Criminalization and Care: The Limits of a Public Health Approach to Addressing Drug Use

by

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Abstract

The attempt by public health programs to reduce harm from illicit drug use faces several barriers, particularly structural barriers stemming from the ongoing criminalization of drug use. The ways in which structural barriers impact the uptake and implementation of key harm reduction programs is an ongoing area of concern, particularly as Canada faces a devastating opioid overdose crisis. Using ethnographic observation and qualitative interviews, this dissertation examines a harm reduction intervention where the homes of people who use drugs become 'satellite' harm reduction programs – the Satellite Sites. This program uses well-known community members as harm reduction workers to provide harm reduction education and equipment directly in the community settings where people gather to buy, use, and sell drugs. The Satellite Sites straddle two worlds: they are sites of illicit and stigmatized activities, while also being sites of public health intervention. Satellite Sites are partially medicalized due to their association with the community health centre running the program. However, the continued criminalization of drug possession and distribution negatively impacts the uptake and effectiveness of public health recommendations within the Satellite Sites. Overdose education and naloxone distribution campaigns provide an example of how criminalization negatively impacts on uptake of public health recommendations. These campaigns aim to prevent morbidity

and mortality from opioid overdose, and findings show that naloxone access is lifesaving. However, these programs may inadvertently exacerbate structural vulnerabilities among people who use drugs, including vulnerability to housing loss and negative emotional impacts from responding to multiple overdoses. This dissertation also explores practices of care among a criminalized group: people who sell drugs. The Satellite Site program employs people who sometimes sell drugs as harm reduction workers, rendering their practices of care visible. The integration of people who sell drugs into harm reduction programming remains underexplored, and may hold promise in addressing high overdose death rates. While the Satellite Sites extend harm reduction into the spaces in the community where people gather to use drugs, criminalization exacerbates existing structural vulnerabilities among people who use drugs, and impedes the attempt of public health programming to intervene to reduce drug-related harms.

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Chapter 1
Introduction

1.1 Background

The associations between drug use and negative health outcomes, such as HIV, hepatitis C, and overdose, have been readily documented (Ciccarone, 2019; Colledge et al., 2019; Degenhardt & Hall, 2012; Degenhardt et al., 2017). Public health interventions based in harm reduction principles intervene to prevent the transmission of HIV and bloodborne viruses like hepatitis B and C (Fernandes et al., 2017; Ritter & Cameron, 2006; Wodak & Cooney, 2006). The efficacy of harm reduction interventions such as needle and syringe distribution programs, outreach activities and supervised consumption services at achieving public health goals has been widely documented (Degenhardt et al., 2010; Fernandes et al., 2017; Hagan, Pouget, & Jarlais, 2011). However, people who use drugs (PWUD) are often hesitant to approach harm reduction programs due to fears of stigmatization, detection by law enforcement and inaccessibility of services (Anderson, Clancy, Flynn, Kral, & Bluthenthal, 2003; Bryant & Hopwood, 2009; McNeil, Kerr, Lampkin, & Small, 2015).

Harm reduction interventions are implemented in policy and legal environments where the use of illicit drugs remains criminalized, and where people who use and sell drugs are subjected to criminal penalties. Criminalization creates complexities as public health and harm reduction programs attempt to implement measures to reduce the negative health consequences of drug use. The policing that accompanies the enforcement of criminal laws surrounding drug use has been shown to contribute both to the negative health outcomes experienced by PWUD (Debeck et al., 2017; Werb et al., 2011; 2008), as well as to difficulties in ensuring access to harm reduction services (Bardwell, Strike, Altenberg, Barnaby, & Kerr, 2019; Cooper, Moore, Gruskin, & Krieger, 2005). This dissertation examines some of the tensions and complexities that emerge from the attempt to deliver public health and harm reduction interventions to PWUD in a larger structural environment that is dominated by criminalization of drug use.

Using ethnographic observation and qualitative interviews, this dissertation examines the delivery of a harm reduction intervention within criminalized environments and with populations

of people frequently subjected to criminalization, to examine the issues involved in program delivery in environments dominated by drug prohibition. The Satellite Site program is a harm reduction intervention that was developed by and for PWUD, which distributes harm reduction equipment, supplies, and education within community settings where people gather to buy, use and sell drugs. The Satellite Site program hires well-known community members as Satellite Site workers (SSWs), and the Satellite Sites are often the homes of the SSWs. Delivering harm reduction services directly in the community settings where people gather to buy, use, and sell drugs, and using well-known community members as harm reduction workers is an attempt to increase the accessibility of harm reduction services among a group of PWUD who may not be accessing more formal harm reduction programming (Strike & Kolla, 2013). However, it also introduces constraints to the delivery of these services due to the criminalization of drug use. The Satellite Sites straddle two worlds: they are sites of illicit and stigmatized activities, while also being sites of public health intervention.

This introductory chapter begins with an examination of the harm reduction landscape in Canada, and how the development of the Satellite Site program emerged from and fits into this landscape. I also focus specifically on the role of peers within harm reduction programming, and the development of secondary syringe exchange, as these two elements of harm reduction service delivery are key to the approach used by the Satellite Site program. Next, the literature on risk environments and safer environment interventions is reviewed to show how Satellite Site program is a safer environment intervention that attempts to intervene on a particular risk environment. Finally, a brief review of the impacts of criminalization on the health of PWUD is provided. The Satellite Site program is then described, followed by the rationale for the study and an overview of the chapters to follow. But first, the research questions are presented.

1.2 Research Questions

The research questions for this study were:

> 1) How has the process of medicalization occurred within the Satellite Sites? How does medicalization interact with the criminalization that SSWs are subject to as they attempt to deliver a public health intervention?

2) How does the attempt by public health authorities to mitigate the harms from overdose through overdose education and naloxone distribution (OEND) programs intersect with the structural vulnerabilities faced by SSWs, particularly those that intersect with the criminalization of drug use?

3) How can people who sell drugs be integrated into harm reduction interventions?

These research questions will be examined in detail in the chapters that follow, using ethnographic and qualitative methods including participant observation within the Satellite Sites, and interviews with clients, SSWs, and staff at the community health centre that runs the Satellite Site program. Additionally, following preliminary analysis of the data collected, a focus group was held with the SSWs and staff members who were part of the project advisory committee. This focus group functioned as a form of member-checking, where initial themes and preliminary findings were presented to participants, to allow for discussion, development, and refinement of the themes. A detailed description of the relevant methods employed are presented in each of the chapters.

1.3 Impacts of People Who Use Drugs on the Development of Harm Reduction Programming

Harm reduction programs and interventions have been developed and deployed by public health authorities as an attempt to intervene and promote the health of PWUD in environments dominated by criminalization (Csete, 2016). There are many examples of harm reduction programs that are now well-accepted as public health interventions, but that began as survival strategies among PWUD that were then adopted, adapted, and frequently medicalized by public health authorities. For example, needle and syringe distribution programs (NSP) are a key public health intervention for PWUD that were first started by people who injected drugs in the Netherlands in the 1980's to address the threat of hepatitis B transmission (Friedman et al., 2007). As injection drug use came to be recognized as a prime method for the transmission of HIV (and later, hepatitis C), people who inject drugs (PWID) were recognized as a population heavily affected by these infections. NSPs were gradually scaled up, first by people who inject

drugs and their allies, and later by public health authorities as a method of reducing the transmission and burden of these diseases (Friedman et al., 2007).

Although these programs have frequently faced opposition in North America (Strike, Myers, & Millson, 2004; Tempalski, Friedman, Keem, Cooper, & Friedman, 2007), NSPs have become one of the key public health interventions targeted at people who inject drugs. This is due to strong evidence that NSPs prevent the transmission of HIV and reduce injection-related risk behaviours, with mixed evidence of effectiveness at preventing the transmission of the hepatitis C virus (HCV), likely due to the greater potential for HCV transmission from sharing injection equipment such as cookers, filters or rinsing/mixing water (De, Roy, Boivin, Cox, & Morissette, 2008; Fernandes et al., 2017; MacArthur et al., 2014). In many jurisdictions - including in Toronto, Canada, the city where this study took place - NSPs have gradually evolved into broader harm reduction programs for PWUD that also distribute equipment for smoking or snorting drugs, such as pipes for smoking crack cocaine or crystal methamphetamine and foil for smoking heroin (Hunter et al., 2012; Ivsins, Roth, Nakamura, Krajden, & Fischer, 2011; Leonard et al., 2008; Malchy, Bungay, Johnson, & Buxton, 2011).

A key benefit of NSPs is that they increase contact between PWUD with service providers; in this way, distribution of harm reduction supplies facilitates the development of relationships between PWUD and service providers, that then serve to increase access to healthcare and social services for PWUD (Needle et al., 2005; Strike et al., 2013). For these reasons, harm reduction education and supply distribution are often considered to be a key service, and recommendations highlight that they should be available in a wide variety of environments frequented by PWUD, including drop-in programs, housing and shelters, healthcare and social service settings, and through community-based outreach (Strike et al., 2013; Needle et al., 2005). Outreach programs have been used within harm reduction programming to locate and interact with populations of PWUD outside the walls of traditional health and social services, with great success (Needle et al., 2004). These programs deliver harm reduction education, equipment and referrals directly within community settings where drugs are used (Medley, Kennedy, O'Reilly & Sweat, 2009). Harm reduction programs that undertake outreach often also use peer workers - commonly people who are current or former drug users - to increase the effectiveness of their programs (Hayashi, Wood, Wiebe, Qi, & Kerr, 2010; Needle et al., 2005).

The development of supervised consumption services (SCS) in Canada provides a second example of a new harm reduction intervention that was instigated primarily by PWUD, and later sanctioned by public health officials and formalized within public health programming. SCS - which are also frequently referred to as drug consumption rooms – refer to legally sanctioned facilities where people can consume pre-obtained drugs under the supervision of trained staff. Some SCS allow varied modes of consumption, such as smoking, inhalation or oral use, while others are referred to as supervised injection services (SIS) and permit only injection drug use. In the months prior to the opening of Insite, Canada's first sanctioned SCS, the Vancouver Area Network of Drug Users opened an unsanctioned injection site in a storefront in Vancouver (Kerr, Oleson, Tyndall, Montaner, & Wood, 2005; See, 2002). For a six-month period, PWUD could have their injections supervised by the peers running the site, which was also staffed by a Registered Nurse (Kerr et al., 2005). Unsanctioned SCS are not uncommon, and have also existed in Australia, Europe and the US (Davidson, Lopez, & Kral, 2018; Hedrich, 2004; Wodak, Symonds, & Richmond, 2003). Unsanctioned supervised smoking facilities have also been documented (Foreman-Mackey, Bayoumi, Miskovic, et al., 2019; McNeil et al., 2015). This pattern has been repeated over the past few years as activists once again opened unsanctioned Overdose Prevention Sites (OPS) to protest government inaction on the overdose crisis (Foreman-Mackey, Bayoumi, Miskovic, et al., 2019; Strike & Watson, 2019; Watson, Kolla, Van derMeulen, & Dodd, 2020).

The implementation of NSPs and SCS contains multiple examples of PWUD and their allies risking criminalization to run underground or unsanctioned NSPs and SCS prior to their official recognition by public health and other authorities as sanctioned health services (Friedman et al., 1987; Friedman et al., 2007; Kerr et al., 2005; Osborne & Small, 2006; Small, Palepu & Tyndall, 2006; Wodak, Symonds & Richmond, 2003). This is partly due to drug policy and programming through much of the 20th century remaining focused on supply and demand reduction efforts using interdiction and criminalization of drug use, and on abstinence-based treatment approaches (Keane, 2000; Valverde, 1998; Wodak, 1999). Additionally, the legal and social status of different drugs – and the criminal sanctions associated with possession, distribution and use of particular drugs – are often not based on the pharmacological properties, health harms or social impacts of the drug (Nutt et al., 2010). This contributes to a situation where possession of needles and syringes has been (and, in many locations around the world, continues to be)

criminalized, and the opening of SCS have frequently been blocked due to stigmas surrounding injection drug use (Friedman et al., 1987; Friedman et al., 2007; Fraser, Moore & Keane, 2014). The early history of harm reduction is one of PWUD and their allies attempting to demonstrate to medical and public health authorities that there were approaches to addressing substance use and improving the health of people who use drugs that did not require criminalization or abstinence-based treatment, with wide variability involved in the very definition of the concepts of 'addiction' and drug 'dependence' (Friedman et al., 2007; Keane, 2002). Additionally, receiving legal sanction and public health approval for these harm reduction interventions alleviated the risks of criminalization for professionals, while leaving PWUD who continue to deliver these interventions outside of approved health settings open to continued criminalization (Kerr et al., 2005; Fraser, Rance & Treloar, 2016). Examples of this include laws that criminalize the secondary distribution of injection equipment by PWUD (e.g. in Australia; see Fraser, Rance & Treloar, 2016), and situations where PWUD and their allies risked arrest to run underground or unsanctioned supervised consumption sites in jurisdictions in Canada (Foreman-Mackey et al., 2019; Kerr et al., 2005; Watson et al., 2020). These cases illustrate how PWUD can experience the potential for criminal sanctions for engaging in harm reduction activities in settings that fall outside the constraints imposed by authorities, highlighting how the criminalization of drug use and the enforcement of criminal laws surrounding the delivery of harm reduction services can both intersect with and contribute to structural vulnerabilities faced by PWUD.

1.3.1 Use of peers in harm reduction programs

Harm reduction programs also provide broader programming for PWUD, often with the involvement of peers (Marshall, Dechman, Minichiello, Alcock, & Harris, 2015). Peer-based interventions, where members of the community develop and/or deliver services to other community members, have become increasingly popular as a cost-effective means of extending the reach of community-delivered HIV prevention programs within a variety of populations including men who have sex with men, sex workers, and people who inject drugs (Broadhead et al., 1998; Evans & Lambert, 2008; Latkin, Forman, Knowlton, & Sherman, 2003; Marshall et al., 2015; Weeks et al., 2009). Peer-based service delivery is widely advocated as a key service feature of programs for marginalized populations because peers can pass on HIV and HCV information among networks that may be poorly connected or mistrustful of traditional health and social service providers (Marshall et al., 2015; van Empelen et al., 2003; Weeks et al., 2009).

Peer-based programming has also been found to be effective at reducing HIV-related risk behaviours among both peers and those who receive interventions from peers (Degenhardt et al., 2010; Garfein et al., 2007; Latkin et al., 2003; Medley et al., 2009; van Empelen et al., 2003). In the current opioid overdose crisis, the involvement of people with lived experience of drug use in the delivery of services in SCS/OPS was found to increase comfort among people using services, and to facilitate broader engagement in overdose preventions services among PWUD (Kennedy et al., 2019).

However, many questions remain regarding the use of peer-based interventions, particularly with populations of PWUD. Research suggests that employment can have a positive, stabilizing effect on PWUD, and given the difficulties PWUD encounter attempting to find employment, peer work provides a method for them to acquire experience and low-threshold employment (Richardson, Wood, Li, & Kerr, 2010; Penn, Strike, & Mukkath 2016). However, stigma from their status as PWUD, low wages, insecure job status, and employment contracts, and role challenges that emerge due to unclear distinctions between whether peers are "clients" vs. "service providers", are all issues that have been identified with peer work (Dechman, 2015; Kennedy et al., 2019; Penn et al., 2016).

1.3.2 Secondary syringe exchange

A common, though often unofficial element of harm reduction programs is "secondary syringe exchange" or "satellite exchange", where PWUD distribute sterile injection equipment obtained from formal harm reduction programs to other PWUD in the community (Anderson et al., 2003; Bryant & Hopwood, 2009). Maintaining supplies of sterile injection equipment to distribute to other PWUD has been described as a practice of care among PWUD, and as part of an 'ethos of community care' that is often under-documented within communities of PWUD (Fraser, Rance, & Treloar, 2016). Research in Canada, the US and Australia has documented that secondary exchange is a common phenomenon, with 64% of clients of a Vancouver needle exchange reporting distributing new needles to others, and 75% of clients in a study in California reporting this behaviour (Bryant & Hopwood, 2009; Kuyper et al., 2006; Lorvick et al., 2006). Secondary syringe distribution has been shown to reach high risk populations of PWUD, including those who are not otherwise accessing harm reduction services (Anderson et al., 2003). Secondary syringe distribution is a key way to ensure that some of the highest risk injectors have access to

sterile injection equipment. Additionally, secondary distribution seems to occur at high rates even in environments with widespread distribution of free injection equipment (Bryant & Hopwood, 2009; Kuyper et al., 2006), as well as in environments where secondary syringe distribution is illegal (Fraser et al., 2016), suggesting a strong need for access outside of formal harm reduction programs.

Another method of increasing the geographic and temporal reach of harm reduction programs is to create Satellite Sites. Based loosely on secondary distribution models, the Satellite Site program was established to train well-known members of the community of PWUD to run satellite harm reduction programs within their own homes (Strike & Kolla, 2013). This novel program developed in Toronto, Canada aimed to expand the reach of existing harm reduction programs by distributing sterile injection equipment and other harm reduction supplies within the spaces where people are already gathering to use drugs. It was an innovative attempt to increase and formalize secondary distribution of harm reduction equipment into areas that were not being reached by traditional public health or outreach activities. As such, the Satellite Site program is an example of a safer environment intervention (McNeil & Small, 2014; Rhodes et al., 2006), where people who use and sometimes sell drugs are employed to deliver harm reduction equipment and education to their peers. The program aims to improve the health of PWUD by altering the socio-spatial relations within these closed spaces in the community where people would gather to use drugs.

1.4 Risk Environments and Safer Environment Interventions

Safer environment interventions have been defined as "a continuum of programmatic responses that directly intervene to mitigate social, structural, and environmental determinants of risk among PWID *[people who inject drugs]*" (McNeil & Small, 2014, p. 152). Underlying safer environment interventions is the concept of the 'risk environment', which is a space - whether social or physical – in which a variety of factors interact synergistically to increase vulnerability to drug-related risk and harm (Rhodes, 2002; Rhodes, Singer, Bourgois, Friedman, & Strathdee, 2005). The risk environment attempts to conceptualize the interaction of factors operating at the level of the "micro" risk environment (such as negotiations between people who inject drugs over the use of sterile equipment), as well as at the "meso" or institutional level (program hours

of operation and locations, or operating procedures) and the "macro" level (which would include policies and laws, as well political or economic conditions and disruptions) (Latkin & Knowlton, 2005; MacNeil & Pauly, 2010; Rhodes, 2009; Rhodes et al., 2005). Attention to these three levels and their interactions allows for a focus on the "social situations, structures and places in which risk is produced" (Rhodes et al., 2005, p. 1027), including how physical, social, economic, policy, and political environments shape drug use, and can contribute to inequities in health.

By focusing on risk environments, proponents of this model aspire to create "enabling environments" for harm reduction (Rhodes, 2002). Here, the focus is on creating safer environments for drug use that reduce the negative health effects of drug use by intervening in the places and spaces where people use drugs (Carlson, 2000; McNeil & Small, 2014; Rhodes et al., 2006; Small, Rhodes, Wood, & Kerr, 2007). Three major types of safer environment interventions have been identified: 1) those designed to increase access to harm reduction supplies and education; 2) those that capitalize on social networks to deliver services (using peer workers to do outreach, for example); and 3) those that intervene to create safer spaces for drug use, either by modifying existing spaces (by changing design features and accessibility of materials within the spaces people use drugs), or through the construction of purpose-built safer environments (such as in supervised consumption sites) (McNeil & Small, 2014; Rhodes et al., 2006). Satellite sites include elements of all three forms of safer environment interventions. First, they increase the availability of harm reduction materials and supplies in the community by formalizing the secondary distribution that is already occurring. Secondly, the Satellite Site program capitalizes on the social networks of PWUD and the use of their homes as places where PWUD gather to use and buy drugs. Finally, the Satellite Site program alters spatial programming and design through physical changes to the Satellite Sites to make them more conducive to safer consumption practices (for example, by ensuring that 'sharps' bins for the disposal of used equipment are readily available within the Satellite Sites).

Several benefits of safer environment interventions have been described. First, they attempt to mitigate barriers that may have been created by more formal harm reduction programs, such as strict rules and regulations, set hours, and the costs and distances required to travel to fixed-site programs (Fairbairn et al., 2010; McNeil et al., 2015; McNeil & Small, 2014). Additionally, safer environment interventions can help to reduce structural barriers that may impede access to health and social services by providing low-threshold services in geographic locations that are

convenient and easy to access for PWUD (Mclean, 2012; McNeil, Small, Lampkin, Shannon, & Kerr, 2013; Small, Van Borek, Fairbairn, Wood, & Kerr, 2009). PWUD may also experience less stigma receiving services in informal environments, which can improve interactions between PWUD and service providers, and lead to better health outcomes (MacNeil & Pauly, 2010; McNeil et al., 2013; 2015). And finally, safer environment interventions provide a refuge from some of the risks that are associated with consuming drugs in public spaces, including the potential for arrest by police, and the risk of violence and robbery (Cooper et al., 2005; Fairbairn, Small, Shannon, Wood, & Kerr, 2008; Mclean, 2012; McNeil & Small, 2014; Small, Kerr, Charette, Schechter, & Spittal, 2006).

Interventions within the spaces in the community where people gather to use drugs - often referred to as trap houses, crack houses or shooting galleries - have been practiced since the beginnings of the HIV epidemic (Page, Smith, & Kane, 1989). There is a growing literature exploring safer environment interventions, including unsanctioned supervised crack smoking spaces (Foreman-Mackey, Bayoumi, Miskovic, et al., 2019; McNeil et al., 2015), peer-run supervised consumption sites (McNeil et al., 2013), and overdose prevention sites that were established in response to the opioid overdose crisis (Bardwell, Boyd, Kerr, & McNeil, 2018a; Bardwell, Kerr, Boyd, & McNeil, 2018b; Foreman-Mackey, Bayoumi, Miskovic, et al., 2019; Kolla, Dodd, Ko, Boyce, & Ovens, 2019; Strike & Watson, 2019). Some research has also has explored the environment within 'piaules' *(crack houses)* in Montreal, describing resistance to allowing both formal and peer-based harm reduction interventions to be established within these spaces, due in part to their close connection to organized crime organizations in that city (Roy & Arruda, 2015). The harm reduction program that will be explored in this dissertation - the Satellite Sites - is a safer environment intervention that takes places in a community setting, and was developed by and for PWUD. This dissertation will explore how attempts to medicalize the Satellite Sites by making them sites of public health intervention are constrained by the structural forces of criminalization. There is a gap in the literature regarding the ways in which criminalization of drug use impedes safer environment interventions, including attempts by public health authorities to address ongoing drug-related risks associated with the overdose crisis within community settings. Additionally, there has been little work examining the integration of people who may move into and out of drug selling into harm reduction interventions and service delivery. Overall, the ways that criminalization impedes public health authorities and PWUD as

they attempt to implement harm reduction interventions, as well as the tremendous barriers that criminalization presents to the integration of people who sell drugs into programming will be examined in detail in this project. Insights from the field of critical drug studies – which includes approaches from new materialism, science and technology studies and post-humanism - will be used to explore how social phenomena such as addiction, medicalization, criminalization and care are continually being constituted in multiple ways, and are shaped and reshaped in practice by human and non-human actors (Fraser, 2017; Fraser & Moore, 2011; Fraser & Seear, 2016; Seear & Fraser, 2014). Examining the Satellite Sites as an evidence-making intervention (Rhodes et al., 2016) opens up the possibility of analysing the relations being enacted within the sites by multiple actors, and to examining the multiple effects that may be generated through the implementation of this intervention.

1.5 Criminalization

Criminalization, or the use of sanctions within the criminal justice system to attempt to stem the negative consequences of drug use is often referred to as drug prohibition, or, more colloquially, as “The War on Drugs”. A growing body of research suggests that criminalization of drug use and increased police enforcement activities targeted at PWUD are not effective at reducing the harms associated with drug use, and may in fact contribute to negative health effects and negatively impact on uptake of HIV prevention and treatment (Debeck et al., 2017; Degenhardt et al., 2010; S. A. Strathdee et al., 2010). Certain factors have been shown to be associated with both using drugs in public or communal spaces, and an increased risk of criminalization, for example: homelessness and lack of another place to use drugs; inability to inject in their own residence; desire to minimize the amount of time between drug purchase and use; and a need for injection equipment or assistance with injecting (Bourgois, 2003; Carlson, Falck, & Siegal, 2000; Fairbairn, Small, & Van Borek, 2010; Ouellet, Jimenez, Johnson, & Wiebel, 1991; Roy & Arruda, 2015). Public health authorities in Canada, as well as organizations and agencies across the spectrum of health and social services have argued for the exploration of alternatives to the current system of criminalization, and for evidence-based and public health approaches to drug use, and this continues to be a developing area of public health policy (Csete, 2016; Woo, 2016; Wood et al., 2010).

1.6 Study Setting: The Satellite Site Program

The Satellite Site program is a harm reduction intervention that capitalizes on social networks among PWUD to create community access points for sterile equipment for drug use, harm reduction information and education, overdose education and naloxone distribution, and, in some sites, unsanctioned supervision of drug consumption (Kolla & Strike, 2019; Strike & Kolla, 2013). This program was established in the east-end of Toronto on an informal basis in 1999, where it began as an outgrowth of a peer-run harm reduction program - COUNTERfit - that was operating in a community health centre. Using a secondary syringe exchange model, the goal of this service expansion was to reach those who did not use the fixed site services offered within the harm reduction program located within the community health centre (Strike & Kolla, 2013). The program was founded by a pioneer in harm reduction activism and programming in Ontario; he had built several early harm reduction programs in the 1990's, had extensive experience with drug user activism and organizing, and openly identified as a person who injected drugs. His deep professional experience in harm reduction, coupled with his lived experience as a drug user allowed him to recognize the opportunity to integrate harm reduction equipment and programming into the communal spaces where PWUD were gathering to use and buy drugs. He began encouraging the people running these spaces to keep large quantities of sterile needles, syringes and injection equipment on hand, as these settings were not being reach by existing public health or outreach strategies; these were the first Satellite Sites (Strike & Kolla, 2013). It was due to in part to his lived experience that he had access to a space that was normally closed to outsiders – including public health workers - and use this access to provide harm reduction equipment for the SSWs to distribute, and train them in the principles of harm reduction.

The Satellite Site program grew out of COUNTERfit's broader approach to service design and delivery. Specifically, the program prioritized a peer approach, where all services were delivered by people with current or former drug use. Each service user at COUNTERfit is seen as a potential service provider. Using people with lived experience of drug use to deliver services is a recognized best practice in harm reduction program delivery (Strike et al., 2013). Additionally, it recognizes that many service users prefer to receive services from other PWUD due to their common experience and first-hand knowledge (Marshall et al., 2015; Weeks et al., 2009). COUNTERfit's approach to peer-based programming, which formalized the integration of PWUD within all levels of harm reduction program management and service delivery, was

pioneering in Canada (Balian & White, 2010). The innovation of the Satellite Site program was to extend the COUNTERfit approach for harm reduction service delivery within a community health centre into informal settings in the community.

SSWs were also recruited because they were already well-known within the community of PWUD. This had the advantage of facilitating their ability to become distribution points for sterile equipment for drug use, within the existing environments where people are already gathering to use drugs. In this way, the Satellite Sites are a prime example of a safer environment intervention (Rhodes et al., 2006). Finally, the program capitalized on what was occurring within the Satellite Sites – that people gathering within the sites were often using and/or selling drugs – to expand distribution of harm reduction supplies. No attempts were made to regulate these behaviours other than to encourage safer drug use through the provision of harm reduction supplies and education.

Not all organizations are well-positioned to undertake harm reduction programming within the spaces in the community where people gather to use drugs. As Grove points out, a key consideration for undertaking this type of work is an understanding of and respect for the community norms among PWUD, and an understanding that useful models for harm reduction are most likely to come from PWUD themselves (Grove, 1996). In the case of the Satellite Sites, the program founder was a well-respected member of the community of PWUD and had a keen understanding of its social norms. This also allowed him to undertake a form of 'screening' with potential Satellite Sites and SSWs, as he had the ability to move within these spaces as an 'insider'. This allowed him to recruit SSWs who were already providing support within their communities, who could manage conflict, and who were not running spaces where drug-market violence or aggression were common. Additionally, because he occupied a professional role running the harm reduction program at the community health centre, he was trusted both by PWUD and by the management of the community health centre. Equally important was that the community health centre had an openness to embracing a harm reduction perspective with regards to working with PWUD and supporting their employment (Balian & White, 2010).

The Satellite Site program ran as a volunteer program for 10 years prior to receiving funding from public health authorities in Toronto in 2010. This funding allowed the community centre running the harm reduction program to formalize it. Program funding transformed the SSWs

from volunteers into paid staff of the community health centre and validated their work. Formalization of the program included beginning to pay the SSWs a modest salary of $250 a month, and providing them with a cellular telephone. Making the SSWs into formal employees of the community health centre had been a priority for the program founder. It not only provided formal recognition of the work they had been doing voluntarily in their communities, but also addressed some of the structural vulnerabilities faced by PWUD due to the stigma and criminalization of drug use. The pay received by SSWs is modest, as it needed to reflect the service that they were providing while not interfering with the social assistance payments that most SSWs are receiving as their primary source of income. Additionally, SSWs are receiving pay for trainings and staff meetings. Paying SSWs also incentivized the collection of data on the volume of harm reduction supplies being distributed and disposed of at their sites. The Satellite Sites were an attractive addition to the COUNTERfit program because of the low cost involved in setting up and delivering these programs, while also providing a model for expanding the reach of the existing harm reduction program within the community health centre, both geographically (by placing Satellite Sites throughout the community) and temporally (Satellite Sites were available outside of the 9am-5pm hours of operation of the community health centre) (Strike & Kolla, 2013).

1.7 Project Rationale

An evaluation of the Satellite Site program was conducted several years ago (Strike & Kolla, 2013), focusing on elucidating the organization and operation of the program, evaluating whether the program was reaching its target population, and assessing the successes and challenges of the program. The evaluation found that the program was reaching its target population with harm reduction education and equipment, was extending the temporal and geographic reach of the fixed-site parent program, and was providing low-threshold job opportunities for PWUD (Strike & Kolla, 2013). The report also noted that the Satellite Site program was attractive from a programmatic standpoint due to the relatively modest funds necessary to operate it, which allowed for the potential to rapidly scale up the program and others like it (Strike & Kolla, 2013).

This evaluation provided the groundwork for the development of the research questions for the present study. The initial evaluation raised the possibility that formalization of the program as a public health intervention may lead the Satellite Sites to begin to resemble the fixed site harm reduction programs, which in turn may cause the most marginalized clients to abandon the Satellite Sites (as their informal nature was one of their most attractive feature). As such, an examination of the interaction between medicalization and criminalization within the Satellite Sites, and the ways in which the Satellite Sites are experienced as a public health intervention by both the SSW and clients is warranted to ensure these sites can continue to function as safer environment interventions. Additionally, the 2013 evaluation did not explore how the continued criminalization of drug use might impact on service delivery within the Satellite Sites, nor did it examine the potential for negative effects from criminalization on SSWs. The major question of how risk and harm from drug use are mitigated by SSWs, and the ways in which these risks and harms intersect with the structural vulnerability experienced by SSWs and their clients due to criminalization of drug use remained unexplored. Finally, there is a gap in the research literature on the ways in which people who sell drugs can be integrated into harm reduction interventions. Given that some SSWs move into and out of drug selling, or allow drugs to be sold in their sites, this research project is well-positioned to investigate the potential for people who engage in drug selling to be integrated into harm reduction interventions.

1.8 Overview

In Chapter 2, the challenges of medicalizing the Satellite Sites to deliver public health programming are explored. Within the Satellite Sites, PWUD accept surveillance from a community health centre due to the protection that medicalization affords from the criminal justice system. However, the protection offered by medicalizing the sites is not complete, and the continued criminalization of drug possession and drug selling negatively impacts the uptake and effectiveness of public health recommendations. The continued criminalization of drug use may be severely limiting the ability of public health authorities to develop safer environment interventions to improve the health of PWUD, including measures to address the current overdose crisis.

Chapter 3 explores the structural vulnerabilities that constrain PWUD as they attempt to implement the advice provided within the Overdose Education and Naloxone Distribution (OEND) programs that have been scaled-up as a response to the opioid overdose crisis. While OEND programs are essential and effective, PWUD experience multiple social and structural vulnerabilities due to their drug use, many of which are related to the criminalization of drug use. This chapter examines the way that these vulnerabilities may be inadvertently exacerbated by OEND program, particularly advice not to use drugs alone, and to call 911 in case overdose occurs.

Chapter 4 explores how people who sell drugs are rarely integrated into harm reduction programming. Negative framings of drug selling as predatory and inherently lacking in care make it difficult to perceive the wide variety of acts of mutual aid and care that surround drug buying and selling as practices of care. This chapter explores how criminalization contributes to the difficulty in making visible the practices of care circulating around drug buying and selling. The Satellite Site program often employs people who may move into and out of drug selling, and this provides an opportunity to explore how people who sell drugs engage in practices of care with other drug users in their community. Rendering these practices of care visible has the potential to remove barriers to the integration of people who use and sell drugs into harm reduction programming, and develop public health interventions that acknowledge the key role of drug buying and selling in the lives of PWUD.

Chapter 5 summarizes the dissertation findings, and then reflects on conducting community-based ethnographic research in criminalized environments. This includes reflections on gaining access to the Satellite Sites and entering the field, exiting the field, and reflections on my positionality as a researcher and on the need for care when conducting research with people who are impacted by criminalization. Then, I examine how the findings from this study contribute to research, policy and practice in the field of public health. Finally, future research directions that to extend the work in this dissertation will be discussed.

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Chapter 2
Medicalization under prohibition: The tactics and limits of medicalization in the spaces where people use illicit drugs

2 Abstract

The ‘Satellite Sites’ are a harm reduction intervention in which people who use illicit drugs are employed by a community health centre to run satellite harm reduction programs within their homes. Satellite Sites straddle two worlds, at once sites of illicit and stigmatized activities, while also being sites of public health intervention. They offer a unique opportunity to examine the challenges of medicalizing a place that is still criminalized. Using data collected during 7 months of ethnographic observation and 20 interviews with key members of the program, we explore the tactics of medicalization that are deployed to legitimize the Satellite Sites. Medicalization provides legitimacy to Satellite Sites, and provides people who use drugs who run the Satellite Sites with some protection from the criminal justice system. Our results explore the frictions between processes of medicalization and criminalization, with continued criminalization of drug possession and distribution negatively impacting the uptake and effectiveness of public health recommendations. Study findings highlight how the ability of public health authorities to develop safer environment interventions to improve the health of people who use drugs – including measures to address the current overdose crisis - may be severely limited by the continued criminalization of drug use.

2.1 Introduction

Within research on illicit drug use, the theoretical framework of the ‘risk environment’ is frequently used to move beyond an individual-level focus on risk behaviours, and examine how elements of the physical, social, economic, and political environments interact to increase the risk of drug-related harms (Rhodes, 2002; Rhodes, Singer, Bourgois, Friedman, & Strathdee, 2005). Focusing attention on the environments where risk is produced allows for the

development of interventions specifically tailored to those environments, an approach that has been termed the development of ‘safer environment interventions’ for harm reduction (Rhodes et al., 2006). Key to this approach is changing the locus of attention from the individuals who use drugs to the social situations, structures and spatial environments in which people use drugs (Kirst, 2009; Rhodes, 2002). The semi-public and communal spaces where people gather to use drugs in the community (which can include ‘crack houses’ or ‘shooting galleries’) are a key example of a risk environment (McNeil & Small, 2014; Rhodes et al., 2006).

The risk environment framework and the subsequent focus on safer environment interventions highlight the advantages of using public health strategies to address the health risks associated with drug use that occur in informal social settings, particularly in HIV, hepatitis C and overdose prevention, and corresponds to a broad shift to a medicalized understanding of illicit drug use (Walker, 2017). Characteristics of safer environment interventions that mitigate some of the risks present in public and communal drug-using spaces include providing a ‘refuge’ from street-based drug scenes, as well as reducing the targeting of people who use drugs (PWUD) by law enforcement (McNeil & Small, 2014; Rhodes et al., 2006). This is important given that law enforcement interventions have been shown to increase drug-related harms, particularly by interfering with HIV prevention initiatives (Cooper, Moore, Gruskin, & Krieger, 2005; Debeck et al., 2017).

Using data from an ethnographic study, we examine a novel form of safer environment intervention: the ‘Satellite Sites’, a harm reduction program in Toronto, Canada that turns spaces where people gather to use drugs into ‘satellites’ of a large peer-run harm reduction program located in a community health centre (CHC). The Satellite Site program has been operating informally since 1999, as an outgrowth of a peer-run harm reduction program that was operating inside a CHC. It was based on a secondary syringe exchange model, where people who inject drugs distribute sterile injection equipment obtained from formal harm reduction programs to other people who inject drugs out in the community (Anderson, Clancy, Flynn, Kral, & Bluthenthal, 2003; Bryant & Hopwood, 2009; Strike, Cavalieri, Bright, & Myers, 2005). The founder of the program, who openly identified as a person who injects drugs, began providing home delivery of sterile injection equipment to increase access for community members. As the program grew, he began asking people who maintained communal spaces where people gathered to use illicit drugs if they wanted to keep extra harm reduction supplies around for others who

might need them (Strike & Kolla, 2013). By distributing sterile drug use equipment directly within the places where people were gathering to use drugs in the community, these spaces functioned as 'satellites' of the larger, institutionally-based harm reduction program embedded in the CHC. The Satellite Sites expanded the reach of the existing program, both geographically (by placing Satellite Sites throughout the community) and temporally (in that these sites would be available outside of the 9am-5pm hours of operation of the CHC).

In 2010, the Satellite Site program adopted a more formal model when program funding was applied for and received by the CHC (Strike & Kolla, 2013). The key objective of the formalization of the program was to transform what were previously volunteer roles into paid staff positions, compensated with a modest salary of $250 a month and cellular telephone for SSW. As employees, the SSW were now required to attend monthly trainings on health-related topics, and report on the quantity of equipment being distributed and disposed of in the sites. In addition to the provision of sterile injection equipment (including needles and syringes, cookers, filters, and sterile water), the Satellite Sites also provided education on safer drug use, distributed equipment for inhalation or smoking of drugs (such as safer crack use kits and crystal methamphetamine pipes), provided safer sex supplies, and more recently, began providing overdose education and naloxone distribution (Kolla & Strike, 2019). SSW determine how to operate their individual sites, including whether they wish to allow clients to consume drugs onsite, and whether they sell or allow drugs to be sold onsite. During the study period, there were 9 Satellite Sites in operation, and each distributed and disposed of approximately 1,500 needles and syringes a month on average.

Creating safer environments in the communal spaces where people gather to use drugs is appealing, as people consuming drugs in these spaces may not be accessing harm reduction or other health services elsewhere (McNeil & Small, 2014; Parkin & Coomber, 2009; Roy & Arruda, 2015). Compared to supervised consumption services, which aim to transform the risk environment by bringing drug use into an environment supervised by medical personnel (Kerr, Mitra, Kennedy, & McNeil, 2017), a key distinction of the Satellite Site program is that it seeks to provide harm reduction services directly in the places where people are already gathering to consume drugs, using people who use drugs to provide services. As such, it provides a novel example of a public health intervention within the existing spatial arrangements where people gather to use drugs (Vitellone, 2010), a complementary yet distinct intervention from spaces that

are purpose-built for supervised drug use by public health authorities (such as the establishment of supervised consumption services). The process of medicalizing risk environments in the community as an attempt to develop safer environment interventions within harm reduction remains underexplored.

In the next section, we examine the literature related to the medicalization of addiction, and then move to exploring the tensions involved in medicalizing illicit and injection drug use – which is still criminalized in Canada. Following this, we begin our results by exploring the development of the Satellite Sites as a safer environment intervention, where several tactics of medicalization - organized strategies developed collaboratively by PWUD and a community health centre (CHC) – are used to implement a medicalized intervention to address the risks associated with illicit drug use in social settings. As spaces that were originally established by PWUD and only later received recognition and funding from public health authorities, the data that we report on here goes on to explore how Satellite Site Workers (SSW) accepted medicalized surveillance because it provided a form of protection from the criminal justice system in case of police intervention within the Satellite Sites. This leads to the Satellites Sites operating in a sort of liminal space, with the Satellite Sites operating as quasi-medicalized, quasi-criminalized intervention that is remade with different effects and impacts through its implementation. We end by exploring the implications of the Satellite Sites as an evidence-making intervention (Rhodes & Lancaster, 2019; Rhodes, Closson, Paparini, Guise, & Strathdee, 2016), where the tensions between the concurrent medicalization and criminalization of illicit drug use both allows for this new type of intervention to emerge, while also interfering with the ability of PWUD to fully take up and implement public health recommendations.

2.1.1 Medicalization of addiction, illicit drug use and harm reduction

The process of medicalization involves “defining a problem in medical terms, usually as an illness or disorder, or using medical intervention to treat it” (Conrad, 2005). It is characterized by prioritizing medical understandings of issues and social problems above lay, political, economic or judicial understandings (Zola, 1972). Classic medicalization theory uses opioid addiction as one of its prime examples of how the expansion of the medical model to include ’deviant’ behaviours allows for more elements of human life to be brought under the control of the medical system (Conrad & Schneider, 1992). It traces the way in which the social control of opioid addiction shifts, as it moves from a ‘deviant’ behaviour to being defined as a medical

problem (and is brought under the control of medical practitioners), is subsequently criminalized (falling under the control of law enforcement), and more recently, is partially remedicalized, ending up both medicalized and criminalized (Conrad & Schneider, 1992). The medicalization of 'deviant' behaviours such as addiction allows medical authorities – including allied health practitioners such as public health authorities - to expand the reach of their activities to encompass a widening array of activities not previously under their purview (Conrad, 1992; Conrad & Schneider, 1992).

The expansion of medicalization to encompass injection drug use, and illicit drug use more generally, gained momentum as injection drug use became recognized as a prime method for the transmission of blood borne diseases such as HIV and hepatitis C. Public health authorities gradually co-opted and scaled-up strategies developed by PWUD, such as needle and syringe exchange programs, to prevent transmission of infectious diseases (Friedman et al., 2007). The emergence of the HIV and hepatitis C epidemics, and more recently, the opioid overdose epidemic, have contributed to advancing a broader medicalization of illicit drug use. One of the major elements that will be explored below is how this broader medicalization was the necessary background that allowed for the spaces where people were congregating to use illicit drugs - like the Satellite Sites - to be transformed into spaces where a medicalized, public health intervention could occur.

2.1.2 Critiques of medicalization

There has been sustained critique of the impacts of medicalization, and the increasing pervasiveness of the medical model. These critiques focus primarily on medicalization as a repressive and coercive process solely concerned with increasing the social power of the medical system and its practitioners, consequently reducing patient autonomy and increasing dependency on medical providers, perspectives, and interventions (Conrad, 2005). While the role of interest groups and individual patients in driving medicalization is well-recognized (Becker & Nachtigall, 1992; Bell, 2017; Conrad, 2005), structural factors such as the criminalization of drug use complicate the interplay between advocacy from grassroots movements of PWUD and the increased involvement of medical and public health professionals in the prevention and treatment of drug use. An additional line of critique highlights how medicalization reinforces social inequality of marginalized groups, by effacing broader social forces that influence health, and masking related social problems as medical problems (Lantz, Lichtenstein, & Pollack, 2007;

Zola, 1972). This approach leads to prioritizing medico-technological solutions to what are essentially social problems, and gives priority to medical treatments and drug therapies rather than strategies that attempt to redress social inequality (Riska, 2003).

In contrast to these critiques, some authors have used a Foucauldian lens to argue that rather than being solely repressive or coercive, medicalization can also be interpreted as a positive and productive strategy, where some 'patients' willingly seek out medicalization or utilize medical strategies because they produce positive health effects and knowledges (Lupton, 1997). Instead of focusing on the targets of medicalization as docile (Armstrong, 1983), this approach sees the possibility for medicalization to be deployed as a strategy of resistance, where "people respond to the external discourses and strategies that attempt to discipline them" (Lupton, 1997).

The field of critical drug studies has also fruitfully explored medicalization, by drawing on approaches from science and technology studies, post-humanism, and new materialism to examine how concepts such as 'addiction' and 'problematic drug use' are not stable phenomena, but are continually made and remade in practice (Fraser, 2017; Fraser & Moore, 2011). Rather than seeing a social phenomenon like addiction as a stable entity or biological fact, this approach highlights how addiction is constituted in multiple ways, by multiple human and non-human actors, continuously shaped and reshaped in practice, and informed by policy, legal and medical discourses (Fraser & Seear, 2016; Seear & Fraser, 2014a). By drawing particular attention to the non-human objects in events of drug consumption, this approach highlights the ways in which a multitude of elements (including subjects, practices, and effects) are assembled in dynamic ways in the drug event (Dennis, 2017; Dilkes-Frayne, 2014; Duff, 2014; Duncan, Duff, Sebar, & Lee, 2017; Race, 2011). This approach provides a way to remain attentive to how interventions (such as the Satellite Sites) are transformed as they are implemented in new spaces, with differing effects being produced as interventions are remade in practice (Rhodes et al., 2016; Rhodes & Lancaster, 2019). As Race has pointed out in relation in his discussion of the performativity of the law as it relates to public health, certain enactments of the law may be 'desired', while others might be seen to 'misfire'; however, careful attention to "these hybrid arrangements and real world encounters" is necessary to respond to most effectively to potential benefits and harms (Race, 2011: pg. 411). The way that particular effects emerge from practices of medicalization and criminalization within the Satellite Sites is a focus of this paper.

2.1.3 Tensions between medicalization and criminalization

Illicit drug use exists at an uneasy nexus of medicalization and criminalization (Conrad & Schneider, 1992). In Canada, the Controlled Drugs and Substances Act (CDSA) is the federal drug control statue that established a schedule of controlled substances, forbids the possession, production, sale, or import/export of controlled substances, and the penalties for contravening the Act. The negative impacts of criminalizing illicit drug use on the health of PWUD are increasingly recognized; these include increased incidence of HIV risk behaviours such as borrowing syringes, and reduced access to HIV prevention and treatment services due to police enforcement activities and/or incarceration (Debeck et al., 2017; Werb et al., 2008). In recognition of these negative impacts and particularly in the face of a mounting overdose crisis, there have been increasing calls by medical and public health authorities in Canada for drug use to be decriminalized – essentially, for possession of scheduled drugs to be decriminalized under the CDSA (Woo, 2016). However, these calls are occurring alongside efforts in other jurisdictions (including some Canadian jurisdictions) to increase penalties for people who share or supply drugs to people who subsequently overdose (The Canadian Press, 2017). Tensions emerge when attempting to simultaneously use both medical authorities and the criminal justice system to address illicit drug use; drug use continues to be criminalized, while also being a prime target for medical and public health programming that aims to prevent and treat infectious disease and overdose. The potential for criminalization to impede the success of public health efforts to address morbidity and mortality from HIV, hepatitis C and overdose among people who use drugs remains a priority area for research, and is a crucial issue in the face of increasing deaths across North America from opioid overdose (Kochanek, Murphy, Xu, & Arias, 2017; Special Advisory Committee on the Epidemic of Opioid Overdoses, 2018; Stein, Gennuso, Ugboaja, & Remington, 2017).

In this paper, we draw attention to the possibility that PWUD are utilizing the productive potential of the medical system as a form of resistance, to counter the even more repressive and coercive power deployed by the criminal justice system. However, medicalization and criminalization are not binary opposites, nor conceptual alternatives to each other. While the shift towards public health models of addressing drug use have many positive factors, medicalization may also contribute to inadvertently reifying addiction-as-disease models, thereby contributing to framing all drug use – even non-problematic use – as deviance (Reinarman,

2011). In fact, the shifts in how drugs are defined and changes to their legal status - including the punishments and criminal sanctions that become attached to drug offences at various points in time and in different societal contexts - is a prime example of how the law and legal processes help to constitute 'addiction', the very problem which it is then mobilized to address (Seear & Fraser, 2014b; 2014a). Using the data collected from the Satellite Sites, we will explore how the limits of medicalization of illicit drug use seen within these community spaces are illustrative of the tensions that can occur when social control over drug use is simultaneously delegated to medical and public health authorities, as well as to the criminal justice system. We conclude by examining how these tensions have potentially negative impacts on the uptake and effectiveness of public health programming aimed at PWUD.

2.2 Methods

2.2.1 Research approach and ethics

This ethnographic study used direct participant observation within the Satellite Sites, complemented by semi-structured interviews with key members of the program. Guided by a community-based research approach, an advisory group consisting of SSW and staff members from the CHC provided guidance on the research questions, study design, implementation, and interpretation of data. All data collected was kept anonymous, and the real names or locations of participants were never recorded in field notes. This was due to concerns about the potential for research data to be subpoenaed, given the criminalized nature of activities being observed. Research ethics board approval was obtained from the authors' home institution.

2.2.2 Participant observation

The lead author had extensive prior experience working with PWUD and was well known as a harm reduction program researcher within this program prior to conducting this study. Building on the connection to SSW, two initial meetings were held with SSW to explain the research approach, solicit feedback from SSW, and answer any questions or concerns. Once a SSW agreed to participate, and prior to the first visit, the SSW provided informed consent for observation in their sites, and were informed that they could ask the researcher to leave at any time, opt out for any reason of a site visit, and also withdraw from the study anytime they

wished, for any reason, without repercussions on their employment with the CHC. The researcher was accompanied during all visits by the Satellite Site Coordinator, a peer who is an employee of the CHC, and is responsible for overseeing the Satellite Site program, and conducts monthly visits to the Satellite Sites. The dates and times of visits were arranged in advance with the SSW. Each SSW was provided with a short script about the research to read to clients present when the researcher was conducting observations. SSW were provided with a $20CAD honorarium at each visit. While the researcher was never asked to leave, there were three occasions when a SSW hinted that they would like the researcher to leave, either due to tiredness or to the presence of people who were uncomfortable with the researcher's presence. On all occasions, the researcher immediately left the site.

The sampling approach was guided by the sequential interviewing approach, where multiple 'cases' are observed and interviewed sequentially until saturation is reached (Small, 2009). Participant observation in the Satellite Sites occurred for a period of 7 months from September 2016-March 2017. Visits to Satellite Sites generally occurred once a week, on varying days in the evening between 6pm and 1am, and lasted an average of 1 hour (with visits ranging from 15 minutes to 2 hours in length). In total 57 observation visits occurred, for a total of 55 hours and 45 minutes of observation time. The number and length of observation visits was decided upon in consultation with the advisory group; considerations informing the length of fieldwork included wanting to minimize intrusiveness (given that the Satellite Sites were the homes of the Satellite Site workers) and that participant observation was complemented by one-on-one interviews with key program members (described in detail below). Notes on observation visits were recorded immediately after leaving the sites and expanded the following day, using principles outlined by Emerson, (Emerson, Fretz, & Shaw, 2011). An observation guide was used to highlight major areas of attention, and focused on instances of drug use observed (including the buying, selling, preparation and consumption of drugs), occurrences of violence or aggression, interventions by police or ambulance, and interactions between Satellite Site workers and clients where harm reduction interventions occurred, including equipment distribution, harm reduction education, naloxone distribution and overdose education, and provision of information and referrals to health or social services. Seven (out of a total of nine) Satellite Sites were visited over the 7 month-period; four were visited on a regular basis, with three other sites visited occasionally. Sites were chosen for regular visits purposively to reflect diversity in clientele (sites where clients are people who smoke crack vs. people who inject

drugs), site location (rented apartments in for-profit buildings vs. community housing), and length of time operating (newer sites vs. those in existence prior to formal funding). An attempt was made to ensure that both female and male SSWs were equally represented.

2.2.3 Semi-structured interviews

While informal questions were asked during observation visits on emergent issues, formal, semi-structured interviews were also conducted. 20 formal interviews were conducted with 15 different participants, including SSW (n=5), Satellite Site clients (n=4), and staff members (n=6) from the CHC that runs the Satellite Site program. SSW were interviewed twice; once prior to the beginning of participant observation to explore general issues related to their Satellite Sites and the work they did, such as benefits and challenges they faced, and a second time following the end of participant observation, to expand on issues and themes that arose during observation. Four clients and six CHC staff were also interviewed once. Clients were interviewed to explore the experience of visiting a Satellite Site, and CHC staff to explore institutional factors associated with running a program of this type.

To recruit clients, the researcher discretely approached clients who frequently attended Satellite Sites to ask if they were interested in participating in a confidential interview at a neutral location (CHC or coffee shop), or in a spare room at the Satellite Site. Clients were asked about their experiences using the Satellite Sites, how they started using the services of the Satellite Site, and their experiences accessing other harm reduction and health services. Staff members were responsible for supervision of the Satellite Site program, or in administrative and leadership roles. They were asked about institutional challenges with running what might be considered a controversial program, including implementation challenges, and how they dealt with any issues that emerge in the running of the program. All interview participants gave verbal informed consent to be interviewed, and were offered $20CAD honorarium.

2.2.4 Analysis

Analysis of ethnographic field notes and interview data was guided by a theoretical approach which aimed to foreground the ways in which structural and social forces shape individual actions that are often viewed (and framed) as individual-level risk behaviours (Campbell & Shaw, 2008; Rhodes & Moore, 2001). Beginning in the early stages of participant observation, field notes were coded for key themes using an iterative process guided by thematic analysis

(Braun & Clarke, 2006). Dedoose qualitative data analysis software was used for data management and coding. As data collection progressed and interviews were conducted, emergent themes were grouped by category, and in subsequent iterations of coding, themes were refined and portions of data were recoded. Key passages considered representative of themes were compared to each other to identify sub-themes, and were analysed to identify social and structural processes at work. After the completion of participant observation visits and once major thematic categories had been identified, a focus group was held with advisory team members to allow for data triangulation, member-checking, and enhancement of the interpretive validity of the findings. During this focus group, key themes and findings were discussed, with the aim of exploring, developing and refining themes, and to ensure they aligned with participants' perceptions and lived experience. Participants in the focus group underwent a separate verbal consent process prior to participation, and were offered a $20CAD honorarium. Data from the focus group were then also analysed to allow for further refinement of the themes identified.

2.2.5 Participant and Satellite Site description

The seven Satellite Sites that were visited regularly were run by eight SSW (six individuals and one couple), including three men and five women. All SSW were between 45-70-years old, injected drugs regularly, and received income from government social assistance or pension program. Five of seven Satellite Sites were in subsidized community housing complexes, while two were in a private apartment buildings. Four were long-standing sites, having been part of the program when it was volunteer based, with the other three sites having joined the program in the year prior to data collection. For Satellite Site clients who participated in formal interviews, three out of four were male, and between 20-30 years of age, with the fourth participant in the 50-60-year age range. Of the clients interviewed, one was homeless, with the remaining three living in subsidized community housing. All names used below are pseudonyms; potentially identifying details are omitted or altered.

2.3 Results

The Satellite Sites straddle two worlds. As places where people gather to use drugs and where drug selling occasionally occurs (as some SSW also sell or allow drugs to be sold), these sites are

subject to the stigma and criminal sanction that accompanies the use and sale of illicit drugs. Yet they are also sites of public health intervention because health education, harm reduction supplies, and overdose intervention are offered in these locations. These sites offer a unique opportunity to examine the challenges of medicalizing a place that is still also criminalized. The results that follow trace the tactics of medicalization used to frame the Satellite Sites as a public health intervention. Next, the interactions between the police and the medicalized Satellite Sites are explored, to examine how SSW are willing to subject themselves to surveillance from medical institutions because it provides protection during police interventions. Finally, the way that criminalization still impedes the ability of individuals to implement public health best practices is examined.

2.3.1 The tactics of medicalization

2.3.1.1 Making public health professionals out of people who use drugs through training and provision of equipment

One of the key tactics of medicalization in the Satellite Sites was to provide legitimacy to SSW by professionalizing them, turning them into formal CHC staff members, employed to provide an official public health intervention. In an interview, the creator of the Satellite Site program was very explicit regarding the importance of receiving funding in 2010, which allowed SSW to become formal, salaried employees of the CHC, and to provide regular training for them. He outlined how:

> "We recruit them, and we train them. We make professionals out of them, and we have them distribute harm reduction materials and make referrals, basically do everything that our other peer workers do, but they do it from their homes." (Staff interview)

SSW receive a modest monthly salary, a cell phone, and weekly supervision in the form of a visit from the Satellite Site Coordinator (who is also a person with lived experience of drug use). Similar to other peer workers, they apply their lived experience and public health training to provide services to a hard-to-reach population, those who do not access traditional harm reduction services at the CHC. One of the major differences between SSW and other types of peers, however, is that SSW not only operate out of their homes, many operate what are commonly perceived as 'crack houses' or 'shooting galleries' as part of their formal employment, since many allow people to use drugs within their Satellite Sites, with some also allowing drugs

to be sold onsite or facilitating drug transactions. One SSW distinguished their site from more stigmatized places:

> "In the next building, there's a crack house there…And they're not getting stems, or any [*harm reduction*] supplies, they're just getting crack. That's the difference, right?" (SSW interview)

The sterile harm reduction equipment being distributed, coupled with the training received by SSW and their ability to provide referrals to health and social services, all reinforce the medicalization of the sites. This provides a distinction between the Satellite Sites and other spaces that are not medicalized and are solely subject to criminalization (even though the illicit activities going on in both are very similar). This is illustrated in the encounter observed in a Satellite Site operated by James, as he tries to convince Amelia to visit the hepatitis C clinic for PWUD at the CHC with him:

> James and Amelia are chatting, and he's clearly checking in with her, and seems worried. Over the next few minutes, her story comes out. Not only does she have hepatitis C, but she is struggling with some mental health issues. She doesn't like leaving her apartment building, but is especially scared to see a doctor, because they've "locked her up" in the past. She tells James: "I don't feel good. I know I've got Hep C, but they told me I can't get treated while I'm still using. My liver hurts. Everything hurts. I think I'm really sick. It doesn't matter anyway, I know there's no chance that they'll treat me."
>
> James spends the next few minutes patiently telling her about how hepatitis C treatment has changed, and that you don't have to stop using drugs to access it. As he's talking, he's making up a bag for her, with a few crack pipes, screens, some alcohol swabs, and a few needle kits – he clearly knows her "regular order". He tells her: "Listen, I'm going on Wednesday. Why don't we go together? I'll introduce you to the people who run the Hep C program. You can check it out with me, see what you think." (Field note – October 2016)

The training that SSWs receive provides them with enhanced knowledge on medical topics related to drug use, such as recent changes in hepatitis C treatment eligibility. Due to the training and the legitimacy that it provides within the community, SSW can play a key role in facilitating

linkages to the formal health care system for marginalized PWUD who may be otherwise unconnected to healthcare services. The training received by SSW, alongside their distribution of equipment for safer drug use, and the education and referrals to the healthcare system that they provide all function to make new subject positions available to PWUD, as a kind of quasi-healthcare worker within a space that has traditionally been difficult for other types of healthcare workers to access.

2.3.1.2 Using overt markers to affirm professional status and affiliation with the health sector

Like other employees in the health sector, SSW are provided with official staff identification badges bearing their photo and job title from the CHC. ID badges are reinforced by a framed plaque on the wall that designates each site as an official satellite location of the CHC. Observations in the sites support the usefulness of these markers in defining the Satellite Sites as "official" settings with a public health role:

> When we arrive, Candice is wearing her ID badge around her neck. It's only Candice's second month as a SSW, and she is clearly very proud of her new position. In her apartment, she shows us her plaque, on a table in the living room. "Everyone who comes in can see that I'm an official site now…I want people to know that this is my job, that I'm doing this for real." (Field note - September 2016)

Even though there is no 'rule' saying they must be displayed, all the sites visited had their plaque prominently displayed on the wall. SSW would occasionally wear their ID badges when observation visits were occurring, but more frequently, the badges would be hung from or close to the plaques, on display even when not being worn. SSW voluntarily take up elements traditionally present in medical settings (such as ID badges), not only to prove their affiliation with the medical system, but also as protection from potential criminalization for drug offences should police enter the site. The utility of ID badges and plaques is explained by a SSW:

> "Oh it does help us, big time. I mean you could have a little snot-nosed cop that thinks he's going to change the world, right? And has never heard nothing about it. He'll give you a hard time. But most of the time, you say harm reduction and you show them the

> thing [*plaque]*, they're more interested in knowing how it works and what it's all about." (Focus group)

The formal employment status of the SSW – as harm reduction workers employed by a CHC - reinforced by ID badges and plaques as markers of this status, are key components in reinforcing the role of SSW as health workers, and of the sites as a legitimate public health intervention.

2.3.1.3 Claiming the Satellite Sites as a public health intervention

In addition to the tactics outlined above, the CHC running the program also took several steps to officially claim the Satellite Sites, and ensure that they would be accepted as a public health intervention. This process closely mirrors the ways in which, in classic medicalization theory, medical professionals expanded their influence by claiming authority over an increased number of health conditions as sites for medical jurisdiction (Conrad, 2005). In this case, senior administrators actively claimed authority over the Satellite Sites as a public health intervention, expanding their medical authority beyond the walls of the CHC. Descriptions of the Satellite Sites were framed using terminology referencing theories and approaches - 'population health' and 'health promotion' – that are formative to the field of public health:

> If you really want to have a big population health level impact on a group of people whose health behaviours are criminalized and pushed underground, you need innovative ways to reach those folks…In good health promotion work, across the board, whether you're talking about drug use or diabetes or cardiovascular disease or healthy activity and eating, we all know that community members reach community members in a different way. And in a way that you need to pair with professional services to have the best, the broadest population health impact. It's not like we're actually working so far out of the box, from a good health promotion model perspective, right? (Staff interview)

The process of claiming medical authority over the Satellite Sites by the CHC – of medicalization them – is necessary to legitimize the sites as a formal public health intervention. It has the effect of undercutting efforts by police to criminalize SSW, which would impede them from providing harm reduction services. One of the program administrators explained that, in the early days of the program, he would get calls in the middle of the night from police who had entered a Satellite Site, to verify their association with the CHC, and the employment status of

the SSW. Because of this, the CHC conducted outreach to local police department division to explain the Satellite Sites, their role, and their public health function: “We had to go and talk with police, train them. Get them involved, get their liaison officers involved” (Staff Interview). By engaging in this outreach to the police, the CHC was officially claiming these sites as locations of public health service delivery and intervention, legitimizing them and reinforcing the affiliation of the Satellite Sites with the medical and public health authorities, to lessen the impact of laws criminalizing drug use and their enforcement on the sites and their clientele.

2.3.1.4 Impacts of medicalization: Interactions with the police

In Canada, a mechanism exists to apply to the federal Minister of Health for an exemption from the CDSA (federal drug laws), which allows supervised injection sites to operate under strict regulations, but without fears of police enforcement of drug-related criminal offences (Kerr et al., 2017). The Satellite Sites do not qualify for an exemption, and are thus subject to the CDSA, which prohibits the possession, purchase and exchange of illicit drugs such as crack cocaine, crystal methamphetamine, and opioids such as heroin and fentanyl. This leaves the Satellite Sites open to potential police intervention. The following incident, which occurred during the time of this study, was described by a client who was present in the Satellite Site when it occurred, and is an example of an interaction with police in the Satellite Sites:

> “We were hanging out at Stephen's house. And like, nine or ten cruisers all pulled up to the building. And somebody that was down in the lobby came up and said 'Hey guys, just so you know, there's a ton of cops outside. Don't go down, just stay in here.' Then, there was a knock at the door, 'Boom, boom, boom, boom.' And I thought, 'Holy fuck, this is it.' And they (*police officers*) came in. They were looking for somebody who had been to Stephen's house, to pick up supplies. And they didn't say anything about any of the things around! I noticed at least one cop was looking at it (*crack pipes, cookers and syringes*), and I've never seen police come in like that, in terms of like, they're there for what we're doing there, and just ignore it.” (Field Note – February 2017)

Both the client and the SSW referred to in the story confirmed that used cookers and crack pipes were clearly visible when the police entered, and that there were three boxes of sterile needles on the table. Stephen (the SSW who operates the Satellite Site in this field note) elaborated that he knew some of the police officers involved, and that they had previously questioned him on his

role as a SSW. He noted improvements in interactions with police over the years, and highlighted the formal affiliation of the Satellite Sites with the CHC as being the major factor leading to this change:

> "I've had them (*the police*) come there a couple times. But, you know, seeing I got the plaque saying I work as a Satellite, right, they know there's no sense of laying a charge, because when it goes to court, the judge is going to give them shit." (SSW interview)

This was not an isolated incident of police respecting the status of the Satellite Sites as a public health intervention. The founder of the program also confirmed that the police would frequently verify the affiliation of the Satellite Sites with the CHC, during investigations or when they would enter a Satellite Site:

> "Some Satellite Sites had direct contact with police, and police have come, especially the ones that have lot of people coming. The police have been supportive of it. And I've had calls, like, two o'clock in the morning, on a weekend. You know, 'This person says they work for you and has ten thousand used needles. Is this yours?' 'Yeah, it's ours.' That's it. No charges." (Staff interview)

Due to the ongoing criminalization of drug use, PWUD are key targets of the criminal justice system, and actively engage in strategies to minimize the risk of arrest and incarceration (Cooper et al., 2005). In the case of the Satellite Sites, operating a space where people gather to use drugs carries a risk of criminalization that can be partially mitigated by the protection afforded by being affiliated with a CHC. This tension between criminalization and medicalization, and the way that medicalization could productively be used to counter the negative impacts of criminalization (as a system of social control), is illustrated in this quote from the program founder:

> "I asked them if they'd like to be a satellite site, for the program. And then, of course, their question would be, 'What's in it for me?' A fair question. And at the time, the 'What's in it for me?' was that if you're busted, because there's a lot of drug activity going on – if you're busted, we're going to come to court and we're going to testify and say, what a peach you are; you're helping the community; you are making sure people don't get HIV.

> And it worked. We were able to keep people out of jail, quite a bit, because of that. And police, even police bought into the concept, eventually." (Staff interview)

Here, the importance of protection from criminalization for SSW is emphasized. The motivations for becoming a SSW are complex, and include the desire to provide a necessary health service to their communities. However, becoming a SSW entails the acceptance of surveillance from the medical and public health authorities of their homes and their everyday lives – through the training they receive, the monthly visit from the Satellite Site Coordinator, and the reporting they complete on the number of visits to their site and the equipment distributed. A key motivation for accepting this surveillance is because it provides protection in case of police intervention.

2.3.2 Limits to the impacts of medicalization

While the medicalization of the Satellite Sites has had concrete effects on the way the police are reported to be interacting with the sites, it is inconsistent and often also directly superseded by the criminalization of drug use that is still in place. Fieldwork for this study occurred during a period of escalating overdose morbidity and mortality, which is being termed an "epidemic" and a "national public health crisis" (Howlett, 2016; Special Advisory Committee on the Epidemic of Opioid Overdoses, 2018). Canadian public health officials have repeatedly framed the epidemic, and the issue of drug use in general, as a "public health crisis", and have been encouraging people to call for help from 911 for paramedic response when overdose occurs. This contrasts with the perception voiced by SSW and their clients in this study, that the police were using calls to paramedics for overdose to identify locations where drug selling and communal drug use was occurring, and target them for police 'raids'. The SSW below tied a recent police raid on his apartment and his subsequent arrest to an overdose that had occurred in the stairwell of his apartment building a few days before.

> "I didn't want her (*the women who overdosed*) to use here. There's been too much heat, and I was getting worried. And I felt a bit bad, right? Cause she's been homeless awhile now, she doesn't have another place to go. But anyway, I heard after (*her overdose and subsequent hospitalization*) that she ratted me out. And that pissed me off! I had helped her out. The cops came at her in the hospital and pressed her and she ratted me out. That was how they got the warrant." (SSW interview)

Some Satellite Sites allow PWUD to use their drugs onsite; while this has advantages by allowing quick response in case overdose occurs, it also puts SSW in a difficult position of having to frequently respond to overdoses, with all the stress this may entail (Kolla & Strike, 2019). The overdose epidemic, and the fears of police enforcement occasioned by calls to paramedics following the occurrence of overdose, has changed how some Satellite Sites are operating:

> It (*increasing police enforcement)* is changing how I'm letting people use at my place. Now, I don't let people use, at all. They could be pissed off at me, and you know what? I can't help it. It is what it is, and I'm sorry. (Focus group)

As seen above, the medicalization of the Satellite Sites has had effects on the way police respond to these spaces. However, a change in the tactics used by police is also having effects on the types of health interventions – in this case supervising drug use - that are SSW are willing to provide in the Satellite Sites. Previously, they would allow people to use drugs onsite, to be able to intervene quickly in case of overdose. However, the fear occasioned by a perceived increase in police enforcement activities, and the perception that police are increasingly targeting places where overdoses frequently occur is trumping the willingness of SSW to implement public health advice to not use drugs alone. This is an example of how the fear of increased police enforcement may be shaping the future possibilities of care within the Satellite Sites (Farrugia et al., 2019), and provides an example of the ways that criminalization of drug use is impeding the uptake of public health messages during a public health crisis.

2.4 Discussion

This paper explores the tactics of medicalization that were used to reframe the Satellite Sites from being only sites of illicit activity, subject to penalties from the criminal justice system, to being a medicalized intervention with a public health mandate. Previous literature on medicalization has highlighted how the support of representatives from the medical community are often necessary for successful medicalization (Conrad, 2007). Here, the concrete tactics of medicalization pursued by the CHC sought to professionalize SSW. The actions of the CHC came about due to grassroots activism by PWUD working within the CHC, who sought to expand and ensure access to harm reduction services in the community and to counter the

negative effects of criminalization of illicit drug use. The professionalization of SSW through training and formal employment, and the affirmation of their status using ID badges and plaques attesting to their affiliation with a CHC were key tactics that provided legitimacy to the Satellite Sites and SSW. Crucially, the CHC 'claimed' the Satellite Sites as a public health intervention in multiple interactions with the police. As a firmly established and well-recognized part of the health care sector, this tactic of medicalization functioned to effectively expand medical authority beyond the walls of the CHC and into the spaces where people gather to use drugs, providing legitimacy to the intervention happening in these spaces.

In contrast to critiques that focus on the disempowering experience of medicalization on 'patients' as medical and public health authorities increase their authority and power (Lupton, 1997), the medicalization of the Satellite Sites was sought out and embraced by PWUD, including the program's founder. This finding contrasts with research highlighting the potential for medicalized environments for PWUD to be sites of surveillance and social control, including supervised injection sites and methadone clinics (Bourgois, 2000; Fischer, Turnbull, Poland, & Haydon, 2004). One of the key differences here is that the Satellite Sites were developed and implemented by PWUD directly in the environments where people were already gathering to use drugs, without the direct participation of healthcare providers or formal public health authorities. The Satellite Sites fill an important gap in service delivery to these populations, by providing a medicalized environment that is nonetheless still informal and markedly less clinical than sanctioned supervised injection services that are operated by medical staff within CHCs and public health clinics. The Satellite Sites provide an example of a peer-run, low-threshold environment that, in conjunction with more medicalized environments (like sanctioned supervised injection services), can form a continuum of services. While the integration of peers within service delivery for PWUD is increasingly recognized (Marshall, Dechman, Minichiello, Alcock, & Harris, 2015), the benefits of developing a continuum of harm reduction services that include low-threshold, peer-led approaches similar to the Satellite Sites should be prioritized as a way to expand the scope of safer environment interventions, and more effectively address a wide range of needs and comfort levels among PWUD.

It is important to note, however, that PWUD are willing to accept having more of their 'everyday lives' under the surveillance of the medical system - as is effectively done by training satellite site workers, making their homes into satellites of the CHC, and having them report on how

many people they see and how much sterile equipment they distribute – because it provides some protection from the continued criminalization of illicit drug use. An expanding field of research examines the effects of criminalization on the health of PWUD, finding overwhelmingly negative effects on both health and social outcomes (Debeck et al., 2017; Werb et al., 2008). And the negative effects of criminalization on the everyday lives of PWUD is clearly a factor influencing participants in our study to accept and expand this initiative. As opposed to being docile or passive in the face of hegemonic medical authorities (Armstrong, 1983), PWUD were active in taking the lead to bring about medicalization within spaces that were traditionally closed off to both medical and criminal justice system authorities. They sought out the legitimacy provided by a formal association with the medical sphere because it afforded them protection from criminalization due to their drug use.

However, this protection from criminalization is inconsistent. We document how the perception that police were increasingly targeting places where overdoses frequently occur is affecting the ability of SSW to put in place public health advice not to use alone during a public health crisis. While we cannot independently confirm whether police enforcement has increased in the way described by SSW and their clients, there are reports of increased penalties associated with selling fentanyl in cases of fatal overdose (The Canadian Press, 2017), despite the lack of evidence that increasing the penalties for drug-related offences is effective (Friedman et al., 2011). The increasing hesitation of PWUD to enact public health advice surrounding overdose prevention - particularly SSW, who have received training, are well-supplied with harm reduction equipment including naloxone kits to reverse opioid overdoses, and are well-positioned to quickly intervene due to their long history of allowing people to use drugs in their Satellite Sites – highlights how criminal enforcement has the potential to undermine a key grassroots and public health response to the overdose epidemic. Public health recommendations not to use alone, which are attempts to keep people safe during an overdose crisis, are directly undermined by police raids and threat of criminal sanctions. While the legitimacy associated with medicalization provides some protection to people who operate and use the Satellite Sites from sanctions from the criminal justice system, there are tensions that occur due to the concurrent medicalization and criminalization at work within the Satellite Sites. These tensions have potentially negative impacts on the uptake and effectiveness of public health programming aimed at PWUD, and contribute to shaping the future possibilities of care within the Satellite Sites (Farrugia et al., 2019).

Here, exploring the Satellite Sites as an 'evidence-making intervention' can be fruitful (Rhodes & Lancaster, 2019). As opposed to seeing the Satellite Sites as a health intervention with stable impacts and fixed effects, framing them as an evidence-making intervention allows for an analysis of relations that are enacted within the Satellite Sites, and the multiple effects that are generated through the implementation of the sites (Rhodes et al., 2016). Rather than practices in opposition to each other, both medicalization and criminalization can instead be seen as 'frictions' that come together locally in the implementation of the Satellite Sites (Rhodes et al., 2016). While medicalization is a key practice in the implementation of the Satellite Sites, our findings highlight how the interplay between medicalization and criminalization that occurs locally in the implementation of the Satellite Sites – particularly the fear that police enforcement activities are targeting places where overdoses frequently occur – is giving rise to variable, multiple and locally-produced lived effects within the Satellite Sites, that may shape the future possibilities of care within the sites. This has particular effects for PWUD who take up roles as SSW within the Satellite Sites, as a type of harm reduction worker outside of formal programs. Like other types of peer positions, the status of SSW as people who use drugs is crucial, as this affords them access to otherwise hidden or closed off community spaces where people gather to use drugs (Kennedy et al., 2019; Kerr, Oleson, Tyndall, Montaner, & Wood, 2005a; Marshall et al., 2015). However, they occupy a liminal position, as quasi-health workers intervening in environments that are still subject to criminalization due to the illicit drug use occurring within them. Despite their crucial role intervening within a risk environment for drug use, they remain in a structurally vulnerable position due to the continued criminalization of drug use, and without the legal protections afforded to workers in sanctioned harm reduction services like supervised consumption services or formal needle and syringe distribution programs (Fraser, Rance, & Treloar, 2016; Kerr, Oleson, Tyndall, Montaner, & Wood, 2005b). Addressing this continuing structural vulnerability from criminalization is crucial in attempting to examine how interventions such as the Satellite Sites can be made otherwise, to address the stigmas and discrimination faced by PWUD due to the legal status of illicit drug use.

Care must be taken in assessing the transferability of these findings to other geographical settings. The criminal laws governing drug use in different jurisdictions, as well as the impacts that the presence or absence of other forms of harm reduction programming may have on the development of harm reduction programming within the spaces where people gather to use drugs should be considered in interpreting transferability to other settings. While there is the potential

for response bias, several strategies were used to attempt to mitigate this limitation. First, the collection of a combination of observational and interview data provides rich, detailed material for analysis and provides a check against response bias. Additionally, the use of a focus group for member checking is a method for ensuring the validity of findings, and was used in this study to enhance credibility (Creswell, 2013). The combination of multiple qualitative data collection methods (observational and interview-based) is useful for providing insights from environments which are hidden and difficult to research due to the nature of the illicit activities occurring within, and can generate important insights to inform both policy and public health practice.

2.5 Conclusion

Medical and public health authorities have been grappling with how to respond to the evidence that the responses of the criminal justice system to illicit drug use may directly contribute to increasing drug-related harms more broadly. Prominent health officials in Canada, including the Medical Officers of Health for Vancouver and Toronto, have publicly called on the federal government to examine decriminalization of illicit drug possession to reduce the harms associated with drug use, with the backing of municipal authorities in both cities (Lupick, 2018; Woo, 2016). Our findings align with the growing body of evidence that criminalization itself is responsible for causing harm to PWUD, with the structural effects of drug laws and drug law enforcement as one of multiple effects at play within the Satellite Sites, leading to continued structural vulnerability for SSW as they attempt implement harm reduction interventions within community spaces where people gather to use drugs. More broadly, it suggests that criminalization is interfering with the ability of public health interventions to have an impact on the considerable opioid overdose crisis. Given the increasing recognition that criminalization of illicit drug use is not only responsible for a wide variety of health and social harms, but is also contributing to impeding the response to a public health crisis, it is increasingly urgent that public health authorities clearly articulate the ways in which criminalization itself is interfering with the medical and public health responses to drug use and advocate for changes to drug policy.

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Chapter 3
‘It’s too much, I’m getting really tired of it’: Overdose response and structural vulnerabilities among harm reduction workers in community settings

3 Abstract

Background: In response to the devastating overdose epidemic across Canada, overdose education and naloxone distribution programs (OEND) targeted at people who use drugs have been scaled-up. The ways in which people who use drugs (PWUD) – who experience social and structural vulnerabilities due to their drug use – enact advice from these health education campaigns remains underexplored. This study examines structural vulnerabilities that constrain PWUD as they attempt to implement OEND program advice.

Methods: Data were drawn from an ethnographic study of “Satellite Sites”, a program where people who use drugs are employed by a community health centre to operate satellite harm reduction programs within their homes. Data collection included participant observation within the Satellite Sites, complemented by semi-structured interviews and a focus group with Satellite Site workers. Thematic analysis was used to explore impacts of responding to overdose.

Results: OEND advice includes not injecting alone, carrying naloxone, and calling 911 if overdose occurs. The ability of Satellite Site workers to respond according to public health guidelines is complicated by contextual and structural factors including a lack of supervised injection services, vulnerability to eviction, and continued criminalization of drug use. Participants described how responding to increasing numbers of overdoses was stressful, with stress compounded by their close relationships with those overdosing. These factors were impacting the willingness of Satellite Site workers to continue to supervise drug use.

Conclusion: OEND programs are essential and effective; however, they are a response to a crisis within a policy and legal environment framed by criminalization of drug use. Efforts to expand access to complementary interventions, such as supervised injection services, safer supply interventions, and protections against evictions are necessary to complement OEND programs,

and address multiple contextual factors within the risk environment for overdose. Additionally, criminalization will continue to impede and constrain the public health response to drug use.

3.1 Introduction

North America is in the midst of a devastating drug poisoning and overdose epidemic; it is estimated that 3,998 people died in Canada of opioid-related overdose in 2017, a death rate of 10.9 per 100,000 (Special Advisory Committee on the Epidemic of Opioid Overdoses, 2018). In response to this crisis, public health education programs consisting of overdose education and naloxone distribution (OEND) have been scaled-up to facilitate overdose response in the community. Naloxone is an opioid antagonist medication that quickly reverses the effects of opioid overdose if administered soon after overdose onset. OEND programs are premised on the idea that having naloxone easily available within community settings allows for friends, family, and members of the general public to be able to intervene and reverse the life-threatening respiratory depression that characterizes opioid overdoses (Green, Heimer, & Grau, 2008). However, OEND programs are primarily aimed at people who use drugs (PWUD), who experience high levels of stigma, as well as social and structural vulnerabilities that stem from or intersect with the criminalization of drug use (such as poverty, repeated interactions with the criminal justice system, and housing insecurity)(Quesada, Hart, & Bourgois, 2011; Rhodes et al., 2011). This paper explores a unique intervention, where PWUD are hired as harm reduction workers to run ‘satellite’ harm reduction programs from their homes, and examines how they enact OEND program advice within these community settings where people gather to use drugs. OEND programs are effective and life-saving, providing PWUD with crucial tools to respond to overdose; however, these programs are implemented amidst the continuing criminalization of drug use, a major contextual factor that frames the risk environment in which overdose, and overdose response, occurs. Our analysis examines how criminalization exacerbates the structural vulnerabilities faced by PWUD as they respond to overdose, constraining their ability to implement OEND program advice. Additionally, we explore how continuing stigma against drug use contributes to structural vulnerability and limits the availability of supports for trauma and burnout for PWUD responding to multiple overdoses.

3.1.1 Structural violence and structural vulnerability

Structural violence and structural vulnerability are two inter-related concepts that address how social, economic and political forces structure the potential for or experience of suffering and harm, and negatively impact health outcomes (Bourgois, Holmes, Sue, & Quesada, 2017; Farmer, Nizeye, Stulac, & Keshavjee, 2006). Structural violence describes the phenomena where social arrangements and large-scale social forces – such as gender and racial inequalities, as well as income inequality and poverty - impose disproportionate injury and suffering on certain people and population groups (Farmer, 2004; Scheper-Hughes, 2003). It highlights how suffering and harm are produced by structural and institutional forces, rather than being the result of an individual's actions or choices (Farmer et al., 2006). The related concept of 'structural vulnerability' highlights the patterned way in which vulnerability to harm or suffering is imposed on and constrains individuals or members of a defined population group due to their social location or 'positionality' within hierarchical social structures (Quesada et al., 2011). Here, the focus is on the ways in which demographic and socioeconomic characteristics interact with various socio-cultural factors and policy trends (such as notions regarding who is deserving of treatment, or the stigma surrounding drug use and the way this influences treatment within healthcare settings), such that an individual's vulnerability to suffering varies differentially based on their position within social, political, economic and institutional structures (Bourgois et al., 2017). Together, these concepts give focus to how the structural contexts surrounding drug use – including the laws that criminalize drug use and the policies that flow from these laws - produce vulnerability to an array of drug and health-related harms, and reflect dominant power structures that normalize these harms as the natural consequences of drug use.

There is accumulating evidence for the criminalization of drug use as a structural risk factor with impact on health outcomes, with particularly negative impacts on HIV prevention and treatment (Debeck et al., 2017; Wolfe, Carrieri, & Shepard, 2010; Wood et al., 2010). Drug use is located at an uneasy nexus of medicalization and criminalization, with the medical system claiming 'substance use disorders' as medical issues requiring treatment, while the criminal justice system concurrently criminalizes the possession and use of many psychoactive drugs, exposing PWUD to arrest, criminal charges, and incarceration (Conrad & Schneider, 1992). Previous research has highlighted how the vulnerability of PWUD to health conditions such as HIV can arise from a "complex system of interactions" between individuals, the social structures

within which they find themselves, and their environments, a framework referred to as the 'risk environment' (Rhodes, 2009; Rhodes et al., 2011). In this way, structural vulnerabilities are akin to the social determinants of health, in that they both highlight the ways in which agency is constrained while vulnerability to negative health outcomes for PWUD is exacerbated by 'upstream' forces and social, economic and political processes such as income inequality, housing instability, gender or racial discrimination, and histories and continuing experiences of colonization, which differentially affect people positioned at particular social locations (Bourgois et al., 2017; Rhodes et al., 2011). As structural vulnerabilities and structural violence are embedded in social structures (Rhodes et al., 2011), they provide a method of examining how laws criminalizing drug use, and institutional policies influenced by those laws can shape the experiences of PWUD as OEND programs are scaled-up to address the overdose crisis and consolidated within public health programming.

3.1.2 Origins and impacts of overdose education and naloxone distribution programs

OEND programs targeting people who use illicit drugs pre-date the current opioid-overdose crisis, having emerged in the late 1990's in Chicago and parts of Europe (Dettmer, Saunders, & Strang, 2001; Maxwell, Bigg, Stanczykiewicz, & Carlberg-Racich, 2006). They rely on the idea of mutual aid, employing the social networks of PWUD to reach populations at high risk of overdose and provide them with the tools to intervene directly when an overdose occurs (Faulkner-Gurstein, 2017). As such, OEND programs capitalize on the fact that PWUD have long been the first line of response when their peers experienced overdose (Green et al., 2008). While several of the original OEND programs emerged from organizations that have strong representation among PWUD, including the Chicago Recovery Alliance (Maxwell et al., 2006), there has been much recent interest in OEND by public health authorities, and program expansion has occurred in reaction to the overdose crisis as an attempt to reduce overdose-related mortality (Fairbairn, Coffin, & Walley, 2017). This situation is broadly similar to the evolution of needle and syringe programs and supervised consumption services (Friedman et al., 2007), where OEND programs developed by and for PWUD are becoming firmly ensconced under the purview of public health authorities as a means to address a public health crisis.

As OEND programs have been scaled-up, there has been little attention paid to the ways in which OEND programs – as a structural intervention within the risk environments where

overdose occurs - may interact with the structural vulnerabilities faced by PWUD as they attempt to respond to overdose. For example, OEND programs provide training on overdose prevention, recognition and response, and commonly focus on several factors, including the following messages: 1) Don't use drugs alone; 2) Carry naloxone; and 3) Call paramedics for emergency response in case an overdose occurs (City of Toronto, 2019; Health Canada, 2019b; 2019c; Towards the Heart, 2019). Recent Canadian materials also include reference to Good Samaritan legislation that was recently passed to provide protection against prosecution for simple possession for those at the scene of an overdose (Clark, Wilder, & Winstanley, 2014; Health Canada, 2019a; 2019b). This legislative change was made to address documented hesitation among PWUD to contact emergency services during overdose events because of the criminalization of drug use (Koester, Mueller, Raville, Langegger, & Binswanger, 2017). It remains unclear whether the legal and policy changes that enabled the roll-out of OEND programs impact the structural vulnerabilities faced by PWUD.

Several evaluations demonstrate that OEND programs are effective, and that PWUD and those in their social networks can successfully administer naloxone during opioid overdose events (Clark et al., 2014; Doe-Simkins, Walley, Epstein, & Moyer, 2011; Green et al., 2008; Tobin, Sherman, Beilenson, Welsh, & Latkin, 2009). Some research suggests that widespread roll-out of naloxone distribution in targeted geographical areas is responsible for significant reductions of overdose-related mortality (Maxwell et al., 2006; Walley et al., 2013). Reports document that some PWUD report a sense of heroism and pride at being able to intervene successfully in overdose and save a life (Marshall, Perreault, Archambault, & Milton, 2017; Wagner et al., 2014). However, negative emotional responses including reports of burn-out, vicarious trauma, and feelings that responding to overdose is a burden due to the stress involved have also been recorded among people who frequently respond to overdose (Bardwell, Fleming, Collins, Boyd, & McNeil, 2018; Marshall et al., 2017; Wallace, Barber, & Pauly, 2018). While there is early recognition that resources for addressing these negative emotional reactions are necessary for frequent responders, this has mostly been focused on professionals, such as paramedics, in highly affected areas (Johnson, 2017). There are few resources available that directly address the stress and negative emotional reactions faced by PWUD who respond frequently to overdose (Shearer, Fleming, Fowler, Boyd, & McNeil, 2018).

3.1.3 Barriers to calling for emergency help

There is a substantial research base documenting that one of the major barriers to calling for emergency help in overdose situations is fear of police involvement and arrest (Bennett, Bell, Tomedi, Hulsey, & Kral, 2011; Davidson et al., 2003; Koester et al., 2017; Wagner et al., 2014). In an attempt to address this, several jurisdictions in North America have implemented 'Good Samaritan' legislation, where people who contact emergency responders at the scene of an overdose receive some legal protections from prosecution for drug-related charges (Davis, Webb, & Burris, 2013). In Canada, the 'Good Samaritan Drug Overdose Act' was passed in 2017, and provides protection against prosecution for simple drug possession to those at the scene of an overdose (Health Canada, 2018). Limitations of this type of legislation are that it only provides protection for a small range of drug-related offences (such as simple possession), and often does not extend protection to people on parole or probation, with the result being that many PWUD remain vulnerable to arrest and criminal charges if they contact emergency services during overdose incidents (Koester et al., 2017; Latimore & Bergstein, 2017a). The limits of Good Samaritan legislation highlight the tensions between criminalization and medicalization in the attempt to respond to the overdose epidemic, and expose the ways in which OEND programs – which are being implemented to attempt to save the lives of PWUD amidst continuing criminalization of drug use - might influence structural vulnerability within the risk environments where people use drugs. This study examines how structural vulnerabilities and the continuing criminalization of drug use constrain PWUD as they attempt to implement the public health advice contained in OEND programs.

3.1.4 The Satellite Sites

Data for this study were drawn from an ethnographic study of "Satellite Sites" in Toronto, Canada. The Satellite Site program is operated by a community health centre with a large, in-house harm reduction program. In order to expand the temporal and geographic reach of their harm reduction program, the community health centre employs Satellite Site workers (SSW) in the community. SSW are PWUD, who are trained and hired to operate small, satellite harm reduction programs within their homes (Strike & Kolla, 2013). The Satellite Site program is based on a secondary distribution model where harm reduction equipment and supplies are distributed throughout the community to people who may not be willing or able to access traditional harm reduction programs. SSW are paid staff of the community health centre to

recognize the work they are performing (Anderson, Clancy, Flynn, Kral, & Bluthenthal, 2003; Bryant & Hopwood, 2009; Strike et al., 2013). Sites are chosen because they are already well-known within the community of PWUD, and represent convenient locations to pick up sterile drug use equipment and supplies. SSW decide how to operate their individual sites, including whether they wish to allow clients to consume drugs onsite, and whether they sell or allow drugs to be sold onsite. SSW receive compensation in the form of a $250CAD stipend per month and a paid cellular telephone, and attend regular training sessions on topics related to their work.

3.2 Methods

This ethnographic research was designed and implemented in collaboration with a group of SSW, including the program founder, using a community-based research approach. The first author had worked extensively with the harm reduction program prior to beginning this study, and was well-known to SSW after having conducted a previous evaluation of the program (Strike & Kolla, 2013). Following research ethics board approval from the authors' institution, all SSW were invited to an information meeting, given information on the study, and offered the option of participating or not without repercussions on their employment with the community health centre. SSW who were interested in participating provided informed consent for observation in their site prior to the first visit, and were informed that they could opt-out of site visits, ask the researcher to leave at any time during site visits, or withdraw from the study at any time. All Satellite Site visits were arranged in advance by the Satellite Site Coordinator, an employee of the community health centre responsible for supervision of the Satellite Site program, who is also a peer. The Satellite Site Coordinator was present during all research visits to the Satellite Sites. SSW were provided with a $20CAD honorarium at each visit, and agreed to inform all Satellite Site clients present during observation visits of the research study using a short script.

Sequential interviewing was used to guide sampling; in this approach, multiple 'cases' are sequentially observed and interviewed until saturation is reached (Small, 2009). In total, 57 observation visits to Satellite Sites were conducted, beginning in September 2016 and ending in March 2017. Visits occurred once or twice a week between 4:30pm and 1am and were conducted on varying days of the week to capture variation between weekday/weekends. Field notes on observations were recorded immediately after leaving sites, and expanded upon in detail the

following day, using principles outlined by Emerson, Fretz, & Shaw (2011). Due to the criminalized nature of activities within the Satellite Sites, all data collected was anonymized, with the real names of participants and locations of Satellite Sites never recorded in field notes.

Seven Satellite Sites were visited on a regular basis. Two Satellite Sites were in privately-owned apartment buildings, and five were located in subsidized social housing complexes. The closest Satellite Site was located 2 kms from the sponsoring community health centre, and the farthest was located 11 km away. The SSW running these seven sites included six individuals and one couple. Three of the SSW were men and five were women, and all were between the ages of 45-70 years old, injected drugs regularly (although their drugs of choice varied), and received much of their income from government social assistance programs.

In addition to participant observation, one-on-one interviews with SSW were conducted outside of field visits as a method of complementing and expanding upon the observations recorded and informal conversations that occurred within the Satellite Sites. Five SSW who participated in frequent observation visits were interviewed twice; the first interview took place prior to the beginning of participant observation and was used to explore their reasons for joining the Satellite Site program, and general issues faced during their work. The second interview occurred following the end of participant observation visits, and was used to expand on and clarify issues and themes that arose during observation visits. Following informed consent, interviews were audio-recorded, and all interview participants were offered a $20CAD honorarium. Two of the SSW who were interviewed were men, and three were women, and were between the ages of 51-70 years old. They all injected drugs regularly.

A focus group was also held with four SSW and the Satellite Site coordinator following the completion of all data collection activities, and once the initial round of thematic coding was completed by the lead author. Four of the focus group participants were women, and one was male; all were between the ages of 51 and 70 years old. During this focus group, which functioned as a form of member-checking, initial themes and preliminary findings were presented to participants, to allow for discussion, development, and refinement of the themes. Conducting this discussion with participants as a focus group allowed for their reflections and insights on the initial themes to be recorded as data, that could then be analyzed to allow for

further refinement of the themes. All participants provided separate consent for the focus group, and were offered a $20CAD honorarium.

3.2.1 Data analysis

Data analysis was guided by a theoretical approach which aimed to foreground the ways in which structural and social forces shape individual actions that are often viewed (and framed) as individual-level risk behaviours (Campbell & Shaw, 2008; Rhodes, 2009; Rhodes & Moore, 2001). This approach shaped the focus on the way that laws and institutional policies encountered by PWUD might constrain and shape their experiences. Dedoose qualitative analysis software was used for data management and coding (www.dedoose.com). Field notes and interview data were analyzed using an iterative process guided by thematic analysis (Braun & Clarke, 2006). Beginning in the early stages of participant observation, field notes were coded for key themes. As data collection progressed and interviews were conducted, emergent themes were grouped by category, and in subsequent iterations of coding, themes were refined and portions of data were recoded. Overdose and overdose response was identified as a key thematic area as the frequency of overdoses picked up in late 2016. Discussions in the second round of interviews with SSW (held in February 2017) and in the focus group (held in June 2017) revolved heavily around overdose due to the deaths of several community members that occurred around the time when these data collection activities were held. A key theme to emerge in the focus group discussion on overdose were the complexities involved in attempting to respond to overdoses according to the advice presented in public health campaigns on OEND, and how this was resulting in unforeseen issues for SSW. Close attention was paid to social and structural factors related to overdose response in further iterations of coding; this highlighted the ways that public health advice presented in OEND programs shaped experiences “on the ground” in situations requiring overdose response. All names presented here are pseudonyms; details that might have potentially identified a participant have been altered.

3.3 Results

As part of the response to opioid overdose deaths, public health authorities across Canada have issued advice and scaled-up OEND to attempt to prevent overdose-related fatalities. All of the

SSW who participated in the study had received training on OEND from a program developed by Toronto Public Health, the municipal public health authority (Leece et al., 2013), and had naloxone on site at their Satellite Sites. The findings are organized by the three common components of OEND program advice that were identified, which intersect with and sometimes exacerbate some of the structural vulnerabilities faced by PWUD: 1) Advice not to use drugs alone; 2) Administration of naloxone to reverse overdose, and; 3) Instructions to call 911 for paramedic response when a person overdoses (City of Toronto, 2019; Health Canada, 2019b; 2019c; Towards the Heart, 2019). Our final theme explores the lack of attention to structural factors influencing overdose within the environments where OEND programs are implemented.

3.3.1 Don't use drugs alone

OEND campaigns encourage PWUD not to consume drugs alone. Information from coroner's investigations into overdose deaths in British Columbia, Canada, found that a minimum of 69% of people who died of overdose had used alone (BC Coroners Service, 2018). Consuming drugs alone in a location where intervention is not readily available could be considered a risk environment for overdose (Rhodes, 2009). While the primary purpose of the Satellite Sites is the distribution and disposal of harm reduction equipment, many Satellite Sites allow clients to inject drugs on site. Participants framed this as providing a safer environment that reduces overdose risk as it allows for quick response in case overdose occurs:

> *"*It's a safe place. It's wonderful because for people in the area, who need any supplies, they can just get it from us, right? Cause most of the places are closed, and a lot of the people are homeless too. So, it's really convenient for them, and it's safer, if they have to inject or do anything like that, at least we're there. If they're by themselves, with the risk of them overdosing, we're there to watch them, right?" *(Interview with SSW)*

Due to their proximity to drug use, SSW had extensive experience responding to overdose prior to the current crisis. However, the increased contamination of the drug supply with illicitly-produced fentanyl and fentanyl-analogues has led to SSW having to respond to a much higher number of overdoses than ever before. They repeatedly spoke of how responding to multiple overdoses within the Satellite Sites was increasingly stressful:

> "Like, I've had three ODs in one week, like, give me a fucking break. You know? I'm exhausted after, right? It's like emotionally, you're exhausted. Physically, you're okay, but emotionally, I'm stressed now." (*Focus Group with SSW*)

The stress of intervening in an escalating number of overdose situations within their Satellite Sites was leading SSW to question the practice of allowing people to inject in their sites. At the time of this study, there were no authorized supervised injection services (SIS) in Toronto to which SSW could refer their clients if they did not want to allow injections:

> "One of the problems I have is a lot of service users are my friends. And I don't particularly like to use alone, just because, I think that's not safe. For me now, it's a dilemma, because I don't want people to use in my house, cause of all the overdoses. But, it's a really fine line. I think it's a great thing to be able to provide a safe place for someone to use. But it's been hard, and so I'm having to take a little bit of a harder line, which is not easy for me.*" (Focus Group with SSW)*

Advice not to use alone ignores that the person who is supervising injections is exposing themselves to having to intervene in a stressful and potentially traumatic situation. At the beginning of the study period, all 7 Satellite Sites that were visited frequently would allow close friends and family members to inject onsite, with 4 also allowing acquaintances to inject onsite. Due to the increase in the number of overdoses, SSW were becoming ambivalent about allowing injections in their sites, and felt torn by a desire to continue assisting community members to stay safe, while wanting to protect themselves against stress and trauma generated by events surrounding overdose response. During the study period, one SSW decided to stop allowing acquaintances to inject at their SSW, and with a second (the speaker above) considering limiting access.

Additionally, SSW also expressed worries that responding to overdose may have repercussions on their ability to maintain their housing:

> "Seriously, if someone ever dies at my place, I'm screwed, right? I'm so screwed. And look at how many overdoses happen. So I stopped that. I can't let people keep using at my place. I can't, like, I'll lose my housing if that happens." *(Focus Group with SSW)*

This fear of eviction was exacerbated by the precarious housing status of SSW, who all described previous experiences with homelessness; additionally, the majority of SSW were currently housed in social housing.

> "When I walk down the hallway, with my keys in my hand, I still have, like just a rush. I was homeless for two years. And every day of those two years is ingrained in my head, of how horrible it was, to not have a place of my own. So yeah, I wouldn't put my housing at risk, in any way." *(Interview with SSW)*

The precarity of their housing status represents an acute example of structural vulnerability; for those in social housing, eviction would result in ineligibility for social housing, and likely result in an inability to find suitable low-cost housing arrangements. This vulnerability to housing loss is not addressed by public health advice not to use alone. Coupled with the stress generated by intervening (and having to be constantly ready to intervene) in multiple overdose events, it functioned as a constraint on the ability of SSW to continue to supervise drug use within the Satellite Sites.

3.3.2 Carry Naloxone

The expansion of OEND programs in the current overdose epidemic has led to increasing availability of naloxone for PWUD - and their family and friends - to have on hand to quickly reverse opioid overdose. Participants in this study repeatedly highlighted how naloxone was a useful and necessary tool in responding to overdoses:

> We arrive at James' place, and he is very agitated, very frazzled. He starts telling us that Tom just ODed in the bathroom, and that he's been trying to get him to come around. I look inside the bathroom as we pass by, and I can see 3 syringes in there, one in the sink, one sitting on top of the (closed) toilet seat, and one on the shelf under the mirror. There is also a cooker on the bathtub ledge, and an empty vial of naloxone is also in the sink, with the top broken off. In the next room, Tom is sitting on the bed, still heavily on the nod, and soaked in sweat. He doesn't seem to be doing too well, and is swaying heavily, like he can barely hold himself up. But he is breathing steadily and responds to us when we talk to him. James tells us: "He went down in the bathroom. I had to naloxone him in there. Thank god I still had some around, I've been running low lately. It was hell getting

> him out of there, it's so small, and he hit his head as he went down. It took me a half hour, to get him out of there. Sorry, I'm so hyped up. Sorry!" Over the next hour, we monitor Tom as he slowly starts to come out of it, and becomes more alert. *(Field note)*

SSW not only used naloxone when people overdosed at their Satellite Sites, they also served as distribution points for naloxone, providing it alongside training on its use to clients:

> We are getting settled, and Susan (*the Satellite Site coordinator*) starts asking Leah (*SSW*) about the amount of injection materials - syringes, cookers, water, and filters - that she has been distributing. Leah immediately cuts her off, saying "Do you have more naloxone? I've been giving out so much. I'm down to my last vial here, and I want to have more around." Susan pulls out her bag, and takes out a small cardboard box, that has about 10 vials of naloxone in it. She takes out 4, and hands them to Leah. "I have to keep some for Mitch," Susan tells Leah, "He's had a run on overdoses lately and needs to restock as well." (*Field note*)

As the overdose crisis escalated, SSW have been responding to increasing numbers of overdoses, as well as serving a vital role in the provision of OEND to people who may be otherwise unconnected to health and social services. As 'go-to' people in their communities with access to harm reduction supplies and training, SSW are frequently intervening in drug-related emergency situations:

> *"*I've had two, three overdoses in the last month. I know what to do with naloxone and do it, and I'm actually pretty calm about it. But it is definitely after the fact that it hits you." *(Focus Group with SSW)*

Access to naloxone is crucial for SSW, and for PWUD in general. However, access to naloxone alone does not mitigate the stress stemming from the increase in the volume of overdoses occurring. Participants expressed that they were beginning to be exhausted by the emotional burden of an increased number of overdoses, despite having access to means to intervene:

> SSW1: But now, because of the drugs being a lot harder, and the carfentanil out there, I'm finding, oh my god, every time someone's using, they go down.
>
> SSW2: It's too much, I'm getting really tired of it.

> SSW1: Yeah. It's stressful, and my son had to do it. He's saved someone [*with naloxone*]. I wasn't home. I was at work. Oh god. He was a mess when I came home and asked him what happened. (*Focus Group with SSW*)

While there is clearly an emotional toll that accompanies having to intervene in overdose so frequently, SSW are trained to respond, and are able to implement their training when necessary. Their closeness to the people experiencing overdose – who are experiencing a life-threatening situation and who they must intervene on - is a major factor complicating the emotional stress and trauma experienced by SSW, particularly since many of the clients of Satellite Sites are their friends and family members. In this field note, a Satellite Site Worker describes receiving a phone call that a family member - her nephew - is overdosing at a friend's house, where they do not have any naloxone. She describes her emotional state as she takes naloxone to the scene of the overdose:

> "I was so scared! As soon as I heard that on the phone, that he was down *(overdosing)*, I just took off running. It's so scary, especially when it's your own family! As I was running there, I just kept thinking, 'Oh my god, am I going to make it there? Am I going to make it on time?' It's not far, it's only about 5 minutes away. But it felt like forever. And since then, I'm having a bit of a hard time, you know? I can't stop thinking about what would have happened if…if I didn't make it in time." *(Field note)*

Participants not only recognized the negative emotional impacts of overdose response, but also highlighted the lack of supports available to them. In the following excerpt, SSW highlight that some attention has begun to be paid to the stress and trauma that front-line emergency service workers are experiencing, and the development of workplace supports for them (Johnson, 2017). They also point out that these resources are not being provided to PWUD, who are also on the front-lines intervening in overdoses, and whose stress may also be compounded by their close emotional ties to the people experiencing overdose:

> SSW1: They're starting to pay attention to paramedics in Vancouver, who are going around to all the different overdoses and the trauma and post-traumatic stress that they're having. But they're not paying attention to the stresses that people who use drugs, who are having to deal with all these overdoses are going through, right?

> SSW2: No, of course not. That's what pissing me off, is once again, you see who's getting prioritized - it's nurses; it's doctors; it's paramedics. We need to be worrying about their feelings. But people who use drugs who are actually dealing with this on their own -
>
> SSW1: - who are already saving more, probably more lives than them to begin with and for a longer period of time! Cause they're people who use drugs and, that's all there is to it. Right? No need to worry about their stress! (*Focus Group with SSW*)

In this excerpt, participants demonstrate attentiveness to the workings of structural violence, which privileges the provision of resources to some groups of people due to their position in the social hierarchy, while constraining access to others who are equally or more in need of resources, but, in this case, are experiencing social marginalization due to their drug use and the stigma that accompanies it (Farmer, 2004; Quesada et al., 2011).

3.3.3 Call 911 if overdose occurs

The third key message in OEND programs is that people should call 911 for emergency medical service (EMS) or paramedic response when an overdose occurs. Negative experiences with police complicate this seemingly straightforward advice, since police often accompany paramedics on overdose calls (Bennett et al., 2011). Following an overdose in one of the Satellite Sites, this SSW explained that fear of attention from police and the possibility of arrest influenced the decision of whether to call 911:

> "When I brought those people back – I gave them the option – do you want an ambulance? Do you want to go to the emergency room? Do you want me to stay with you? Cause no one wants to call the ambulance. You only do it if you have to. Too much risk of heat, of having the cops at your place." *(Field note)*

While allowing people to use drugs at Satellite Sites is not a program requirement, many SSW do so out of a sense of responsibility for fellow community members. This presents a particular risk for SSW living in subsidized or social housing, as mentioned above, who repeatedly spoke of incidents where eviction proceedings were started against other tenants following calls to 911 for overdose. Because ambulances attending overdoses were often accompanied by police and/or the security service employed by the social housing provider, an overdose was used as grounds to establish that a tenant was using or allowing others to use drugs in their apartment, in

buildings where illicit drug use is expressly forbidden. Additionally, the excerpt below refers to the impression - prevalent within certain buildings with high volumes of drug use and calls to 911 for overdose - that police were using 911 calls for overdose to identify locations for future drug-related ‘raids’:

> SSW1: So part of the whole thing is that they just put in place the Good Samaritan Act, which is so that if, so it's to encourage people to call 911, if you have an overdose, and get help, right? And part of the thought behind that is that if it's hard for people to call, then people are more likely to die.
>
> SSW2: But the only thing is it doesn't address the housing issue. It addresses the police issue, but it doesn't address if you're in a building that doesn't want any kind of drugs, and you know that going in.
>
> SSW3: I heard that all the people that were raided [*by police*], all the people that were raided in the building, they were evicted. Because of the no tolerance thing *[no tolerance to drug use in a social housing building]*. (*Focus Group with SSW*)

While Good Samaritan legislation is designed to prevent arrests during 911 calls for overdose, it was not designed to prevent other negative outcomes such as eviction. As described above, tenants in social housing buildings may be evicted for using or allowing illicit drugs to be used in their homes. These housing policies highlight the ways in which PWUD experience structural vulnerability, where precarious housing and vulnerability to housing loss can constrain the decision to call emergency medical services during an overdose situation, even within a larger legal environment characterized by the presence of Good Samaritan legislation.

3.3.4 Lack of attention to structural factors influencing overdose

As noted above, a major factor in the local environment impacting SSW was the lack of SIS in operation at the time when this study was conducted. The lack of SIS meant that even if SSW did not want to supervise injections in their Satellite Sites, there was a lack of safer environment interventions to refer people to, where they could be supervised in a sanctioned environment. SSW also recognized the need for additional intervention at the structural level, since SIS, similar to OEND programs, have as a major goal to prevent harm to PWUD by intervening after they have overdosed:

> SSW 1: Because SIS are not going to stop people from overdosing. It's just going to save them, right? It's not going to stop the amount of overdoses.
>
> SSW2: Like, the only way they're going to be able to make it safe is by legalizing it. (*Focus Group with SSW*)

Here, participants recognized and highlighted the potential to address the overdose crisis with interventions that recognize the vulnerability inherent in leaving people dependent on a toxic illicit drug supply, and intervene to divert people who use drugs onto a safer, legal and regulated drug supply. These types of interventions might include forms of heroin assisted treatment or newer innovations in injectable opioid agonist treatment (Ferri, Davoli, & Perucci, 2005; Oviedo-Joekes et al., 2016; Supervised Injectable Opioid Agonist Treatment Committee, 2017), as well as novel pilot interventions such as safer supply programs that aim to divert people from the illicit drug supply by providing pharmaceutical hydromorphone tablets without the supervision or treatment goals inherent in opioid agonist treatment (Rai, Sereda, Hales & Kolla, 2019; Tyndall, 2018; Woo, 2018). This would represent a move to intervene at the level of the drug supply, and prevent the occurrence of overdose, rather than solely focusing on interventions, such as OEND programs and supervised injection services, that ensure quick and effective intervention following the occurrence of overdose.

3.4 Discussion

This study explores how OEND programs, which rely on community networks of PWUD, are both necessary and life-saving. However, OEND programs are implemented within an overall risk environment where criminalization of drug use remains the legal framework. Criminalization influences policy in ways that have repercussions for PWUD, particularly with regards to policies governing housing and the provision of supports for addressing the emotional stress from dealing with repeated overdoses. In this environment, the effective implementation of OEND as a measure to address the opioid overdose crisis is complicated and impeded by the continuing criminalization of drug use, and the ways in which the constraints imposed by criminalization exacerbate the structural vulnerability of PWUD.

This paper highlights three policy areas that clearly increase structurally vulnerabilities of PWUD, and reflect the structural violence inherent in these policies: Good Samaritan legislation, housing policies allow for evictions for those who use drugs or allow drug use in their apartments, and the lack of safer environment interventions. Reflecting an attempt at medicalization of the opioid overdose epidemic, Good Samaritan legislation introduces limits to the criminal charges possible against PWUD at the scene of overdoses, in an attempt to remove barriers to calling 911 for assistance (Latimore & Bergstein, 2017b). In the Canadian context, however, this legislation is limited to preventing charges related to simple drug possession. The larger legal and policy environment is characterized by continued broad criminalization of drug use, which influences housing policy, including policies that specify that tenants may be evicted for using or allowing illicit drugs to be used in their apartments. These types of evictions have been documented in several jurisdictions, and can have negative effects on the health of those evicted (Bruijn & Vols, 2019; Bruijn, Vols, & Brouwer, 2018). Housing insecurity resulting from an eviction occasioned by a 911 call not only increases structural vulnerability, but the use of eviction against people who call 911 following an overdose in their apartment is a clear example of structural violence.

While our study illustrates that OEND can be lifesaving and are necessary in the context of increasing overdose deaths, they should ideally be accompanied and supported by the broad scale-up of environmental and structural measures that aim to increase the health and safety of PWUD while also addressing the structural vulnerabilities they face. A major element of structural vulnerability is the lack of supervised injection services in operation during the period where fieldwork was conducted, despite longstanding documented need (Bayoumi et al., 2012). SIS are a form of safer environment intervention, that provide supervision of drug use by trained workers who can quickly intervene in case of overdose, and where state sanction of their services means that workers do not risk arrest or eviction. The efficacy of SIS are backed by strong research evidence, including findings that they reduce morbidity and mortality from overdose (Potier, Laprévote, Dubois-Arber, Cottencin, & Rolland, 2014). SIS are not a panacea for addressing the high rates of overdose in the context of the current highly toxic drug supply; however, they form an integral part of a comprehensive response to the overdose crisis, and provide an important service for those who choose to use them (Scheim & Werb, 2018). Most importantly, lack of SIS in a community means there is no alternative intervention available if

SSW decide not to supervise injections. This reveals a fundamental tension with the public health advice not to use alone: in the absence of SIS, PWUD have no choice but to implement haphazard measures, including requests to other PWUD to supervise injections, to ensure that someone is available to administer naloxone in case overdose occurs.

Echoing other research with peer workers, shelter workers, and PWUD who have been involved in front-line overdose response during this crisis (Bardwell et al., 2018; Marshall et al., 2017; Wallace et al., 2018), SSW in our study clearly identified that the increase and intensification in the number of overdoses occurring was having a negative impact on their stress levels and mental health. This was leading some to question whether they would continue to allow people to inject within their Satellite sites. OEND rely on social networks within the community to supervise drug use and respond when overdose occurs, particularly those in areas lacking SIS (Faulkner-Gurstein, 2017). Additionally, recent research drawing on approaches from the field of science and technology studies highlights how the conditions of and outcomes from naloxone administration emerge in relation to a multitude of forces, including the relationships of care between those present at the overdose event, and those receiving naloxone (Farrugia et al., 2019a; Farrugia et al, 2019b). Our findings highlight how the stress and traumatic reactions experienced by some SSW in response to having to intervene in multiple overdoses may have important implications for shaping the future possibilities of care (Farrugia et al., 2019a). If PWUD - or others within their social networks, including family and friends - respond to the stress caused by responding to overdoses with reticence to supervise drug use for those who are at risk for overdose, this may undermine the overall effectiveness of OEND. The experience of trauma – and efforts to protect themselves from experiencing future trauma - may be shaping the future conditions of administration of naloxone, particularly where this interacts with structural vulnerabilities such as housing insecurity. This is a particular danger in areas without sanctioned SIS, where PWUD already face a lack of spaces to use drugs that are supervised by people trained and equipped to respond to overdose.

Attention to the multitude of experiences and outcomes that surround naloxone administration – including those that could be described as positive experiences, negative or traumatic ones, or something more complex – highlight how interventions and support for PWUD and peer workers like SSW who are on the front-lines of the response to the overdose crisis are urgently needed. The development of supports must include attention to the histories of trauma and loss that

PWUD have often experienced, including how stress from overdose response and multiple overdose-related losses may be exacerbating these histories (Bohnert, Tracy, & Galea, 2012; Richert, 2015; Templeton et al., 2016). Additionally, care must be taken to ensure that any interventions are adapted to the realities and needs of PWUD, and the structural vulnerabilities they may be facing (Shearer et al., 2018). OEND programs – particularly the ability to administer naloxone during life-threatening overdose - have provided a group of people who are frequently marginalized by their drug use with both the capacity and power to provide care during overdose events, and attention to the politics of care surrounding OEND programs is necessary to recognize the complexities involved in this contested act of care (Farrugia et al., 2019b). A politics of care approach highlights, for example, the dedication of material resources to addressing trauma among some groups responding to overdose (such as paramedics) but not to others (such as PWUD experiencing marginalization due to their drug use). Given that the current overdose crisis shows no sign of abating, attention to the social relations and arrangements that are contributing to a situation where the stress and trauma of repeated overdose response is being neglected among PWUD within program and policy responses is urgently needed.

In assessing the transferability of these findings to other geographical settings, geographical particularities, including the specificity of the laws in place (particularly Good Samaritan laws), the impacts that the presence or absence of SIS may have on overdose response in the community, and the potential to put in place supports for people engaging in overdose response within community setting should be considered. Multiple data collection methods were used to guard against the potential for social desirability bias, including the use of observation within the Satellite Sites, in addition to one-on-one interviews with SSW, clients and program staff at multiple time points in the study period. Additionally, a focus group was conducted with SSWs and the Satellite Site coordinator to allow for member checking to triangulate findings and enhance credibility (Creswell, 2013). Within the context of this study, ethnographic methods provide insights from environments that can be difficult to access for research, in this case due to the illicit activities occurring and the stigma surrounding them. The combination of multiple qualitative data collection methods (observational and interview-based) is a strength which can generate useful data that can be used to inform public health programs and practice.

It is also important to recognize that both OEND programs and the provision of safer environments (such as SIS) are important yet limited methods of responding to the overdose crisis. Both provide a method of intervening quickly and effectively after overdose has occurred, and they are part of a comprehensive response to the overdose crisis. As important as they are, the overall impact of these types of reactive measures is necessarily limited as they do not address one of the major causes of the current overdose crisis, which is the systematic contamination of the illicit opioid supply with fentanyl (Ciccarone, 2019). Nor do they address the ways in which the privileging of criminalization and interdiction efforts impact the drug market, and structure the larger environment in which the responses to this crisis are occurring (Beletsky & Davis, 2017). While criminalization creates a context that limits the effectiveness of OEND, it also restricts the ability of public health authorities to fully intervene, particularly at the level of the drug supply. Measures needed to address this would include decriminalization and an expansion of safer supply interventions that provide people who are using opioids with pharmaceutical heroin or hydromorphone to divert them from illicit sources (Oviedo-Joekes et al., 2016; 2009; Tyndall, 2018; Wood et al., 2010).

3.5 Conclusion

Health education and promotion campaigns such as OEND are often framed in positive terms, as a method to provide information that individuals may use to protect or improve their health (Gastaldo, 1997). However, OEND campaigns are not simply providing neutral health education. Findings from this study suggest that the arrangements of care made possible by OEND programs provide PWUD – a group frequently marginalized by their drug use - with the capacity to provide care during overdose events. It also explores how, similar to other harm reduction interventions, OEND program implementation is impacted by a legal environment that criminalizes drug use. Implementation of OEND programming within this environment can inadvertently reinforce and exacerbate structural and systemic vulnerabilities that constrain PWUD. Public health authorities must ensure they address structural factors that constitute a major determinant of overdose among PWUD, with a focus on the ways in which criminalization of drug use can impact eviction policies, and on how stigma surrounding drug use limits the supports available to PWUD attempting to cope with stress and trauma from repeated overdose

response. Early OEND programs were initiatives by and for the PWUD community. Public health authorities must ensure the full and authentic participation of PWUD, not only in OEND programs, but also in the development and implementation of the full range of structural changes and supports necessary to effectively respond to the overdose crisis.

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Chapter 4
Practices of care among people who buy, use and sell drugs in community settings

4 Abstract

Introduction: Popular perception of people who sell drugs is often negative, with drug selling framed as predatory and morally reprehensible. In contrast, people who use drugs (PWUD) often describe much more positive perceptions of the people who sell them drugs, describing trust in the people they regularly buy drugs from. This paper explores a harm reduction program – known as the Satellite Sites - that provides harm reduction equipment distribution, education on safer drug use, and naloxone distribution in the community spaces where people gather to buy, use and sell drugs. This program hires PWUD – who may also move into and out of drug selling - as harm reduction workers. It provides an opportunity to examine the integration of people who sell drugs directly into harm reduction service provision, and their practices of care with other PWUD in their community.

Methods: Data were drawn from an ethnographic study of Satellite Sites, where PWUD are employed by a community health centre to operate satellite harm reduction programs within their homes. Data collection included participant observation within the Satellite Sites, complemented by semi-structured interviews with Satellite Site workers, clients and program supervisors. Thematic analysis was used to examine acts and practices of care emerging from the activities of the Satellite Site workers, including those circulating around drug selling and sharing behaviours.

Results: Observations reveal that Satellite Site workers engage in a wide variety of practices of care with the people accessing their sites. Practices like the distribution of harm reduction equipment are more easily visible as practices of care because they conform to normative framings of care. Criminalization, coupled with negative framings of drug selling as predatory, contribute to the difficultly in examining acts of mutual aid and care that surround drug buying and selling as practices of care. By taking seriously the importance for PWUD of procuring good quality drugs, a wider variety of practices of care are made visible. These additional practices of

care include assistance in procuring or buying drugs, the provision of information on drug potency, and a refusal to sell drugs that are perceived to be too strong.

Discussion: Our results suggest a potential for harm reduction programs to incorporate some people who sell drugs into programming. Criminalization is a major factor contributing to the difficulty in making visible the practices of care circulating around drug buying and selling. Taking these practices of care seriously may remove some barriers to the integration of people who use and sell drugs into harm reduction programming. It may also assist in the development of more pertinent public health interventions that understand the key role of drug buying and selling within the lives of PWUD.

4.1 Introduction

Research examining drug selling (frequently referred to as 'drug dealing') has found that it is a common income generation strategy among people who inject drugs, particularly among people who report daily drug use (Debeck et al., 2007; Sherman & Latkin, 2002). In fact, the category of 'drug seller' or 'drug dealer' itself is somewhat elastic, with many people who use drugs (PWUD) moving into or out of low-level drug selling depending on circumstance and economic necessity (Dwyer & Moore, 2010; Fitzgerald, 2009; W. Small et al., 2013). When examining the relationship between PWUD and people who sell drugs, PWUD often describe high levels of trust when buying from their 'regular' drug seller (Bardwell, Boyd, Arredondo, McNeil, & Kerr, 2019), and consider a long and trusted relationship with the person selling them drugs as a source of protection against overdose (Carroll, Marshall, Rich, & Green, 2017; Mars, Ondocsin, & Ciccarone, 2018a; McKnight & Jarlais, 2018). PWUD frequently cite buying from a trusted or known drug seller as a harm reduction strategy that they engage in (Bonar & Rosenberg, 2014; Carroll et al., 2017; Mars, Ondocsin, & Ciccarone, 2018a; McKnight & Jarlais, 2018); despite this, harm reduction programming and research has been slow to engage with people who sell drugs directly.

With few exceptions, harm reduction programs have focused on their clients as consumers of drugs, and little attention has been paid to the ways in which people who engage in drug selling - often the very same people - could be integrated into harm reduction efforts. In the context of the North American overdose crisis, multiple interventions have been scaled up including overdose

education and naloxone distribution programs, overdose prevention and supervised consumption sites, and drug checking programs (Fairbairn, Coffin, & Walley, 2017; Strike & Watson, 2019; Tupper, McCrae, Garber, Lysyshyn, & Wood, 2018; Wallace, Pauly & Pagan, 2019). While there has been some interest in how people who sell drugs might be integrated into drug checking interventions as part of the response to the overdose crisis (Bardwell et al., 2019), the integration of people who sell drugs into other areas of harm reduction programming remains underexplored, and may hold promise as a way to address continuing high overdose death rates.

In this paper, we present and analyse qualitative data from interviews and ethnographic observations of the Satellite Site program - a low-threshold, peer-led harm reduction program operating within the community spaces where people gather to buy, use and sell drugs. The Satellite Site program hires PWUD to be Satellite Site workers (SSW), a form of community-based harm reduction worker. SSWs are well-known in their communities, and are trained to offer harm reduction services from their homes. The Satellite Sites become community access points for harm reduction equipment and information, overdose education and naloxone distribution, and, in some sites, monitoring of drug consumption (Kolla & Strike, 2019; Strike & Kolla, 2013). One of the unique elements of the Satellite Site program is that it works directly with people who may move into and out of drug selling; the result is that some of the SSWs are people who sell, or allow drugs to be sold within their sites. The Satellite Site program is an example of a safer environment intervention (McNeil & Small, 2014; Rhodes et al., 2006), where people who use and sometimes sell drugs are employed to deliver harm reduction equipment and education to their peers. The program aims to improve the health of PWUD by altering the socio-spatial relations within these closed spaces in the community where people gather to use drugs. In this paper, we focus on the practices of mutual aid and support – or practices of care – that were observed within the Satellite Sites. These practices of care circulate in the harm reduction work that occurs between SSWs and their clients, and were also observed during instances of drug selling and sharing. The existence of practices of care surrounding drug selling troubles popular conceptions of drug selling as always or solely predatory, and offers insights into how people who sell drugs might be integrated into harm reduction programs more broadly.

4.1.1 Drug selling and harm reduction

Focusing on drug selling within harm reduction programming is not a new idea. A key early example of this is provided by Grove (1996), who argued that 'real harm reduction' must focus on the key concerns of PWUD, which frequently revolve around availability of drugs, how to find enough money to buy good-quality drugs, and how to avoid detection by the police. 'Real harm reduction' focuses on the harms caused to PWUD by drug prohibition, particularly the harms stemming from an unregulated drug market with no quality control or method of verifying the potency and composition of drugs, and where the risk of arrest and incarceration is ever-present. These are major problems for PWUD, and Grove critiqued early public health interventions for completely ignoring them while also attempting to justify harm reduction by focusing solely on its ability to prevent HIV transmission among PWUD (Grove, 1996). Highlighting that 'drug use is profoundly normal', Grove traces how prohibition and criminalization not only fail to dissuade drug use, but are also social policies that accentuates the harms associated with drug use (1996). He also highlights the drug user organizing that led to 'shooting galleries' being early spaces of harm reduction, where PWUD are able to use drugs off the street and where they don't have to hurry to attempt to avoid law enforcement (Grove, 1996).

While many key components of public health interventions for PWUD (such as needle and syringe distribution programs) started out as survival strategies among PWUD, their uptake and operationalization by public health authorities (who may have little to no connection with communities of PWUD) can lead to services that are not accommodating nor reflective of the needs of people who use drug (Friedman et al., 2007). A prime example of this is the way in which public health interventions have almost completely ignored drug buying and selling except to prohibit it within formal programs and service offerings. Due to criminalization, drug selling represents a particularly contentious issue to be managed for organizations providing services to PWUD, necessitating an institutional focus on rules and regulations. This includes rules that prohibit the sharing or selling of drugs, or—within the context of supervised consumption services—that specify particular methods of drug administration and whether people can receive assistance with injections (Kolla et al., 2020; McNeil, Small, Lampkin, Shannon, & Kerr, 2013). This focus on the enforcement of rules and regulations can alienate and exclude PWUD from accessing much-needed harm reduction services (Davidson, Lopez, & Kral, 2018; McNeil et al., 2013; Small et al., 2011). Unsanctioned and peer-run services that are designed to be 'low-

threshold' and function with fewer rules (or with behavioural guidelines that emerge organically from communities of PWUD) may attract more marginalized service users who would otherwise choose not to access or be excluded from accessing services (Davidson et al., 2018; Foreman-Mackey et al., 2019; Kolla et al., 2020; McNeil et al., 2013; McNeil, Kerr, Lampkin, & Small, 2015; Watson, Kolla, VanderMeulen, & Dodd, 2020).

The difficulties in ensuring that the institutional rules and regulations that surround the delivery of harm reduction services are low-threshold and reflect the local culture among PWUD are amplified in any attempt to work with people who sell drugs, despite the frequent acknowledgment that engaging in low-level drug selling is common for people with high frequency or daily drug use (Debeck et al., 2007; Sherman & Latkin, 2002). Alternate framings of drug selling remain rare. Research has documented how PWUD frequently engage in "helping" and mutual aid behaviours – such as procuring and sharing drugs with each other – that are technically drug distribution or trafficking offences under drug laws (Coomber & Moyle, 2014; Kirst, 2009). Previous research has also documented how the mutual aid that emerges from social ties between PWUD can be protective in cases where people cannot secure an adequate supply of drugs for themselves, and must rely on other PWUD to supply them with opioids as they attempt to avoid opioid withdrawal (Bourgois & Schonberg, 2009; Harris & Rhodes, 2013). Programs that formally and explicitly engage with people who sell, share or exchange drugs (activities that are frequently and often interchangeably referred to as 'drug dealing') in pursuit of harm reduction or public health goals are rarely documented. Framings of people who sell or supply drugs as predatory and morally reprehensible remain popular and enduring (Mclean, 2016). This renders it difficult to explore the practices of mutual aid and support – or practices of care – that surround drug selling and sharing in communities of PWUD.

4.1.2 Practices of care in harm reduction

This paper explores the practices of care that SSWs engage in as part of their harm reduction work, with a focus on the practices of care that circulate around drug selling. Drawing on Foucault's ethics as well as more recent work on pleasure in drug use (Race, 2008), Duff examines how "drug users cultivate and sustain practices of care in contexts of social and economic disadvantage" (Duff, 2015) (pg. 83). Here, 'practices of care' refers both to the practices used by PWUD to care for the self within larger social and economic contexts that remain hostile to drug use, as well as the ways in which people care for others, emphasizing the

often relational character of practices of care (Duff, 2015). Research on the practices of care surrounding drug use has emerged from a concern that the experience of pleasure has been neglected in research on illicit drug use (Race, 2008; Duff 2015). Instead, a focus on the risks and harms associated with drug use has reinforced the 'pathologizing tendencies' of research on drug use, with drug policy and programming reflecting this view of drug use as almost exclusively harmful (Duncan, Duff, Sebar, & Lee, 2017; Race, 2008). In contrast, 'thinking with' pleasure in drug use may provide a way to counter this tendency towards pathologization, allowing for examinations of the pragmatic ways people use drugs to manage illness or pain, and to experience pleasurable sensations and states of consciousness, in addition to the oft-documented negative effects of drug use (Race, 2017; Sybylla, 2001). Nuancing drug use in this way may hold potential to counter stigma and moral judgment against PWUD, and open space to explore how practices of care circulate among PWUD (Duff, 2015).

Much of the concern with care stems from the work of scholars in science and technology studies, where the concept of 'care' carries multiple and often interwoven meanings, including care as indicative of paying attention to something in a careful or watchful manner, 'caring about' as a state of being emotionally attached to something, and 'caring for' as a way of providing for or looking after someone as part of a social relationship (Puig de la Bellacasa, 2017; Martin, Myers, & Viseu, 2015; Mol, 2019; Murphy, 2015). We focus on 'practices of care' to reflect care as an active practice, a moment of active 'doing' of care that engages practitioners in their worlds (la Bellacasa, 2011; Martin et al., 2015). However, it is also important to note that care is a contested concept, and that practices of care are not neutral or uniformly positive acts of affection or attachment (Murphy, 2015). Instead, the concept of care is constrained by uneven and asymmetrical power relations that dictate which practices of care are worthy of attention and to 'count' as care (Murphy, 2015). Practices of care are often embroiled in a complex politics that determines which practices, people and phenomena are recognized as caring or worthy of care, and which are excluded from recognition or analysis (Martin et al., 2015). Acknowledging this contested 'politics of care' highlights how attention to care is selective, where some lives and phenomena are included and attended to, while others are neglected and excluded from consideration or analysis – particularly those marginalized by drug use and related social inequities (Farrugia et al., 2019; Martin et al., 2015). Focusing on 'real harm reduction' (Grove, 1996) by listening to the expressed needs of PWUD around the centrality of drug buying in their lives, and developing interventions that take seriously the practices of care among people who

sell drugs, provides recognition of the practices of care among a marginalized group of people that are frequently ignored.

Practices of care in harm reduction proliferate, yet have only recently begun to be described as such. Examining the practices of care among PWUD builds off research that has repeatedly documented the mutual aid among PWUD. This includes the ways that PWUD (whether formally employed as 'peer workers' or not) support others within harm reduction programs and overdose prevention sites, with more recent research exploring their experiences reversing overdoses in housing and community settings (Bardwell, Fleming, Collins, Boyd, & McNeil, 2018a; Dechman, 2015; Farrugia et al., 2019; Faulkner-Gurstein, 2017; Kennedy et al., 2019; Kolla & Strike, 2019). Practices of care range from the provision of sterile injection equipment to the administration of naloxone to reverse a life-threatening opioid overdose. For example, Fraser describes the 'ethos of community care' that inspires people to maintain large supplies of sterile injection equipment on hand, so that they can engage in secondary distribution of this equipment – a practice of care – to people in need (Fraser, Rance, & Treloar, 2016). Similarly, the way in which the expansion of take-home naloxone programs has allowed new practices of care to develop between a person administering naloxone and a person who is overdosing, has been explored to describe how people will use naloxone to gently reverse overdose, in an attempt to avoid the harms of precipitated withdrawal from more forceful naloxone administration (Farrugia et al., 2019).

Increased attention is being paid to how a strong focus on risk and harm in research on drug use may obscure the wide variety of drug use experiences (Duff, 2015; Duncan et al., 2017; Race, 2017). However, such nuance is lacking when examining drug selling. People who sell drugs are routinely framed not only as uncaring, but as actively predatory towards others (Mclean, 2016). Many studies of drug selling and drug markets focus on the aggression, theft and violence that can occur around drug selling and buying within unregulated drug markets (Erickson, 2001; Fast, Shoveller, & Kerr, 2017; Small et al., 2013). Without ignoring the existence of these important issues, we attempt to broaden the discussion of what constitutes 'care' within harm reduction practice by exploring the variety of practices of care that people are engaging in related to drug selling and drug sharing. Starting with Grove's insight that 'real harm reduction' must attend to the primacy of drug buying and selling in the lives of PWUD (Grove, 1996), in this paper we explore the practices of care that surround drug procurement, buying and selling. Exploring the

practices of care that exist among people who use and sell drugs opens the possibility for a reconceptualization of some aspects of drug selling more generally, and for imagining a place for the broader participation of people who sell drugs in harm reduction programs specifically.

4.2 Methods

4.2.1 Setting

This research was conducted with the "Satellite Site" program, implemented in Toronto, Canada. The Satellite Site program started informally in 1999, as an outgrowth of a peer-developed and peer-run harm reduction program operating inside a community health centre. The founder of the program, who ran the harm reduction program at the community health centre and who openly identified as a person who injected drugs, began to provide home delivery of sterile injection equipment to increase access for community members outside the hours of operation at the community health centre. Noticing that many people maintained communal spaces where people gathered to use illicit drugs, he began asking the people running these spaces if they wanted to keep extra harm reduction supplies around for others who might need them; this was the beginning of the Satellite Site program (Strike & Kolla, 2013). The Satellite Sites were based on a secondary syringe exchange model, where PWUD would distribute sterile injection equipment obtained from formal harm reduction programs to other people who inject drugs out in the community (Anderson, Clancy, Flynn, Kral, & Bluthenthal, 2003; Bryant & Hopwood, 2009; Strike et al., 2005). Since he was familiar with the sites and had spent time observing their operation first-hand, the program founder was able to choose Satellite Sites deliberately, and was able to assess potential Satellite Site workers for their suitability and privilege choosing spaces that were already engaged in high volume needle and syringe distribution and disposal. Due to his close connections with the community, the program founder was also able to verify that the people running the sites were interested in working within a harm reduction philosophy and were not formally associated with any criminal organizations. He also ensured that SSWs were well-connected to the community health centre so that they could provide referrals to the centre for healthcare and social service needs. In 2010, the Satellite Site program adopted a more formal model when the program received external funding (Strike & Kolla, 2013). This allowed for the SSWs –who were previously in a volunteer role - to be employed as paid staff, receiving a

modest salary of $250 a month and cellular telephone. During the study period, there were 9 Satellite Sites in operation, and each distributed and disposed of, on average, approximately 1,500 needles and syringes a month.

4.2.2 Data collection

A community-based research approach was used to guide the data collection in this ethnographic study. The lead author was well-known to SSWs due to previous involvement in an evaluation of the program (Strike & Kolla, 2013), as well as work on other research projects in the community health centre. An advisory group consisting of key members of the program, including the program founder, the Satellite Site coordinator, and several SSWs met regularly with the lead author to provide guidance on research design, data collection and recruitment, and on the interpretation of the data. Research ethics board approval was obtained from the researchers' institution.

SSWs were invited by the lead author to participate in site visits and/or one-on-one semi structured interviews. SSWs who expressed interest in participating provided informed consent for observations at their site prior to the first visit. The consent process included a discussion of how they could opt-out of site visits, ask the researcher to leave at any time, or withdraw from the study completely. As part of the consent process, SSWs were asked to inform any Satellite Site clients who were at the site at the time of a visit about the research study using a short script. Ethnographic observation at the Satellite Sites occurred over a period of 7 months, from September 2016 to March 2017. In total, 57 observation visits were conducted. Sampling was guided by the sequential approach described by Small (2009). Visits occurred once or twice a week, generally in the evenings, with visits held on different days to capture variations in operations between weeknights and weekends. Days and times of observation visits were arranged in advance by the Satellite Site Coordinator, an employee of the community health centre responsible for supervision of the Satellite Site program who regularly visited the sites as part of their job responsibilities and who was present during all site visits. SSW were provided a $20CDN honorarium at each visit. Field notes on observations were recorded immediately after leaving sites, and expanded upon in detail the following day, using principles outlined by Emerson, Fritz and Shaw (2011). An observation guide was used to highlight major areas of attention, and focused on instances of drug use observed (including the buying, selling, preparation and consumption of drugs), any instances of violence or aggression, interventions by

police or paramedics, and interactions between SSWs and clients where harm reduction interventions occurred, including: equipment distribution, harm reduction education, naloxone distribution, overdose education, overdose intervention, and provision of information and referrals to health or social services. All fieldnotes were anonymized using pseudonyms, with names of participants and locations of Satellite Sites never recorded in fieldnotes due to the criminalized nature of activities being observed.

Seven Satellite Sites were visited on a regular basis. Two of these Satellite Sites were in privately-owned apartment buildings, and five were located in subsidized social housing complexes. The closest Satellite Site was located 2 km from the sponsoring community health centre, and the farthest was located 11 km away. The SSWs running these seven sites included six individuals and one couple; three men and five women, all between the ages of 45-70 years old who injected drugs regularly (although their drugs of choice varied), and who received much of their income from government social assistance programs.

One-on-one, semi-structured interviews were also conducted to complement the information gathered during observation visits. SSWs were interviewed twice; once prior to the beginning of observation visits in the Satellite Sites, and once following the completion of visits. In the first interview, they were asked about general issues relating to their work as a SSW, such as how they became part of the program, challenges they faced, and benefits of being a SSW. The second interview was used to expand on issues and themes that emerged from the observation visits. Clients and supervisory staff were each interviewed once only. Clients were recruited from the Satellite Sites, where the researcher would discretely approach them to determine interest in participating in a confidential interview in a spare room in the Satellite Site (if available), or at another location (e.g., a coffee shop or community health centre). They were asked about the experience of visiting the Satellite Site, and their use of other health or harm reduction services. Community health centre staff were also interviewed; staff were all involved in different aspects of administering or supervising the Satellite Site program. They were asked about institutional factors associated with running the program, such as challenges faced in implementation or program expansion. All interview participants gave verbal informed consent to be interviewed, and were offered $20CAD honorarium.

In total, 15 participants were interviewed, including five SSWs, four Satellite Site clients, and six staff members from the community health centre who administered and worked in supervisory

roles over the program. Two of the SSWs who were interviewed were men, and three were women, and all were between the ages of 51-70 years old. They all injected drugs regularly, with four injecting daily, and four lived in subsidized housing complexes, with the remaining SSWs living in a privately-owned apartment building. For Satellite Site clients who participated in formal interviews, three out of four were male, between 20-30 years of age, with the fourth participant in the 50-60-year age range. One client was homeless, with the remaining three living in subsidized community housing.

4.2.3 Data analysis

Data analysis was guided by a theoretical approach that aimed to foreground the ways in which a marginalized group of people engage in harm reduction work in community settings, with a focus on how structural and social forces shape actions that are often viewed (and framed) as individual-level risk behaviours (Campbell & Shaw, 2008; Rhodes, 2009; Rhodes & Moore, 2001). This approach shaped the focus on care as a practice, and on the ways that practices of care were being actively enacted by SSWs in their work with PWUD in the Satellite Sites. Field notes and interview data were analyzed using an iterative process guided by thematic analysis (Braun & Clarke, 2006). Beginning in the early stages of participant observation, field notes were coded for key themes. As data collection progressed and interviews were conducted, emergent themes were grouped by category. The ways in which SSWs engaged in thoughtful practices of care within their work was identified in subsequent iterations of coding as a major analytic trajectory. Later iterations of data analysis refined this analysis by focusing on the interactions between drug selling and acts of care. Dedoose qualitative data analysis software was used for data management and coding. In the excerpts below, all participants are identified by pseudonyms only, and potentially identifying details have been altered.

4.3 Results

4.3.1 Drug selling and practices of care

The Satellite Site program integrates the distribution of harm reduction materials directly into the spaces in the community where people are already gathering to buy and use drugs, and helps make sterile drug injection and unused inhalation equipment more widely available in these community settings. During the observations for this study, people were repeatedly observed

visiting Satellite Sites to get harm reduction supplies and to make use of the sterile equipment available. No instances of needle or syringe sharing were noted. Clients of the sites recognized the health-related benefits of the widespread availability of sterile injection equipment at the Satellite Sites. As one client indicated: “It's probably allowed me to avoid certain health complications. Like, I don't have Hep C, right? I don't have HIV or anything like that. So that's a positive.” *(Interview with Satellite Site Client 1).* This client also stated that he had never accessed a formal harm reduction program, and accessed all his injection equipment at a Satellite Site where drugs were being sold. This speaks to the long history of secondary distribution within harm reduction, where PWUD maintain a reserve of harm reduction materials to distribute to people who may not otherwise be accessing formal harm reduction programs (Anderson et al., 2003; Lorvick et al., 2006; Strike, Myers, & Millson, 2004). Secondary distribution has been well-documented even in jurisdictions where it is illegal, as continues to be the case in Australia (Newland, Newman, & Treloar, 2016). The distribution of harm reduction materials – including the stockpiling of large amounts of equipment by PWUD for friends, family and community members to use - has been described as a practice of care for others (Fraser et al., 2016). The Satellite Site program formalizes this practice of care to further the public health goal of improving access to sterile injection equipment, as this is a key public health intervention to reduce the transmission of bloodborne infections (Fernandes et al., 2017).

Satellite Sites are not required to allow either drug use or drug selling within their sites: SSWs decide for themselves how they wish to run their sites. The Satellite Site program goes beyond the traditional public health focus on the distribution of harm reduction equipment and moves towards ‘real harm reduction’ by acknowledging the ways that buying, using and sometimes selling drugs are intertwined within the lives of PWUD (Grove, 1996). Unlike traditional harm reduction programs located in community organizations or health centres where drug use and drug buying, selling and sharing are not allowed, the Satellite Site program is designed to be located in places in the community where these activities are already taking place. The program recognizes that while access to sterile equipment for drug use is important for PWUD, it is not necessarily their top priority. The following fieldnote is from a Satellite Site run by Phil, a man in his 50’s who injects heroin and also engages in small-scale heroin selling to friends and acquaintances who live in his apartment building. It illustrates the benefits of co-locating harm reduction equipment within the spaces where people are buying and using their drugs:

> There is a knock at the door, and Phil walks over, opening the door a crack. He speaks quietly for a moment to the person at the door, before letting a woman in. Phil asks her what she needs, and she quietly says, "Can I get some kits, and a point *[of heroin]* too?" He goes into the kitchen, grabs an empty grey plastic bag, and passes it to her, gesturing to the stack of plastic drawers holding all the harm reduction supplies. She opens the top drawer, takes a bunch of injection kits (that contain sterile needles, cookers, filters, water, and tourniquets), and then grabs a handful of crack pipes, putting them all in the bag. Phil heads to the bed, and, sitting on the edge, he pulls out a scale and a tiny Ziploc bag. The woman sits on the floor in front of him, watching intently as Phil shakes a little bit of heroin powder onto a small square of paper that he's placed on the scale. He's going slow, tipping powder out of the baggie, carefully weighing the drugs out. Once he gets to the right number on the scale, he looks up at her, and she nods, before he carefully folds up the little piece of paper. She passes him some money, says thanks, and nods a goodbye at us. *(Field note 2016-11-19)*

Increasing access to sterile injection equipment within the spaces where people are buying and using their drugs can facilitate the important public health goal of preventing transmission of HIV and hepatitis C. Additionally, combining the provision of sterile injection equipment with drug purchasing can enable small practices of care in the lives of people who may not be accustomed to receiving care around their drug use.

Another example of a practice of care occurs when SSWs use their personal knowledge of drug potency, and translate it into harm reduction education. Adrienne is a long-time harm reduction worker in her 50's, and runs a Satellite Site out of her apartment. Her clients are mostly friends and family members, and she knows their drug use habits very well. She injects opioids but does not sell them, and mobilizes her personal experience to attempt to prevent overdose among clients:

> They *[client]* will say, 'Oh, what's the junk like?' And I'll say 'I don't know. Which one did you get?' and they'll show me: 'This one'. And I can tell them, 'Be careful, it's a little strong. You can always do more'. But also, they know, 'Don't worry', you know, 'I'll keep an eye on you'. (*Interview with SSW 8*)

Here, Adrienne references both her knowledge of drug potency and her ability to intervene in case an overdose occurs. The Satellite Site program formalize overdose response as a practice of

care by providing SSWs with training in overdose intervention and equipping the sites with naloxone kits that could be used onsite or distributed to their clients (Kolla & Strike, 2019). For clients who use the Satellite Sites, the combination of harm reduction services and quick intervention in case of overdose created a feeling of safety:

> I like that it's a place that's safe and you know nothing's going to happen to you. And shit, Adrienne *[the SSW]* has all the supplies and everything. For example, like, when people overdose, she has everything ready. And she's actually used it *[naloxone]*. (*Interview with Satellite Site Client 2*)

The Satellite Sites were developed as a way of building on the practices of care that exist between PWUD surrounding the distribution of sterile needles and syringes. In the context of the overdose crisis, SSWs also mobilize practices of care to improve overdose prevention and response in the community.

4.3.2 Drug potency, overdose and practices of care

Over the period of field work for this study, the contamination of the illegal heroin supply with illicitly-produced fentanyl and fentanyl analogues translated into an increase in the frequency of overdoses within Canada; this increase in overdose was also seen within the Satellite Sites (Kolla & Strike, 2019; Special Advisory Committee on the Epidemic of Opioid Overdoses, 2019). There are strong indications that fentanyl and its analogues are entering the drug supply chain early, likely in source countries (Ciccarone, Ondocsin, & Mars, 2017; Mars, Rosenblum, & Ciccarone, 2018b). Those involved in street-level drug selling are low on the supply chain and often unaware of the content or potency of the drugs they are selling. The following fieldnotes describe how Tommy - a SSW who also sells heroin - engages in a practice of care related to overdose prevention:

> I arrive at Tommy's place with Sonia, who is looking to buy some heroin from him. After knocking for almost 10 minutes, Tommy finally answers the door. He is clearly very intoxicated, sedated. His speech is disconnected, and he is walking slowly around his apartment running a hand through his hair, barely able to keep his eyes open. "I think I was totally unconscious. I did some dope, Sam brought some new dope over, and it was crazy. You know me, I'm no lightweight, but it just knocked me out. And I only had half a point! That stuff is crazy strong."

> Hearing this story, Sonia pipes up and says, “Hey, Tommy, could I get a bit of that from you? I’ve got 40 bucks. I’ll take some of that good stuff that knocked you out. I can take that off your hands, if you want.” Tommy shakes his head, and says, “No way! There’s no way I’m selling that – it’s too strong. Maybe it’s cut with fentanyl, but it doesn’t feel heavy like fentanyl – it had the smooth, gradual start like good junk. But it’s really too strong. That could kill someone, and I don’t want to be responsible for that.” He takes a dime bag out of his pocket, and takes out a small chunk of beige heroin, putting it on the table. It looks a bit like silly putty, and he takes a kitchen knife from the table and cuts a small chunk off the end, saying, “But don’t worry, this stuff is good too.” *(Fieldnote, 2016-12-14)*

This fieldnote complicates the simplistic narratives that portray people who sell drugs as reckless and indifferent to the wellbeing of their clients. Here, Tommy is troubled by the strength of the heroin he has just consumed, and is unwilling to sell it to Sonia, as he worries that it might cause a fatal overdose. While the idea of integrating PWUD into harm reduction programming and service delivery in the response to the overdose crisis is not new (Kennedy et al., 2019), there has been little formal integration of people who sell drugs into harm reduction programming. This fieldnote points to the potential benefits of integrating people who sell drugs into harm reduction programs within the context of the current opioid overdose crisis.

4.3.3 Mutual aid, drug procurement and practices of care

The example in the fieldnote above is an illustration of a practice of care in relation to drug selling. However, the heavy stigma surrounding drug selling can make it difficult to recognize this and other common practices of care that circulate around drug buying and selling. Common, normative narratives frame people who sell or procure drugs in almost exclusively negative terms, as reckless, predatory, and unconcerned about their clients (Mclean, 2016). The fieldwork for this study challenges this portrayal: PWUD were frequently observed engaging in mutual aid and practices of care to assist each other with drug procurement, which is sometimes referred to as social supply. In social supply, drug transactions within social networks are facilitated either at cost as a means of reinforcing social ties, or at a small mark-up to compensate the seller for their effort, risk or to allow them to finance their own use (Coomber & Moyle, 2014; Hathaway, Mostaghim, Erickson, Kolar, & Osborne, 2018). Helping other people to procure drugs is very common; however, these acts are nonetheless drug trafficking offences. SSWs would frequently

engage in these types of social supply or ‘helping’ behaviours, despite the risk of arrest. During observation visits, a form of mutual aid was frequently observed where clients and SSWs pooled their money and arranged to ‘pick up’ from a drug seller:

> SSW: And I pick up for people too, so. By me picking up, I'm usually, you know, I'm in and out, in and out, in, I'm surprised I haven't got nabbed yet, knock on wood. *(laugh)*
>
> Interviewer: And what's in it for you for picking up for them?
>
> SSW: It depends. From the dealers, I get, you know, some extra. From the people themselves, they'll throw me something. I usually go if I'm making money. *(laugh)* If I'm not making money, I don't want to go. *(laugh)* I mean, it's not a lot of money but it helps.” (*Interview with SSW 7*)

Pooling money for a pick-up was mutually beneficial, both from an economic perspective as the people putting in money would receive a better deal, and because assisting with these transactions helped sustain and cement social relationships. There is also risk involved in providing this help due to criminalization. These helping behaviours are complex, as they comprise elements of assisting others to procure drugs and self-interest in acquiring free drugs.

Additionally, some SSWs were observed helping their clients to negotiate the vagaries of drug markets that lack formal dispute resolution procedures. For example, Sandra, a SSW who did not formally sell drugs, explains how she would often help to procure drugs for Satellite Site clients who were unable to buy drugs due to disputes or unpaid debts with drug sellers:

> Service users know that I do have a good rapport with dealers, and good credit. So sometimes, that will come up, like, you know, 'Oh, well, you get it and then I'll pay you’. (*Interview with SSW 10*)

The Satellite Site program was built around the practices of care surrounding harm reduction equipment distribution within communities of PWUD. By recognizing the importance of drug buying and selling in the lives of PWUD, the practices of care circulating between SSWs and their clients around drug procurement can be rendered visible. Revealing the diversity of relationships and arrangements that surround drug selling may contribute to decreasing the pathologization associated with this often stigmatized practice (Duff, 2015; Farrugia et al., 2019). The following field note from a busy Satellite Site provides an example of how social

supply networks function, and how a SSW was motivated to assist in the procurement of drugs out of a desire to provide assistance to community members:

> It's Saturday night and we are at Bobby's place, sitting in the living room with the TV on in the background. It's been busy, with people coming in and out all night, picking up both injection kits and crack smoking kits. There is a knock on the door, and Bobby comes back with Stella. She says hello to me, as we hadn't seen each other in a while. She turns to Bobby and somewhat sheepishly says, "Bobby, can I ask a favour? Would you mind getting some crack for me, a 40 piece? Your guy, it's good stuff?" Tom perks up, and answers, "Oh yeah, it's good. It's a little grainy right now, like, it's not big rocks, but it's good."
>
> Stella, looking visibly relieved, replies, "Okay, would you mind? My guy, he usually comes to me, he delivers. But he's not working right now. And I know someone else, but we have to meet on the street. And I hate that. I hate standing out on the street, waiting, not knowing if there are cops around. I get so nervous, I hate it. And I feel like the guy I'm seeing now, that he's shorting me. Maybe it's just paranoia, but it seems like the bags are getting smaller and smaller." Stella hands $40 to Bobby, and he gets up, heading towards the door to his apartment, saying, "No problem, I'll be right back."
>
> Stella and I make small talk and watch TV while we wait. About 10 minutes later, Bobby comes back, and hands her a little baggie. Stella looks at it quickly, saying, "Thanks. This is 40?" She's looking closely at the rocks in the bag, and I can tell that she is unsure about the quantity, and probably wondering if she is getting ripped off. Bobby replies to her, "Yeah, this is good stuff. See what I mean, it's a little grainy? But that's the same stuff I had earlier. It's good. Do you need pipes?" Stella, still looking at the bag, and probing it with her nail, replies, "Yeah, that would be great, thanks." Tom packs up a bag of new crack pipes, filters, and push-sticks for her to take. (*Fieldnote 2016-11-12)*

The importance of ensuring an adequate supply of good quality drugs, while also avoiding getting ripped off and being criminalized for drug use is highlighted as a key concern within 'real harm reduction' (Grove, 1996). However, it is not frequently attended to within drug policy or harm reduction research, despite the prominent role it plays in the lives of PWUD. In the fieldnote above, Tom is making it possible for Stella to avoid a situation that was clearly causing her great stress and anxiety, by procuring drugs for her. Stella's expressed fears of getting ripped

off and of encountering police (and by extension, being criminalized for her drug use) are frequent among PWUD. Attending to the primacy of safety during drug procurement is not a traditional concern of public health-oriented harm reduction activities. This is partly due to normative framings of drug use as negative and dangerous, which can make it difficult to see acquiring, procuring or selling drugs as a practice of care, since drug use is almost exclusively framed as dangerous and having no potential of positive benefits for the person using them (Duff, 2015). Validating these acts of mutual aid as practices of care opens up the possibility of integrating interventions around drug selling into harm reduction programming.

4.4 Discussion

The findings from this ethnographic research document the practices of care occurring around drug buying, using and selling within a community-based harm reduction program staffed by SSWs – some of whom are actively engaged in drug selling alongside their harm reduction roles. Common portrayals of PWUD, and particularly people who sell drugs, as solely predatory, lacking in self-control, or as careless obscure the practices of care that were observed in this study. These negative portrayals also make it difficult to integrate these practices of care – and the people who sell drugs who practice them – into public health programming to facilitate harm reduction goals. Harm reduction programs are well-placed to work with people who sell drugs due to their philosophy of meeting PWUD "where they're at," of integrating PWUD within program development and delivery, and of highlighting the health harms associated with the criminalization of drug use. Our findings suggest that there is potential to expand the relevance and reach of harm reduction programming by recognizing the practices of care that occur around drug selling, and integrating them into harm reduction. The criminalization of behaviours that we observed as common among people who use drugs (such as buying drugs together, buying for another person, and pooling money to buy and share a larger quantity of drugs) contributes to the difficulty in making visible the practices of care circulating within drug buying and selling. The criminalization of drug selling has also rendered these behaviours highly stigmatized. Highlighting these practices of care has the potential to remove barriers that hinder the integration of people who use and sell drugs into harm reduction programming, and to develop public health interventions that take seriously the key role of drug buying and selling within the lives of PWUD.

Some of the practices observed in this study are easily recognizable as 'care' (e.g., the provision of equipment for drug use and intervention when overdoses occur) because they align with traditional framings of affective care work as a form of looking after another, or 'caring for' someone (Murphy, 2015). These practices of care are already well-established and practiced within harm reduction programming, particularly in harm reduction programming that utilize 'peer' workers (Kennedy et al., 2019; Marshall, Dechman, Minichiello, Alcock, & Harris, 2015). Offering harm reduction equipment in the same location as drug selling allows for more widespread dissemination of sterile injection equipment, a key public health strategy in reducing the transmission of HIV and hepatitis C. In association with drug selling, these more traditional practices of care lead to increased trust and help facilitate harm reduction education and equipment distribution.

However, other practices we identified are frequently overlooked as 'care' because they are often associated with criminal acts (e.g., assistance in procuring or buying drugs, the provision of information on drug potency, or refusing to sell drugs that are deemed to be too strong). Our results underline how behaviours such as buying drugs together, buying for another person, and pooling money to buy and share a larger quantity of drugs are common within the social networks of PWUD. Despite their frequency, as well as their role in decreasing and sometimes preventing overdose, these behaviours are nonetheless heavily criminalized as drug distribution or trafficking under current drug laws. The criminalization of commonplace behaviours contributes to alienating people who use and sell drugs from the health and social service system, and results in missed opportunities to engage people who are selling drugs in potentially beneficial public health interventions (Debeck et al., 2007; Erickson, 2001). There is potential to expand the relevance and reach of harm reduction programming by recognizing the practices of care associated with drug buying and selling, and integrating them into formal harm reduction programming. The Satellite Site program recognizes and builds upon the practices of care that SSWs are already engaging in within their communities (such as secondary syringe distribution). The inclusion of people who sell drugs in formal roles within harm reduction programming is not only a recognition that they are already engaging in practices of care within their communities, but can contribute to shifting the possibilities of care by "contingently co-producing different capacities for, and subjects of, care" (Farrugia, Fraser, & Dwyer, 2017, pg. 433). This is particularly the case in the context of the overdose crisis in North America; our finding that SSW transmit important information on drug potency to their clients highlights an important potential

role within harm reduction programming for people who sell drugs in the transmission of information on drug potency within social networks.

A key feature of the Satellite Sites is that the drug selling sometimes occurring within them is not seen as a liability, but is utilized to achieve public health goals like increasing access to sterile equipment for drug use. Secondary distribution programs have long been used to increase the reach of more formal harm reduction programs (Anderson et al., 2003; Bryant & Hopwood, 2009; Strike et al., 2005). By situating a harm reduction intervention directly in the spaces where drugs are being bought, used and sold, the Satellite Site program operationalizes Grove's insight that the key concerns of PWUD revolve primarily around how to find and purchase good quality drugs (1996). The program then extends this insight by training PWUD who may move into and out of drug selling as peer harm reduction workers. In doing so, the Satellite Sites provide an example of how to reduce the structural barriers faced by PWUD that impede access to health and social services by providing convenient access to sterile injection equipment directly within the environments where drugs are sold. Importantly, this program also recognizes and formalizes the practices of care surrounding secondary distribution that are already occurring within communities of PWUD (Fraser et al., 2016). Similar to calls for exploring the potential integration of people who sell drugs into drug checking interventions (Bardwell et al., 2019), our findings suggest that an expanded recognition of what 'counts' as care to encompass the practices of care that circulate around drug selling can be mobilized within harm reduction programs in an attempt to address the overdose crisis. Provision of information on drug potency and integration of people who sell drugs into drug checking interventions represent a promising area for expansion for harm reduction programming. It acknowledges a potential role of people who sell drugs in addressing overdose risk from the wide variations in the composition of the opioid supply. Additionally, people who sell drugs represent an avenue for reaching 'hidden' populations of PWUD, who are unconnected to formal harm reduction programs or other health services.

Mobilizing PWUD as peer workers within harm reduction programming and in response to the overdose crisis is an important strategy to expand service delivery and improve engagement with harm reduction services (Kennedy et al., 2019). However, there is a strong need to ensure that this care work is not downloaded onto peer and community harm reduction workers in ways that may reinforce existing marginalization (Farrugia et al., 2019; Kolla & Strike, 2019). Scholars

have highlighted the potential for care work to be exploited and/or exploitative, particularly since care work is traditionally devalued , as it is frequently gendered, unpaid, and associated with groups experiencing marginalization (Puig de la Bellacasa, 2011; Martin et al., 2015). Criminalization of drug use and drug selling contributes to the marginalization of PWUD as they take on work within harm reduction, which has led to documented inequities in stipends, salaries and access to benefits, contingent work, and lack of job protections (Kennedy et al., 2019; Marshall et al., 2015). Harm reduction workers – even those who sell drugs - must be adequately compensated for their labour, and provided with proper supports to address the grief and negative emotional impacts associated with providing front-line services during the overdose crisis (Kennedy et al., 2019; Kolla & Strike, 2019).

Care must be taken when attempting to extrapolate the findings from this study to other geographical settings, as not all environments or contexts would be amenable to this type of intervention. For example, ethnographic research in Montreal, Canada, exploring 'piaules' (the local term for "crack houses") found that these spaces were closely tied to and often operated by criminal organizations, rendering the integration of harm reduction programming into them very difficult (Roy & Arruda, 2015). The Satellite Sites, by contrast, are run out of private apartments by individuals who are not associated with any criminal organization. As mentioned earlier, the founder of the Satellite Site program was very deliberate and took great care in the selection of the Satellite Sites. He used both his familiarity with the community settings where people gathered to use drugs and his in-depth knowledge of harm reduction practices to choose potential Satellite Sites. An in-depth examination of the local norms within the spaces where drugs are used and sold in the community, in partnership with PWUD who are knowledgeable about the local context, is necessary prior to the development of any programming that aims to integrate people who sell drugs into harm reduction service delivery.

4.5 Conclusion

The increased prevalence of fentanyl in the illicit opioid market in most parts of North America has led to a massive increase in overdose deaths in the US and Canada (Ciccarone, 2019; Ciccarone et al., 2017; Special Advisory Committee on the Epidemic of Opioid Overdoses, 2019). It also constitutes a changing risk environment for PWUD (Ciccarone, 2017), where the

presence of fentanyl in the illicit opioid supply is disrupting the ways in which both PWUD and people who sell drugs attempt to keep themselves and others safe from overdose (Ciccarone et al., 2017; Mars, Rosenblum, & Ciccarone, 2018b). Available information suggests that this contamination is happening far up the supply chain, and not primarily among street or low-level drug sellers (Mars, Rosenblum, & Ciccarone, 2018b). Findings from this study suggest there is strong potential to integrate low-level drug sellers– particularly those who know their clients well and are already engaging in practices of care towards them – in harm reduction programming. PWUD have already been integrated into community based initiatives that equip them to intervene quickly when overdose occurs (Bardwell, Kerr, Boyd, & McNeil, 2018b; Kennedy et al., 2019; Kolla & Strike, 2019). Expansion to formally engage some people who sell drugs in overdose response initiatives, transmission of information on drug potency, or in drug checking interventions (Bardwell et al., 2019) may provide an additional avenue for capitalizing on existing practices of care among people who sell drugs, and addressing the opioid overdose crisis at the community level.

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Chapter 5
Conclusion

5

This dissertation has examined a harm reduction intervention - the Satellite Sites program - as a safer environment intervention to reduce drug related harm within the spaces where people gather to use, buy and sell drugs in the community (McNeil & Small, 2014; Rhodes et al., 2006). While implemented to serve a public health goal, the continuing criminalization of drug use means that the Satellite Sites are forced to straddle two worlds; they are concurrently places where illicit and stigmatized drug-related activities occur, while also being sites of public health intervention. The three papers that form the core of this dissertation examine different aspects of how the Satellite Sites are able to 'do' harm reduction in environments of criminalization and prohibition, as well as the limitations that criminalization imposes on the practice of harm reduction and the ability of public health to intervene to reduce drug-related harms.

5.1 Summary of the Chapters

There are several characteristics of the Satellite Sites that make them unique environments to conduct research on how criminalization impacts harm reduction interventions and their ability to achieve public health goals. Due to their location in the homes of PWUD - where drug use, buying, and selling frequently occur - the Satellite Sites offer a unique opportunity to examine the challenges of medicalizing a place that is still also criminalized. In Chapter 2, I focus on the tactics of medicalization used by Satellite Site workers (SSWs) to gain legitimacy as public health workers engaged in harm reduction within these quasi-medicalized, quasi-criminalized spaces. Theoretically, this article extends our understandings of how medicalization functions within harm reduction programs, as it provides legitimacy to the Satellite Sites. By becoming a Satellite Site, PWUD accept surveillance from medical authorities due to the protection it affords from the criminal justice system. By aligning the Satellite Sites with a community health centre in the formal health care sector, the medicalization of these sites has had some success in changing the perceptions of them and lessening the criminal enforcement that occurs within these spaces. However, there are frictions in between the medicalization of the Satellite Sites

under the current regime of criminalization of drug use. The protection that medicalization can provide to Satellite Sites from police enforcement and subsequent criminalization is not complete, which limits the uptake and effectiveness of public health recommendations within the Satellite Sites. In effect, criminalization limits the ability of public health approaches to fully engage with major sources of drug-related harm within these environments, and may be limiting the future possibilities of care within the Satellite Sites.

In Chapter 3, I examine the scale-up of overdose education and naloxone distribution programs (OEND) targeted at PWUD, paying particular attention to the structural vulnerabilities that constrain PWUD as they attempt to implement OEND program advice. OEND advice teaches: 1) not to inject alone; 2) to carry naloxone; and, 3) to call 911 when overdose occurs. However, when SSWs attempt to implement this advice, they are constrained by contextual and structural factors. Advice not to use alone ignores how the person who is supervising injections may have to intervene in a stressful and potentially traumatic situation. At the time of data collection, the lack of supervised injection services in the city led to a situation where SSW did not have the option of referring people to a supervised site with trained workers available to respond. And while access to naloxone provided SSW with the means to respond quickly and effectively to overdoses when they occur, it did not mitigate the stress that people experience from responding to the rising number of overdoses. One of the major findings of this chapter is that people are experiencing stress and negative emotional impacts from the burden of responding to an increasing number of overdoses, despite having access to naloxone. This stress is further compounded by the close relationships of the SSW with those who are overdosing, which is impacting their willingness to continue to supervise drug use. Finally, a significant source of structural vulnerability for SSW stemmed from housing policies that allowed for eviction if they permitted or used illicit drugs in their homes. Even within a larger legal environment that included Good Samaritan legislation, these housing policies constrained the decision to call 911 during an overdose situation, as ambulances attending overdoses were often accompanied by police and/or the security service employed by the social housing provider. Overdose events could then be used as grounds to establish that a tenant was using or allowing others to use drugs in their apartment, in buildings where illicit drug use was expressly forbidden. The continued criminalization of drug use structured housing policies that led to an inability among SSW to fully implement public health guidelines.

In Chapter 4, I explore how the continued criminalization of drug use has made it difficult to work with people who sell drugs within harm reduction interventions. There are few examples of harm reduction programming that integrate people who sell drugs as formal employees; in fact, even the idea of integrating them into harm reduction programming is rare (Bardwell, Boyd, Arredondo, McNeil, & Kerr, 2019). The Satellite Site program provides an example of a safer environment intervention that incorporates some people who use and sell drugs as harm reduction workers. This chapter explores the wide variety of practices of care that SSW engage in with the people accessing their sites around drug selling. Some are more easily visible as practices of care because they conform to normative framings of care; for example, the distribution of harm reduction equipment. However, there are a wide variety of acts of mutual aid and care that surround drug buying and selling that are difficult to perceive as practices of care due to negative framings of drug selling as solely predatory and inherently lacking in care. Using the idea of 'real harm reduction', a term used by Grove (1996) to call attention to the ways in which the priorities of PWUD - such as the primacy of procuring good quality drugs - can diverge significantly from those of public health authorities, a wider variety of practices of care are made visible. Some of these practices of care include assistance in procuring or buying drugs, the provision of information on drug potency, and a refusal to sell drugs that are perceived to be too strong by drug sellers. The findings from this chapter suggest the practices of care that currently circulate between some people who sell drugs and their clients can be harnessed and incorporated into harm reduction programming. However, this is not a straightforward process, as SSW occupy liminal positions, where they are simultaneously harm reduction workers fulfilling a public health function, as well as drug sellers who are criminalized and stigmatized within the current legal system.

In this concluding chapter, I will reflect on conducting community-based ethnographic research in criminalized environments. This includes reflections on gaining access to the Satellite Sites and entering the field, exiting the field, and strategies I employed during data collection and analysis to ensure rigour in my research. I also reflect my positionality as a researcher conducting research during the overdose crisis, and on the need for care when conducting research with people who are impacted by criminalization. Then, I examine the contribution of this research project to public health research, policy and practice, and summarize some of the

limitations of my research. Finally, I examine future research directions that can extend the work accomplished in this dissertation project.

5.2 Reflecting on the Research Process

In this section, I will explore the strategies I used to gain access and enter the field, and reflect on the process of exiting the field. Included in this section are the ways in which people who use drugs were involved in actively shaping the data collection and analysis process. I will also explore the way that the developing overdose crisis impacted the research process that I was undertaking and immersed in, and how ethnographic methods were particularly useful in this rapidly changing and emotionally charged environment. Finally, I will examine my positionality as a researcher undertaking a research project with people who were not only currently using drugs, but who were at risk for criminalization for their drug use. I will explore how my standpoint as a scholar structured my approach to data collection, data analysis, and contributed to the problem I was both creating and attempting to solve through this research project.

5.2.1 Gaining access and entry to the field

Gaining access and entry to the field are key concepts within ethnographic research (Jensen, 2008). As the Satellite Sites are spaces in the community where drug use, buying and selling occur, it was necessary to spend time gaining the trust of the Satellite Site workers, and ensuring that they would be comfortable with my presence in the sites. This was necessary even though I had long experience working with the harm reduction program running the Satellite Site program prior to beginning this research project. I had also been part of the team that had previously conducted an evaluation of the Satellite Sites; due to this evaluation, most of the SSW already knew me as a researcher (Strike & Kolla, 2013). However, I took several deliberate steps to earn the trust of SSWs prior to undertaking fieldwork in the Satellite Sites. This was necessary due to the criminalized nature of drug use and accompanying fears of police enforcement within the Satellite Sites, which renders spaces where illicit activities occur almost completely closed off to outsiders, with newcomers generally also regarded with high levels of suspicion (of being undercover members of law enforcement, for example) (Williams, Dunlap, Johnson, & Hamid, 1992).

One of the major strategies that I used to gain trust was having well-known and well-trusted members of the community vouch for my identity as a researcher, and for my trustworthiness. First, I attended one of the regularly scheduled meetings for SSW at the community health centre. During this meeting, the founder of the Satellite Site program (who was also the Harm Reduction Program Coordinator at the community health centre that ran these programs) explained the research project that I wanted to undertake within the Satellite Sites. While I provided details on the research and what it would entail, he explained that we had a long history of working together and that he trusted me. Not only did he vouch for me, but he also explained to that SSWs that we had been talking about doing research on the issue of drug selling, and that we wanted to explore how to engage with people who sell drugs within harm reduction programming. The use of a contact to vouch for a researcher and assist in facilitating entry into the field is a fairly common practice when conducting ethnography, particularly ethnography with people who use drugs (Dunlap & Johnson, 1998; Northcote & Moore, 2010; Williams et al., 1992). Having a well-respected member of the drug-using community not only vouch for me but explicitly mention that he was working on projects relating to drug selling with me was essential in gaining access to the Satellite Sites. This signaled to SSWs that they could both discuss and potentially engage in drug selling around me. At the end of this meeting, people who were interested in participating in the research project were asked to tell the Satellite Site Coordinator of their interest. In this way, all participation was voluntary – only Satellite Site workers who explicitly stated that they wished to be part of the research project were recruited.

I also formed a project advisory committee to guide me throughout the project, comprised of the Harm Reduction Program Coordinator, the Satellite Site Coordinator, and the Satellite Site workers who I would be regularly visiting. This advisory committee met once prior to the beginning of data collection, and provided advice for field visits including: the best times of day to visit, ideal length of time for visits, how to handle questions about my role in the site and the purpose of the research project, and how to handle questions about client confidentiality. They also provided feedback on the types of questions that I should be asking in the one-on-one interviews with them and with clients. I also met with the advisory committee approximately one month after the start of fieldwork for feedback on the initial visits, with another advisory meeting being held 6 weeks prior to the end of fieldwork, to talk about the process of exiting the field. Having an advisory committee composed of Satellite Site workers allowed for them to not only

have a voice in the research process, but it was a deliberate strategy that I used to decenter the authority of the researcher and build trust, by signaling that I appreciated their perspectives and expertise related to the Satellite Sites (Ronai, 1995). It also allowed for the SSWs to be involved in formulating research questions and ensuring that the data collected would address community concerns and information needs (Israel, Schulz, Parker, & Becker, 1998).

Further steps that I used to gain trust and build rapport included having a one-on-one meeting with each interested Satellite Site worker at the community health centre prior to the beginning of data collection to explain the research project and how they would be compensated for research activities (further details on methods are available in each individual chapter). I also conducted one-on-one qualitative interviews with each of the Satellite Site workers who I would be visiting for observation visits, prior to beginning the field work. While this first interview was a formal step in the data collection process and all Satellite Site workers provided informed consented prior to participating in it, it was also a moment for building rapport and trust as it gave me a chance to ask each SSW questions about their work, their Satellite Site, and its functioning. It also gave the SSWs who didn't know me well a chance to get to know me better, prior to having me visit their homes.

5.2.2 Observation visits to the Satellite Sites and exiting the field

To ease the process of entry to the field, initial visits to the Satellite Sites were shorter than subsequent visits, to give the Satellite Site workers and their clients time to become accustomed to my presence. There was never a set amount of time that I spent in the sites, and I emphasized to Satellite Site workers that if they wanted me to leave at any point, that they should feel free to ask me to go. I also attempted to remain attentive to non-verbal cues that indicated that the SSW wanted me to leave, realizing that SSW may be hesitant to ask directly due to politeness or the potential for my role as a researcher to be experienced as a power imbalance. While I was never asked to leave by a SSW or a client in the site, there were two occasions when a SSW hinted that they were tired, and once when they hinted that someone was coming over who would be uncomfortable with my presence. In both cases, I immediately took the hint and left. I would also occasionally bring coffee or donuts to the Satellite Sites as a small way to recognize the hospitality being offered to me by the Satellite Site workers.

Exiting the field was a process that was planned in advance with the SSWs. During the third advisory team meeting 6 weeks prior to the end of fieldwork, I began to discuss the process of wrapping up the field visits. The Satellite Site workers, Satellite Site Coordinator, Harm Reduction Program Coordinator and I collectively decided when the end of the visits would be at this meeting. The SSWs also knew that I had planned to hold another one-on-one interview with each of them following the end of fieldwork, and to host a focus group several months later for feedback on initial findings with them. I also invited the Satellite Site workers, the Satellite Site Program Coordinator, and the Harm Reduction Program Coordinator to a dinner to celebrate the end of fieldwork and thank them for welcoming me into their Satellite Sites for so many months. The Satellite Site workers chose the restaurant for the meal.

However, my exit from the field was complicated by the tragic and unforeseen death of the Harm Reduction Program Coordinator from an overdose just two weeks prior to the planned end of the field visits. Two final visits to each Satellite Site occurred following his death, and were incredibly emotional, with Satellite Site workers, clients and myself trading memories and stories of him. The community health centre where he worked also held two grief counselling sessions for staff and members of the harm reduction community who had worked with him, which I was invited to. I attended these sessions with the Satellite Site workers, and we spent time processing his loss together. I also attended his memorial service with several of the Satellite Site workers (and hundreds of other community members who also came to honour his memory). I spent hours after the two grief counselling sessions and the memorial sitting with some of the Satellite Site workers, talking with them and grieving together with them.

While I had always planned to hold post-observation interviews after the end of the field visits to the Satellite Sites, these interviews yielded little useful data for this research project. These interviews occurred so soon after the Harm Reduction Program Coordinator's death, and the SSW who participated in them were not interested in reflecting on their work as Satellite Site workers. Some of them had known the deceased for over 20 years, and the SSWs struggled to make sense of his death. My professional background includes several years as a counsellor and social worker, and includes having received training in several forms of specialized counselling. The skills that I gained in counselling have been useful to me as a qualitative interviewer; however, when I first began conducting research interviews, I would consciously remind myself that I was not conducting counselling sessions to remain focused on the research goals of the

interview. During these one-on-one interviews with SSWs, the topic of the Harm Reduction Program Coordinator's death was so central - and their grief was so raw - that I made a conscious decision to leave behind the research goals of the interview. Instead, during these interviews, we spent time talking about him, crying together, exchanging memories, and attempting to put his death into perspective. These interviews were moments to grieve together and contemplate his impact on our lives, and on the development of harm reduction programming in Toronto. In conducting the analyses for this dissertation project and writing up the findings, I have consciously chosen not to engage with the material surrounding the Harm Reduction Program Coordinator's death. This is partly due to the strong emotion that this death still evokes in me several years later, and partly out of respect for the intense and visceral nature of the grief and the emotions that the Satellite Site workers shared with me following his death.

From an analytic point of view – and in contrast to the post-observation interviews - the focus group to discuss initial results from data analysis yielded incredible insights from the SSWs. This focus group was held 4 months after data collection was completed. Enough time had passed that the death of the Harm Reduction Program Coordinator was not the dominant theme discussed. The purpose of this focus group was to engage in a form of member checking and triangulation of the findings, to enhance their interpretive validity and ensure the most valid and rigourous representations of the situations that I had encountered during data collection. Triangulation refers to a method of ensuring validity within qualitative research, and involves observing a phenomenon from a variety of empirical perspectives (Denzin, 1970). In this study, the use of one-on-one qualitative interviews with key informants, participant observation and a focus group provided a modified form of triangulation. The focus group functioned as a form of member-checking, with initial themes and preliminary findings presented to participants for discussion, development, and to help to further refine themes. I had wanted to create a space for participants being 'researched' to review the analyses and representations that were emerging from the study, and provide their own (and possibly alternate) interpretations (Fine, Weseen, & Wong, 2011; Lerum, 2001; Wong, 1998). To facilitate this, the members of the advisory group participated in a formal focus group, so that if alternate or dissenting interpretations were voiced of the finding and analyses, this could be documented and included as data.

By including Satellite Site workers in the data analysis and interpretation process, I wanted a method to allow for people who use drugs and work directly in harm reduction service provision

to provide their perspective on the emerging results, as this might differ from the perspective of the academic researchers (Flicker, Savan, Mcgrath, Kolenda, & Mildenberger, 2007). Allowing participants to challenge the interpretations and analyses allows for validity to be introduced by the very participants who are being represented within the research process (Fine et al., 2011; Fine & Weis, 1996). I wanted to utilize this method as I recognized the social and cultural differences between myself and the participants in this research process, particularly due to the social marginalization and structural vulnerability that can result from the criminalization of drug use. I wanted to ensure that if there was dissent, disagreements and contestations regarding my interpretations of the data, there was a way for these challenges to my perspective to be integrated as findings, and allow for multiple interpretations of the data to be produced (Ronai, 1995). While there was no direct dissent or challenge to any of the analyses or research findings that I presented, including participants in the analysis process also allowed for contextual factors to emerge that may have otherwise been missed in the interpretation of the data. This was particularly the case regarding the findings on the emotional impacts that overdose response was having on Satellite Site workers. Here, new perspectives on the data were proposed which deepened the analysis, which I interpreted as a positive sign of the engagement of Satellite Site workers in the research process (Namaste & Jauffret, 2006). One example related to how paramedics were being offered formal institutional supports for coping with stress from overdose response, while people who use drugs were not. This reflection during an exchange between Satellite Site workers in the focus group clearly highlighted an attentiveness by SSW to the workings of structural vulnerability and structural violence, an important insight that I was then able to integrate into the findings (for example, see Chapter 3, pg. 79-80).

5.2.3 Researching the overdose crisis

One element that was not foreseen in the planning of the dissertation was the extent to which this research project would be impacted by and would centre on the overdose crisis. This impact was felt not only in the deaths due to overdose that occurred during data collection, such as the death of the Harm Reduction Program Coordinator mentioned earlier. It was also felt in the magnitude of the overdose crisis that hit Ontario from late 2016 through 2017 – the exact period when fieldwork for this study was being completed. While the overdose rate in Ontario had been rising for over a decade prior to this period, and a Public Health Emergency had already been declared in the province of British Columbia by April 2016, the number from overdose in Ontario rose

dramatically from 2016 to 2017, from 867 deaths in 2016 to 1265 deaths in 2017, an increase of 46% (Special Advisory Committee on the Epidemic of Opioid Overdoses, 2019; Strike & Watson, 2019). As of the time of writing, there have been 4543 deaths from opioid overdose in Ontario from the beginning of 2016 to the end of June 2019, and there has not yet been a declaration of Public Health Emergency in this province (Special Advisory Committee on the Epidemic of Opioid Overdoses, 2019).

While we were unaware of the total numbers at the time that it was occurring, this massive increase in overdose deaths was felt viscerally at the time by front-line harm reduction workers like the Satellite Site workers, and was also apparent during the fieldwork for this study. During the time that I was conducting observation visits in the Satellite Sites, the number of overdoses being reported by Satellite Site workers within the Satellite Sites and in the community surrounding them rose dramatically. Reviewing my field notes, discussions within the Satellite Sites clearly shift during this period, as overdose and how to address it become an increasingly frequent subject of conversation. As I write this, thinking back to this period, grief washes over me. Not only regarding the deaths while I was doing field work, or the death of the Harm Reduction Program Coordinator as I was completing data collection. But also of the continuous losses that have happened since then. One of the Satellite Site clients whose overdose and resuscitation is part of an early fieldnote later died of another overdose, this time in prison where no one was available to resuscitate him with naloxone. One of the Satellite Site workers who I spent much time with has also died, as have several other Satellite Site clients who I had the pleasure of getting to know, and whose stories figure anonymously in this work. In the time since data collection for this study has been completed, I have attended multiple funerals for people I got to know during this study. I sat with friends and family members as they grieved, and reminisced and recounted memories at their memorials. It is so difficult to begin to capture the scale of the loss that this community has undergone, and will continue to undergo in the foreseeable future - particularly as many of the structural factors identified in this dissertation remain unaddressed, and the scale of the response by government authorities remains too slow (Kolla, Dodd, Ko, Boyce, & Ovens, 2019). Due to the overdose crisis, I have never truly ‘exited the field’, instead becoming more involved in the response to the overdose as time has gone on, in part due to the early connections that I made within the Satellite Sites as this crisis was beginning to be recognized.

There has been increasing attention paid to the value of rapid ethnographies, as well as rapid qualitative research methods within health emergencies and in healthcare delivery more generally (Johnson & Vindrola-Padros, 2017; Vindrola-Padros & Vindrola-Padros, 2018). Methodologically, rapid ethnographic methods are used intentionally to quickly gather social, cultural and behavioural data within a specific context or on a targeted health issue through intensive fieldwork in a compressed time period (Pink & Morgan, 2013; Vindrola-Padros & Vindrola-Padros, 2018). These methods can be particularly useful within the context of health emergencies such as disease outbreaks so that action can be urgently taken (Johnson & Vindrola-Padros, 2017). However, in contrast to some of the ethnographic research conducted in Vancouver during the overdose crisis that sought to intentionally employ rapid ethnographic methods (Collins et al., 2019; Kennedy et al., 2019), that was not the intention of my dissertation. Instead, the fact that a health crisis was unfolding during the period of data collection was incidental. In my research, ethnographic methods were particularly adept at capturing the impacts that the overdose crisis was beginning to have within the community, as front-line workers and PWUD began to realize that a crisis was unfolding. This approach is especially important as the focus is often on the massive number of deaths – over 13,900 from January 2016 to July 2019 - who have died in this crisis (Special Advisory Committee on the Epidemic of Opioid Overdoses, 2019). Lost in this discourse is an appreciate of the individual stories and impacts that harm reduction workers made in community settings during the early days of the crisis.

My experience watching the overdose crisis unfold in the living rooms of people who use drugs within the Satellite Sites also brought me to reflect on our standpoint as scholars, and how our perspective structures not only the way that we frame the problems that we study, but also frames what we consider to be worthy questions for study. In these reflections, I've been informed by the perspective of Science and Technology Studies (STS) scholars, whose work is part of an ontological turn in the social sciences that focuses on how the 'things' we are researching are being constantly made and remade in practice and in research, rather than being fixed entities waiting to be discovered and described (Fraser, 2017; Mol, 2019). Following Martin, Myers, & Viseu (2015), this has led me to reflect on how – as a researcher – I actively operationalize certain ideas and realities into being through the relations that I enact in the worlds I study, and through the relations that circulate among the actors in the worlds I

encounter. This became clear to me as I began grappling with practices of care, and how they function to produce a politics of care in relation to overdose (Farrugia, Fraser, & Dwyer, 2017). This attention to care also implies that in the turn to investigating 'matters of care' – the way that care operates and is operationalized - we as researchers also need to take care in our research and research practices (Puig de la Bellacasa, 2011).

My encounter with the work of STS scholars also challenged me to push my thinking on medicalization in a different and useful direction. When I initially began using the idea of medicalization in analysing my data, it was in line with its usage in classic medicalization theory, which focuses on how the medical model is expanded to include an increasing number of 'deviant' behaviours in order for more elements of human life to be brought under the control of the medical system (Conrad & Schneider, 1992). I also engaged with the critiques of classic medicalization theory, particularly those that focus on medicalization as a repressive and coercive process solely concerned with increasing the social power of the medical system and its practitioners, consequently reducing patient autonomy and increasing dependency on medical providers, perspectives, and interventions (Conrad, 2005). Finally, I also engaged with the work of authors that used a Foucauldian lens. Here, medicalization has been broadly interpreted, in some instances to examine the 'medical gaze', as well as to explore the targets of medicalization as docile (Armstrong, 1983). In other instances, Foucault's work has been used to argue that rather than being solely repressive or coercive, medicalization can also be interpreted as a positive and productive strategy, where some 'patients' willingly seek out medicalization or utilize medical strategies because they produce positive health effects and knowledges (Lupton, 1997). However, as I moved through these theoretical engagements with medicalization, these perspectives did not fully capture the tensions between medicalization and criminalization that were evident in my data from the Satellite Sites – particularly the tensions that emerge due to social control over drug use being simultaneously delegated to medical and public health authorities, as well as to the criminal justice system. The tensions from this concurrent medicalization and criminalization were evident within the Satellite Sites, particularly regarding the uptake and effectiveness of public health programming around overdose response aimed at PWUD. It was here that I began engaging with the work of STS scholars; this proved to be a very fruitful complement to the previous conceptualizations of medicalization employed within different theoretical frameworks. Chapter 2 best illustrates how this movement occurred in my own work, as I explore how the tensions between medicalization and criminalization -

particularly the fear that police enforcement activities are targeting places where overdoses frequently occur – is giving rise to variable, multiple and locally-produced lived effects within the Satellite Sites. In turn, this is contributing to shaping the future possibilities of care within the Satellite Sites (Farrugia et al., 2019), as Satellite Site workers have become reticent to supervise the injection drug use of PWUDs, for fear of police intervention if overdose occurs and they have to call 911 for medical care. The insights from STS scholars, including the idea of 'evidence-making interventions' (Rhodes et al., 2016; Rhodes & Lancaster, 2019) provided me with a very fruitful way to tie together elements from classic medicalization theory with my ethnographic observations of how the overdose crisis was remaking practices on the ground, with practices were being remade locally within the Satellite Sites in response to the increases in overdose that were occurring.

When I reflect on the process of doing ethnography during the early days of a developing public health crisis, the ethnographic methods I was using were extremely well adapted to capture the complexities of the emerging overdose response in Toronto. The combination of ethnographic research and a process for member checking with SSWs who were participating in the advisory committee and focus groups were a useful way for me to ensure that I was taking care – and being careful – in my research process. These methods allowed for the early adaptations in harm reduction practices by people who use and sell drugs to be recognized and recorded. It allowed for the emotional impacts of overdose response on PWUD to be made visible, as these impacts were taking places in hidden spaces that would have otherwise been overlooked. The worst impacts of the overdose crisis have been felt by people who were already experiencing structural vulnerability and marginalization due to the criminalization of drug use. By remaining attentive to the structural violence that often accompanies institutional response – or lack of response - to health issues among marginalized peoples, the ethnographic and qualitative methods I employed provided a way to capture the early impacts of this crisis on the population most affected by it, while also being careful regarding the political and ethical questions that I was researching into being.

5.3 Contributions

Taken together, the three chapters that form the core of this dissertation contribute to the evidence base on the ways in which criminalization limits the impact of a public health intervention that attempts to improve the health of PWUD. By interfering with the full implementation of harm reduction interventions in the community settings where people gather to use drugs, criminalization is a structural factor with significant continuing impacts on the attempt by public health authorities to reduce morbidity and mortality associated with drug use. This has important implications for policy and practice.

Chapter 2 contributes to the theoretical work on medicalization by nuancing the ways in which medicalization played out in the Satellite Sites. Many critiques of medicalization examine it as disempowering for 'patients', and explore how it is used by medical and public health authorities to increase their authority and power (Lupton, 1997). However, in the case of the Satellite Sites, association with medical authorities was sought out and embraced by PWUD, including the program's founder, as medicalization of the sites provided protection from criminalization and police enforcement. The finding that PWUD sought out medicalization also contrasts with research highlighting the potential for medicalized environments for PWUD - such as supervised injection sites and methadone clinics - to be experienced as sites of surveillance and social control of drug use (Bourgois, 2000; Fischer, Turnbull, Poland, & Haydon, 2004). A major difference identified in Chapter 2 is that the Satellite Sites were developed and implemented by PWUD themselves, directly within in the environments where people were already gathering to use drugs. There are no healthcare providers or formal public health authorities directly involved in program development or service delivery. The integration of peers within service delivery for PWUD is increasingly recognized, particularly within harm reduction programming (Kennedy et al., 2019; Marshall, Dechman, Minichiello, Alcock, & Harris, 2015). The findings from this chapter provide further evidence of the benefits of developing a continuum of harm reduction services that include low-threshold approaches that are led and delivered by PWUD to expand the scope of safer environment interventions, particularly within the spaces in the community that are frequently closed off to formal health and social service providers.

Additionally, the exploration in Chapter 2 of the 'frictions' involved when medicalization and criminalization come together in the implementation of the Satellite Sites has key implications

for public health practice. Evidence-making interventions are a relatively new approach to conceptualizing the practices and social relations enacted during the implementation of interventions (such as the Satellite Sites), but also of the multiple effects that are generated through their implementation (Rhodes et al., 2016). Rather than positing a static intervention that is implemented to stable effects and outcomes, evidence-making interventions recognize the variable and multiple effects generated through the implementation of interventions, and how local knowledges are mobilized to shape the form and effects of an intervention. This is easily visible in the Satellite Sites, due to the latitude given to Satellite Site workers to determine the workings of their individual Satellite Sites. Through their implementation, the Satellite Sites fill an important gap in service delivery to PWUD. They are providing a medicalized environment that is nonetheless still informal and markedly less clinical than formal service delivery within community health centres or other agencies providing harm reduction services, while also shaping local ecologies of care (Rhodes et al., 2016). Here, a contrast to more formal, medicalized supervised consumption sites is useful, even though there were no supervised consumption services (SCS) in operation at the time of data collection for this dissertation. The Satellite Sites allow a wider range of sharing and communal drug preparation behaviours than are permitted within SCS (Kolla, Kenny, Bannerman, Boyce, Chapman, Dodd, et al., 2020). The rules against drug sharing within SCS represent a documented barrier to using SCS for many PWUD (Small et al., 2011). By allowing behaviours that are restricted in more medicalized spaces, the Satellite Sites - as well as other spaces run by and for PWUD - provide a space for people who are either unable or unwilling to attend an SCS (due to needing assistance to inject or wanting to share drugs), want a less medicalized environment, or want an environment where they can buy and use their drugs immediately (Gagnon, 2017; Kerr, Oleson, Tyndall, Montaner, & Wood, 2005; Small et al., 2011). In this context, an evidence-making intervention approach is useful as it acknowledges the highly variable effects that are produced through the implementation of interventions like SCS and the Satellite Sites, and that different contexts can make different Satellite Sites, that in turn shape local ecologies of care to allow for the accommodation of a wider range of needs and comfort levels with medicalized environments.

There is a growing body of evidence that criminalization itself is responsible for causing health harms to PWUD (Cooper et al., 2005; Debeck et al., 2017). This dissertation contributes to research in this area by examining how criminalization hampers the potential for innovative

harm reduction practices to reduce risk to PWUD. One major example of this involved the ways that criminalization negatively impacted the ability of SSW to enact public health advice regarding overdose response, due in large part to structural vulnerabilities they experienced as PWUD. In both Chapters 2 & 3, this dissertation documents the perception that police were increasingly targeting places where overdoses frequently occur for enforcement initiatives. These two chapters explore how fear of police accompanying paramedics on overdose calls is affecting the responses of SSW to overdose. Chapter 3 explores this issue in detail. SSW reported hesitation to enact key pieces of public health advice that aim to reduce overdose mortality - namely, not to use drugs alone and to call 911 when overdose occurs - due to fears of police enforcement and/or of losing their housing. One of the major contributions of this chapter is to highlight the ways in which existing structural vulnerabilities among PWUD - which are primarily driven by criminalization - are being exacerbated by the overdose crisis. The criminalization of drug use and patterns of police enforcement have the potential to undermine a key grassroots and public health response to the overdose epidemic. This is particularly an issue as the burden of fatal overdose within private residences is increasingly recognized (BC Coroners Service, 2018; Public Health Ontario, 2019). The continuing criminalization of PWUD within the environments where they use drugs - which are frequently their homes – is impacting on the ability of SSW to put in place public health advice during the overdose crisis.

More broadly, the findings from this dissertation illustrate how criminalization is negatively impacting the uptake and effectiveness of public health recommendations within the Satellite Sites, which in turn limits the ability of public health approaches to fully engage with a major source of harm within these environments. For example, chapter 2 documents how the perception that police are increasingly targeting places where overdoses frequently occur has changed how some Satellite Sites are operating, with SSWs no longer willing to supervise injections. And chapter 3 documents how the continuing criminalization of drug use exacerbates the structural vulnerabilities faced by SSWs as they attempt to implement public health advice on overdose response. This dissertation documents how the frictions stemming from criminalization not only have potentially negative impacts on the uptake and effectiveness of public health programming aimed at PWUD, but that they are also contributing to shaping the future possibilities of care within the Satellite Sites (Farrugia et al., 2019).

These findings suggest that the attempt by public health authorities to address the current overdose crisis is being severely limited by the continued criminalization of drug use. The overdose crisis in Canada has led to a shift among health and public health leaders in Canada. Calls for the decriminalization of drug use and possession as a method of addressing the overdose crisis were made by Toronto's Medical Officer of Health in 2018, and were echoed by the Director of Montreal's Public Health Department in 2018, and by the Provincial Health Officer in British Columbia in 2019 (CBC News, 2018; Ghoussoub & Schmunk, 2019; Lupick 2018). People who use drugs have long been vocal in calling attention to the need for the decriminalization and legalization of drug use, and for a reorientation within public health to focus on the health and social harms associated with the criminalization of drug use (Balian, 2016). The findings from this study contribute to the evidence base on the harms attributable to criminalization of drug use, and lends support to the need for a reorientation within public health to focus on decriminalization as a public health strategy to mitigate the harms associated with drug use. This would not only represent a shift to focusing on criminalization as one of the major structural factors shaping the risk environment, but would also represent an alignment of the priorities of public health with the longstanding priorities of people who use drugs.

Chapter 4 provides a novel contribution to public health research by exploring the ways in which people who sell drugs might be integrated into harm reduction practice. Harm reduction has always worked with people who engage in illegal activities such as selling drugs, albeit often without explicitly acknowledging this facet of practice. One of the impressive attributes of harm reduction programs are that they are effective at improving public health outcomes despite having to work with a population that is heavily criminalized, and frequently reticent to use health and social services. Grove's call to focus on the key concerns and priorities of PWUD – which revolves primarily around drug market-related issues such as how to find and purchase good quality drugs – reflects an early moment of insight on the potential utility of integrating people who sell drugs in harm reduction programming (Grove, 1996). The Satellite Sites utilize Grove's insight and co-locate a harm reduction intervention directly in the spaces in the community where drugs are being used and sold. By directly locating services within the community spaces where people are gathering to use, buy and sell drugs, the Satellite Sites provide an example of how to reduce the structural barriers that may impede access to health and social services by providing low-threshold safer environment interventions in geographic

locations that are convenient and easy to access. They also provide a clear example of the integration of people who sell drugs into harm reduction service provision.

Within a public health perspective, the concepts of the risk environment and safer environment interventions are useful when attempting to theorize the elements of macro- and micro-environments that may be contributing to drug-related risks and health harms. However, approaches that attend to the relational and performative elements circulating between PWUD and Satellite Site workers within these spaces can provide additional insights. One of the contributions of this thesis is to explore the practices of care that are being undertaken by SSWs within this safer environment intervention, as this allows for the social relations that shape and are shaped by their practices of care to be foregrounded. This is particularly important as some SSWs engage in drug selling, and people who sell drugs are generally portrayed in very stigmatizing ways (McLean, 2016). Exploring the practices of care undertaken within the risk environment of the Satellite Sites makes visible the way in which SSWs – particularly those who sell drugs - are actively intervening and providing care to other PWUD. Making visible the practices of care of people who sell drugs contributes to co-producing the possibility for different capacities for care for a group of people who have been traditionally marginalized due to their drug selling, and routinely stigmatized as predatory and incapable of care.

Examining the care work that occurs within the Satellite Sites also provides nuance to the frequently artificial distinction between people who use drug and people who sell drugs. Rather than simply seeing drug selling as a liability or as an activity that is tolerated if it is hidden or occurs outside of work hours, the Satellite Site program employs some people who sell drugs directly in harm reduction programming to achieve public health goals like increasing access to sterile equipment for drug use. Rendering the practices of care of SSWs who sell drugs visible as care has the potential to remove barriers to the integration of people who use and sell drugs into harm reduction programming. It also provides evidence for the development of public health interventions that take seriously the key role of drug buying and selling within the lives of PWUD. Integrating people who sell drugs more broadly into peer-based programs is a strategy for building capacity for overdose response within community settings, which may offer new methods of expanding interventions to address the overdose crisis. Due to continued political resistance, sanctioned supervised consumption services will not be scaled up in all communities where need exists (Kolla, Dodd, Ko, Boyce, & Ovens, 2019). And since some Satellite Sites

allow drugs to be used on site, they are de-facto unsanctioned supervised consumption sites. Additionally, many Satellite Sites allow drugs to be smoked onsite, including crack cocaine and crystal methamphetamine. Supervised smoking services are rare in Canada, and this continues to be an area of unmet need (McNeil, Kerr, Lampkin, & Small, 2015). The Satellite Sites provide an example of a community-based model for the supervision of drug use where trained peers can provide overdose-related interventions - including naloxone distribution and overdose response - to populations who may be unable or unwilling to access sanctioned supervised injection services.

This leads to one of the other major implications for policy and practice to come out of this dissertation - the need for support for peer workers doing overdose response work in community settings. Participants in this study clearly identified the overwhelming trauma and emotional burden that can come from witnessing and having to respond to overdoses among friends and family members. The provision of support for people who are responding to overdoses in community settings is a vital necessity. This finding aligns with the accumulating body of research evidence examining the ways in which responding to overdose and overdose-related loss during this crisis are negatively impacting the mental health and emotional well-being of front-line workers and PWUD (Bardwell, Fleming, Collins, Boyd, & McNeil, 2018; Marshall, Perreault, Archambault, & Milton, 2017; Wallace, Barber, & Pauly, 2018). Chapter 3 explores how the negative emotional responses reported by SSW in response to having to intervene in multiple overdoses may have important implications for shaping the future possibilities of care. Chapter 4 further develops this insight, exploring how the recognition of practices of care among people who sell drugs expands the subject positions available to this stigmatized group, and opens the possibility of integrating them into harm reduction interventions. However, in both cases, public health authorities must also be cognizant of how the extreme stress being faced by PWUD who are responding to overdose may also be undermining the possibilities of care, and the potential effectiveness of overdose responses more generally. A major recommendation from this dissertation is that the implementation and scale-up of supports and interventions to help PWUD address grief and loss from the overdose crisis is urgently needed.

5.4 Limitations

The combination of multiple qualitative data collection methods (observational and interview-based) within this project is a strength, and allows for the generation of insights from environments which are often hidden and difficult to research due to the nature of the illicit activities occurring within. In assessing the transferability of the findings from this research project, attention to how geographical particularities and structural factors may differ across different contexts is necessary. Relevant factors to consider here include: the specificity of the laws in place in different localities and their application, particularly laws surrounding drug possession, distribution and trafficking, and Good Samaritan laws on overdose response; the impacts that the presence or absence of harm reduction programming (including NSP and SCS) may have on availability of supports for PWUD in the community; and the functioning of illicit drug markets within community settings. Consideration of the particular environments or contexts is crucial in assessing the feasibility and appropriateness of any type of harm reduction program development or expansion. For example, ethnographic research in Montreal, Canada, exploring 'piaules' (the local term for crack houses) found that these spaces were closely tied to and often operated by criminal organizations, rendering the integration of harm reduction programming into them very difficult (Roy & Arruda, 2015). As explored in Chapter 4, the founder of the Satellite Site program was very familiar and well-connected within the community settings where people were gathering to use drugs. He was very deliberate in selecting potential Satellite Sites, and used his familiarity with the community to assess both potential Satellite Site workers for their suitability for the program, and to ensure that the Satellite Sites were not running afoul of any criminal organizations. An in-depth examination of the local context and norms within the spaces where drugs are used and sold in the community, in partnership with PWUD who are knowledgeable about the local context, would be necessary prior to the development of any programming in community settings or that aims to integrate people who sell drugs into harm reduction programming.

Within the context of this study, ethnographic methods provide insights from environments that can be difficult to access for research, in this case due to the illicit activities occurring and the stigma surrounding them. Social desirability bias is a potential source of bias in any type of research investigating controversial, contested or illegal behaviours, as participants may be hesitant to report stigmatizing behaviours or present themselves in ways that do not conform to

social norms (Jerolmack & Khan, 2014). Multiple data collection methods were used to guard against the potential for social desirability bias, including the use of observation within the Satellite Sites, in addition to one-on-one interviews with SSW, clients and program staff. Additionally, a focus group was conducted with SSWs and the Satellite Site coordinator to allow for member checking to triangulate findings and enhance credibility (Creswell, 2013). The use of multiple qualitative data collection methods (observational and interview-based), alongside a focus group to provide feedback on initial findings during the analysis process is a strength and provides useful data to inform public health programs and practice.

5.5 Directions for future research

This dissertation has examined the impacts of criminalization on the ability of public health interventions to address drug-related harms. The current overdose crisis has drawn attention to some of the issues inherent in leaving the drug supply in the hands of an illicit market. There has been increasing recognition of the harms that stem from criminalization and drug prohibition (Debeck et al., 2017; Werb et al., 2008; Werb et al., 2011), and the way that prohibition itself can drive dangerous changes in the illicit drug market (Beletsky & Davis, 2017). This recognition of the harms from criminalization corresponds to calls from PWUD for a reorientation within harm reduction to focus on how, under the current legal system that criminalizes drug use, many of the harms associated with drug use stem from the criminalization of drug use, rather than from drug use itself (Balian, 2016). An increasingly necessary focal point within public health research involves a shift in perspective: from harm reduction as a way to reduce the harms associated with drug use, to harm reduction as a way to focus on the harms stemming from criminalization and drug prohibition regimes. For example, PWUD have a long history of emphasizing that their key priority is ensuring an adequate supply of safe drugs (Canadian Association of People who Use Drugs, 2019; Grove, 1996). As the opioid overdose crisis has expanded, there is a growing movement among medical officers of health and public health authorities across Canada - including most recently, the former Federal Minister of Health Dr. Jane Philpott - to recommend both decriminalization of drug possession and use, and to call for an exploration of alternate methods of regulating drug distribution, such as Safer Opioid Supply programs (CBC News, 2018; Lupick, 2018; Philpott, 2019; Tyndall, 2018). Studies examining heroin assisted treatment

and other forms of injectable opioid agonist programs show that people who have access to a safe and consistent supply of pharmaceutical opioids experience multiple health and social benefits (Ferri, Davoli, & Perucci, 2005; Jozaghi, 2017; Oviedo-Joekes et al., 2009; 2016). What is urgently necessary is research that examines interventions at the structural level to prioritize access to a safe and consistent supply of drugs that does not leave PWUD reliant on the illicit market. Additionally, as Safer Opioid Supply programs become an increasingly viable option for intervening in the overdose crisis, research must be attentive to the ways in which criminalization may interfere with the implementation of Safer Opioid Supply programs. The implementation of Safer Opioid Supply programs in environments that continue to be dominated by criminalization may exacerbate structural vulnerabilities among PWUD. Research sensitive to the workings of structural violence and structural vulnerability in the implementation of Safer Opioid Supply programs are necessary.

An important future direction for research is to further examine the Satellite Sites as an 'evidence-making intervention' (Rhodes & Lancaster, 2019). Evidence-making interventions are a relatively new way of conceptualizing the social relations enacted through the implementation of interventions such as the Satellite Sites, which also remains attentive to the multiple effects that are generated through their implementation (Rhodes et al., 2016). The concept of evidence-making interventions was used in this dissertation (see Chapter 2, pg. 58) to examine medicalization and criminalization as 'frictions' that come together locally in the implementation of the Satellite Sites, and that give rise to variable, multiple and locally-produced lived effects (Rhodes et al., 2016). The criminalization of drug use is a structural factor that contributes to continued structural vulnerability for Satellite Site workers. Using the evidence-making interventions approach to explore how this continued structural vulnerability is shaping the possibilities of care through the implementation of safer environment interventions like the Satellite Sites merits further analytic attention.

For example, Chapters 3 and 4 both highlight how the experience of trauma in relation to overdose – and efforts to protect themselves from experiencing future trauma - may be shaping the future conditions of overdose response among PWUD, particularly where this interacts with structural vulnerabilities such as housing insecurity. There is a strong need for research that attempts to identify the impacts of the grief and loss associated with the overdose crisis on PWUD. Additionally, it is important to ensure that all PWUD - including people who sell drugs -

are being provided with supports as they respond to the overdose crisis within their communities. Public health research should focus on examining how the extreme stress being faced by PWUD who are responding to overdose may also be undermining the possibilities of care, and the potential effectiveness of overdose responses more generally. Additionally, future research should focus on attempting to ascertain the types and forms of support that would help PWUD to address the tremendous grief and loss associated with the overdose crisis, and to develop and scale-up appropriate emotional supports for PWUD to mitigate these negative impacts. Within this research, attention must also be paid to the ways in which the continued criminalization of drug use may be amplifying the stigma associated with overdose-related grief and loss, and further complicating efforts to address the emotional impacts of loss from overdose.

Chapter 4 highlighted how the distinction between PWUD and people who sell drugs is simplistic and ignores evidence that PWUD frequently move into and out of drug selling (Dwyer & Moore, 2010; Fitzgerald, 2009; Small et al., 2013). This distinction between people who use and sell drugs must also be challenged because it reinforces framing PWUD as needing a medicalized response to their drug use, with people who sell drugs being legitimate targets of the criminal justice system. The Satellite Site program attempts to move past this simplistic framing; whether workers also sell drugs is immaterial to their job status. This demonstrates how some people who sell drugs can be engaged as part of the response to the health issues surrounding drug use, including in the response to the overdose crisis. However, the continuing criminalization of drug selling has the potential to hinder the way that people who sell drugs can respond to situations that they encounter. Cases where overdose fatalities are followed by the prosecution of the person who provided or sold the drugs involved – often on severe charges such as manslaughter (Canadian Press, 2017) - may contribute to increased demonization of people who sell drugs in popular discourse. These types of charges may also make PWUD less comfortable disclosing their drug selling, less likely to participate in formal harm reduction programming, and less likely to call 911 when overdose occurs. Futher research is necessary to examine how the practice of dispatching police alongside paramedics following 911 calls for assistance during an overdose may impact on the willingness of people who sell drugs to participate in harm reduction initiatives, even in jurisdictions with Good Samaritan Laws in place. Additionally, the trend towards criminal prosecution of people who sell drugs on severe manslaughter and murder charges may also reinforce pre-existing stigmas towards people who

sell drugs, making it more difficult for organizations to develop programming with people who sell drugs. Future research exploring the integration of people who sell drugs into harm reduction should explore these dynamics. Close attention should be paid to the way that the structural vulnerabilities may impede the ability of harm reduction programs to properly integrate people who sell drugs into programming and interventions, as this integration may inadvertently expose them to increased surveillance and policing.

5.6 References

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