Couched in Context: exploring how context shapes drug use among structurally marginalized people who use drugs in Vancouver's Downtown Eastside

by

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B.A., Hons. Trent University, 2001
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A Dissertation Submitted in Partial Fulfillment of the
Requirements for the Degree of

DOCTOR OF PHILOSOPHY

in the Department of Sociology

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Abstract

Social factors and social contexts have long been implicated in shaping/influencing behaviours, actions, and outcomes, including social and health inequities. The social determinants of health concept has shown that health and health inequities are shaped by a variety of socio-cultural factors including education, socio-economic status, gender, ethnicity, and the social and physical environments in which people live. Critical drug scholars have specifically sought to understand how contexts and environments shape drug use and related harms. The "risk environment" framework, for example, suggests that drug use, risky drug use practices (e.g., needle sharing), and drug use-related harms are shaped by social, physical, economic and policy environments. Yet while contexts are frequently implicated in framing and shaping behaviours, the specific mechanisms at play are rarely unpacked. I address this gap by further "opening up" contexts of drug consumption and social marginalization in order to extend our knowledge of drug use among marginalized people who use drugs (PWUD)

My dissertation includes 3 analyses of my data in the form of published (2) and submitted (1) manuscripts. Two-stage interviews (a short quantitative survey and longer qualitative interview) were conducted with fifty PWUD in the Downtown Eastside (DTES) neighbourhood in Vancouver, Canada. Data were analyzed with conceptual and theoretical tools borrowed from Situational Analysis, as well as actor-network and assemblage theories.

In my first paper, I explore reasons for using drugs, and suggest that, despite known negative consequences of drug use, substance use among marginalized PWUD can be meaningful and beneficial. Participant narratives revealed four main themes regarding positive aspects of drugs and drug use in their lives: (1) pain relief and management; (2) alleviating mental health issues; (3) fostering social experiences; (4) pleasurable embodied experiences. These findings draw attention to the fallacies of drug prohibition and much current drug policy which has fabricated boundaries between the acceptable and unacceptable, resulting in the criminalization and stigmatization of certain substances and the people that use them.

In my second paper, I draw upon actor-network theory and event analysis to explore how contexts shape drug consumption practices. My findings illustrate how specific methods of drug consumption (e.g., smoking or injecting) are shaped by an assemblage of objects, actors, affects,

spaces and processes. Rather than emphasising the role of broad socio-structural factors (e.g., poverty, drug policy) participant narratives reveal how a variety of actors, both human and non-human, assembled in unique ways produce drug consumption events that have the capacity to influence or transform drug consumption practices.

In my third paper, I explore how spaces/places frequently used by PWUD in the DTES that are commonly associated with risk and harm (e.g., alleyways, parks) can be re-imagined and re-constructed as spaces/places of safety and wellbeing. Conceptualizing spaces/places as assemblages, I trace the associations among/between a host of seemingly disparate actants – such as material objects, actors, processes, affect, temporal elements, policies and practices – to better understand *how* experiences of harm, or conversely wellbeing, unfold, and shed light on how risky spaces/places can be re-constructed as places that enable safety and wellbeing.

Taken together these 3 papers/analyses provide unique insight into not only drug use among marginalized PWUD, but our understanding of the ways in which contexts and environments shape behaviour and social phenomena. These findings have direct implication for harm reduction theory and drug policy. With greater insight into the contexts of drug use, drug policy and harm reduction strategies may be better tailored to prevent drug use-related harms.

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Acknowledgements

Pursuing a doctoral degree can be a lengthy solitary affair (especially those last stages of dissertation writing), but would not be possible without the quiet and unseen support of many.

To my parents, for always encouraging me in my academic pursuits, showing a keen interest in my ideas (even if you didn't understand or agree with them), and despite being thousands of miles away, each helping me in different but important ways.

A special thank you to Averil and Tiga, for your infinite patience, love, and unceasing support throughout the course of this long endeavour. Thank you for putting up with the stress, the grumps, and the solo outings on weekends so that I would have a quiet place to study and write. I could not have done this without you.

To my committee members, Cecilia, Susan and Karen. Your guidance through the many stages of my doctoral studies helped get me here when, at times, I thought I wouldn't. You gently pushed me to think bigger, inspired me to contemplate deeper, edited my papers to help me write better, and encouraged me to pursue the topics of this dissertation when I found myself questioning their importance and validity. For all of that, thank you.

To everyone at the Canadian Institute for Substance Use Research, for the many years of support, and for building a wonderful research community at the University of Victoria. During my time there I was fortunate to be part of great diversity of projects and work with so many amazing and dedicated people.

To the Vancouver Area Network of Drug Users (VANDU), for inviting me in, supporting my research, and opening my eyes to the strength and beauty of your community. The passion, compassion, and determination of VANDU members is inspiring, and continually motivates me to keep fighting this fight. And to the VANDU members who participated in this research, for generously sharing their time and stories with me.

This research, and my life over the course of my doctoral studies, greatly benefited from financial support from the University of Victoria, Canadian Institute for Substance Use Research, Department of Sociology, and the Canadian Institutes for Health Research.

Dedication

This dissertation is dedicated to the casualties and survivors of the War on Drugs,

and to all those involved in the fight against it.

Integrative Chapter

Why do people use psychoactive substances? Why do people experiencing structural oppression and vulnerability take drugs? Why do marginalized people who use drugs (PWUD) find themselves in the situations they are in? What can be done to reduce the harms of drug use, and the inequities experienced by marginalized PWUD? These are the questions that drive my fascination with drug use, and that motivate not only my desire to understand drug use among structurally marginalized PWUD, but my commitment to improving their lives and how they are treated by society. These are not uncommon questions, but they are tough ones. They are questions that have been taken up by scholars and the wider public alike in recent years, and have been the focus of much media attention and public debate. While I make no promise to unequivocally answer these questions in my dissertation, it is my hope that my PhD research findings will contribute something useful to the pursuit of these tough questions.

I'll start here with two terms, *process* and *emergence*, which I will bring up again later, and which are important in all of this. This dissertation is in many ways the culmination of a process (in more than just "this PhD was one hell of a process!") that began just over a decade ago, and which has emerged not just from my academic pursuit of a PhD, but as part of a vast assemblage of relations. Without getting into too much biographical detail, suffice to say this stems back to my foray into the drug research field in 2006 when I joined a research team studying crack cocaine use in Toronto, Ontario, and was introduced to novel ways of thinking about drug use and related harms. Then in 2007 I joined the Sociology Department at the

University of Victoria and was re-introduced to complex approaches to understanding society, social groups, and social relations. Prior to starting my career in drugs research, I knew (or believed to know) two things: 1) drugs were fun, and 2) drugs were (potentially) dangerous. Spending countless nights and early mornings dancing at raves was fun; watching friends overdose or experience drug use-related problems was not. My desire to learn more about drugs, drug use, and drug-related problems drove me to quit a burgeoning career in finance and pursue a career in drug research.

I mention those two specific dates as, although prior to the start of my PhD in 2010, they are an important part of my PhD assemblage – a time when health sociologist Tim Rhodes' "risk environment" framework (Rhodes, 2002, 2009) was gaining real traction and wide application in the critical drug research field[1]. This particular framework, which suggests that drug use and related harms are shaped by physical, social, policy and economic environments, offered me a new way to think about drug use and related harms. The framework opened up the context of drug use, broadening the scope of what I thought to be important in relations and experiences of drug consumption. This is not to say I had overlooked the importance of social contexts in mediating drug experiences prior to joining academia – raves are immersive social, embodied, affectual, spatial and technological experiences – but that academia and research pushed my thinking and questioning further, elucidating the forces and relations implicated in drug use experiences and drug related harms.

[1] In a 1997 paper Rhodes (1997) challenges dominant conceptualizations of "risk behaviour" as an individual phenomenon, suggesting instead that risk needs to be understood as "socially organized". A paper 3 years later (Rhodes et al., 1999) sees the first reference to the concept of "risk environment", in which Rhodes suggests that the risk behaviours of people who inject drugs are influenced by social and material contexts (and he refers specifically to physical, social, economic and policy environments). It is in 2002 that Rhodes (2002) fully fleshes out these ideas and proposes for the first time the "risk environment framework" as a means to understand drug use and related harm.

The risk environment, along with the social determinants of health framework, shaped much of my thinking about, and understanding of, the intersection of substance use and structural disadvantage/marginalization as I made my way through my M.A. degree. From this standpoint, drug use is seen as an outcome of various socio-structural mechanisms (e.g., socioeconomic status, stigma, social capital, neighbourhood) that impact health and risk behaviours (Braveman, Egerter, & Williams, 2011). My Master's thesis, which explored the "social dimensions and functions" of crack pipe sharing, was a blend of these two perspectives, as well as symbolic interactionism. The thesis was my attempt at demonstrating how socio-structural/cultural/economic factors shape a particular "risk behaviour". Central to my argument was social interaction – not surprising since the sharing of pipes necessitates two or more people using a material object together. A paper published later (Ivsins, Roth, Benoit, & Fischer, 2013) using the same data expanded on and clarified the role of socio-environmental factors (i.e., risk environments) in shaping pipe sharing. Revisiting my M.A. thesis and that published paper, what jumps out to me in those analyses is the centrality of the human subject, and the rather passive role of the pipe as a tool imbued with symbolic meaning. Reinterpreting older data is an interesting exercise. Looking over those interview transcripts with people who share crack pipes I might now interpolate conceptual ideas of process, emergence, and assemblage, and perhaps even insist on the agency of the pipe. This re-interpretation is not necessarily more valid than my previous analysis of that data, but rather underscores the evolution of my thinking and understanding of drug use through my PhD.

I recall a particular conversation during my dissertation proposal defence in which I was encouraged by my supervisors to think beyond the risk environment framework. This moment stuck with me, and my dissertation is an attempt to do just that. Critical drug scholars have

sought to understand how contexts and environments shape drug use, and for some time now have been drawing connections between the physical and social environments and contexts of substance use and related risks and harms (Burris et al., 2004; Cooper, Moore, Gruskin, & Krieger, 2005; Marshall, Kerr, Qi, Montaner, & Wood, 2010; Tim Rhodes et al., 2007). Yet while contexts are frequently implicated in framing and shaping behaviours, the specific mechanisms at play are rarely unpacked. It is not always clear in what specific ways, or through what particular mechanisms or arrangement of forces, these contexts and socio-cultural environments shape drug use, risky drug use practices, and related harms. Instead, contexts and environments of drug consumption are often portrayed as discrete entities exerting a sort of structural force that influences the behaviour of individuals and groups. In my dissertation I address this gap by further "opening up" contexts of drug consumption and social marginalization in order to extend our knowledge of drug use among marginalized people who use drugs (PWUD), and offer insight into the study of social contexts of drug use.

In the following pages I provide a brief overview of the three papers that make up my dissertation. Each paper addresses different aspects of drug use among people experiencing structural disadvantage. While each of the three papers are unique in their topics, findings, and implications, each in its own way addresses the "why" questions: why is this happening, why in this place, and why in this way? I then discuss how, taken together as part of my PhD assemblage, these papers provide novel insights into drug use, the contexts of drug use, and our understanding of social contexts in general.

Contexts of consumption: three papers on drug use

My dissertation research is squarely situated in the Downtown Eastside (DTES) neighbourhood of Vancouver, BC, Canada. I conducted 50 two-stage interviews (a short

quantitative survey immediately followed by a longer semi-structured interview) with PWUD in the Vancouver Area Network of Drug Users (VANDU) storefront building in the heart of the DTES.[2] Almost all (45) of the people I interviewed lived in the DTES; the remaining 5 reported coming to the DTES daily or almost daily, and had at one time lived in the neighbourhood. Most of the study participants spoke fondly of the DTES, referred to it as "home", and evoked notions of community, solidarity, kinship and resilience when talking about the infamous neighbourhood. Their lives were in many ways shaped by living and spending time in the DTES, and the uniqueness of their lived experience, enmeshed with this particular neighbourhood, is clearly reflected in their narratives and in the research findings of my three papers.

An interview guide was drafted prior to data collection, which evolved over the course of data collection as topics emerged that I thought (or rather, discussion indicated) relevant to pursue. For example, while I initially intended to only briefly discuss participants' living situations, it became clear that for participants this was an important and meaningful topic, and interviews often contained lengthy and deep discussions of life in the DTES. Similarly, a question I imagined would elicit a brief response – "what is good or positive about your drug use?" – ended up being a subject that generated significant discussion and became the topic of the first paper. This is one of the strengths of qualitative research – the freedom and capability to shift and adapt to the undetermined movement and flows of social situations, in itself an example of the potential fruitfulness of enabling and allowing for process and emergence (Holloway & Todres, 2003). This flexibility prioritizes topic over method, allowing the researcher to follow emerging themes or topics down paths unseen by structured quantitative surveys. While the quantitative data I collected is useful in sketching a profile of the study participants as an

[2] A detailed description of my research methods can be found in each of the 3 papers.

aggregate, my qualitative data provides the richness to paint a more full portrait of the participants and their lived experiences.

In the first paper (Ivsins & Yake, 2018) I (re)turn to what is both a simple and extremely complex question: why do people take drugs? My interest in this particular topic has to do with how drug use is generally conceptualized and presented in research concerning marginalized PWUD. Substance use among marginalized PWUD has historically been constructed as problematic, replete with risks and harms to both individuals and society. While positive and beneficial aspects of drug consumption have been studied among other groups (e.g., university students, "functional" adults, individuals engaged in the night time economy, "recreational" drug users) (for examples: Askew, 2016; Farrugia, 2015; Niland, Lyons, Goodwin, & Hutton, 2013), rarely have scholars afforded marginalized PWUD the same opportunity (that is, the opportunity to express meaningful, positive, or beneficial aspects of taking drugs). Instead, marginalized PWUD are presented over and over with surveys that expound and report the innumerable risks and harms of doing what they do. This is not to deny that drug use can be harmful, or to gloss over individuals' negative experiences of structural violence and marginalization. Rather, it is to suggest that in certain contexts drugs and drug use can be positive, beneficial, and meaningful for marginalized individuals who use them. Indeed, study participants expressed four ways drugs were positive and beneficial in their lives: 1) pain relief and management; 2) alleviating mental health issues; 3) fostering social experiences; and 4) pleasurable embodied experiences. That 43 of the 50 participants expressed positive aspects of drug use is significant, and illustrates the important role drugs and drug use can play in the lives of structurally marginalized PWUD.

In my second paper (Ivsins & Marsh, 2018) I explore what influences PWUD to choose certain methods of drug consumption (i.e., smoking, injecting). There has been a great deal of

research on the transition from non-injection to injection drug use (Bravo et al., 2003, 2003; Harocopos, Goldsamt, Kobrak, Jost, & Clatts, 2009; Witteveen, Van Ameijden, & Schippers, 2006), with little attention paid to PWUD who have never injected or stopped injecting (but continue to used by non-injection methods). In this paper, I draw on actor-network theory and event analysis (Dilkes-Frayne, 2014; Latour, 2005) to explore what moves people to inject or not, and how contexts shape drug consumption practices. I present three unique events that in some way shaped or transformed drug use practices for the individuals involved: in one event the participant was influenced to try injecting; in a second event another participant was moved to stop injecting; in a third event, a variety of forces shaped a study participant's decision to not try injecting. In each event specific methods of drug consumption (e.g., smoking or injecting) were shaped by an assemblage of objects, actors, affects, spaces and processes that moved participants in certain ways. Rather than emphasising the role of broad socio-structural factors (e.g., poverty, drug policy), participant narratives reveal how a variety of actors, both human and non-human, assembled in unique ways produce drug consumption events that have the capacity to influence or transform drug consumption practices.

In my third paper (Ivsins, VANDU, Benoit, Kobayashi & Boyd, submitted for review) I turn to spaces/places in the DTES that have commonly been portrayed and experienced as risky and harmful, and are implicated in experiences of structural (and physical) violence and marginalization (Small, Kerr, Charette, Schechter, & Spittal, 2006; Wood & Kerr, 2006). I explore how certain spaces/places frequently used by PWUD in the DTES that are normally associated with risk and harm (e.g., alleyways, parks) can be re-imagined and re-constructed as spaces/places of safety and wellbeing. That my study participants recounted both negative and positive experiences with particular spaces/places in the DTES suggests the possibility of making

certain spaces more safe and less risky. Conceptualizing these spaces/places as assemblages (DeLanda, 2006, 2016), I trace the associations among/between a host of seemingly disparate actants – such as material objects, actors, processes, affect, temporal elements, policies and practices – to better understand *how* experiences of harm, or conversely wellbeing, unfold, and shed light on how risky spaces/places can be re-constructed as places that enable safety and wellbeing. This point is illustrated by constructing diagrams of both "assemblages of harm" and "assemblages of wellbeing, which show how variously inter/intra-related forces produce certain situated effects (risk/harm, safety/wellbeing), and demonstrates the promise of "assembling otherwise".

Contexts and assemblages: opening up the contexts of drug use

Each of my interconnected papers deals with a unique aspect of the lived experience of marginalized people who use drugs in the DTES. As stand-alone materials, each provides insight into a specific and situated topic, offering what I hope to be interesting perspectives into common questions pursued by sociologists and drug scholars alike: why are people doing this, why here and why in this way? As materials making up part of my PhD assemblage, the three papers bring together a number of conceptual ideas to offer insight into contexts of drug use. Exploring contexts of drug use is not new. Drug scholars have long been interested in the associations between spaces/environments/contexts and drug use and related harm. Much of this work has been quantitative and epidemiological in nature, and lacks the exploratory power and depth offered by qualitative approaches (for examples see: Hunter et al., 2018; Schroeder et al., 2001; Williams & Latkin, 2007). At the same time there has been a burgeoning movement among qualitative scholars to better understand and elucidate the intricate workings of contexts (Demant, 2013; Dilkes-Frayne, 2014; Duff, 2011). Yet there has been a tendency among many

scholars to use "context" (or "environment") as a blanket term to explain behaviour/harm, granting contexts and environments the power and force to shape behaviour without clarifying precisely how they do so (Schroeder et al., 2001; Williams & Latkin, 2007). Terms such as "social network", "risk environment", and "neighbourhood disadvantage" are often invoked and implicated in somehow shaping things like drug consumption practices and related harms (Ciccarone, 2017; Jain et al., 2018). These interpretations are not wrong or misguided, and have played a significant role in broadening our understanding of substance use (Rhodes, 2009). However, much of this work has not attended to the minutiae of contexts to clarify more precisely how these experiences, relations and associations play out. Given the weight contexts and environments are granted in the social sciences (for example in the risk environment framework, or social determinants of health model), an important task should be to provide a more theoretically refined presentation of the contexts. Scholars like David Moore, Suzanne Fraser, Cameron Duff, Kane Race, Ella Dilkes-Frayne, and Nicolle Vitellone, among others, have grappled with this problem and other matters of critical drug scholarship, and much of their work has provided the impetus for my "thinking beyond the risk environment" (for examples of their work see: Dilkes-Frayne, 2014; Duff, 2016, 2007, 2011; Moore, Pienaar, Dilkes-Frayne, & Fraser, 2017; Race, 2014; Vitellone, 2010, 2015).

In attempting to "open up" contexts I borrow a term from Duff (2012) and suggest that contexts might usefully be characterized as "relational achievements" that are the culmination of human and non-human forces acting together. Based on my qualitative dissertation findings, these "forces" can include human actors, material objects, technologies, spaces, practices, affects and emotions, and temporal elements, all of which act together, or are assembled together, to shape or influence behaviours. Approached in this way, things like drug consumption and drug

overdoses are understood not as the outcome of singular substances or practices, but as a relational *processes* involving various actants assembled in various ways which, through their association generate a particular outcome. Similarly, Duff (2007) proposes that contexts are best understood as "an *assemblage of relations*" (p. 504, emphasis in original) made up of spaces, embodiment and practice that shape drug use behaviours. An important feature of this line of thinking is a decentreing of the human subject in experience and phenomena, allowing for a symmetrical consideration of all things relevant in a situation. This concept was useful in my analytic process as it brought into focus elements of the participants' narratives that I may have before now glossed over. For instance, affect and emotion, forces which I had not previously ascribed importance to in contexts of drug consumption, became significant considerations when attempting to clarify relations and experiences of drug use in my dissertation. Where previously I may have attributed some activity to, say, one's "social network" or the "social environment", I now envision as mediated by a process of relations in which various actants of various sorts (both human and non-human) shape and transform experience. In a similar vein, expanding notions of agency to include the force of non-human actants in situations allowed for an understanding of drug consumption "events" and their role in shaping drug consumption practices. Focusing on events of consumption allowed space for new relations and subjectivities, shifting a singular focus on the human subject to also include the various heterogenous forces assembled within the event. In my pursuit to open up context, I found in events, assemblages and actor-networks new possibilities of understanding why and how drug consumption occurs, and new ways of understanding the influence of contexts in shaping behaviour. These theoretical approaches each provide a means of "opening up" contexts of any sort by identifying and

describing the vast array of actants, processes, and relations involved, without having to fall back on comfortably alluding to tropes commonly ascribed to contexts.

Along with the notion of process, another central feature of this way of conceptualizing context, drawn from DeLanda (2006, 2016) and assemblage theory, is the concept of "emergence". Delanda (2006) refers to the assemblage as the "emergent whole", suggesting that "a whole emerges from the interaction among its parts [and that] once it comes into existence it can affect those parts" (p. 34). This line of reasoning is effective when applied to studying contexts of drug consumption as it shifts the spotlight from the individual and the substance, to take into account the full range of forces and their interactions. Thinking in this way about, for example, events of drug consumption allows us to tease out relations, or as Latour (2005) states *trace the associations*, between and among a host of sometimes seemingly disparate forces. In a study of how spaces used by PWUD can shift between safe and dangerous, Dovey, Fitzgerald, and Choi (2001) state that "[s]coring [obtaining drugs] and injecting are not separate acts so much as different phases of a single trajectory which encompasses economic, symbolic, chemical, spatial and experiential consumption" (p. 329). In other words, illustrating this very point, scoring and injecting drugs are not singular distinct acts, but emerge from a process involving many heterogenous parts, including social, symbolic, material and economic actants (i.e., drugs, money, people, places, etc.).

Conclusion

Whether my study participants were speaking about why they used drugs, how they consumed drugs, or where they consumed drugs, each narrative was situated contextually, meaning that the context of use in some way shaped or influenced their consumption practices and behaviours. What is obvious from the participants' narratives is that the contexts within

which they are situated are not stable and predictable features of social life, but fluid and relational processes made up of a variety of forces. What is also obvious from this is that context is crucial, both in terms of shaping, and understanding, drug use and other social behaviours and practices. There is, in essence, no escaping context if we seek to broaden our knowledge of, and ability to respond to, drug use and related harms.

The ideas presented in my dissertation, and the broadening of my understanding of contexts, substance use, and structurally marginalized PWUD, will no doubt shape my future academic pursuits and influence my thinking on future research projects. As I move into a post-doc position I bring with me novel insights into contexts of drug consumption, and I hope to apply these insights to the projects I will be involved in. This approach to understanding context, as explored through my dissertation, is crucial to informing and implementing effective public health and harm reductions measures, illustrating the importance of attending to situated and localized contexts of drug use and harm. Approaching context this way might be usefully applied to refining our conceptualization of "enabling environments" as a potential response to drug use-related risks and harms, providing richer accounts of contexts of drug use to design more effective harm reduction initiatives, including harnessing forces and resources that enable safety and wellbeing.

References

Askew, R. (2016). Functional fun: Legitimising adult recreational drug use. *International Journal of Drug Policy*, *36*, 112–119. https://doi.org/10.1016/j.drugpo.2016.04.018

Braveman, P., Egerter, S., & Williams, D. R. (2011). The Social Determinants of Health: Coming of Age. *Annual Review of Public Health*, *32*(1), 381–398. https://doi.org/10.1146/annurev-publhealth-031210-101218

Bravo, M. J., Barrio, G., De La Fuente, L., Royuela, L., Domingo, L., & Silva, T. (2003). Reasons for selecting an initial route of heroin administration and for subsequent transitions during a severe HIV epidemic. *Addiction*, *98*(6), 749–760. https://doi.org/10.1046/j.1360-0443.2003.00393.x

Burris, S., Blankenship, K. M., Donoghoe, M., Sherman, S., Vernick, J. S., Case, P., … Koester, S. (2004). Addressing the "Risk Environment" for Injection Drug Users: The Mysterious Case of the Missing Cop. *Milbank Quarterly*, *82*(1), 125–156. https://doi.org/10.1111/j.0887-378X.2004.00304.x

Ciccarone, D. (2017). Fentanyl in the US heroin supply: A rapidly changing risk environment. *International Journal of Drug Policy*, *46*, 107–111. https://doi.org/10.1016/j.drugpo.2017.06.010

Cooper, H., Moore, L., Gruskin, S., & Krieger, N. (2005). The impact of a police drug crackdown on drug injectors' ability to practice harm reduction: A qualitative study. *Social Science & Medicine*, *61*(3), 673–684. https://doi.org/10.1016/j.socscimed.2004.12.030

DeLanda, M. (2006). *A New Philosophy of Society: Assemblage Theory and Social Complexity*. A&C Black.

DeLanda, M. (2016). *Assemblage Theory*. Edinburgh University Press.

Demant, J. (2013). Affected in the nightclub. A case study of regular clubbers' conflictual practices in nightclubs. *International Journal of Drug Policy*, *24*(3), 196–202. https://doi.org/10.1016/j.drugpo.2013.04.005

Dilkes-Frayne, E. (2014). Tracing the "Event" of Drug Use: "Context" and the Coproduction of a Night Out on MDMA. *Contemporary Drug Problems*, *41*(3), 445–479. https://doi.org/10.1177/009145091404100308

Dovey, K., Fitzgerald, J., & Choi, Y. (2001). Safety becomes danger: dilemmas of drug-use in public space. *Health & Place*, *7*(4), 319–331. https://doi.org/10.1016/S1353-8292(01)00024-7

Duff. (2016). Assemblages, territories, contexts. *International Journal of Drug Policy*, *33*, 15–20. https://doi.org/10.1016/j.drugpo.2015.10.003

Duff, C. (2007). Towards a theory of drug use contexts: Space, embodiment and practice. *Addiction Research & Theory*, *15*(5), 503–519. https://doi.org/10.1080/16066350601165448

Duff, C. (2011). Reassembling (social) contexts: New directions for a sociology of drugs. *International Journal of Drug Policy*, *22*(6), 404–406. https://doi.org/10.1016/j.drugpo.2011.09.005

Duff, C. (2012). Accounting for context: exploring the role of objects and spaces in the consumption of alcohol and other drugs. *Social & Cultural Geography*, *13*(2), 145–159. https://doi.org/10.1080/14649365.2012.655765

Farrugia, A. (2015). "You Can't Just Give Your Best Mate a Massive Hug Every Day": Young Men, Play and MDMA. *Contemporary Drug Problems*, *42*(3), 240–256. https://doi.org/10.1177/0091450915601520

Harocopos, A., Goldsamt, L. A., Kobrak, P., Jost, J. J., & Clatts, M. C. (2009). New injectors and the social context of injection initiation. *International Journal of Drug Policy*, *20*(4), 317–323. https://doi.org/10.1016/j.drugpo.2008.06.003

Hunter, K., Park, J. N., Allen, S. T., Chaulk, P., Frost, T., Weir, B. W., & Sherman, S. G. (2018). Safe and unsafe spaces: Non-fatal overdose, arrest, and receptive syringe sharing among people who inject drugs in public and semi-public spaces in Baltimore City. *International Journal of Drug Policy*, *57*, 25–31. https://doi.org/10.1016/j.drugpo.2018.03.026

Ivsins, A., & Marsh, S. (2018). Exploring what shapes injection and non-injection among a sample of marginalized people who use drugs. *International Journal of Drug Policy*, *57*, 72–78. https://doi.org/10.1016/j.drugpo.2018.04.006

Ivsins, A., Roth, E., Benoit, C., & Fischer, B. (2013). Crack Pipe Sharing in Context: How Sociostructural Factors Shape Risk Practices among Noninjection Drug Users. *Contemporary Drug Problems*, *40*(4), 481–503. https://doi.org/10.1177/009145091304000403

Ivsins, A., & Yake, K. (2018). Looking beyond harm: meaning and purpose of substance use in the lives of marginalized people who use drugs. *Drugs: Education, Prevention and Policy*, *0*(0), 1–10. https://doi.org/10.1080/09687637.2018.1497145

Jain, J. P., Bristow, C. C., Pines, H. A., Harvey-Vera, A., Rangel, G., Staines, H., … Strathdee, S. A. (2018). Factors in the HIV risk environment associated with bacterial vaginosis among HIV-negative female sex workers who inject drugs in the Mexico-United States border region. *BMC Public Health*, *18*(1), 1032. https://doi.org/10.1186/s12889-018-5965-9

Latour, B. (2005). *Reassembling the Social: An Introduction to Actor-network-theory (Clarendon Lectures in Management Studies)*. {Oxford University Press}. Retrieved from http://www.amazon.ca/exec/obidos/redirect?tag=citeulike09-20&path=ASIN/0199256047

Marshall, B. D. L., Kerr, T., Qi, J., Montaner, J. S. G., & Wood, E. (2010). Public injecting and HIV risk behaviour among street-involved youth. *Drug and Alcohol Dependence*, *110*(3), 254–258. https://doi.org/10.1016/j.drugalcdep.2010.01.022

Moore, D., Pienaar, K., Dilkes-Frayne, E., & Fraser, S. (2017). Challenging the addiction/health binary with assemblage thinking: An analysis of consumer accounts. *International Journal of Drug Policy*, *44*, 155–163. https://doi.org/10.1016/j.drugpo.2017.01.013

Niland, P., Lyons, A. C., Goodwin, I., & Hutton, F. (2013). "Everyone can loosen up and get a bit of a buzz on": Young adults, alcohol and friendship practices. *International Journal of Drug Policy*, *24*(6), 530–537. https://doi.org/10.1016/j.drugpo.2013.05.013

Race, K. (2014). Complex Events: Drug Effects and Emergent Causality. *Contemporary Drug Problems*, *41*(3), 301–334. https://doi.org/10.1177/009145091404100303

Rhodes, T., Stimson, G. V., Crofts, N., Ball, A., Dehne, K., & Khodakevich, L. (1999). Drug injecting, rapid HIV spread, and the "risk environment": implications for assessment and response. *AIDS (London, England)*, *13 Suppl A*, S259-269.

Rhodes, T. (1997). Risk theory in epidemic times: sex, drugs and the social organisation of 'risk behaviour.' *Sociology of Health & Illness*, *19*(2), 208–227. https://doi.org/10.1111/1467-9566.ep10934410

Rhodes, T. (2002). The 'risk environment': a framework for understanding and reducing drug-related harm. *International Journal of Drug Policy*, *13*(2), 85–94. https://doi.org/10.1016/S0955-3959(02)00007-5

Rhodes, T. (2009). Risk environments and drug harms: A social science for harm reduction approach. *International Journal of Drug Policy*, *20*(3), 193–201. https://doi.org/10.1016/j.drugpo.2008.10.003

Rhodes, T., Watts, L., Davies, S., Martin, A., Smith, J., Clark, D., … Lyons, M. (2007). Risk, shame and the public injector: A qualitative study of drug injecting in South Wales. *Social Science & Medicine*, *65*(3), 572–585. https://doi.org/10.1016/j.socscimed.2007.03.033

Schroeder, J. R., Latkin, C. A., Hoover, D. R., Curry, A. D., Knowlton, A. R., & Celentano, D. D. (2001). Illicit Drug Use in One's Social Network and in One's Neighborhood Predicts Individual Heroin and Cocaine Use. *Annals of Epidemiology*, *11*(6), 389–394. https://doi.org/10.1016/S1047-2797(01)00225-3

Small, W., Kerr, T., Charette, J., Schechter, M. T., & Spittal, P. M. (2006). Impacts of intensified police activity on injection drug users: Evidence from an ethnographic investigation. *International Journal of Drug Policy*, *17*(2), 85–95. https://doi.org/10.1016/j.drugpo.2005.12.005

Vitellone, N. (2010). Just Another Night in the Shooting Gallery?: The Syringe, Space, and Affect. *Environment and Planning D: Society and Space*, *28*(5), 867–880. https://doi.org/10.1068/d12609

Vitellone, N. (2015). Syringe sociology. *The British Journal of Sociology*, *66*(2), 373–390. https://doi.org/10.1111/1468-4446.12124

Williams, C. T., & Latkin, C. A. (2007). Neighborhood Socioeconomic Status, Personal Network Attributes, and Use of Heroin and Cocaine. *American Journal of Preventive Medicine*, *32*(6, Supplement), S203–S210. https://doi.org/10.1016/j.amepre.2007.02.006

Witteveen, E., Van Ameijden, E. J. C., & Schippers, G. M. (2006). Motives for and Against Injecting Drug Use Among Young Adults in Amsterdam: Qualitative Findings and

Considerations for Disease Prevention. *Substance Use & Misuse*, *41*(6–7), 1001–1016. https://doi.org/10.1080/10826080600669561

Wood, E., & Kerr, T. (2006). What do you do when you hit rock bottom? Responding to drugs in the city of Vancouver. *International Journal of Drug Policy*, *17*(2), 55–60. https://doi.org/10.1016/j.drugpo.2005.12.007

Drugs: Education, Prevention and Policy

ISSN: 0968-7637 (Print) 1465-3370 (Online) Journal homepage: http://www.tandfonline.com/loi/idep20

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To cite this article: Andrew Ivsins & Kevin Yake (2018): Looking beyond harm: meaning and purpose of substance use in the lives of marginalized people who use drugs, Drugs: Education, Prevention and Policy, DOI: 10.1080/09687637.2018.1497145

To link to this article: https://doi.org/10.1080/09687637.2018.1497145

Published online: 11 Sep 2018.

DRUGS: EDUCATION, PREVENTION AND POLICY
https://doi.org/10.1080/09687637.2018.1497145

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Looking beyond harm: meaning and purpose of substance use in the lives of marginalized people who use drugs

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ABSTRACT

Substance use among marginalized populations has historically been constructed as a social problem to be managed, cured, and eliminated. Much social science research concerning drug use among marginalized populations focuses on risks and harms, with little attention to positive aspects of substance use. In this paper we explore positive roles of drugs/drug use among marginalized people who use drugs. We draw on in-depth qualitative interviews conducted with 50 people who use drugs in Vancouver's Downtown Eastside neighbourhood. Forty-three participants reported positive aspects of drug use. Participant narratives revealed four main themes regarding the role and function of drugs and drug use in their lives: (1) pain relief and management; (2) alleviating mental health issues; (3) fostering social experiences; (4) pleasurable embodied experiences. Our findings show that despite known negative consequences of substance use, in many ways drug use was beneficial for these individuals. Our study demonstrates that given the opportunity, meaningful and useful conversations that shed light on why people take drugs is possible. By understanding why marginalized individuals choose to consume the drugs they do we can begin to engage in truly helpful conversations about how to reduce drug-related harm.

ARTICLE HISTORY
Received 20 March 2018
Revised 12 June 2018
Accepted 1 July 2018

KEYWORDS
Drug use; illicit drug use; qualitative research; pain management; pleasure; marginalized populations

Introduction

Substance use in Western nations among marginalized people who use drugs (PWUD)[1] has historically been constructed as a social problem shaped by moral concerns and cultural norms of psychoactive substance use. As a social problem, drug use among marginalized individuals is seen as something to be managed, cured, and eliminated through treatment, intervention, policy, and policing. When problematized, the public at large as well as many researchers appear unable (or forget) to ask about the place of drugs/drug use in marginalized peoples' lives, and instead focus on associated risks and harms. Subjective accounts of substance use, especially in marginalized populations, tend to emphasize the variety of problems that result from using drugs (e.g. violence, criminal activity, and a host of social and health harms), with positive coverage limited to the success of drug treatments and interventions. Approaching substance use from this perspective leaves little room for individual agency, rational choice, and understanding of the potential benefits of substance use for the individuals involved. As O'Malley and Valverde (2004) remark in their discussion of drug consumption and pleasure, reasonable motives for problematic activities such as drug use are silenced and denied. Consequently, certain substances (e.g. heroin, crystal methamphetamine) and people that use them (e.g. homeless individuals, 'street youth') are criminalized and stigmatized. This lies in stark contrast to both medically-prescribed use of similar, or often the same, substances (Baldwin, 2000; McQuay, 1999), and cultural norms of pleasurable substance use (Parker, Aldridge, & Measham, 1998).

Nearly three decades ago, Moore (1990) laid out a number of criticisms of Australian drug researchers (see also MacLean, 2005) noting among other things a lack of attention to the social context of substance use, the tendency to pathologize drugs and the people who use them, and misrecognition of concrete benefits of drugs/drug use for PWUD. For the most part, these criticisms remain valid today and extend to the international arena of substance use research in general, and in particular when concerning substance use among marginalized PWUD. Social, psychological, and epidemiological research continues to primarily report on the harms associated with substance use. Indeed, inputting the search term "illicit drug use" in various academic databases (Google Scholar, PubMed, Web of Science, Social Sciences Abstracts) results in the identification of articles with words such as 'delinquency', 'abuse', 'consequences', 'violence', 'disorders', 'dependence', 'risk', 'problems', 'infection', and 'comorbidity' in their titles. Such research paints an incomplete picture of the lived experience of marginalized PWUD.

At the same time, as per Moore's (1990) astute observations, there have been appreciable gains in our understanding of how contexts shape substance use among a variety of populations in different settings, particularly among critical

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drug research scholars. For example, physical settings have been shown to influence non-medical use of prescription opioids among young adults (Yedinak et al., 2016), increase 'problematic' drug use among street youth (Fast, Small, Wood, & Kerr, 2009), and shape drinking practices among university students (Wilkinson & Ivsins, 2017). Similarly, social networks have been found to influence cocaine use among gay and bisexual men (Fazio, Hunt, & Moloney, 2011), and shape drug injection practices (Neaigus et al., 2006) and how crack is consumed (Ivsins, Roth, Benoit, & Fischer, 2013) among marginalized PWUD. Rhodes' (2009) risk environment framework has broadened our understanding of the roles various physical, social, economic, and policy environments play in shaping substance use and related harms at both macro and micro levels. At the same time, there has been a recent push to better understand the minutiae of social drug use contexts, and micro-level interactions, by scholars like Duff (2012, 2016), Demant (2013), and Dilkes-Frayne (2014, 2016).

Researchers have also made advances in understanding drug consumption more broadly by exploring various benefits and functions of, or motivations for, substance use. Boys, Marsden, and Strang (2001) identified a number of functions of substance use among young PWUD, including to relax, become intoxicated, enhance activities, and alleviate depression. Other studies have reflected on motivations for substance use including 'party drug' use (White et al., 2006), 'controlled' heroin use (Warburton, Turnbull, & Hough, 2005), stimulant use among gay men (Díaz, Heckert, & Sánchez, 2005), and inhalant use (MacLean, 2005). An important feature of this line of inquiry has been a shift in focus away from a concern with the risks and harms associated with using drugs. Instead, drug consumption has been shown to have some positive benefits or functions for the people that use them. As a point of criticism however, Moore (2008) points out that 'benefits' are often coupled with 'risks' (e.g. Hartwell, Back, McRae-Clark, Shaftman, & Brady, 2012; Levy, O'Grady, Wish, & Arria, 2005; White et al., 2006), such that positive aspects of drug consumption remain contrasted with negative consequences.

In addition, much of the attention on any positive aspects of substance use has been limited to 'recreational' drug use, only allowing for meaningful conceptions of drug consumption among certain populations. A number of scholars have drawn attention to the important place of pleasure in young people's drug consumption (Duff, 2008; Niland, Lyons, Goodwin, & Hutton, 2013; Pennay & Moore, 2010). Farrugia (2015), for example, describes the 'playful sociality' of young men's ecstasy use (p. 252), while Askew (2016) refers to the 'functional fun' of adult recreational drug use. (p. 112). Yet there remains an empirical paucity of any positive effects of substance use among marginalized PWUD. Aside from a handful of studies examining positive motivations of substance use among marginalized youth (Foster & Spencer, 2013; MacLean, 2005; O'Gorman, 2016), little research has addressed the meaningful and purposeful aspects of substance use among marginalized PWUD. This paper begins to fill this gap by exploring positive roles of drugs/drug use among a sample of marginalized PWUD in Vancouver's Downtown Eastside (DTES) neighbourhood.

Methods

Research setting

The Downtown Eastside is a diverse neighbourhood, and one of the oldest in Vancouver. It is also considered one of the poorest neighbourhoods in Canada with a visible street scene, open drug market, and high rates of homelessness, unemployment, poverty, and substance use (City of Vancouver, 2013). Conservative estimates are that 1 in 18 people in the DTES are homeless (Carnegie Community Action Project, 2016). Many residents of the DTES who are housed live in single-room occupancy (SRO) hotels, most of which have shared common bathroom and kitchen facilities, and are known for unsanitary and other undesirable living conditions, ranging from safety concerns (e.g. violence, drug dealing, theft), to noise, and lack of privacy.

The DTES contains numerous public, social and health services for the homeless and people living in poverty such as drop-in centres, free meals, health clinics, outreach programs, and homeless shelters. The neighbourhood is also home to numerous services for PWUD including harm reduction supply outlets, detox facilities, both sanctioned and unsanctioned supervised consumption facilities, and overdose prevention sites. The Vancouver Area Network of Drug Users (VANDU), a peer-run drug user organization established in 1998, is also located in the DTES.

The study was carried out at the VANDU building, which serves as a drop-in centre, harm reduction supply outlet, general safe space for PWUD, and since December 2016, one of several overdose prevention sites. VANDU is made up of former and current PWUD. VANDU actively engages in advocacy to promote social justice issues and improve the lives of PWUD. Permission to involve VANDU and its members in this study, and conduct interviews at their location, was granted by the VANDU Board of Directors (made up of approximately 12 VANDU members elected to the Board) after meeting with them and explaining the study. Ethics approval was obtained by the Human Research Ethics Board at the University of Victoria, Victoria, BC.

Participant recruitment

VANDU Board members were hired to recruit and pre-screen some of the potential participants, and helped to schedule interview appointments, and maintain interview schedules. About one half of the Board members expressed interest in working on the study, and took turns recruiting participants over the course of data collection. In agreement with the VANDU Board, and in line with previous research conducted at VANDU, recruiters were paid $10 CAD per hour and worked 2–3 h per interview shift. Study participants were recruited inside the VANDU building, on the street, and in other nearby locations frequented by PWUD. Potential participants were required to be: (1) at least 19 years old and, (2) currently using drugs (not prescribed, or not as prescribed)

by any method. Given the liberal definition of "drug use" employed in our eligibility requirement, data collection captured the use of a wide variety of substances, and varied methods of consumption (i.e. oral, intranasal, injection, smoking). At the time of the interview, potential participants were screened again to ensure eligibility. Only one person was found ineligible at the second screening, for being under 19 years old.

Data collection

Interviews were conducted in various rooms in the VANDU building by the first author between June and December 2014. Prior to the interview the study was described in detail, and verbal consent was provided by answering 'yes' to a statement of consent read by the interviewer after a digital voice recorder was turned on. Participants were offered a paper copy of the consent form for their records. None of the potential participants refused to consent or participate in the study. Participants were provided with a $25 CAD honorarium for participating in the study after the interview.

Interviews ($n = 50$) consisted of a short quantitative survey and a longer semi-structured qualitative interview, conducted face-to-face with the same participant during the same interview session. The survey instrument covered the following topics: demographics; drug use history and current drug use; injection drug use; non-injection drug use; sexual risk behaviour; health, crime, and violence; stigma and discrimination; and social and health service utilization. A qualitative interview guide was used to foster discussions around drug use (history of use, current use, and method of use), social networks, social and health issues, violence and safety, and experiences of stigma and discrimination. While the focus of this paper is on meaningful conceptions of drug use among participants, it is important to note that the participants also spoke about negative aspects of substance use. For example, participants were asked why they use drugs, which led into a discussion about positive aspects of drug use with the questions: What is good about drugs/your drug use? What do you like about your use of (heroin, crack, cocaine, etc.)? How have drugs been positive in your life? Following this, participants were given the chance to discuss negative aspects of drug use with the following questions (or some iteration thereof): What is bad about drugs/your drug use? What don't you like about (heroin, crack, cocaine, etc.)? How have drugs negatively impacted you/your life? The interview guide was revised over the course of the study as important topics to pursue emerged during data collection. Interviews lasted between 60 and 90 min.

Data analysis

Interviews were transcribed verbatim and reviewed for accuracy by the first author. Qualitative data management and analysis was facilitated with NVivo 10 (2012), and quantitative data was analyzed using SPSS 24 (Chicago, IL). For the purpose of this paper, which focuses on qualitative discussions of positive aspects of using drugs we present only simple descriptive statistics here (e.g. demographics and drug use characteristics).

A preliminary coding framework was developed to categorize the data into a set of broad categories or 'general orders' (Clarke, 2003, 2005), such as 'individual/collective human elements', 'non-human elements', 'drugs and drug use', 'issues and debates', 'spatial elements', 'sociocultural elements', and 'temporal elements'. Analyses focused on reasons/motivations for drug use, such that all discussions of why people used drugs were initially broadly coded into the category 'reasons for drug use'. As specific themes around reasons/motivations for drug use emerged, new codes were added to the framework, and further refined to capture specific themes related to positive roles of substance use. Over the course of re-reading and re-coding transcripts and coded portions of data, a number of main themes were established which captured the positive roles of substance use in the lives of the participants. This analysis was presented to the VANDU Board of Directors (which contained some study participants) for feedback and to ensure the validity of thematic interpretations. The VANDU Board also provided feedback on various drafts of the paper.

Sample characteristics

Table 1 presents demographic characteristics and substance use patterns of the study sample, split by current method of drug use. While much public health research focuses on specific substances and methods of consumption (e.g. heroin use by injection), our study uniquely reports on a spectrum of both drugs and consumption methods, as seen in Table 1.

Results

During the interviews participants were encouraged to discuss both positive and negative aspects of their drug use to avoid any kind of bias. Almost all (43) participants reported positive aspects of drug use, while 39 participants discussed negative aspects of drug use. Figure 1 provides a visual representation of the thematic construction of our results on the positive aspects of drug use, as reported by participants. Participant narratives revealed four main themes regarding the role and function of drugs and drug use in their lives: (1) pain relief and management; (2) alleviating mental health issues; (3) fostering social experiences; (4) pleasurable embodied experiences. Pseudonyms are used throughout.

'As soon as I wake up every bone in my body hurts' – Pain relief and management

Regularly experiencing physical pain was common among numerous participants, and for many, living with and managing pain was a part of daily life. Participants described various causes of pain such as injuries, operations, violence, the effects of living on the street, and chronic conditions such as arthritis and osteoporosis. Chloe described her daily struggle with pain:

Table 1. Sample demographics and substance use.

	Current PWSD ($n = 26$) *N* (%)	Current PWID ($n = 24$) *N* (%)	Total ($n = 50$) *N* (%)
Age			Mean: 44.6 Range: 19–71
19–25	2 (8)	3 (12)	5 (10)
26–35	1 (4)	4 (17)	5 (10)
36 and above	23 (88)	17 (71)	40 (80)
Gender			
Male	17 (65)	12 (50)	29 (58)
Female	9 (35)	12 (50)	21 (42)
Ethnicity			
Indigenous	13 (50)	13 (54)	26 (52)
Caucasian	11 (42)	9 (38)	20 (40)
Other	2 (8)	2 (8)	4 (8)
Housing status			
Stable	3 (11)	4 (17)	7 (14)
Unstable*	23 (89)	20 (83)	43 (86)
Drugs used past 30 days			
Alcohol	15 (58)	13 (54)	28 (56)
Marijuana	19 (73)	18 (75)	37 (74)
Cocaine	3 (11)	13 (54)	16 (32)
Crack	24 (92)	20 (83)	44 (88)
Heroin	4 (15)	19 (79)	23 (46)
Prescription opioids	5 (19)	10 (42)	15 (30)
Crystal meth	8 (31)	12 (50)	20 (40)
Drugs injected past 12 months			
Cocaine	NA	15 (63)	
Crack	NA	5 (21)	
Heroin	NA	20 (83)	
Prescription opioids	NA	12 (50)	
Crystal meth	NA	16 (67)	

*Includes SROs, shelters, couch surfing, homeless.

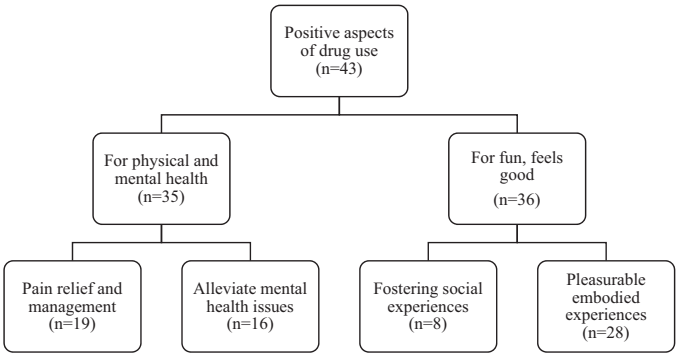

Figure 1. Process of thematic construction.

> I have really bad neuropathy, I have osteo, which is very, like stairs are really bad. In the morning my boyfriend has to sometimes sit me up in bed. You know that kind of thing. I need rails when I'm in the shower, in the bathroom, those kinds of things. Cups, in the morning I can't hold very well. You know it's getting to that point. (NIDU/F/43)[2]

Chloe later went on to describe how she manages her pain with crack cocaine:

> But for me personally, it's a pain med. It's a thing to function during the day when, I have nothing else … because acetaminophen or ibuprofen don't work that well. And my focus is more on my pain than what I'm doing so, a toke is what I need, and it kind of just forgets about all the pain for the hour … where I can function. So the positive thing is it helps me with my pain. (NIDU/F/43)

Chloe's talk about pain, how she manages her pain, and why she uses a criminalized substance to alleviate her pain symptoms, was common in many participants' narratives, and underscores systemic deficiencies in current pain management strategies for PWUD. For many participants who suffered from pain, inadequate treatment within the health care system (e.g. due to restrictive prescribing practices among physicians) led them to find other means of alleviating symptoms. As Yuri described:

> I have to use it [opiates] or I get muscle contractions and doctors are afraid to prescribe it because the cops are on their case, so what, I'm supposed to walk around not being able to use my hands or should I spend ten bucks and be able to use them? I think I'll spend the ten bucks. (IDU/M/55)

A surprising finding was the use of stimulants such as crack, cocaine, and crystal meth to alleviate pain symptoms, suggesting that non-traditional pain relievers (i.e. as opposed to acetaminophen, ibuprofen, opioids) can serve an important role in helping PWUD function without pain (or with less pain). A number of participants spoke about stimulants as pain relievers. Sabeena suggested that crack 'dulls the pain a bit' (NIDU/F/49) and Carrie mentioned that crack 'takes away some of the body stiffness' (IDU/F/36). Liam referred to a similar role crystal meth played in his pain relief stating, 'it takes care of the pain. It takes away a lot of the pain … Sports injuries, fractures. Stuff like that' (NIDU/M/40).

In these and other instances, use of criminalized substances served an important role in participants' lives, providing them temporary relief from pain, and the freedom to go about their daily lives. Yelena, for instance, emphasized the functional aspect of her heroin use: 'Honestly, it's medicinal. For me. It really is. I don't think I'd be able to do what I have to do without it … it's the difference between wanting to get high and having to get high, you know what I'm saying?' (IDU/F/38).

'It softens the blow emotionally' – Alleviating mental health issues

Given the broader context of structural inequality which shapes people's lives in the DTES – one of economic deprivation, unstable housing/homelessness, racism, discrimination and segregation, and a lack of access to adequate social and health supports (Boyd & Kerr, 2016; City of Vancouver, 2013; Culhane, 2004; Linden, Mar, Werker, Jang, & Krausz, 2012) – it is perhaps not surprising that many participants used drugs to alleviate stress, depression, and other mental health issues. A number of participants referred to their drug use as providing a calming effect, or a brief respite from an otherwise often stressful daily life. When asked why she used crack Natasha responded, 'I use it for just for … just like a mental relax to me. It's like an Ativan is to somebody else or something … I know that it's a stimulant, but it's like a calming effect I guess' (IDU/F/36). Similarly, Liam discussed why he used crack, noting it had evolved from being a source of pleasure to something used to ease his mind:

> It used to be enjoyable and pleasurable for me. But now it's just, I don't know why, I don't really get high off of it anymore, but it kind of just eases me. It kind of just sets me free, kind of thing, for a few minutes, and that's about it … Puts my mind at ease. (NIDU/M/40)

Other participants revealed deep-seated emotional issues stemming from past traumatic incidents (e.g. history of child abuse, violence) or negative impacts of substance use (e.g. separation from family, loss of income/jobs). For these participants, drug use was discussed as helping them get through tough times, or temporary relief from sensitive emotional states. Yuri elaborated on the role heroin played in helping him cope with difficult emotional matters:

> I made a lot of money in my lifetime and did a lot of things for them to take it all and lose my kid. That really put me in a depressed state of being. I'm surprised I'm still not dead. You get through it. Without the dope [heroin], I wouldn't. Even if I didn't need it for the muscle contractions, I'd still be using it just to get through the day. (IDU/M/55)

Similarly, Andre discussed how heroin helped ease his depression related to past family and work problems:

> I had things in my life, like the divorce and shit like that, that depressed me really bad and … I was having trouble at work and it all creeped up on me and I just couldn't handle it without anything so I started using … I mean, you can tell, it makes you happy and, I don't know what to say, yeah, it's just … if I'm having a bad day I go and inject and it makes me feel better right away. (IDU/M/58)

Some participants discussed their use of criminalized substances in reference to other licit drugs, or as replacements for prescribed drugs. Natasha (IDU/F/36) compared her crack use with Ativan, while Carrie suggested that for her crack was 'almost like a Ritalin type thing' (IDU/F/36). In a discussion about her bi-polar disorder, Brenda talked about self-medicating, and explained why she uses heroin rather than prescribed drugs to control it:

> I went to a psychiatrist and they put me on a bunch of pills. I felt like a zombie, man, I fucking hated it. That was one of the times I was in rehab. Probably if I would've stuck with it and maybe like worked out some type of accommodation, I could've figured it out. But I just decided that I could do a better job myself. (IDU/F/26)

Despite research showing that substance use may create or worsen mental health problems (Marshall & Werb, 2010), in these narratives drugs and drug use play an important role in alleviating mental health issues such as stress, depression, and anxiety, and help participants function in their day-to-day lives. Surprisingly crack, a stimulant, was used by some participants to relax and 'ease their mind', pointing to the need to explore the role of non-traditional substances in helping PWUD to address emotional health issues. While the root causes of mental health issues among PWUD require greater attention, it is important to recognize that without proper services and supports, and in some cases despite them, criminalized substances function to, at least temporarily, provide emotional relief and support mental well-being.

'It's not about just sitting behind closed doors and getting high' – fostering social experiences

For a number of participants drugs had a clear social function, and were often used to foster or enhance social experiences. Although the study participants had limited access to traditional leisure venues where substance use is common (i.e. bars, nightclubs, pubs), drugs were often used in social situations to reduce inhibitions, 'let loose', and party. Speaking about the social aspect of cocaine Ben said that '[w]hen I snort cocaine, I'm a social butterfly. Like I love it. I love it. I'm the life of the party, right, "Let's go, all night long"' (NIDU/M/56). Similarly, Brenda described how crystal methamphetamine helped her to open up, stating 'I find I'm a little bit, I'm shy and awkward a lot of the time and when I do jib I'm a little bit more extroverted. Like I express myself a little bit more. A little bit more colorful' (IDU/F/26).

While research has found that drug use may sometimes discourage individuals from participating in social settings (Homer et al., 2008), a number of participants talked about drugs as playing a role in social connection or bonding. Dave (NIDU/M/45) stated that the 'only social thing I do with people' was using drugs, and Carl spoke about using cocaine with friends, referring to it as 'a social drug' (IDU/M/53). Alex (IDU/M/51) talked about using drugs and 'socializing with people and friends', and went on to describe the importance of maintaining social connections, stating '[i]t's not about just sitting behind closed doors and getting high … But you know, going to different events with people. It's just important not to get, trapped'. For many participants the experiences of structural inequality, and the context of living in the DTES (e.g. living in SROs, avoiding being outdoors for fear of violence or arrest), could at times be quite isolating. Substance use often provided avenues of escape from social isolation and loneliness. The important role substance use can play in structuring and fostering experiences of social connection and bonding was highlighted by Dane:

> I think for the most part, it's more of a social thing. It's … it is quite sociable because if you look around, very rarely you'll see, you'll see somebody smoking a rock by themselves, but when it

> comes down to it, you usually see people in groups. And there's usually drugs at the centre of it, but you know what I mean, that's the social aspect of it. (IDU/M/51)

'It's for the kick and the buzz more than anything' – pleasurable embodied experiences

Pleasure was commonly discussed by participants as a positive aspect of their substance use. Participants often spoke about 'liking the high', or that drugs simply made them 'feel good'. When pressed to elaborate on the pleasurable sensations derived from using drugs participants sometimes found their experiences hard to describe, often at a loss for words, such as when Jake stated simply that crack 'just makes me high and it feels good' (NIDU/M/51). Similarly, Sheldon struggled to articulate the pleasure elicited from his crack use: 'It gives me a vast high. [long pause] It's, it's instant … it's really hard to … It makes me feel good, it makes my body feel good you know and … It puts a smile on my face!' (NIDU/M/53). For many participants, regardless of the specific substance being used, 'the high' as an embodied state of being (shifting both physical and mental states) was the meaningful and pleasurable sought-after drug effect.

Other participants articulated intense pleasurable embodied experiences derived from using drugs, at times providing richly detailed descriptions of bodily sensations. These experiences varied depending on the type of substance used. For participants who used stimulants (cocaine, crack and/or crystal meth), metaphors of speed were frequently elicited to describe their associated pleasurable experiences. Ellen spoke about enjoying the 'quick burst of energy' (NIDU/F/19) from smoking crack, while Albert described injecting cocaine as 'quite the rush'. When asked if he could describe the 'rush' Albert replied, 'It's kind of like being in the ejection seat. Just, you're just sitting there, all of a sudden [ejection noise] and you're gone' (NIDU/M/45). Ben's description of the effect from smoking crack was similar:

> This is like being on a 747 [airplane] thirty-seven thousand feet in the air, right, boom! Without a parachute … So that's why I say, that after the first ten or twenty seconds or whatever, it, that's the ecstasy part of it. (NIDU/M/56)

For participants who used opiates, embodied pleasures from drug use were described in gentler terms, depicting feelings of euphoria, relaxation and warmth. Yuri described the physical pleasure he gets from using opiates:

> Well it's a nice euphoric feeling, you get a hundred milligram of morphine for a couple minutes, it feels really good to me. A lot of guys don't like the morphine, you get the pins and needles and stuff. To me, it's about, I love it. (IDU/M/55)

Kate similarly described the enjoyable physical sensations derived from her heroin use:

> They feel good, when I do enough heroin, I like the feeling … You feel like, warm, and you get like pins and needles in your toes and the palms of your hands and like, your back burns. (IDU/F/27).

While many participants who used opiates required daily doses of the drug to avoid withdrawal symptoms, they still often found pleasure in using the drug. Brenda recounted the beginning of her physical dependence on opiates, describing the first time she 'got sick' (experienced withdrawal symptoms):

> I was sixteen and I was in a small town in Manitoba. And they can't get any good drugs out there, so people buy prescriptions and I started sniffing oxycontin and it was great, until I realized that I couldn't not sniff oxycontin and not be brutally sick. (IDU/F/26)

Despite her ongoing physical dependence on opiates some ten years later, Brenda still found pleasure in her opiate use:

> Brenda: I love, I just love how it feels. I love being high. I just, I don't know why. I always have, like ever since I started using drugs I just, I crave it. I don't know.
>
> Interviewer: But it makes you feel good?
>
> Brenda: Yeah, it does make me feel good. (IDU/F/26)

Discussion

The qualitative findings demonstrate that drugs/drug use can play an important positive role in the lives of marginalized PWUD. While drug use can certainly be harmful as demonstrated by abundant research, and many participants also described negative aspects of using drugs, in certain contexts drug use for these participants was rational, purposeful, and even beneficial. Rather than being contextualized in terms of risks and harms, drug use for these participants was framed positively as providing relief from physical and mental health issues, fostering and enhancing social experiences, and providing pleasurable embodied experiences.

Our finding that participants used drugs to self-manage their pain highlights the need to better understand pain and pain management among PWUD. Previous studies show that pain is common among PWUD (Dahlman, Kral, Wenger, Hakansson, & Novak, 2017; Neighbor, Dance, Hawk, & Kohn, 2011; Voon et al., 2015) and often goes undertreated (Berg, Arnsten, Sacajiu, & Karasz, 2009; McNeil, Small, Wood, & Kerr, 2014; Merrill, Rhodes, Deyo, Marlatt, & Bradley, 2002). Negative attitudes among health care professionals of PWUD, informed by cultural stereotypes of 'drug seeking', coupled with the ambiguity of pain and concerns about drug dependence, result in substandard health care and shape prescribing practices (Berg et al., 2009; Merrill et al., 2002; van Boekel, Brouwers, van Weeghel, & Garretsen, 2013). This was a common experience among study participants who were self-managing their pain; they spoke about not receiving adequate pain medication from physicians, or abstaining entirely from interacting with the healthcare system for as long as possible to avoid stigmatizing experiences. That some participants managed their pain with substances not traditionally thought/used to alleviate physical pain (i.e. stimulants) further underscores the need to reform current pain management strategies and explore alternative, non-traditional approaches to pain management, particularly among PWUD. Additionally, our findings point to the need

for better education and training programs aimed at reducing stigmatizing practices within the healthcare system.

Similarly, that participants used criminalized substances to cope with mental health issues suggests that PWUD in the DTES may not have access to adequate mental health treatment and supports, or that existing supports do not adequately meet their needs (i.e. are not culturally or gender appropriate) (Christiani, Hudson, Nyamathi, Mutere, & Sweat, 2008). A number of participants spoke about deep-seated emotional issues stemming from past traumatic incidents (e.g. history of childhood abuse, experiences in residential schools and foster care, violence, abduction, cross-generational transmission of trauma) and the role drugs played in helping them cope with these experiences. For these participants, criminalized substances provided temporary relief, a way of momentarily forgetting about highly emotional issues. While self-medicating and using drugs for health reasons without supervision/advice from a health professional is perhaps not an adequate means of addressing mental health issues, without proper supports participants relied on criminalized substances to briefly alleviate emotional suffering. Given the clear link between past traumatic experiences and substance use (Dube et al., 2003; Kerr et al., 2009; Mills, Teesson, Ross, & Peters, 2006; Wu, Schairer, Dellor, & Grella, 2010), it is crucial that marginalized PWUD have access to appropriate mental health services.

Further to this, and in line with extant research on the relationship between stress and substance use (Sinha, 2001, 2008), our findings point to a need to better help PWUD cope with daily stress. That a number of participants referred to their use of criminalized substances as a replacement for prescription drugs used to deal with stress (e.g. Ativan) suggests that their medication needs are not being adequately met. At the same time, our findings show that it is essential to not only offer band-aid solutions to stress management (i.e. prescribing medication), but to reduce PWUD's interaction with environmental stressors (i.e. poverty, violence, discrimination). This can only be accomplished, however, by addressing the socio-environmental factors implicit in experiences of oppression and marginalization.

That three quarters of participants brought up pleasure and sociality as positive aspects of their drug use is not surprising given previous research demonstrating the important place of pleasure and sociality in drug consumption among other groups (Ahmed et al., 2016; Duff, 2008; Farrugia, 2015; Foster & Spencer, 2013; Levy et al., 2005; Szmigin et al., 2008). Yet pleasure, leisure, and sociality are rarely acknowledged in this particular context (drug use at the margins of society), and are most often replaced by concepts of risk, harm, and addiction. Nevertheless, narratives of pleasure and the role of drug use in social bonding were common, and mirror the experiences of participants in other studies (Farrugia, 2015; Fazio et al., 2011). Participants in our study speaking about using drugs to enhance social experiences, and ascribing importance to pleasurable embodied experiences of drug consumption indicates a need to better understand not only how these factors shape drug consumption among marginalized PWUD, but how this knowledge can also be used to reduce drug-related harms.

Clearly, pleasure and social bonding played important roles in mediating the drug consumption of many study participants, yet the topic was often broached with hesitation. The idea that they could openly discuss pleasure, without having to breach the subject of risk and harm, seemed a novel idea; a taboo subject that does not normally fit in their repertoire with, say, social workers or health care providers. This again points to the need to improve training within the healthcare system to better attend to and address stigmatizing practices. Enabling honest dialogue, allowing for PWUD to openly discuss their drug use without fear of judgement, discrimination, and possible negative repercussions (e.g. being denied medication) is an important step in fostering healthier relationships between marginalized PWUD and the current healthcare system. While not denying the importance of attending to the risks and harms of substance use, adopting a more holistic and balanced approach to addressing substance use should be pursued. Without doubt, it needs to be acknowledged that embodied pleasurable experiences, and the enhancement of social experiences, play an important role in drug consumption practices of marginalized PWUD. Our understanding of how this might translate to improved development and implementation of drug policy, treatment, and harm reduction initiatives would benefit from further research into this area.

A difficult yet important question remains: how can we fit these findings, that substance use is both meaningful and purposeful for marginalized PWUD, into current discourses of drug use/addiction/policy? It is here we often come to an impasse, where the spotlight is diverted from any positive framing of drug consumption to more common ideas of risk and harm, and conceptual notions of addiction and dysfunction. What is it about drug use among marginalized populations that makes it so difficult to move beyond the problematic and harmful, for both users and non-users alike? Valentine and Fraser (2008) observed that 'problematic' substance use is most often associated with material and social inequality, such that drug consumption becomes an outcome of poverty and deprivation. An unintended consequence of this, they suggest, is robbing marginalized PWUD of the capacity and agency to take account of their drug consumption, and closing off space where pleasure and other meaningful conceptions of drug use are allowed. As the lived experience of the study participants shows, drug use can be meaningful and beneficial. Yet, when drug use is constructed and presented as a social problem, these voices and discourses are silenced or ignored. Consequently, substance use among marginalized PWUD becomes anchored to stigmatizing discourses focused on problems, risks, and harms. This ambiguity points to the need to make space for marginalized PWUD to express their own understanding of substance use and related experiences (Benoit, Magnus, Phillips, Marcellus, & Charbonneau, 2015). By opening up spaces where meaningful and honest discourse of substance use is permitted, stigmatizing practices and discourses might be reduced.

Rather than providing a place for meaning, function, or purpose, drug use among marginalized PWUD is more commonly framed as harmful to both the individual and society at large. As such it becomes impossible to look beyond

harm, if harm is the only effect presented to us. In this study we identified four meaningful or functional reasons for using drugs among a sample of marginalized PWUD. This demonstrates that given the opportunity, allowing for the space to do so, meaningful and useful conversations that shed light on why people take drugs is possible. By understanding why individuals choose to consume the drugs they do, in the context of intersecting social and cultural contexts, we can begin to engage in truly helpful conversations about how to reduce drug-related harm.

Perhaps we should begin by posing this simple question: Why is it alright for one kind of person to use drugs, but not another? Or, why is one kind of drug use acceptable (e.g. drinking alcohol), but not another (e.g. smoking crack cocaine)? What is required is a shift in how drug use is conceptualized and talked about, a re-making/imagining of the conceptual landscape, as it were. Popular conceptualizations of drug use stemming from discourses rooted in pathology, prohibition, neoliberalism, and public health have difficulty moving beyond the dichotomous 'good vs. bad' rhetoric, which rarely allows for the separation of drugs and risk, or the co-occurrence of pleasure and safety (Barratt, Allen, & Lenton, 2014). This is especially evident when concerning drug use among people experiencing socio-cultural/structural/economic oppression and marginalization. While members of the broader public are often permitted to participate in 'functional' or 'acceptable' drug taking (i.e. when condoned by the healthcare system through sanctioned drug prescriptions, or imbibed within regulated alcohol consumption locales) without risk of social, moral or legal sanctions, marginalized PWUD are rarely afforded the same luxury (Askew & Salinas, 2018). Drug prohibition and much current drug policy has fabricated boundaries between the acceptable and unacceptable, resulting in the criminalization and stigmatization of certain substances and the people that use them. This points to what Taylor, Buchanan, and Ayres (2016) refer to as the 'drug apartheid', which hypocritically divides substances into the legitimate and illegitimate. The participants in this study – a group of people subject to socio-structural oppression whose drug use is, by and large, deemed illegitimate – articulated meaningful and functional aspects of drug use highlighting the inherent messiness in delineating the legitimacy or illegitimacy of certain substances and their use. Through this study we attempt to destabilize the boundaries between acceptable and unacceptable, and draw attention to alternative constructions of functionality and benefit that should be taken into consideration when developing and implementing drug policy and harm reduction initiatives.

Our study demonstrates that, despite known negative consequences of substance use, in many ways substance use was beneficial for these individuals living in Vancouver's DTES. In saying this, however, we are not denying the role of socio-cultural, political, and economic factors in shaping people's lives (including their drug consumption) in the DTES. Their experiences of vast, deep, and brutal inequalities – including poverty, homelessness, lack of access to adequate healthcare, entanglement in the justice system, violence (both physical and structural), and discrimination – undoubtedly shape their substance use and related harms. In many ways, participants' drug use is a response to these numerous and continuous experiences of social marginalization. At the same time, it would be amiss to deny marginalized PWUD any rationality in their decision to use drugs. If, for example, we can make a place in our social lexicon for embodied pleasurable drug experiences among, say, young people using drugs in clubs, this privilege should be extended to other groups as well.

Notes

1. In this paper when referring to marginalized people who use drugs, we are referring to people who are generally experiencing poverty, homelessness or unstable housing, structural and everyday violence, and who may rely on criminalized and stigmatized means of income generation.
2. Format: (Current method of drug use/Gender/Age). Methods of drug use: NIDU = non-injection drug use, IDU = injection drug use.

Disclosure statement

No potential conflict of interest was reported by the authors.

Funding

This work was funded by a Canadian Institutes of Health Research Frederick Banting and Charles Best Canada Graduate Scholarship Doctoral Award [Grant number 201110GSD-277587-173933].

References

Ahmed, A.-K., Weatherburn, P., Reid, D., Hickson, F., Torres-Rueda, S., Steinberg, P., & Bourne, A. (2016). Social norms related to combining drugs and sex ("chemsex") among gay men in South London. *International Journal of Drug Policy*, *38*, 29–35. doi:10.1016/j.drugpo.2016.10.007

Askew, R. (2016). Functional fun: Legitimising adult recreational drug use. *International Journal of Drug Policy*, *36*, 112–119. doi:10.1016/j.drugpo.2016.04.018

Askew, R., & Salinas, M. (2018). Status, stigma and stereotype: How drug takers and drug suppliers avoid negative labelling by virtue of their 'conventional' and 'law-abiding' lives. *Criminology and Criminal Justice*, doi:10.1177/1748895818762558

Baldwin, S. (2000). Living in Britalin: why are so many amphetamines prescribed to infants, children and teenagers in the UK? *Critical Public Health*, *10*, 453–462. doi:10.1080/09581590010005386

Barratt, M.J., Allen, M., & Lenton, S. (2014). "PMA sounds fun": Negotiating drug discourses online. *Substance Use and Misuse*, *49*, 987–998. doi:10.3109/10826084.2013.852584

Benoit, C., Magnus, S., Phillips, R., Marcellus, L., & Charbonneau, S. (2015). Complicating the dominant morality discourse: Mothers and fathers' constructions of substance use during pregnancy and early parenthood. *International Journal for Equity in Health*, *14*, 72. doi:10.1186/s12939-015-0206-7

Berg, K.M., Arnsten, J.H., Sacajiu, G., & Karasz, A. (2009). Providers' experiences treating chronic pain among opioid-dependent drug users. *Journal of General Internal Medicine*, *24*, 482–488. doi:10.1007/s11606-009-0908-x

Boyd, J., & Kerr, T. (2016). Policing 'Vancouver's mental health crisis': a critical discourse analysis. *Critical Public Health*, *26*, 418–433. doi:10.1080/09581596.2015.1007923

Boys, A., Marsden, J., & Strang, J. (2001). Understanding reasons for drug use amongst young people: A functional perspective. *Health Education Research*, *16*, 457–469. doi:10.1093/her/16.4.457

Carnegie Community Action Project (2016). *2016 Hotel Survey and Housing Report*, Vancouver, BC. Retrieved from http://www.carnegieaction.org/wp-content/uploads/2017/03/CCAP-SRO-HOTEL-REPORT-2016.pdf

Christiani, A., Hudson, A.L., Nyamathi, A., Mutere, M., & Sweat, J. (2008). Attitudes of homeless and drug-using youth regarding barriers and facilitators in delivery of quality and culturally sensitive health care. *Journal of Child and Adolescent Psychiatric Nursing*, *21*, 154–163. doi:10.1111/j.1744-6171.2008.00139.x

City of Vancouver (2013). Downtown Eastside Local Area Profile 2013. Retrieved from http://vancouver.ca/files/cov/profile-dtes-local-area-2013.pdf

Clarke, A. (2005). *Situational analysis: Grounded theory after the postmodern turn*. Thousand Oaks, CA: SAGE.

Clarke, A.E. (2003). Situational analyses: Grounded theory mapping after the postmodern turn. *Symbolic Interaction*, *26*, 553–576. doi:10.1525/si.2003.26.4.553

Culhane, D. (2004). Their spirits live within us: Aboriginal Women in downtown eastside vancouver emerging into visibility. *The American Indian Quarterly*, *27*, 593–606. doi:10.1353/aiq.2004.0073

Dahlman, D., Kral, A.H., Wenger, L., Hakansson, A., & Novak, S.P. (2017). Physical pain is common and associated with nonmedical prescription opioid use among people who inject drugs. *Substance Abuse Treatment, Prevention, and Policy*, *12*, 29, doi:10.1186/s13011-017-0112-7

Demant, J. (2013). Affected in the nightclub: A case study of regular clubbers' conflictual practices in nightclubs. *International Journal of Drug Policy*, *24*, 196–202. doi:10.1016/j.drugpo.2013.04.005

Díaz, R.M., Heckert, A.L., & Sánchez, J. (2005). Reasons for stimulant use among latino gay men in San Francisco: A comparison between methamphetamine and cocaine users. *Journal of Urban Health*, *82*, i71–i78. doi:10.1093/jurban/jti026

Dilkes-Frayne, E. (2014). Tracing the "event" of drug use: "Context" and the coproduction of a night out on MDMA. *Contemporary Drug Problems*, *41*, 445–479. doi:10.1177/009145091404100308

Dilkes-Frayne, E. (2016). Drugs at the campsite: Socio-spatial relations and drug use at music festivals. *International Journal of Drug Policy*, *33*, 27–35. doi:10.1016/j.drugpo.2015.10.004

Dube, S.R., Felitti, V.J., Dong, M., Chapman, D.P., Giles, W.H., & Anda, R.F. (2003). Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: The adverse childhood experiences study. *Pediatrics*, *111*, 564–572. doi:10.1542/peds.111.3.564

Duff, C. (2008). The pleasure in context. *The International Journal on Drug Policy*, *19*, 384–392. doi:10.1016/j.drugpo.2007.07.003

Duff, C. (2012). Accounting for context: Exploring the role of objects and spaces in the consumption of alcohol and other drugs. *Social and Cultural Geography*, *13*, 145–159. doi:10.1080/14649365.2012.655765

Duff, C. (2016). Assemblages, territories, contexts. *International Journal of Drug Policy*, *33*, 15–20. doi:10.1016/j.drugpo.2015.10.003

Farrugia, A. (2015). "You can't just give your best mate a massive hug every day": Young men, play and MDMA. *Contemporary Drug Problems*, *42*, 240–256. doi:10.1177/0091450915601520

Fast, D., Small, W., Wood, E., & Kerr, T. (2009). Coming "down here": Young people's reflections on becoming entrenched in a local drug scene. *Social Science and Medicine*, *69*, 1204–1210. doi:10.1016/j.socscimed.2009.07.024

Fazio, A., Hunt, G., & Moloney, M. (2011). "It's one of the better drugs to use": Perceptions of cocaine use among gay and bisexual Asian American men. *Qualitative Health Research*, *21*, 625–641. doi:10.1177/1049732310385825

Foster, K., & Spencer, D. (2013). Just a social thing': Drug use, friendship and borderwork among marginalized young people. *The International Journal on Drug Policy*, *24*, 223–230. doi:10.1016/j.drugpo.2012.12.005

Hartwell, K.J., Back, S.E., McRae-Clark, A.L., Shaftman, S.R., & Brady, K.T. (2012). Motives for using: A comparison of prescription opioid, marijuana and cocaine dependent individuals. *Addictive Behaviors*, *37*, 373–378. doi:10.1016/j.addbeh.2011.11.014

Homer, B.D., Solomon, T.M., Moeller, R.W., Mascia, A., DeRaleau, L., & Halkitis, P.N. (2008). Methamphetamine abuse and impairment of social functioning: A review of the underlying neurophysiological causes and behavioral implications. *Psychological Bulletin*, *134*, 301. doi:10.1037/0033-2909.134.2.301

Ivsins, A., Roth, E., Benoit, C., & Fischer, B. (2013). Crack pipe sharing in context: How socio-structural factors shape risk practices among non injection drug users. *Contemporary Drug Problems*, *40*, 481–503. doi:10.1177/009145091304000403

Kerr, T., Stoltz, J.-A., Marshall, B.D.L., Lai, C., Strathdee, S.A., & Wood, E. (2009). Childhood trauma and injection drug use among high-risk youth. *Journal of Adolescent Health*, *45*, 300–302. doi:10.1016/j.jadohealth.2009.03.007

Levy, K.B., O'Grady, K.E., Wish, E.D., & Arria, A.M. (2005). An in-depth qualitative examination of the ecstasy experience: Results of a focus group with ecstasy-using college students. *Substance Use and Misuse*, *40*, 1427–1441. doi:10.1081/JA-200066810

Linden, I. A., Mar, M. Y., Werker, G. R., Jang, K., & Krausz, M. (2012). Research on a vulnerable neighborhood—the vancouver downtown eastside from 2001 to 2011. *Journal of Urban Health*, *90*, 559–573. doi:10.1007/s11524-012-9771-x

MacLean, S. (2005). "It might be a scummy-arsed drug but it's a sick buzz": Chroming and pleasure. *Contemporary Drug Problems*, *32*, 295–318. doi:10.1177/009145090503200206

Marshall, B.D., & Werb, D. (2010). Health outcomes associated with methamphetamine use among young people: A systematic review. *Addiction*, *105*, 991–1002. doi:10.1111/j.1360-0443.2010.02932.x

McNeil, R., Small, W., Wood, E., & Kerr, T. (2014). Hospitals as a "risk environment": An ethno-epidemiological study of voluntary and involuntary discharge from hospital against medical advice among people who inject drugs. Social Science and Medicine, 105, 59–66. doi:10.1016/j.socscimed.2014.01.010

McQuay, H. (1999). Opioids in pain management. *The Lancet*, *353*, 2229–2232. doi:10.1016/S0140-6736(99)03528-X

Merrill, J.O., Rhodes, L.A., Deyo, R.A., Marlatt, G.A., & Bradley, K.A. (2002). Mutual mistrust in the medical care of drug users. *Journal of General Internal Medicine*, *17*, 327–333. doi:10.1007/s11606-002-0034-5

Mills, K.L., Teesson, M., Ross, J., & Peters, L. (2006). Trauma, PTSD, and substance use disorders: Findings from the Australian national survey of mental health and well-being. *American Journal of Psychiatry*, *163*, 652–658. doi:10.1176/ajp.2006.163.4.652

Moore, D. (1990). Anthropological reflections on youth drug use research in Australia: What we don't know and how we should find out. *Drug and Alcohol Review*, *9*, 333–342. doi:10.1080/09595239000185471

Moore, D. (2008). Erasing pleasure from public discourse on illicit drugs: On the creation and reproduction of an absence. *International Journal of Drug Policy*, *19*, 353–358. doi:10.1016/j.drugpo.2007.07.004

Neaigus, A., Gyarmathy, V.A., Miller, M., Frajzyngier, V.M., Friedman, S.R., & Des Jarlais, D.C. (2006). Transitions to injecting drug use among noninjecting heroin users: Social network influence and individual susceptibility [Miscellaneous Article]. *Journal of Acquired Immune Deficiency Syndromes*, *41*, 493–503. doi:10.1097/01.qai.0000186391.49205.3b

Neighbor, M.L., Dance, T.R., Hawk, M., & Kohn, M.A. (2011). Heightened pain perception in illicit substance–using patients in the ED: Implications for management. *The American Journal of Emergency Medicine*, *29*, 50–56. doi:10.1016/j.ajem.2009.07.018

Niland, P., Lyons, A.C., Goodwin, I., & Hutton, F. (2013). "Everyone can loosen up and get a bit of a buzz on": Young adults, alcohol and friendship practices. *International Journal of Drug Policy*, *24*, 530–537. doi:10.1016/j.drugpo.2013.05.013

O'Gorman, A. (2016). Chillin, buzzin, getting mangled, and coming down: Doing differentiated normalisation in risk environments. *Drugs: Education, Prevention and Policy*, *23*, 247–254. doi:10.1080/09687637.2016.1176991

O'Malley, P., & Valverde, M. (2004). Pleasure, freedom and drugs: The uses of "pleasure" in liberal governance of drug and alcohol consumption. *Sociology*, *38*, 25–42. doi:10.1177/0038038504039359

Parker, H. J., Aldridge, J., & Measham, F. (1998). *Illegal leisure: The Normalization of adolescent recreational drug use*. Psychology Press.

Pennay, A., & Moore, D. (2010). Exploring the micro-politics of normalisation: Narratives of pleasure, self-control and desire in a sample of young Australian "party drug" users. *Addiction Research and Theory*, *18*, 557–571. doi:10.3109/16066350903308415

Rhodes, T. (2009). Risk environments and drug harms: A social science for harm reduction approach. *International Journal of Drug Policy*, *20*, 193–201. doi:10.1016/j.drugpo.2008.10.003

Sinha, R. (2001). How does stress increase risk of drug abuse and relapse? *Psychopharmacology*, *158*, 343–359. doi:10.1007/s002130100917

Sinha, R. (2008). Chronic stress, drug use, and vulnerability to addiction. *Annals of the New York Academy of Sciences*, *1141*, 105–130. doi:10.1196/annals.1441.030

Szmigin, I., Griffin, C., Mistral, W., Bengry-Howell, A., Weale, L., & Hackley, C. (2008). Re-framing "binge drinking" as calculated hedonism: Empirical evidence from the UK. *International Journal of Drug Policy*, *19*, 359–366. doi:10.1016/j.drugpo.2007.08.009

Taylor, S., Buchanan, J., & Ayres, T. (2016). Prohibition, privilege and the drug apartheid: The failure of drug policy reform to address the underlying fallacies of drug prohibition. *Criminology and Criminal Justice*, *16*, 452–469. doi:10.1177/1748895816633274

Valentine, K., & Fraser, S. (2008). Trauma, damage and pleasure: Rethinking problematic drug use. *International Journal of Drug Policy*, *19*, 410–416. doi:10.1016/j.drugpo.2007.08.001

van Boekel, L.C., Brouwers, E.P.M., van Weeghel, J., & Garretsen, H.F.L. (2013). Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review. *Drug and Alcohol Dependence*, *131*, 23–35. doi:10.1016/j.drugalcdep.2013.02.018

Voon, P., Hayashi, K., Milloy, M.-J., Nguyen, P., Wood, E., Montaner, J., & Kerr, T. (2015). Pain among high-risk patients on methadone maintenance treatment. *The Journal of Pain*, *16*, 887–894. doi:10.1016/j.jpain.2015.06.003

Warburton, H., Turnbull, P.J., & Hough, J.M. (2005). *Occasional and controlled heroin use: Not a problem*? York: Joseph Rowntree Foundation.

White, B., Degenhardt, L., Breen, C., Bruno, R., Newman, J., & Proudfoot, P. (2006). Risk and benefit perceptions of party drug use. *Addictive Behaviors*, *31*, 137–142. doi:10.1016/j.addbeh.2005.04.003

Wilkinson, B., & Ivsins, A. (2017). Animal house: University risk environments and the regulation of students' alcohol use. *International Journal of Drug Policy*, *47*, 18–25. doi:10.1016/j.drugpo.2017.06.002

Wu, N.S., Schairer, L.C., Dellor, E., & Grella, C. (2010). Childhood trauma and health outcomes in adults with comorbid substance abuse and mental health disorders. *Addictive Behaviors*, *35*, 68–71. doi:10.1016/j.addbeh.2009.09.003

Yedinak, J.L., Kinnard, E.N., Hadland, S.E., Green, T.C., Clark, M.A., & Marshall, B.D.L. (2016). Social context and perspectives of non-medical prescription opioid use among young adults in Rhode Island: A qualitative study. *The American Journal on Addictions*, *25*, 659–665. doi:10.1111/ajad.12466

International Journal of Drug Policy 57 (2018) 72–78

Contents lists available at ScienceDirect

International Journal of Drug Policy

journal homepage: www.elsevier.com/locate/drugpo

Research Paper

Exploring what shapes injection and non-injection among a sample of marginalized people who use drugs

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ARTICLE INFO

Keywords:
Actor-network theory
Injection drug use
Non-injection drug use
Qualitative
Harm reduction
Context
Event

ABSTRACT

Background: Few studies have specifically explored what influences people who use drugs to consume them in certain ways (i.e., smoking, injecting). While a great deal of research has examined the transition from non-injection to injection routes of drug administration, less is known about people who use drugs (PWUD) but have never injected or have stopped injecting. This paper draws on actor-network theory to explore what moves people to inject or not, among both people who currently smoke/sniff drugs (PWSD) and people who currently inject drugs (PWID), to better understand factors that shape/influence methods of drug consumption.

Methods: Two-stage interviews (a quantitative survey followed by a qualitative interview) were conducted with 26 PWSD and 24 PWID. Interviews covered a range of topics related to drug use, including reasons for injecting drugs, never injecting, and stopping injecting. Data were analysed by drawing on actor-network theory to identify forces involved in shaping drug consumption practices.

Results: We present three transformative drug use events to illustrate how specific methods of drug consumption are shaped by an assemblage of objects, actors, affects, spaces and processes. Rather than emphasising the role of broad socio-structural factors (i.e., poverty, drug policy) participant narratives reveal how a variety of actors, both human and non-human, assembled in unique ways produce drug consumption events that have the capacity to influence or transform drug consumption practices.

Conclusion: Actor-network theory and event analysis provide a more nuanced understanding of drug consumption practices by drawing together complex material, spatial, social and temporal aspects of drug use, which helps identify the variety of forces involved in contexts that are thought to shape substance use. By attending to events of drug consumption we can better understand how contexts shape drug use and related harms. With greater insight into the transformative capacity of drug use events, strategies may be better tailored to prevent drug use-related harms.

Introduction

Few studies have specifically explored what influences people who use drugs to consume their drugs in certain ways, whether by smoking, injecting, sniffing, or other means. While abundant research demonstrates socio-structural and contextual influences of harm, and the production of harm, associated with various drug use methods and practices (e.g., injection drug use, needle and pipe sharing, rushed injections) (Burris et al., 2004; Rhodes, Singer, Bourgois, Friedman, & Strathdee, 2005; Small, Kerr, Charette, Schechter, & Spittal, 2006), little research has examined how drug use contexts shape specific methods (i.e., smoking, injecting) of drug consumption. A handful of studies have directly explored the issue of personal motivations for choice of drug use method. These studies have elucidated a variety of reasons for deciding to inject drugs, including curiosity, belief that injection drug use (IDU) is more efficient and economical, search of a better/stronger effect, influence of the social environment, and ritual (Bravo et al., 2003; Giddings, Christo, & Davy, 2003; Kelley & Chitwood, 2004; Witteveen, Van Ameijden, & Schippers, 2006). Similarly, reasons found for choosing to not inject drugs include: concerns with assumed negative consequences of injection (e.g., overdose, physical health issues, dependence, loss of control), fear of needles, preference for smoking, influence of the social environment, past negative experiences with IDU, and stigmatized IDU identity (Bravo et al., 2003;

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https://doi.org/10.1016/j.drugpo.2018.04.006
Received 31 July 2017; Received in revised form 12 March 2018; Accepted 3 April 2018

Des Jarlais et al., 2007; Kelley & Chitwood, 2004; Smith, Best, & Day, 2009; Witteveen et al., 2006). While useful in highlighting particular and discrete factors that might move people to choose specific methods of drug consumption, what is largely missing from these accounts is an understanding of how contextual dimensions of drug use influence or shape the decision to consume drugs in certain ways.

A robust body of literature now exists that expounds the relationship between socio-cultural/political/economic contexts and substance use and related harms. The risk environment framework (Rhodes, 2009), for instance, has been applied to show how specific "environments" (social, physical, economic and policy) shape and produce drug use-related risks and harms. For example, physical settings have been found to influence risky drinking practices among university students (Wilkinson & Ivsins, 2017) and risky drug consumption activities among PWID (e.g., rushed injections) (Cooper, Moore, Gruskin, & Krieger, 2005), while the policy environment has been implicated in shaping how crack is consumed (Ivsins, Roth, Benoit, & Fischer, 2013) and impeding harm reduction strategies among marginalized PWID (Small et al., 2006). As Duff (2011) notes, an important feature of work on social contexts "is the contention that social contexts exert a *structural force* that exceeds individual settings or locales" (p. 404, emphasis in original) such that contexts/settings are presented as determinants of behaviour. However, while contexts are frequently implicated in framing and shaping behaviours, the specific mechanisms at play are rarely unpacked. It is not always clear beyond simple identification, how and why specific mechanisms shape and influence drug consumption behaviours. Looking at the diversity of reasons given for choosing a specific method of consuming drugs (above), it is evident that drug consumption practices are shaped by a vast array of actors, material objects, physical and emotional concerns, and social encounters that require more than a broad framing of context or environment to adequately understand.

Following in the footsteps of Duff (2011, 2012, 2013) and other scholars (e.g., Dilkes-Frayne, 2014; Race, 2015; Vitellone, 2015), we turn to Latour (2005) and actor-network theory (ANT) to help uncover and identify forces that mediate drug consumption practices. We use ANT to understand how both human and non-human forces may transform the experience of drug consumption. This is accomplished by exploring the many actors, objects, spaces, ideas, processes, and so on, that form what Latour (2005) calls actor-networks. Also useful here is the notion of "assemblage" as used by Fraser, Moore, and Keane (2014), whereby the assemblage is understood as "an ad hoc cluster of knowledges, technologies, bodies and practices that contingently gather to form a temporary phenomenon, be it abstract or material" (p. 19). It is through these assemblages, within these actor-networks, that particular actions or phenomena are enabled (Duff, 2013). And by tracing/following the trail of relations, associations, and actions that form actor-networks we may better understand the intimate workings of the phenomena studied.

Unique to ANT is the idea that all things that make a difference to a situation, whether human or non-human, are ascribed agency and considered "actors" in the situation. This idea has also been put forth by Clarke (2003) in her conceptualization of situational analysis, stressing the need to include in analyses all consequential things in a situation, including histories, practices, symbols, material things, and so forth, "and provoke analyses of relations among them" (p. 554). As Sayes (2014) suggests, of prime importance is not whether actions follow from human or non-human entities, but to trace the actions of actors, regardless of what the actors look like. ANT provides the means of tracing connections between the various actors (people, objects, ideas) in a situation, and to articulate more precisely how the various forces assembled work to shape drug consumption.

In this paper we use principles of ANT to explore what influences PWUD to inject criminalized substances, or consume them by other means. We present three transformative drug use "events", and analyse the various associations involved, an assemblage of actors, material objects, place/space and affect, to better understand how contexts shape the decision to inject drugs or not. By focusing on the event we "disrupt and reorganise" conventional understandings of drug consumption which often rely on "a distinction between drugs, bodies and environments", and take into full account the varied relations of human and non-human forces assembled in unique consumption networks (Dennis, 2017, p. 340). The focus here is on localised drug use experiences of PWUD, which draw together complex material, spatial, social and temporal aspects of drug use often overlooked by both epidemiological studies, and those whose primary focus is on broader structural determinants of substance use. In using the "event" as our primary unit of analysis we are able, as Dilkes-Frayne (2014) notes, to explore the "*process* of context" and the "shifting network of human and nonhuman actors" assembled in social phenomena (p. 452, emphasis added). This approach uncovers the various mediating relations among and between the various actants involved in particular situations. This paper adds to this growing body of research by highlighting the social, material and affective forces that shape drug consumption practices of PWUD.

Methods

Data were collected as part of the first author's PhD dissertation project comparing PWID with PWSD in Vancouver's Downtown Eastside (DTES). Fifty two-stage, face-to-face interviews were conducted at the Vancouver Area Network of Drug Users (VANDU) building. VANDU is an organization made up of current and former PWUD who engage in advocacy and activism to promote social justice issues, with a specific mandate to improve the lives of PWUD. VANDU operates within a storefront building in the DTES which serves as a drop-in centre, harm reduction supply distribution outlet, and general safe space for PWUD. Since December 2016 VANDU has also operated one of several overdose prevention sites that have been set up to respond to the current overdose crisis in British Columbia.

Ethics approval was obtained by the Human Research Ethics Board at the primary author's university. Permission to involve VANDU and its members in this study, and conduct interviews at their location, was granted by the VANDU Board of Directors after meeting with them and explaining the study. It was agreed with the Board that interested VANDU Board members would be hired to conduct participant recruitment, schedule all interview appointments, and maintain interview schedules (i.e., ensure participants arrived on time, recruit additional participants when appointments were missed). Payment of the VANDU members was discussed with the Board, and in line with previous similar studies conducted at VANDU these members were paid $10 CAD per hour, and generally worked 2–3 h per interview shift (generally involving 2–3 interviews). While two other community partners were considered to use as additional interview locations, neither was able to consistently provide safe and private space in which to conduct interviews.

Study participants were recruited by the VANDU members inside the building, on the street, or in other locations frequented by PWUD (e.g., drop-in centres, shelters). The VANDU members in charge of recruitment were provided with a set of eligibility requirements to prescreen and recruit potential participants. Participants were required to be: 1) 19 years or older and; 2) currently using drugs for non-medical purposes. Additionally, based on extant research on non-injection drug use (NIDU) and injection relapse, which commonly uses 6 or 12 month time periods for measurement (Des Jarlais et al., 2014; Galai, Safaeian, Vlahov, Bolotin, & Celentano, 2003; Gossop, Griffiths, & Strang, 1988; Mehta et al., 2012; Neaigus et al., 2001) current IDU was defined as having injected drugs for non-medical purposes at least once per month in the previous 12 months, and current NIDU defined as never having injected, or not having injected a drug for non-medical purposes in the previous 12 months. The recruiters were instructed to tell potential participants that the study was about drug use, and a comparison of

PWID and PWSD, and that both PWID and PWSD could participate equally. The recruiters were also instructed to not strategically recruit either PWSD or PWID, and were not given quotas to recruit a specific number of PWSD and PWID. The sample of PWID and PWSD was recruited freely, and by chance. Generally, study participants were recruited a day or two before the scheduled appointment (and provided with a card indicating the date and time of the interview), or the day of the interview.

Interviews were conducted by the first author in various private rooms in the VANDU building. At the time of the interview, participants were screened again to ensure they met the eligibility criteria. Only one potential participant turned out to be ineligible at the time of the interview, for being under 19 years old. Prior to beginning the interview, the study was described in more detail, and the consent form was either read by participants, or read to participants by the interviewer. Verbal consent was provided by answering "yes" to a statement of consent read by the interviewer after a digital voice recorder was turned on, and participants were offered a paper copy of the consent form for their records. None of the potential participants refused to consent or participate in the study. Participants were provided with a $25 CAD honorarium for participating in the study after the interview.

Fifty interviews were conducted with 17 people who had never injected a drug, nine who had previously injected, and 24 with people who were currently injecting drugs. Two-stage interviews were conducted face-to-face with the same participant during the same single interview session, and consisted of a short (approximately 20 min) interviewer-administered quantitative survey followed by a longer (approximately 60 min) semi-structured interview. The survey instrument covered the following topics: demographics; drug use history and current drug use; injection drug use; non-injection drug use; sexual risk behaviour; health, crime and violence; stigma and discrimination; and social and health service utilization. A qualitative interview guide was drafted prior to data collection, but evolved over the course of the study as important topics and avenues to pursue emerged during the process of data collection. The interview guide broadly covered the following: experiences of living in the DTES; drug use (both history of, and current); method of drug use; social networks; social and health issues; violence and safety; and opinions on the City of Vancouver's response to homelessness and substance use.

Quantitative data was analysed using SPSS (v. 24). For the purpose of this paper, which focuses on participant narratives and discussions of drug injection, only simple descriptive statistics (e.g., demographics and drug use characteristics) are presented. Interviews were transcribed and imported into NVivo (v. 10) and analysed inductively and iteratively. Our analysis initially borrowed from Clarke (2003, 2005) and situational analysis, whereby a preliminary coding and ordering framework was developed to partition the data into broad categories (or general orders) such as "individual/collective human elements", "non-human elements", "drugs and drug use", "issues and debates", "spatial elements", "sociocultural elements", and "temporal elements". For this paper, analyses focused on method of drug use, such that all discussions concerning injecting, smoking, eating or sniffing drugs were initially broadly coded into the categories "injection drug use" or "non-injection drug use." As specific themes around method of consumption were developed, new codes were added to the framework, and further refined, to capture specific themes related to the decision to inject drugs or not. At this point we were introduced to ANT, and as coding continued and prominent themes began to emerge, it became clear that principles of ANT (ascribing agency to non-human actants, tracing of associations, a symmetrical consideration of all actants in the situation) were particularly relevant to our topic and direction of analysis. It became clear, for instance, that decisions concerning drug consumption method were not influenced by singular and distinct factors (e.g., in search of a better high, concerns about the consequences of injecting), but were shaped by a variety of forces interwoven in unique situations (i.e., "events"). This analysis was presented to the VANDU Board (which contained some study participants), along with various drafts of the paper, for feedback and to ensure validity of thematic interpretation.

Sample characteristics

Fifty people were interviewed for the study, of which 21 identified as women, 20 were Caucasian and 26 Indigenous. The average age of participants was 44 (range 19–71). Almost all (45) of the participants lived in the DTES, while the remainder reported coming to the DTES daily or almost daily. Forty-three participants reported living in unstable/no housing, which included single room occupancy hotels (24), transitional/supported housing (7), shelters (3), couch surfing (4), or on the street (5). All participants reported substance use in the 30 days prior to the interview, the most common being crack cocaine (44), alcohol (28), powder cocaine (16), heroin (23), prescription opioids (15), and crystal methamphetamine (20). Twenty-four participants were currently using drugs by injection, nine had not injected in the past year (average time gone without injecting was 17 years), and 17 had never injected.

Results

Recent work has drawn attention to the importance of events of drug consumption, recognizing the capacity of varied social, spatial, material and embodied forces of drug use events to shape substance use practices (Dennis, 2017; Dilkes-Frayne, 2014; Duff, 2016; Duncan, Duff, Sebar, & Lee, 2017; Jayne, Valentine, & Holloway, 2010). When discussing why they used their drugs in certain ways (i.e., smoking, injecting, sniffing), study participants often recounted specific events that influenced or transformed their drug consumption practices. Participant narratives reveal that the decision to use drugs in certain ways was shaped by an assemblage of material objects, actors, affect, practices and space/place. In what follows we present three transformative drug use events to show how an association of human and non-human forces shape the experiences of drug consumption among PWUD.

Event 1: starting drug injection

Participants who were currently injecting described specific events that influenced their decision to try injecting. Often these situations stemmed from spending time with PWID. Heather described the move she made from using alcohol and marijuana to injecting drugs:

> I had a girlfriend, she did it for me. Injected like, powder [cocaine] …Straight injection. Because I was hanging around with this woman that…like when we're drinking at the bar, we take a break, go to her place and I'd be smoking my joint and she'd be doing her hit and I got so curious because she was so high and fucking having a good time, I wanted to try it so bad. So we tried it. And that was it. (Female, 42 years old)

We can see in this narrative a relational account that requires an extension of our consideration beyond what might be seen as the influence of "social network" or "social environment", to take in the full event and the numerous associations within, including the various actors, objects (alcohol, the marijuana joint, the needle), spaces (the bar, the friends house), practices (taking a break from the bar, smoking a joint, injecting drugs) and both embodied and affective experiences (curiosity, wanting to try it so bad, she was so high and having a good time). While some might suggest it was Heather's friend who influenced her to try injecting (vis a vis the "social environment"), it requires a closer look at the full event, a tracing of the various associations assembled within the situation, to fully elucidate the transformative effect of this event on Heather's drug consumption practices.

The decision to try injecting did not stem from simply seeing her friend inject, but was shaped by movement within and through a

particular space and time. If we follow Heather's narrative and allow for a symmetrical consideration of all things assembled in the situation, we note the associations between/among alcohol, the bar, her friend's place, Heather's marijuana joint, and her friend's act and experience of injecting, all of which mediate Heather's own drug injection. As Heather and her friend move through the bar, taking a break from drinking and shifting to new spaces and practices (smoking a joint, injecting drugs), the association of various affects, objects and practices mediate Heather's relation to and with drugs in new ways, in which new practices are formed. Heather moves from drinking alcohol in a bar, a very public space of sociality and intoxication, to the more intimate setting of her friend's place in which joints, needles, marijuana and cocaine are used to continue, augment, change, and/or increase embodied drug use experiences. The spatial and material relations of this particular time and place, moving through space, to and from particular places, all work together to transform Heather's drug consumption practices. What is striking is that all of this precedes the actual act of injecting, yet we would be amiss to deny their important place in this situation (i.e., it is not the singular act of injecting for the first time that transforms Heather's consumption practices). Taken together we can see that the decision to inject was not simply an act of curiosity stemming from watching an experience of injecting, nor was it determined by some extra-structural force of the "social environment", but was shaped by an assemblage of actors, objects, practices and places.

Event 2: stopping drug injection

In the following excerpt Dan, who injected drugs for almost a year, recounts a particular event that transformed his drug consumption practices, leading him to give up injecting drugs (but continue smoking drugs). The account is taken from a longer conversation about why he uses drugs in the way he does.

> You know the notorious Maples Hotel (pseudonym)? The big bad place…I'll tell you what happened…Went and grabbed my shit [drugs] from the Maples, and I'm in the alley of the Maples of all places. All the fucking, most of the fucking, the most notorious wanted criminals in fucking Canada hide out there…I've got money on me, I went and got my shit, and it's always the same logic, "Just quick, do this now", so quick I get my shit into me in the alley and then fuck off, right…And there's always fucking guys crying there, fucking robbing people, beating people down there all the time. And this is a weird, I fucking end up doing the chicken [overdosing]. I did so, in the alley, of the Maples, but this is the wild part: I don't know how long I was there, I had serious money on me, there's nobody around…Didn't get robbed, I was all blood and cut the fuck from doing the chicken on the ground and rolling in the alley behind the Maples. Pick my ass up, clean myself up, never touched another rig [needle] again. Never touched the shit again…That's just scary to think about that. To this day. Yeah. Could've robbed me. They could've killed me. You have no idea…Yeah, never touched it again. (Male, 48 years old).

Here we find an assemblage of actants involved in a specific event that clearly transformed this participant's drug consumption practices. Dan identified a variety of forces implicated in influencing his drug use practices when recounting the event. We can trace the association of place (the "big bad place" [the Maples Hotel], and then the alley), actors (the most notorious wanted criminals in Canada, the robbers and murderers), material objects (money, drugs, the needle), the embodied experience ("doing the chicken"), all of which resulted in an emotional response (fear and wonderment) to an event that shaped his decision to no longer inject.

While it might be suggested (and not necessarily incorrectly) that Dan's decision to stop injecting was influenced by the "physical environment", such a broad framing misses much of what transpired in, and shaped, this particular transformative event. What should be noted here is that Dan's decision to stop injecting did not result simply from the specific experience of the drug overdose, nor was it shaped by having to use drugs in the spatial margins, but by an assemblage of place, affect, actors and objects within a particular event at a particular time. What is normally a routine practice for Dan (picking up drugs from the Maples and quickly injecting in the alley) is transformed this particular time by an association of social, spatial and material relations. For Dan it was not the actual overdose experience that transformed his consumption practices, but the associations between and among the various actants involved in the event. In Dan's recounting of the experience we can trace the mediating effect of the alleyway, the overdose, the money, the criminals, rolling on the ground and cheating death twice (a non-fatal overdose and not getting killed by the "criminals"), assembled together in a transformative event of drug consumption. Again, it is these material and spatial relations – the movement in and through the Maples and the abutting alleyway, the money that doesn't get stolen, the wonderment at the absence of various actors normally present, the blood, cheating death – that have a transformative effect on Dan and his drug use practices. In essence, it is everything that passes before, through, and after the physical act of injecting that transform Dan's consumption activities.

Event 3: preventing drug injection

The drug consumption practices of many participants in this study who only smoked or sniffed drugs, and in particular their decision to not use drugs by injection, were often shaped by specific transformative events. In the following account Ellen, who smokes crack and crystal meth, describes an event she found particularly troubling, and which influenced her decision to not try injecting:

> Like this one time I went out to smoke crack with my friend. Well she wasn't really my friend, she was like, my boyfriend's auntie. And she bought us a rock [crack] and then she bought herself heroin. And then she did like a whole needle full of heroin, and she did it right here [indicates neck], or she got the guy to do it for her…And then like all of a sudden she just started freaking out, and it was just like, oh my God, she could hear us but she wasn't there. So it scared the crap out of me. And we didn't know what to do, so we left…But it was just really scary. And I don't know, I could never do that…I can't do that. I just cause, I don't want to be crazy, crazy, crazy. (Female, 19 years old).

Central to this account is a relational interplay of actors (the auntie, the guy who did it for her), material objects (the crack rock, the "whole needle full of heroin"), and practices (smoking crack, the neck injection), resulting in the embodied experience of the substance ("she just started freaking out" and "she could hear us but she wasn't there"), all of which combine to elicit an emotional response (fear, confusion) to the injection event.

Looking at the event in it's entirety, and considering the various actants involved, we can trace the various associations assembled within the event to see how it shaped Ellen's decision to only smoke drugs. While Ellen chooses to smoke crack, at the same time the auntie begins a process that Ellen finds disturbing, and culminates in what Ellen sees as "crazy, crazy, crazy". Through the neck injection with the needle "full of heroin", performed by a silent and nameless actor, the auntie is transformed into a state (seemingly) out of control, and not of this place ("she could hear us but she wasn't there"). While Ellen is able to smoke crack and remain cognisant and self-aware, the auntie is transported to some otherness, in which she is unable to attend to her surroundings. For Ellen, who had up to this point in her life neither tried heroin nor injected a drug, the associations between and among the actants in this event instill an affectual response of fear, confusion, and the desire to escape. Importantly, we see how nothing in this event acted alone (i.e., it was not simply the auntie's behaviour that affected

Ellen), nor did the event transpire in the same way for all actants involved (perhaps the auntie was in fact enjoying the corporeal experience). While the objects, actors and practices assembled in this event have one effect on the auntie, we see how these same actants mediate Ellen's experience of the event in a distinct and transformational way. Ellen is deeply affected by the relational interplay of the needle full of heroin, the neck injection, and the resulting embodied experience of heroin, culminating in an affectual response to both flee (leaving the place of injection) and choose to only smoke drugs.

Discussion

In this study we borrowed from ANT (Latour, 2005) to better understand what influences PWUD to consume drugs in certain ways (i.e., smoking, injecting). Our findings illustrate how this decision is shaped by an assemblage of objects, actors, affects, practices and spaces/places. Participant narratives reveal the varied associations between and among the actants identified, and the capacity of drug use events to shape or transform specific drug consumption practices. What ANT uniquely brings to this study is an "opening up" of the context, or situation, of substance use, to better understand context not merely as a setting of drug consumption and other "risk behaviours", but "as an active agent of drug use" (Keane, 2011, p. 408) that has the ability to transform drug consumption activities. By focusing on all things – both human and non-human – in the situation, ANT provides the means to better understand the inner workings of complex situations.

The role of drug use events in shaping consumption practices illustrates this point. In discussing why they used drugs in certain ways, participants in this study often recounted specific events that shaped or transformed their drug consumption method (i.e., injecting, smoking). Among PWSD these events were so powerful they were convinced to not inject; among PWID these events were powerful enough to persuade them to try injecting; among former injectors these experiences were described as turning them off injecting for good. We presented three unique events and traced the association of various actants involved, an assemblage of actors, objects, affects, practices and spaces/places, to show how drug use contexts may transform peoples' drug consumption practices. While each event is unique in it's situatedness, what the three events share in common is an elaborate relational interplay of an assemblage of actants, both human and non-human. Our analyses demonstrate what Dennis (2017) refers to as the "collaborative effort" (p. 343) of events whereby hierarchical relationships among actants are destabilized allowing for a symmetrical consideration of all human and non-human forces involved. This elucidates the complex nature of substance use, and points to the need to understand substance use not simply as a singular act of drug consumption and the attendant embodied experience, but as a process that may involve any number of actors, objects, processes, affects, spaces, technologies, and so forth. As Dilkes-Frayne (2014) notes in her study of a particular drug use event, the importance of studying events lies in the capacity to see drug use not as "an act of momentary consumption or a period of psychoactive drug effects" but rather "a range of actions and transformations" (p. 451–452). Key here is the transformative effect of events, involving various actors of various sorts – including here for example individuals and their social networks, others present, practices, physical locations, embodied and affective responses, and material objects – that actively mediate and transform substance use practices and experiences. The important task is identifying particular configurations of consumption networks while understanding that these forces (and others not identified in this study) may or may not be involved in particular actor-networks at any given time, such that the role various actors play in a situation depends on how particular consumption networks are assembled at specific times (Duff, 2013).

Much recent social science research has drawn associations between socio-cultural contexts and substance use and related harms, such that physical spaces/places, social networks, polices, and so on, have been implicated in shaping drug consumption practices (e.g., needle sharing) and producing harms (Neaigus et al., 2006; Rhodes, 2009; Schroeder et al., 2001; Small, Fast, Krusi, Wood, & Kerr, 2009). While playing an significant role in broadening our understanding of substance use, much of this work has not attended to the minutiae of particular drug use contexts to explain more precisely how and why these associations and relationships play out. ANT and event-based analyses complement these approaches (e.g., the "risk environment" framework) by elucidating and elaborating on the variety of actants at play *within* these socio-cultural contexts and environments, and by tracing the associations among/between them. As the participant narratives and drug use events we presented demonstrate, there is much going on within these environments and contexts that require a more careful consideration to understand the full force these contexts have. Rather than indiscriminately exerting force on individuals and their activities (in the way that socio-cultural contexts and environments are often portrayed), our findings illustrate that consumption practices are interwoven with(in) complex assemblages. For instance, it was not simply that Dan was using drugs in an alleyway (i.e., the "physical environment") that shaped his decision to stop injecting, nor was is merely the result of watching her friend inject (i.e., the "social environment") that convinced Heather to try it. In these situations it was a variety of actants assembled in unique ways that mediated the participant's drug consumption practices. In this way ANT complements existing socio-cultural/structural/environmental perspectives by expounding the various forces at play in drug use contexts. Thus, we come to understand it is not simply the influence of "friend", "brother", or "social network" that convinces one to inject or not, but a complex association of actants situated within a particular place at a particular time.

How then might a fuller accounting of the contexts of drug use help in reducing drug-related risks and harms among marginalized PWUD? How might these findings be applied to developing harm reduction strategies attendant to events of drug consumption? While current harm reduction strategies targeting individual substance use practices have been relatively successful in encouraging safer behaviours (e.g., sterile needle and pipe distribution programs), there is a need to better address environmental aspects of substance use and related harm (Moore & Dietze, 2005). Approaching drug consumption and related harms from the perspective of ANT, or with an assemblage and event focused analysis, we see harm not as a property or outcome of singular substances or practices, but as a relational *process* involving various actants which, by and through their association, "generate harmful transformations" (Dilkes-Frayne, 2014, p. 474). Following from our analysis, in the same way that drug consumption practices are shaped by an assemblage of social, material, affective and spatial forces, so too can events (and the actants assembled) shape drug-related harms. The key then would be to make drug use events safe(r).

The transformative capacity of particular drug use experiences and events, and their intersection with specific places and spaces, highlights the general lack of safe spaces available for PWUD, and points to the need for more "safer environment interventions" (SEIs). SEIs can serve a number of functions including refuge from street-based drug scenes (fostering safety and mitigating exposure to violence and law enforcement), access to social, material and health resources, and enabling and facilitating safer consumption practices (McNeil & Small, 2014). For instance, housing-based managed alcohol programs in Canada have, in addition to decreasing harmful alcohol use, been described as safe/enabling spaces that effectively remove marginalized PWUD from recurring cycles of detrimental involvement with law enforcement, jails, hospitals and emergency departments (Evans, Semogas, Smalley, & Lohfeld, 2015; Pauly et al., in press). These programs shift the context of alcohol consumption from the street (where spatial, temporal and material relations mediate harmful consumption practices like chugging drinks and drinking non-beverage alcohol) to safe spaces where the various actants involved prevent rather than produce harm. Similarly, in a study of drug use events and pleasure within a supervised

drug consumption room Duncan et al. (2017) demonstrate how drug use contexts can give rise to variable (i.e., positive/negative, safe/harmful) drug use experiences, such that shifting the context of drug use can alter peoples' relations with drugs and how they are used. They found, for instance, that drug use events in public locations elicited feelings of shame, fear, pressure and anxiety (which may lead to unsafe consumption practices like rushed injections), whereas drug use events within the consumption room evoked feelings/experiences of peace, safety, comfort and pleasure (allowing for safer consumption practices). Such harm reduction programs are evidence that shifting or altering the contexts of drug use may work to reduce or prevent substance use-related harm.

Yet widespread implementation of SEIs, particularly those that permit substance use, is lacking. While the growing establishment of supervised injection facilities (SIFs) across Canada is encouraging, PWSD are not provided a similar refuge, and are still forced to consume their drugs in public and unsafe setting, and engage in harmful practices such as pipe sharing (Ivsins et al., 2013). Given that safer smoking rooms (SSRs) are shown to encourage less harmful smoking practices, and that both SSRs and SIFs have been found to limit exposure to both physical and structural violence associated with street-based drug scenes (Fairbairn, Small, Shannon, Wood, & Kerr, 2008; McNeil, Kerr, Lampkin, & Small, 2015), it is a crucial next step that SIFs expand to allow all forms of drug consumption and that future smoking/sniffing rooms be set up alongside (either within or separate from) SIFs. By attending to the events of consumption, and gaining a better understanding of how drugs, spaces, processes, objects and so forth are assembled and mediate practices and produce harm, safe places/environments in which marginalized PWUD can consume their drugs can be effectively established. Our findings illustrate the potential to reduce drug use-related harm by shifting or altering the contexts of drug consumption to facilitate safe(r) drug use events.

This study has explored what influences marginalized PWUD to use drugs in certain ways, whether by sniffing, smoking, or injecting. We used principles of ANT to better understand the forces involved in experiences of substance use, and to elucidate more clearly how contexts shape and influence specific forms of drug consumption. While it is often the goal of social research to present generalizable characteristics of phenomena being studied, our study illustrates the complexity, even "messiness", of the processes involved in the contexts of drug use. At the same time, this approach provides opportunity to better understand the socio-spatial/cultural/contextual dimensions of substance use. With greater knowledge of why PWUD choose to consume drugs in certain ways, intervention and prevention efforts can be better tailored to address harms associated with drug consumption. This is, in general, a relatively unexplored area with the potential to make a significant contribution to preventing drug use-related harm.

Funding

Andrew Ivsins was supported by a Canadian Institutes of Health Research (CIHR) Frederick Banting and Charles Best Canada Graduate Scholarship.

Conflict of interest statement

The authors have no actual or potential conflict of interest to declare.

Acknowledgements

The authors wish to thank the study participants for sharing their time and stories with us, and for their contribution to the research project. We extend a heartfelt thanks to VANDU for their support and assistance. We are also grateful to Cecilia Benoit, Susan Boyd, Karen Kobayashi, and the anonymous reviewers for their insightful and constructive advice on earlier versions of this paper.

References

Bravo, M. J., Barrio, G., De La Fuente, L., Royuela, L., Domingo, L., & Silva, T. (2003). Reasons for selecting an initial route of heroin administration and for subsequent transitions during a severe HIV epidemic. *Addiction, 98*(6), 749–760. http://dx.doi.org/10.1046/j.1360-0443.2003.00393.x.

Burris, S., Blankenship, K. M., Donoghoe, M., Sherman, S., Vernick, J. S., Case, P., ... Koester, S. (2004). Addressing the risk environment for injection drug users: The mysterious case of the missing cop. *Milbank Quarterly, 82*(1), 125–156. http://dx.doi.org/10.1111/j.0887-378X.2004.00304.x.

Clarke, A. E. (2003). Situational analyses: Grounded theory mapping after the postmodern turn. *Symbolic Interaction, 26*(4), 553–576. http://dx.doi.org/10.1525/si.2003.26.4.553.

Clarke, A. (2005). *Situational analysis: Grounded theory after the postmodern turn.* SAGE.

Cooper, H., Moore, L., Gruskin, S., & Krieger, N. (2005). The impact of a police drug crackdown on drug injectors' ability to practice harm reduction: A qualitative study. *Social Science & Medicine, 61*(3), 673–684. http://dx.doi.org/10.1016/j.socscimed.2004.12.030.

Dennis, F. (2017). The injecting 'event': Harm reduction beyond the human. *Critical Public Health, 27*(3), 337–349.

Des Jarlais, D. C., Arasteh, K., Perlis, T., Hagan, H., Heckathorn, D. D., Mcknight, C., ... Friedman, S. R. (2007). The transition from injection to non-injection drug use: Long-term outcomes among heroin and cocaine users in New York City. *Addiction, 102*(5), 778–785. http://dx.doi.org/10.1111/j.1360-0443.2007.01764.x.

Des Jarlais, D. C., McKnight, C., Arasteh, K., Feelemyer, J., Perlman, D. C., Hagan, H., & Cooper, H. L. F. (2014). Transitions from injecting to non-injecting drug use: Potential protection against HCV infection. *Journal of Substance Abuse Treatment, 46*(3), 325–331. http://dx.doi.org/10.1016/j.jsat.2013.09.004.

Dilkes-Frayne, E. (2014). Tracing the event of drug use: Context and the coproduction of a night out on MDMA. *Contemporary Drug Problems, 41*(3), 445–479. http://dx.doi.org/10.1177/009145091404100308.

Duff, C. (2011). Reassembling (social) contexts: New directions for a sociology of drugs. *International Journal of Drug Policy, 22*(6), 404–406. http://dx.doi.org/10.1016/j.drugpo.2011.09.005.

Duff, C. (2012). Accounting for context: Exploring the role of objects and spaces in the consumption of alcohol and other drugs. *Social & Cultural Geography, 13*(2), 145–159. http://dx.doi.org/10.1080/14649365.2012.655765.

Duff, C. (2013). The social life of drugs. *International Journal of Drug Policy, 24*(3), 167–172. http://dx.doi.org/10.1016/j.drugpo.2012.12.009.

Duff (2016). Assemblages, territories, contexts. *International Journal of Drug Policy, 33*, 15–20. http://dx.doi.org/10.1016/j.drugpo.2015.10.003.

Duncan, T., Duff, C., Sebar, B., & Lee, J. (2017). 'Enjoying the kick': Locating pleasure within the drug consumption room. *International Journal of Drug Policy, 49*, 92–101.

Evans, J., Semogas, D., Smalley, J. G., & Lohfeld, L. (2015). This place has given me a reason to care: Understanding 'managed alcohol programs' as enabling places in Canada. *Health & Place, 33*(Supplement C), 118–124. http://dx.doi.org/10.1016/j.healthplace.2015.02.011.

Fairbairn, N., Small, W., Shannon, K., Wood, E., & Kerr, T. (2008). Seeking refuge from violence in street-based drug scenes: Women's experiences in North America's first supervised injection facility. *Social Science & Medicine, 67*(5), 817–823. http://dx.doi.org/10.1016/j.socscimed.2008.05.012.

Fraser, S., Moore, D., & Keane, H. (2014). *Habits: Remaking addiction.* Springer.

Galai, N., Safaeian, M., Vlahov, D., Bolotin, A., & Celentano, D. D. (2003). Longitudinal patterns of drug injection behavior in the ALIVE study Cohort, 1988–2000: Description and determinants. *American Journal of Epidemiology, 158*(7), 695–704. http://dx.doi.org/10.1093/aje/kwg209.

Giddings, D., Christo, G., & Davy, J. (2003). Reasons for injecting and not injecting: A qualitative study to inform therapeutic intervention. *Drugs: Education, Prevention and Policy, 10*(1), 95–104. http://dx.doi.org/10.1080/0968763021000040932.

Gossop, M., Griffiths, P., & Strang, J. (1988). Chasing the dragon: Characteristics of heroin chasers. *British Journal of Addiction, 83*(10), 1159–1162. http://dx.doi.org/10.1111/j.1360-0443.1988. tb03022.x.

Ivsins, A., Roth, E., Benoit, C., & Fischer, B. (2013). Crack pipe sharing in context: How sociostructural factors shape risk practices among noninjection drug users. *Contemporary Drug Problems, 40*(4), 481–503. http://dx.doi.org/10.1177/009145091304000403.

Jayne, M., Valentine, G., & Holloway, S. L. (2010). Emotional, embodied and affective geographies of alcohol, drinking and drunkenness. *Transactions of the Institute of British Geographers, 35*(4), 540–554. http://dx.doi.org/10.1111/j.1475-5661.2010.00401.x.

Keane, H. (2011). The politics of visibility: Drug users and the spaces of drug use. *International Journal of Drug Policy, 22*(6), 407–409. http://dx.doi.org/10.1016/j.drugpo.2011.09.006.

Kelley, M. S., & Chitwood, D. D. (2004). Effects of drug treatment for heroin sniffers: A protective factor against moving to injection? *Social Science & Medicine, 58*(10), 2083–2092. http://dx.doi.org/10.1016/j.socscimed.2003.08.006.

Latour, B. (2005). *Reassembling the social: An introduction to actor-network-theory (Clarendon lectures in management studies).* Oxford University Press. Retrieved from http://www.amazon.ca/exec/obidos/redirect?tag=citeulike09-20&path=ASIN/0199256047.

McNeil, R., & Small, W. (2014). Safer environment interventions: A qualitative synthesis of the experiences and perceptions of people who inject drugs. *Social Science & Medicine, 106*, 151–158. http://dx.doi.org/10.1016/j.socscimed.2014.01.051.

McNeil, R., Kerr, T., Lampkin, H., & Small, W. (2015). We need somewhere to smoke crack: An ethnographic study of an unsanctioned safer smoking room in Vancouver, Canada. *International Journal of Drug Policy, 26*(7), 645–652. http://dx.doi.org/10.1016/j.drugpo.2015.01.015.

Mehta, S. H., Sudarshi, D., Srikrishnan, A. K., Celentano, D. D., Vasudevan, C. K., Anand, S., ... Solomon, S. S. (2012). Factors associated with injection cessation, relapse and initiation in a community-based cohort of injection drug users in Chennai, India. *Addiction, 107*(2), 349–358. http://dx.doi.org/10.1111/j.1360-0443.2011.03602.x.

Moore, D., & Dietze, P. (2005). Enabling environments and the reduction of drug-related harm: Re-framing Australian policy and practice. *Drug and Alcohol Review, 24*(3), 275–284. http://dx.doi.org/10.1080/09595230500170258.

Neaigus, A., Miller, M., Friedman, S. R., Hagen, D. L., Sifaneck, S. J., Ildefonso, G., & Des Jarlais, D. C. (2001). Potential risk factors for the transition to injecting among non-injecting heroin users: A comparison of former injectors and never injectors. *Addiction, 96*(6), 847–860. http://dx.doi.org/10.1046/j.1360-0443.2001.9668476.x.

Neaigus, A., Gyarmathy, V. A., Miller, M., Frajzyngier, V. M., Friedman, S. R., & Des Jarlais, D. C. (2006). Transitions to injecting drug use among noninjecting heroin users: Social network influence and individual susceptibility. *Journal of Acquired Immune Deficiency Syndromes, 41*(4), 493–503. http://dx.doi.org/10.1097/01.qai.0000186391.49205.3b Miscellaneous Article.

Pauly, B. B., Vallance, K., Wettlaufer, A., Chow, C., Brown, R., Evans, J., ... Stockwell, T. (2018). Community managed alcohol programs in canada: Overview of key dimensions and implementation. *Drug and Alcohol Review*.

Race, K. (2015). Party and Play: Online hook-up devices and the emergence of PNP practices among gay men. *Sexualities, 18*(3), 253–275. http://dx.doi.org/10.1177/1363460714550913.

Rhodes, T. (2009). Risk environments and drug harms: A social science for harm reduction approach. *International Journal of Drug Policy, 20*(3), 193–201. http://dx.doi.org/10.1016/j.drugpo.2008.10.003.

Rhodes, T., Singer, M., Bourgois, P., Friedman, S. R., & Strathdee, S. A. (2005). The social structural production of HIV risk among injecting drug users. *Social Science & Medicine, 61*(5), 1026–1044. http://dx.doi.org/10.1016/j.socscimed.2004.12.024.

Sayes, E. (2014). Actor-network theory and methodology: Just what does it mean to say that nonhumans have agency? *Social Studies of Science, 44*(1), 134–149. http://dx.doi.org/10.1177/0306312713511867.

Schroeder, J. R., Latkin, C. A., Hoover, D. R., Curry, A. D., Knowlton, A. R., & Celentano, D. D. (2001). Illicit drug use in one's social network and in one's neighborhood predicts individual heroin and cocaine use. *Annals of Epidemiology, 11*(6), 389–394. http://dx.doi.org/10.1016/S1047-2797(01)00225-3.

Small, W., Kerr, T., Charette, J., Schechter, M. T., & Spittal, P. M. (2006). Impacts of intensified police activity on injection drug users: Evidence from an ethnographic investigation. *International Journal of Drug Policy, 17*(2), 85–95. http://dx.doi.org/10.1016/j.drugpo.2005.12.005.

Small, W., Fast, D., Krusi, A., Wood, E., & Kerr, T. (2009). Social influences upon injection initiation among street-involved youth in Vancouver, Canada: A qualitative study. *Substance Abuse Treatment, Prevention, and Policy, 4*(1), 8. http://dx.doi.org/10.1186/1747-597X-4-8.

Smith, A. C., Best, D., & Day, E. (2009). Assessing non-injecting heroin use in birmingham, UK: A comparison of characteristics and reasons for non-injecting in samples of never-injected and formerly-injecting heroin users in contact with adult drug treatment. *Journal of Drug Issues, 39*(3), 477–493. http://dx.doi.org/10.1177/002204260903900302.

Vitellone, N. (2015). Syringe sociology. *The British Journal of Sociology, 66*(2), 373–390. http://dx.doi.org/10.1111/1468-4446.12124.

Wilkinson, B., & Ivsins, A. (2017). Animal house: University risk environments and the regulation of students' alcohol use. *International Journal of Drug Policy, 47*, 18–25.

Witteveen, E., Van Ameijden, E. J. C., & Schippers, G. M. (2006). Motives for and against injecting drug use among young adults in Amsterdam: Qualitative findings and considerations for disease prevention. *Substance Use & Misuse, 41*(6–7), 1001–1016. http://dx.doi.org/10.1080/10826080600669561.

Title: From risky places to safe spaces: re-assembling spaces and places in Vancouver's Downtown Eastside

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Abstract:

Vancouver's Downtown Eastside (DTES) neighbourhood is commonly associated with stigmatized and criminalized activities and attendant risks and harms. Many space/places in the DTES are customarily portrayed and experienced as risky and harmful, and are implicated in experiences of structural (and physical) violence and marginalization. Drawing on 50 qualitative interviews, this paper explores how spaces/places frequently used by marginalized people who use drugs (PWUD) in the DTES that are commonly associated with risk and harm (e.g., alleyways, parks) can be re-imagined and re-constructed as spaces/places of safety and wellbeing. Study participants recounted both negative and positive experiences with particular spaces/places suggesting the possibility of making certain spaces more safe and less risky. Our findings demonstrate how spaces used by PWUD in the DTES can be understood as assemblages, a variety of human and nonhuman forces – such as material objects, actors, processes, affect, temporal elements, policies and practices – assembled in unique ways that produce certain effects (risk/harm or safety/wellbeing). Conceptualizing these spaces/places as assemblages provides a means to better understand *how* experiences of harm, or conversely wellbeing, unfold, and sheds light on how risky spaces/places can be re-assembled as spaces that enable safety and wellbeing.

Keywords: Place, space, assemblage, drug use, enabling places

1. Introduction

The geographical settings in which people are situated have been shown to influence both their health and experiences of health inequality, such that space/place is an important social determinant of health (Bambra et al., 2009; Braveman & Gottlieb, 2014; Cohen et al., 2003; Curtis & Jones, 1998; Fitzpatrick & LaGory, 2003). A variety of place-related factors have been found to impact health, including access to resources (e.g., healthcare, food and clean water sources, recreational facilities, schools), social networks, secure housing, and the physical/ecological factors of the geographical area (e.g., air quality, levels of traffic and congestion, building and street design, population density) (Browning & Cagney, 2003; Carpiano, Kelly, Easterbrook, & Parsons, 2011; Cohen et al., 2003; Macintyre, Maciver, & Sooman, 1993).

Research shows that people living in disadvantaged neighbourhoods are more likely to experience deprivation on these social determinants of health and are subject to stigma and discrimination because of intersecting factors such as gender, poverty and Indigeneity (Author, 2003; Boardman, Finch, Ellison, Williams, & Jackson, 2001; Collins et al., 2018; Schroeder et al., 2001; Williams & Latkin, 2007). Further, disadvantaged spaces/places inhabited by people who use drugs (PWUD) have been associated with increased risk and harm for their residents. One study of people who inject drugs (PWID) in Vancouver's Downtown Eastside (DTES) neighbourhood found that place of residence was independently associated with HIV infection (Maas et al., 2007). Similarly, other places commonly used by marginalized PWUD to consume drugs (e.g., alleyways and parks) have been associated with restricted access to harm reduction resources as well as increased risky drug use practices and associated harms (Author, 2018; Author, 2011; Small, Kerr, Charette, Schechter, & Spittal, 2006).

Due to their generally reduced social status within disadvantaged neighbourhoods, marginalized PWUD disproportionately face multiple forms of social and spatial exclusion, including precarious housing or homelessness, harassment from law enforcement and security guards, detainment, arrest, and stigma and discrimination. This is often heightened by their use of public space, particularly evident in the DTES. Indeed, marginalized PWUD in the DTES, many of whom are homeless or live in substandard housing such as single room accommodations (SRAs) and experience a variety of intersecting inequalities, often have no other choice but to frequently be in public spaces as a result of not having a home, or restrictive and demoralizing housing policies that essentially force people outdoors (Boyd, Cunningham, Anderson, & Kerr, 2016; Collins et al., 2018). For many PWUD in the DTES their days consist of moving to and from various places and spaces (e.g., SRAs, drop-in centres, parks, etc.), often using public and semi-private spaces for economic opportunities (e.g., selling things and services) as well as to procure and consume drugs, relax, socialize, and sleep. Oftentimes these places are visible (on the street, in doorways), or spaces that afford some level of privacy such as alleyways, bathrooms, parkades, and abandoned buildings. The goings-on of the DTES (e.g., drug dealing and consumption, sex work, panhandling, SRAs, public sleeping and "loitering") are mostly tolerated within this particular geographic area, while largely prohibited in others. Such neighbourhoods, and the public spaces within them commonly used by PWUD (e.g., parks, alleyways), are often associated with stigmatized and criminalized activities and are subsequently conceptualized as "open drug scenes", "skid rows", "strolls", "ghettos" and so forth (Huey & Kemple, 2007; Wacquant, 1997). Images of such places in popular culture portray them and their inhabitants as destitute, broken, and in disrepair, and typically conjure impressions of risk, harm, delinquency and danger. Yet these neighbourhoods and the spaces/places they

contain are peoples' living places/spaces, provide a means of livelihood, and are spaces of leisure and sociality. They are also at times places of solidarity, empowerment, safety and wellbeing (Beazley, 2016; Author, 2014), although popular culture (i.e., media sources) often lead us to believe otherwise (Woolford, 2001). While extant research abounds with studies focusing on the risk characteristics of such neighbourhoods (Linden, Mar, Werker, Jang, & Krausz, 2012; Ross & Mirowsky, 2001; Wood & Kerr, 2006), less is known about how these places can be understood as spaces of safety, wellbeing, and resilience.

In this paper we examine how certain spaces/places frequently used by PWUD in the DTES that are commonly associated with risk and harm (e.g., alleyways, parks) can be re-imagined and re-constructed as spaces/places of safety and wellbeing. While many of the spaces/places of the DTES are highly regulated and impacted by broad socio-structural/political/economic forces, it is important to recognize that these spaces/places are not pre-determined by structural forces, but rather constructed and shaped in and through their use. Fast et al. (Fast, Shoveller, Small, & Kerr, 2013) suggest that "occupying a particular physical geography is a dynamic experience in which meanings tied to place are continually remade through the *social interactions* within (and increasingly beyond) these locations" (p. 99 emphasis added). We take this one step further by suggesting that it is not just social interactions that shape and (re)make space, but a myriad of human and non-human forces and mechanisms assembled in unique ways.

Our paper is framed by assemblage theory (DeLanda, 2006, 2016) which provides a novel means to better understand how spaces/places in the DTES can be understood as generating both positive and negative outcomes. It is useful to conceptualize these spaces/places as assemblages, that is, arrangements of variously connected heterogenous forces including

bodies, materials, and affects that shape behaviour and produce certain (situated) effects (i.e., risk/harm, safety/wellbeing) (Duff, 2016, 2011b). Borrowing a concept from actor-network theory (Latour, 2005) we can trace the *trail of associations* and relations of varied forces, including actors, affects, material objects, processes, technologies and so on that make up spaces/places and their effects (Duff, 2013; Latour, 2005). The spaces and places in and through which actors move in disadvantaged neighbourhoods are shaped by their interactions with/in these spaces, which involve relations between and among a variety of actants, including other actors, law enforcement figures and practices, economies, materials, rules/laws/codes of conduct and affect.

Key to assemblage theory is a rejection of subjects or contexts as the basis for empirical research. Instead, subjects and contexts are understood as unique arrangements of processes, relations, affects, spaces, materials and so forth (DeLanda, 2006; Duff, 2016). Importantly, this type of analysis sees space/place as "a process of 'co-functioning' whereby heterogeneous elements come together in a non-homogeneous grouping" (Anderson & McFarlane, 2011). This approach destabilizes linear understandings or explanations, providing instead a means to understand things/phenomena as relational processes made up of variously assembled actants (Farias, 2017). Conceptions of space and place as static and bounded physical geographies are replaced instead with notions of emergence, process, and multiple temporalities and possibilities (McFarlane, 2011). Rather than suggesting that outcomes such as risk/harm or safety/wellbeing are shaped by various structural forces, including social/political/economic "risk environments", we argue that analyses of space/place and their varied effects need to take into consideration events, relations, and processes (Duff, 2014). Applying these ideas to our exploration of space/place in the DTES through the voices of PWUD, we see these spaces/places as relational

and emergent, involving constant interaction among a host of human and nonhuman forces. Through an assemblage framework we can trace the association among/between a host of seemingly disparate actants to better understand *how* experiences of marginalization, or conversely resilience/wellbeing, unfold, and to shed light on how risky spaces/places can be re-imagined/constructed. The potential for such an exercise is noted in McFarlane's (2011) suggestion that "assemblage focuses on the disjunctures between the actual and the possible, between how urban inequality is produced and lived and how relations might be assembled otherwise" (p. 210).

While much scholarly work on substance use by marginalized groups is concerned with changing the behaviour of PWUD – including by promoting safer drug injection practices and other methods of harm reduction – our focus instead is concerned with the potential of altering the environments of risk and harm. This is accomplished by drawing on the enabling places literature to explore how certain spaces can be re-imagined and constructed as enabling spaces that produce - rather than risk and harm - safety and wellbeing (Duff, 2010, 2011a; J. Evans, Semogas, Smalley, & Lohfeld, 2015; Moore & Dietze, 2005). The agency of PWUD is often depicted as being constrained by contextual forces that shape their experiences of risk and harm (e.g., engaging in unsafe injection practices). This paper aims to illustrate instead how PWUD in the DTES actively shape experiences of space/place, and their potential in (re)constructing spaces in the DTES as enabling environments and "geographies of resistance" (Beazley, 2002). Key here is attempting to understand spaces/places in the DTES not only in terms of their properties and conditions, but of their capacities and potentialities for change. We thus pose two main questions:

1) How are certain spaces/places in the DTES assembled to produce risk and harm?

2) How can these spaces/places commonly associated with risk and harm be re-constructed as spaces/places of safety and wellbeing?

2. Methods

2.1 Research setting

The DTES is considered one of the poorest neighbourhoods in Canada with high rates of homelessness, unemployment, poverty and substance use (City of Vancouver, 2013). There is also a visible street scene, open drug market, and a proliferation of various stigmatized and criminalized activities (e.g., sex work, "loitering", vending, public sleeping, public intoxication). It is estimated that 1 in 18 people in the DTES are homeless (Carnegie Community Action Project, 2016). Single room accommodations make up the majority of housing in the area, with 94% of the city's SRAs located in the DTES neighbourhood (City of Vancouver, 2017). Single room accommodations are for the most part substandard and undesirable, yet often are the only option available for area residents. Most have shared bathroom and kitchen facilities, and are infamous for unsanitary and undesirable living conditions including bug and rat infestations, violence, drug dealing, noise, and lack of privacy (Collins et al., 2018; Lazarus, Chettiar, Deering, Nabess, & Shannon, 2011). In response to the lack of affordable housing and persistent homelessness, the city recently committed to building temporary modular housing (600 units proposed with close to 300 already built) for low income and homeless individuals (City of Vancouver, 2018).

A significant number of social and health care services for the homeless and people living in poverty operate in the DTES, including drop-in centres, health clinics, outreach programs and homeless shelters, as well as services specifically for women (e.g., Sheway, an organization that

provides social and health supports for pregnant and new mothers who use drugs) and Indigenous communities (e.g., Vancouver Native Friendship Centre). The neighbourhood has also seen a proliferation of services for PWUD, including numerous harm reduction supply outlets, detox facilities, both sanctioned and unsanctioned supervised consumption facilities, and various overdose prevention sites. Vancouver has long been at the forefront of innovative responses to drug use, often being the first Canadian city to adopt harm reduction measures, including the first federally sanctioned supervised injection site (Insite), opioid assisted treatment trials (NAOMI and SALOME), and the current expansion and evolution of heroin assisted treatment. The DTES is also home to the Vancouver Area Network of Drug Users (VANDU), the first peer-run drug user organization in Canada established in 1998 to advocate for the rights of PWUD.

The current study was carried out at VANDU, which operates out of a storefront building and serves as a safe space for PWUD. VANDU runs various education and support groups; these include groups for people who drink illicit alcohol, Indigenous individuals who use drugs, people receiving methadose, and those who were part of the NAOMI and SALOME trials. The organization also provides harm reduction supplies, operates one of several overdose prevention sites in the city, and actively engages in advocacy in Vancouver and surrounding municipalities to promote social justice issues and improve the lives of PWUD. To conduct interviews at their location and ensure the ethical and just involvement of its members, permission must be granted by the VANDU Board of Directors (made up of approximately 12 VANDU members elected to the Board) after they review the research protocol and meet with the investigator(s). Ethics approval was obtained by the Human Research Ethics Board at the University of Victoria.

2.2 Data collection and analysis

Fifty semi-structured interviews were conducted with PWUD in the DTES neighbourhood of Vancouver, BC in 2014. A number of VANDU Board members were hired to assist the first author with data collection by assisting in the recruitment of potential study participants, scheduling all interviews, and managing interview schedules. Study participants were recruited in and around VANDU, as well as in nearby locations frequented by PWUD (e.g., shelters, drop-in centres). Most interviews were scheduled a day or two in advance. Potential participants were initially screened for eligibility by the recruiters, and eligibility was again confirmed by the first author prior to conducting the interview. Study participants were required to: 1) be at least 19 years old; and 2) use drugs for non-medical purposes.

Two-stage interviews were conducted by the first author in various private rooms in VANDU. A short (approximately 20 minute) quantitative survey was followed by a longer (approximately 60 minute) semi-structured qualitative interview. The quantitative survey included questions on: demographics; past and current drug use; methods of drug consumption; sexual involvement; mental and physical health; criminal involvement; stigma and discrimination; social and health service utilization. The qualitative interviews followed an interview guide drafted prior to data collection, but which evolved as topics emerged that were deemed relevant to pursue further (including the topic of this paper). The interview guide broadly covered the following topics: housing and homelessness; experiences living in the DTES; drug use history; methods of drug consumption; social networks; experiences of stigma and discrimination; violence, safety, and other social issues. Participants received a $25 CAD honorarium for participating in the study once the interview was complete. All interviews were digitally recorded.

Quantitative data were analyzed with SPSS (v. 24). For this paper, which focuses on in-depth accounts of space and place, only descriptive/demographic quantitative data are combined with the relevant qualitative data. Interview transcripts were imported into NVivo (v. 10) for coding and analysis. Preliminary analyses were based on methods borrowed from Situational Analysis (Clarke, 2005, 2003), which involves including in the analyses all things (both human and non-human) relevant to the phenomena being studied, and analysing relations among them. An initial coding framework was developed based on a set of broad "general orders" such as 'individual/collective human elements', 'non-human elements', 'drugs and drug use', 'issues and debates', 'spatial elements', 'sociocultural elements', and 'temporal elements'. As themes around space/place began to emerge, a coding framework was developed to capture more specifically themes related to experience of space/place in the DTES. It was at this stage that further analyses took into consideration assemblage theory and the coding framework was refined accordingly (DeLanda, 2006, 2016). It became clear, for instance, that narratives on space/place involved the confluence of human and non-human forces (and not just physical geographies), and that it would be pertinent to our analysis to allow for a symmetrical consideration of all actants involved in experiences of space/place. Further analysis involved engaging in the process of tracing or mapping associations found in participant narratives, which led us to understand space/place as relational, processual and emergent, and thus capable of re-imagining and re-making. This analysis was presented to the VANDU Board of Directors (which contained some study participants) for feedback and to ensure the validity of thematic interpretations. The VANDU Board also provided critical feedback on various drafts of the paper.

3. Results

In the following section, we demonstrate how spaces/places in the DTES can at times be assemblages of risk and harm, and at other times assemblages of safety and wellbeing. We first illustrate the role housing (and homelessness) – an assemblage itself – plays in shaping the use of space/place by frequently pushing PWUD into the public domain of the "street". We then show how certain spaces/places are experienced as harmful, unsafe, and implicated in experiences of oppression and inequality. Finally, we demonstrate how these same spaces are sometimes experienced as places of safety and wellbeing, highlighting the potential to re-construct risky spaces as enabling spaces, which is particularly important in the current context of the overdose/drug poising crisis in North America. Pseudonyms are used throughout for participant and place/building names.

3.1 "It's an address. But I don't call it home" – The housing assemblage

A number of participants were truly homeless at the time of the study (five reported living on the street, and three in shelters). Those who were housed tended to be living in SRAs, including social supportive housing. While the City of Vancouver has recently taken measures to improve the state of housing in the DTES through renovations and newly constructed social housing buildings, most SRAs contain deplorable living conditions. Typical SRAs in Vancouver are approximately 120 square feet, and are notoriously dilapidated and rodent/bug-infested. When asked about the living conditions in SRAs, study participants commonly described unsanitary environments, such as when Irving stated simply, "It's got bugs and rodents" (M/57/C) [1], or as Alex described a former room he had rented: "It was just, there was the bugs, cockroaches. It was just…you didn't want to go there half the time you know" (M/51/I). This feeling expressed

[1] (Gender [M=Male; F=Female])/Age/Ethnicity [I=Indigenous; C=Caucasian; B=Black; O=Other)

by Alex – of not wanting to be there – was a common theme among many study participants who lived in SRAs, and related to various other issues associated with SRAs including shared facilities, cramped quarters, and restrictive rules.

Single room accommodations in the DTES commonly have shared bathrooms and kitchen facilities, although residents will often acquire their own small bar fridges, hot-plates, or microwaves. Having to share bathroom and kitchen facilities was a common complaint, as Ryan remarked, "it would be nice to have my own shower and a real stove because I really like to cook…I only have a little fridge, and you know it's good for a six-pack and two sandwiches and it's full. It's kind of a joke" (M/45/C). Justin's experience was similar, and he described how shared facilities force him away from his home for meals: "Well I would like my own bathroom, my own shower, my own little kitchen. Like I used to cook my own meals before…And now I got to go eat at these other places. The food line ups." (M/55/I). Study participants also commonly recounted negative experiences with shared bathroom facilities including frequently clogged toilets and other plumbing issues, showers/tubs being used to store and clean items such as bikes, and general uncleanliness and unsanitary conditions.

Participants who lived in SRAs commonly referred to them as jail cells, complete with tenant policies that greatly restrict their freedom and are not typical in standard rental properties (including intrusive security and surveillance measures). These policies control residents' use of space including curfews, guest restrictions (including overnight stays with partners), room inspections, and general codes of conduct. Speaking about the extensive rules, Lukas suggested that SRAs have "gone beyond being a hotel…it's like an open prison" (M/41/I). Similar to other participants, Nancy expressed how these experiences of living in cramped quarters under the watchful eye of building staff, discouraged people from spending time in their homes: "when

you're in the hotel you can't have visitors and stuff so you got to go outside…if you want to do something" (F/71/I). Similarly, Ben related how the cramped quarters of his SRA room shaped his use of space by pushing him outdoors during the day, often only returning to his home at night:

> If I stay there, during the daytime…to me, it feels like the walls are closing in…I don't want to be there. But once it gets dark, I'm okay. During the daytime, it's not a good place to stay for any length of time. (M/56/C)

These narratives demonstrate how, even when housed, the type of housing in which most PWUD in the DTES live shapes their experience of marginalization and inequality by pushing them out of their rented homes and into public spaces outdoors. We can see how the SRA can be understood as an assemblage of material objects (and their varied states of disrepair), actors (building staff, other residents), rules and regulations, and affect and emotion that result in a specific effect (not wanting to be there). Through this particular assemblage, SRA residents are affectively/emotively moved to flee their home only to find themselves in spaces/places customarily associated with risk and harm.

3.2 Spaces of risk and harm

During the day the streets of the DTES are lively, fervent with activity. Some blocks, such as those with overdose prevention sites and unsanctioned street markets, are teeming with people; there is at times a constant flow of movement and sense of urgency as people move in and out of buildings, up and down streets and alleyways, crossing intersections, looking for people, finding people, laughing crying and arguing. Outdoors, study participants would spend time in various public and semi-private spaces, including main avenues, alleyways, parks, drop-in centres and

other social or health services. To the casual observer passing through the DTES it might seem hectic, but in all of this there is purpose as people socialize, sell things and services, procure and consume drugs, rest, eat, sleep, and generally go about their daily lives. Yet being outdoors increased participants' exposure to things like violence, stigma, unsafe drug consumption, harassment and arrest. Simply being on the street, under the gaze of the general public, resulted in stigmatizing experiences. Describing the feeling of being stigmatized by people driving through the DTES Maya stated, "It's just, like the other people that are looking in…They're judging us because we're addicts, right…But we're still people" (F/50/I).

Many of theses spaces have been conceptualized as, and indeed can be, potential sites of risk and harm. Study participants often discussed the outdoors, or specific places like parks and alleyways, as spaces that increased exposure to violence, unsafe drug use, stigma, and negative interaction with law enforcement and security personnel. A number of local parks in the DTES are popular among PWUD as spaces in which to spend time as they offer places to sit and relax, and respite from the street. At the same time, these spaces were described as inherently risky, increasing the vulnerability of PWUD to violence and harassment from both other people and law enforcement. Speaking about violence at one local park Ben stated, "I see it on a daily basis…I'll see drunks beating up on drunks. I'll see drug dealers beating on customers because, for whatever reason right…I see it all the time. It's not pleasant" (M/56/C). Andre explained his trepidation about a local park, describing the physical location in terms of an assemblage of actors, temporal elements and affect that shaped his use (i.e., avoidance) of those types of spaces:

> Well I never go out late at night near Eagles Park, for sure, but that's, you're looking for trouble if you go there. Because the dealers are all there and the [sex workers] are all

there. Fights start over nothing. And I don't know those people at all. So it's not a good place to hang out at nighttime. (M/58/C)

Alleyways, another potential site of risk and harm in the DTES, are regularly used and travelled through by PWUD. Downtown Vancouver contains numerous alleys that criss-cross the landscape, many of which run parallel between major avenues. Most storefronts, office buildings and housing units in the DTES have access to alleys, which are used as alternate entrances/exits as well as for deliveries and garbage storage/pick-up (and thus contain many places to hide including secluded doorways and behind garbage bins). Although public spaces, alleyways provide a level of privacy away from the gaze of the general public. As such, alleys are frequently used for sex work activities, to purchase and consume drugs, or simply to be off the main streets. Not surprisingly, however, the secluded nature of alleyways increases the potential for negative experiences, including altercations with police. Study participants commonly spoke about alleyways as spaces of risk and harm, where people engaged in unsafe drug use practices, were at heightened risk of fatal overdose and violence, or risked negative interactions with law enforcement. Jake recounted an especially upsetting experience: "I was living in the Maples Hotel, I heard this girl screaming in the alley…I found out the next day it was a girl that was getting raped back there" (M/51/I). Natasha suggested that using drug in alleyways was "a reason for the police to arrest me" (F/36/C), while Andre declared that "they've found bodies in the back lane like that. But violence happens every day" (M/58/C). Phil described a particularly troubling event he had witnessed in a laneway involving the police:

I've seen, for no reason whatsoever, a girl and this guy were doing crack in the alley beside The Tridel and three cops ran, literally ran down the alley, pulled out their batons. And as soon as the kid turned around, smashed him. Didn't say "Freeze! Stop!

> Police!" Nothing like this. Just smashed him in the face with it. I thought what the fuck, this is straight out of the movies. Shit like that happens movies, not in real life. (M/46/C)

These narratives demonstrate how certain public spaces shape experiences of vulnerability and marginalization for PWUD in the DTES. Figure 1. (below) illustrates the relations among various forces which make up an example of an assemblage of risk and harm. We can trace the association of SRAs (or homelessness), physical spaces (e.g., alleys), actors (e.g., drug dealers, other PWUD, police), temporal elements, affect, and material objects assembled in unique ways that produce or shape risk and harm. By being pushed outdoors, PWUD in the DTES spend a significant amount of time in public and semi-private spaces that increase their exposure to violence, harassment, stigma, arrest, unsafe drug use practices, and overdose. While these spaces are not inherently risky or dangerous, they become so through the interaction of variously assembled actants that produce certain effects (in this case danger, harm, unsafety).

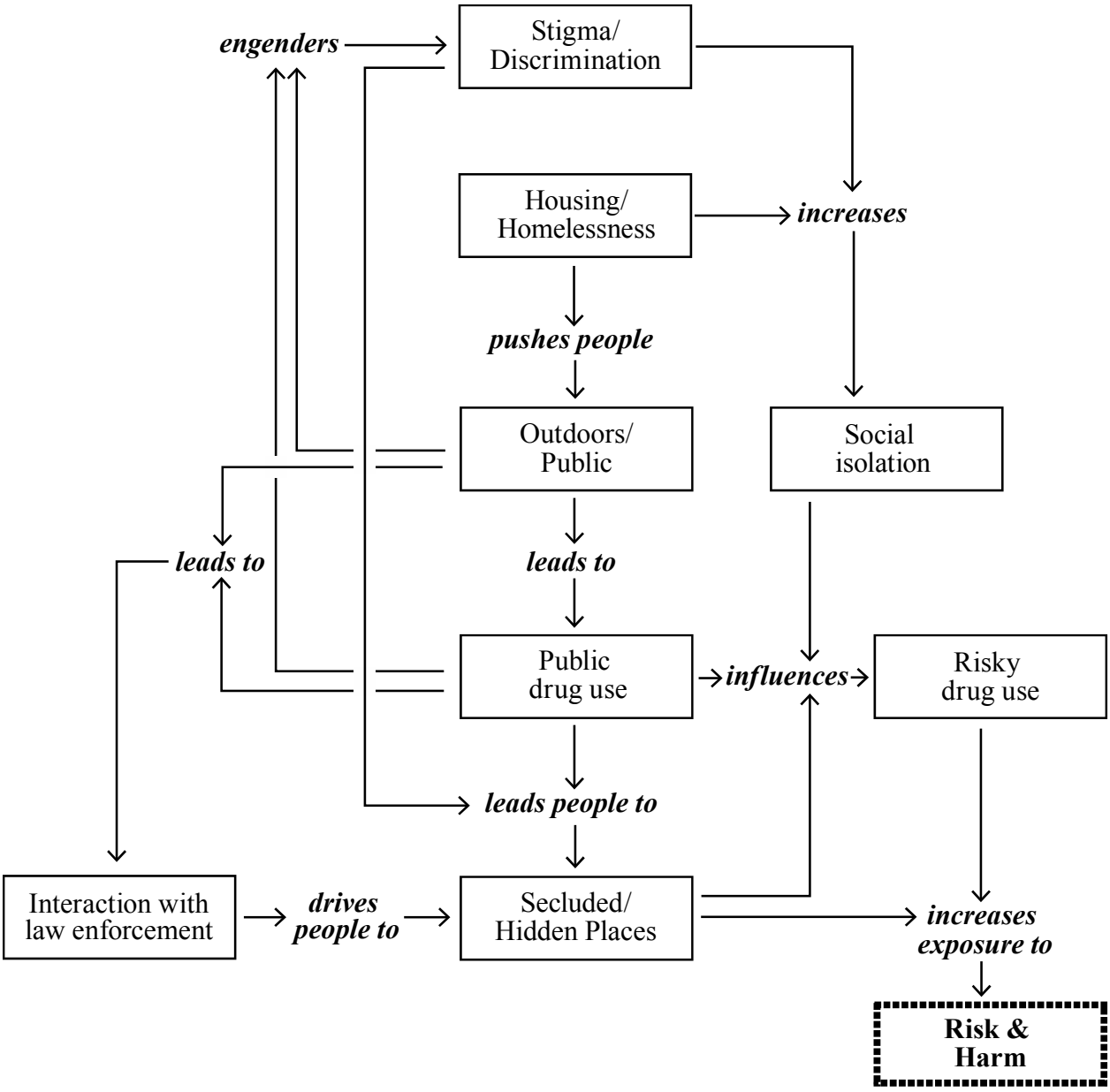

Figure 1. Diagram illustrating an assemblage of risk and harm in the DTES

3.3 Spaces of safety and wellbeing

In late-September 2016 a small pop-up tent was erected in an alleyway in the DTES to function as an unsanctioned overdose prevention site (OPS) (Puri, 2016). This particular alley quickly became known as a safe place to consume drugs, and PWUD started not only utilizing the OPS,

but also consuming drugs nearby, knowing that in the event of an overdose they would be within quick reach of OPS staff or others with Naloxone[2]. The OPS drastically changed the dynamic of the alley as a space of risk and harm, to one of safety and wellbeing inspiring affective and emotive forces of care, trust and responsibility for each other. Participant narratives support this notion that spaces/places in the DTES commonly conceptualized as risky and harmful can be re-made as enabling spaces of safety and wellbeing.

As noted above, while many participants spoke about risks and harms associated with certain spaces/places in the DTES such as alleyways and parks, some of them also depicted these same spaces as places of safety and wellbeing. These participants described feeling safer in the DTES than in other neighbourhoods of Vancouver, and spoke about a sense of caring and "looking out" for one another. Sergio described how he felt safer in alleyways in the DTES than in other areas since the alleys were often busy: "It's a lot safer to be down here in an alley than somewhere else because somewhere else, like, I'd get robbed and nobody would be around to see it or hear it. But here, people everywhere" (M/28/I). Carrie similarly described feeling safe in alleyways in the DTES:

> I walk home after dinner through a dark alley every night on my own. And I'm, you know what I mean? And I'm safe…I just know that the same people are in that alley everyday. It's that tight thing you know we have…I don't know, it just feels kind of safe. (F/36/C)

Sometimes participants spoke about the social caring among PWUD in the DTES, many of whom look out for one another in the event of overdose, violence or robbery. As Dan stated,

[2] Naloxone is an injectable medication used to block the effects of opioids and reverse opioid-related overdoses. Naloxone kits are now commonplace in the DTES, and many people in the DTES carry them.

"when the chips are down and it's something important, not one of these people in this community would let you die" (M/48/C). Alex similarly described how PWUD look out for one another: "Like down in the alleys like that. And you see women, street workers, and girls addicted and stuff up and down the alleys all hours and nights, because people look out for people down here. It's really like, a tight community like that" (M/51/I). This was especially important for Ben who discussed how using drugs in the presence of other people fostered a sense of safety and wellbeing:

> I feel safe, yeah. Especially if, *especially* if I'm using and getting high with other people, right. I feel that if something happens, they got my back. And they can feel the same way about me, too. (M/56/C)

What is evident in these narrative is the role participants ascribed to relations with and among other PWUD within the alleyways and other spaces they inhabit, fostering a sense of community, trust and safety. This notion of community, of people taking care of each other and looking out for one another, was brought up by many participants. Participants expressed notions of togetherness and even family, referring to others in the neighbourhood as their brothers and sisters. Such bonding with others in the DTES heightened not only participants' sense of safety, but fostered affectual and emotive responses of solidarity, community and general wellbeing. Dane attributed this to sharing common experiences with other PWUD in the DTES: "you live in an area where the majority of people have gone through the same things as you…So there's already that connect and everybody knows that shit happens…There's still a lot of empathy" (M/51/B). Sheldon described this sense of community, including how the local Eagles Park described above as dangerous, could be transformed into a space that fostered community and social bonding among PWUD:

> What I like about here everything is, to me everything, every individual around here is closely knit. We get together, it's a picnic, there's a party, an engagement, a protest…or like meetings that are happening here at VANDU. We all get together, all happy and cheery talking to each other. Then at Eagles Park…there would always be an event happening there, a barbecue or whatnot. We all go there. Other places where there's free food, we go there and congregate and have fun, laugh. (M/53/I)

This shows that spaces/places commonly associated with risk have the potential to be re-made as spaces of safety. Figure 2. (below) illustrates the relations among various forces which make up an example of an assemblage of safety and wellbeing. Viewing these spaces as an assemblage of variously interconnected human and nonhuman forces, we see the importance of not only the physical feature of spaces in shaping risk or safety, but of a host of affectual, material, processual and other forces as well. We can trace the association of the SRA (or homelessness), geographic elements (alleys, parks, streets), other actors, material objects, processes, temporal elements, and affectual responses that when assembled in particular ways at particular times produce a given effect that is different from the above risk assemblage. Key to this assemblage of safety/wellbeing is affect and emotion, which fosters feelings of care and solidarity that lead PWUD in the DTES to look out for one another in the event of harmful situations such as violence and drug overdose.

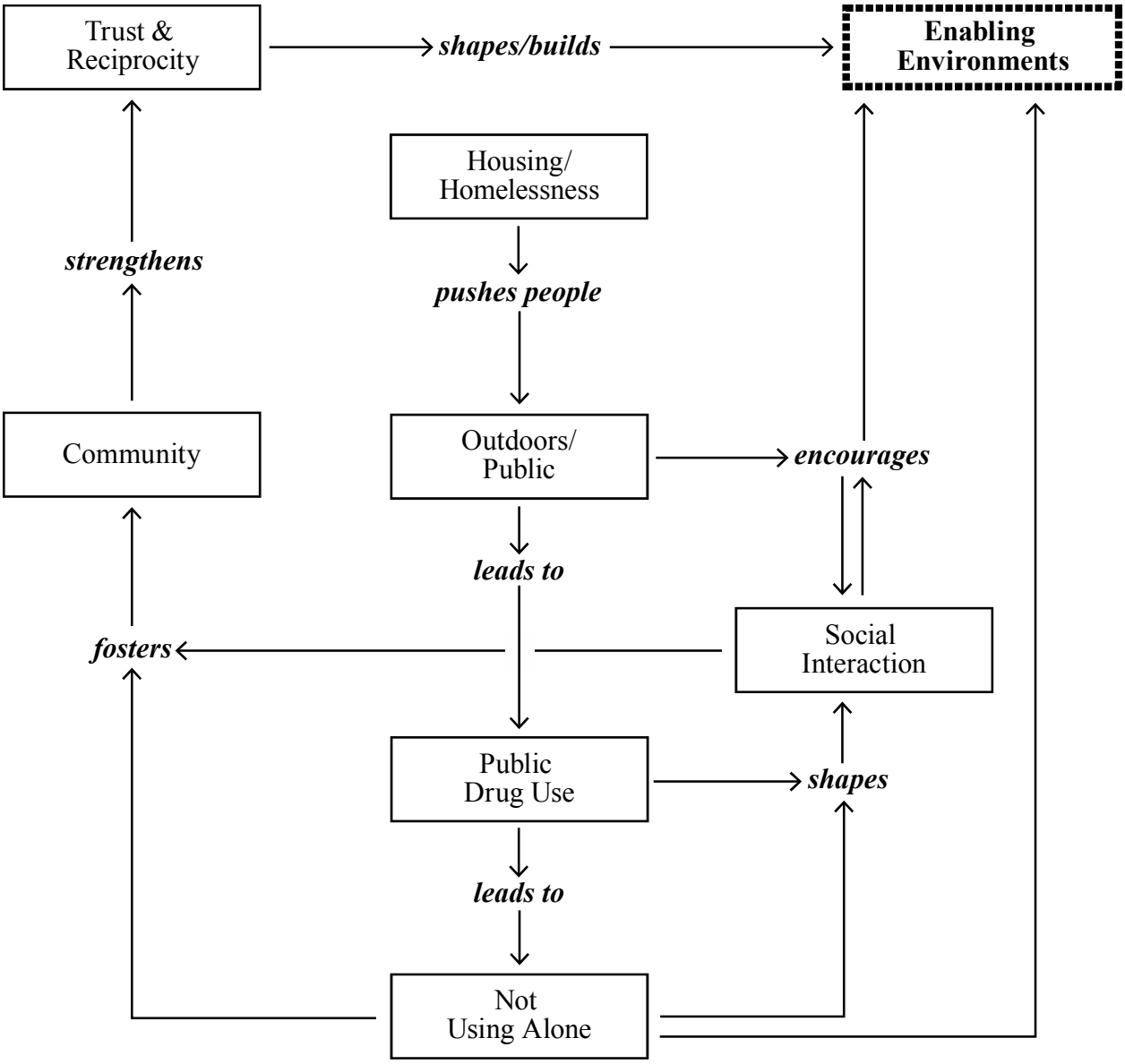

Figure 2. Diagram illustrating an assemblage of safety and well-being in the DTES

Discussion

A robust body of literature has established an association between the settings in which people are situated and their health outcomes, such that space/place is an important social determinant of health and health inequity (Bambra et al., 2009; Braveman & Gottlieb, 2014; Cohen et al.,

2003; Curtis & Jones, 1998; Fitzpatrick & LaGory, 2003). While the association between social factors and health is certain, what remains largely unexplored is precisely in what manner health and health inequity manifests in space/place. In other words, what exactly is going on in certain spaces/places that shape health and health inequity? While critical drug scholars have, for example, been drawing connections between the physical environments of substance use and related risks and harms for some time now (Hunter et al., 2018; Maas et al., 2007; Small et al., 2006), it is not always clear in what specific ways, or through what particular arrangement of forces, these places or environments shape risk and harm (or conversely, safety and wellbeing). Building on what Duff (2011b, 2018) refers to as the "reification" of context and social determinants of health, in this paper we have attempted to trace "how diverse bodies, objects and forces actually come to shape, disrupt and transform experiences" in spaces/places in Vancouver's DTES neighbourhood (Duff, 2018, p. 142).

Our findings demonstrate how spaces used by PWUD in the DTES can be understood as assemblages, a variety of human and nonhuman forces – such as material objects, actors, processes, affect, temporal elements, policies and practices – assembled in unique ways that produce certain effects (DeLanda, 2016). Conceptualizing place in this way allows for an understanding of space/place that takes into consideration the full range of variously interconnected heterogenous forces to better discern how spaces shape experience. Thus, the riskiness of the alleyway is not shaped simply by its seclusion, or by discrete activities that take place within it, but by complex relations between a variety of human and nonhuman forces. To borrow the concept of "throwntogetherness" from Demant and Landolt (2014), our findings demonstrate how drug consumption in the alleyways is the result of a host of disparate factors coming together including SRAs (which push people outdoors), experiences of stigma (which

drive people to want to hide), lack of supervised consumption sites, drug policies (i.e., criminalization), private security (who prohibit people from "loitering" in public areas), other PWUD, and fear of police (which again pushes people into secluded areas). All of these forces (and likely others not captured in the data) assembled in unique ways produce a given effect, such as pushing people into secluded spaces, potentially increasing their exposure to risk and harm. These findings are supported by other studies conducted in the DTES and elsewhere which highlight the role of similar forces (e.g., police, stigma, violence) in shaping experiences of space/place (Boyd & Kerr, 2016; Link & Phelan, 2014; McNeil, Shannon, Shaver, Kerr, & Small, 2014; Small et al., 2006).

By bringing in notions of process, emergence, and ebbs and flows, assemblage theory uniquely contributes to our understanding of space/place and provides the ability to conceptualize things otherwise. As suggested by McFarlane (2011), assemblage theory provides a means to see how inequality is produced and experienced, and how these relations might be assembled differently. Our findings support this notion, demonstrating how certain spaces/places used by PWUD can at times be assembled as spaces of risk/harm, and at other times spaces of safety/wellbeing. The resultant experiences of these places, of risk/harm or safety/wellbeing, were invariably shaped by and dependent upon what particular forces were assembled at particular times. Thus with assemblage theory we see that, for instance, a fatal overdose in a park is not simply the result of an individual unknowingly ingesting fentanyl, but is the result of a vast assemblage of forces culminating in that particular effect. In the same way, the safety of an alleyway is not simply due to the existence of an OPS tent (although this is a crucial element), but a variety of forces including those that lead people to consume drugs in alleyways, as well as

affectual and emotive notions within the DTES community of care and responsibility for each other (particularly during the current overdose epidemic).

Continuing with this idea of "assembling otherwise", our findings provide examples of how spaces/places commonly associated with risk and harm might be re-imagined and re-constructed otherwise. Drawing on the "enabling places" framework (Duff, 2010, 2010; J. Evans et al., 2015), which identifies three types of enabling resources (material, social, affective), helps us to imagine the potential role certain spaces/places in the DTES might play in enabling safety and wellbeing. Re-assembling risky spaces as enabling places thus involves altering forces within the risk assemblage, and harnessing forces and resources depicted in the safety assemblage, to facilitate safety and wellbeing. Integrating an enabling places framework with our conceptualization of spaces/places as assemblages, we see that responding to the risks/harms associated with particular spaces in the DTES requires more than simply providing additional services, programs, and material resources (e.g., needle/pipe distribution, SCSs/OPSs). It also requires attending to the place-making capacities of people and the social and affective resources that engender wellbeing. This is not to deny the importance of material resources in enabling safety and wellbeing, but to ensure that social and affective resources be given equal consideration. While it has been suggested that neighbourhood disadvantage may diminish social ties, community attachment, and weaken social cohesion (Browning & Cagney, 2003; Forrest & Kearns, 2001), our findings are supported by other studies demonstrating the positive role of social and affective resources among PWUD in the DTES (Boyd & Boyd, 2014; Kerr et al., 2006). Discussing spaces of safety and wellbeing, participants in our study emphasized the important role of social connections, as well as notions of trust, reciprocity and care, demonstrating the potential for affective and social resources to shape positive experience of

space/place. Duff (2010) suggests that, given the under-analysis of social resources among marginalized PWUD, an important task remains to explore how such resources can be made available and utilized to facilitate enabling places. What this might look like depends on the unique and situated dynamics of places. Thinking about the experiences of marginalized PWUD in the DTES this should involve harnessing social and affective resources among PWUD themselves (as is done, for example, through peer-run organizations like VANDU), while at the same time increasing additional harm reduction services (e.g., mobile OPSs) and limiting interaction with law enforcement (e.g., decreasing police presence around OPSs). The establishment of the alleyway OPS tent described above sheds light on how such endeavours might be realized through not only introducing material resources, but rather changing the social and affective dynamics of spaces/places.

Given the place of housing in our assemblage of space/place, it is a critical undertaking to address its part in risk/harm or safety/wellbeing. In line with previous studies on housing in the DTES (Boyd et al., 2016; Collins et al., 2018; L. Evans & Strathdee, 2006; Lazarus et al., 2011; Shannon, Ishida, Lai, & Tyndall, 2006), our findings highlight the role housing plays in shaping exposure to risk and harm, and demonstrate the pressing need to improve housing for PWUD including better integration of social and health supports. The "housing first" model, for instance, recommends the incorporation of harm reduction initiatives within housing for PWUD, such as on-demand or on-site harm reduction services (Pauly, Reist, Belle-Isle, & Schactman, 2013). A number of recent initiatives in the DTES provide examples of how material, social and affective resources among PWUD can be utilized to shift the housing assemblage from one of risk/harm to one enabling safety and wellbeing. The peer-led Tenant Overdose Response Organizers (TORO) pilot program (in which residents of SRAs were hired and trained to respond to overdoses in

their buildings) and the "peer witness injection programs" in select emergency shelters (in which drug use is permitted and supervised in onsite injection rooms) demonstrate the vital role of social and affective forces (such as collective responsibility, care, hope) among PWUD in transforming spaces of risk/harm into enabling places of safety and wellbeing (Bardwell, Boyd, Kerr, & McNeil, 2018; Bardwell, Fleming, Collins, Boyd, & McNeil, 2018). Our findings are supported by these and other studies on peer naloxone programs (Marshall, Perreault, Archambault, & Milton, 2017; Mitchell et al., 2017; Wagner et al., 2014) that demonstrate the importance of not only material resources (i.e., naloxone, supervised consumption spaces), but of affective and social resources – notions of care, reciprocity, solidarity, trust, and hope – in facilitating the construction of enabling places.

By drawing from assemblage theory and the enabling places framework, we have demonstrated how spaces/places of inequality can be re-constructed otherwise, as enabling places of safety and wellbeing. That the alley or park can be a space of both risk and safety demonstrates that a shift should be possible to make these spaces more safe and less risky. Clearly, notions of "sense of community" in fostering social ties/bonding and a holistic notion of health and wellbeing (including community wellbeing) should drive the re-making of space, building on feelings of something affectual/emotional/moving that binds people together through action. It is, in essence, about a shared respect and concern for others in a similar situation, and a sense of needing to care for each other within a hostile environment in which PWUD regularly experience structural and symbolic violence. In a time of rapid gentrification in the DTES, the priority should not be to remove the so-called "problematic" individuals and elements from public spaces in the DTES, but to more effectively integrate and (re)make enabling spaces in the community.

References

Anderson, B., & McFarlane, C. (2011). Assemblage and geography. *Area*, *43*(2), 124–127. https://doi.org/10.1111/j.1475-4762.2011.01004.x

Bambra, C., Gibson, M., Amanda, S., Wright, K., Whitehead, M., & Petticrew, M. (2009). Tackling the wider social determinants of health and health inequalities: evidence from systematic reviews. *Journal of Epidemiology & Community Health*, jech.2008.082743. https://doi.org/10.1136/jech.2008.082743

Bardwell, G., Boyd, J., Kerr, T., & McNeil, R. (2018). Negotiating space & drug use in emergency shelters with peer witness injection programs within the context of an overdose crisis: A qualitative study. *Health & Place*, *53*, 86–93. https://doi.org/10.1016/j.healthplace.2018.07.011

Bardwell, G., Fleming, T., Collins, A. B., Boyd, J., & McNeil, R. (2018). Addressing Intersecting Housing and Overdose Crises in Vancouver, Canada: Opportunities and Challenges from a Tenant-Led Overdose Response Intervention in Single Room Occupancy Hotels. *Journal of Urban Health*. https://doi.org/10.1007/s11524-018-0294-y

Beazley, H. (2002). "Vagrants Wearing Make-up": Negotiating Spaces on the Streets of Yogyakarta, Indonesia. *Urban Studies*, *39*(9), 1665–1683. https://doi.org/10.1080/00420980220151718

Beazley, H. (2016). Bus Stops and Toilets: identifying Spaces and Spaces of Identity for Indonesian Street Children. In N. Worth & C. Dwyer (Eds.), *Identities and Subjectivities* (pp. 163–190). Singapore: Springer Singapore. https://doi.org/10.1007/978-981-287-023-0_8

Author. (2003). Details removed for peer review

Boardman, J. D., Finch, B. K., Ellison, C. G., Williams, D. R., & Jackson, J. S. (2001). Neighborhood Disadvantage, Stress, and Drug Use among Adults. *Journal of Health and Social Behavior*, *42*(2), 151–165. https://doi.org/10.2307/3090175

Author. (2014). Details removed for peer review

Boyd, J., Cunningham, D., Anderson, S., & Kerr, T. (2016). Supportive housing and surveillance. *International Journal of Drug Policy*, *34*, 72–79. https://doi.org/10.1016/j.drugpo.2016.05.012

Boyd, J., & Kerr, T. (2016). Policing 'Vancouver's mental health crisis': a critical discourse analysis. *Critical Public Health*, *26*(4), 418–433. https://doi.org/10.1080/09581596.2015.1007923

Braveman, P., & Gottlieb, L. (2014). The Social Determinants of Health: It's Time to Consider the Causes of the Causes. *Public Health Reports*, *129*(1_suppl2), 19–31. https://doi.org/10.1177/00333549141291S206

Browning, C. R., & Cagney, K. A. (2003). Moving beyond Poverty: Neighborhood Structure, Social Processes, and Health. *Journal of Health and Social Behavior*, *44*(4), 552–571. https://doi.org/10.2307/1519799

Carpiano, R. M., Kelly, B. C., Easterbrook, A., & Parsons, J. T. (2011). Community and Drug Use among Gay Men: The Role of Neighborhoods and Networks. *Journal of Health and Social Behavior*, *52*(1), 74–90. https://doi.org/10.1177/0022146510395026

Cohen, D. A., Mason, K., Bedimo, A., Scribner, R., Basolo, V., & Farley, T. A. (2003). Neighborhood Physical Conditions and Health. *American Journal of Public Health*, *93*(3), 467–471. https://doi.org/10.2105/AJPH.93.3.467

Collins, A. B., Boyd, J., Damon, W., Czechaczek, S., Krüsi, A., Cooper, H., & McNeil, R. (2018). Surviving the housing crisis: Social violence and the production of evictions among women who use drugs in Vancouver, Canada. *Health & Place*, *51*, 174–181. https://doi.org/10.1016/j.healthplace.2018.04.001

Curtis, S., & Jones, I. R. (1998). Is There a Place for Geography in the Analysis of Health Inequality? *Sociology of Health & Illness*, *20*(5), 645–672. https://doi.org/10.1111/1467-9566.00123

DeLanda, M. (2006). *A New Philosophy of Society: Assemblage Theory and Social Complexity*. A&C Black.

DeLanda, M. (2016). *Assemblage Theory*. Edinburgh University Press.

Duff. (2016). Assemblages, territories, contexts. *International Journal of Drug Policy*, *33*, 15–20. https://doi.org/10.1016/j.drugpo.2015.10.003

Duff, C. (2010). Enabling places and enabling resources: New directions for harm reduction research and practice. *Drug and Alcohol Review*, *29*(3), 337–344. https://doi.org/10.1111/j.1465-3362.2010.00187.x

Duff, C. (2011a). Networks, resources and agencies: On the character and production of enabling places. *Health & Place*, *17*(1), 149–156. https://doi.org/10.1016/j.healthplace.2010.09.012

Duff, C. (2011b). Reassembling (social) contexts: New directions for a sociology of drugs. *International Journal of Drug Policy*, *22*(6), 404–406. https://doi.org/10.1016/j.drugpo.2011.09.005

Duff, C. (2013). The social life of drugs. *International Journal of Drug Policy*, *24*(3), 167–172. https://doi.org/10.1016/j.drugpo.2012.12.009

Duff, C. (2014). The place and time of drugs. *International Journal of Drug Policy*, *25*(3), 633–639. https://doi.org/10.1016/j.drugpo.2013.10.014

Duff, C. (2018). After posthumanism | Routledge Handbook of Health Geography | Taylor & Francis Group. Retrieved August 30, 2018, from http://www.taylorfrancis.com/

Evans, J., Semogas, D., Smalley, J. G., & Lohfeld, L. (2015). "This place has given me a reason to care": Understanding 'managed alcohol programs' as enabling places in Canada. *Health & Place*, *33*(Supplement C), 118–124. https://doi.org/10.1016/j.healthplace.2015.02.011

Evans, L., & Strathdee, S. A. (2006). A roof is not enough: Unstable housing, vulnerability to HIV infection and the plight of the SRO. *International Journal of Drug Policy*, *17*(2), 115–117. https://doi.org/10.1016/j.drugpo.2005.10.003

Fast, D., Shoveller, J., Shannon, K., & Kerr, T. (2010). Safety and danger in downtown Vancouver: Understandings of place among young people entrenched in an urban drug scene. *Health & Place*, *16*(1), 51–60. https://doi.org/10.1016/j.healthplace.2009.07.004

Fast, D., Shoveller, J., Small, W., & Kerr, T. (2013). Did Somebody Say Community? Young People's Critiques of Conventional Community Narratives in the Context of a Local Drug Scene. *Human Organization*, *72*(2), 98–110. https://doi.org/10.17730/humo.72.2.86005462778382u2

Fitzpatrick, K. M., & LaGory, M. (2003). "Placing" Health in an Urban Sociology: Cities as Mosaics of Risk and Protection. *City & Community*, *2*(1), 33–46. https://doi.org/10.1111/1540-6040.00037

Forrest, R., & Kearns, A. (2001). Social Cohesion, Social Capital and the Neighbourhood. *Urban Studies*, *38*(12), 2125–2143. https://doi.org/10.1080/00420980120087081

Huey, L., & Kemple, T. (2007). `Let the Streets Take Care of Themselves': Making Sociological and Common Sense of `Skid Row'. *Urban Studies*, *44*(12), 2305–2319. https://doi.org/10.1080/00420980701540911

Hunter, K., Park, J. N., Allen, S. T., Chaulk, P., Frost, T., Weir, B. W., & Sherman, S. G. (2018). Safe and unsafe spaces: Non-fatal overdose, arrest, and receptive syringe sharing among people who inject drugs in public and semi-public spaces in Baltimore City. *International Journal of Drug Policy*, *57*, 25–31. https://doi.org/10.1016/j.drugpo.2018.03.026

Author. (2018). Details removed for peer review

Author. (2011). Details removed for peer review

Kerr, T., Small, W., Peeace, W., Douglas, D., Pierre, A., & Wood, E. (2006). Harm reduction by a "user-run" organization: A case study of the Vancouver Area Network of Drug Users (VANDU). *International Journal of Drug Policy*, *17*(2), 61–69. https://doi.org/10.1016/j.drugpo.2006.01.003

Latour, B. (2005). *Reassembling the Social: An Introduction to Actor-network-theory (Clarendon Lectures in Management Studies)*. {Oxford University Press}. Retrieved from http://www.amazon.ca/exec/obidos/redirect?tag=citeulike09-20&path=ASIN/0199256047

Lazarus, L., Chettiar, J., Deering, K., Nabess, R., & Shannon, K. (2011). Risky health environments: Women sex workers' struggles to find safe, secure and non-exploitative housing in Canada's poorest postal code. *Social Science & Medicine*, *73*(11), 1600–1607. https://doi.org/10.1016/j.socscimed.2011.09.015

Linden, I. A., Mar, M. Y., Werker, G. R., Jang, K., & Krausz, M. (2012). Research on a Vulnerable Neighborhood—The Vancouver Downtown Eastside from 2001 to 2011. *Journal of Urban Health*, *90*(3), 559–573. https://doi.org/10.1007/s11524-012-9771-x

Link, B. G., & Phelan, J. (2014). Stigma power. *Social Science & Medicine*, *103*, 24–32. https://doi.org/10.1016/j.socscimed.2013.07.035

Maas, B., Fairbairn, N., Kerr, T., Li, K., Montaner, J. S. G., & Wood, E. (2007). Neighborhood and HIV infection among IDU: Place of residence independently predicts HIV infection among a cohort of injection drug users. *Health & Place*, *13*(2), 432–439. https://doi.org/10.1016/j.healthplace.2006.05.005

Macintyre, S., Maciver, S., & Sooman, A. (1993). Area, Class and Health: Should we be Focusing on Places or People?*. *Journal of Social Policy*, *22*(2), 213–234. https://doi.org/10.1017/S0047279400019310

Marshall, C., Perreault, M., Archambault, L., & Milton, D. (2017). Experiences of peer-trainers in a take-home naloxone program: Results from a qualitative study. *International Journal of Drug Policy*, *41*, 19–28. https://doi.org/10.1016/j.drugpo.2016.11.015

McFarlane, C. (2011). Assemblage and critical urbanism. *City*, *15*(2), 204–224. https://doi.org/10.1080/13604813.2011.568715

McNeil, R., Shannon, K., Shaver, L., Kerr, T., & Small, W. (2014). Negotiating place and gendered violence in Canada's largest open drug scene. *International Journal of Drug Policy*, *25*(3), 608–615. https://doi.org/10.1016/j.drugpo.2013.11.006

Mitchell, K., Durante, S. E., Pellatt, K., Richardson, C. G., Mathias, S., & Buxton, J. A. (2017). Naloxone and the Inner City Youth Experience (NICYE): a community-based participatory research study examining young people's perceptions of the BC take home

naloxone program. *Harm Reduction Journal*, *14*(1), 34. https://doi.org/10.1186/s12954-017-0160-3

Moore, D., & Dietze, P. (2005). Enabling environments and the reduction of drug-related harm: re-framing Australian policy and practice. *Drug and Alcohol Review*, *24*(3), 275–284. https://doi.org/10.1080/09595230500170258

Pauly, B., Reist, D., Belle-Isle, L., & Schactman, C. (2013). Housing and harm reduction: What is the role of harm reduction in addressing homelessness? *International Journal of Drug Policy*, *24*(4), 284–290. https://doi.org/10.1016/j.drugpo.2013.03.008

Ross, C. E., & Mirowsky, J. (2001). Neighborhood Disadvantage, Disorder, and Health. *Journal of Health and Social Behavior*, *42*(3), 258–276. https://doi.org/10.2307/3090214

Schroeder, J. R., Latkin, C. A., Hoover, D. R., Curry, A. D., Knowlton, A. R., & Celentano, D. D. (2001). Illicit Drug Use in One's Social Network and in One's Neighborhood Predicts Individual Heroin and Cocaine Use. *Annals of Epidemiology*, *11*(6), 389–394. https://doi.org/10.1016/S1047-2797(01)00225-3

Shannon, K., Ishida, T., Lai, C., & Tyndall, M. W. (2006). The impact of unregulated single room occupancy hotels on the health status of illicit drug users in Vancouver. *International Journal of Drug Policy*, *17*(2), 107–114. https://doi.org/10.1016/j.drugpo.2005.09.002

Small, W., Kerr, T., Charette, J., Schechter, M. T., & Spittal, P. M. (2006). Impacts of intensified police activity on injection drug users: Evidence from an ethnographic investigation. *International Journal of Drug Policy*, *17*(2), 85–95. https://doi.org/10.1016/j.drugpo.2005.12.005

Wacquant, L. J. D. (1997). Three Pernicious Premises in the Study of the American Ghetto. *International Journal of Urban and Regional Research*, *21*(2), 341–353. https://doi.org/10.1111/1468-2427.00076

Wagner, K. D., Davidson, P. J., Iverson, E., Washburn, R., Burke, E., Kral, A. H., … Lankenau, S. E. (2014). "I felt like a superhero": The experience of responding to drug overdose among individuals trained in overdose prevention. *International Journal of Drug Policy*, *25*(1), 157–165. https://doi.org/10.1016/j.drugpo.2013.07.003

Williams, C. T., & Latkin, C. A. (2007). Neighborhood Socioeconomic Status, Personal Network Attributes, and Use of Heroin and Cocaine. *American Journal of Preventive Medicine*, *32*(6, Supplement), S203–S210. https://doi.org/10.1016/j.amepre.2007.02.006

Wood, E., & Kerr, T. (2006). What do you do when you hit rock bottom? Responding to drugs in the city of Vancouver. *International Journal of Drug Policy*, *17*(2), 55–60. https://doi.org/10.1016/j.drugpo.2005.12.007

Woolford, A. (2001). Tainted space: Representation of injection drug-use and HIV/AIDS in Vancouver's downtown eastside. *BC Studies; Vancouver*, (129), 27–50.

Appendix A

Drug Use-Related Risk Behaviour Among Drug Injectors and Non-injectors: Study Questionnaire

Draft: Mar. 4, 2014

Survey number: ___ ___ ___

Date (dd/mm/yyyy): ___ ___/___ ___/___ ___ ___ ___

Location: _____

Time started: _____AM/PM

Section A. Demographics

A.01 What is your date of birth? (YYYY/MM/DD) _____

A.02 What is your current gender identity?

- Male
- Female
- Transgender
- Intersex
- Don't know
- Refused

A.03 What is you ethnicity?

- Caucasian
- Aboriginal
- Chinese
- Japanese
- Korean
- Black
- Latin American
- South Asian (e.g., East Indian, Pakistani)
- Southeast Asian (e.g., Cambodian, Vietnamese)
- West Asian (e.g., Afghan, Iranian, Turk)
- Other (specify): _____
- Don't know
- Refused

A.04 What neighbourhood in Vancouver do you currently live in?

- The DTES (SKIP TO QUESTION A.05)
- Strathcona
- Mount Pleasant
- West End
- False Creek
- Commercial Drive
- East Village (Hastings Sunrise)
- Other (specify): _____
- Don't know
- Refused

A.04a How often do you come to the DTES?

- Daily or almost daily
- 2 to 5 times a week
- Once a week
- 2 to 3 times a month
- Once a month
- Less than monthly
- Don't know
- Refused

A.04b When you come to the DTES what do you normally do? (check ALL that apply)

- Get harm reduction supplies
- Use Insite
- Score drugs
- Use drop-in centres
- See a doctor or nurse
- Visit friends
- Visit family
- Other (specify): _____
- Don't know
- Refused

A.05 What type of accommodation do you currently live in?
(Prompt: where did you sleep most in the previous 30 days?)

- Own house/apartment/condo
- Rented house/apartment/condo
- Parents home
- Boarding house/SRO/Hotel room/Motel room
- Shelter
- Transitional/supportive housing
- Drug treatment/detox
- Squat
- Couch surfing
- On the street
- Don't know
- Refused

A.06 What is the highest level of education you have completed?

- No school
- Some elementary school
- Completed elementary school
- Some high school
- Completed high school
- Some community college
- Some university
- Completed college
- Completed Bachelor's Degree
- Post graduate training: MA, MSc, MSW
- Post graduate training: PhD
- Professional degree: Law, Medicine, Dentistry
- Don't know
- Refused

A.07 What is your current relationship status?

- Married/common law
- Separated
- Divorced
- Widowed
- Single, never married
- In a committed relationship
- Don't know
- Refused

A.08 How would you describe your employment status?

- Full time paid work
- Part time paid work
- Sick leave, maternity leave
- Unemployed
- Retired
- Homemaker
- Self-employed
- Disability
- Casual/seasonal worker
- Other
- Don't know
- Refused

A.09 What is your **MAIN** source of income? (check ONE box only)

- o Paid legal work
- o Paid work under-the-table (not including sex work)
- o Income assistance (including disability)
- o Drug dealing/drug middling
- o Sex work
- o Criminal activity (e.g., theft, robbery, not including drug dealing)
- o Panhandling
- o Bottle/can collecting
- o Other (specify): _____
- o Don't know
- o Refused

A.10 If you have multiple sources of income, how else do you make money? (check ALL that apply)

- o No other source of income (SKIP TO QUESTION A.11)
- o Paid legal work
- o Paid work under-the-table (not including sex work)
- o Income assistance (including disability)
- o Drug dealing/drug middling
- o Sex work
- o Criminal activity (e.g., theft, robbery, not including drug dealing)
- o Panhandling
- o Bottle/can collecting
- o Other (specify): _____
- o Don't know
- o Refused

A.11 In the past year, what was your estimated monthly income from all sources?

- o Amount: $_____
- o Don't know
- o Refused

Section B. Drug and Alcohol Use

In this section I'm going to be asking you questions about your drug use. By drugs, I mean illegal drugs like cocaine, crack, and heroin. Or non-medical use of legal drugs like oxys, dilaudid, and dexadrine. By non-medical use I mean using these drugs when not prescribed to you, or using them beyond how they are prescribed by a doctor.

B.01 Have you injected a drug for non-medical purposes in the PAST 12 MONTHS?

- Yes (SKIP TO QUESTION B.03)
- No

B.02 Have you ever injected a drug for non-medical purposes?

- Yes
- No (SKIP TO QUESTION B.03b)

B.03 When was the last time you injected a drug for non-medical purposes?

- Today
- Days ago: _____ OR,
- Months ago: _____ (converted to number of days _____)

ASK THE FOLLOWING QUESTION ONLY TO PARTICIPANTS WHO ANSWERED "NO" TO QUESTION B.01 AND "YES" TO QUESTION B.02.
OTHERWISE SKIP TO QUESTION B.04

B.03.a Why did you stop injecting drugs?
(Record participant's response in their own words as best you can)

ASK THE FOLLOWING QUESTION ONLY TO PARTICIPANTS WHO ASNWERED "NO" TO QUESTION B.02. OTHERWISE SKIP TO QUESTION B.04

B.03.b Why have you never injected a drug?

- Fear of infection/disease
- Fear of needles
- Stigma attached to injecting drugs
- Don't know anyone who injects drugs
- Don't hang out with people who inject drugs

- Other (specify):

Note:

- *Participants answering YES to A.01 are considered the 'current injection drug user' (IDU) sample.*
- *Participants answering NO to B.01 are considered the 'current non-injection drug user' (NIDU) sample.*
- *Participants answering NO to A.01 and YES to B.02 are considered the 'former-injector' sample*

B.04 Please indicate your experience with the following drugs. Note that these questions refer only to *non-medical* use.

Drug **Y= yes** **N= no** **DK= don't know**	**Have you ever tried or used the following?**	**Age when first tried?**	**Used in past 12 months?**	**Injected in past 12 months?**	**Number of days the drug was used in the PAST 30 DAYS** **(0-30)**	**Main route of administration in the PAST 30 DAYS?** **O= oral** **N= nasal** **S= smoke** **I= inject**
Alcohol	Y N DK		Y N DK			
Cannabis	Y N DK		Y N DK			
Cocaine powder	Y N DK		Y N DK	Y N DK		
Crack	Y N DK		Y N DK	Y N DK		
Heroin	Y N DK		Y N DK	Y N DK		
Prescription Opioids	Y N DK		Y N DK	Y N DK		
Speedballs	Y N DK		Y N DK	Y N DK		
Crystal meth	Y N DK		Y N DK	Y N DK		
Ecstasy	Y N DK		Y N DK	Y N DK		
Benzodiazepines	Y N DK		Y N DK	Y N DK		
Other: _____	Y N DK		Y N DK	Y N DK		
Other: _____	Y N DK		Y N DK	Y N DK		
Other: _____	Y N DK		Y N DK	Y N DK		
Other: _____	Y N DK		Y N DK	Y N DK		

B.04.a Do you smoke tobacco?

- Yes
- No (SKIP TO QUESTION B.05)
- Don't know (SKIP TO QUESTION B.05)
- Refused (SKIP TO QUESTION B.05)

B.04.b How long have you been smoking tobacco?

- Time period: _____

B.04.c How many days in the past 30 did you smoke tobacco?

- Number or days: _____

B.05 Where do you most typically use drugs? (check ONE box only)
Prompt if participant is unsure: "in the last 30 days where were you most often when using"

- Outdoor public places (street, alleyways, parks)
- Public bathrooms
- My own home
- Friend or partner's home
- Family member's home
- Dealer's home
- Night club/bar
- Crack house/shooting gallery
- Client's home/car (referring to sex workers)
- Workplace
- Other (specify): _____
- Don't know
- Refused

B.06.a Do any of the following people you know inject drugs? (check ALL that apply)

- Friends
- Mother
- Father
- Brother(s)
- Sister(s)
- Other family member
- Partner/Intimate relationship
- Other (specify): _____

B.06.b Who do you most often use drugs with? (check ALL that apply)
Prompt if participant is unsure: "in the last 30 days who were you with most often when using." Emphasis is on "most often"

- Friends who inject drugs
- Friends who do not inject drugs
- Partner who injects
- Partner who does not inject
- Family member who injects
- Family member who does not inject
- Drug dealer
- Sex work clients
- Strangers/people I meet on the street
- Alone
- Other (specify): _____
- Don't know
- Refused

B.07 Have you ever overdosed from drug use?

- Yes
- No (SKIP TO QUESTION B.10)
- Don't know (SKIP TO QUESTION B.10)
- Refused (SKIP TO QUESTION B.10)

B.08 About how long ago was your MOST RECENT overdose?

- Days ago: _____ OR,
- Months ago: _____ (converted to number of days _____)
- Don't know
- Refused

B.09 What drugs were you using when you experienced your MOST RECENT overdose? How much did you use? How did you use them?

Drug (specify)	**Amount used**	**Method of use (O, N, S, I)**

B.09a Who were you with when you experienced your MOST RECENT overdose?

- Friend(s)
- Intimate partner
- Family member(s): Specify: _____
- Drug using acquaintance
- Drug dealer
- Stranger
- Alone
- Other (specify): _____
- Don't know
- Refused

B.09b How did you recover from your MOST RECENT overdose?

- Was given Narcan/Naloxone at a hospital
- Was given Narcan/Naloxone by someone I was with
- Slept it off
- Other (specify): _____
- Don't know
- Refused

B.10 What is the longest period of time you have gone without using drugs since you first started using drugs regularly? To remind you, we're talking about your use of drugs for non-medical purposes.

- Days: _____ OR,
- Months: _____ (converted to number of days _____)
- Don't know
- Refused

B.11 Do you think your drug use is harmful to you/your life in any way?

- Yes
- No (SKIP TO QUESTION B.13)
- Don't know (SKIP TO QUESTION B.13)
- Refused (SKIP TO QUESTION B.13)

B.12 What sort of harms/problems have you experienced from your drug use? (check ALL that apply)

- Physical health problems
- Mental health problems
- Negative effect on friendships/social life
- Marriage/relationship problems
- Work problems

- Financial problems
- Legal problems
- Housing problems
- Other (specify): _____

NOTE: The next set of questions refer ONLY TO ALCOHOL USE. If the participant has never tried alcohol (refer to Question B.04), SKIP TO NEXT SECTION.

B.13 How often did you drink alcoholic beverages in the PAST 12 MONTHS?

- Never (SKIP TO NEXT SECTION)
- Less than once a month
- Once a month
- 2 to 3 times a month
- Once a week
- 2 to 3 times a week
- 4 to 6 times a week
- Every day
- Don't know
- Refused

B.14 How often in the PAST 12 MONTHS have you had 5 or more drinks on one occasion?

- Never
- Less than once a month
- Once a month
- 2 to 3 times a month
- Once a week
- 2 to 3 times a week
- 4 to 6 times a week
- Every day
- Don't know
- Refused

B.15 In the PAST 30 DAYS on how many days did you have 5 or more drinks on one occasion?

- Number of days: _____
- Don't know
- Refused

B.16 Do you think your use of alcohol is harmful to you/your life in any way?

- Yes

- No (SKIP TO NEXT SECTION)
- Don't know (SKIP TO NEXT SECTION)
- Refused (SKIP TO NEXT SECTION)

B.17 What sort of harms/problems have you experienced from your alcohol use? (check ALL that apply)

- Physical health problems
- Mental health problems
- Negative effect on friendships/social life
- Marriage/relationship problems
- Work problems
- Financial problems
- Legal problems
- Housing problems
- Other (specify): _____

Section C. Injection Drug Use

NOTE: This section is only for participants who have ever injected drugs (refer back to Question B.01)

C.01 How old were you when you first injected a drug?

- Age: _____
- Don't know
- Refused

C.01.a How long had you used drugs by non-injection methods before you injected for the first time?

- Days: _____ OR,
- Months: _____ (converted to number of days _____)
- Don't know
- Refused

C.02 Why did you decide to inject for the first time? (check ONE box only)

- Curiosity/experimentation
- Economic reasons (i.e., cheaper to inject)
- Better high
- Coercion

- Peer pressure
- Problems with other modes of injection
- Tolerance to other modes of injection
- Don't know
- Refused

C.03 Who were you with the first time you injected? (check ALL that apply)

- Friend who injects
- Friend who does not inject
- Family member who injects
- Family member who does not inject
- Partner who injects
- Partner who does not inject
- Drug dealer
- Stranger
- Other (specify): _____
- Don't know
- Refused

C.04 Did someone help you inject the first time?

- Yes
- No (SKIP TO QUESTION C.06)
- Don't know (SKIP TO QUESTION C.06)
- Refused (SKIP TO QUESTION C.06)

C.05 Who was it that helped you inject the first time?

Specify: _____

C.06 Had you used drugs (not including cannabis) by non-injection methods before you started injecting?

- Yes
- No (SKIP TO QUESTION C.08)
- Don't know (SKIP TO QUESTION C.08)
- Refused (SKIP TO QUESTION C.08)

C.07 What methods had you used to take drugs before starting to inject? (check ALL that apply)

- Smoked
- Sniffed

- Taken orally
- Other (specify): _____

C.08 Have you EVER shared a needle that was used by somebody else?

- Yes
- No
- Don't know
- Refused

Read to participant:
"The next set of questions refer to the past 12 months. Just to clarify, have you injected a drug in the past 12 months?" (Refer back to Question B.02).

IF THE PARTICIPANT HAS NOT INJECTED IN THE PAST 12 MONTHS SKIP TO NEXT SECTION

C.09 In the PAST 12 MONTHS, about how often have you injected drugs for non-medical purposes?

- Less than once a month
- Once a month
- 2 to 3 times a month
- Once a week
- 2 to 3 times a week
- 4 to 6 times a week
- Every day
- Don't know
- Refused

C.10 In the PAST 12 MONTHS have you shared a needle that was used by somebody else?

- Yes
- No (SKIP TO NEXT SECTION)
- Don't know (SKIP TO NEXT SECTION)
- Refused (SKIP TO NEXT SECTION)

C.11 In the PAST 12 MONTHS about how many times have you shared a needle that was used by somebody else?

- Once or twice
- 3-5 times
- 6-10 times
- 11-20 times
- 21-50 times
- More than 50 times
- Don't know
- Refused

Section D. Non-injection drug use

D.01 In the PAST 12 MONTHS have you used a drug (not including cannabis) by non-injection methods?

- Yes
- No (SKIP TO NEXT SECTION)
- Don't know (SKIP TO NEXT SECTION)
- Refused (SKIP TO NEXT SECTION)

D.02 When using drugs by non-injection methods, how do you most typically use them? (check ONE box only)

- Smoke
- Sniff
- Take orally
- Other (specify): _____
- Don't know
- Refused

D.03 In the PAST 12 MONTHS what drugs have you used by non-injection, and how have you most typically used them?

Drug	Used?			Typical method of use		
Cocaine powder	Y	N	DK	Smoke	Sniff	Oral
Crack	Y	N	DK	Smoke	Sniff	Oral
Heroin	Y	N	DK	Smoke	Sniff	Oral
Prescription opiods	Y	N	DK	Smoke	Sniff	Oral
Crystal meth	Y	N	DK	Smoke	Sniff	Oral
Other:	Y	N	DK	Smoke	Sniff	Oral
Other:	Y	N	DK	Smoke	Sniff	Oral

D.04 Have you ever shared non-injection drug use equipment (i.e., pipes, straws)?

- Yes
- No (SKIP TO QUESTION D.10)
- Don't know (SKIP TO QUESTION D.010)
- Refused (SKIP TO QUESTION D.10)

D.05 Have you ever shared non-injection drug use equipment with someone you know who injects drugs?

- Yes
- No
- Don't know
- Refused

D.06 In the PAST 12 MONTHS have you shared any of the following non-injection drug use equipment? (check ALL that apply)

- Not shared equipment in the past 12 months (SKIP TO QUESTION D.10)
- Drug smoking equipment (i.e., pipes, cans, bottles)
- Drug sniffing equipment (i.e., straws, dollar bills)
- Other (specify): _____
- Don't know
- Refused

D.07 In the PAST 30 DAYS what non-injection drug use equipment have you shared, and what drug(s) were you using?
(*If not shared in the past 30 days SKIP TO QUESTION D.10)*

Drug	**How used?**	**Equipment shared**
e.g., Crack	e.g., smoked	e.g., pipe
e.g., Heroin	e.g., sniffed	e.g., empty pen

D.08 In the PAST 30 DAYS how many times have you shared <u>drug smoking</u> equipment?

- Not in the past 30 days
- Once or twice
- 3-5 times
- 6-10 times
- 11-20 times
- 21-50 times
- More than 50 times
- Don't know
- Refused

D.09 In the PAST 30 DAYS how many times have you shared drug sniffing equipment?

- Not in the past 30 days
- Once or twice
- 3-5 times
- 6-10 times
- 11-20 times
- 21-50 times
- More than 50 times
- Don't know
- Refused

D.10 Do you use drugs with people who you know inject drugs? (*refer back to QUESTION B.06.b)*

- Never
- Sometimes
- Often
- Always
- Don't know
- Refused

D.11 Do you ever feel pressure to inject drugs?

- Never (SKIP TO NEXT SECTION)
- Sometimes
- Often

- Always
- Don't know (SKIP TO NEXT SECTION)
- Refused (SKIP TO NEXT SECTION)

D.12 Who do you feel pressure from to inject drugs?

Specify: _____

Section E. Sexual Risk Behaviour

E.01 Have you ever had sex with somebody who you know injects drugs? Here I'm still talking about injecting drugs for non-medical purposes, but this can also include people you know who are patients in SALOME.

- Yes
- No (SKIP TO QUESTION E.03)
- Don't know (SKIP TO QUESTION E.03)
- Refused (SKIP TO QUESTION E.03)

E.02 In the PAST 12 MONTHS have you had sex with somebody who you know injects drugs?

- Yes
- No
- Don't know
- Refused

E.03 In the PAST 12 MONTHS have you had unprotected sex?

- Yes
- No (SKIP TO QUESTION E.05)
- Don't know (SKIP TO QUESTION E.05)
- Refused (SKIP TO QUESTION E.05)

E.04a Who have you had unprotected sex with in the PAST 12 MONTHS? (check ALL that apply)

- Partner/intimate relationship
- Regular sexual partner
- Friend/acquaintance
- Sex-work client
- Stranger
- Other (specify): _____
- Don't know

- Refused

E.04b What are some situations in which you have unprotected sex? (check ALL that apply)

- Protection (i.e., condoms) is not available
- I want to
- Partner wants to
- Pressure from sex work client
- Sex work client pays to
- Other (specify): _____
- Don't know
- Refused

E.05 Have you ever exchanged sex for money, drugs or anything else?

- Yes
- No (SKIP TO QUESTION E.08)
- Don't know (SKIP TO QUESTION E.08)
- Refused (SKIP TO QUESTION E.08)

E.06 In the PAST 12 MONTHS have you exchanged sex for money, drugs or anything else?

- Yes
- No (SKIP TO QUESTION E.08)
- Don't know (SKIP TO QUESTION E.08)
- Refused (SKIP TO QUESTION E.08)

E.07 What have you exchanged for sex in the PAST 12 MONTHS? (check ALL that apply)

- Drugs
- Alcohol
- Money
- Somewhere to sleep
- Other (specify): _____

E.08 About how many sexual partners have you had in the PAST 12 MONTHS?

- One
- 2-4
- 5-10

- More than 10
- Don't know
- Refused

Section F. Health

F.01 Currently, how would you rate your overall physical health?

- Excellent
- Very good
- Good
- Fair
- Poor
- Don't know
- Refused

F.02 Currently, how would you rate your overall mental health?

- Excellent
- Very good
- Good
- Fair
- Poor
- Don't know
- Refused

F.03 Can you tell me about any current physical or mental health issues? And are they adequately being addressed (i.e., are you receiving treatment?) (*record participant's response as best you can)*

F.04 Have you ever been tested for HIV?

- Yes
- No (SKIP TO QUESTION F.05)
- Don't know (SKIP TO QUESTION F.05)
- Refused (SKIP TO QUESTION F.05)

F.05 What was the result of your most recent HIV test?

- HIV positive
- Indeterminate

- HIV negative
- Don't know
- Refused

F.06 Have you ever been tested for hepatitis C?

- Yes
- No (SKIP TO NEXT QUESTION)
- Don't know (SKIP TO NEXT QUESTION)
- Refused (SKIP TO NEXT QUESTION)

F.07 What was the result of your most recent hepatitis C test?

- HCV positive
- Indeterminate
- HCV negative
- Don't know
- Refused

Section G. Crime, Violence, the Law

G.01 Do you have a criminal record?

- Yes
- No
- Don't know
- Refused

G.02 Have you been stopped/searched by the police in the PAST 12 MONTHS?

- Yes
- No (SKIP TO QUESTION G.08)
- Don't know (SKIP TO QUESTION G.08)

- Refused (SKIP TO QUESTION G.08)

G.03 How would you rate your interactions with the police when you have been stopped/searched by them in the PAST 12 MONTHS?

- Positive
- Neutral
- Negative
- Don't know
- Refused

G.04 Can you briefly elaborate on any positive or negative experiences with having been stopped/searched by the police in the PAST 12 MONTHS?
(Take notes on what the participant says)

G.05 Have you been stopped/detained by a security guard in the PAST 12 MONTHS?

- Yes
- No (SKIP TO QUESTION G.08)
- Don't know (SKIP TO QUESTION G.08)
- Refused (SKIP TO QUESTION G.08)

G.06 How would you rate your interactions with security guards when you have been stopped/detained by them in the PAST 12 MONTHS?

- Positive
- Neutral
- Negative
- Don't know
- Refused

G.07 Can you briefly elaborate on any positive or negative experiences with having been stopped/detained by the security guards in the PAST 12 MONTHS?
(Take notes on what the participant says)

G.08 Have you been arrested in the PAST 12 MONTHS?

- Yes
- No (SKIP TO QUESTION G.07)
- Don't know (SKIP TO QUESTION G.07)
- Refused (SKIP TO QUESTION G.07)

G.09 How many times have you been arrested in the PAST 12 MONTHS?

- Number of arrest: _____

G.10 For what reason(s) have you been arrested in the PAST 12 MONTHS?

- List reasons:

G.11 Have you had your drug use equipment (pipes, needles, cookers, etc.) confiscated or broken by the police or security guards in THE PAST 12 MONTHS?

- Yes
- No
- Don't know
- Refused

G.12 In the PAST 12 MONTHS have you been involved in any of the following criminal activities? (check ALL that apply)

- Drug dealing
- Drug middling
- Theft from a store
- Broke into a car
- Broke into a house/apartment/condo/hotel room
- Robbed someone
- Stolen a car
- Stolen a bike
- Other (specify): _____
- Don't know
- Refused

G.13 In the PAST 12 MONTHS have you been robbed/mugged?

- Yes
- No

- Don't know
- Refused

G.14 In the PAST 12 MONTHS have you been assaulted?

- Yes
- No
- Don't know
- Refused

G.15 In the PAST 12 MONTHS have you assaulted someone?

- Yes
- No
- Don't know
- Refused

G.16 In the PAST 12 MONTHS have you been in physical fights with anyone?

- Yes
- No
- Don't know
- Refused

Section H. Stigma and Discrimination

H.01 Have you ever experienced stigma or been discriminated against? By stigma and discrimination I mean feeling that people are treating you negatively or unfairly for some reason.

- Yes
- No (SKIP TO NEXT SECTION)
- Don't know (SKIP TO NEXT SECTION)
- Refused (SKIP TO NEXT SECTION)

H.02 In the PAST 12 MONTHS have you experienced stigma or been discriminated against?

- Yes
- No
- Don't know
- Refused

H.03 Why do you think you have been stigmatized or discriminated against? (check ALL that apply) *read list to participant*

- Because I use drugs
- Because I inject drugs
- Because I smoke crack
- Because of my gender
- Because of my sexual orientation
- Because of my race/ethnicity
- Because of how I look
- Because I am homeless
- Because I have HIV
- Because I have Hepatitis C
- Because I am involved in sex work
- Other (specify): _____
- Don't know
- Refused

H.04 Who have you experienced stigma or discrimination from? (check ALL that apply) *read list to participant*

- Family doctor
- Emergency department nurse/doctor
- Street nurse
- Social service staff (i.e., drop-in centre staff)
- Police
- Friends
- Family members
- Strangers (i.e., people on the street)
- Housing staff (i.e., SRO/motel manager)
- Landlord
- Other (specify): _____
- Don't know
- Refused

H.05 How do you think being stigmatized or discriminated against has affected you? (check ALL that apply) *read list to participant*

- Prevented me from seeking health care
- Prevented me from seeking drug treatment
- Received inadequate health care/treatment
- Prevented me from getting housing, or got evicted
- Led to being detained or arrested
- Prevented me from obtaining legal representation
- Prevented me from getting a job, or got fired from a job
- Strained/lost relations with family
- Strained/lost relations with friends
- Other (specify): _____
- Don't know
- Refused

Section I. Social and Health Service Utilization

I.01 Which of the following services did you use in the PAST 12 MONTHS?

I.02 How would you rate your experience with the services you used in the PAST 12 MONTHS?

I.03 For the services you did not use in the PAST 12 MONTHS, was it because: a) you did not need them, or b) they were not available/accessible to you?

Facility/service	**Used PAST 12 MONTHS? (circle one)**	**Rating (circle one)**	**Did not need (X)**	**Could not access (X)**
Income assistance	Y N DK	Pos Neut Neg		
Drop-in centre	Y N DK	Pos Neut Neg		
Shelter	Y N DK	Pos Neut Neg		
Food bank	Y N DK	Pos Neut Neg		

Family doctor	Y N DK	Pos Neut Neg		
Walk-in clinic	Y N DK	Pos Neut Neg		
Street nurse	Y N DK	Pos Neut Neg		
Emergency room	Y N DK	Pos Neut Neg		
Street outreach	Y N DK	Pos Neut Neg		
Needle exchange	Y N DK	Pos Neut Neg		
Pipe distribution	Y N DK	Pos Neut Neg		
Detox	Y N DK	Pos Neut Neg		
Methadone program	Y N DK	Pos Neut Neg		
Addiction treatment	Y N DK	Pos Neut Neg		
Other:	Y N DK	Pos Neut Neg		

I.04 Are you currently, or have you ever been, a participant in an experimental drug treatment trial (example: NAOMI, SALME)?

- Yes, specify: _____
- No (SKIP TO QUESTION I.06)
- Don't know (SKIP TO QUESTION I.06)
- Refused (SKIP TO QUESTION I.06)

I.05 Can you briefly tell me your experience with the program? (Probe: In what ways is/was it beneficial or harmful? Pros and cons?) (record participants response):

I.06 Are you currently in any kind of drug treatment program?

- Yes
- No (SKIP TO QUESTION I.08)
- Don't know (SKIP TO QUESTION I.08)
- Refused (SKIP TO QUESTION I.08)

I.07 What kind of drug treatment are you currently receiving?

- Kind of treatment: _____

(THEN SKIP TO NEXT SECTION)

I.08 If not in treatment, do you currently want to, or are you trying to get in to, drug treatment?

- Yes
- No
- Don't know
- Refused

End of Survey

We are now finished the short survey, and will be moving on to the open-ended interview. Before moving on are there any other comments you would like to make? Any suggestions about the survey?

In this next part of the interview we will be exploring in more detail many of the topics covered in the survey we just did. I encourage you to speak freely on the topics covered. And if I don't ask about something you feel is important, please tell me and we will talk about that.

Drug Use-Related Risk Behaviour Among Drug Injectors and Non-injectors: Interview Guide
(Draft: Mar 4)

1) Opening Questions

i. Tell me a bit about yourself. How long have you been in Vancouver? [If not from Vancouver] What brought you here? What part of Vancouver did you come to?

ii. Earlier you told me about your housing situation. Remind me, where do you spend most of your nights? How would you say your current housing situation affects your daily life/activities?

Probe: How long have you been on the street/living at _____? What would you like to see changed about your current housing situation?
What circumstances led to you being on the street? How did you end up on the street?

iii. If a resident of the DTES: What is life like for you living in the DTES? What do you like about it? What do you not like about it? Can you tell me about positive and negative experiences of life in the DTES?

iv. If lives elsewhere: Why do you come to the DTES? How much time do you spend here? Why do you live elsewhere?

2) Drug use history & general drug use

In this next section we will be talking about your use of drugs. By drugs, I mean illegal drugs like cocaine, crack, and heroin. Or non-medical use of legal drugs like oxys, dilaudid, and dexadrine. By non-medical use I mean using these drugs when not prescribed to you, or using them beyond how they are prescribed by a doctor.

i. Can you tell me about when you first started using illicit drugs? Or legal drugs (like morphine for example) for non-medical purposes? Where/how old/what circumstances/who with?

Probe: What was 1st drug used?
Why did you start using?
What was going on in your life when you started using?

ii. Has your drug use changed over time? If yes: How?

iii. What drugs do you currently use, and how do you use them?

iv. Can you tell me about the last time you used a drug? Where, with who, how?

v. What is your primary drug of choice? And method of use?

vi. Why do you use drugs in that way (i.e., why do you smoke or inject these drugs?)

vii. What do you like about drugs? What is good about using drugs? How has drug use been helpful, positive, or enjoyable?

viii. Is there anything that you dislike about using drugs? How have they been harmful, or negatively affected your life?

3) Method of drug use

i. How do you typically use your drugs?

ii. Why do you use your drugs in this way?

In this section participants will be encouraged to talk about their preferred or chosen method of use.

Current-IDUs: how long they have been injecting, age of first injection, circumstances and context of first injection, have they ever stopped injecting, do they see themselves stopping IDU, have/do they share needles (why, who with, etc)

Never-injectors: why have they never injected drugs, do they see themselves ever injecting, have they come close to injecting but changed their minds, do they share NIDU equipment (why, with who, etc)

Former-injectors: when did they stop injecting and why, how long had they injected for, why did they start injecting, circumstances and context of first injection, what is the longest period gone not injecting, did they ever share needles, do they share NIDU equipment (why, with who, etc)

4) Social networks

i. Would you say you have a main social network or group of friends? Can you describe this group of friends? *(Probe: Does your group of friends include other drug users? Injectors? Non-injectors? What do you tend to do with them?)*

ii. Are you married or in a committed relationship? If yes, does your intimate partner use drugs? Does your partner know about your drug use? Do drugs

play any role in your relationship? Are drugs good or bad for your relationship? How so?

iii. Do you have friends who do not use drugs? If so, do they know about your drug use? And how do they feel about it? Supportive or judgmental?

iv. Do you have a relationship with any of your family members (parents, siblings, etc)? How would you describe your relationship with them? Do they know about your drug use? Your current social/financial situation (i.e., if they live on the street)? If so, how do they feel about it?

v. Do you ever feel pressure from friends/family members/partners to use and/or inject drug? How do you deal with that pressure? How does it make you feel? Do you ever do/inject drugs because of peer pressure? Can you tell me about a situation where you did drugs/injected drug because of peer pressure?

5) Risk behaviours and other social/environmental factors

This section will largely be guided by the participants responses in the above surveys on the topics of sexual risk behaviours, interactions with law enforcement and the legal/penal system, criminal involvement, experience with violence, experiences of stigma and discrimination.

Example questions:

i. Earlier you told me you experience discrimination from XX_____. Can you tell me what makes you feel this way? What made you think you were being discriminated against? And how do these experiences impact your use of or access to health and social services? How does experiencing discrimination affect your daily life?

ii. Earlier you mentioned having negative interactions with the police or private security guards. Can you tell me about a recent time you experienced this? How do you think the situation could have been handled differently?

6) Social & Health Issues

i. How would you rate your overall health? Physical health? Mental health?

ii. What physical health problems have you had/been dealing with recently? Long term? Do you feel they're related to your drug use? How so?

iii. What mental/emotional health problems have you had/been dealing with recently? Long term? Do you feel they're related to your drug use? How so?

iv. What do you do to stay healthy?

v. What social, health and harm reduction services do you incorporate into your life? Used recently? Using regularly? What are your experiences with the services you use?

vi. Do your experiences with the services you use, or choose not to use, determine how often you use them, if at all? Can you elaborate? *(Probe: Are there obstacles to obtaining health and harm reduction services? Social services?)*

vii. How do you think the services could be improved?

Probe: Earlier you told me you don't use [health service]. What could be done/improved that would encourage you to use that [health service]? What kinds of harm reduction or health services would you like to see implemented that the city doesn't have? How could the current harm reduction programs you use be improved?

7) Closing questions

i. Are there any other issues you would like to talk about? Is there anything you would like to add that might help others understand your situation/what it is like to be homeless/a drug user/resident of the DTES?

ii. Do you have any questions for me?

Participants will then be thanked for participating in the study. They will also be provided with contact information should they wish to see the results of the study. They will also be informed that results will be made available at the service agencies once the study is completed.

Time ended: _____AM/PM

Total interview time:

NOTES:

Appendix B

PARTICIPANT SCREENING INSTRUMENT

1. *How old are you?*
   - Participants under the age of 19 are not eligible for this study. This is a mandatory requirement to participate.
   - If the participant is under the age of **19**, complete the screener and **inform participant of ineligibility at the end of the screener**.

2. *Have you used drugs other than alcohol and marijuana in the **past 12 months**?*
   - Participants must use drugs in order to be eligible for this study. This is a mandatory requirement to participate.
   - If the participant does not use drugs, complete screener and **inform participant of ineligibility at the end of the screener.**

3. *About how often have you used drugs **in the past 12 months?***
   - Participants must have used drugs at least once per month in the past 12 months.
   - If the participant has not used drugs this frequently, complete screener and **inform participant of ineligibility at the end of the screener.**

4. *Have you **ever** injected drugs for non-medical purposes?*
   - Participants who have never injected drugs will be considered <u>never-injectors</u>.
   - If the participant has ever injected, ask the following question.

5. *Have you injected drugs for non-medical purposes in the **past 12 months**?*
   - Participants who have NOT injected in the past 12 months will be considered <u>former-injectors</u>.
   - If the participant has injected drugs in the previous 12 months, ask the following question.

6. *About how often have you injected drugs for non-medical purposes in the **past 12 months**?*
   - Participants must have injected drugs at least once per month in the past 12 months.
   - If the participant has not injected drugs at least monthly they will not be eligible for the study.

~ End of Screening Questionnaire ~

If the participant is **<u>not</u> eligible** for the study read:

Thank you for your time, regretfully, you are not eligible for the study. Would you like any information about health and social services in Vancouver?

If the participant **<u>is</u> eligible** for the study read:

OK. You are eligible for our study. Are you still interested in participating?
- If **"no"**, say: *Thank you for your time.*
- If **"yes"** and screening in-person: attempt to conduct interview immediately
- If **"yes"** and screening over the phone: arrange a day and time to conduct an interview at one of the study sites (*to be determined)*

Appendix C

Participant Consent Form

The social-structural production of risk behaviour among marginalized non-injection drug users.

You are invited to participate in a study entitled *The social-structural production of risk behaviour among marginalized non-injection drug users* that is being conducted by Andrew Ivsins.

Mr. Ivsins is a PhD student in Sociology at the University of Victoria and Centre for Addictions Research of BC (CARBC). You may contact Mr. Ivsins if you have further questions by phone at 778-874-5026.

Purpose and Objectives

This is a study of drug use and in Vancouver. The purpose of this research project is to examine social and health risk behaviours of street-involved non-injection drug users. The goal of the research project is to learn more about the experiences of non-injection drug users, and about the various risks and harms associated with use of drugs by non-injection methods.

Importance of this Research

Research of this type is important because there is very limited research on this population, and the prevention of health risks associated with drug use is very difficult. Your participation will help us better understand the characteristics of both injection and non-injection drug users, provide information to assist in the development of interventions and treatment programs, and recognize the needs for and possible use of targeted health interventions presently considered for people who use drugs by non-injection methods.

Participant Selection

You are being asked to participate in this study because you regularly use drugs. You also must be 19 years of age or older to participate in this study.

What is involved?

If you agree to voluntarily participate in this research, you will be interviewed about your drug use history and current drug use. You will also be asked about problems related to your use of drugs, and questions about your health and use of health care and social services. You have the right to refuse to answer any question, and there will be no consequence for refusing to answer any questions. The interview will last approximately 60-90 minutes.

Inconvenience

Participation in this study may cause some inconvenience to you**,** including the travel time to and from the research site, and the time required for the interview.

Risks

There are some remote but potential risks to you by participating in this research and they include possible negative emotional response to some of the questions in the interview pertaining to your drug use. You may refuse, for any reason, to answer any questions that make you feel uncomfortable, and there will be no consequences for refusing to answer any questions. You should know that using street drugs can be dangerous and the interviewer will be willing to assist you in referring you to expert help at any time. The interviewer will provide you with information on receiving information or support for drug use/mental health concerns. The interviewer can also provide referrals to other local social service and health agencies.

Benefits

The potential benefits of your participation in this research include contributing to a project that will ultimately benefit others in a situation similar to yours, and to society as a whole. Participation in this study will contribute to gaining a better understanding of the issues surrounding non-injection drug use, as well as the potential to better inform treatment and prevention programs. This research has the potential to contribute to policy or programs concerning illicit substance use and public health.

Compensation

As a way to compensate you for any inconvenience related to your participation in this study, you will be given a $20 honorarium. Should you choose to withdraw from the study at any time after consent, for any reason, you will still receive the $20 honorarium. If you agree to participate in this study, this form of compensation to you must not be coercive. It is unethical to provide undue compensation or inducements to research participants. If you would not participate if the compensation was not offered, then you should decline.

Voluntary Participation

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. However, because your data are collected without any personal identifying information, it will be impossible to remove your data from the database if you do withdraw from the study.

Anonymity

Your privacy and anonymity will be protected by the use of an anonymous study code and pseudonym in place of your name. Your participation in this study will be anonymous to the extent that we will *not* collect *any* personal information (e.g. your name, address, etc.) that would allow anyone to identify you.

Confidentiality

Your confidentiality and the confidentiality of the data will be protected by locking all transcripts of the interview a filing cabinet, and using password protection and other electronic security measures for the electronic files. No one has access to these files without the permission of the study Principal Investigator. All documents associated with your interview will be identified only by an anonymous study code. You will never be identified by name in any reports derived from the completed study. Only pseudonyms will be used in the report. While confidentiality is ensured, we are required to report any future indications to harm yourself or others.

It is anticipated that the results of this study will be shared with others in the following ways: to participants upon request; in published articles; in presentations at scholarly meetings; in presentations/reports to health and social service providers, and to public health policy makers.

Disposal of Data

Data from this study will be disposed of five years after the last publication or scholarly presentation of the research data by shredding paper records and by electronic erasure of computer files.

Contacts

Individuals who may be contacted regarding this study include Mr. Andrew Ivsins.

In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Associate Vice-President, Research at the University of Victoria.

By verbally agreeing to participate in the study and by completing the questionnaire, **you are providing your free and informed verbal consent.** This shows that you understand the above conditions for participating in this study and that you have had the opportunity to have your questions answered by the researchers.

Please retain a copy of this letter for your reference.