Health in Focus

2SLGBTQ+ Substance Use Health and Harm Reduction

An evidence review and practical guide designed for healthcare providers and researchers

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PURPOSE

This *Health in Focus* educational resource was created to highlight the substance use health needs of 2SLGBTQ+ people. This document will help you create safer, more inclusive substance use health promotion, harm reduction and treatment supports.

TERMS OF USE

KEYWORDS

2SLGBTQ+, substance use health, harm reduction, toxic drug crisis, polysubstance use, minority stress, structural stigma, health equity, gender-affirming care, trauma-informed care, sexualized drug use, chemsex, integrated care, social determinants of health, syndemics, substance use prevention, overdose prevention, 2SLGBTQ+ youth, Two-Spirit health, criminalization of drug use

Produced by Rainbow Health Ontario, April 2026.

SUMMARY

Substance use is a common part of life in Canada, and for many people it is social, pleasurable and woven into everyday life. But it also carries risks, which are shaped far more by structural forces like discrimination and criminalization than by individual choices. Canada is in the midst of an unprecedented toxic drug crisis, and the populations most exposed to harm are those already marginalized by the conditions in which they live.

2SLGBTQ+ people are among those most affected. They use substances at higher rates than their cisgender, heterosexual counterparts, face greater barriers to care and carry the compounding burden of minority stress, structural marginalization and the "double stigma" of both substance use and 2SLGBTQ+ identity. Substance use in 2SLGBTQ+ communities can be both a response to discrimination and unmet needs, and a driver of additional risk, making it a complex, intersecting issue that requires a nuanced response. Yet 2SLGBTQ+ people are largely invisible in substance use data, programming and policy.

This *Health in Focus* educational resource provides an overview of the substance use health (SUH) needs of 2SLGBTQ+ people, with particular attention to harm reduction, and offers practical guidance for providers across the care continuum. It is designed to help understand why 2SLGBTQ+ people use substances, what gets in the way of care and what providers can do to offer more affirming, effective and equitable support.

SUBSTANCE USE CONTEXT

SUBSTANCE USE HEALTH

Substance use is a common part of life in Canada: 90 per cent of the general public have ever used alcohol, two thirds (63 per cent) have ever used cannabis and one in five (21 per cent) have ever used an illegal drug (Health Canada, 2025). Across these prevalence rates, reasons and use patterns vary widely, spanning social connection and pleasure, coping and self-medication, performance enhancement and survival, and cultural and spiritual practices (Canadian Public Health Association, 2024; Health Canada, 2023), creating a wide range of risk profiles and needs.

Substance use health encompasses more than just the illness state (addiction) alone, creating opportunities for care at every point.

This range is captured by the SUH Spectrum (CAPSA, 2023), which frames substance use as existing on a continuum, from no use to occasional or regular use to substance use disorders, and recognizes benefits, risks and stigma at every point across the spectrum. Much like the concept of physical or mental health, SUH encompasses more than just the illness state (addiction) alone, creating opportunities for health promotion, prevention and care at every point. This framing can help providers recognize health needs across a variety of substance use patterns and develop strategies that meet people where they are to support them in their health goals.

DRIVERS OF RISKS AND HARMS

Although many people use substances without significant negative impact on their wellbeing, all substance use carries risks. These risks are shaped by a complex mix of individual and structural factors (Chief Medical Officer of Health [Ontario], 2024).

Individual factors include those that precede use, such as genetics, adverse childhood experiences and mental and physical health, as well as those that follow once use has been initiated, such as effects of a substance and substance use practices (e.g., route of administration, using alone, polysubstance use).

Most harms are driven not by individual choices but by structural forces... linked to the social determinants of health.

However, most harms are driven not by individual choices but by structural forces that operate both upstream, making initiation or escalation of use more likely, and downstream, compounding risks and harms once use has begun. These are commonly linked to the social determinants of health, with factors such as employment, housing stability and social supports shaping use trajectories across the life course. For those accessing substances from the unregulated supply, drug criminalization adds significant risk as it stigmatizes use, driving it underground and creating barriers to safer use and services (Elliott, 2023). Criminal justice involvement also creates lasting barriers to the social determinants of health, further entrenching structural risk, while prohibition creates a drug supply with no quality control that exposes people to an ever-changing mix of variably potent substances with unexpected effects (CATIE, 2025). These risks are compounded for people impacted by racism, colonization, poverty and co-occurring housing and affordability crises, further eroding their conditions for health.

The outcome of this mix of forces has become increasingly apparent over the past decade as Canada has faced an unprecedented toxic drug crisis (Public Health Agency of Canada, 2025). In Ontario, there were over 12,000 substance-related toxicity deaths between 2018 and 2022 - up to 8 per day - with opioids involved in 84 per cent of deaths, followed by stimulants (62 per cent), alcohol (13 per cent) and benzodiazepines (9 per cent), and more than half (57 per cent) involving combinations of substances (Ledlie et al., 2025; Ontario Drug Policy Research Network, 2024). Policy changes and disparities in service access (see section on Policy Considerations) have added structural barriers that further increase risks for people who use drugs (Chief Medical Officer of Health [Ontario], 2024; Ontario Drug Policy Research Network, 2025).

TOWARDS SOLUTIONS

The toxic drug crisis is the most visible manifestation of these forces, but SUH risks touch a much broader population. Most people who use substances do so without developing a substance use disorder (Chief Medical Officer of Health [Ontario], 2024) but are still exposed to risk as a result of the forces above. In addition, SUH risks are not limited to criminalized substances (CSUCH, 2023). In recognition of this, Ontario's Chief Medical Officer of Health (2024) has called

for an all-of-society, health-first approach to substance use that offers evidence-based interventions spanning prevention and health promotion, harm reduction, and treatment and recovery. The report recognizes that within this context, specific populations, including 2SLGBTQ+, Indigenous communities, and youth, need focused attention. This Health in Focus expands on that call, presenting an overview of SUH needs and care considerations across the spectrum of services, with particular attention to harm reduction, which by its nature is often affirming and non-judgmental (Paschen-Wolff et al., 2024) and where the opportunity for meaningful intervention is most concentrated.

SUBSTANCE USE IN THE 2SLGBTQ+ COMMUNITY

2SLGBTQ+ populations are commonly found to use substances at higher rates than their cisgender, heterosexual counterparts (Bellows et al., 2025; Connolly et al., 2020). The most recent Canadian Substance Use Survey shows up to four times higher substance use rates among 2SLGBTQ+ than non-2SLGBTQ+ respondents, with the greatest disparities for past-year use of stimulants (17 per cent vs. 4 per cent), illegal substances (21 per cent vs. 6 per cent) and polysubstance use (51 per cent vs. 26 per cent) (Health Canada, 2025). These patterns expose 2SLGBTQ+ people to greater risks and harms, including risk of developing substance use disorders (Eccles et al., 2024; Hughto et al., 2021) and acute emergencies (Dusing et al., 2024).

Despite this elevated risk, little is known about 2SLGBTQ+-specific SUH outcomes. Health outcome and overdose statistics are often not disaggregated by sexual orientation or gender identity (SOGI), and small study samples often lead to data suppression, making 2SLGBTQ+ people effectively invisible in monitoring efforts and service development (Moazen-Zadeh et al., 2019; Paschen-Wolff et al., 2023). Nonetheless, some common themes are apparent from the data and are described below.

DRIVERS OF RISKS AND HARMS

For 2SLGBTQ+ populations, risk factors described in the previous section are amplified by the intersection with additional forces unique to this group.

Minority Stress

The most common explanatory framework for these disparities is minority stress (Meyer, 2003), which describes the chronic psychological strain from stigma, discrimination, identity concealment, expectations of rejection and internalized negativity that 2SLGBTQ+ often experience. In the presence of minority stress, the substance use and risk drivers described in the previous section are compounded and amplified, resulting in disparities. For example, 2SLGBTQ+ people experience higher rates of adverse childhood experiences, violence and trauma throughout their lives, including family rejection and identity-based violence, and report using substances to cope (Chief Medical Officer of Health [Ontario], 2024; Dowling et al., 2023). In a Canadian study, sexual minorities were more than twice as likely as heterosexual people (24 per cent vs 10 per cent), and transgender people more than three times as likely as cisgender people (36 per cent vs 11 per cent), to use drugs or alcohol to cope with violence and victimization (Jaffray, 2020). Substance use has also been linked to internalized negativity, such as shame,

self-rejection, and diminished self-worth associated with internalized homophobia (Huynh et al., 2022).

Higher rates of co-occurring mental health conditions, themselves often driven by minority stress, further increase vulnerability as both a driver and consequence of substance use (Chief Medical Officer of Health [Ontario], 2024).

Structural Drivers

These risks are compounded by structural forces that disproportionately affect 2SLGBTQ+ people (Elliott, 2023; Henderson et al., 2022). Identity-related discrimination in employment, housing, and healthcare contribute to social and economic marginalization, known to drive substance use. 2SLGBTQ+ people are also disproportionately impacted by drug criminalization as contact with the criminal legal system further entrenches social and economic marginalization. Together this contributes to the over-representation of 2SLGBTQ+ people in precarious employment such as survival sex work, further increasing SUH and other health risks.

2SLGBTQ+ people with additional marginalized identities (e.g., racialized or Indigenous) face multiple, overlapping forms of discrimination that further increase SUH risks (Gitelman et al., 2025; Schilt-Solberg et al., 2025) (for broader context, see Health in Focus: Racialized 2SLGBTQ Health). For example, a study found significant heavy drinking disparities by sexual orientation among racialized but not white Canadians (Gitelman et al., 2025). Disparities are also further intensified during times of added stress, as was seen during the COVID-19 pandemic (CCSA & MHCC, 2020; Goodyear et al., 2021; Slemon et al., 2022).

Cultural Drivers

Substance use in 2SLGBTQ+ communities is not solely about coping with adversity. Much of it is normative, social and woven into community life and spaces, where it is closely tied to identity, relationships and belonging (Elliott, 2023; Queer & Trans Health Collective, 2023) - an important protective factor for SUH risks.

In 2SLGBTQ+ communities, substance use can be social and embedded in community life and spaces.

However, some community-embedded practices can also increase risks. For example, polysubstance use is more common among 2SLGBTQ+ people (Cascalheira et al., 2023), and practices such as sexualized drug use or equipment sharing among friends or sexual partners, which can be integral to the social experience, can create additional health risks, including transmission of sexually transmitted and blood-borne infections (STBBIs; discussed in more detail below) (Elliott, 2023; Queer & Trans Health Collective, 2023). Understanding that the same community contexts can be simultaneously protective and harmful is essential for providing effective support.

BARRIERS TO SUH CARE

Together these forces create syndemic conditions (Singer et al., 2017), referring to the overlapping and reinforcing challenges including substance use, mental health concerns, trauma and violence, STBBI risk, housing instability and economic marginalization

that increase harm and make recovery more complex. Few services are designed to address the intersection of these co-occurring and mutually reinforcing conditions (Milaney et al., 2022), creating fragmented systems of care that only ever partially address people's SUH goals.

Within these systems, 2SLGBTQ+ people who use substances face additional barriers. These include access barriers, with cost, wait times and location creating obstacles for those that are already socioeconomically marginalized, and criminalization creating additional safety and trust concerns, particularly for those that engage in sex work or have prior contact with the legal system (Elliott, 2023).

Providers who understand the full context of why 2SLGBTQ+ people use substances are better positioned to offer care that resonates.

Among 2SLGBTQ+ people, anticipation or experiences of discrimination, stigma and refusal of care lead to delays in accessing health services or service avoidance (Comeau et al., 2023). For 2SLGBTQ+ people who use substances, this experience is intensified by double stigma (Xin et al., 2023). Substance use services may lack 2SLGBTQ+-affirming approaches, while 2SLGBTQ+ services may not address substance use, and some services are not equipped to address either. This has been associated with poorer treatment outcomes and early dropout, particularly among trans and gender-diverse (TGD) people and those with multiple marginalized identities (Xin et al., 2023). Providers who understand the full context of why 2SLGBTQ+ people use substances, including pleasure, connection and community belonging alongside coping and survival, are better positioned to offer care that resonates and that people will return to.

However, as a function of the data gaps and paucity of research, it is not entirely clear what 2SLGBTQ+-affirming SUH care even looks like (Kidd et al., 2022; Moazen-Zadeh et al., 2019; Paschen-Wolff et al., 2023).

POPULATION-SPECIFIC CONSIDERATIONS

Within this context, there are important variations between 2SLGBTQ+ populations (Ruppert et al., 2020; Ruppert et al., 2021), creating unique SUH needs for each. The following sections address considerations for specific groups.

PEOPLE WHO ENGAGE IN CHEMSEX AND/OR ARE AT RISK FOR STBBIS

SUH and sexual health are closely linked for many 2SLGBTQ+ people who use drugs (for broader context see Health in Focus, 2SLGBTQ+ Sexual Health), creating unique care considerations and pathways.

People who engage in Chemsex/Party and Play (PnP)

Chemsex or Party and Play (PnP) refers to the use of substances before or during sex to facilitate, prolong, or enhance the encounter (CATIE, 2019; Elliott, 2023; Rapid Response Service, 2025). Chemsex is most commonly associated with gay, bisexual, trans, and/or queer men who have sex with men (MSM),

but it is not exclusive to these groups, and not everyone in these groups participates. It is often organized through specific physical and digital spaces, including apps, clubs, and bathhouses.

Chemsex can strengthen social bonds and community belonging.

Chemsex promotes pleasure, intimacy, and sexual confidence, and participation can strengthen social bonds and community belonging (Elliott, 2023; Rapid Response Service, 2025; Queer & Trans Health Collective, 2023). Despite the benefits, chemsex practices can also increase risks (Elliott, 2023; Rapid Response Service, 2025; Queer & Trans Health Collective, 2023). Chemsex has been associated with higher-risk sexual practices, including condomless sex and multiple partners, which can increase exposure to HIV and other STBBIs. It has also been associated with higher-risk substance use practices such as equipment sharing (Queer & Trans Health Collective, 2023) which can add to this risk. People who engage in chemsex may also have less access to harm reduction supports, as physical spaces may not have them available and some virtual spaces have banned discussion of substances (Elliott, 2023). Sexual violence and consent concerns can also occur in these settings, including situations where drugs are administered without consent (Rapid Response Service, 2025).

Substances commonly used during chemsex, including methamphetamine, gamma-hydroxybutyrate (GHB; a depressant), and alkyl nitrites (“poppers;” a vasodilator) among others, also have specific risks (Elliott, 2023; Rapid Response Service, 2024, 2025). Methamphetamine in particular has been associated with health impacts including psychosis, especially when injected (“slamsex”) (Rapid Response Service, 2024), and combining multiple depressants, such as GHB and alcohol, can increase overdose risk. These risks are compounded by prohibition (Schwartz et al., 2023) and reliance on the unregulated drug supply, where stimulants, opioids, and depressants can unexpectedly co-occur (CATIE, 2025).

People at Risk for STBBIs

STBBI transmission risk in the context of substance use extends beyond sexualized drug use. HIV and hepatitis C can be transmitted through shared drug use equipment (CATIE, 2020), but knowledge around this is uneven. In one survey of 2SLGBTQ+ people who use substances, 81 per cent of respondents knew the risks of sharing injection equipment, but awareness dropped to 62 per cent for inhalation equipment and 58 per cent for snorting equipment, and the large majority who shared equipment did not ask about disease status beforehand (Queer & Trans Health Collective, 2023). Uptake of prevention measures such as HIV pre-exposure prophylaxis (PrEP) is also low compared to people who engage in chemsex, even though it has been shown to be effective, a missed opportunity for substance use harm reduction (CATIE, 2024).

Considerations for Care

For people who engage in chemsex, culturally competent care starts with understanding that substance use and sexual and social life cannot be decoupled; changing one element would mean changing the others, which is not

always desired or possible. This makes harm reduction a more resonant approach than abstinence-based approaches for this group. It also includes understanding and addressing the different sources of stigma impacting this group, including identity-based stigma from healthcare providers, substance use stigma from 2SLGBTQ+ service providers, and combined stigma from within the 2SLGBTQ+ community itself.

Providers working with this population also need familiarity with the specific substances involved and associated harm reduction strategies, as well as potential interactions of these substances with antiretroviral medications. Providers should also understand the role that apps and physical spaces play in their clients' lives, as these are both where risk occurs and where interventions can reach people.

Across all 2SLGBTQ+ people who use substances, sexual health interventions (e.g., PrEP, STBBI screening) should be treated as directly relevant to their SUH goals (CATIE, 2024), and integrating SUH and sexual health could decrease the burden of navigating separate systems that may not be equipped to address their intersection. Integrated services have long been requested and shown to be feasible (Coulaud et al., 2024; Salway et al. 2019) but remain rare in Canada.

BISEXUAL AND OTHER NON-MONOSEXUAL PEOPLE

Bisexual people and others with multi-gender attractions (e.g., pansexual, queer, fluid) often have substance use rates that exceed not only heterosexual but also gay and lesbian populations (Ford et al., 2023). Bisexual individuals have the highest prevalence of lifetime alcohol use and heavy episodic drinking (Shokoohi et al., 2022), but disparities are also seen for other substances as well as polysubstance use (Ford et al., 2023; Paschen-Wolff et al., 2023; Schuler & Collins, 2020). This puts bisexual/non-monosexual people, and especially women, at high risk of substance-related harms. In an Ontario study, bisexual women had more than twice the risk of alcohol and substance-related hospitalization compared to heterosexual women, a difference that was not seen for lesbian women (Dusing et al., 2024). Disparities are even greater for people with intersecting marginalized identities, with one study showing significantly more heavy drinking among racialized bisexual/pansexual women than racialized heterosexual women, a disparity that was not seen among white women (Gitelman et al., 2025).

These patterns reflect minority stress that is distinct from that experienced by gay and lesbian people (Ford et al., 2023). Bisexual/non-monosexual people face discrimination from both heterosexual and gay/lesbian communities, rooted in negative stereotypes, stigma and identity invalidation (biphobia or bi-negativity), and these attitudes often become internalized. Erasure in both 2SLGBTQ+ and mainstream spaces and lack of social support and community infrastructure compared to gay and lesbian communities compounds these stressors, increasing vulnerability to substance use as a coping strategy (Ford et al., 2023; Schuler & Collins, 2020).

In addition, certain upstream drivers of substance use are more prominent among bisexual/non-monosexual people. For example, the link between adverse childhood experiences and substance use is stronger for bisexual

people than other sexual minorities (Dowling et al., 2023), and bisexual women experience elevated rates of interpersonal violence and sexual assault compared to both heterosexual and lesbian women (Ford et al., 2023). On the 2018 Survey of Safety in Public and Private Spaces, almost two-thirds (62 per cent) of non-monosexual people reported having been victimized since age 15, and among those reporting lifetime abuse or violence, 29 per cent reported using substances to cope, compared to 18 per cent of gay/lesbian and 10 per cent of heterosexual people (Jaffray, 2020). Among sexual minorities, bisexual people, especially women, also show the highest rates of co-occurring mental health challenges (Bellows et al., 2025; Salway et al., 2024), further compounding SUH vulnerabilities.

Considerations for care

Bisexual/non-monosexual people are largely invisible within health systems, creating fundamental barriers to affirming and effective care (Schuler & Collins, 2020; Shokoohi et al., 2022). Most 2SLGBTQ+-specific interventions do not distinguish their needs from those of gay and lesbian populations, and providers may not recognize bisexual/non-monosexual people as a distinct high-risk population.

Culturally competent SUH care involves recognizing bisexuality as its own identity with its own risk patterns, including biphobia, identity erasure and social exclusion, and not assuming it is equivalent to gay/lesbian or heterosexual experiences. Given elevated and distinct risks, especially higher rates of alcohol use, trauma and co-occurring mental health challenges, screening bisexual/non-monosexual people for these specific conditions allows for more effective and tailored care.

TRANS AND GENDER-DIVERSE PEOPLE

TGD people experience some of the greatest SUH disparities within 2SLGBTQ+ communities. Prevalence rates are higher than among cisgender people (Connolly & Gilchrist, 2020), as are rates of substance use disorders and other SUH complications (Eccles et al., 2024; Paschen-Wolff et al., 2023; Ruppert, Kattari & Sussman, 2021). Gaps in measurement and under-reporting may mean that currently available studies underestimate the full burden, and disparities are only expected to intensify as transphobic rhetoric rises (Connolly et al., 2025).

Disparities have been linked to negative attitudes, discrimination and hostility towards TGD people (transphobia or transnegativity), especially toward those with high visual gender non-conformity, along with mental health co-occurrence, economic and housing instability, and sex work (Connolly & Gilchrist, 2020). Transphobia operates at multiple levels, ranging from misgendering and harassment to exclusionary policies and hostile social climates (Henderson et al., 2022; Ogarrio et al., 2025), and includes uniquely high rates of violence. On the Canadian Survey of Safety in Public and Private Spaces, 59 per cent of TGD respondents reported lifetime violent victimization compared to 37 per cent of cisgender respondents, and among respondents with lifetime experiences of abuse or violence, 36 per cent of TGD people reported using substances to cope, compared to 11 per cent of cisgender people (Jaffray, 2020). Transphobic violence is a lifelong risk factor, with school-based victimization, bullying and discrimination already linked to substance use disparities among TGD youth (Fahey et al., 2023). Internalized

transnegativity, gender dysphoria and chronic vigilance create additional internal stressors that further compound risk (Connolly & Gilchrist, 2020; Henderson et al., 2022; Mammadli et al., 2025). These stressors also contribute to exceptionally high rates of co-occurring mental health conditions, with 64 per cent of TGD adults in a Canadian sample reporting lifetime depression and 73 per cent lifetime anxiety, compared to 14 per cent each in their cisgender counterparts (Eccles et al., 2024).

Structural barriers contributing to substance use in this group include high rates of housing instability and economic marginalization, driven by cisnormative employment and housing systems; this results in overrepresentation in survival economies such as sex work, which further increases SUH and other health risks (Connolly & Gilchrist, 2020; Henderson et al., 2022). Criminalization (of both substance use and sex work) and incarceration compound these pathways, further driving SUH disparities (Elliott, 2023).

Structural barriers contributing to TGD substance use include high rates of housing instability and economic marginalization.

As a unique opioid risk, TGD people may also experience chronic pain at higher rates than cisgender people and are more likely to receive opioid prescriptions following gender-affirming surgery (Paschen-Wolff et al., 2023).

Considerations for care

Services tailored to TGD needs are rare (Glynn & van den Berg, 2017), and anticipated and experienced discrimination creates barriers to accessing services that do exist (Xin et al., 2023) – a dynamic that itself can increase substance use (Kidd et al., 2021). Fragmented care compounds these barriers: services that address substance use in isolation, without attending to the full syndemic context of TGD lives, may reduce engagement by failing to meet people where they actually are.

When TGD people do access treatment, stigma and transphobia within treatment settings can drive premature departure (Lyons et al., 2015; Xin et al., 2023). This includes misgendering by staff and peers, forced use of facilities inconsistent with gender identity, stigma toward sex work, and a lack of understanding of the structural reasons why TGD people use substances. The inverse matters equally: when gender identity is affirmed and respected, TGD people report positive treatment experiences and are more likely to complete care.

Providers working with TGD clients require specific clinical competencies. For example, some commonly used alcohol screening tools rely on cut-off scores that were not designed with transgender populations in mind and require awareness of limitations (Dermody et al., 2023). Providers also need competency around gender-affirming hormones, including awareness of potential interactions with substances and the need for continued access during substance use treatment (Girouard et al., 2019).

Understanding the structural drivers of TGD substance use, including housing instability, sex work involvement and cumulative trauma,

can also help providers offer contextually appropriate and comprehensive care, while integrating substance use services with gender-affirming healthcare can further reduce fragmentation and improve engagement (Elliott, 2023).

TWO SPIRIT AND INDIGENOUS LGBTQ+ PEOPLE

For Two Spirit and Indigenous LGBTQ+ people, SUH must be understood in the context of the historical and ongoing impacts of colonization and structural racism that already drive SUH disparities among Indigenous peoples (Canadian Aboriginal AIDS Network & Interagency Coalition on AIDS and Development, 2019; Public Health Ontario & Indigenous Primary Health Care Council, 2023). Within this context, harms for Two Spirit and LGBTQ+ people are compounded by colonial suppression of diverse Indigenous understandings of gender and sexuality, layering additional identity-specific trauma onto existing harms (Beaudry et al., 2024; BlackDeer, 2025; Dykhuizen et al., 2022; Robinson, 2022) (for broader context, see Health in Focus: Racialized 2SLGBTQ Health).

Available evidence on Two Spirit and Indigenous LGBTQ+ SUH is limited and often qualitative (Dykhuizen et al., 2022; Robinson, 2022). Even so, the data show a consistent pattern of elevated substance use, driven by high burdens of violence, trauma and unmet mental health needs (Dykhuizen et al., 2022; Elliott, 2023; Robinson, 2022). This includes high rates of physical assault, sexual assault and childhood abuse among Two Spirit compared to cisgender/heterosexual Indigenous people (Beaudry et al., 2024; Robinson, 2022). Experiences of family or community rejection following disclosure of gender or sexual identity (itself a legacy of colonialism) further compound substance use risk through social isolation and distress (Dykhuizen et al., 2022; 2-Spirited People of the 1st Nations, 2024; Robinson, 2022).

DEFINING TWO SPIRIT

Two Spirit is a pan-Indigenous umbrella term describing diverse identities and roles related to gender, sexuality, and spirituality outside Western colonial LGBTQ+ frameworks; not all Indigenous LGBTQ+ people use the term (Dykhuizen et al., 2022).

Economic marginalization compounds these risks. The majority of Two Spirit urban populations live below low-income thresholds and face high unemployment (Robinson, 2022), while punitive drug laws contributing to over-representation in carceral systems and reliance on survival economies deepen this instability. Together these factors drive vulnerability to both higher-risk substance use and service avoidance (Beaudry et al., 2024; Elliott, 2023; 2-Spirited People of the 1st Nations, 2024).

Two Spirit and Indigenous LGBTQ+ people also face compound stigma that can create a substance use “service desert”: lack of Indigenous cultural awareness in mainstream services, along with homophobia or transphobia in some Indigenous services and settings, means no setting may feel fully safe (BlackDeer, 2025; Elliott, 2023; Robinson, 2022). Connection to culture, ceremony, traditional practices and land-based activities are consistently identified as protective, and most Two Spirit people report cultural belonging

and ceremony participation as central to healing (Dykhuizen et al., 2022; Robinson, 2022). However, feeling unwelcome in these spaces due to sexual or gender identity can create barriers and disconnection, adding substance use risk factors. Physical barriers including remote locations, transportation and cost compound this further (2-Spirited People of the 1st Nations, 2024; Robinson, 2022; Community-Based Research Centre, 2025), leaving many poorly served by all available systems.

Considerations for care

Effective SUH care for Two Spirit and Indigenous LGBTQ+ people must be simultaneously culturally safe for Indigeneity and affirming of diverse genders and sexualities. Providers should not assume that Indigenous services or 2SLGBTQ+ services automatically meet both needs. Since many services do not, Two Spirit and Indigenous LGBTQ+ people report avoiding services or delaying access to avoid racism, discrimination or judgment, while confidentiality concerns in smaller communities further discourage engagement (Dykhuizen et al., 2022; Elliott, 2023; Robinson, 2022).

To improve service access, providers need to understand how colonial trauma, identity loss and structural deprivation shape substance use and address it in the historical and structural context that drives it (Beaudry et al., 2024) (for guidance on cultural humility see *Health in Focus: Racialized 2SLGBTQ Health*). 2SLGBTQ+ organizations may play an especially important role in improving access to care: in one Canadian sample, Two Spirit and Indigenous LGBTQ+ people reported low trust in healthcare and government systems but high trust in 2SLGBTQ+ organizations (Community-Based Research Centre, 2025), suggesting that community-based collaboration is essential.

The most effective approaches to SUH care for Two Spirit and Indigenous LGBTQ+ people are Indigenous- and Two Spirit-led, recognizing land-based activities and traditional healing as legitimate approaches while also affirming diverse genders and sexualities (2-Spirited People of the 1st Nations, 2024). Effective approaches must also provide wraparound supports for housing, mental health and other social determinants (Public Health Ontario & Indigenous Primary Health Care Council, 2023). This means approaching harm reduction as “not just needles and naloxone” but an opportunity for decolonization and connection (Canadian Aboriginal AIDS Network & Interagency Coalition on AIDS and Development, 2019; Elliott, 2023). Addressing substance use without restoring or affirming Two Spirit and Indigenous LGBTQ+ identities risks reproducing colonial harms.

2SLGBTQ+ YOUTH

Youth is a critical period for SUH because identity development, experimentation and substance use initiation often co-occur and patterns established during this time can shape lifelong health trajectories. Compared to cisgender and heterosexual peers, 2SLGBTQ+ youth are more likely to initiate substance use and to do so earlier (Mereish, 2019). For example, across Canada, twice as many 2SLGBTQ+ students in Grades 7 to 12 have used an illegal drug as their non-2SLGBTQ+ peers (13 per cent vs. six per cent) (Health Canada, 2025). These disparities are especially pronounced for TGD youth and those with intersecting identities (Fahey et al., 2023; Taylor et al., 2020). 2SLGBTQ+ youth also show elevated rates of polysubstance

use and prescription drug use (Taylor et al., 2020; Varatharajan et al., 2024), adding risk in the context of the toxic drug supply.

For 2SLGBTQ+ youth, SUH risks are shaped by the environments they are exposed to the most, including school, peer and family environments. Peer-peer interactions (both positive and negative) can mediate substance use initiation or escalation (Brown et al., 2024), and where social connections are unavailable, isolation can increase reliance on substances for relief or connection (Mereish, 2019). In addition, negative interactions including bullying, assault and victimization are linked with increased substance use risk and poorer mental health, and internalized negativity can further compound these risks, particularly among TGD youth (Brown et al., 2024; Kingsbury & Findlay, 2024; Mammadli et al., 2025; Watson et al., 2019). Conversely, school connectedness and safety, social support groups, and affirmative community supports are protective (Fahey et al., 2023; Varatharajan et al., 2024; Watson et al., 2019).

Family rejection can add stressors that increase substance use amongst 2SLGBTQ+ youth.

Family dynamics, and specifically family rejection, can add stressors that increase substance use (Brown et al., 2024; Mereish, 2019), while family connectedness is associated with lower substance use rates (Varatharajan et al., 2024). Family rejection also contributes to homelessness and housing instability. A study of TGD youth found that 15 per cent had run away from home at least once (Taylor et al., 2020), and 2SLGBTQ+ youth are overrepresented among youth experiencing homelessness, where substance use is both a reason for and consequence of homelessness (Abramovich et al., 2024; Kidd et al., 2022).

Considerations for care

2SLGBTQ+ youth face unique family, peer and life stage dynamics that shape SUH, meaning SUH care must be tailored to their context and adult approaches may not transfer. For example, normative exploration and identity formation make abstinence-only approaches unlikely to resonate and could instead drive concealment (Mammadli et al., 2025; Quinn et al., 2025). This makes harm reduction an important approach, although youth may face barriers to access such as age restrictions, confidentiality concerns and limited youth-tailored options. Youth-led, culturally competent models are emerging but remain limited (Mammadli et al., 2025; Quinn et al., 2025).

In addition, family dynamics can shape access to care, as consent, confidentiality and parental involvement requirements can create barriers and deter help-seeking, particularly where family rejection is a factor. In an Ontario study of TGD youth, 35 per cent of those who needed mental health care avoided seeking it specifically because they did not want parents to know (Taylor et al., 2020). Where family rejection is a factor, models that require parental involvement can deter help-seeking and may not be experienced as supportive.

IMPLICATIONS FOR SERVICE PROVIDERS

Effective support for 2SLGBTQ+ people who use substances requires fluency in both non-stigmatizing SUH care and 2SLGBTQ+-affirming care, and the ability to deliver them together (Chief Medical Officer of Health [Ontario], 2024; Elliott, 2023; Paschen-Wolff et al., 2024; Xin et al., 2023). This is consistent with Ontario's Chief Medical Officer of Health's (2024) call for culturally competent, trauma-informed care that meets people where they are and offers better screening, low-barrier treatment and harm reduction access.

At the provider level, this means building competency on the full breadth of the SUH spectrum and drivers of risks (particularly structural drivers and criminalization), alongside minority stress, compound stigma and the functions substances serve for 2SLGBTQ+ people. Providers with these competencies will be better positioned to understand clients' self-determined SUH goals, including goals other than abstinence, and to discuss sexuality and substance use together where they intersect.

At the practice level, screening and referrals should be comprehensive, addressing trauma history, violence exposure, mental health concerns, housing and economic stability, and social support alongside substance use patterns and goals, as these are often co-occurring considerations in 2SLGBTQ+ populations, which interact in complex ways and cannot be understood or addressed in isolation. Clinical decisions should also take into account any potential interactions between substances and hormone therapy or antiretroviral treatment, and rapidly shifting drug-interaction and risk profiles shaped by the ever-changing unregulated drug supply.

RECOMMENDED RESOURCES

- National 2S/LGBTQIA+ Substance Use Study: https://www.ourhealthyeg.ca/research/national-2slgbtqia-substance-use-study
- CATIE harm reduction resources: https://www.catie.ca/prevention-harm-reduction/general-harm-reduction
- CAMH Take Pride: https://www.camh.ca/en/health-info/guides-and-publications/substance-use-issues-to-consider-for-the-lgbtttiq-communities
- Party and play (GMSH): https://partyandplay.info/
- Max Ottawa Substance Use Support: https://maxottawa.ca/programs-and-services/substance-use-support/
- Connection, Care, Community: https://www.hivlegalnetwork.ca/site/connection-care-community
- CBRC Our Stats Dashboard: https://www.cbrc.net/ourstats_dashboard

At the organizational level, essential components of affirming care include enforced non-discrimination policies, tailored programming, regular staff training, collection of SOGI data, visible affirming cues and gender-affirming facilities (Paschen-Wolff et al., 2024). Program design, delivery and evaluation should involve the communities being served, including 2SLGBTQ+ people with lived experience of substance use, and should integrate Indigenous principles and frameworks where appropriate. Peer-led and peer-delivered support could be an especially lower-barrier modality for care.

Services are most effective when they integrate substance use health with sexual health, mental health and gender-affirming care.

At the systems level, services are most effective when they integrate SUH with sexual health, mental health and gender-affirming care rather than requiring people to navigate fragmented systems. In addition, services that include supports for structural barriers to the social determinants of health, including housing and economic supports, will more comprehensively address syndemic conditions. Making harm reduction information and materials easily accessible in 2SLGBTQ+ community spaces (both physical and virtual) will also extend their reach to where they might be particularly needed. 2SLGBTQ+-led community organizations and peer networks are essential partners in this work.

While tailored services are a key recommendation, lack of data limits their development (Glynn & van den Berg, 2017; Kidd et al., 2022; Milaney et al., 2022; Moazen-Zadeh et al., 2019). Routine collection of SOGI data in substance use research, surveillance and service evaluation will strengthen the evidence base for population-specific care.

POLICY CONSIDERATIONS

Service providers across the SUH continuum (prevention, harm reduction, treatment and recovery) are delivering care within a rapidly changing policy and service landscape. Across Ontario, services are fragmented, unevenly distributed geographically, and difficult to access, with long wait times, cost barriers and few options for youth (Ali et al., 2025; Chief Medical Officer of Health [Ontario], 2024; Ontario Drug Policy Research Network, 2023). Recent provincial legislation has further reduced access and created critical service gaps; specifically, Bill 223 (Safer Streets, Stronger Communities Act, 2024) restricts where harm reduction services can operate and limits municipal ability to pursue new sites and supports. This has contributed to service closures, significantly increasing SUH risks and limiting referral pathways for those relying on them (Ontario Drug Policy Research Network, 2025), and replaced them with abstinence-based approaches that are not aligned with everyone's SUH goals and needs.

For 2SLGBTQ+ people, who already face greater barriers to services and higher rates of substance use, these restrictions are compounded by additional gaps: funding for 2SLGBTQ+-specific substance use programming remains short-term and precarious, and federal and provincial strategies on substance use and STBBIs have not adequately addressed the specific needs of 2SLGBTQ+

people who use drugs (Elliott, 2023; HIV Legal Network, 2024). For some 2SLGBTQ+ people, shifts toward abstinence-first or coerced approaches may also raise particular safety and trust concerns given histories of pathologizing and forced interventions.

Ontario's Chief Medical Officer of Health (2024) has called for an approach that includes decriminalization of simple possession, expansion of harm reduction services, enhanced treatment access, diversion from the criminal justice system, sustained funding, and efforts to address structural stigma. Strengthening the response for 2SLGBTQ+ communities specifically also requires that relevant government strategies explicitly incorporate 2SLGBTQ+ SUH needs, and that sexual orientation and gender identity data be routinely collected in substance use surveillance and outcome reporting so that these needs become visible and actionable (HIV Legal Network, 2024). Sustained funding, integrated services and evidence-based approaches grounded in autonomy and dignity would give providers the conditions they need to deliver the care described in this document.

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