Supporting Gay, Bisexual, Trans, Two-Spirit, and Queer (GBT2Q) People who Use Crystal methamphetamine in Metro Vancouver and Surrounding Areas

BRITISH COLUMBIA CENTRE ON SUBSTANCE USE
Networking researchers, educators & care providers

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Executive Summary

About this Report

While sexual health services catering to gay, bisexual, trans, Two-Spirit, and queer (GBT2Q) people are available in Metro Vancouver, mental health and substance use harm reduction services that are tailored to the needs of this group remain limited. Integrated services that acknowledge the interconnected nature of substance use, sexual health and mental health in this population are rarer still. This is problematic given markedly elevated rates of substance use among GBT2Q people and unique patterns of substance use, including the sexualized use of crystal methamphetamine (crystal meth). For example, GBT2Q people are reportedly 10 to 20 times more likely to use crystal methamphetamine compared with the general population (Cheng et, al, 2020; Canadian Drug Summary). Distinct patterns of trauma, motivations for substance use, and other social factors that drive substance use among GBT2Q people highlight the need for targeted services and supports for this population.

This project sought to identify gaps and opportunities in crystal meth harm reduction services and treatment for GBT2Q people in the Fraser Health and Vancouver Coastal Health regions. All project activities were led by a steering committee composed of GBT2Q community members, researchers, and service providers from the Community-Based Research Centre, BC Centre on Substance Use, Health Initiative for Men, and the University of Victoria who met regularly, made project decisions by consensus, and collaborated on this final report. In order to assess ways to improve the accessibility and uptake of crystal meth-related care for GBT2Q people, we analyzed existing data on access to crystal methamphetamine services. These data included qualitative interviews conducted with 77 GBT2Q people in Metro Vancouver since 2016, as well as over 850 survey responses collected from participants in Vancouver Coastal and Fraser Health regions in 2019 and 2020.

To complement these existing data, we conducted 16 new key informant interviews with frontline harm reduction workers and GBT2Q community members with lived experience using crystal meth in Vancouver Coastal Health and Fraser Health Authorities. This new consultation data generated rich, nuanced data on the barriers and facilitators to harm reduction and substance use treatment and care for GBT2Q people who use crystal meth.

All findings were integrated into this summative report bringing together the review of existing crystal meth data with the novel findings from these new consultations. Ultimately, this analysis generated a series of recommendations for new and enhanced programming, improving continuity and competency of care, future research, and drug policy changes to support the health and wellbeing of GBT2Q people who use crystal meth in Metro Vancouver and beyond.

Recommendations

Recommendations for New and Enhanced Programming

1. **Support GBT2Q-specific and GBT2Q-led programming:** More equity-oriented policies and programming to facilitate opportunities for safer substance use among GBT2Q people are critically needed, including access to low-barrier harm reduction services within commonly frequented social spaces (e.g., Pride events, night clubs, bathhouses) and nonjudgmental and GBT2Q-competent substance use-related health services.
2. **Support peer-based programming, interventions, and activities:** Integration of peer knowledge into interventions provides key contextual and subjective knowledge that adds both value and relatability/authenticity for participants. Greater involvement of peers (e.g., as co-facilitators, navigators, and leads), including youth, in future program planning and implementation will improve access, uptake, and quality of substance use care.
3. **Develop and implement crystal meth-specific programs and treatment options**: Crystal meth- and GBT2Q-specific services, including peer support groups, inpatient and outpatient programs, and individualized and group counselling, are needed to address the specific needs and contexts of GBT2Q people who use crystal meth. Importantly, these services must also be financially and otherwise low-barrier.
4. **Develop and implement phased and flexible programming:** Meet each client where they are at based on their readiness to reduce their use or quit completely or neither. Interventions should be tailored toward and responsive to the various trajectories of crystal meth use among GBT2Q people in order to best meet their needs. Harm reduction should be integrated into all aspects of programming and service provision and make space for multiple definitions of success to align with the goals of GBT2Q people.
5. **Remove fixed time durations in substance use programs and services and provide connections to other services:** These should continue as long as participants feel that support is needed. Also ensure a network of care options are available to provide retention and continuation in care, such as intensive multi-week interventions that provide ongoing social and wrap-around supports.
6. **Improve access to harm reduction supplies through GBT2Q organizations**: Funding should be provided to GBT2Q-affirming organizations to distribute these supplies in innovative ways (e.g., through online ordering/access, peer distribution, via community events).

7. **Expand programming outside of urban cores**: Importantly, crystal meth-specific harm reduction services (e.g., supervised inhalation sites) must also be offered outside of the urban cores, especially in rural and remote areas with less service density and availability.
8. **Scale up and evaluate virtual programming:** During the COVID-19 pandemic, in-person services have been tested in virtual formats and proven efficacious. Virtual services may be a crucial way of reaching individuals who live in more rural settings and/or who face other barriers to accessing in-person services.
9. **Implement anti-stigma campaigns and interventions**: Campaigns should focus on redressing the impacts of crystal meth-related and other intersecting stigmas on GBT2Q people who use crystal meth. Targeted anti-stigma efforts are needed both within GBT2Q communities and among healthcare providers.

Recommendatons for Enhancing Care Delivery and Coordination

10. **Map the current intervention landscape and create a directory of services:** Mapping existing services and integrating any new interventions is key for ensuring continuity of care within and across trajectories of use to maximize overlapping benefits of existing services and ensure fewer gaps across trajectories of care. Existing referral services, such as BC211, could serve as a model for this directory, which would need to be updated frequently as the service landscape continues to evolve. This service directory could be used by frontline providers across sectors and organizations to ensure referral to appropriate services.
11. **Promote knowledge and awareness of existing services:** Disseminating information about existing harm reduction services is required to improve uptake. Resources should be invested into promotion via geosocial networking applications and traditional GBT2Q spaces (e.g., bars/clubs, saunas/bathhouses), and by direct service provider outreach. This should include funding GBT2Q-specific outreach position(s) to connect those using crystal meth with harm reduction programs, services and supplies.
12. **Promote knowledge sharing and program referrals across sectors and organizations:** Opportunities must be created to share knowledge and lessons learned across sectors and organizations. Recurring intersectoral meetings with key stakeholders, perhaps through a community of practice model, would help advance knowledge sharing and mobilization.
13. **Develop and implement an acute care strategy for crystal meth-using clients:** This should be specific to discharge planning and referral pathways for GBT2Q people who use crystal meth to ensure linkage to harm reduction and overdose prevention services after accessing acute care (e.g., in hospital emergency rooms and psychiatric stabilization units).

14. **Develop and implement well-constructed guidelines and screening tools for providers related to crystal meth use among GBT2Q people:** These tools could be used by service providers in various health settings (e.g., providing mental and/or sexual health services to GBT2Q people, in emergency rooms) and could be used by frontline service providers to ensure appropriate referrals to relevant harm reduction services.

15. **Provide wrap-around care by integrating harm reduction services with other health services**: There is a need for services that are comprehensive and responsive to GBT2Q people's multiple health priorities, such as overlapping concerns related to substance use, sexual health, and mental health. Harm reduction services must be positioned within this holistic health framework and provided alongside other health services. Additionally, services must be attentive to social determinants of health, such as housing precarity, poverty, and racism.

16. **Develop, implement, and evaluate curricula for service providers about crystal meth use among GBT2Q people:** Care providers must be able to talk about sex, substance use, and GBT2Q people in a manner that is non-stigmatizing, inclusive, and evidence-based. Training curricula on cultural competency for harm reduction workers and on crystal meth and sexualized substance for GBT2Q service providers (e.g., sexual health nurses who conduct PrEP screening) should be developed and evaluated.

17. **Deliver anti-racist and Indigenous cultural safety training for care providers**: In order for the needs of all GBT2Q people to be addressed, mandatory anti-racism and cultural safety training for service providers, as well as corresponding accountability mechanisms, are necessary to promote GBT2Q people's access to and engagement in substance use care.

Recommendations for Policy Change

18. **Support targeted harm reduction research and evaluation efforts**: Additional research and evaluation is needed to assess strategies for improving BC's harm reduction service landscape, and peer- and community-based interventions, particularly as new interventions are piloted and scaled up. Partnering with researchers and co-funding research positions (e.g., Health Systems Impact Fellows) would help advance this work. This should include data collection regarding accessibility and outcomes of harm reduction services/interventions with GBT2Q communities, inclusive of indicators related to overdose interventions and prevention. Future research should centre GBT2Q people who are harder to reach and not accessing existing services.

19. **Support calls to extend provisions for prescribing safer pharmaceutical alternatives to crystal meth indefinitely, while continuing to develop and expand accessible models of safe supply.** There is an urgent and ongoing need for a safe, accessible supply of stimulants and other substances. Health authorities should work alongside grassroots community advocates to support safe supply provisions and implement local access models that work for GBT2Q communities. Additionally, community-based programs and infrastructure must be in place to ensure low-barrier access to this safe supply.
20. **Improve access to safe consumption sites and drug testing services:** These services should be explicitly aimed at GBT2Q people and available in both urban and rural environments.
21. **Support decriminalization of illicit substances**: Safe supply infrastructure should be accompanied with the decriminalization of drug use to further reduce barriers to substance use services. Health authorities should support grassroots advocacy efforts to change drug criminalization legislation and improve access to substance use services.
22. **Increase broad social support and services, including available housing and employment opportunities:** GBT2Q people who use crystal meth report higher instances of housing, food insecurity, and unemployment. Large scale improvement to the availability of affordable housing (e.g., via Housing First approaches), access to food, and access to employment will allow people to focus on meeting their substance use goals.

Section 1:
Summary of Quantitative Research

Overview

The information presented in this section draws from a program of quantitative research (2019-present) led by Dr. Nathan Lachowsky, Associate Professor, School of Public Health and Social Policy, University of Victoria. Data for this section are drawn from two surveys: (1) The 2019 Sex Now Survey (*Sex Now*) and (2) The Crystal Methamphetamine Project (*CMP*). For these analyses, samples in each survey are restricted to survey participants living in Fraser Health and Vancouver Coastal Health Authorities.

Methods

Sex Now 2019 Survey

Sex Now is a national survey of GBT2Q people. Participants were recruited between November 2019 and February 2020 using social media (e.g. Facebook) and popular geosocial networking applications (e.g., Grindr, SCRUFF, Squirt). Sex Now had 1,012 participants across the two health authorities – 699 from Vancouver Coastal Health and 313 From Fraser Health. Of those, 637 answered the survey question about crystal meth use. The majority of participants identified as men 95.3% (n = 607/637), 77.7% (n = 492/633) self-identified as white, 9.8% (n = 62/633) as Asian, 3.3% (n = 21/633) as South Asian, and 4.9% (n = 31/633) as Indigenous. Additionally, 83.8% (n = 534/637) identified as gay, 16.2% (n = 103/637) identified as bisexual, 89% (n = 565/635) lived in a large urban centre, and 83% (n = 527/633) had post-secondary education. The average age of participants was 38 years old.

Crystal Methamphetamine Project

The study included an online survey specifically of GBT2Q people who reported using crystal methamphetamine (crystal meth) in the past six months. Participants were recruited between February and March 2020 predominately via popular geosocial networking applications (e.g., SCRUFF, Squirt). The CMP study had 219 participants across the two health authorities, including 151 from Vancouver Coastal Health and 68 from Fraser Health. The majority 96.3% (n = 211/219) of participants identified as men, 70.8% (n = 155/219) self-identified as white, 8.7% (n = 19/219) as East or Southeast Asian, 3.7% (n = 8/219) as South Asian, 5.9% (n = 13/219) as Indigenous, 72.1% (n = 158/219) identified as gay, 21% (n = 46/219) identified as bisexual, and 69.9% (n = 130/186) had post-secondary education. The average age of participants was 45 years old.

Detailed socio-demographic information and survey results from each study are provided via tables in **Appendix 1**. Below, we narratively describe key take-aways from these studies with respect to crystal meth use and service delivery with GBT2Q people.

Key Findings

Crystal meth use is within a limited, concentrated population of GBT2Q people, and elevated in comparison with the general population. Of 637 *Sex Now* respondents, 8% (n = 51/637) reported using crystal methamphetamine in the past six months. For comparison, the 2015 Canadian Tobacco, Alcohol, and Drugs Survey found that approximately 0.2% of the general population used crystal meth in the past year. While the samples are not directly comparable due to differences in sampling methodology (household survey vs. online survey), time period (2014/15 vs. 2019), and recall periods (1 year vs. 6 months), a much higher proportion of Sex Now participants reported crystal meth use compared with the general population.

Approximately two-thirds of GBT2Q people using crystal meth do so at least weekly. Data from the Crystal Meth Project suggests that among GBT2Q people who used crystal meth, 44.7% (n = 98/219) used daily or almost daily, 20.1% (n = 44/219) used weekly, 12.3% (n = 27/219) used monthly, and 22.8% (n = 50/219) used once or twice in the past six months. **Figure 1** shows the frequency of use among participants, in each health authority.

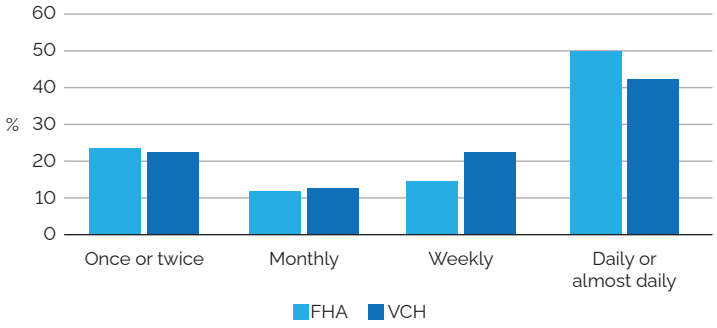

Figure 1. Frequency of crystal meth use among GBT2Q people, by health authority. *(Source: CMP Survey)*

Data from the Crystal Meth Project showed that over the past six months, approximately one-third had used crystal meth by injection (34.0%, n = 48/141) and half (48.9%, n = 69/141) by snorting it. Notably, most GBT2Q people reported not sharing injection related materials with others (72.9%, n = 35), but injection equipment sharing was still common. Injection

drug use was also more frequently reported among those who use crystal meth. Data from Sex Now 2019 showed 31% [n=16/51] of GBT2Q people who use crystal meth had injected any substances in the past six months compared with 0.7% [n = 4/586] of those who do not use crystal meth. Data from the CMP indicated one-third of respondents had used materials previously used by someone else while injecting crystal meth, including water (31.2%; n = 15/48), and syringes (27.1%; n = 13/48).

Nearly half of GBT2Q people who use crystal meth are living with HIV. Data from the CMP showed that 44.2% (n = 80/181) of GBT2Q people who use crystal meth were living with HIV. The Sex Now survey indicates that GBT2Q people who use crystal meth are more likely to be living with HIV (41.2% [n = 21/51] vs. 8.6% [n = 50/583]). Among HIV-negative GBT2Q people who used crystal meth, 46.8% (n = 44/94) were using HIV Pre-Exposure Prophylaxis (PrEP).

Condomless sex is more common among GBT2Q people who use crystal meth. 74% [n = 37/50] of GBT2Q people who use crystal meth reported having anal sex as receptive partner without a condom compared with 57.4% [n=336/585] of those who do not use crystal meth.

Reasons for crystal meth use are diverse among GBT2Q people. Data from the Crystal meth Project showed that most participants reported using crystal meth prior to or during sex at least most of the time (75.0%; n = 105/140). Relatedly, the most common reasons for crystal meth use were to connect with others sexually (48.4%, n = 106/219), to make sex more intense or pleasurable (46.1%, n = 101/219), to "feel good and have a good time" (43.8%, n = 96/219), to make sex last longer (32.9%, n = 72/219), to feel more confident to have sex or try new things (31.1%, n = 54/219), and to connect with others socially (24.7%, n = 54/219).

Most GBT2Q people who use crystal meth do not perceive it as a problem or are not ready to change their use. Data from the CMP showed that 33.1% (n = 50/151) did not think they had a crystal meth use problem and an additional 27.2% (n = 41/151) thought they might have a problem but were not ready to act. Otherwise, 19.9% (n = 30/151) thought they would act in the future, 9.3% thought they'd act soon, and 10.6% (n = 14/151) thought they would act immediately (n = 16/151) to change their crystal meth use. Importantly, 46.9% (n = 68/145) agreed or strongly agreed that they were "addicted to drugs."

Participants reported a wide range of consequences associated with their crystal meth use, including problems with their sex life (46.4%, n = 64/138), social problems with friends and family (37.4%, n = 52/139), health problems (n = 34.5%, n = 48/139), problems at work or with those they work with (31.6%, n = 42/133), and difficulties paying bills (28.3%; n = 39/138). Few participants reported legal problems associated with their crystal meth use over the past six months (4.3%, n = 6/139). In the Sex Now survey, crystal meth use was associated with a higher percentage of respondents reporting poor mental health (13.7% [n = 7/51] vs. 7.4% [n = 43/585]), having depressive symptoms (31.4% [n = 16/51] vs. 20.3% [n = 118/581]), having anxious symptoms (27.5% [n = 14/51] vs. 24.5% [n = 143/583]), and having ever experienced an overdose (14.8% [n = 7/51] vs. 1.0% [n = 6/575]).

GBT2Q people who use crystal meth commonly use other drugs. Data from the CMP showed that 44.0% (n = 73/166) used tobacco daily or almost daily; 43.4% (n = 72/166) binge drank alcohol at least weekly; 31.1% (n = 52/167) used cannabis at least weekly, 27.5% (n = 42/153) used poppers weekly; 19.1% (n = 31/162) used GHB about weekly; and 5.6% had used opioids at least once or twice in the past three months (n = 9/161).

Many GBT2Q people who use crystal meth reported it was not easy to get help for their substance use. Data from the CMP showed that 22.3% (n = 23/103) felt that it was "not at all" easy to get help and 36.9% (n = 38/103) felt that it was only "a little" easy to get help. When asked how confident they felt about being able to get help, only 37.7% (n = 52/138) were "very confident" and 30.4% (n = 40/138) were "somewhat confident." These data suggest that nearly half of GBT2Q people perceived considerable difficulties in accessing help for substance use challenges. Relatedly, in terms of direct use of services, 70.0% (n = 84/120) had not used services providing safer injection materials in the past six months, and less than half had ever received treatment, counseling, or harm reduction services (41.9%; n = 52/124).

On average, FHA participants traveled 14.5 kilometers (SD = 47.1) to access health services and VCH participants traveled 11.7 kilometers (SD = 13.8). In the Sex Now survey, a sizable portion of GBT2Q people lacked confidence about being able to access care, including for counselling (22.4%; n = 11/49), group therapy (33.3%; n = 16/48), harm reduction supplies (34.7%; n = 17/49), and safe consumption sites (46.8%; n = 22/47).

Many GBT2Q people who use crystal meth need broad social supports and services. Data from the CMP showed that 24.9% (n = 47/189) were precariously housed, 32.8% (n = 63/192) faced food insecurity sometimes (23.4%; n = 45/192) or often (9.4% n = 18/192), and 37.3% made less than $30,000 CAD per year (n = 69/185). Furthermore, 81.7% (n = 143/173) indicated that most employers would not hire a qualified individual if they used drugs – suggesting significant perceived barriers to employment and pronounced stigmatization. In the Sex Now Survey, crystal meth use was associated with a higher percentage of respondents indicating that they could not "make ends meet" with their current money situation (21.6% [n = 11/51] vs. 7.6% [n = 44/582]). Relatedly, GBT2Q people who used crystal meth were more likely to be unemployed (14% [n = 7/50] vs. 4.8% [n = 28/583]) compared with those who did not use crystal meth.

CMP participants also faced a wide range of stressful life experiences, including the death of a close friend (62.9%; n = 73/116), the death of an intimate partner (20.7%; n = 25/121), the end of a relationship in the last 12 months (18.3%; n = 22/120), the loss of a job in the past 12 months (19.2%; n = 23/120), and/or incarceration (11.6%; n = 14/121). When asked about social support, 33.8%

(n = 42/124) said that they did not have someone to confide in about their problems at least "some of the time." In the Sex Now survey, participants who used crystal meth were more likely to be single compared with those who did not use crystal meth (62.7% [n = 32/51] vs. 43.0% [n = 252/586]) and were more likely to report often feeling socially isolated (42.0% [n = 21/50] vs. 19.4% [n = 111/572]).

Many GBT2Q people who use crystal meth are not "out" about their sexual identity or their crystal methamphetamine use. GBT2Q people may choose to "come out" or disclose their sexual identity to other people in their lives. Data from the CMP suggests that 49.5% (n = 102/206) were open about their sexual identity to everyone they know, 20.4% (n = 42/206) were open to most people they know, 7.8% (n = 16/206) were open in some contexts (but not others), 12.1% (n = 25/206) were open to only a few people, and 10.2% (n = 21/206) were not "out" at all. Among the 79% (n = 98/124) who reported having a regular healthcare provider, 90.8% (n = 89/98) were out to their provider about their sexual orientation while only 54.1% (n = 53/98) were out to their provider about their crystal methamphetamine use.

When asked how confident they were that they could disclose their crystal meth use to their doctor if they wanted to, only 61.3% (n = 84/137) were "very confident" or "somewhat confident" that they could do so. Yet, in the Sex Now Survey, GBT2Q people who used crystal meth were more likely to go to family physicians for sexual health care compared with GBT2Q people who didn't use crystal meth (42.0% [n = 21/50] vs. 25.3% [n = 140/553]), and GBT2Q people who used crystal meth were more likely to have a regular family doctor or nurse practitioner (80.4% [n = 41/49] vs. 69.7% [n = 394/565]).

Figure 2 shows the people that participants would be comfortable having ask them about their crystal meth use, stratified by health authority.

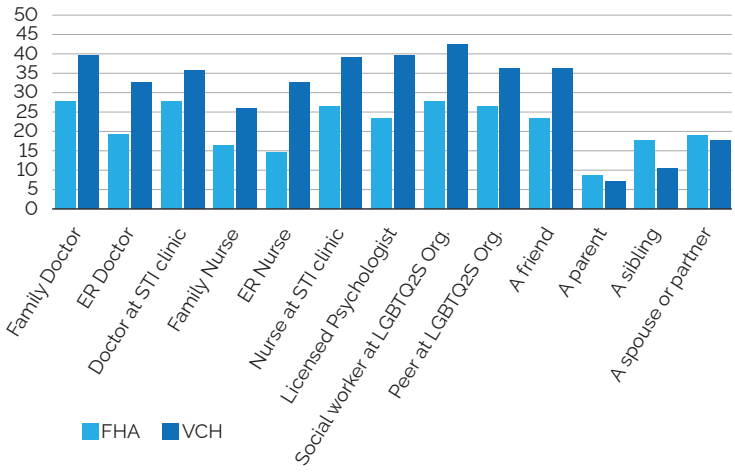

Figure 2. People that GBT2Q people report feeling comfortable talking to about their crystal meth use, stratified by health authority. *(Source: CMP Survey)*

Participants provided a variety of recommendations for the structure and design characteristics of crystal meth interventions. The average desired length of a program was 13.2 weeks (SD = 19.6 Weeks) or 25.7 sessions (SD = 28.8). Overall, GBT2Q people (46.7%, n = 57/122) wanted program sessions to last approximately 60 minutes – with 86.9% endorsing sessions between 30 and 90 minutes. Many participants wanted events to occur "Once every few days" (45.0%, n = 54/120), with an additional 18.3% (n = 22/120) wanting daily sessions, 25.0% (n = 30/120) wanting weekly sessions, and 11.7% (n = 14/120) wanting sessions less frequently than weekly.

Figure 3 shows the most important program characteristics identified by CMP participants.

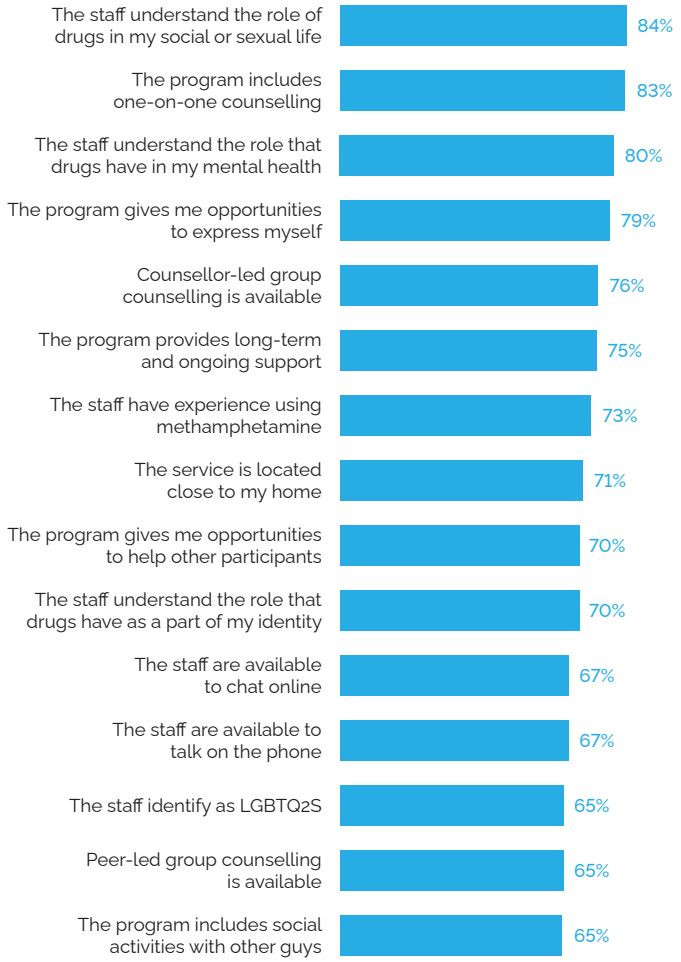

Figure 3. Commonly endorsed program characteristics for GBT2Q people who use crystal meth.

Section 2:
Summary of Qualitative Research

Overview

The information presented in this section draws from a program of qualitative research (2016-present) led by Dr. Rod Knight, Assistant Professor, Dept. Medicine, based at the British Columbia Centre on Substance Use. These findings stem from interview data with a total of n=77 GBT2Q men (ranging in age from 18-57 years) across Greater Vancouver who participated in 4 studies exploring the intersections of substance use, sexual health, and sexual and gender identity (for additional details, see: British Columbia Centre on Substance Use, 2020). We also conducted a series of interviews with n=28 key stakeholders – including clinicians, policy makers, and community-based organization representatives – who provide services or care to GBT2Q men who use substances, including stimulants. Finally, we draw on a community report that emerged from a Participatory Planning Summit co-organized and facilitated by a Youth Advisory Committee with Dr. Knight's team. This Summit brought together 17 youth who had lived experience of using crystal methamphetamine (crystal meth). In the sections below, we summarize each study and provide data-driven recommendations for improving the healthcare landscape for GBT2Q men who use crystal meth.

Methods & Key Findings

Qualitative Study #1. Sociocultural Contexts and Young Men's Sexual Lives

Methods

This study examines the contextual factors influencing young men's decision-making related to substance use and sexual health. During this wave of data collection, we interviewed young (18-30 years of age) GBT2Q men living in the Greater Vancouver area about their experiences of using substances with sex.

For this analysis, we limited the sample (Appendix 2, Table 1) to 18 participants who reported using crystal meth in the 12 months prior to their interviews.

Key Findings

1. **Study participants told us that they initiated and continued to use crystal meth for a variety of reasons, including:**
    - Boredom & seeking euphoric experiences
    - Sexual benefits (Party n' Play; PnP), including to enhance intimacy and pleasure
    - Coping with trauma, grief, and social isolation
    - Managing mental health challenges, including anxiety and depression
    - Improving confidence, self-esteem, and feelings of self-worth
2. **Study participants discussed a variety of harm reduction strategies that they employ to use crystal meth more safely, including:**
    - Attending Naloxone training, and carrying and using Naloxone;
    - Using at-home fentanyl-test strips and local drug-checking services
    - Purchasing substances from trusted dealers and online drug sources (e.g., darknet);
    - Using substances purchased by trustworthy peers and partners;
    - Peer-based risk-mitigation practices, including having one peer take a "test dose" of a substance to ensure it does not cause overdose;
    - Having a designated peer responsible for caring for others when using crystal meth.
    - Accessing supervised consumption sites and needle-distribution programs;
    - Having self-care items readily available, including snacks, water, and other beverages; and
    - Having cannabis (or other drugs with perceived depressive effects) available for use to "come down" after using crystal crystal meth.

Qualitative Study #2. A group-based intervention for GBT2Q men who use crystal meth

Methods

We conducted 11 qualitative, semi-structured interviews with n=8 participants who identified as GBT2Q men and who used or currently use crystal meth with sex. We interviewed participants both during and after two stimulant use-focused healthcare interventions that were run in parallel. One intervention was primarily abstinence-based, whereas the other adopted a harm reduction approach. Participants self-selected into their

preferred intervention stream. Both intervention streams were adapted from existing manuals authored by Vincent Francoeur at ACT in Toronto, Ontario. Participants ranged in age from 25-57 years, with an average age of 41 years. Half of participants were living with HIV and six of the eight participants had university degrees.

Key Findings

1. **Separation of intervention groups based on the goals of participants (e.g., to either abstain from using crystal meth or to reduce harms associated with their use) was appreciated by participants.**
2. **The integration of new interventions into the pre-existing intervention landscape is needed and is both feasible and effective.**
3. **Peer-based knowledge enhances the quality, applicability, and uptake of evidence-based interventions.**

Qualitative Study #3. Interviews with Stakeholders

Methods

We held semi-structured interviews with service providers and key stakeholders working with young GBT2Q men in the fields of substance use, mental health and/or sexual health. A total of 28 participants ranging in age from 22-65 shared their experiences with us. Six participants identified themselves as VCH employees. Other participants included 6 physicians, 6 nurses (including 2 psychiatric nurses, 1 nurse who specialized in substance use, and 1 HIV Outreach nurse). Program managers and decision makers were also included in this set of interviews.

Key Findings

1. **Participants reported difficulty navigating the current intervention landscape;**
2. **Harm reduction was discussed as a foundational approach across fields of care (e.g., substance use, sexual health, mental health) and across the spectrum of prevention, use, treatment, and recovery;**
3. **Services need to be responsive to and tailored for individuals' trajectories and patterns of substance use, in addition to their care preferences and goals. For example, one clinician detailed their person-centered and conversational approach to providing stimulant use care (Figure 1).**

Recommendation	Example
Be direct	"When you use Grindr do you also Party n' Play?"
Remove the stigma	"I know you're using Tina (crystal meth), and a lot of the guys that I see, when they use Tina they often use it while having sex. Is that the case for you also?"
Start with the positives	"I'm just curious about what that experience is like, and what the draw is?"
Get a more complete picture	"You know, so those are the positives. Are there any drawbacks? Have you ever had any bad experiences?"
Room for reflection	"How do you feel about the entire experience?"
Play the tape forward	"What happens the day after, a week after, a month after?
Make room to listen	Open up to hearing about potential alternatives, and ways to connect the individual with specific resources.

Figure 1: An adaptive approach to a 'conversational' screening tool, explained by one service provider

Qualitative Study #4. The Side By Side Summit

Methods

Working together with our Youth Advisory Committee, our team co-hosted a community summit with 17 youth who use crystal meth. This group of youth participants was aged 18-29 (average = 21 years), ethnoculturally diverse, and inclusive of youth representing a range of sexual and gender identities, with the majority of participants identifying as queer, trans, and/or Two-Spirit, and with many participants identifying as men and/or as non-binary persons. Findings from this summit are described in detail in our community report (Lowik, Lister, Aalhus, Stehr, & Knight, 2020). The three guiding questions for this summit were: 1) *What do youth who use crystal meth say is working?* 2) *What do youth who use crystal meth say is not working?* 3) *What do youth who use crystal meth say they need?*

Key Findings

1. **Wrap-around comprehensive care**: Participants described a need for services that are comprehensive and responsive to youth's multiple health priorities, such as overlapping concerns related to substance use, sexual health, and mental health.
2. **Crystal meth-specific programs and treatment options**: Youth participants emphasized a demand for crystal meth-specific services, including peer support groups, inpatient and outpatient programs, and individualized and group counselling. Importantly, crystal meth-specific harm reduction services (e.g., supervised inhalation sites) must also be offered outside of the Downtown East Side core and/or through mobile services.

3. **Substance use-tailored social programs**: Participants expressed a desire for education and employment training opportunities that are specifically tailored toward the needs of youth who use substances. For example, youth indicated a need for services that are strengths-based, inclusive of harm reduction, and directly applicable, such as through promoting financial literacy (e.g., how to apply for government assistance) and facilitating opportunities for peer employment in outreach and harm reduction work.
4. **Anti-racist and Indigenous cultural safety programming for all care providers**: Youth viewed the inclusion of mandatory anti-racism and cultural safety training in health care, as well as corresponding accountability mechanisms, as necessary for promoting their access to and engagement in substance use care.
5. **More peer-based programming**: Youth underscored that peer-based healthcare services, as well as low-barriers recreational events for peers (e.g., movie nights, games, arts), have significant potential for facilitating access to and quality of substance use care.
6. **Targeted research efforts**: Summit participants called for additional research into pharmaceutical treatments for stimulant use disorder, strategies for improving BC's substance use care landscape, and peer- and community-based interventions.
7. **Indefinite extension of safe supply provisions**: Finally, youth participants highlighted the urgent need for a safe, accessible supply of stimulants and other substances. They also called for safer supply infrastructure to be accompanied by the decriminalization of drug use and possession.

Qualitative Study #5. Young GBT2Q Men, Polysubstance Use, And The Overdose Crisis

Methods

This study investigated how young GBT2Q men's patterns and contexts of substance use, including crystal meth use, are unfolding alongside the overdose crisis in Greater Vancouver, BC. Findings from this now-published study (Goodyear, Mniszak, Jenkins, Fast, & Knight, 2020) draw on qualitative interviews with the above-mentioned 18 young GBT2Q men who use crystal meth (Appendix 2, Table 1) and an additional 32 young GBT2Q men who use substances other than crystal meth, such as opioids, cocaine, and cannabis. Together, findings from this study underscore that the overdose crisis and its "knock-on" effects are greatly influencing young GBT2Q men's experiences with polysubstance use (including crystal meth).

Key Findings

1. **Awareness, perceptions, and experiences of the risk in the context of the overdose crisis**: Young GBT2Q participants described being deeply aware of and impacted by the fentanyl-adulterated drug supply. Several participants indicated that they themselves and their peers had experienced an overdose, which, in some cases, had even been fatal. As such, participants tended to describe a sense of apprehension and fear related to using substances (including crystal meth) amid the overdose crisis, which one participant characterized as "It's like you're playing Russian roulette." Of note, even participants who previously did not think of themselves at risk of overdose – for example, those who used stimulants but not opioids, or those who only used drugs recreationally or with sex – felt that they were now in danger of experiencing an overdose.
2. **Strategies to mitigate risk**: Young GBT2Q men in this study used various healthcare-driven and peer-led harm reduction strategies to mitigate risk of drug-related harms, including overdose. For example, several participants indicated that they accessed drug-checking services, frequented supervised consumption sites, used sterile injection supplies and practices, and obtained and used Naloxone kits. In addition, participants indicated that they rarely used substances alone, and that they relied on "trustworthy" drug suppliers including from within their networks (e.g., friends and romantic and/or sexual partners), and from illicit online drug markets, such as the darknet. Many participants also indicated that they had strategically altered their substance use practices in response to the overdose crisis, such as by transitioning from injecting to smoking drugs (i.e., so that they are absorbed less rapidly), and by first taking small "test doses" of their substances to determine whether they are contaminated with fentanyl.
3. **Barriers to safer substance use**: The young GBT2Q men we interviewed also described a variety of barriers to safer substance use, generally, and to mitigating overdose risk, specifically. Many participants felt that existing substance use-related services in Greater Vancouver were not "for them." Here, participants often described being unsure if services would be queer- and trans-friendly, and they also tended to perceive services as geared toward the needs of people who regularly use opioids and/or inject drugs – not their needs, particularly, for folks who only used stimulants, or who only used from time to time and/or with sex. Participants also described how concerns related to stigma and criminalization had deterred them from accessing key harm reduction services, including supervised consumption sites, as they were worried about being targeted by police while doing so. Finally, young GBT2Q men emphasized that, despite all of their harm reduction practices, the risk of overdose remained – and would continue to remain – in the absence of access to a legal and regulated safer drug supply.

Section 3:
Consultations with Key Informants in Fraser Health and Vancouver Coastal Health Authorities

Overview

This section provides results from consultations conducted with peers (i.e., lived experience as GBT2Q people who use/used crystal methamphetamine) and service providers. The purpose of these consultations was to identify gaps and opportunities in crystal meth harm reduction services and treatment for GBT2Q people in the Fraser Health and Vancouver Coastal Health regions. We aimed to conduct consultations with a diverse group of GBT2Q people with different sexual and racial identities and living in both health authorities and in urban and non-urban settings.

Methods

Recruitment was conducted online through social media posts on Instagram and Facebook, including on Health Initiative for Men (HIM) and Community-Based Research Centre's social media channels, and by word of mouth through individual social networks. All potential consultants were asked to complete a brief sociodemographic screener to assess eligibility and allow for the selection of a diverse pool of consultants. From February to May 2021, we conducted 16 in-depth semi-structured consultations (one-on-one interviews), of whom 8 were front-line harm reduction workers and 12 were GBT2Q community members with lived experience using crystal meth (peers); 4 individuals had experiences as both providers and peers. Most participants had experience living in Vancouver Coastal Health Authority, while 5 reported living in Fraser Health Authority. Participants were not explicitly asked about their gender identity, but the consultations were promoted as being for GBT2Q people. Participants identified as gay (n=11), queer (n=5), asexual (n=1), questioning (n=1), heteroflexible (n=1), and straight (n=1). In terms of self-identified race and ethnicity, most participants identified as white (n=14), followed by East Asian (n=2) and Latin American (n=1). Consultation interviews were conducted by a GBT2Q peer researcher, were audio recorded, transcribed verbatim, anonymized, and analyzed into themes.

Key Findings

Below, we describe key recommendations that emerged from participants' experiences and insights, many of which speak to perceived needs, gaps and missed opportunities in relation to existing services for GBT2Q people who use crystal meth. This includes recommendations about how barriers related to service access and service provision generally, and due to COVID-19 and geographic distribution of services specifically, can be addressed. Quotes from peers and providers are included in italics to illustrate each of these recommendations.

Peers and providers described particular facets of ideal crystal meth related services, many of which were unavailable (or inconsistently available). Participants perceived that the addition or consistent provision of these elements would substantially improve the care of GBT2Q people who use crystal meth. Below, we describe recommendations grouped into four sub-sections: service development, service awareness and access, services addressing other aspects of health, and social and policy-level considerations for service provision.

1. GBT2Q-sensitive and specific programs are needed

While peers had to use services that were not GBT2Q-specific, they consistently emphasized the necessity of GBT2Q-sensitive general services and GBT2Q-specific services.

GBT2Q-Specific Programs: Peers and providers highlighted the importance and demand for GBT2Q-specific harm reduction/intervention services. Most of existing services were perceived to be provided through Three Bridges, HIM (Health Initiative for Men), and AIDS Vancouver. Specific programs included Vancouver Addictions Matrix Program (VAMP) (i.e., a 16-week abstinence-based outpatient treatment program including individual and group counselling), SPUNK (an 8-week harm reduction outpatient program based on peer support, cognitive-behavioral therapy and motivational interviewing), The Corner (a drop-in space for men and gender-diverse sex workers), additional drop-in groups, and stand-alone queer-affirming counselling services for GBT2Q people (e.g., at HIM). According to participants, the value of GBT2Q-tailored programming was centered in addressing the sexualized context of crystal meth use. Further, it provided a safer space for GBT2Q people to engage in open conversations regarding the connections between crystal meth use, queer identities and life, GBT2Q community venues (e.g., bathhouses), and psychological problems (e.g., poor body image, internalized homonegativity). Further, some peers emphasized the value of tailored programming in creating a sense of belonging that prevented social alienation and relapse. At the provider-level, notable strategies to tailor services to GBT2Q people included GBT2Q-specific program adaptations (i.e., VAMP's Getting Off manual) and the implementation of filterable service databases

with criteria related to sexual/gender identity and substance use. Lastly, a few participants highlighted gaps in GBT2Q-specific services including trans/queer competency, treatment of pertinent "process addictions" (e.g., sex, gambling) and tailored services for sex workers. Participants' experiences suggest that GBT2Q-tailored programming is essential for ensuring users' safety and program relevance.

> *"When we got back to our own group on the Friday, people would say, I have this that I wanted to say but I didn't feel comfortable saying that in front of the group. So it was important, I think, to have a group where we could actually talk about our experience in the total way that we experienced it. I mean it's my feeling, even from like SMART groups that I attend, that perhaps straight people experience some of the drugs differently than gay men do, or possibly even lesbians…" (peer, urban core)*

> *"Depending on the treatment centre, or space that they're accessing, they're not always allowed to talk in great detail about their experience because it often has to do with a lot of sex and so they might be in a hetero, strict hetero – yeah, just hetero environment and it might not be in a place that's very welcoming for them to be sharing their experiences. So that's why I think the tailored, specifically tailored programming for 2SLGBTQ people is very important, cause it's hard for them to open up and feel safe sharing in a space that's hetero- or cis-centric" (provider, urban area)*

Inclusive Standard Programming: Peers and providers also reported utilizing services that were not GBT2Q-specific. While these services lack GBT2Q-specific programming, some affiliated providers emphasized their commitment to inclusivity for people of all genders and sexualities, and some peers had positive experiences with these services. These services were provided through the Rapid Addiction Access Clinic (RAAC), Together We Can, PHS Community Services Society (PHS) and the Shambhala Centre. Programs included contingency management (e.g., SMART goals), supervised consumption sites (i.e., Insite), Buddhist recovery groups (e.g., Recovery Dharma), and abstinence-based groups (i.e., 12 Steps). Several peers expressed satisfaction with the harm reduction focus of SMART goals programming.

> *"SMART recovery is an incredible program, especially for those who struggle with the 12 Step program which is a really cut and dry kind of program – either people get it, or they don't get it, they keep coming back for years and years and years and they still might get it, or they don't get it. And so it's tough because it's so black and white in the 12 Step programs as opposed to a SMART recovery program which is more cognitive behavioural therapy, forming strategies, understanding, getting awareness around the addiction, so it's more of a harm reduction and a CBT approach" (peer, urban core)*

> *Vancouver Coastal Health has officially stated that we support these populations [GBT2Q communities] as well as all of our diverse populations, you know and as we drill down – I can only really speak to public health [in rural region] because that's what I've got my head buried in right now but definitely at the [area] Public Health Unit and [area] Public Health Unit, we run youth clinics that are very friendly – and open to all youth, period, just all youth" (provider, rural area)*

2. Peers must be centred in service development and provision

Most peers and service providers commented on the need and benefits of peer involvement in harm reduction/treatment services. In some instances, peers reported that such involvement facilitated honest and non-judgemental conversations about crystal meth use, fostered meaningful mentoring relationships in a service-context and deepened their understanding of how others have advanced along their recovery process. In other instances, providers expressed how peers' lived experiences served as bridges between users and healthcare providers, provided users with empathetic reassurance about substance-related challenges, and informed feedback-loops regarding the quality of existing services and motivations for crystal meth use. This underscores that peer involvement is a critical component of crystal meth support services, with the potential to greatly improve the quality and range of care.

> *"But I still feel like there isn't much out there, just in general, even just a lack of people who have been through it maybe? I think they need more peers kind of helping inform some of these decisions or working with them or something because there's a lot of people that want to do the right thing I feel like I'm just not sure… sometimes some of the things still seem a little, not tone deaf but … Sometimes I just feel like some of the things you do see you can tell … they're only seeing it from their perspective" (peer/service provider, urban core)*

> *"I think for a lot of my clients, when they're kind of really stuck in their active using there isn't a lot of hope and so having peer navigators or peer facilitators really just brings them that hope and understanding, just like deep, authentic understanding and complete zero judgement has been really amazing" (peer/provider, urban core)*

> *"I personally think I would be at a disadvantage if I didn't have my own experiences along with the same topics. I wouldn't know …I wouldn't be able to be empathetic, I wouldn't be able to really kind of begin to grasp –I wouldn't say that I wouldn't be able to understand" (peer/provider, urban core)*

Lack of Representation: Several peers and service providers commented on the importance of GBT2Q representation among target program users and staff. Specifically, they believed that GBT2Q representation in service settings promoted safety, solidarity and greater understanding between providers and users. Importantly, they also pointed out how

existing services left out certain subgroups of GBT2Q people, including those who are: trans, older, disabled, and Indigenous, Black, and People of Colour.

> *"it's inarguable that People of Colour, that Indigenous people, that people with different accessibility issues are people who are also further greatly impacted, and also overrepresented in kind of substance use systems, and yet there is very little specificity when it comes to cultural competency and working with these kinds of groups within these communities, and I think that's something that's a really big problem, for sure" (peer/provider, urban core)*

> *"it can be kind of a hostile place at times, so I think to have such queer solidarity is good and beneficial for me, but especially for the queer residents and clientele that we serve because I know that they thrive off it. I would imagine that it's very affirming for them and I have built a lot of good relations because of that" (provider, urban area)*

Consultation with GBT2Q: Many peers and providers expressed that listening to the needs, interests, and values of GBT2Q people who use crystal meth is essential for fostering effective policy, program, and research development.

> *"The thing that they can do is they can engage people with lived experience in any policies that they make. I'll say that, because I think that is the answer, instead of prescribing things for people let's ask them what they need and then let's try to find a way to give it to them, and that's, I think, with all substance use services" (provider, urban area)*

> *"I feel like just listen more to the people who are … that the services are for. I feel like when you get these policies that don't do that, everyone just kind of goes through the motions of what they're doing sort of, you're doing these things, but sometimes even the participants themselves, but I don't feel like it's actually accomplishing what it's supposed to" (peer/provider, urban core)*

3. Phased and flexible approaches are needed to allow for multiple definitions of success

The vast majority of peers and providers expressed the need for a "phased" or "graded" approach to service provision. That is, a variety of services are needed to meet unique individual needs based on the frequency of crystal meth use (e.g., few times a year versus every day) and goals related to substance use (e.g., harm reduction versus abstinence versus both). Both peers and providers reported two main benefits associated with this graded approach. First, it would facilitate access to preferred service modalities based on individuals' needs, goals and state of readiness for engagement in treatment or other supports. Second, it would foster individual autonomy in service uptake in instances where providers may coerce them to access limited service options, a situation reported by some participants. Hence, offering a wide range of services responsive to different levels of crystal meth use may promote service engagement and satisfaction among GBT2Q people.

> *"Yeah, the one program being much – having a much lower barrier, in order to access, gave me experience in what a group session would be like, so it also prepared me for what came later. It's almost like taking an introductory course to something and then of course you take the more advanced courses later, but I mean there's no requirement basically to get into the intro course, other than to show up. So in that sense, to me the first program, the one at HIM, really got me started. It did transform me from having a mindset of harm reduction or moderation towards actually getting some place where I thought, oh, I actually am able to abstain" (peer, urban core)*

> *"People are at different levels and different places with their use, so that is a really important factor I think in treating somebody, how people use – like where they're at with their use, I think. That has been a problem for me, maybe it's just me but I feel like empathizing with people who are similar to the way I use is really important because we don't all use and relate the same way. Some people are daily users, some people use every day and are [sex workers], some people don't do that at all, some people use once a month and then go to their professional career, so their experiences are very, very different" (peer, urban core)*

Time and Duration Flexibility: A few peers and service providers reported that strict and/or limited program schedules prevented users from accessing services. Thus, flexible programs or alternative delivery of program resources may improve service uptake among certain GBT2Q people.

> *"I had actually requested possibly joining the HIM service of the group sessions of people who have been using crystal meth, but I think either it was right around then the space had to close because of the COVID changes, or the scheduling didn't work because it was a very specific time only once a week, and you couldn't just join in between. It had to be like you start on this day, you end on this day, and it just didn't … there wasn't enough flexibility in that for me so it didn't work out" (peer, urban area)*

Client-Centred Definitions of Success: Service providers and peers described differing ways of assessing the success of various harm reduction programs. Providers reported various indicators used to evaluate the impact of harm reduction services. Some providers reported assessing the extent to which individuals were meeting their personal/individual substance management goals as a key indicator of program impact. Additional indicators included users' behavior and presentation, harm reduction supply use, and global assessment of functioning.

> *"it's really just what the person is defining as progress for themselves. Yeah, like I mean if their goal is to just cut down, or you know, be in different spaces when they use, or whatever their goals are around that, then that's a win" (provider, urban area)*

Rather than relying solely on individual-level indicators, several providers mentioned the importance of assessing the impact of services by using program-level metrics such as number of overdose deaths, STI diagnoses, attendance/attrition rates, substance use disorder diagnostic and acuity scales, and various indicators to capture changes in access to social determinants of good health (e.g., income, housing stability, employment).

> *"I think attendance is a very basic outcome. So, we do look at like attrition rates for groups, or counselling, and how people are showing up. There's also acuity scales that we can use to measure so that's kind of like, how complex people are presenting with substance use, mental health, housing, finances, all those things, and then you can kind of measure them every few weeks and then that kind of gives you an indication of how someone's doing" (provider, urban area)*

4. Services must be non-stigmatizing and affirming

The stigma associated with general and sexualized crystal meth use was commonly reported as a barrier to service access among peers and providers, especially when this intersected with stigma related to HIV and GBT2Q identities. Participants expressed that internal feelings of shame and fear of judgment prevented users from openly discussing their sexual preferences and crystal meth use with healthcare providers and other service users. Importantly, most participants felt that stigma was connected to users' hesitation to seek support and underestimation of risk in using crystal meth.

> *"I think stigma is definitely something that weighs in heavily and I think a lot more people would get help, or seek help, or some kind of assistance if the stigma around crystal meth wasn't so large. But in order for the stigma to go away we have to be a little more accepting of it and I don't know how ready queer men are to accept that this is a part of some people's sex life, or part of their culture in general" (peer/provider, urban core)*

Participants specifically argued that harm reduction services must also be attentive to experiences of HIV stigma and criminalization among GBT2Q people living with HIV, as this may serve as an additional barrier to service access.

> *"I'm also HIV positive, so there's still some stigma around that… That was definitely a hurdle in terms of having those parties, or having people over, associating with other people who use drugs, to have stigmatization, or have judgment around people who are positive, definitely was an impact… and also criminalizing HIV just increases stigmatization, you know?" (peer, urban core)*

Anonymous Services: One peer explicitly commented on the need for anonymous services where sensitive information is not linked to users' identity in order to reduce the impacts of stigma on service access. In turn, this would prevent users' discomfort and hesitation while accessing services due to concerns around disclosure of personal information.

> *"I guess when it did start feeling uncomfortable was when they had to do a screening phone call and you had to like, I guess, admit to these practices and stuff, or that you had a problem, so for me that was really difficult because I didn't have a private space accessible when they first called me to screen for getting counselling services. So I think in general just having more anonymous spaces, whether it's in person, you make an appointment and then you can talk to someone that can point you in the right direction and give you support, or having more online services that you're not even associated with an email necessarily, and then by the time you have all your questions answered and stuff, you can chose to be contacted somewhere" (peer, urban area)*

5. Training for service providers on sexualized substance use is needed

Several peers and service providers commented on the lack of knowledge among service providers about the ways in which GBT2Q people often use crystal meth. According to participants, such minimal understanding of crystal meth use manifested as bias/prejudice among some professionals, which undermined timely investments in evidence-based substance use support services. This demonstrates the need to strengthen GBT2Q-specific cultural safety and responsiveness in the context of substance use care.

> *"Even within our contingency management group, it took 6 months of a working group which included 10 different people, psychiatrists, and doctors, and we had to find all this research, all to just say, that we know that this works. And yeah, we really just need to create more opportunities in which we really can understand, and see, and showcase the value of substance use [programs] because it really doesn't feel like that exists" (peer/provider, urban core)*

> *"When it comes to alcohol and meth, there's really not a lot of willingness to kind of interact with people who are under the influence from those things, probably just because of some of the belligerence, and the chaos that can sometimes come along when people are presenting to the ER [emergency room]" (provider, urban area)*

Opportunities for Additional Training: Service providers expressed receiving inadequate or insufficient training regarding sexualized crystal meth use among GBT2Q people. Importantly, they reported how training deficits negatively affected service provision among staff and undermined the safety of GBT2Q people in service contexts. Providers indicated that they would benefit from training in various formats (e.g., workshops, seminars, and email updates). Participants'

experiences signal that comprehensive training opportunities have the potential to both boost providers' capacity and users' comfort in service delivery.

> *"I think some of the staff should be more properly trained, at least for [Housing Society], at least when I work night shifts, I hear staff making inappropriate comments or ignoring people talking, I guess maybe because the position was different than the social worker ones. I think other organizations… I don't think they were aware that crystal meth was very common among queer people also. I feel like more social workers should be trained, have informative courses or training in that" (peer/ service provider)*

> *"We're doing the overdose training, and that's a huge part of all of this, of course, but like outside of the overdose response there's hella trauma and hella abuse, and like all different kinds of people, and mental illness, and intense drug use, and the intersection of all of these things at the same time, so it's like, there should be more facilitated programing, I think, before starting work" (provider, urban area)*

6. Active promotion of existing services is needed to increase uptake

Various peers reported that a lack of awareness of available services was a barrier to accessing harm reduction services. This demonstrates that service promotion is essential to ensure GBT2Q people who use crystal meth are able to access the support they need.

> *"Well, one, it's not advertised enough, two, it's not personalized enough, and three, it's not encouraged, I guess you could say, just because of the lack of advertising or lack of awareness around those resources. There's an abundance of resources for people with mental health and addictions in Vancouver, it's just a lot of people don't even know about them" (peer, urban core)*

> *"I feel like downtown Vancouver doesn't really advertise much of health support services" (peer/service provider, urban area)*

Service Promotion: Most peers and service providers commented on the need to actively promote existing services in inviting and non-stigmatizing ways to reach the full spectrum of GBT2Q crystal meth users. Online advertisements (e.g., dating apps, social media) were identified as appropriate and useful channels for service promotion.

> *"So maybe some more, or a wider range of marketing campaigns, or creative ways to market things might be helpful, or just kind of having safe spaces for people available to be there for people who are even just curious to talk about this topic… Personally I've seen lots of posters on clinic walls and stuff but it's still very intimidating to follow-up on any of that" (peer, urban area)*

> *"I feel like also some kind of advertisement on gay dating apps might work. I don't know how that be possible, or how much money that would cost but I feel like having specific ads for public health might kind of help different people" (peer/ provider, urban area)*

7. More service provider outreach is necessary

Peers and service providers described a lack of public and intentional outreach about the existing services available for GBT2Q people who use crystal meth, particularly services specializing in sexualized substance use. Several peers reported that they often heard about services through their social networks, independent internet searches, or via previous contact with organizations (e.g., STI testing at Three Bridges, volunteering at HIM). Nearly all the peers indicated that more outreach by service providers about the existing services available to reduce harms for those who use crystal meth with sex is needed. A few peers reported that new outreach interventions would help them identify personal substance-related problems and make services more approachable. For example, a list of these resources could be provided to relevant service providers on a small card and given to clients who are interested in accessing harm reduction services. Hence, expanding active and intentional outreach initiatives may increase service uptake among GBT2Q people seeking support.

> *"In terms of accessing services, to be honest, I didn't really know what services were available, I didn't really know anything about like what was possible, I would say I'm not particularly tuned in to the gay men's support services in Vancouver" (peer, urban area)*

> *"In the context of the pandemic right now, focussing more advertising material on all the apps that LGBT people use. Or having dedicated professionals who can offer support without much judgement, available, kind of like a chat or something – like you can reach out anonymously and chat to a professional during these hours and either we can offer you some support on the spot, or just kind of meet you where you're at and then direct you to a service that might be helpful" (peer, urban area)*

Recent Immigrants and Newcomers: A few peers noted that there may be missed opportunities for connecting GBT2Q people who use crystal meth and who had recently immigrated to Canada with services, due to potential isolation, lack of familiarity with existing supports, language barriers, and lack of culturally appropriate care. To a lesser extent, this was also the case for GBT2Q people who had recently moved to the Vancouver Coastal and Fraser Health regions from other parts of the country. Participants' experiences suggest that establishing trust between newcomers and service providers is key to reduce service barriers and ensure linkage to care. GBT2Q-specific newcomer and refugee organizations, like Rainbow Refugee, have an important role to play in linking these communities to care.

> *"I think he comes from a country that like the government couldn't be trusted and you know he came here as a refugee as a result of political persecution so like I really think that he didn't feel at all like government or government services could be something that helped" (peer, urban area)*

> *"I also want to – sometimes I feel alone and I just want to find somebody to talk to and I don't want to hid[e] my drug using problem because I want to change it. So I talked [about] this problem very seriously with a volunteer in Rainbow Refugee, so he referenced [sic] me to the Burnaby Mental Health, so I trusted Rainbow Refugee" (peer, urban area)*

8. Gaps in care continuums and referral pathways need to be addressed

Peers and service providers commented on the need for better continuity of care between different service providers to meet users' crystal meth related needs. Several providers acknowledged that many individuals referred to alternative services likely do not reach them. For example, financial constraints in accessing treatment, mismatches between clients' degree of treatment readiness and program referrals, and lack of case management or tracking procedures to ensure individuals' linkage to care were reported. Referral processes between public and private institutions (i.e., non-profit/community organizations) and staff shortages were also identified as barriers to appropriate follow-up. Thus, expanding service infrastructure to optimize care continuity for GBT2Q people who use crystal meth remains a priority.

> *"When I was first diagnosed [with HIV], they alerted the people they alert and stuff and someone did call me the next morning, which was amazing, but at first I left there and it was Friday night and I found out I was [HIV] positive, and I had nowhere to go, and I had no money, and I was sitting there … I'm like, I have no money, I have no food, I'm HIV positive… that was such a weak point, or low point. It was really sad. And so I begged the guy at the bathhouse to let me have a room or something and they were nice enough to give me a room. If that hadn't happened I don't even know if I'd still be alive today because … the next morning though someone did get a hold of me, it was a Saturday, they came obviously on their day off or something and met me at like 7 in the morning which was amazing, that saved my life. But still, I feel like that kind of showed how there was some like gaps sort of…" (peer/service provider)*

> *"The groups that things like HIM run are so awesome, and so amazing, and really create support, but they're also, and this isn't necessarily a fault, those are opportunities for people to completely fall through the cracks, because it's like, you're having this group, you're doing this thing, but what if this person doesn't show up, or what's the plan for afterwards? And they aren't necessarily connected to the health authority and so I think on both ends if these kind of formal interventions and places like HIM had that kind of role within their organization it would do so much good, just to make sure the continuum of care continues after any kind of given intervention" (service provider, urban core)*

Acute Care and Emergency Services: Peers and service providers reported that GBT2Q people who use crystal meth sometimes access an Emergency Department due to health concerns and side effects related to crystal meth use (e.g., overdose, anxiety, panic attacks, psychosis). Despite this being a potentially important point of contact between the individual and the health care system, GBT2Q men reported seldom being provided with care that adequately responded to their crystal meth use-related needs. Rather, they were typically monitored and discharged as soon as symptoms abated, at times without appropriate follow-up plans in place. There is a need for improved communication and referral systems and policies between acute care units and specialized crystal meth related services.

> *"I had two occasions where I overdosed and ended up at hospital, and one time they had a conversation with me, but the second time which was more serious, I had OD'ed [overdosed] at a bathhouse and was taken by ambulance – in my head it's more serious. I OD'ed at a bathhouse, I was taken by ambulance to [name of inner-city hospital], I had no clothes, and basically they just sobered me up and then got me clothes, and sent me home, which happened to be two blocks away. Nobody came to have a conversation with me about how I was feeling about what had happened, would I be seeking assistance with my substance use" (peer, urban core)*

> *"I think forming better relationships between acute care and community care is always a struggle but is definitely needed so that if a hospital is seeing somebody present [for care] over, and over, and over again they're not constantly being turned away, they're being directed towards helpful services" (provider, urban area)*

In-Patient Services: Several peers and service providers reported a lack of in-patient treatment services available that could meet the unique needs of GBT2Q people who use crystal meth. For example, they identified a limited availability of services that are queer/trans friendly and that can address crystal meth use occurring within sexualized contexts. They also mentioned the limited availability of publicly-funded in-patient services and noted that opioid users were typically prioritized in these settings. Moreover, private in-patient treatment services were reportedly inaccessible to GBT2Q people who did not have access to money or private health insurance.

> *What's not worked well, I think in my experience is more the systems thing, like within Vancouver Coastal Health, how it works is like one of the first places of contact are community healthcare centres, which is where I work, and we can offer out treatment things there, but for people who identify that they need more support that goes beyond outpatient, they need inpatient, that's where things get really fucking challenging" (peer/provider, urban core)*

9. A centralized referral service directory/database is needed

Peers and service providers acknowledged that information about the existence of services specific to crystal meth use by GBT2Q people was not built into centralized information systems (i.e., repository/directory of services). Participants reported that information about the types of available services often came from peer navigators or staff members. Given that the level of knowledge about these services varied between providers, an individual may or may not receive the information they need to access appropriate harm reduction services.

Intra- and Inter-organizational Sharing/Communication: Service providers reported the lack of a centralized referral service database. Further, they expressed a need for knowledge sharing across organizations (particularly from organizations that provide specialized sexualized crystal meth services to organizations that provide more general substance use services). One provider reported greater interorganizational resource-sharing in rural communities where resources were more limited. This suggests that creating and implementing standardized service information systems would help promote the reach of crystal meth related services. Similar databases, like BC211, already exist for many health and social services.

> *"Like when you were asking, oh, is there a resource guide you could just go to? No, it would kind of be up to each individual staff to take it upon themselves to learn how to navigate whatever the process that needs to be done is, and so what that means is that some people take the initiative, and a lot of people don't" (provider, urban area)*

> *"So, in a lot of ways we're lucky in small communities because we can get outside our silos and work with other agencies to better support our clients, but we're also limited on resources here, so we really have no choice but to share resources with each other and try to support this work over all of our agencies" (provider, rural area)*

10. Financial barriers to service access must be addressed

Finances: Several peers and one provider reported financial barriers when accessing services. Peers expressed lacking sufficient financial resources to access paid services (i.e., mental health counselling, residential rehabilitation programs). One provider explained how stringent income-related requirements to access free or subsidized services resulted in middle-class GBT2Q people's inability to access them. Hence, setting services' income-related requirements on a spectrum of financial ability may provide service options to a wider range of GBT2Q people.

> *"I was mainly looking for counselling, but like I couldn't pay like $140 an hour for a professional, so whatever was accessible within those lines, basically. And personally I guess if I couldn't have found any services that way, then I would have just kind of tried to deal with it on my own" (peer, urban area)*

> *"When it comes to treatment, it is extremely inaccessible for people who would be probably considered middle class, or lower to middle class, and I find that just kind of … and I'm sure you could probably speak to this more, but the majority of queer, gay, trans, Two-Spirit men who come through my doors, really fit that model of like, they're not really on social assistance, they've been able to kind of hold down jobs here and there, they have their own apartment, and yet to be able to be qualified to go to treatment and not pay anything you have to make under $1600 a month" (peer/provider, urban core)*

Program Resources: Some peers and service providers commented on the need for greater funding and improved resource allocation to enhance services for GBT2Q people who use crystal meth. Limited funding often meant that organizations were unable to hire needed staff or expand/develop programs. These funding constraints were further exacerbated by the overdose crisis, as resources are being allocated toward other substance use services deemed more pressing, including (in particular) overdose prevention and response efforts.

> *"There's a lot less funding in the province towards substance use services. Pretty much all the money goes towards overdose prevention, which you know is not – overdose prevention is very important but there's many types of overdose, and drug toxicities not just to opiates, but it's very specifically used in a certain way so we haven't seen much of our funding increase or more services be added" (provider, urban area)*

> *"Pay the psychotherapists. Get funding for psychotherapists so they can run different groups and advertise them. And, because I haven't connected to this… my circle as I said is very small, but there are no psychotherapy groups for gay men, or queers, to come together and to process together" (peer, urban core)*

11. Infrastructural and bureaucratic barriers to service provision must be addressed

A number of service providers reported that organizations lack the internal structures or procedures needed to provide better care (e.g., lack of case management team, standardized note-taking systems), due in part to funding constraints.

> *"Some doctors, and social work, and nurses and stuff, they don't want to be in like a care setting, like a case management care setting, they like the triage aspect of things, right, that it's always something different every day but no long-term follow-up. So, I think it's just sort of competing with those kind of realities as well" (provider, urban area)*

> *"I don't see a queer initiative popping up at the Beacon Hotel where there's a handful of queer folk, but collectively with all the other buildings, there would be like an auditorium of queer people. So yeah, I think it's just like informing staff, prioritizing actually – like elevating it as an issue, and something that is scared about, and then having a grant in place, and having the infrastructure in place, and all of that" (provider, urban area)*

Bureaucracy was cited by service providers as a barrier to making institutional or organizational changes. It was also reported as a critical barrier to effective communication whereby front-line workers struggled to get their knowledge and resource requests received by those higher up in the organization.

> *"We've been trying to fight for it, like something we want to have is people with lived experience and family members or friends of people who use and things like that to kind of sit on a board to advise the programming and things, but that does not get a lot of uptake. So that's another thing that we're trying to do, and trying to force our superiors into allowing us to do, and it's always kind of just … like really big organizations are historically difficult with all of the bureaucracy you have to go through to do that, so we try to do it in our own little ways, and if we're quiet about it then nobody really asks" (provider, urban area)*

12. Services must address social determinants of health and promote social connection

Peers and providers often emphasized the need for various sources of additional support outside of the realm of formal substance use services. Some participants mentioned the importance of addressing basic needs (e.g., food, housing) to facilitate individual stability and readiness for treatment, and to promote health more generally. Additionally, most support was aimed at promoting community engagement, as well as social connection and belonging. For example, peers expressed the need and benefits of volunteering, sober social spaces (e.g., drag shows, sport/dance groups, GBT2Q-specific libraries), social support structures (e.g., drop-in support groups), leisure planning and holistic therapies (e.g., yoga, psychedelics). Thus, concurrently addressing social dimensions of health is key to supporting the wellness of GBT2Q people who use crystal meth.

> *"Food was an issue at first, 'cause I mean income assistance you don't get much money and rent's expensive, but once I got on disability it was a little easier to kind of just not have to spend my whole day worrying about the necessities… Once I was able to kind of not worry about those things I felt like I was actually able to deal with my addiction, or at least that's when the issues of loneliness kind of came up or that hole that I guess you're just… you're never actually dealing with because you're always distracting yourself with all these other things like food, or shelter." (peer/service provider, urban core)*

> *"Leisure planning is probably something that has not been explored very much but might be a really good opportunity to help people weave out of, get out of their addiction. And I say that because, I saw a recreation and leisure therapist once thinking, oh this would do nothing but it really helped my kind of plan other things where I might be hesitant, or have some fears around some group things" (peer, urban core)*

Meaningful Social Connections: Several peers expressed that unmet social needs were drivers of their crystal meth use. Whilst they recognized using crystal meth as a strategy to attain social connection, some pointed out that its effects were short-lived. As a result, creating community-building and social spaces for GBT2Q people may help them foster lasting social connections and positively manage their crystal meth use.

> *"People are looking for intimacy. I mean, they're using meth so … the closer the better, or the more effective people achieve intimacy and develop friendships, whether it's like sexual intimacy or like friends, or going to dinner, there are many ways that that can be facilitated, like developing community with the idea of like, we want to be sober" (peer, urban core)*

> *"I guess just as much as it does provide connection, it provides connection in a temporary and sort of I guess you could say fake way. And when I took a break and basically since the beginning of January, I very intentionally tried to cut a lot of those people [who use meth] of. So, as much as it provides community in the short term, I don't think it like, you know, really leads to actual community building or actual trust between people" (peer, urban area)*

Intergenerational Contact: Several peers and providers pointed to the value of intergenerational communication among GBT2Q people as a way to build a stronger sense of community and foster learning from diverse lived experiences.

> *"In some way we would inter-generationally meet and value each other, and learn from each other, because we're queer, and there's gonna be a new crop of queers every year. Every year there's a new crop of queers. There's something there that is very important, about bringing generations together so we can learn together" (peer, urban core)*

14. Services must be trauma-informed and address mental health

Various service providers voiced that GBT2Q people's concurrent issues (e.g., mental health and substance use) were often not appropriately addressed given the lack of integration and capacity across service areas. This was attributed to systemic procedural barriers associated with access to isolated service areas. However, a few service providers highlighted the importance and emergence of interprofessional collaboration within their organizations to better support the needs of GBT2Q people who use crystal meth. Participants' experiences accentuate the need for integrative models of care and improved collaboration between related service areas.

> *"Though mental health and substance use are co-located, we can't refer any of our clients to the mental health team. They have to go through the same pathways, but what we notice is especially with the access and assessment centre, if any clients come with a mental health crisis and they say that we have a history of substance use, they won't see them because they will say either this is substance induced, or a psychiatrist won't be able to do a proper assessment because of your using history, come back when you're not using substances any more" (peer/provider, urban core)*

> *"Most of the people that we see, probably 98% of them have co-occurring mental health and substance use issues, and our mandate as well is kind of geared more towards that end. So instead of seeing people with mild substance use we see people with moderate to severe, and so kind of what the research says about that is the more severe substance use become, the more likely it is to be co-morbid with mental health, and that's just because of the interplay [between the two]" (provider, urban area)*

Trauma-Informed Care: Most peers and service providers framed crystal meth use as a strategy to cope with and mediate unresolved trauma and concurrent mental health issues (e.g., internalized homophobia, fear of rejection, anxiety). Hence, trauma-informed and specialized trauma services are needed to address issues underlying motivations and patterns of crystal meth use among GBT2Q people.

> *"We're seeing the effect of unresolved childhood trauma in adults, every one of our clients has had a traumatized childhood and it's as of yet, unresolved. We try to address the symptoms higher up on the tree and not the root cause, whether we're talking about methadone or treatment or whatever, in reality there's a very good reason why people have developed that problematic substance use and that is the reason, that is what needs to be dealt with and resolved" (provider, rural area)*

> *"I think many people who are using crystal meth are suffering from trauma, sexual trauma, poverty, and struggling, and I think that comes out and it hurts other people. And a lot of it's unresolved, people are using drugs to connect and escape, as a means to soothe something that is very unresolved" (peer, urban core)*

15. Crystal meth services should be offered alongside sexual health services and supports

The vast majority of peers reported that crystal meth use was combined with sex among GBT2Q people and that the sexualized context of use needed to be addressed within harm reduction services. This could include providing sexual health promotion services (e.g., HIV and STBBI prevention, safer sex practices, U=U information, PEP, PrEP) alongside substance use harm reduction services.

> *"When I use crystal meth, sex has to follow, like something associated with sex needs to follow with my drug use because otherwise I just get antsy and I feel like I'm wasting a high because you know, the surge of dopamine in the brain that comes through when you use right? So, I definitely find they're very, very, very intertwined" (peer, urban core)*

> *"My prefrontal cortex shuts off and I just become a fucking machine, and I then have been exposed to STIs [sexually transmitted infections]. How many times have I got syphilis, gonorrhea, I am HIV positive but I didn't become HIV positive until I was 48, what the fuck? And really, it's a crap shoot because I was sexually active all through the 80s and 90s and I did not get AIDS, so I get HIV when I'm 48 because of participating in the sex and meth culture, that's why I got HIV at 48" (peer, urban core)*

Opportunities for Contact with Services: A few peers commented on how their HIV diagnosis was directly related to being connected with HIV-related health care/harm reduction services as well as services related to crystal meth use (i.e., HIV diagnoses represented critical touchpoints for connection with harm reduction services). Others commented on the need for more points of contact in places frequented by GBT2Q people who use crystal meth, particularly within sexualized spaces such as bathhouses.

> *"I don't know if the bathhouses are still open [since the COVID-19 pandemic], but when they were they had the nurses there and stuff like that, and sometimes that was the only time I'd get tested. Like whenever I saw them at the bathhouse I was always being tested that way. That's what got me familiar with HIM and then they mentioned I think their office you can come to or whatever any time, so that's where I got tested when I found out I was positive, but I wouldn't have known about that unless it was for the ones that were at the bathhouse" (peer/provider, urban core)*

Consent Education: Peers reported that consent within the context of sexualized crystal meth use could be blurred or even unattainable. Thus, providing novel consent education among

GBT2Q people who use crystal meth that is attentive to the unique realities of GBT2Q people's sexual cultures is critical to mitigating potential experiences of sexualized violence.

> *"I think it does become a really blurred line for people who don't do that ahead of time because it's a lot harder to stick to safer sex practices when you're in the middle of using the drug without having any boundaries set beforehand, or if you're using with people you don't know very well" (peer, urban area)*

> *"It's common for people to offer it to lure people in, it's much easier to sexually assault someone if they're high on meth […] I've seen horrific things happen, when I was high. I've seen people's lives destroyed within minutes" (peer, urban core)*

16. Geographic disparities in service provision must be addressed

Several peers and providers expressed that existing services were concentrated in particular urban neighbourhoods within Vancouver Coastal Health (e.g., Downtown Eastside, the West End), leaving other areas unattended or under-resourced. Importantly, one provider commented on regional disparities in the availability of specialized crystal meth services for GBT2Q people between Fraser Health and Vancouver Coastal Health.

> *"I think they're doing better with the harm reduction people walking around in certain areas. I feel like they should add more of those workers to Davie area and other places, not just like Downtown Eastside. I also feel like they should be advertising more services in the scene, I guess" (peer/service provider, urban area)*

> *"I guess maybe one thing is that as I was saying that a lot of these organizations are like geographically centered on either like Davie Street or like I guess the Downtown Eastside and I think it would be great if like if those could be kind of expanded to other places in the city" (peer, urban area)*

> *"At Fraser Health I don't think they're as available, so I think those are more specialised so probably you had to go to like a HIM clinic or like an Options for Sexual Health, or public health clinic to kind of access harm reduction supplies. I don't think they're quite as available as – obviously there's a lot of that kind of uptake in buildings around Vancouver like the SROs and modular housing buildings always have supplies, all the hotels always have supplies, so I think Fraser Health is just a little bit less in that sense" (provider, urban area)*

Uneven Distribution of Stigma: Community and healthcare workers' perspectives on substance use and GBT2Q people were relatively dated in some non-urban settings. That is, abstinence, rather than harm reduction, was prioritized or believed to be superior. Moreover, some GBT2Q individuals who used drugs described being met with little compassion and understanding when accessing some health care services (e.g., Emergency Department, HIV specialist).

> *"Even discussing some of my sexual preferences with the HIV specialist [in the Interior Health Authority] got looks. Maybe it's just part of the urban environment here, I chose to often travel down here for my HIV speciality because I found often up there it was just like, well you just shouldn't have that, you just shouldn't do that" (peer, urban core)*

> *"It's a busy little ER as well so that plays into it as well, but I think there's been this pervasive, shame-based attitude that has survived [in rural community] in some circles whether we're talking about people who use drugs, or people who have different sexual orientations. I think it just may not be a very welcoming attitude that people are approached with and this just ripples out in so many ways that it immediately doesn't make people feel safe to disclose things that are difficult to disclose" (provider, rural area)*

Limited Attention to HIV Prevention and GBT2Q Issues: One service provider in a non-urban environment was not informed about HIV pre-exposure prophylaxis (PrEP) – a publicly-funded medication that HIV-negative people can take to prevent getting HIV – and was not told about where individuals could access PrEP. This was partly attributed to slower developments in health services in rural environments compared with other regions in Vancouver Coastal Health. Moreover, given the prioritization of opioid-related harm reduction services in this rural environment, patterns of crystal meth use among GBT2Q people were not widely known and tailored programming was generally unavailable.

> *"I have not had anyone speak to me about [PrEP], nor have I heard anything through the health authority channels either. Definitely that makes my ears prick up, that's something that we need to ask some questions and find out how it's being offered, where it's being offered, if it's being offered, that sort of thing. I will say historically, [rural area] has lagged behind parts of the health authority in some aspects and I fear that our ability to work with all diverse populations are part of that lagging" (provider, rural area)*

Mobile Harm Reduction Services: Due to the geography and population density of some rural areas, mobile services were critical to reaching and providing harm reduction supplies to those who need them most.

> *"We call it a ribbon community, it's about 100kms with a number of small communities all stretched out along one highway, so we feel like it was a priority to try to set it up so that people were encouraged not to get in vehicles and drive" (provider, rural area)*

17. COVID-19-related service impacts must be addressed

Peers and providers commented on how the COVID-19 pandemic affected harm reduction service delivery. In relation to services that transitioned from in-person to virtual formats, participants' perceptions were mixed. On one hand, several

participants acknowledged that virtual services were convenient, efficient, and helpful in reducing staff burnout. On the other hand, they expressed that virtual services made it more difficult to talk about personal matters and build rapport, and raised issues regarding the confidentiality of conversations (e.g., trouble finding a confidential space or protecting the confidentiality of digital material). A few participants also explained that the pandemic negatively impacted in-person service delivery, such as through reduced staffing, impaired outreach and service promotion efforts, and limited freedoms within residential treatment settings (e.g., shopping, socializing). Given the mixed perceptions of virtual services, providers should consult users' preferences during program development.

> *"It's been difficult not having in-person meetings. Zoom has been great because it's enabled us to do so many things, but it's also really difficult sometimes to talk about such deeply personal things over an electronic platform that you don't really know where it's going, or where it could be intersected" (peer, urban core)*

> *"I think kind of in the ways of telehealth it's been really amazing, so like on the mental health team, many of the clients are mandated to kind of receive treatment under the mental health act and what often happens is if those clients – which happens very often for many reasons, if they can't make their appointments, or they're not taking their case managers calls, they'll be recalled and forcibly brought into the team to do an assessment and get their depos and all that kind of stuff, but now with the pandemic case managers are just like able to go up to the SROs with their phones and like turn on FaceTime and they have a conversation with their psychiatrist in their room, so that's been really cool" (peer/provider, urban core)*

Crystal Meth Use During COVID-19: Most peers reported that their use of crystal meth started or increased during the pandemic. They expressed that during the pandemic, crystal meth was used as a way to cope with social isolation, stress, anxiety, depression and other difficult life experiences. Others reported that impaired structure and routine (e.g., working from home rather than going into the office) opened the door for increased crystal meth use.

> *"Yeah well, I mean that was more or less why I started using, I think if COVID hadn't happened I probably never would have used meth. I think it allowed for connection in a time when connection was really difficult" (peer, urban area)*

> *"Well, you know, the restrictions, isolation, the sex parties and stuff were kind of ramped up because people had nothing else to do and they kind of got depressed and lonely, and that's human nature was done to seek – what's the word I'm looking for – have a sense of community when you're feeling depressed" (peer, urban core)*

Decreased Access to Services During COVID-19: Participants reported that their access to services was negatively impacted by the COVID-19 pandemic. Whilst some services completely shut down (e.g., in-person sexual health screening clinics), others had to operate virtually or with reduced capacity due to physical distancing protocols and resource re-allocation towards COVID-19 response efforts. As a result, participants expressed how this could exacerbate their sense of isolation and minimized service options.

> *"Our mental health club house had to close down for a number of months, and it's reopened but only maybe five people allowed inside the building whereas before they would have lunches every day with 30 people. So, what I've seen is that people who are unhoused were now unhoused with basically zero supports, our mental health population that were accessing the clubhouse for networking, and social interaction, and general life skills, that was taken away and people were isolated in their homes, in their tents" (provider, rural area)*

18. Decriminalization and safe supply must be prioritized

Various peers and providers communicated that the decriminalization of illicit drugs (e.g., crystal meth) and provision of a safe drug supply would serve as a harm reduction strategy. Decriminalization of drug use would help to prevent immediate health risks stemming from users engaging with a toxic drug supply, and would also support users to feel more comfortable asking for help and accessing services before their problems escalate.

> *"You're subjected to a lot of violence at the purchasing points, the transit between. And the police are not the best people – I've had encounters with police and I would say my substance use changed my impression of police, probably because I ended up being on the opposite side of them but, anyway. It's more about safe supply because I don't think the people… the best people are not the police to sort of get you through that and I think if we had safe places to go and get not only our supplies, but also the substance, if you're in that head space, that's the place you probably could have the greatest impact, before it becomes like medical emergency" (peer, urban core)*

> *"If the government passes the law, it lets the personal use [of] drugs like crystal meth, drugs, legally, I'm more confident to find the medical treatment about that, do you understand?" (peer, urban area)*

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Notice

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Appendices

Appendix 1: Tables for Section 1

Table 1: Demographics from Sex Now 2019

Variable	Total N=637 n (%)	No crystal meth usage in the past 6 months N=586 n (%)	Used crystal meth in the past 6 months N=51 n (%)
Health Authority			
Fraser Health	171 (26.8%)	159 (27.1%)	12 (23.5%)
Vancouver Coastal Health	466 (73.2%)	427 (72.9%)	39 (76.5%)
Gender Identity:			
Man	607 (95.3%)	559 (95.4%)	48 (94.1%)
Non-binary	26 (4.1%)	25 (4.3%)	1 (2.0%)
Other	4 (0.6%)	2 (0.3%)	2 (3.9%)
Identify as White	492 (77.7%)	451 (77.5%)	41 (80.4%)
Identify as Asian	62 (9.8%)	58 (10.0%)	4 (7.8%)
Identify as South Asian	21 (3.3%)	19 (3.3%)	2 (3.9%)
Identify as Indigenous	31 (4.9%)	25 (4.3%)	6 (11.8%)
Identify as a person with a disability	73 (11.5%)	58 (9.9%)	15 (29.4%)
Identify as Gay	534 (83.8%)	490 (83.6%)	44 (86.3%)
Identify as Bisexual	103 (16.2%)	90 (15.4%)	13 (25.5%)
Environment you live in:			
Large urban centre (100,000+ people)	565 (89.0%)	527 (89.3%)	38 (84.4%)
Not large urban centre (<100,000+ people)	70 (11%)	62 (10.6%)	8 (15.7%)
Highest level of education completed:			
Did not finish high school	14 (2.2%)	11 (1.9%)	3 (7.0%)
High school, or equivalent	92 (14.5%)	85 (14.4%)	7 (16.3%)
Post-secondary certificate	156 (24.6%)	140 (23.7%)	16 (37.2%)
Bachelor's degree	225 (35.5%)	213 (36.1%)	12 (27.9%)
Above a bachelor's degree	146 (23.1%)	141 (23.9%)	5 (11.6%)
Age (mean (sd))	38.4 (13.9)	37.9 (14.0)	44.0 (11.8)

Table 2: Demographics from CMP study stratified by health region

	Total N=219 n (%)	**Fraser Health** N=68 n (%)	**Vancouver Coastal Health** N=151 n (%)
Age (mean (sd))	44.6 (11.3)	46.7 (11.6)	43.7 (11.1)
Income groups			
<$30,000	69 (37.3%)	19 (33.3%)	50 (39.1%)
$30,000 - $59,999	58 (31.4%)	25 (43.9%)	33 (25.8%)
$60,000 - $89,999	32 (17.3%)	4 (7.0%)	28 (21.9%)
>$90,000	26 (14.1%)	9 (15.8%)	17 (13.3%)
Identify as East or Southeast Asian	19 (8.7%)	2 (2.9%)	17 (11.3%)
Identify as Indigenous	13 (5.9%)	5 (7.4%)	8 (5.3%)
Identify as South Asian	8 (3.7%)	4 (5.9%)	4 (2.6%)
Identify as White	155 (70.8%)	54 (79.4%)	101 (66.9%)
Gender			
Man	211 (96.3%)	67 (98.5%)	144 (95.4%)
Non-binary	8 (3.7%)	1 (1.5%)	7 (4.6%)
Have trans experience	18 (8.7%)	4 (6.0%)	14 (10.1%)
Identify as Bisexual	46 (21.0%)	27 (39.7%)	19 (12.6%)
Identify as Gay	158 (72.1%)	46 (67.6%)	112 (74.2%)
Highest level of education completed:			
Some high school, no diploma	19 (10.2%)	10 (17.5%)	9 (7.0%)
High school graduate, diploma or the equivalent	37 (19.9%)	10 (17.5%)	27 (20.9%)
Some college credit, no degree	38 (20.4%)	15 (26.3%)	23 (17.8%)
Associate degree	20 (10.8%)	6 (10.5%)	14 (10.9%)
Bachelor's degree	40 (21.5%)	9 (15.8%)	31 (24.0%)
Master's degree	18 (9.7%)	5 (8.8%)	13 (10.1%)
Professional degree	11 (5.9%)	2 (3.5%)	9 (7.0%)
Doctorate degree	3 (1.6%)	0 (0.0%)	3 (2.3%)

Table 3: Frequency and method of crystal meth use from CMP

	Total N=219 n (%)	**Fraser Health** N=68 n (%)	**Vancouver Coastal Health** N=151 n (%)
Frequency of crystal meth use in the past 6 months:			
Once or twice	50 (22.8%)	16 (23.5%)	34 (22.5%)
Monthly	27 (12.3%)	8 (11.8%)	19 (12.6%)
Weekly	44 (20.1%)	10 (14.7%)	34 (22.5%)
Daily or almost daily	98 (44.7%)	34 (50.0%)	64 (42.4%)
Have you ever snorted crystal meth?:			
No, never	29 (20.6%)	10 (26.3%)	19 (18.4%)
Yes, in the past 6 months	69 (48.9%)	16 (42.1%)	53 (51.5%)
Yes, more than 6 months ago	43 (30.5%)	12 (31.6%)	31 (30.1%)
Have you ever used crystal meth by injection?:			
No, never	75 (53.2%)	24 (63.2%)	51 (49.5%)
Yes, in the past 6 months	48 (34.0%)	12 (31.6%)	36 (35.0%)
Yes, more than 6 months ago	18 (12.8%)	2 (5.3%)	16 (15.5%)

Table 4: HIV related variables Sex Now

	Total N=637 n (%)	**No crystal meth usage in the past 6 months** N=586 n (%)	**Used crystal meth in the past 6 months** N=51 n (%)
Ever diagnosed with HIV: Yes (I am living with HIV)	71 (11.2%)	50 (8.6%)	21 (41.2%)
Anal receptive sex with no condom P6M	373 (58.7%)	336 (57.4%)	37 (74.0%)
Any injection drug use:			
No, never	600 (94.2%)	569 (97.1%)	31 (60.8%)
Yes, in the past 6 months	20 (3.1%)	4 (0.7%)	16 (31.4%)
Yes, longer than 6 months ago	17 (2.7%)	13 (2.2%)	4 (7.8%)

Table 5: HIV related variables CMP

	Total N=181 n (%)	Fraser Health N=54 n (%)	Vancouver Coastal Health N=127 n (%)
Ever been diagnosed with HIV:			
Never tested for HIV	7 (3.9%)	5 (9.3%)	2 (1.6%)
No	94 (51.9%)	25 (46.3%)	69 (54.3%)
Yes	80 (44.2%)	24 (44.4%)	56 (44.1%)
On PrEP	44 (46.8%)	6 (24.0%)	38 (55.1%)
In the past 6 months while injecting crystal meth shared			
Syringe			
Never	35 (72.9%)	11 (91.7%)	24 (66.7%)
Rarely	7 (14.6%)	0 (0.0%)	7 (19.4%)
Sometimes	4 (8.3%)	1 (8.3%)	3 (8.3%)
Often	0 (0.0%)	0 (0.0%)	0 (0.0%)
Almost every time	0 (0.0%)	0 (0.0%)	0 (0.0%)
Always	2 (4.2%)	0 (0.0%)	2 (5.6%)
Water			
Never	33 (68.8%)	11 (91.7%)	22 (61.1%)
Rarely	9 (18.8%)	1 (8.3%)	8 (22.2%)
Sometimes	3 (6.2%)	0 (0.0%)	3 (8.3%)
Often	1 (2.1%)	0 (0.0%)	1 (2.8%)
Almost every time	0 (0.0%)	0 (0.0%)	0 (0.0%)
Always	2 (4.2%)	0 (0.0%)	2 (5.6%)
Filter			
Never	44 (93.6%)	12 (100.0%)	32 (91.4%)
Rarely	3 (6.4%)	0 (0.0%)	3 (8.6%)
Sometimes	0 (0.0%)	0 (0.0%)	0 (0.0%)
Often	0 (0.0%)	0 (0.0%)	0 (0.0%)
Almost every time	0 (0.0%)	0 (0.0%)	0 (0.0%)
Always	0 (0.0%)	0 (0.0%)	0 (0.0%)
Spoon/container			
Never	43 (91.5%)	12 (100.0%)	31 (88.6%)
Rarely	3 (6.4%)	0 (0.0%)	3 (8.6%)
Sometimes	1 (2.1%)	0 (0.0%)	1 (2.9%)
Often	0 (0.0%)	0 (0.0%)	0 (0.0%)
Almost every time	0 (0.0%)	0 (0.0%)	0 (0.0%)
Always	0 (0.0%)	0 (0.0%)	0 (0.0%)

Table 6: Reasons for using crystal meth CMP

	Total N=219 n (%)	**Fraser Health** N=68 n (%)	**Vancouver Coastal Health** N=151 n (%)
In the past 6 months what percent of the time: Does your crystal meth use occur prior to or during sex?			
Hardly any of the time (0 - 19%)	16 (11.4%)	4 (11.1%)	12 (11.5%)
Only some of the time (20 - 39%)	11 (7.9%)	5 (13.9%)	6 (5.8%)
About half the time (40 - 59%)	8 (5.7%)	4 (11.1%)	4 (3.8%)
Most of the time (60 - 79%)	27 (19.3%)	5 (13.9%)	22 (21.2%)
Nearly all the time (80 - 100%)	78 (55.7%)	18 (50.0%)	60 (57.7%)
Why use crystal meth:			
To feel good/have a good time	96 (43.8%)	21 (30.9%)	75 (49.7%)
To connect with others socially	54 (24.7%)	19 (27.9%)	35 (23.2%)
To connect with others sexually	106 (48.4%)	27 (39.7%)	79 (52.3%)
To feel more confident to have sex or try new things	68 (31.1%)	15 (22.1%)	53 (35.1%)
To make sex more intense or pleasurable	101 (46.1%)	27 (39.7%)	74 (49.0%)
To make sex last longer	72 (32.9%)	19 (27.9%)	53 (35.1%)
Because of other stresses in my life	44 (20.1%)	11 (16.2%)	33 (21.9%)
Because other people use it	41 (18.7%)	12 (17.6%)	29 (19.2%)
Because I am addicted	40 (18.3%)	12 (17.6%)	28 (18.5%)

Table 7: Impacts of crystal meth use CMP

	Total N=219 n (%)	**Fraser Health** N=68 n (%)	**Vancouver Coastal Health** N=151 n (%)
View of your current crystal meth use:			
I do not think I have a crystal meth use problem and therefore nothing should be done about it.	50 (33.1%)	17 (40.5%)	33 (30.3%)
I think I have a crystal meth use problem. However, I am not yet ready to take any action to solve the problem.	41 (27.2%)	9 (21.4%)	32 (29.4%)
I think I have a crystal meth use problem, and I might take action to solve the problem in the future.	30 (19.9%)	8 (19.0%)	22 (20.2%)
I know I have a crystal meth use problem, and I intend to take action to solve it soon.	14 (9.3%)	7 (16.7%)	7 (6.4%)
I know I have a crystal meth use problem, and I am ready to take action to solve it now.	16 (10.6%)	1 (2.4%)	15 (13.8%)
I am addicted to drugs:			
No! Strongly disagree	32 (22.1%)	8 (20.5%)	24 (22.6%)
No disagree	25 (17.2%)	11 (28.2%)	14 (13.2%)
Unsure or undecided	20 (13.8%)	4 (10.3%)	16 (15.1%)
Yes agree	38 (26.2%)	7 (17.9%)	31 (29.2%)
Yes! Strongly agree	30 (20.7%)	9 (23.1%)	21 (19.8%)
Meth Led to health problems			
Never	91 (65.5%)	29 (76.3%)	62 (61.4%)
Once or twice	29 (20.9%)	8 (21.1%)	21 (20.8%)
Monthly	13 (9.4%)	1 (2.6%)	12 (11.9%)
Weekly	1 (0.7%)	0 (0.0%)	1 (1.0%)
Daily or almost daily	5 (3.6%)	0 (0.0%)	5 (5.0%)
Meth Led to legal problems			
Never	133 (95.7%)	38 (100.0%)	95 (94.1%)
Once or twice	4 (2.9%)	0 (0.0%)	4 (4.0%)
Monthly	0 (0.0%)	0 (0.0%)	0 (0.0%)
Weekly	2 (1.4%)	0 (0.0%)	2 (2.0%)
Daily or almost daily	0 (0.0%)	0 (0.0%)	0 (0.0%)
Meth Led to social problems with your friends or family			
Never	82 (59.0%)	27 (73.0%)	55 (53.9%)
Once or twice	37 (26.6%)	6 (16.2%)	31 (30.4%)
Monthly	10 (7.2%)	3 (8.1%)	7 (6.9%)
Weekly	4 (2.9%)	0 (0.0%)	4 (3.9%)
Daily or almost daily	6 (4.3%)	1 (2.7%)	5 (4.9%)

Meth Led to problems at work or with those you work with			
Never	91 (68.4%)	29 (80.6%)	62 (63.9%)
Once or twice	30 (22.6%)	3 (8.3%)	27 (27.8%)
Monthly	5 (3.8%)	2 (5.6%)	3 (3.1%)
Weekly	2 (1.5%)	1 (2.8%)	1 (1.0%)
Daily or almost daily	5 (3.8%)	1 (2.8%)	4 (4.1%)
Meth Led to difficulty paying your bills			
Never	99 (71.7%)	27 (71.1%)	72 (72.0%)
Once or twice	23 (16.7%)	6 (15.8%)	17 (17.0%)
Monthly	10 (7.2%)	4 (10.5%)	6 (6.0%)
Weekly	1 (0.7%)	0 (0.0%)	1 (1.0%)
Daily or almost daily	5 (3.6%)	1 (2.6%)	4 (4.0%)
Meth Led to problems with your sex life			
Never	74 (53.6%)	24 (63.2%)	50 (50.0%)
Once or twice	39 (28.3%)	8 (21.1%)	31 (31.0%)
Monthly	10 (7.2%)	5 (13.2%)	5 (5.0%)
Weekly	9 (6.5%)	0 (0.0%)	9 (9.0%)
Daily or almost daily	6 (4.3%)	1 (2.6%)	5 (5.0%)

*P6M = past six months

Table 8: Impacts of crystal meth use Sex Now

	Total N=636	No crystal meth usage in the past 6 months N=585	Used crystal meth in the past 6 months N=51
In general, how would you say your mental health is:			
Poor	50 (7.9%)	43 (7.4%)	7 (13.7%)
Fair	123 (19.3%)	112 (19.1%)	11 (21.6%)
Good	198 (31.1%)	181 (30.9%)	17 (33.3%)
Very good	177 (27.8%)	165 (28.2%)	12 (23.5%)
Excellent	88 (13.8%)	84 (14.4%)	4 (7.8%)
PHQ-2 depression scale (3 and over indicate depression)			
Depression Score < 3	498 (78.8%)	463 (79.7%)	35 (68.6%)
Depression Score >= 3	134 (21.2%)	118 (20.3%)	16 (31.4%)
GAD-2 anxiety scale (3 and over indicate anxiety)			
Anxiety Score < 3	477 (75.2%)	440 (75.5%)	37 (72.5%)
Anxiety Score >= 3	157 (24.8%)	143 (24.5%)	14 (27.5%)
Have you ever overdosed from opioids to the point of losing consciousness?:			
No, never	613 (97.9%)	569 (99.0%)	44 (86.3%)
Yes, in the past year	3 (0.5%)	2 (0.3%)	1 (2.0%)
Yes, longer than 1 year ago	10 (1.6%)	4 (0.7%)	6 (11.8%)

Table 9: Other drugs used in the past 3 months CMP

	Total N=168 n (%)	**Fraser Health** N=49 n (%)	**Vancouver Coastal Health** N=119 n (%)
Tobacco use past 3 months:			
Never	72 (43.4%)	17 (34.7%)	55 (47.0%)
Once or twice	10 (6.0%)	1 (2.0%)	9 (7.7%)
Monthly	4 (2.4%)	1 (2.0%)	3 (2.6%)
Weekly	7 (4.2%)	2 (4.1%)	5 (4.3%)
Daily or almost daily	73 (44.0%)	28 (57.1%)	45 (38.5%)
Alcohol use past 3 months:			
Never	35 (21.1%)	12 (25.0%)	23 (19.5%)
Once or twice	42 (25.3%)	12 (25.0%)	30 (25.4%)
Monthly	17 (10.2%)	3 (6.2%)	14 (11.9%)
Weekly	49 (29.5%)	14 (29.2%)	35 (29.7%)
Daily or almost daily	23 (13.9%)	7 (14.6%)	16 (13.6%)
Cannabis use past 3 months:			
Never	55 (32.9%)	15 (30.6%)	40 (33.9%)
Once or twice	38 (22.8%)	11 (22.4%)	27 (22.9%)
Monthly	22 (13.2%)	6 (12.2%)	16 (13.6%)
Weekly	18 (10.8%)	9 (18.4%)	9 (7.6%)
Daily or almost daily	34 (20.4%)	8 (16.3%)	26 (22.0%)
Poppers use past 3 month:			
Never	36 (23.5%)	14 (31.8%)	22 (20.2%)
Once or twice	44 (28.8%)	16 (36.4%)	28 (25.7%)
Monthly	31 (20.3%)	6 (13.6%)	25 (22.9%)
Weekly	42 (27.5%)	8 (18.2%)	34 (31.2%)
Daily or almost daily	0 (0.0%)	0 (0.0%)	0 (0.0%)
GHB use past 3 months:			
Never	59 (36.4%)	24 (50.0%)	35 (30.7%)
Once or twice	44 (27.2%)	14 (29.2%)	30 (26.3%)
Monthly	28 (17.3%)	7 (14.6%)	21 (18.4%)
Weekly	31 (19.1%)	3 (6.2%)	28 (24.6%)
Daily or almost daily	0 (0.0%)	0 (0.0%)	0 (0.0%)
Opioid use past 3 months			
Never	152 (94.4%)	47 (97.9%)	105 (92.9%)
Once or twice	7 (4.3%)	1 (2.1%)	6 (5.3%)
Monthly	1 (0.6%)	0 (0.0%)	1 (0.9%)
Weekly	1 (0.6%)	0 (0.0%)	1 (0.9%)
Daily or almost daily	0 (0.0%)	0 (0.0%)	0 (0.0%)

Table 10: Access to services CMP

	Total N=138 n (%)	Fraser Health N=37 n (%)	Vancouver Coastal Health N=101 n (%)
If you wanted to access professional help to control, cut down, or stop using crystal meth how confident are you that you could: Find a program			
Very non-confident	29 (21.0%)	9 (24.3%)	20 (19.8%)
Somewhat non-confident	15 (10.9%)	2 (5.4%)	13 (12.9%)
Somewhat confident	42 (30.4%)	7 (18.9%)	35 (34.7%)
Very confident	52 (37.7%)	19 (51.4%)	33 (32.7%)
At this time, overall, would you say it is easy for you to get help in reducing or abstaining from substances:			
Not at all	23 (22.3%)	6 (24.0%)	17 (21.8%)
A little	38 (36.9%)	7 (28.0%)	31 (39.7%)
A lot	20 (19.4%)	3 (12.0%)	17 (21.8%)
Completely	22 (21.4%)	9 (36.0%)	13 (16.7%)
In the past 6 months, how many times have you used services providing safer injection materials?			
0	84 (70.0%)	26 (81.2%)	58 (65.9%)
1	4 (3.3%)	0 (0.0%)	4 (4.5%)
2	8 (6.7%)	1 (3.1%)	7 (8.0%)
3 to 5	10 (8.3%)	2 (6.2%)	8 (9.1%)
6 to 10	4 (3.3%)	2 (6.2%)	2 (2.3%)
More than 10	10 (8.3%)	1 (3.1%)	9 (10.2%)
Have you ever received treatment, counselling or harm reduction services for your use of any drug, not counting cigarettes?:			
No, never	72 (58.1%)	19 (59.4%)	53 (57.6%)
Yes, in the past 6 months	11 (8.9%)	4 (12.5%)	7 (7.6%)
Yes, more than 6 months	41 (33.1%)	9 (28.1%)	32 (34.8%)
Normal distance travelled (in km) to access healthcare services (mean (sd))	11.7 (47.1)	14.5 (13.8)	10.7 (54.3)

Table 11: Access to services Sex Now

	Total N=600	No crystal meth usage in the past 6 months N=551	Used crystal meth in the past 6 months N=49
How confident are you that you could access these services?: One-on-one counselling therapy?			
Not confident at all	39 (6.5%)	35 (6.4%)	4 (8.2%)
Only a little confident	102 (17.0%)	95 (17.2%)	7 (14.3%)
Somewhat confident	184 (30.7%)	169 (30.7%)	15 (30.6%)
Very confident	275 (45.8%)	252 (45.7%)	23 (46.9%)
How confident are you that you could access these services?: Group counselling/therapy			
Not confident at all	63 (10.6%)	58 (10.6%)	5 (10.4%)
Only a little confident	132 (22.1%)	121 (22.0%)	11 (22.9%)
Somewhat confident	202 (33.8%)	185 (33.7%)	17 (35.4%)
Very confident	200 (33.5%)	185 (33.7%)	15 (31.2%)
How confident are you that you could access these services?: Harm reduction supplies			
Not confident at all	60 (10.6%)	54 (10.5%)	6 (12.2%)
Only a little confident	80 (14.2%)	69 (13.4%)	11 (22.4%)
Somewhat confident	175 (31.0%)	164 (31.8%)	11 (22.4%)
Very confident	250 (44.2%)	229 (44.4%)	21 (42.9%)
How confident are you that you could access these services?: Safe injection/consumption sites			
Not confident at all	82 (14.6%)	72 (14.0%)	10 (21.3%)
Only a little confident	91 (16.2%)	79 (15.3%)	12 (25.5%)
Somewhat confident	165 (29.3%)	155 (30.0%)	10 (21.3%)
Very confident	225 (40.0%)	210 (40.7%)	15 (31.9%)

Table 12: Social support needs CMP

	Total N=219 n (%)	Fraser Health N=68 n (%)	Vancouver Coastal Health N=151 n (%)
How often was the following true in the past 12 months: The food I bought just didn't last and I didn't have money to get more			
Never True	129 (67.2%)	44 (72.1%)	85 (64.9%)
Sometimes True	45 (23.4%)	14 (23.0%)	31 (23.7%)
Often True	18 (9.4%)	3 (4.9%)	15 (11.5%)
Personally experienced any of the following:			
Death of a close friend			
Yes, in the past 12 months.	27 (23.3%)	7 (24.1%)	20 (23.0%)
Yes, more than 12 months ago.	46 (39.7%)	11 (37.9%)	35 (40.2%)
End of relationship			
Yes, in the past 12 months.	22 (18.3%)	4 (13.3%)	18 (20.0%)
Yes, more than 12 months ago.	73 (60.8%)	19 (63.3%)	54 (60.0%)
Loss of job			
Yes, in the past 12 months.	23 (19.2%)	8 (26.7%)	15 (16.7%)
Yes, more than 12 months ago.	43 (35.8%)	8 (26.7%)	35 (38.9%)
Death of a partner			
Yes, in the past 12 months.	4 (3.3%)	0 (0.0%)	4 (4.4%)
Yes, more than 12 months ago.	21 (17.4%)	4 (13.3%)	17 (18.7%)
Incarceration			
Yes, in the past 12 months.	3 (2.5%)	1 (3.3%)	2 (2.2%)
Yes, more than 12 months ago.	11 (9.1%)	1 (3.3%)	10 (11.0%)
How often are the following supports available: Someone to confide in or talk to about yourself or your problems			
None of the time	11 (8.9%)	5 (16.1%)	6 (6.5%)
A little of the time	31 (25.0%)	5 (16.1%)	26 (28.0%)
Some of the time	30 (24.2%)	5 (16.1%)	25 (26.9%)
Most of the time	29 (23.4%)	4 (12.9%)	25 (26.9%)

Table 13: Social support needs Sex Now

Variable	Total N=637 n (%)	No crystal meth usage in the past 6 months N=586 n (%)	Used crystal meth in the past 6 months N=51 n (%)
Current money situation:			
Cannot make ends meet	55 (8.7%)	44 (7.6%)	11 (21.6%)
Have to cut back	100 (15.8%)	91 (15.6%)	9 (17.6%)
Enough, but no extra	239 (37.8%)	225 (38.7%)	14 (27.5%)
Comfortable, with extra	239 (37.8%)	222 (38.1%)	17 (33.3%)
Employment: Unemployed	35 (5.5%)	28 (4.8%)	7 (14%)
In a relationship:			
No	284 (44.6%)	252 (43.0%)	32 (62.7%)
Yes, with a man	278 (43.6%)	268 (45.7%)	10 (19.6%)
Yes, with a non-binary person	8 (1.3%)	7 (1.2%)	1 (2.0%)
Yes, with a woman	33 (5.2%)	29 (4.9%)	4 (7.8%)
Yes, with more than 1 person	34 (5.3%)	30 (5.1%)	4 (7.8%)
How often do you feel isolated?:			
Hardly ever	238 (38.3%)	228 (39.9%)	10 (20.0%)
Some of the time	252 (40.5%)	233 (40.7%)	19 (38.0%)
Often	132 (21.2%)	111 (19.4%)	21 (42.0%)

Table 14: Openness about sexual identity and crystal meth use healthcare CMP

	Total N=206 n (%)	**Fraser Health** N=67 n (%)	**Vancouver Coastal Health** N=139 n (%)
How open (out) are you about your sexual identity?:			
Not at all open (out)	21 (10.2%)	11 (16.4%)	10 (7.2%)
Out to only a few people	25 (12.1%)	12 (17.9%)	13 (9.4%)
Out in some contexts, but not others	16 (7.8%)	4 (6.0%)	12 (8.6%)
Out to most people I know	42 (20.4%)	13 (19.4%)	29 (20.9%)
Open (out) to everyone I know	102 (49.5%)	27 (40.3%)	75 (54.0%)
Have a regular healthcare provider, such as a general practitioner (GP): Yes	98 (79.0%)	26 (81.2%)	72 (78.3%)
Regular healthcare provider knows you use crystal meth: Yes	53 (54.1%)	16 (61.5%)	37 (51.4%)
Regular healthcare provider knows you have sex with other men: Yes	89 (90.8%)	22 (84.6%)	67 (93.1%)
If you wanted to access professional help to control, cut down, or stop using crystal meth how confident are you that you could: Disclose to your doctor that you use meth and need help			
Very non-confident	29 (21.2%)	8 (22.2%)	21 (20.8%)
Somewhat non-confident	24 (17.5%)	2 (5.6%)	22 (21.8%)
Somewhat confident	27 (19.7%)	6 (16.7%)	21 (20.8%)
Very confident	57 (41.6%)	20 (55.6%)	37 (36.6%)

Table 15: Openness about sexual identity healthcare SN2019

	Total N=614	**No crystal meth usage in the past 6 months** N=565	**Used crystal meth in the past 6 months** N=49
Usual place for STI testing:			
Family physician	161 (26.7%)	140 (25.3%)	21 (42.0%)
Walk-in medical clinic	46 (7.6%)	41 (7.4%)	5 (10.0%)
A clinic or service offering testing for gay, bi, queer and trans people	184 (30.5%)	171 (30.9%)	13 (26.0%)
A youth clinic	7 (1.2%)	7 (1.3%)	0 (0.0%)
An STI or sexual health clinic	136 (22.6%)	130 (23.5%)	6 (12.0%)
Emergency room	2 (0.3%)	2 (0.4%)	0 (0.0%)
Other community clinic	16 (2.7%)	16 (2.9%)	0 (0.0%)
Other	32 (5.3%)	29 (5.2%)	3 (6.0%)
No usual place	18 (3.0%)	16 (2.9%)	2 (4.0%)
Has a regular family doctor or nurse practitioner	435 (70.8%)	394 (69.7%)	41 (83.7%)
Regular family doctor or nurse practitioner know that you have sex with men:			
No	42 (10.0%)	40 (10.4%)	2 (5.1%)
Unsure	43 (10.2%)	38 (9.9%)	5 (12.8%)
Yes	337 (79.9%)	305 (79.6%)	32 (82.1%)

Table 16: Ideal program characteristics from CMP

	Total N=122 n (%)	**Fraser Health** N=31 n (%)	**Vancouver Coastal Health** N=91 n (%)
Ideal duration of a program aimed at helping you to control, cut down, or stop using crystal meth in weeks (mean(sd))	13.2 (19.6)	16.6 (26.6)	12.0 (16.4)
Ideal duration of a program aimed at helping you to control, cut down or stop using crystal meth in number of sessions (mean(sd))	25.7 (28.8)	21.5 (21.6)	27.2 (31.0)
Ideal duration of a session or activity:			
30 minutes	21 (17.2%)	7 (22.6%)	14 (15.4%)
60 minutes	57 (46.7%)	17 (54.8%)	40 (44.0%)
90 minutes	28 (23.0%)	3 (9.7%)	25 (27.5%)
120 minutes	13 (10.7%)	2 (6.5%)	11 (12.1%)
150 minutes	0 (0.0%)	0 (0.0%)	0 (0.0%)
180 minutes	3 (2.5%)	2 (6.5%)	1 (1.1%)
Ideal frequency of a program:			
Daily	22 (18.3%)	5 (16.1%)	17 (19.1%)
Once every few days	54 (45.0%)	13 (41.9%)	41 (46.1%)
Once a week	30 (25.0%)	5 (16.1%)	25 (28.1%)
Once every two weeks	7 (5.8%)	5 (16.1%)	2 (2.2%)
Once a month	3 (2.5%)	1 (3.2%)	2 (2.2%)
Other	4 (3.3%)	2 (6.5%)	2 (2.2%)

Appendix 2. Tables for Section 2

Table 1: Characteristics of in-depth interview participants from the Sociocultural Contexts and Young Men's Social Lives Study, 2018, Vancouver, Canada

	N
Participants (who have used crystal meth in the past 12 months)	18
Age (average, range)	25.22 (18-30) Years
Ethnicity[1]	
Indigenous	8
Black	1
Filipino	2
Latin American	2
South Asian	2
South-East Asian	1
White	4
Other: Vietnamese and Chinese	1
Gender[2]	
Cis man	17
Trans man	1
Queer	1
Sexual Orientation[3]	
Bisexual	8
Gay	7
Pansexual	2
Queer	1
Straight	1
Unsure	1
Other (incl. homoflexible)	2
Immigrant to Canada?	
Yes	4
No	14
Level of Education completed	
Elementary	2
Secondary (high school)	12
University, college, trade school	4
Sources of health information[4]	
Family members	3
Friends and peers	5
Healthcare provider	9
Internet	9
Youth clinic	6
Other	4

	N
Last tested for STIs[5]	
Less than a month ago	5
One to three months ago	8
Four to six months ago	2
Seven months to a year ago	2
Never been tested	1
Substances used in the past 12 months	
Alcohol	17
Benzodiazepines	5
Cocaine	12
Crack	5
Erectile Dysfunction Drugs	5
Fentanyl	4
GHB	6
Goofball	3
Heroin	5
Ketamine	7
Cannabis	14
MDMA	12
Methadone	2
Mushrooms	6
Opioids (other)	3
Poppers	7
Prozac	1
Speed	7
Steroids	2
T3s	3
Others[6]	3

1. Some participants selected more than one ethnic identification.

2. One participant selected more than one gender identification.

3. Some participants selected more than one sexual orientation identification.

4. Some participants selected more than one source of health information. Other sources of health information included: walk-in clinic, IDC at St. Paul's, WebMD and bars.

5. Last date tested at the time of interview.

6. Other substances used by participants included: LSD and Adderall.

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