

	Total n=185	Women n (%)	Men n (%)	Two-spirited
Ever overdosed	76 (41.1)	41 (46.1)	34 (35.8)	1

Figure 7.1 Ways naloxone kits were acquired by gender.

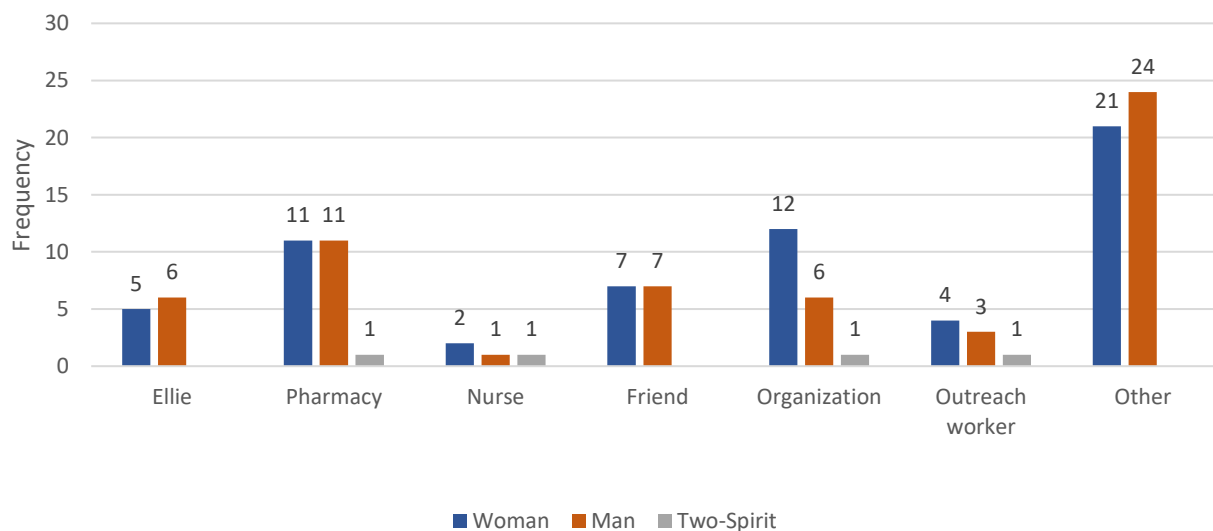


Figure 7.2 Naloxone knowledge, access, and use.



172 (n=185, 93.0%) respondents heard of naloxone and among them 11 (n=172, 6.4%) requested a refresher on what was naloxone.



111 (n=185, 60.0%) respondents had a naloxone kit, 13 (n=102, 12.8%) needed another kit, and 33 (n=74, 44.6%) wanted a one.



95 (n=111, 85.6) respondents with a naloxone kit were trained to use it, 5 (n=95, 5.3%) needed a refresher on how to use it, and 5 (n=16, 31.2%) wanted to be trained.



77 (n=185, 41.6%) respondents had used naloxone and 45 (n=77, 58.4%) called an ambulance after using it.

89 (n=183, 48.6%) respondents were aware of the Good Samaritan Drug Overdose Act, and because of it 170 (n=185, 91.9%) were more willing to call 911.

- 13 used the injectable form typically for unconscious individuals
- 68 use the spray form requiring an individual be capable of inhaling

- Fifteen respondents indicated that the Good Samaritan Drug Overdose Drug Act did not increase their willingness to call 911.
- Several reasons were described for not calling 911.
 - Police not following rules related to the act, still charging people, and being uncertain about whether they would be charged



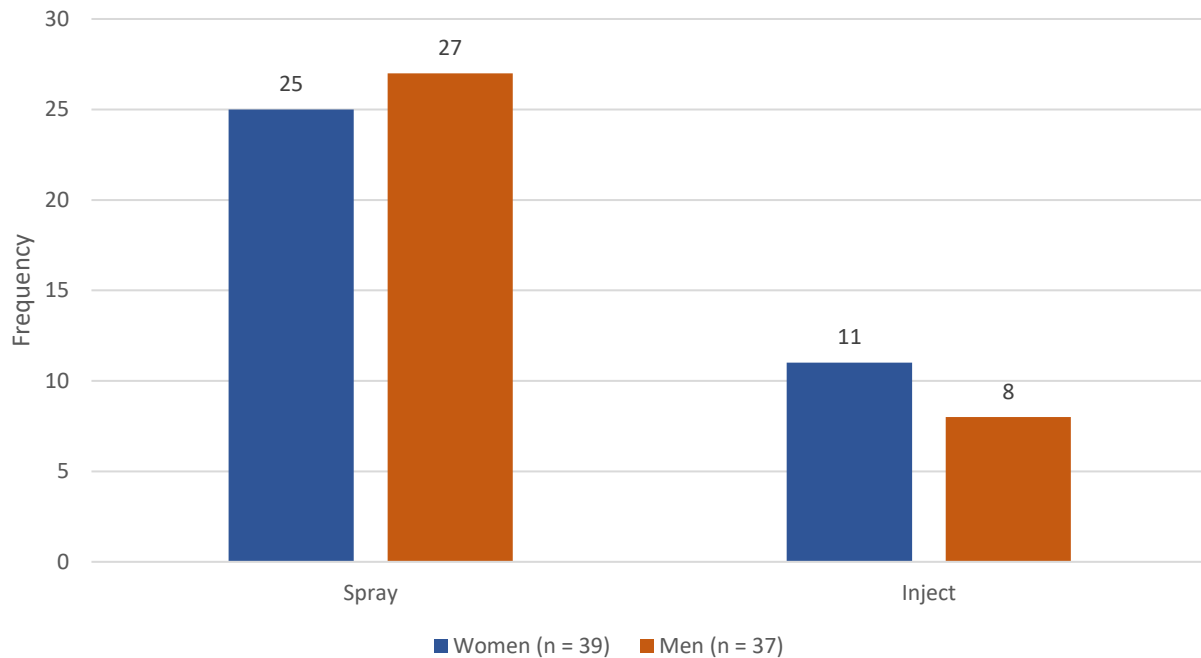
- Other responses included: not needing to call 911, being scared, not having a phone, and not wanting to be noticed.

Table 7.3 Naloxone knowledge, use and access by gender.

	Women n (%)	Men n (%)	Total* n (%)
Has heard of naloxone	84 (98.8)	87 (91.6)	172* (93.0)
Needs a refresher on what naloxone is	4 (4.7)	6 (6.3)	11* (5.9)
Has a naloxone kit	57 (67.1)	53 (55.8)	111* (60.0)
Needs another naloxone kit	7 (8.2)	5 (5.3)	13* (7.0)
Wants a naloxone kit	15 (17.6)	18 (18.9)	33 (17.8)
Has been trained to use naloxone	48 (56.5)	46 (48.4)	95* (51.4)
Needs a refresher on how to use a naloxone kit	1 (1.2)	3 (3.2)	5* (2.7)
Wants to be trained on how to use a naloxone kit	4 (4.7)	1 (1.1)	5 (4.2)
Has had to use naloxone	39 (45.9)	37 (38.9)	77* (41.6)
Called an ambulance after using naloxone on someone	22 (25.9)	22 (23.2)	45* (24.3)
Was aware of Good Samaritan Drug Overdose Act (GSDOA)	41 (48.2)	48 (50.5)	89 (48.1)
Given knowledge of the GSDOA, would call 911 if witnessed an overdose	83 (97.6)	86 (90.5)	170* (91.9)

* One two-spirited participant responded 'Yes' to this question.

Figure 7.3 Mode of naloxone delivery among those who have used naloxone by gender.



8. Self-Practiced Harm Reduction

Table 8.1 Harm reduction skills practiced by the respondents or others by gender.

Skills n=185	Women n (%)	Men n (%)
Getting new needles/pipes for others	85 (95.5)	91 (95.8)
Getting new needles/pipes for yourself	88 (98.9)	93 (97.9)
Sharing food with someone that is hungry	80 (89.9)	87 (91.6)
Carrying condoms	63 (71.6)	71 (75.5)
Disposing needles in sharps containers	74 (90.2)	84 (92.3)
Wearing a seatbelt in a vehicle	86 (96.6)	88 (92.6)
Walking someone home at night	78 (87.6)	84 (90.3)
Using the same dealer	70 (78.7)	66 (71.0)
Calling SOS* for somebody	61 (68.5)	65 (68.4)
Trying a small amount before using full amount	64 (72.7)	72 (76.6)
Other	1 (1.4)	2 (2.5)

*Street outreach services

A two-spirited person did complete the question.

Indigenous people using drugs suggested other harm reduction strategies to address the consequences of drug use.

- More support was needed for people doing sex work and more could be done to understand the impact of drugs on pregnancy as well as increase education on the topic.
- Training around substance use including on professionalism for the police and health professionals was needed. This might lead to less judgement towards people using drugs.
- Systemic changes are needed to mimic the decriminalization of drugs in Portugal as is a financial investment from the government to address substance use in Canada.
- Increased harm reduction services on reserves was needed.

DISCUSSION

Immediate Policy and Administrative Implications

- A high percentage (58.4%) of Indigenous people completing WHiSE indicated seeing reflections of Indigenous identity through advertisements.
 - Communication of services and programming will include campaigns and program materials through advertisements.
 - A shift in advertisements for job positions will occur to develop a focused recruitment strategy to better target Indigenous people.
- Development and implementation of an IDU clinic or clinic for people who use substances to be held monthly where:
 - People who use substances may discuss the impact of certain drugs and suppliers of 'bad/contaminated' drugs as well as to provide support to each other to stay safer.
 - New harm reduction strategies will be discussed and the effectiveness or usefulness of existing strategies on the streets will also be discussed.
 - Health service providers managing the clinic will assess and look at the clients' needs without a long wait time.
 - A meal and refreshments will be provided.
- New shifts and locations will be added to the Ellie Van to better reach the population using drugs.
- Make more focused 'asks' and donations for resources such as feminine hygiene products, sunscreen, food, socks, etc.
- Indigenous medicines will be made available for both the outreach services and during office work.

Impact

The findings may inform Elevate NWO's services and programming including those at the Joseph Esquega Health Centre, a partner of Elevate NWO, and other local stakeholders that provide services to Indigenous people who use drugs such as Oahas. We will also prioritize the needs expressed by the study participants to continue an ongoing discourse regarding harm reduction, health access issues and next steps. The short-term, medium-term, and long-term impacts below reflects Elevate NWOs intentions to serve the community of people who use drugs with specific strategies for Indigenous peoples, as it relates to this project and their services.

Short-term

- Provide necessary harm reduction resources, services and relevant training to street affected Indigenous people who use drugs, directly within their community thereby bridging the health access gap existing in Thunder Bay.
 - Education on the decriminalization of drugs within the injection drug use community is needed.

- Education on the Good Samaritan Drug Overdose Act for people using drugs as well as generating communication material that can be shared more broadly reaching law enforcement.
- Hire Indigenous persons to fill the research assistant positions and project manager position for the WHiSE project and provide training where applicable.
- Engage the Indigenous Ambassadors Initiative in the WHiSE survey design process to obtain research experience.
- Generate a final report summarizing findings, recommendations, and lessons learned to be shared with other AIDS Service Organizations (ASOs) seeking to create more culturally-relevant programs designed for Indigenous people who use drugs.

Medium-term

- Inform and develop plans for existing and future harm reduction services and resources to ensure quality, consistency, and effectiveness in these services for Indigenous peoples.
 - Develop strategies to provide outreach services to those using substances given that only 55.7% of WHiSE respondents had used the Ellie Van.
 - More strategies are needed to ensure safer harm reduction practices are maintained because only 53.8% of Ellie Van clients continued to use it in the winter months.
- Hold a community forum, which will include other local organizations, and a webinar to present findings and next steps to implement changes to stakeholder communities.
- A practical guideline to be shared with Elevate staff to inform services and programming within future efforts for a SIS and other harm reduction services.

Long-term

- A research proposal will be developed to support a pilot project to hire a full-time Elder to work part-time in the clinic for people who use substances and dedicate the rest of their time to the clinical team.
- Assist other ASOs and communities in their efforts to develop services and programming that meet the unique and cultural needs of Indigenous populations.
- Inform the requirements for supervised consumption and injection sites.
- Contribute to the growing literature concerning Indigenous needs, and strategies to address their harm reduction needs.
- Commit to the meaningful engagement of community in research by hiring and training Indigenous person.
- Enhance the capacities and knowledge of non-Indigenous research team members on Indigenous harm reduction needs and perspectives.
 - Develop training modules to share guidelines and lessons learned with other community agencies serving Indigenous peoples (e.g. ONWA and PACE). These materials will also be shared at the Opening Doors Conference in 2020.
- Initiate discussions to evaluate the services provided by Elevate NWO and how it can improve its alignment with Oahas and Nishnawbe Aski Nation.
 - Over the course of several years review its program, services and participant demographics to assess the impact on the Indigenous community and if a devolution of services is in the best interest of the community.

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