SAFER WASHROOM EVALUATION

Healthy Sexuality & Harm Reduction, WRHA

February 2019

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CONTENTS

BACKGROUND

The conditions for drug-related harms and benefits are shaped by structural, material, and social aspects of the spaces and places in which drugs are consumed. It is not possible to offer supervised consumption services everywhere, and where supervised consumption services are available, they will not be used by most people who inject drugs. Existing spaces of drug consumption, such as private residences, public washrooms, and other public and private spaces will always be used for drug consumption, and public health should promote conditions that enhance safety in all spaces that may be used for drug consumption.

Public injection has been associated with an array of health and social risks (Ickowicz et al., 2010; Marshall et al., 2010; Parkin, 2013; Parkin and Coomber, 2009; 2010; Small et al., 2007). Privacy and comfort are important features that make spaces safer for drug use (Marshall et al. 2019). Although the use of public washrooms for drug consumption cannot be officially or legally permitted, it cannot be prevented as people have a right to privacy, and people who use drugs need spaces to consume drugs. Using in a public washroom is often safer than using outdoors or in public spaces where lack of sanitation, police presence, and rushed injection can result in harm (Dovey et al. 2001; Parkin 2013). Some needle exchange/distribution programs have taken overdose prevention or early detection measures in their washrooms (Vallejo 2018). Manitoba Health, Seniors and Active Living (n.d) have provided recommendations for overdose prevention and response policies and practices for service organizations.

"Safer washrooms" is a term used to describe public washrooms in which steps have been taken to prevent overdose or other drug-related harms. Unlike interventions that attempt to displace people who use drugs from public washrooms (for instance the installation of

ultra-violet lights which attempt to make intravenous drug use difficult), safer washroom interventions are grounded in harm reduction. Safer washrooms are promoted on the assumption that people *are already* using drugs in public washrooms and enhancing the safety features of these spaces is a responsibility and ethical imperative. They provide a more 'controlled' injecting environment, increasing safety and comfort (Parkin 2013). Drug use is not promoted in these spaces, but rather acknowledged as inevitable.

Safer washrooms attempt to provide the basic needs for safer drug consumption, such as a clean preparation surface, sharps disposal, privacy, adequate lighting, and an emergency call button – without providing a supervising staff person to oversee drug consumption. If an overdose occurs, overdose response measures are enacted, but in a timely manner increasing the likelihood that the overdosing person will be revived.

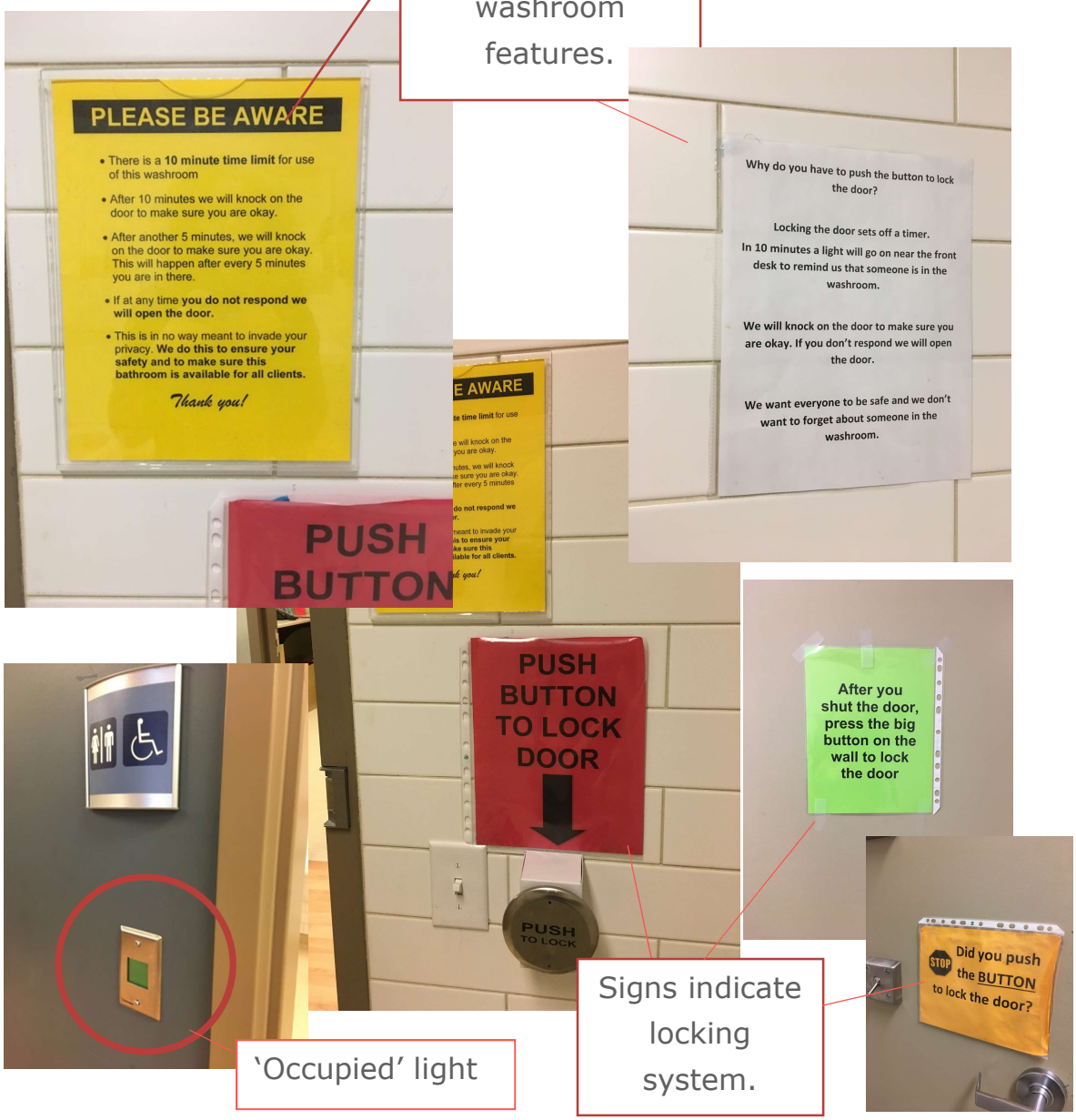
THE SAFER WASHOOM AT HSHR

In 2016 Healthy Sexuality and Harm Reduction, WHRA, retrofitted the large single stall washroom across the harm reduction distribution room, by the reception area, to address potential overdose.

A door lock time that signals a light to go on after 10 minutes remind staff that someone is in the washroom. Staff members are required to check on a person in the washroom at that time make sure the person inside is responsive. The 10 minute mark was decided upon the understanding that would be sufficient time for people to use the washroom, and a short enough time to detect an overdose before it becomes fatal. A master key is accessible to staff in case of emergency.

Service users may enter and use the washroom without asking staff, but if the opportunity arises, staff would inform service users that someone may knock on the door in 10 minutes to make sure they are okay.

There is also a sharps container for the safe disposal of sharps that may be used for drug or prescription medication administration; an emergency call button near the toilet, and a shelf on which to place things.



SAFER WASHROOM EVALUATION

Safer washrooms are difficult to evaluate in terms of their ability to reduce harms, especially in sites where harms are unknown and infrequent. As this space is not sanctioned for drug consumption asking people to talk about their experiences or views complicates the evaluation approach.

This evaluation was designed to capture the experiences and perceptions of service recipients and staff, and data on harm-related events that occurred.

This evaluation is considered a program/intervention evaluation, not research. Thus, research ethics board approval has not been sought. Still ethical considerations processes have been incorporated.

1. **Log of Events**

A log of washroom events for use by HSHR staff was developed. The log was designed to capture events occurring in the washroom require staff intervention (those constituting a need for organizational reporting as well as non-reportable near misses), as well as provide a rough measure of injection drug use within the space by monitoring how often the sharps container is changed. This log was kept with the Outreach Worker position at the front desk at 496 Hargrave Street (appendix A). We assessed data from the log for the period from June to the end of the December 2018.

2. **Consultation of Service Users**

Qualitative interviews were conducted with service users to gain their understanding about safer washrooms, their experiences using the space, and to seek out recommendations to make the space better.

In summer 2018, Outreach Workers promoted the study among harm reduction service users attending the office. Most clients seeking harm reduction supplies interact with staff in the privacy of the supply distribution room. Outreach Workers would then introduce the evaluation during these interactions, seeking participation of those who have used the washroom. This approach required tactful consideration as to avoid actual or perceived coercion, and making inappropriate assumptions of service users' drug use practices while at the same time making participation widely available (see appendix B, invitation script). Many invitees declined participation without explanation – many service users would come in for supplies and leave quickly. Others may have declined interviews due to avoid having to potentially disclose using drugs in the washroom, a practice that is illegal and stigmatized.

The interviews were conducted by the HSHR Program Specialist, who although integral to the program, does not provide direct services to clients. This was believed to offer some assurance to participants that their comments would remain private and not affect a care or service relationship (see appendix C, ethics script, and appendix D, interview guide).

Seven (N=7) clients were recruited for semi-structured confidential interviews. A few others were interested but upon further discussions they had not used the washroom or did not inject drugs. The interviews lasted between 15 and 30 minutes, and detailed notes were taken. Participants were compensated with $20 gift card for a popular store in downtown Winnipeg.

3. Consultation of Organizational Staff

Staff perceptions and experiences on the safer washroom were gathered formally through focused group discussions, and informally around specific events or incidents. Notes were taken. Appendix E includes the question guide of focused discussions. Seven staff members participated in the evaluation.

FINDINGS

ABOUT THE PARTICIPANTS (SERVICE RECIPIENTS)

Three females and four males chose to participate in interviews. Overall, the females were younger (in their 20s and 30s) while the age of the males was spread out (from 20s to 50s). All participants lived in inner-city Winnipeg, with many having often experienced unstable housing arrangements. Still, at the time of the interview most had a place to stay or live and preferred consuming drugs in their private residences. Only one of the participants did not have stable housing and preferred to stay mostly outdoors. Although history of incarceration was not asked, a few made a point of telling this as part of their drug use trajectories. Most were using crystal methamphetamines, but some have used or were also using other substances such as opioids or cocaine.

ACCESS TO HARM REDUCTION SERVICES

All community participants were **frequent users of HSHR harm reduction services**. They have been using these services from one to fifteen years. Some accessed harm reduction supplies from other supply distribution services in the inner-city (many mentioned one or two other specific locations), and the Street Connections van. Access depended on where they lived or found themselves at a given time. All service users indicated being able to obtain the supplies they wanted or needed. However, one participant would "often re-use [their] own needles." This was a matter of convenience, even though they would often "have trouble with [their] veins."

Participants came for needles and other safer injection supplies, and a few also accessed safer crack use kits. Some often would procure

needles for others in their drug use social networks. Those who had witnessed people sharing their used needles made an extra effort to have extra sterile supplies for distribution. One of the evaluation participants described in detail his role as a "doctor" [providing injection assistance] for a network of injection drug users who would regularly congregate in his home.

As part of the overall conversations on drug use and access to supplies, a few participants volunteered information on how they disposed their used supplies. They were concerned about used needles that were "left around." People talked abjectly about drug-related litter. Participants reported to **discarding their needles according to common safer disposal guidelines** (e.g., put them on a puncture proof container for disposal in the garbage). One participant would discard his needles in the drop box nearby his home, and another participant would keep them in a hard case for later disposal in known sharps containers in healthcare facilities, including HSHR's washroom.

Concealing safer drug supplies was important for a participant who was concerned about "walking down the streets, people see my stuff, if in a clear plastic bag. I try to get one like this one," he said showing his black, sturdy and yet well-used bag the Outreach Worker has given him. He felt "embarrassed" every time that someone would see his needles, as "they look at you like you are no good, like anybody else, you are bad. They should mind their own business." **Stigma associated with drug use** shaped the lives of participants, including their experiences accessing harm reduction supplies.

In all, service users found HSHR staff "polite" and the **services acceptable and accessible** (e.g., "in and out"). Some of the participants fondly spoke of specific individuals, public health nurses or Outreach Workers they often received services from.

Although participants knew that nurses were present at HSHR, **nursing-related services** were not explored. On the other hand, the conversation around the sore foot of one of the young women

indicated that in her mind nurses were available for specific services. For instance, this service user had a swollen foot that she attributed to some "bad drugs" she took the night before; however, in her mind this was not something a nurse in the program would be concerned with as she explained in the interview that she did not shoot in her legs and feet. She would only considered accessing nursing services if concerning wounds related to drug-injection.

THE WASHROOM

The Space and its Rules

Drug consumption in public washrooms, including HSHR's, was **a matter of immediacy** for evaluation participants. Finding accessible and acceptable spaces is an ongoing quest for people who consume drugs. Participants indicated a need for private spaces for drug consumption; however, not all public spaces offered the privacy and necessaries desired. In public spaces, **well-kept public washrooms** were most **desirable**. Although, we did not ask participants to disclose if they have consumed drugs in HSHR washroom, many shared that they did.

HSHR washroom was described as a "good" space. It was the preferred public washroom for one of the participants. It was also highly praised by another participant, who despite using mostly at home, felt that this was the "right thing to do." This person also identified the washroom at Nine Circles Community Health Centre to having similar amenities. Two participants reported that they had not used the washroom for consuming drugs.

When asked what participants believed made the washroom a safer space, among the desirable features were that the washroom was **clean**, **well-lit**, and **spacious**. Access to a **sharps container** was also important to them. One of the participants would bring various

needles to dispose in the office. She had repurposed a hard case for glasses to transport used needles for safe disposal.

In most cases, comments about the **safety locking system** had to be prompted. An explanation on how the system worked was offered to generate responses. Although an unusual way to lock a door, participants had never thought about it, and most would think this was a "good thing." None of the participants had found themselves in the situation that someone had to knock at the door or check on them. However, it was not clear if they would have consistently activated the lock.

For most, injection drug use in public spaces is done **quickly to avoid being detected or interrupted**. This also translated to the use of the safer washroom, as one of the participants would put it, they would go "in and out. It's okay. You do it, but, can't relax." Another participant said not to take "more than one or two minutes" to inject. This person would often use the washrooms in bars or coffee shops where he had learned to inject at such speed. The time allotted for the use of the washroom (initial 10 minutes, plus additional limited time) may interrupt the service user's experience, when the "in and out" rule could not be or was not applied. It is also important to distinguish between a rushed and a rapid injecting practice (Parkin 2013). The evaluation participants showed confidence in their injecting practice, suggesting that **they did not feel rushed when using in the washroom**. **However, potential disruption continued to mark this space as public and externally controlled**.

Participants had not used the washrooms of other places where they gather harm reduction supplies. Only the person who did not have stable housing arrangements had more to say about her current options and preferences. This person did not access private residences, and would mostly use public spaces for injecting drugs. Hospital washrooms were a preferred option. Although she was not sure if there were fitted with an emergency call button, these washrooms

were clean, spacious and had sharps containers. In addition, they could **hang out outside, access comfortable sitting, and not be bothered if resting or high**. **Access to other services** such as computers or free Wi-Fi made those locations meaningful.

Another participant commented that people in their circles of drug users would access supplies and use the washroom of neighborhood organization that also distributed harm reduction supplies. He explained that many would use their washroom for drug use, and believed that this was a sanctioned space for drug use ("that place where the (drop)box is, they have a space for injecting too"). Whether this washroom, located in the West End neighbourhood, had all safety features (i.e., emergency call button, a door lock timer, and staff checking on users) was not clear for this participant.

Events or incidents

There were no deaths or incidents where medical intervention was required in the 6-month evaluation period. In the period of the evaluation, there was only one instance in which staff intervened or enacted the procedures put in place to deal with a drug-related incident. In this case the service user pushed the emergency button to alert of a health emergency, but staff did not have to open the door. The client opened the door and left the washroom.

Medical personnel were mobilized. A nurse offered to check on this person. Nursing personnel checked on key physical vital signs, and comforted the client. The client was concerned about the side effect of the drug they had just injected. Having acquired drugs from a new source, this person did not expect nor was familiar with the immediate effects of the drug (this person had consumed a stimulant). Further, during their interaction the client indicated an interest in accessing drug treatment services, and their inability to find a healthcare provider to complete their assessment and referral/clearance forms.

The nurse was able to provide a successful referral to appropriate services.

A second event was registered in the log. In this case, the client was interrupted at the expected 10 minutes, and offered additional 5 minutes. After 3 additional time extensions were given, staff opened the door. The client was responsive, and upon this disruption visibly upset. However, the episode was diffused and the individual left without causing disturbance. A recent needs assessment with people who use drugs revealed that loud knocking or other jarring sounds can be unsafe for people who use drug, by way of startling and potentially causing injection errors (Marshall et al., 2019).

OTHER HARM REDUCTION SERVICES

Supervised Consumption Services

Safer washrooms are a distinct type of spatial intervention, differentiated from supervised consumption services in key ways. While both are grounded in harm reduction, safer washrooms do not provide supervision or require disclosure of drug use. Safer washrooms are operationally low cost and low threshold, and allow privacy for the space user, and early intervention in the case of overdose or other adverse drug or health-related emergency.

Conversely, supervised consumption services [SCS] "provide clean and decriminalized environments in which people can use illegal drugs under the supervision of a health care professional, a trained allied service provider, or a peer (i.e., person who formerly or currently uses illegal drugs), without the risk of arrest for drug possession" (BC Ministry of Health and BC Centre on Substance Use, 2017).

Participants were asked to comment on SCS based on their experiences with safer washrooms or other spaces of drug consumption. One of the participants believed that HSHR's washroom

was already a supervised space; “but the bathroom here is supervised!” Because most did not know what SCS were, a simple definition was offered. With that definition in mind, participants reacted to the idea of SCS in various ways.

Some participants expressed full support for SCS and considered the presence of health care personnel during consumption acceptable, and stated they would use the SCS depending on the location. Another participant who had many years of drug use experience had “seen many changes in the drug scene,” and experienced the death of friends to overdose, was a strong advocate for SCS. He claimed to be actively creating public awareness on the topic. Aware of decriminalization of drug possession in Portugal and diversion programs in New Zealand, he believed that new approaches to harm reduction and drug use were needed in Winnipeg.

Other participants did not value SCS were because they already had access to private spaces where drugs could be consumed, and because SCS would require disclosure of their drug use. Privacy and stigma were key considerations in people’s perceptions of their own safety. Even with the explanation that supervised consumption services could provide protection from drug possession charges on the premises, one of the young women stated that “people would know I have drugs on me. That wouldn’t be good.”

Some participants promoted the idea of SCS for other people, but not for themselves. Particularly, SCS were seen as useful for people who did not have access to private spaces for drug consumption. As indicated by one of the participants: “Only if you do it outside in the cold, if nobody is around and you need someone around. That would be good for them.”

Another participant, who had not heard of SCS before, took some time to fully understand what this would mean in the context of his life. Then, he explained the reasons for not utilizing such space when he said, “I doctor myself and doctor others, I know how to do this, I see

some people who need help, I help out." He described that he would open the private space of his home to a network of trusted people who would consume drugs together, and help each other. Supervised consumption did not resonate with him as he was already providing a safe(r) space for drug use.

Drug Checking

Although the focus of the evaluation was on the safer washroom, we extended the conversation to include another harm reduction service that has become more evident in harm reduction circles in the city: drug checking. A definition of drug checking was offered. Drug checking was defined as a service where individuals can anonymously test samples of their street-drugs to find out the contents, and learn about the potential harms of the contents to inform their actions (Kerr & Tupper, 2017).

Some of the participants showed initial ambivalence about this service. Having to show or bring drugs to be checked was a major deterrent as it would make drug possession and use visible. A few participants were concerned about being "spotted" by others, including the police. One of the young women said that she would have to be reassured that the service was discreet; however, knowing that "your drugs are clean" would be important. She reflected on her previous day's experience with a street drug that was "not very good."

Another participant believed that it would be "helpful to see what it is in your drug." Similar responses were found among other participants. But again, they would use such a service if "nobody knows you come for this."

Two participants indicated that they would not use the services at all. Even when they understood that drugs were often "cut," sometimes in unexpected ways (e.g., "people are mixing meth with cocaine, or "falling sleep on meth"), they had a trusted regular dealer or "trust my source." One participant explained everyday ways of checking the

quality of the drugs. For instance, they would smoke it before and assess by the smell and taste if was suitable for injecting. Conversely, one of them said that the service would be of benefit if "the drug comes off the street" – for those scoring drugs from unknown sources.

STAFF'S PERCEPTIONS AND EXPERIENCES

From our *Log of Events*, from June to December 2018, an estimated average of 75-100 needles a month were discarded in the washroom's sharps container. As service users would also bring in used needles to dispose in the washroom's sharps container, this number is an imperfect proxy measure for drug use in the washroom. Staff indicated that service users have occasionally asked if they could use drugs in the washroom, or assumed that the washroom was a supervised consumption space. These questions or comments would prompt an explanation of HSHR staff on the washroom and its features.

This evaluation did not track the number of the times staff had to knock on the washroom door, Outreach Workers estimated doing so a few times per week. In all cases, people in the washroom were responsive. Staff indicated that sometimes people would be surprised by the knocking, suggesting that clients were not aware of or had forgotten the rules or features of the washroom, regardless of the signage within the washroom.

Staff expressed concern that sometimes service users would not press the button that locks the washroom door. This would result in the green "occupied" light and 10 minute timer light not being activated to alert the staff that someone has been in the washroom for 10 minutes. Staff wished for a more fool-proof or automatic or locking mechanism.

With the safer washroom situated across the hall from the supply distribution room, staff providing harm reduction supplies were more aware of someone being in the washroom, as they could see that the

door was closed. Nurses using other clinical spaces would often inform their clients of the washroom features and locking mechanism.

Some staff felt that they should speak more openly with service users about the washroom features that have been installed to prevent drug-related harms as this may open conversation about overdose risk, take-home naloxone and specific reasons for the important of monitoring spaces for early detection.

On the other hand, some staff believed that these features should be normalized across public washrooms and required no special conversations, as the safety features could address all kinds of health emergencies beyond those related to drug use.

CONCLUSIONS

The Safer Washroom evaluation became an entry point to the understanding of the lives of people who use injection drugs receiving services from HSHR/Street Connections. Participants' assessment of the HSHR safer washroom was informed by personal stories of family disruption, economic hardship, violence – including police violence towards people who use drugs, segregation, precarious housing arrangements, stigma and racism. Private spaces for drug injection helped people to avoid violence – symbolic, sexual and physical.

Although safer washrooms are not advertised as a place where people who use drugs can legally or openly inject; they have become a response to public injecting. Our evaluation tapped into views of people who have injected in public washrooms (including HSHR's one) and a few that had not but could recognize the safety features and characteristics of the space. Although evaluation participants preferred to inject at home or in private residences, the immediate need or opportunity to consume drugs had compelled situations of drug use in public spaces, including public washrooms. Increased access to the experiences of service users who only or mostly inject in public would have strengthened our understanding of the use of public washrooms and of the evaluation of HSHR safer washroom.

Some of the participants believed that the few safer washrooms in the city qualified as "supervised" spaces of drug use. This offered an understanding of what "supervised" spaces people may want or need. Safer washrooms provide clean and private spaces for drug consumption, "de facto consumption sites," as Wallace and colleagues stated (2016). In addition, when safer washrooms are located in harm reduction services, healthcare or other trained personnel is available during drug-related emergencies, strengthening this intervention.

However, the **distinction between participants' notion of "supervised" and what a supervised consumption site is needs to be made** for service users.

Since its inception in 2016, there was only one drug-related event in which staff responded to. This harm-related drug event intervention seems to be **acceptable, easy to manage, and cost-effective**. On a regular basis the staff knocks on the door to see if service users are responsive. Although none of the evaluation participants had anything to say about this practice, there was only one recorded event in which staff had to call security, after a service user was upset for having the door opened and being disrupted. **Guidelines as to what to do when the service user is responsive, but the time has lapsed should be fully communicated to all staff.**

No suggestions about the safety of the washroom were offered by service users. However, one participant suggested that a **shower** be added to the space. Staff confirmed that service users would use the washroom for personal hygiene.

A recent assessment on safer spaces of drug consumption in Winnipeg adds to the list of desirable amenities to make public washrooms safer for those who chose to consume drugs in them. Among participants' suggestions were: **having harm reduction and drug use information available, naloxone, and an intercom system to facilitate the communication between users and staff** (Marshall et al., 2019). Other safer washrooms have added **good vein maintenance posters, hand warmers, and a digital clock** (Vallejo 2018). A needle exchange program in New York added an **electric door strike** to its bathroom. This device allows staff to open the door at the push of a button (Vallejo 2018).

In all, there are minimal recommendations for improving this intervention. These include:

- *Considering the installation of an intercom, and a digital clock inside the washroom*
- *Ensuring to tell participants using the washroom of the door locking and our check in process*
- *Knocking lightly*

Safer washrooms advance the harm reduction philosophy and contribute to the reduction of health and social harms of public injecting. The use of public washrooms for drug consumption is an everyday reality, and washrooms designed for early detection of overdose or other health emergencies are a pragmatic response that resonates with the desires of service users AND service staff.

As per **other harm reduction interventions** that would enhance local services, participants suggested that **supervised consumption services should be made available**. However, some were still concerned for their safety as the presence of illegal drugs becomes visible in supervised consumption sites. Similar reactions were gathered around access to **drug checking services**. The integration of these services where other health, social or recreational spaces are available would make these additional harm reduction interventions more acceptable.

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APPENDICES

Appendix A: Log of Safer Washroom Events

Year_____

	Date (DD/MM)	Note (optional)
Washroom door unlocked and opened by staff		
	Date	Note (optional)
Washroom sharps container changed		
	Date	Note (optional)
Incident or near miss (RL6) related to clients in waiting room or washroom		
Other (anything deemed relevant by staff)		

Appendix B: Information for Staff involved in Recruitment

Safer Washroom Evaluation –

Staff (Outreach & Nursing) doing harm reduction supplies distribution at the front-desk will be instrumental in connecting people to the evaluation.

During your interactions with people coming to our offices you will be able to share the opportunity for participating in the evaluation.

Our criteria for participating are a person who is:

- a **client of Street Connections** (has obtained HR supplies) **AND** has **used the washroom at Street Connections** (496 Hargrave) in the last 3 months
- **over the age of 16**
- **able to provide informed consent** (understands what participation entails and is not intoxicated at the time of interview

You will let them know that our washroom here at Street Connections is designed to be a safer space for our clients, but we haven't had the chance to talk to our clients about it and get their feedback on it. We are looking for **10 to 12 people** to talk to about this, and the **conversation** would be **anonymous**. It will last about **15-20 minutes**. If you are interested Paula will come and talk with you privately. They will be compensated for their time and insights with a **$20 gift card**.

Phone or text Paula at 204-XXX-XXXX. Paula will provide an updated schedule of her availability if things change.

Appendix C: Safer Washroom Evaluation – Verbal consent

People helping out with the project:
Paula Migliardi, Healthy Sexuality & Harm Reduction

What are we doing? We are interested in learning from you and other folks who come through our door what you think of our washroom.

We can't tell people that it's okay to inject drugs in our washroom, but we know that people will anyway, and it's not totally our business what people do in there. At the same time we want people to be safe. For these reasons, we have a door lock that sets off a light after 10 minutes so that we know to knock on the door and make sure a person is okay if a person is still in there. This is mostly to make sure a person hasn't overdosed, and if they have we can respond quickly to revive them. If we knock on the door and someone doesn't respond, we will open the door and check on them. We also have an emergency call bell in there and sharps container so people can safely dispose of needles, and a shelf so people could put their stuff, purse, etc.

Procedure: we are going to have a conversation for about 15 to 20 minutes on your views and experiences with the washroom in the context of our services. I will keep your conversation private and confidential. This is anonymous. With your permission I would like to audio record the conversation, so I don't have to write and talk at the same time. I will delete the recording after I transcribe notes.

Why should I do this? The information you share will help us learn what works well, and what we should change to make our space and services better for you and other people who come here.

Confidentiality: Information gathered in this evaluation may be published or presented in public. But, we will not use your name when we share the information. I am the only person who will see your real name when she changes your name to a code.

Do I have to do this? You are free to answer or decline to answer any questions. There is no right or wrong answer. You can also stop participating at any time with no negative repercussion. You are entitled to our services even if you don't participate in the evaluation.

Is there a "Thank You" if I participate? Yes. To thank you for your time and ideas, you will receive a $20 gift card. You will still get the "thank you" even if you decide to stop participating in the activities part way through.

Questions: You are free to ask any questions that you may have about this project. If you have questions after the interview is finished, you can get in touch with Paula (info at the top of the first page).

Statement of consent:
Do you agree that the process of giving consent has been explained to you?
You understand that your name will not be used in this evaluation?
You understand that notes from the conversation will be taken?
You understand that you can stop participating at any time?
If yes to all, we will proceed with the interview

Appendix D – Consultation of Service Recipients

Eligibility criteria:

- *Person is over the age of 16*
- *Person is able to provide informed consent (understands what participation entails and is not intoxicated at the time of interview*
- *Person is a client of Street Connections (has obtained HR supplies) AND has used the washroom at Street Connections (496 Hargrave) in the last 3 months*

Preamble: Our washroom here at Street Connections is designed to be a safer space for our clients, but we haven't had the chance to talk to our clients about it and get their feedback on it. We are looking for about 10-12 people to talk to about this, and the conversation would be anonymous. The conversation would be audio recorded so we don't have to write and talk at the same time (go to consent form).

We can't tell people that it's okay to inject drugs in our washroom, but we know that people will anyway, and it's not totally our business what people do in there. At the same time we want people to be safe. For these reasons, we have a door lock that sets off a light after 10 minutes so that we know to knock on the door and make sure a person is okay if a person is still in there. This is mostly to make sure a person hasn't overdosed, and if they have we can respond quickly to revive them. If we knock on the door and someone doesn't respond, we will open the door and check on them. We also have an emergency call bell in there and sharps container so people can safely dispose of needles.

Interview guide:

- *What had brought you here today? Do you usually come here to pick up your supplies? Is there anything you would like to share about your experience coming to this office?*

- *What are your thoughts about our efforts to make our washroom safer?*
    - *Prompts: how do you feel about the washroom here, for yourself or others?*

- *Have you had any experiences where the staff have knocked on the door? Tell me about this*

- *Have you had any relevant experiences in this washroom or other public/business washrooms you would like to share?*
- *Do you have any thoughts about this kind of safer washroom space compared to a supervised injection service (i.e., official place where you go to consume your drugs under a watchful eye of staff)? Tell me more.*

- *Do you have any other suggestions for how we can keep our washroom safe for people who use it? Anything else that should be shared with others about safer public washrooms? [this may help us understand if people are using other public washrooms vis-à-vis our space]*

- *When you think of all the things you have come for or received here, is there anything that you would like to see changed? Is there anything you would like to see happening?*

- *Have you heard of "drug checking"? What do you know about it? Would you use something like this [here]?*

- *Is there anything else you'd like to share?*

Appendix E – Consultation with Organizational Staff

Questions that guide the discussion will include:

1. *What are your thoughts on the safety of our washroom used by clients at 496 Hargrave?*
2. *Can you share any experiences you have had navigating safety of clients using the washroom at 496 Hargrave? (Positive experiences? Challenges?)*
3. *Do you have any suggestions regarding the safety of clients who may use the washroom for drug consumption?*
4. *Any other concerns or issues concerning our services/locale?*