Navigating Conservative Drug Policy in Ontario's Safe Consumption Sites:

A Critical Investigation of Harm Reduction Policy and Practice

By

Stephanie Arlt
B.A McMaster University, 2016
M.A McMaster University, 2018

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**Supervisory Committee**

Dr. Karen Urbanoski, School of Public Health and Social Policy
Supervisor

Dr. Lisa Mitchell, Department of Anthropology
Co-supervisor

# Abstract

As harm reduction is increasingly integrated into social and health services and programs, it is essential to recognize the tension between healthcare provided by mainstream institutions and the values of harm reduction. Based on ten interviews with frontline staff who work at safe consumption sites in Ontario, Canada, I explore the challenges of providing harm reduction services under the 2018 Progressive Conservative Government's Consumption Treatment Service (CTS) reform. My study interrogates the sociopolitical assumptions about drugs and drug use within the CTS policy and examines practices of micro-policy implementation by frontline staff. I characterize` harm reduction as an ontological expression rooted in the lived experience of drug use that places value on relationships and depathologizing drug use. I ask how frontline staff respond to the CTS policy if it changes their understanding and practice of harm reduction and how the policy is accommodated, refused, and disrupted? To answer these guiding questions, I turn my attention to investigating Policy Navigation Practices (PNP) which I define as the creative discretion staff use to balance policy implementation in their encounters with guests. I apply critical medical anthropology theory and methodology to analyze public health policy and services for people who use drugs. This research illuminates the gulf between the lived experience of drug use and the Ontario provincial government's response to the overdose crisis. I prioritize how networks of care emerge in relation to and are embedded into, sociopolitical contexts that force these practices of care into existence. I situate Safe Consumption Sites (SCS) under the CTS policy as a microcosm of two conflicting worldviews about substance use, ideas of health, and forms of care. The findings advance our understanding of policy implementation practices in SCS and harm reduction as a form of care.

*Key words:* Harm reduction; health policy; care; safe consumption sites; Ontario, consumption treatment service, ethnography

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*“Our task is to learn the new language of struggle and, by learning, to participate in its formation.”*
John Holloway, *Crack Capitalism*

*"Knowledge is a mirror and for the first time in my life I was allowed to see who I was and who I might become."*
David Mitchell, *Cloud Atlas*

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# Dedication

To my nana, Martina Atzori.
Per te, con te, e perché tu.

# Chapter One: Introduction

## 1.1 Research Context: Conceptualizing a Crisis

Jane, a Harm Reduction Worker, told me, "No matter what kind of policy came into effect, I would do the best care for my client anyway." Like other frontline staff I interviewed, Jane was clear in her approach to caring for People With Lived and Living Experience of drug use (PWLLE)[1], "At the end of the day I fight 'til I get [it], if I believe it's the correct thing for the client then I'm gonna do whatever I have to make sure that happens." Jane works in one of twenty-four supervised consumption sites (SCS) in Ontario. Since 2018, 8,312 people across the province have died from an opioid overdose (Government of Canada, 2022a). Jane was one of many participants who felt a sense of responsibility to address this crisis. It is that commitment to providing care that shapes how she responds to the range of circumstances she encounters in her daily work.

The overdose crisis continues to unfold across Canada[2] while governments and public health authorities have repeatedly failed to take actions to save lives (Fischer et al., 2019; Kolla et al., 2019). There is a long history of PWLLE and activists taking matters into their own hands (Smith, 2012). For example, community efforts include the operation of underground naloxone distribution, grassroots drug checking, PWLLE organized safe supply, operating underground needle exchanges, and unsanctioned Overdose Prevention Sites (OPS) (Kerr et al., 2017). The introduction of the Consumption Treatment Service (CTS) policy (Government of Ontario,

[1] There are other common terms such as "drug user/s" or "People Who Use Drugs", however not everyone involved in drug policy advocacy and further, not all participants in this study, currently use drugs. Thus, PWLLE was selected because it is a more temporally expansive term that allows for a variety of encounters with drugs throughout one's life.

[2] Within Canadian public health literature, the year 2015 is considered as the beginning of the overdose crisis, marked by when fentanyl poisoning began. Rates of overdoses dramatically increased due to the emergence of illicitly manufactured fentanyl on the drug market (Kerr et al., 2017).

2018c, 2018b) has led to a similar situation. To address the high rates of overdose deaths, in October 2018, the recently elected Ontario Progressive Conservative government under the Ford administration unveiled their policy reform that renamed SCS to CTS. Jane and other participants informed me that the policy reform imposed changes to staffing structures, reporting procedures, and notably required integration into Community Health Centres (CHC) as a stipulation to receive funding. Further, the expectation within the policy that SCS will lead to the succession of drug use is increasingly at odds with the type of care frontline workers find PWLLE require. Jane's dilemma forms the essence of what this thesis explores.

## 1.2 Background: What is Harm Reduction?

Harm reduction is the central organising concept of this thesis. There is no ubiquitously agreed upon definition of harm reduction (Harm Reduction International, n.d.). However, it is agreed upon that harm reduction seeks to reduce consequences associated with drug use rather than eliminating drug use itself. Harm reduction includes elements of rationalism by recognizing drug use as an inescapable fact and response to experiences of trauma and poverty. Supervised consumption sites and harm reduction have been extensively researched, and shown to be an effective strategy in mitigating drug-related deaths and harms [3] (Kerr et al., 2017; Klein, 2020). . Following this line of thinking, harm reduction is linked to pragmatism— whatever works, works and without judgement (Klein, 2020). Harm reduction is often considered to be value neutral, however that does not mean it is value free. The values embedded in harm reduction are evident in the principles (see Appendix A) that comprise harm reduction theory and practice (Pauly, 2008). Central to harm reduction are the ideas that an individual is worthy of a healthy

[3] See Levengood et al., (2021) in which a systematic review of quantitative studies of SCS across the globe found SCS reduce morbidity, mortality, and risky injection behaviours amongst other outcomes.

life regardless of their personal habits. A harm reduction approach rejects the expectation that individuals be abstinent or aim for sobriety to be worthy of care.

The origins of harm reduction efforts, born out of grassroots efforts by PWLLE for PWLLE, are rooted in needle exchanges, which materialised during the HIV/AIDS crisis of the late 1980's and early 1990's. At this time, PWLLE were experiencing high rates of blood-borne illnesses contracted from sharing syringes and other gear for drug use. Since its inception, harm reduction's values and philosophy have included the recognition of systemic inequalities that we understand as the social determinants of health, as well as models of restorative justice (Smith, 2012). Harm reduction as a philosophy and social movement rejects authoritarian and punitive approaches. The political orientation of harm reduction is based on anarchist beliefs about the state's inability to correctly identify sources of harm and well-being (Klein, 2020). Since harm reduction was created by PWLLE, a key aspect is its grounding in the needs, voices, and experiences of those most affected by drug prohibition. As harm reduction is increasingly integrated into social and health services and programs, it is important to recognize the tension between state provided healthcare and the origin of harm reduction as an explicit response to the state's failures. Due to the widespread mistreatment of PWLLE by authorities and poor uptake of harm reduction's values in existing medical and social institutions, harm reduction is most effective when it is conceptualised and enacted by PWLLE themselves (Boucher et al., 2017, p. 4).

In this thesis, I view harm reduction as an ontological expression. Specifically, harm reduction is conceptualized as a form of care that is rooted in a particular lived experience and method of thinking about and being in the world. Harm reduction as practised by experiential workers—individuals employed in sites who are PWLLE— is an enactment of social claims

about the world. As such, harm reduction operates as an alternative to long standing prohibition informed realities. Harm reduction involves practises of ways of knowing and relating to drugs and drug use that are rooted in the experiences of PWLLE. While the application of these experiential ways of knowing and being can be adopted by people who do not have lived experience of drug use in service provision, it is key to elevate the PWLLE knowledge in health service policy and operations. My intention is to evaluate how these practises are sustained or influenced by the CTS policy reform, primarily through the mechanism of increased medical institutionalisation under neoliberal policy.

If policy provides insight into the priorities of governance, then refusals can offer insight into the priorities of the governed. The CTS policy offers a window into understanding the tensions between community-oriented practice and an exercise of governance attempting to form a certain type of neoliberal subject. Given that SCS have a strong grassroots origin, developed by PWLLE who possess a material reality of drug use that manifests in their social practices, I seek to illuminate the tensions embedded in the institutionalization of harm reduction through the Ontario CTS policy reform.

## 1.3 Research Problem: Coping with a Conservative Policy Reform to Safe Consumption Sites

This thesis grew out of previous work which involved a Critical Discourse Analysis (CDA) I conducted on the CTS policy using Bacchi's (Bacchi, 2012) "What is the Problem Represented to be?" (WPR) policy-as-discourse analytical framework (Arlt, 2022). The WPR framework is comprised of six questions[4] that aim to problematize assumptions, values and

[4] **1)** What is the 'problem' represented to be in a specific policy? **2)** What presuppositions or assumptions underlie this representation of this 'problem'? **3)** How has this representation of the 'problem' come about? **4)** What is left unproblematic in this 'problem' representation? Where are the silences? Can the 'problem' be thought about

power relations within policy proposals (Bacchi, 2012). The WPR method acknowledges the social and political context that informs the policy process and illuminates how problems identified in a policy are representative of dominant cultural and social beliefs. I applied this framework to the CTS policy because "moral and social claims about drug use manifest in policy, securing the social legitimacy that public policy commands" (Duff, 2021). I sought to identify how the broader sociopolitical discourse surrounding drug use, PWLLE and SCS were reproduced and perpetuated in the CTS policy. Bacchi's (2012) fifth question asks, "what effects (discursive, subjectification, and lived) are produced by the representation of the "problem?". In the CDA, I identified discursive/subjective assumptions within the CTS policy. The primary findings include the lack of recognition of the social determinants of health, drug use and addiction as the source of the overdose crisis and regulating subjects through an emphasis on abstinence-based treatment and views[5]. My thesis research seeks to answer the "lived" component of the fifth question.

The spurious references to harm reduction approaches in the CTS policy are overshadowed by the explicit discursive privileging of abstinence (Arlt, 2022). I want to explicitly state that harm reduction is not in opposition to treatment, and its categorical distinction within this thesis is to shine light on processes of governance that lead to specific forms of subject making. I aim to investigate frontline staff's response to the aspects of the policy that undermine the foundation of harm reduction. Many SCS staff do not privilege perspectives of drug-use as inherently harmful and in need of amelioration from SCS guests. As

differently? **5)** What effects (discursive, subjectification, and lived) are produced by this representation of the "problem"? **6)** How and where has this representation of the "problem" been produced, disseminated, and defended? How has it been and/or can it be questioned, disrupted, and replaced?

[5] I further detail how these themes arose and shaped my understanding of the policy in chapter two

such, my thesis focuses on the meaning behind the tensions SCS frontline workers experience as they practice a form of care rooted in experiential knowledge of drug use with increased institutionalization of harm reduction service. In my research, I ask how staff practice care within a policy and political context that is at odds with their values.

To answer this guiding question, I turn my attention to investigating Policy Navigation Practices (PNP), which I define as the creative discretion staff use when enacting policy implementation in their encounters with guests. Attention to resistance and refusals within significant sites of cultural and political practice is needed (Kingfisher & Maskovsky, 2008). This study attempts to capture these moments and practices through interviews with frontline staff.

My analysis follows how practices of care that are rooted in particular lived experiences become constrained and enabled by broader social forces within and beyond SCS. Using the lens of critical interpretive theory, I present harm reduction as an alternative to the nature of existence under prohibition and one that is rooted in experiential knowledge of PWLLE.

## 1.4 Research Questions

I formulated these questions to understand frontline staff's thoughts and practices of providing care in the context of the CTS policy change.

1. What are SCS frontline worker's responses to and positions on the SCS to CTS policy reform?
2. How has this policy change shaped the implementation of harm reduction ideas and practices at CTS sites?
3. How is this policy accommodated, refused, and disrupted?

## 1.5 Significance: Pubic Health Problems Through the Lens of Anthropology

Critical medical anthropologists have long focussed on the politics of health systems, using policy and health staff as an entry point into the power structures that operate in the complex systems that shape health outcomes (Closser et al., 2022). I aim to advance our understanding of the social influences of health outcomes for PWLLE by scrutinizing the diverse ideas of care enacted by those tasked with implementing health policy.

Applying an anthropological lens to public health topics can help to identify underlying cultural assumptions about health and illness that guide political and medical interventions. Much qualitative work in public health relies heavily on frameworks that consist of boxes and arrows, a mechanistic depiction of humans and society, whereas an anthropological approach offers a people-centred view of a health system and its actors with an emphasis on complexity (Closser et al., 2022, pp. 114313-114314). I approach the topic of harm reduction and health as interconnected with a broader sociopolitical context that acknowledges the continuity of social forces in frontline staff's daily practices. Closser and Finley (2016) argue that the one of the greatest challenges to healthcare is a widespread adoption of useful and effective clinical practices that reduce suffering. Thus, in addition to an examination of the sociopolitical context, in this thesis I offer an in-depth account of the unique conditions that frontline staff draw their practice from.

Applying an anthropological lens to health policy means questioning how policies function as a tool of governance and why they sometimes fail to function as intended (Shore et al., 2011). Framing policy as a cultural category offers a more nuanced approach, going further to consider what constitutes policy. Closser and colleagues (2022) state that with few notable

exceptions, anthropology is missing from health systems research. The authors go on to say that within anthropology there is no defined “health system” with the aim of an anthropological investigation is not to “explore the meaning of a ‘health system’ in an abstract sense, but rather in describing the complexities of a system as it plays out in the political cultural, and social context”. Such an approach complements health promotion's move from an individual-based to a sociopolitical context of health (Cook, 2005, pp. 129–130).

## 1.6 Thesis Organization

This thesis is divided into five chapters. The first chapter introduced the context, the research problem, and the main research objective and questions. The second chapter presents a brief history of SCS in Canada and Ontario and provides an overview of the CTS policy, along with a summary of relevant public health and social theory literature. Chapter three outlines my approach of a critical methodology paradigm and interview and data analysis methods. The next two chapters present the data as embedded in various system-levels and demonstrate the interconnectedness between the individual experience and the broader social forces. To best trace the relationship between social mechanisms of power and frontline staff’s experiences, chapter four and five’s findings and discussion sections are interwoven. This technique is common in the field of anthropology and allows for the production of a rich narrative between findings and interpretation. Chapter four addresses the first two research questions: what are CTS frontline worker’s responses to and positions on the SCS to CTS policy reform? And how has this policy change shaped the implementation of harm reduction ideas and practices at CTS sites? In chapter five, I answer the third and final research question: how is this policy accommodated, refused, and disrupted? In chapter six I conclude by summarizing the research findings, the implications

for research in the social determinants of health for PWLLE, anthropology's contribution to health policy, and relevance for future work.

# Chapter Two: Theoretical and Empirical Literature Review

## 2.1 Introduction

In this chapter, I introduce the research studies and theoretical literature my research draws upon and to which it contributes. I begin with an overview of the history of SCS in Canada with a focus on sites in British Columbia (BC) as exemplary and Ontario for context. I then move onto a discussion of critical studies of harm reduction services and supports to lay the foundation for my theoretical inquiry. The literature provides a critical analytical account of the integration of harm reduction services into mainstream health institutions. I include a review of the critical discourse analysis I conducted on the CTS policy because it was the starting point for my research questions. The CDA situates my thesis research within broader sociopolitical dynamics of beliefs around drug use. I then present relevant literature on critical policy analysis with an emphasis on neoliberalism, presenting policy as a concept that is rich for critical analysis. This section includes how care is situated within an individual-focussed neoliberal society and how we can otherwise enact care. I conclude with a review of mechanisms of micro-policy implementation and introduce a concept I termed policy navigation practices to describe participants' engagement with policy.

## 2.2 Overview of Safe Consumption Sites in Canada: History and Terminology

In this section, I provide a brief historical account of the development of SCS in Canada starting in BC where I introduce the terminology and principles associated with SCS. I then detail the shift from the emergence of OPS in Ontario to the CTS model, emphasising the

grassroot civil disobedient nature of drug user healthcare provision. I end by narrowing my focus onto the relevant features of the CTS policy for this thesis.

Safe Consumption Sites (SCS), sometimes referred to as Supervised Injection Facilities (SIF) or Supervised Injection Sites (SIS), first began to arise in Canada during the early 2000's with some sites evolving out of unsanctioned operations. A note on terminology, I will refer to the policy change as "CTS" and the physical site as "SCS". I use the term consumption rather than injection to reflect that as part of their policy navigation practices, staff allow guests to use alternative routes of administration in addition to intravenous. Further, participants have noted that they continue to refer to the space as a SCS. Additionally, I use the term "SCS" over "CTS" because it encompasses the services obligation to the traditions of harm reduction and safe use rather than treatment.

Currently, there are 39 SCS operating in Canada (Government of Canada, 2022b). The layout of these sites vary, but include some form of individual stalls, each equipped with a mirror and bright lighting to help individuals find veins for injection. At the injection booths individuals have access to medical personnel and harm reduction supplies, such as new syringes, clean water, and cookers (Small et al., 2006). Sites staff often provide coffee, juice, snacks and a "chill room" where individuals can socialize and receive emergency care in case of an overdose (Lupick, 2018). The operations of these sites are premised on non-judgment and acceptance, reflecting the primary harm reduction principle of "meeting people where they are at". In this sense, it means creating an environment PWLLE would want to do drugs in rather than expecting SCS guests to conform to pre-existing clinics.

Early unsanctioned SCS found success in their horizontal and non-hierarchal model of care. Research has demonstrated that actions taken to minimize traditional power relations and

medical perspectives of drug use, such as pairing someone with lived experience with a nurse, has demonstrated better health outcomes for PWLLE (Watson et al., 2020). Horizontal care is cooperatively developing and running SCS and maintaining low-threshold services with minimal rules and regulations. This model of care provides a safer and more welcoming space for PWLLE (Watson et al., 2020). Beyond the physical set up of a site, hierarchy is managed through the geographic location of sites. Traditionally, SCS centrally locate their fixed services in areas where people are using drugs. Physically and geographically, but in other ways such as emotionally and culturally, the establishment of SCS enact the principle of "meeting people where they are at" in ways that were previously unrealized. Due to these features, SCS often act as a bridge between target populations and health services.

Historically, SCS have offered health and social intervention through the efforts of community members such as neighbours, doctors, fellow PWLLE who were concerned about high rates of overdoses and resident health (Small et al., 2006). Travis Lupick's account of the origins of InSite, Canada's first sanctioned SCS, describes how harm reduction innovators Bud Osborn and Ann Livingston struggled to find allies outside of their impoverished neighbourhood (Lupick 2018, p. 203). Lupick's (2018) account highlights the communal core of how harm reduction and SCS came to be. For example, InSite started as an unsanctioned SIF (Kerr et. al 2017). The origins of SCS in Canada as a result of sustained civil disobedience cannot be understated (Small et al., 2006). InSite was granted permission by local health authorities to operate, in large part, because the physical site has already been established in rogue by the Portland Hotel Society (PHS)— an organization advocating for and providing housing and health care for structurally marginalized/vulnerable people in Vancouver (Kerr et al., 2017). InSite was given a three-year exemption as a scientific pilot study (Kerr et al., 2017). In the final year of the

pilot study, Canada elected a Conservative federal government that was vocally against SCS. In a pre-emptive attempt to ensure the continued operation of InSite, PHS took the federal government of Canada to the Supreme Court of British Columbia Supreme and the court ruled in favour of PHS. The Canadian Government appealed in Supreme Court of Canada's and the Court decreed in favour of PHS again (Small, 2010). Harm reduction is now integrated as one of Canada's official pillars for the Canadian Drugs and Substances Strategy (Canada, 2016), legitimising the philosophy within government funded institutions.

However, given that around 19 Canadians die from an overdose every day (Government of Canada, 2022), it is clear these efforts fall short in preserving life. Safe consumptions sites as they exist in Canada lack the capacity to entirely alleviate the effects of the increasingly toxic drug supply that "cause the vast majority of overdose fatalities" (Ivsins et al., 2020, p. 102768). Further, current features of SCS such as prohibiting inhalation of drugs, the presence of security guards, and the clustering in urban centres (McNeil et al., 2015) makes the service inaccessible for many PWLLE. Another reason for the persistence of high rates of overdose deaths is that there is a gap in the communicative function of the policies and their instrumental function. Hyshka and colleagues (2017) found that across the country the majority of harm reduction policies were generically worded and did not name specific harm reduction interventions. Similarly, the disconnect between traditional harm reduction philosophy and practice is evident in the discursive tone of the CTS policy. This thesis focusses on the implications of SCS policy that is divorced from the tradition of harm reduction.

### *2.2.1 A Brief History of Safe Consumption Sites in Ontario*

While there are similarities within the operations of sites, SCS are not ubiquitously conceived or implemented throughout Ontario, let alone Canada. Once formalised SCS were

established, unsanctioned sites known as OPS began to emerge. Appearing first in British Columbia in 2016 and then in Ontario in 2017 these sites operated as makeshift facilities in high need areas (Watson et al., 2020). Overdose prevention sites are innovative response to the fentanyl tainted drug-supply crisis that has led to an increase in overdoses since 2015 (Wallace et al., 2019). These sites are efficient because they do not require the lengthy SCS implementation procedures; and they are implemented rapidly by concerned community members and activists in high need locations (Wallace et al., 2019). Similar to the origins of InSite in Vancouver, OPS are established outside of state sanctioned healthcare by concerned community members and PWLLE during a time of crisis. Frustrated by the lack of formal response by health authorities, OPS have popped up as temporary sites, with the goal of reducing overdose deaths – not becoming an ongoing service (Wallace et al., 2019). Unlike sanctioned SCS in Ontario, OPS do not require a registered healthcare professional to be on staff and is primarily staffed by PWLLE (Watson et al., 2020). Currently, OPS persist in Ontario because of ongoing demand for their low-barrier services. Since 2017, PWLLE in Ontario have mobilised to scale up supervised injection service and the result was a shift in government behaviour that recognized and funded OPS as health services. Through advocacy, PWLLE brought much need services more in line with harm reduction traditions of low-barrier services; exposing its cracks and creating new forms of care within them.

In August of 2017, Moss Park OPS opened in Toronto as the first OPS in Ontario. Moss Park's medical directives were established cooperatively with service users, an approach that led to services such as a space for inhalant use, which few formalised SCS offer (Watson et al., 2020). The Moss Park OPS had a "strong impact on Ontario drug policy" (Watson et al., 2020, p. 102615). In January 2018, Moss Park received provincial funding notably with considerable

flexibility in the site's operational model, with a variety of services being accepted for funding such as assisted injection (Watson et al., 2020). By August 2018, there were a combined sixteen OPS and SCS operating in Ontario (Watson et al., 2020). At this time, the new elected Progressive Conservative (PC) government changed the course of drug policy in Ontario by pausing three previously approved OPS to "determine the merit of OPS and harm reduction practises" (CBC News 2018). Subsequently, the PC government announced the CTS reform.

In Ontario, all but three OPS have now been absorbed into the CTS model, entailing a dramatic shift from the nimble and low-threshold response to drug user care to a formalised and standardised procedure[6]. The OPS model's success lay in the leadership and input from PWLLE, whereas efforts to formalise these sites from government and public health authorities have negotiated away from the grassroots model to a bureaucratic and surveillance-based model (Watson et al. 2020).

### *2.2.2. The Consumption Treatment Service Model (2018)*

The CTS policy was announced on October 22, 2018 in two documents, the *Backgrounder*: *Review of Supervised Consumption Services and Overdose Prevention Sites- Key Findings* and *News Release: Ontario Government Connecting People with Addictions to Treatment and Rehabilitation.* The *Backgrounder* includes highlights of the key findings of the provincial review of SCS and OPS, conducted by Ontario's Health Minister, Christine Elliot. Min. Elliot allegedly consulted with representatives from various sectors to receive feedback on existing sites, including healthcare professionals, community leaders, local business representatives, police, municipal leaders, site operators, researchers and persons with lived

[6] This analysis excludes Urgent Public Health Needs Sites (UPHNS) that arose in shelter-settings during the pandemic because these sites were not included in the CTS policy decision making. The future of these temporarily-funded sites is yet to be determined.

experience (*Backgrounder*, 2018). The *News Release* offers five bullet points outlining how the Ontario government will move forward with the new CTS model. Two notable changes included a provincial cap of just twenty-one sites and the requirement that existing SCS and OPS had to reapply under new guidelines to maintain their provincial government funding (Zwarenstein, 2019).

It is significant to note that Ontario Premier Doug Ford has stated he is "dead against safe injection facilities" (Maloney, 2018). The SCS to CTS reform drew criticism from frontline workers, activists, researchers, and other politicians (Kolla et al., 2019). Growing concerns and resistance stem from an ideological shift with the policy from a harm reduction model, involving a rights-based approach to health recognizing bodily autonomy and collaborative healthcare, toward a rehabilitation-oriented model and the invocation of a 'abstinence-as-best-practice' narrative (Arlt, 2022).

## 2.3 Harm Reduction and the Institutional Encounter

Watson and colleagues (2020) ask, "is there a place for critical theory-informed studies of harm reduction during times of drug policy failures and overdose crisis?" (p. 102615). The authors posed this question in regards to SCS in Ontario, and within the context of the CTS reform. Watson and colleagues go on to answer that yes, there is a need for critically interrogating harm reduction studies and in particular, harm reduction's relationship with health authorities (2020). In comparison to standard empirical, evaluative research on harm reduction, studies that engage with theory to critique or attempt to reconceptualize harm reduction principles and practices are scant (Watson et al., 2020). In reference to critical harm reduction studies, Watson and colleagues (2020) suggest "such studies can help reveal for a larger audience what many service providers and service users already know from their own

experiences about the ways in which political expediency can sacrifice the needs of people who use drugs" (p.102615).

I categorise the CTS policy as an explicit instance of a politically expedient policy. There is a large body of literature outlining the ways in which harm reduction philosophy is diverted and/or sacrificed (Fischer et al., 2004; Smith, 2012; Watson et al., 2020). My thesis aims to investigate frontline staff's response and the modes through which they accommodate or resist policy in their daily clinical practice. The incorporation of harm reduction philosophy into healthcare is meant to shift the moral context for healthcare providers from an individualistic moral judgement to understanding substance use where deservedness is not a factor in healthcare (Pauly, 2005). This noble intention is not consistently realised or seamlessly achieved, with medicalization and concerns for public safety increasingly characterising the development of institutionalised harm reduction (Fischer et al., 2004; Smith, 2012).

Harm reduction's elusiveness as a concept is precisely what makes it such a powerful force, particularly in healthcare (Klein, 2020). Medical anthropologists describe processes within a place as a "field of practice" which are unfixed, occurring in a particular infrastructural, special, and epidemiological setting rather than a therapeutic ideal (Livingston, 2012, p. 95). Harm reduction's inherent flexibility leaves its field of practice susceptible to contamination from competing ideological forces. Smith (2012) describes the evolution of harm reduction as "a story of compromise and cooptation, revealing evidence of an uneasy historical relationship with institutionalization" (p. 210). My thesis follows this trajectory with a focus on the role of provincial health policy governing SCS.

Public health discourse is now steeped in harm reduction, with a notable shift from the original social activist underpinnings, part of which informs health services through the calls for

evidence-based policy. As evidence-based policy grew out of evidence-based medicine, there is an emphasis on the authority of research and clinicians over the value of lived experience of drug use (Lancaster et al., 2017). Previous accounts have suggested that harm reduction has become rendered as an inflexible tool of the brain-disease model of addiction (Smith 2012, p.209). This evolution of harm reduction within the medical sphere has been criticized for eschewing social problems in favour of addressing the drug-using subject as a site of risk and medical therapies (Fischer et al. 2004). The medicalization of harm reduction has resulted in the framing of drug use as deviant from ideas and norms of health that must be ameliorated in order to rectify the adverse effect on the patient as well as broader society. Similar to how harm reduction's field of practice as unfixed and unfolding in specific settings, addiction is not a static phenomenon, becoming ripe for political expediency (Seear & Fraser, 2014). Addition has been used to cover a range of behaviours and therefore may also be ambiguously enacted in public policy.

Fischer et al. (2004) categorises SCS as the shift from the punitive repression of drug use to a form of risk regulation through "'health' logics" (p. 358). The CTS policy reflects the longstanding relationship between criminal and moral models of addiction and the biomedical paradigm through its focus on not only treatment, but appeal to public order (Arlt, 2022). These "progressive" practises of governance exist alongside traditional forms, such as law enforcement (Fischer et al. 2004, p. 358). People who work directly with PWLLE should be alerted by political strategies that divert harm reduction services (Quirion 2003, p. 254). Indeed, "it is unacceptable that an essential health service is subject to political whims" (Kolla et al. 2019, p.e180). Therefore, I ask, how can we understand the role of politics and social norms in the establishment or maintenance of health services?

In their commentary on the emergence of OPS in Ontario, Watson and colleagues (2020) summarise critical theoretical perspectives as they relate to harm reduction. The authors conclude that the "majority of studies about harm reduction are empirical and evaluative in comparison to those that engage with theory to produce new ways of thinking about harm reduction" (Watson et al., 2020, p. 102615). Interrogating harm reduction as a concept does not dismiss the evidence behind it, rather it is an effort to present alternative narratives to better inform services, policies and practice (Watson et al., 2020). Watson and colleagues (2020) identify three critical approaches to harm reduction studies. The first is recognizing the lack of pleasure discourse within harm reduction, and providing a much needed analysis of emotions and desire in using drugs (Moore, 2008; Race, 2017). The second draws from science and technology and new materialism approaches to the making and remaking of concepts such as "addiction" and "drug use". The final approach examines the once proposed value-neutral and amoral aspect of harm reduction as it is implemented in specific sociopolitical contexts (Fischer et al., 2004; Quirion, 2003). The final approach primarily derives its critiques from Foucauldian notions of biopolitics and governmentality logics (Watson, 2020). I pull from all three approaches because centering the joys of drug use are relevant to participants' practice while interrogating the construction of subjects as produced by policy is part of my analysis. This thesis primarily applies the latter stream and investigates how interventions, once institutionalised and likely bureaucratized, get diverted from their original intentions and the consequences of this diversion.

One avenue of understanding the aims of a harm reduction worldview is through institutionalized efforts made by state health authorities. Despite the increased efforts to reduce deaths, little progress has been made which necessitates a critical analysis of existing methods, especially in regards to the overmedicalized approaches to harm reduction and specifically SCS

(Kerr, 2019). There remains a need to examine the impact of the CTS policy on enabling or constraining harm reduction work. There has been minimal inquiry and a limited understanding of how SCS staff work to accommodate policy mandates that do not reflect the reality of their daily clinical practice.

### *2.3.1 The Lived Effects of the Consumption Treatment Service Policy's Problematization*

Previous studies have found that the institutionalization of SCS diverts the service from the traditional humanistic based approaches fostered by grassroots movement to public and societal goals rather than elevating PWLLE health (Fischer et al., 2004; Quirion, 2003; Smith, 2012). I wondered, what exactly happens in the harm reduction and health system encounter? How do harm reduction services change once absorbed into a formalized healthcare system? As mentioned in chapter one, I conducted a CDA when the policy was first announced in October 2018. I applied Bacchi's (2012) post-structural, the WPR policy-as-discourse, critical analysis. Discourse can be defined as a set of concepts and ideas that form an agenda to accomplish change (Lancaster, et al., 2015). The key findings from the CDA reveals the assumptions, what Bacchi (2012) refers to as "taken for granted truths", that compose discourses surrounding substance use and the overdose epidemic that lead to the 'problem' identified in the policy. Within the policy, the three primary drug and health service discourses include: 1) drug use as "the problem" and therefore abstinence as best practice; 2) othering guests through the label of "addiction" with a need to manage the "other's" behaviour; 3) the CTS policy as an innovative health treatment reform to the current SCS models.

By treating terms "addiction" and "drug use" as interchangeable while citing addiction as the core of the overdose crisis, the policy logically sets up a medical model of enforced abstinence as the solution to the overdose crisis. This approach was further accomplished by

referring to PWLLE as an “other” in two key ways. First, it constructs SCS guests as in opposition to “local residents” therefore excluding guests from community membership (Arlt, 2022). Second, the policy emphasizes the management of the “public disorder” that stems from SCS guests. The focus on the behaviour of SCS visitors is based on the distinctive factor that one group is problematized as addicted to illicit substances. Thus, the change in services is warranted because the problematization has effectively demonstrated that SCS are ineffective in ameliorating addiction. The PC government signals a shift in approach through their rehabilitation and abstinence oriented treatment, diminishing the accomplishments and purpose of an SCS in the first place.

Bacchi’s approach considers problems within policies as “ontologically situated”— that is, claims about the nature of reality which privilege those who get to “set the problem” and have implications for how people are governed (Bacchi, 2016 pp. 3-6). To best understand the experience under the CTS policy I decided the likeliest next step was to trace the path of the CTS policy as it travelled to the hands of those on the frontlines in SCS. The decision to ask staff instead of SCS guests about the policy is because of staff's position between policy and guests is where creative discretion is crucial to a SCS guest’s healthcare encounter. Situating harm reduction as an ontological stance that differs from the CTS policy creates an opportunity to explore the nature of drug user health as it plays out within the health policy and service arena.

## 2.4 Theoretical Framework: Thinking Critically About Policy

### *2.4.1 Policy as a Technology of Governance*

In my thesis I conceptualize policy as an actant that is reinterpreted as it enters new relations with other actors and institutions, and travels across cultural domains (Shore and

Wright 2011, p.20). By applying an interpretive lens to policy I extend my analysis beyond the traditional model of policy analysis as straight-forward and rational. I situate policies as tools of government that can offer insight into strategies and priorities of governance. These insights reflect the social reality conveyed through the language of policy that presents itself for inquiry. Often, the primary intention of policy language is to persuade rather than inform (Wright & Shore, 1997). Governance refers to processes of classification and management, often in contexts where it is difficult to identify the author (Shore et al., 2011). This approach to understanding policy is beneficial because it conceives of policy as a malleable process and does not obscure the human component to policy conception, implementation and enforcement.

Policy is then a technological object employed by human actors to enact pre-existing intentions (Mol, 2008). With this in mind, I focus to a critical interpretive approach to policy. In this study, policies are conceived as Political Technologies of Power (PTP), that is, a means by which power conceals its own operation yet influences norms of conduct (Wright & Shore, 1997, p.8). The aim of PTP is for individuals to internalise the normative assumptions of behaviour reflected in policy and to govern themselves accordingly (Wright & Shore 1997, p.9). Through the external influence of the beliefs and language about health and self-regulation individuals constitute themselves in terms of these norms (Rainbow 1984, cited in Wright & Shore p.9). As such, it is through policy that individuals are categorised in essentializing statuses such as "citizens", or "criminals" (Wright & Shore, 1997).

Policy serves to obscure the decision maker and deny the role of human agency in the policy-making process (Shore and Wright 1997, p.11). The inability to identify human doing within the web of policy is especially alarming when the policy enacts a form of violence onto its recipients. Violence is structural when one cannot point to a single perpetrator as it is built into

the structure of power; it is not a victimless crime, but a crime without a criminal (Gupta, 2012, pp. 20-21). As such, it is difficult to pinpoint and address the source of the oppressor directly. Arthur Koestler (1997) eloquently articulated that "policy is the ghost in the machine—the force which breathes life and purpose into the machinery of government and animates the otherwise dead hand of bureaucracy" (cited in Wright & Shore 1997, p.5). The instruments that PTP aptly includes are those of increased bureaucracy such as data collection procedures to support evidence-based policy (Shore and Wright, 2015). Consequently, "rather than being neutral instruments of patient care, these technologies and their operation, mirror social worlds in which they emerge, producing far-reaching consequences for both providers and recipients of care" (Saluk 2021, p. 3).

Over the past few decades, social policies have been subjected to neoliberal logics of market restructuring. Health policy, one of the pillars of social policy, is not immune to this line of thinking (McGregor, 2001). For the purpose of this study, neoliberalism is referred to as economic and ideological practises of governance, whose influences have been as social and political as economic particularly within the last forty years (Kingfisher & Maskovsky, 2008). It is outside the scope of this thesis to detail the function of neoliberalism except to set the foundation for how healthcare is susceptible to governmentality under neoliberal logics as enforced through a punitive coercion. What remains relevant are the assumptions within neoliberalism, which consist of individualism, decentralisation, and deregulation (McGregor, 2001). Within the CTS policy the tenant of individualism is most evident. A core value in neoliberal policies is self-governing rationalities; a person's success in managing their health is a result of their competence and ability to be responsible, if they fail it is their fault (McGregor, 2001). Relatedly, "the concept of individual responsibility for one's drug use, health and well-

being is closely related to ideas about citizenship, productive roles, and what it means to make a meaningful contribution to society" (Lancaster et al., 2015, p. 621). Within the CTS policy there is an emphasis on individual behaviour that employ a narrative of PWLLE as agents of risk to both themselves and the general public, neglecting the role of the social determinants of health.

In an attempt to combat reproducing the neoliberal values referenced above, I follow Smith's (2012) observation that the encroaching neoliberalism and built-in authoritarian nature of "doctor/patient" to "provider/client" relationship within health settings entrenches capitalist consumerism language (p.211). In a conscious effort to remove neoliberal terms from the realm of health services, in this thesis I am choosing to refer to the people who use SCS as "guests", as suggested by one of the participants.

### *2.4.2 Practicing Care*

During data analysis, the concept of care emerged as a central part of frontline staff's daily work. As Jane's powerful comment in the opening of this thesis clearly conveyed, the act of providing care is a central motive in staff's engagement with policy. Two aspects of care emerged: care as contextual and care as relational. Care is not singularly conceived and implemented. As such, "how care is practiced depends in part on who is drawn to care for whom and on the role institutions and national policies play in shaping those dynamics." (Buch 2015, p. 279). The type of care that one is at the mercy of being provided is deeply enmeshed with cultural attitudes of subjectification, who has autonomy in deciding what type of care a person needs, attitudes, and beliefs about what one needs care for (i.e., drug use). Further, "care is persistently undervalued in capitalist economies, where personhood and citizenship are often deeply tied to participation in productive labor" (Glenn 2010, cited in Buch 2015). Those who

fall into the margins of what is considered a productive citizen fall wayward in in receiving state sanctioned care.

Care is conducted relationally, it is "an activity of relationship, of seeing and responding to need, taking care of the world by sustaining the web of connection so that no one is left alone" (Gilligan 1982, p. 62: cited in Smith-Morris 2018, p. 430). The expressed need for these networks of care in SCS reveals the indifference of the state (Stevenson, 2014). As such, social networks of care appear when governments fail to provide it (Smith-Morris 2018, p. 427). Care as a "political philosophy is heartfelt, embodied, and articulated" through frontline staff whose stakes of their work is life or death (Livingston 2012, p. 96). Thus, I focus my attention to how care arises and takes shape in the social relations between frontline staff and SCS guests. In this thesis, I prioritize how these networks of care emerge in relation to and are embedded into, sociopolitical contexts that force them into existence.

### *2.4.3 Spaces for Resistance*

I conceptualize SCS as ontological interstitial opportunities and contexts. I apply Holloway's (2012) metaphor of cracks to describe the incompleteness of oppressive social forces as spaces where power can be challenged. Holloway (2010) defines "cracks" as faults beneath the surface which individuals "stand back to see, or throw themselves against the wall to create" (p.9). Holloway (2012) refers to the implications of grasping these moments as "embryos of a new world, the interstitial movements from which a new society could grow" (p.11). The imagery of cracks is fitting, because SCS were born out of a need to address fatal gaps in the healthcare system, forcing a productive and alternative form of care into existence. However, since then, these spaces have been co-opted by the very institutions that necessitated their existence. Encased in an SCS is both policy that regards drug use as a health and social ill to be

eradicated and the embodied experience of drug use as both enjoyable and a logical response to social disadvantage. As such, "like any other form of social response, harm reduction strategies must be analysed within a wider social and political context" (Quirion 2003, p.247). Thus, SCS offer an ideal space to scrutinise the manifestations of dominant social claims and drug morals effects on health. Cameron Duff's critical reflection on drug policy formulation astutely sums up my endeavour with this thesis,

> "...It is not the role of social scientists to arbitrate between ontological claims at the level of truth or accuracy, because reality does not exist as some kind of external referent that may serve as the measure against which all such epistemological claims might be adjudicated. Instead, social scientists should struggle to elucidate what particular ontological claims actually do; what social, affective and material effects they engender, what forms of life they either support or suppress, what modes of care they enable or restrain, what kinds of worlds they help bring into material form and what kinds of differences these matterings make."
>
> (Duff 2021, p.103032).

By acknowledging that there are multiple ontological claims present, with each creating its own form of subjectification, the opportunity to recognize and assess the "forms of life they support or suppress" comes into focus. Specifically, within an SCS, it is fruitful to examine "what modes of care they enable or restrain" by examining frontline staff's response to the ideological tenor within the policy; since the "opening of cracks is the opening of presenting itself of a world that is closed" (Holloway 2010, p. 9). The cracks I speak of are not merely the incompleteness of the specific policy at hand, rather the fragile nature of the ideology it is born within.

Social change is the outcome of the barely visible transformation of the daily activities of people such as "the millions and millions of refusals and other-doings, the millions and millions of cracks that constitute the material base of possible radical change" (Holloway 2010, p.12). One of the cracks identified within this thesis is the top-down nature of the CTS policy

(Watson, 2020), producing a space to pry open and reinsert slivers of the world one wants to create. The existence of these cracks reveals the limits of the state's social reach (Dolson, 2015). Through this lens, one does not see the world as complete and uncontrollable but, exposes the power of human doing in responding to powerful social forces (Holloway, 2010 p. 9). It is through these cracks that we can peer into the needs and desires of forms of care, and the failures of the state to provide them. de Certeau (1984) describes these moments of disruption, unpredictable and difficult to track as "…snowy waves of the sea, slipping in among the rocks and defiles of an established order" (p. 34). The shifting manifestation of these cracks is reflected in the ephemeral nature of their handling.

### *2.4.4 Framing Micro-Policy Implementation*

The concept of micro-policy implementation focusses on the direct interaction between public sector employees' and citizens. As such, attention is on the modification, discretion and accommodation of policy during this exchange (Weatherly and Lipsky 1977, pp. 172-173). The broader literature on micro-policy implementation is derived from Lipsky's (1970) theory of street-level bureaucrats; where he states "frontline workers make decisions in the day-to-day that change the course of policy implementation" (Lipsky,1971). Street-level Bureaucracy (SLB) is a sociological theory that seeks to explain the working practises and beliefs of frontline workers in public services and the ways that they enact public policy in their routine work (Cooper et al., 2015). Similarly, there are studies that apply psychology to health sciences that investigate why healthcare workers resist policy changes (Dubois et al., 2014). Both approaches position policy responses from workers as either resulting in substandard care or an act of non-compliance that must be ameliorated. Framing workers as active in the policy implementation process is a shift from the previously common assumption that people are passively guided by established rules

(de Certeau, 1984). However, the commentary in these studies approach resistance as ineffective and a barrier to progress, rather than a creative reinterpretation of policy to better one's practice. The SLB theory and literature on humanitarian aid propose pragmatic reasons (e.g. lack of time or funding) to explain why actors do not robotically implement policy as prescribed.

Within my thesis I explore how frontline workers actively care for people. A key tenet of SLB theory is that due to constrained resources, public sector workers have to make choices as to who gets care within their organisation, ultimately leaving some people without care. While SLB is a theory of deficit, focussing on frontline workers' inability to fulfil their duties, my own framing of micro-policy implementation considers the ways that frontline staff go above and beyond in their roles to provide care. An important critique is that SLB theory overlooks the frontline workers who fill gaps in care. Therefore, SLB is antithetical to the values of harm reduction, where a primary principle is to provide care to those commonly left behind. For this reason, I do not apply SLB as a primary analytical framework for my thesis. However, I do apply Lipsky's (1970) conceptualization of micro-policy implementation because it is a seminal approach to considering policy as beyond passively implemented by workers.

While I focus on practices of policy implementation, it is important to note that this study is not an implementation evaluation. There is a need for an implementation and outcome evaluation of the CTS policy. However, this study does not evaluate the efficacy of the proposed outcomes of the policy, such as how many people have been diverted into treatment. Rather, the aim is examination of the rich sociopolitical context that frontline workers are immersed in as they engage with the policy. The findings may have implications for harm reduction policy in SCS.

### *2.4.5 Mechanisms of Micro-Policy Implementation: Policy Navigation Practices*

This thesis should be read as a conversation between policy and those whose livelihood depends on implementing it, even when their own values exists in opposition to the policy's fundamental values. The process of balancing opposing values is accomplished through Policy Navigation Practices (PNP). I use the term "navigation" because it requires the ability to locate oneself in relation to other known markers to arrive at a determined location. Policy Navigation Practices require an individual to use creative discretion in a situation where policy demands require modification to meet the needs of service users. My thesis identifies the choice practices that are deployed by frontline staff to navigate and orient themselves in order to incite agency within their social circumstances. These instances allow for staff to provide a much needed form of care to SCS guests.

Discretionary policy behaviours are not unique to harm reduction workers. In Dolson's (2015) study, Ontario Works (OW), a workfare income assistance program, recipients were observed allocating funds to best suit their needs. This practice was informed by their knowledge of living as street-involved youth, rather than how the prescribed policy intended the monies to be spent. "Partial accommodation" is enacted through tactical and strategic use of resources provided by the state (Dolson, 2015). Partial accommodation is the "range of acts that manipulate mechanisms of discipline who are not its makers in a culture that is imposed on them to briefly conform to it, only to intentionally evade it" (de Cetreau 1984, p. xiii). "Selective resistance" is a complementary strategy that is not necessarily straightforward resistance but allows one to reinterpret and alter an intended result (Dolson 2015, 118). PNP are comprised of both tactics and strategies.

I borrow Dolson's (2015) application of "selective resistance" and "partial accommodation" as an explanatory model for the mechanisms to adhere to, or forgo policy mandates. Dolson

(2015) observed the emergence of an alternative moral economy underpinning the decisions made by OW recipients that exist in tension with the OW program's expectations. As such, Dolson's participants' oscillating methods of creative engagement with OW policy allowed them to live more in line with their day-to-day needs than if they were simply adhering to the expectations in OW policy. While there is an explicit emphasis on practises of "making do" for pragmatic reasons such as survival, "tactical thinking and doing are becoming important parts of socio-political landscapes around the world" (Kyriakides, 2018, p. 425). Kyriakides (2018) goes on to say that "by focussing on the individual and collective ability of social agents to incite social circumstances through modes of thinking or acting" we witness expanding and contracting spaces of possibility (p. 453). As such, tactics have an inherently political dimension that speak to possibilities for existence under larger structures of power.

It is important to note that tactics differ from strategies because strategies produce, tabulate, and impose on spaces, whereas tactics can only use, manipulate, and divert spaces (de Certeau 1984, p. 30). As Hanssmann et al. (2022) discussed in their study, health workers develop and enact practices that positioned housing as healthcare to surmount barriers to housing programs. One example included intentional referral pathways that would result in a legitimizing diagnosis of disability. In the health workers case, the referral pathway was not formally established and could not be continually relied on. A key feature of tactics is that they "are fleeting, whatever it wins is does not keep, it must constantly manipulate events to turn them into opportunities" (de Certeau 1984, p.xix). Whereas strategies are defined by their ability to maintain existence in the nexus of power. A strategy is a calculated manipulation of a subject as soon as it becomes isolated (de Certeau 1984 p.36). For example, small-scale Yoruba traders in Nigeria replicate market networks amongst themselves that allow them to take control of some aspects of the

system being imposed upon them (Cornwall, 2007). Cornwall's (2007) application of de Certeau's concept of "strategy" builds upon the initial understanding that only those in-power can strategize. The author demonstrates that by leaning on their affective relationships Yoruba women have been able to maintain interventions that broaden the horizon of possibility within an economic system that seeks to disempower them (Cornwall, 2007). Similar to the examples above, aspects of a policy can be isolated and SCS workers engage and reinterpret its mandates. This process takes place within the interstitial context, this study elevates the exertion of power in the interstices by "ordinary people" (Holloway, p.11). "Strategies" and "tactics" are actions taken within the metaphorical cracks that reveal the substance of alternative ontological claims.

"Strategies" are still relational and situational and require one to exercise agency in structural constraints. "Tactics" depend on time and one's ability to seize an opportunity; whereas strategies establish space within power reappropriate a landscape. Both are necessary for individuals to reclaim autonomy as "they remain caught in the structural dynamics they seek to address' (Hanssmann et al. 2021, p. 3). Through the application of strategies and tactics, I catalogue how staff accommodate, refuse, and disrupt the ideological implications of the CTS policy on care.

# Chapter Three- Capturing Practices of Care: Methods and Methodological Approach

This chapter outlines my methodology, including the methods for data collection and analysis I used, as well as s reflection on my positionality within this research. I begin by describing my methodological approach: critical ethnography. I then outline my data collection methods, including my recruitment strategy and data collection tools, followed by a reflection on how my position influenced my research design, interview questions, interactions with participants and, consequently, the study results. Finally, I will explain my analytical process, including the stages of thematic analysis and the process I used for synthesizing participants' feedback collected during the member-checking stage.

## 3.1 Methodological Approach

### *3.1.1 Critical Ethnography*

My methodological approach is informed by Carspecken's (1996) critical ethnography process as adapted by Cook (2005) for health promotion research. Critical ethnography "begins with an ethical responsibility to address processes of unfairness or injustice within a particular lived domain" (Madison, 2019, p. 5). Conventional ethnography is derived from an interpretive paradigm and can offer a glimpse into a participant's life by describing "'what is'; while critical ethnography speaks on participant's behalf by stating 'why this is, and what can be done about it?'" (Cook 2005, p. 132). By including an analysis of the political, social and economic forces that shape health, adding critical theory to ethnography progresses the tradition of health promotion away from individual lifestyle choices that previously dominated the field (Cook, 2005).

In the context of my research, I elucidate how sociopolitical forces influence how frontline workers provide care within a health service for structurally vulnerable populations. Critical theory is premised on the vehement critique of positivism, making it a suitable epistemological starting point to question political normativities. Positivism posits that there is a single truth that can be measured. Critical theory allows for the unveiling of multiple truths by placing epistemological questions at the centre of its research concerns, particularly relating them to their impact on politics and society.

Critical ethnography "attends to an expansive analysis of power relationships by highlighting issues of social exclusion, marginalization, and injustice in its research focus" (Shih, 2019, p. 223). Therefore, critical ethnography challenges the status quo by elevating the "often unheard plight of the oppressed and confronts the ruling structure" (Cook, 2005, p. 132). By asking participants how they provide alternative forms of care I probe at other possibilities under the current regimes of knowledge and institutions that participants find themselves in. Thus, critical ethnography can provide meaningful suggestions for health promotion research.

Due to the inescapable circumstances of the COVID-19 pandemic, I was unable to conduct participant observation at a SCS in Ontario as originally planned. This led me to shift my data collection to remote interviews over Zoom and to update my interview guide to include interview questions to elicit the data previously expected to be collected by participant observation. Questions included asking participants to describe a typical day at work for them since I could no longer observe their work day. However, my understanding of the circumstances of the policy change, and thus my interview guide, are still shaped by critical ethnography. Part of an effective critical ethnographic approach is to go "beneath surface appearances, disrupt the status quo, and unsettle both neutrality and taken-for-granted assumptions by bringing to light

underlying and obscure operations of power and control" (Madison 2005, p. 4). In reference to critical discourse analysis, Cook (2005) claims that it is essential that critical ethnographies "explore the link between hegemonic and ideological discourses underlining the social structure that colour the everyday experiences of participants" (p. 134). Thus, my study design aimed to capture participant's individual experiences with an emphasis on a gradient of power relations.

# 3.2 Study Design

### *3.2.1 Recruitment and Participants*

Following ethical review approval from the University of Victoria's Research Ethics Board in July 2020 (REB #20-0148), I recruited ten interview participants from three large urban population centres[7] in Ontario. Recruitment took place from July to December of 2020. Although an initial target sample size of 12 was identified, recruitment was cut-off at 10 participants, because of challenges related to the ongoing impacts of COVID-19 on health services. With rising COVID-19 cases during the recruitment period (December 2020-Feburary 2021), it became ethically problematic to request interviews of individuals who had been increasingly voicing their concern for their well-being because they are working under two public health crises. By the tenth interview common experiences and responses had been identified across numerous interviews, an indication that the data was saturated well enough to discontinue recruitment.

Participants were considered eligible if they worked frontline[8] in a SCS before and after the CTS policy reform in 2018. The timeline was necessary to ensure they could speak about the

[7] According to Statistics Canada a population of 100,000 or greater is considered large urban population centre (Population Centre, Statistics, Canada, 2017)
[8] "Frontline" was considered any staff who worked directly with those accessing SCS.

impact of the policy change. Exceptions were made for two frontline workers who worked in the CTS only after the policy change, but had an extensive history of harm reduction knowledge. One additional exception was made for a Social Support Worker who spoke to the process of planning the CTS site in her city, and, along with her coworkers, was to influence the location and functions of the site. I was interested in her perspective because I wanted to see how it compared to how established sites had to adapt their operations to the CTS policy. Intervention at a higher level of policy-implementation offered important data about the possibilities for how staff influenced operations and maintained harm reduction practices.

At the time of recruitment, there were twenty-one CTS in Ontario, and two OPS. No one particular city was selected for recruitment to elicit an array of experiences. I excluded the OPS as they did not receive funding to transition to a CTS. I recruited participants using convenience and snowball sampling. I used my academic Twitter account, where I am followed by the accounts of harm reduction advocates and similar networks, to send a direct message to the following groups: Canadian Institute for Substance Use Research, Street Health OPS, Toronto Overdose Prevention Society, Harm Reduction Nurses Association, Canadian Association of People Who Use Drugs (CAPUD), and a Safe Consumption Site Working Croup (see Appendix C for the recruitment script**)**. I also reached out over Twitter to prominent national and provincial organizations that work in the fields of homelessness, Hepatitis C care and drug use, and I used the same Twitter account to tweet about the study to distribute the invite more broadly (see Appendix B). I received an email from a member of Toronto Drug Strategy at Toronto Public Health offering to circulate the recruitment call within their network. Finally, I also employed snowball sampling by asking interested participants who did not meet the eligibility

criteria to consider passing along the recruitment call to their coworkers. Two participants were recruited due to having known another participant.

Once individuals contacted me, I confirmed eligibility by asking how long they have worked at the site and if their site was open prior to the CTS reform. The participants that were selected who did not meet this criterion explained their unique involvement in harm reduction. Once eligibility was confirmed, participants were sent the consent form and asked if they had any questions. No one declined to consent after they were sent the form. Participants were screened through my University of Victoria email account. In total, 23 respondents responded to the study advertisement by either Twitter (n=2) or SCS and working group listserv emails (n=21). Of the 23, four did not meet the eligibility criteria, seven did not respond when contacted by email, and two emails bounced back due to internal server security and could not be further contacted.

### *3.2.2 Sample Characteristics*

The chart below indicates participant's pseudonym, an appellation for their role at the SCS they work at[9], gender and how many years they have worked at their site and in harm reduction generally. Frontline workers consist of nurses, outreach workers, social workers, program coordinators, and experiential workers (which encompass a range of titles, depending on what site they are employed with). Experiential workers are hired because of their past or current experience with drug use. Often known as "peers" the leadership and involvement of PWLLE in harm reduction services have demonstrated numerous benefits (McNeil, 2018). In other studies, participants have described that the term "peer" segregates them from other

[9] I standardized titles according to lived experience or not to avoid any identifying characteristics. I want to note from participants had multiple titles over the years but this was not a significant factor in analysis and may contribute to identifying the individual.

frontline staff and render's their contributions as less valuable (Greer et al., 2021; Mamdani et al., 2021). In a conscious effort not to perpetuate minimizing PWLLE roles, I have made the decision to refrain from the use of the term "peers" with the exception of direct quotes from participants. Instead I use the term "experiential workers" throughout my thesis to highlight their unique positionality and skill set in their role. Eight out of the ten participants identified as having lived/living experience of drug use.

| **Participants** | **Position(s) at the SCS** | **Gender Identity** | **Years at site/Years in Harm Reduction** | **Lived Experience** |
|---|---|---|---|---|
| Maya | Harm Reduction Worker | She/Her | 1.5 years<br>2.5 years | Yes |
| Celia | Social Support Worker | She/Her | 1.5 years<br>8-10 years | No |
| Brad | Harm Reduction worker | He/Him | 2 years<br>15 years | Yes |
| Vivienne | Harm Reduction worker | She/Her | 3 years<br>Over 30 years | Yes |
| Natalie | Social Support Worker | She/Her | 1 year<br>5 years | No |
| Linda | Harm Reduction Worker | She/Her | 10 months<br>3 years | Yes |
| Leanne | Harm Reduction worker | She/Her | Missing | Yes |

| | | | | |
|---|---|---|---|---|
| Ingrid | Harm Reduction worker | She/Her | 3 years<br>17 years | Yes |
| Joe | Harm Reduction worker | He/Him | 2 years<br>11 years | Yes |
| Jane | Harm Reduction worker | She/Her | 6-7 years<br>9 years | Yes |

### *3.2.3 Semi-structured Virtual Interviews*

Qualitative interviewing is foundational in health research and the social science to gather data on participant's attitudes, beliefs and experiences (Nathan et al., 2019). I conducted semi-structured interviews with participants using the online video meeting platform Zoom. Initially, interviewing was meant to be embedded in participant observation, but due to COVID-19 related concerns semi-structured interviews became the main form of data collection. Semi-structured is best suited for balancing the interests of the interviews and the participant, adapted to each context and participant, this flexibility also increases the likelihood of achieving the quality and depth of perspective that is required (Nathan et al., 2019, pp. 392–393). A significant benefit of interviewing involves prompting participants to reflect upon aspects of their life in a way they have not before (Gerson & Damaske, 2020). For example, early in interviews a few participants consider something as simply a part of the job but further along in the interview they had a more defined opinion about their experience.

Eight of the ten participants had their camera on for the interview, which made it useful to document body language and their general demeanor. I requested the participants be in a location they felt most comfortable. I followed an interview protocol for each interview (see Appendix C)

that went through the consent form, and then transitioned into my interview questions. I assured participants that they could skip over any questions or stop the interview at any point and still receive the honorarium. Due to the discussion of a distressing topic of overdoses, I also offered a list of supports. No participant requested the list of supports after their interview.

Implied verbal consent was obtained at the beginning of the interview after reading through the consent form. Given the nature of discussing illicit substance use and breaking rules in an already precarious health service, the issue of confidentiality came up on multiple occasions. Some participants feared their employers finding out about their responses. I assured participants that I was ethically bound to keep confidentiality and that my aim with this research is to strengthen harm reduction responses. Part of building rapport included sharing my genuine enthusiasm for how participants found ways to practice meaningful care.

Data collection started with demographic questions, such as age, gender identity, the city of the SCS the individual worked in, the title of their position at their job, how long they have worked at the SCS, and how long they have worked in harm reduction in general. The interview contained fifteen open-ended questions with follow up prompts (Appendix C). The interview guide was developed to move from general questions such as, the length daily tasks at work, to more difficult questions requiring a higher level of rapport such as thoughts on the policy change. As this was a semi-structured interview, many questions were open ended and asked for examples or started with “could you tell me about…” to ensure a wide variety of responses (Jacob & Furgerson, 2012). The questions were curated to elicit comments within the domains of harm reduction practices, participant viewpoints on the new policy, and policy navigation practices. During the creation of the interview guide, each domain was traced back to at least one of my research questions. Questions were also informed by the gaps in the literature of micro-

policy implementation focussing on how beliefs and attitudes towards provincial policy shaped their daily work. Participants were asked about their beliefs and perception about harm reduction, working at a SCS prior to the change, their perception on the role of SCS in healthcare and society, and their motivation for working in an SCS.

Participants were also asked to speak about their perception of the policy change, if and how it has impacted their work, how the change was implemented at their site, the new expectations that accompanied the change, and experience with various community members such as SCS guests, healthcare practitioner's provincial administrators and authorities since the change. Finally, participants were asked to speak about the ways in which they managed the changes that occurred, decision making about their management tactics, and resources they find useful to manage the change. All participants were asked some variation of the same questions, depending on the flow of the conversation. At the beginning of each interview, I largely guided the conversations, however once participants started speaking more openly they guided the conversation while I asked follow-up questions about concepts and experiences and prompted additional details that were relevant to the established research domains.

Asking people to share over Zoom how they negotiate and break rules presented challenges to rapport and the intimacy that face-to-face research and time spent together during participant observation might have enabled. While research questions were revised to accommodate for this unanticipated shift, they cannot perfectly account and substitute the relationship produced through long periods of physical co-location in the field.

During the interview, I took notes under the headings: keywords, about the participant, and questions/thoughts/comments. Within twenty-four hours of conducting an interview, I recorded my thoughts and observations about the participants' behaviour and general demeanour, common

themes found in other interviews, and any connections to my research questions. All interviews were transcribed verbatim, with non-verbal cues indicated in the transcript for additional context. Both audio and video for interviews were downloaded and stored on the Canadian Institute for Substance Use Research's remote server in a locked file. Since I was limited to remote interviews, the reliance on technology for the virtual interviews meant the increase of potential technological mishaps. One interview failed to fully download, and I was left with only twenty-two minutes of what was a forty-five-minute interview. Thus, the missing audio was not transcribed and excluded from the analysis.

# 3.3 Data Analysis

### *3.3.1 Analytical Model*

My analytical model is modified from Newnham, Pincombe, and McKellar's (2016) adaptation of Baer et al., (1986) approach to Critical Medical Anthropology (CMA). The CMA model was developed in conversation with Foucauldian theory and is a variation of a socio-ecological model that has been adapted for critical medical anthropology studies taking place in health services. The discipline of CMA originated out of critique of traditional medical anthropology for taking authoritative biomedical knowledge for face-value (Newnham et al., 2016). For the purpose of this thesis, the CMA model is applied to practices of harm reduction in SCS. The CMA framework is guided by an awareness of the social and political influences of health and the delegation of power within biomedicine and the healthcare system. I found this especially apt for the CTS policy as there is an increase of medical authority and integration into the healthcare system. I apply the CMA Framework principally as a model to answer my research questions and structure my writing, where I trace how power-relationships are

experienced in SCS. The intent is to link the individual experience of frontline staff within the context of macro-structures that influence their work worlds.

There are four layers to the CMA framework. The model moves from the macro-social, to the intermediate social, to the micro-social and finally the individual level (Baer et al., 1986). The authors emphasize that these levels of analysis are not exclusive. Rather, the model works as a heuristic device to assist with understanding the complexity of social forces and where they might sit in relation to each other and to the process of data analysis. Such an approach is mirrored in the organization of this thesis. Chapter four teases out the macro and intermediate social levels by connecting participants' thoughts to discourses on medicalization and prohibition as they relate to the CTS policy. Chapter five provides a micro-level analysis of individual level knowledge of harm reduction as applied in frontline work through policy navigation practices.

### *3.3.2 Thematic Analysis*

Data analysis did not occur at one distinct stage of the research but began during the discourse analysis of the policy (Arlt, 2022), continued into the study design as the research questions were developed, and while reviewing interviews during my period of data collection to inform or alter interview questions. For example, when I was noticing the term “treatment” being used in different ways by either different participants or by the same participant, I decided it was important to explicitly ask participants what they thought treatment meant to them. This amendment led to one of my key PNP categories. Each interview was transcribed, verbatim and including non-verbal cues, by me which also contributed to the analysis. I applied Braun et al., (2019) based on Braun and Clark’s (2006) model, reflexive thematic analysis which is particularly fitting because it is geared towards health social science research and recognizes the iterative process of data analysis. The approach consisted of six phases.

**3.3.2.1 Phase One- Familiarizing Yourself with the Data.** The first process of analysis is to become familiar with the data. This stage entailed "reading close", similar to the process of data immersion in anthropology (Newnham et al., 2016) where the researcher employs active reading. For me, this process looked like first reading individual interviews by focussing on particular words that were repeated or unfamiliar. Then reading across interviews guided by individual interview questions and focussing on connections between participants and moments, such as their response when I repeated my interpretation of what they said back to them. Finally, I read over interviews with my research questions in mind. I also reviewed the notes I took during and after the interviews and listened to some parts of interviews to elicit participant's tones.

**3.3.2.2 Phase Two- Generating Codes.** Systematic engagement with the data follows the data immersion step. The intent is to identify meaning as captured through codes. I applied both an inductive and deductive coding process. When reading the data, I kept in mind three concepts; harm reduction, policy navigation practices, and policy as a political technology. Eventually a concept like harm reduction broke into codes such as "practices, beliefs, origins of beliefs" and so on. I allowed room for other concepts to form as I moved through the process. For example, the concept of "education" emerged, and codes such as "lived experience" or "medical training" emerged. Codes encompassed implicit and explicit meaning consisting of participant's language and more abstracted language. Keeping within the CMA framework my codes ranged from the macro-social to the individual. Codes then became the basis in which themes were established.

***3.3.2.3 Phase Three- Generating Initial Themes.*** Themes materialize through connections to the selected concepts, emergent typologies, metaphors, transitions and missing data (Ryan & Bernard, 2003). At this point, I started selecting quotes that spoke directly to the

research question to outline my initial themes. Quotes were selected on the basis that they related to research questions or one of the three pre-existing concepts. Other considerations were instances when participants explicitly stated that what they were saying was important, something that was surprising, repeated sentiments, or disagreements on topics. Themes at this stage included topics such as “tension in staffing model”, “policy disruption” and “explicit refusal”. Not all themes were included in the next stage.

***3.3.2.4 Phase Four- Revising Themes.*** I drew a visual map of my candidate themes. Themes are situated within a critical theory framework so it was essential at this step to begin to write about themes to test their strength. During this phase I collapsed weak and similar themes into larger themes and let go of earlier ideas that lacked strong analytical characteristics. For example, the theme of “tensions in types of knowledge” did not survive as an independent theme and became a repeated strand that formed multiple themes. This exercise strengthened the overall story of the analysis.

**3.3.2.5 Phase Five- Defining Themes.** Braun et al. (2019) described this phase as defining each theme by its strongest characteristic. Themes were analyzed for similarities and differences and grouped to conceptual themes that translated into findings. I read over the entire data set to ensure themes relate to the central organizing concept. In this section, etic and emic codes were reviewed to ensure the selected themes adequately represented the data. Themes became attached to concepts that produced the basis for the theoretical analysis to be expanded on during the writing phase. For example, themes such as “hierarchy of knowledge” were matched with the concept of medicalization.

**3.3.2.6 Phase Six- Producing the Report.** Analysis continued during the write up stage. In ethnographic research, the process of writing is an important part of the analysis (Newnham et al. 2016). Through writing and rewriting, concepts became clearer as patterns were formed and identified. I included one additional phase that was not outlined in the Braun et al. (2019) model. Member checking was applied in an attempt to democratize knowledge, assess for accuracy in my interpretation, and because participants expressed interest in reviewing the findings.

### 3.3.3 Member Checking

Member checking is used to validate, verify, or assess the trustworthiness of qualitative results . I applied Synthesized Member Checking (SMC), where participant data is analyzed for themes, and findings have been distilled (Birt et al. 2016). The objectives of SMC are to enhance reflexivity in the research process and provide an opportunity for additive data while confirming or contesting my interpretation of the data. The aim is not to be guided by participant's response to adopt an "average" perspective to offer generalizable findings so much as to obscure individual participant's actual realities (Doyle, 2007, p. 894; Linda Birt et al., 2016). Participants should be able to recognize their own experiences within these findings and add comments that are reflective of their experience.

Member checking is aligned with the aspect of ethnography of investing variation in a population and knowledge as socially shared and transmitted. In Comprehending Drug Use: Ethnographic Research at the Social Margins, Page and Singer (2010) assert that ethnography is transformative drug science and that the hallmark of drug ethnography is policy application. My aim is to create space to elevate voices that have been previously ignored by including those who feel disregarded in policy-making into the research process. Production of knowledge is a strong

thread throughout my thesis from the methodology to the analysis of the findings. Critical ethnography elicits how individuals view the world in contrast to power. In this case the power was my interpretation of their experience.

During their interviews, all members agreed to receive a one to two-page document detailing key findings (see Appendix D for email script and key findings summary) with the expectation to provide feedback on my interpretation of the data. The key findings report was sent out to all ten participants with the following questions:

1) Do you think the above interpretation reflects one or more of your experiences working at a CTS? If yes, please elaborate. If not, how so?
2) Is there anything you would want to rephrase, such as policy navigation definitions or the summary of concerns about the CTS policy?
3) Can you think of any other examples of policy navigation practices you would like to share?

The data was returned to participants 12-18 months after the interviews (in January 2022). There is the possibility of a shift in participant's recollection of the phenomenon due to passing time (Birt, et al. 2016). I requested participants to return their comments within two weeks of receiving the document. Eight out of ten participants responded to the member-checking request and six participants offered feedback; the other two were unable to offer substantial commentary at the time due to personal reasons. Participant's responses are integrated into chapters four and five alongside interview data within relevant themes. One notable response involved a participant who shared her concern that the study would result in the provincial government cracking down and regulating operations to an even greater degree. To address this concern, I

have been judicious in my summary of PNP and do not include specific examples of behaviours that could result in harmful consequences to participants.

Ethical considerations specific to member-checking include feelings of distress when reading over experiences of overdoses or working in a constraining system. To mitigate this, I offered support resources. It is possible that participants could experience feelings of isolation if they do not recognize themselves in the findings. To address this concern, I reminded participants that not everyone has the same experiences and we are not trying to generalize findings. Two participants relayed that they did feel very seen and that the analysis was "spot on".

Apart from satisfying qualitative method rigour, member-checking allows an opportunity for participants to recognise and feel ownership of their stories (Harvey, 2015). There is also the possibility that the process of seeing personal experiences validated and reflected in those of others can help participants to see they are not alone (Harper and Cole 2012, cited in Birt et al., 2015). Such feelings were expressed by one participant in particular.

> **Stephanie:** Would you like to review the key findings?
>
> **Joe:** Yeah, I would like that a lot. That's really great too, I've participated in research so many times, and you don't get the end product. You just feel a lot of the time, what's this all for? I think this is great you putting it back out like this.

Joe's response to the opportunity to view the findings indicates gaining a sense of purpose in sharing his story. By "putting it back out" member checking contributes feelings of inclusion as opposed to the unknown of how one's experiences contribute to the larger research project.

## 3.4 Researcher's Positionality and Reflexivity

My encounters with participants contributes to the quality of the research produced. I acknowledge my role in the co-production of knowledge which necessitates a critical reflection of the sociopolitical aspects involved in the research encounter. Reflexivity in qualitative research is where the researcher engages in explicit self-aware meta-analysis (Finlay, 2002, p. 209). Within my thesis, this applies to my position as someone who stands at the margins of academia and advocacy; and the influence it had on the co-production of knowledge.

Throughout my interviews, maintaining my position as a researcher but also as a drug policy advocate became a challenge. Since "critical ethnography values the researcher's subjectivity in shaping the explicitly political angle that the data takes" (Shih 2019, p.232); my interest in this research is guided by my own values of equity, justice, and human rights. I am steeped in the discourses surrounding drug policy in Ontario, through shared avenues of communication, such as Twitter. As such, I rarely challenged participants' worldviews. This does not mean I did not further inquire into their responses. Rather, my approach includes empathising with illicit and otherwise morally condemned behaviours. Through my advocacy work I developed an alternate and deeper understanding of what can be considered normative morally ambiguous behaviour. Consequently, my own thinking often aligned with participants' worldviews. My own view, like Shih (2018), is that "remaining politically neutral in the face of injustice is deeply unethical" (p.13) and defies the aims of critical research. Challenging the idea that people deserve access to inject drugs safely, and that drug use was a tool to keep individuals physically and mentally well during an overdose crisis was not agreeable to my own values. Additionally, integrating my recognition of the sociopolitical injustices participants endure into my approach aligns with the aims of the CMA model. Further, engaging with people who have suffered loss during a double health crisis required me to exhibit a level of tenderness toward

participants. Overall, my disposition was informed by my gratitude for their generosity in sharing their experiences in an encounter than encourages them to reflect on the ways in which they are oppressed.

On an epistemic level, researchers have been expected to maintain an objective disposition as outsiders to produce an unproblematic interpretation of the social reality they study (Shih, 2019). Since I have not experienced addiction or homelessness, I emphasized that as a researcher I was curious about participants' experiences working in SCS and that I was there to learn from them. I explicitly stated that they are experts in the daily functioning of SCS and harm reduction. Traditionally, the disciplines of public health and anthropology have urged the notion of "objectivity" in order to maintain a level of detachment in an attempt to avoid "contaminating the field with one's political biases" (Maher, 2002 cited in Shih 2018, p.225). However, it is much more commonly accepted that the interpretation of research participants' experiences includes the sociopolitical context in which they emerge, and the injustices that result.

The interview questions are aimed to elicit responses from participants that may include behaviour that deviates from the site's policies and procedures. Policy navigation practices were originally expected to be observed in person, but only after building rapport and trust with workers. Since this was not possible, acquiring data on potentially "rule-breaking" behaviours became a matter of how comfortable a participant felt with the stranger on the screen in front of them.

My strategy to mitigate the intersubjective tension involved revealing two pieces of information about myself partway through the interview. The first was responding in agreement once a participant verbalized explicit disapproval of the CTS policy reform, using their words to speak back to them my shared thoughts on the efficacy of the policy. My expressed disapproval

of the site was a genuine response. Effective critical ethnography does not shy away from the researcher's politicization of participants, rather it is the skillful shift between an outsider and an insider (Shih, 2019). I executed this by sharing my position as a drug policy advocate and probing ideas about care and experiences of drug use that I knew I lacked in. The aim is to stand in solidarity with participants in the face of injustice, without the introducing act of making conclusions about the phenomenon on their behalf (Shih 2019, p. 233). By voicing my own anger about the overdose crisis in tune with them and responding with genuine curiosity to their experiences in SCS, we created an opportunity to share our grievances and learn from one another.

The second tactic was used more often with participants who have lived experience of drug use. Once a participant would talk about their experience with mental health and drug use, if relevant, I would mention my own experience in these areas. My revelation was often met with a more relaxed demeanour. I shared my views and experiences with participants because I wanted participants to feel comfortable with sharing information with me. However, this does not mean the connection that was fostered during the interview was ingenuine and simply motivated with the sole intent to gather data.

People who use drugs consistently share their experiences of being discriminated against, with many participants voicing their perceived division from "professionals" such as someone in my position. I wanted to close the perceived gap by showing my more human side, in hopes to bridge our class, educational, and work differences, even just to some extent. Within this thesis I did not simply seek to understand how frontline staff engaged with practices of harm reduction under an abstinent-focussed policy, I want to confront the injustice by bringing to light systems of power and control. By working in dialogue to open a space that recognized shared perceptions

and experiences, participants and I created a rich understanding of drug use and the CTS policy. In the next chapter I begin describing how broader social forces compel as well as constrain my participant's ability to provide harm reduction care.

# Chapter Four: Responding to the Institutionalization of Harm Reduction

## 4.1 Introduction

In this chapter, I analyze frontline staff's positions on the CTS policy. Following the organization of the CMA model, this chapter discusses the macro-social and intermediate social levels of analysis. Newman et al. (2016) state "that attention to the macro sphere is important to unearth the cultural perspectives and beliefs that perpetuate these practices and experiences" (p.2). Harm reduction is inherently a relational way of operating in the world, both discursively and interpersonally. The product of relations is shared experience and understanding that can render political response. Hence, I aim to elucidate frontline staff's thoughts and feelings that lead to the political action referred to as policy navigation practises. I also address what effect, if any, the CTS policy change had on how frontline staff understood and practised harm reduction within SCS. By elevating staff's concerns with the ontological claims in the CTS policy, I tease out how these tensions are actualized in the sites.

The first section of this chapter explores how frontline workers' understanding of harm reduction underpins their approach to care. I establish what harm reduction means to participants to better understand the influence of the CTS policy. Based on participant's description of harm reduction care and the services their guests require, tensions emerged between the political motivations of the policy and staff's understanding of the function of SCS. Here, I turn to Quirion's concept of neutralization to characterise the PTP aspects of the CTS policy. Neutralization is "the process by which particular populations are contained in order to eliminate the risks they represent towards the larger community" (Quirion 2003, p.249). The CTS policy was conceptualized and designed with an expression of a social reality that views PWLLE of

drug use as risks that require containment. This goal is achieved by attempting to sanitize PWLLE through a restructured SCS. Importantly, the process of risk management and neutralization primarily governs subjects through surveillance techniques and the relationship between evidence and knowledge.

The second section of this chapter seeks to answer, what are SCS frontline workers' responses to and positions on the SCS to CTS policy reform? To answer this question, I situate frontline staff's experiences providing harm reduction informed care within the increasingly institutionalized landscape of a CHC. I describe how PTP operate under the justification of "accountability". Within policy studies, accountability is a governance system laden with terms "effectiveness", "efficient", and "transparency" where institutions and individuals must manage their behaviours to optimize "what counts", often through processes of enumeration and record keeping, resulting in new forms of relationships (Shore and Wright 2015, pp. 422-430). A hallmark of accountability governance is that it is "characteristically one-way, top-down" (Shore and Wright 2015, p. 429). I dissect SCS in Ontario as a new environment under the CTS policy, where PTP result in a diversion of priorities in the SCS. Diversion is primarily accomplished through various forms of accountability practices such as the datafication of health as a technology of population making. I demonstrate how the CTS policy constrains both frontline staff and the populations they serve.

## 4.2 "Meeting people where they are at": Establishing Harm Reduction Characteristics

> **Joe:** I guess how I feel about harm reduction is to meet people where they're at and encourage use in a safe and healthy possible way. To encourage safe use—or the safest protocol that you know. It's certainly not to abstain from drugs in my opinion but it's to

> really meet people where they are and maybe help make supportive decisions as much as possible.

Joe, a Harm Reduction Worker, considers himself a seasoned "vet of the war on drugs". Joe's understanding of harm reduction reflects many participants' approaches to care. Six out of ten participants used the phrase "meet people where they are at"—an established mechanism to enact core values and philosophies within the harm reduction tradition—to couch their explanations for particular worldviews, behaviours, justifications, and concerns about the CTS policy. I viewed this repetition within my data to indicate a common understanding of harm reduction amongst frontline staff.

Harm reduction was mentioned throughout the CTS policy announcement, despite the abstinence-coded shift towards treatment. As Brad astutely shared, "They use the term harm reduction now, the Conservative Government, but what they mean by it is, like, drastically different than what we do. So it often just feels like we're speaking different languages". I focus my inquiry on whether the ways in which the CTS policy impacted how participants understood and subsequently practised harm reduction. Throughout this chapter, I return to the phrase "meeting people where they are at" as a unifying and guiding adage by which participants mobilised practices of care within the SCS.

Even when the phrase is not explicitly mentioned, participants describe the qualities that encompass the phrase. Maya shared how this approach influences her work. She is employed as a Harm Reduction Worker at an SCS and has worked at multiple sites over her career. To Maya, SCS are places that empower people to make the best choices for themselves.

> **Maya:** I'm a person in recovery as well, so I super gravitated towards working with people who had any sort of substance use issues, and it just felt, like, super natural to me to be in that kinda role engaging with people. So yeah, kinda like as soon as I first got a taste of harm reduction it was kinda like 'oh I feel like I'm at home, this is where I should

> be', working with people—like *working with* people rather than feeling like I'm above people, so working on like a level ground with folks was really speaking to me" (emphasis added)

As someone with lived experience of substance use, Maya said "harm reduction feels like home", because she feels like the people who visit the SCS could have been her "friends in a different scenario". Harm reduction is grounded in non-hierarchical and anti-authoritarian beliefs (Smith, 2012). Maya's introduction to harm reduction work offered a way of supporting those in her care in a horizontal manner. She built upon this approach to include working with people to meet their needs instead of managing those needs. Maya's emphasis around the feeling of "working on level ground" versus "above people" suggests a relational reorganization that enacts "meeting people where they are at" to deliver successful community-appropriate care. In addition to the metaphorical direction of care within harm reduction, hierarchies present themselves throughout frontline staff's encounters with policy.

## 4.3 Accounts of Policy: Frontline Staff Positions and Opinions About the Consumption Treatment Service Policy

Those who practice drug policy intimately observe the ideological political shifts that characterise the bounds of their work worlds. In this section, I elucidate the ideological tone of the policy as experienced by participants. I then move to participants' experiences of exclusion in the policy process and the implications for knowledge making in health policies. I end the section by discussing the challenges that staff mentioned, including conflicting views around the purpose of the policy and diverging views of drug use. To understand why workers may refuse or subvert policy changes that diverge from the principles and philosophies of harm reduction, it is essential to detail the origins of the social justice and political motivations. There is a need to examine frontline staff's response to the expectations within the CTS policy. Safe consumption

sites and the CTS policy specifically, act as a microcosm of the ontological multiple, because it is an intensive space where "critical moral, political, and social questions arise regularly and with great urgency, and where broader political, social, and moral forces in society can be witnessed in a condensed fashion" (Livingston, 2012, p. 25). However, claims about drug use transcend morality insofar as they establish ground for the character of the world as we experience it (Duff, 2021). This point is crucial and the implications offer fertile grounds for an analysis of motivation, positionality, and the threads that lead into the tension between policy and practice.

### 4.3.1 "What policy change?" Characterising the Shift by the Change in Government

> **Stephanie:** I'm just wondering if in your experience you've experienced that or if you've noticed anything after the CTS policy change.
>
> **Leanne:** I don't know what a CTS policy change is.
>
> **Stephanie:** Oh the Consumption Treatment Service policy change?
>
> **Leanne:** Apparently not, I do not know of it.
>
> **Stephanie**: You don't know of the CTS policy change?
>
> **Leanne:** No.

Leanne was not the only participant who required probing into her familiarity of the CTS policy. Mentioning the policy change by name was sometimes met with confusion. My exchange with Leanne and other participants signalled two important factors. First, people who work in SCS are a diverse group of individuals whose political engagement with their work varies. For instance, Maya found her coworkers, rather than her managers, to be more of an obstacle because some staff "are just doing a job, and don't know about North America wide activism that is happening". Thus, political awareness differs across frontline staff which required additional inquiry on my part. This finding provided a variety of experiences that led to a richer understanding of the policy reform. Second, SCS operations are not fully dependent on

provincial mandates. This finding was significant because I anticipated the policy would immensely disrupt staff's work practices. Both of these observations lend to a set of circumstances that offers a fruitful exploration of the policy-worker encounter.

Nevertheless, a lack of awareness does not equate to indifference. Even if participants do not recognize the policy by name, they recognize the negative assumptions about drug use and potential consequences on health services for PWLLE woven into the policy. For example, Leanne was concerned the SCS she worked at would be shut down, when the Conservatives came into power.

> **Leanne:** I know we were really worried that our facility was going to be one of the many that were going to be closed. That was a big worry for us…. So there was a huge movement where they're trying to save a bunch of safe consumption sites but we served like fucking honestly a lot of people we served at least 500 people a day, or something stupid like that. Like we weren't gonna be one of the ones being closed.
>
> **Stephanie**: Yeah, okay. When I say, like "this policy change" can you do a little, like a free association, what comes to mind for you?
>
> **Leanne:** I mean, you know, honestly, I think that as governments change, like the more conservative the government is the more addicts, addictions, mental health always falls wayside, you know? I can't necessarily speak to this policy, but I do know that depending on the government, depending on the funding, depending on where the winds change, like I find that addictions and reform like, addictions and mental health always get fucked."

Indeed, staff recognize the policy change as a reflection of Conservative political ideology is a defining feature in how frontline staff understand and respond to the policy's implementation. As Ingrid, a long-time harm reduction advocate, stated, "it doesn't fit with their political ideology. Before [Doug Ford] was elected he said that he was 'dead set against supervised injection sites'. He wanted to close them down." Other participants mentioned the same remark made by Ford, stating the high numbers of overdose deaths as the reason the PC Government could not justify closing all the sites. Leanne and Ingrid's comments indicate that

staff felt the CTS policy was ultimately a half-hearted attempt at maintaining the existing sites while shifting their approach to substance use that is more amenable to conservative political beliefs.

Has this policy change shaped the implementation of harm reduction ideas and practices at CTS sites? Based on my conversations with participants like Leanne, I argue the core ideas that compose harm reduction and its practices have persisted, despite the CTS policy exacerbating pre-existing tensions in health services such as medicalization, practices of risk management, and knowledge making. A consequence of excluding of PWLLE from the policy process the CTS policy reform further legitimises techniques of population regulation. In place of the voices of PWLLE, arises a policy that aims to fundamentally shift both site operations and public perception. Thus, the first PTP I recognize is Quirion's (2003) concept of risk management by means of neutralization. I detail the frustration my participants feel with the increased emphasis on public order and exclusion of those with lived experience in the policy process. The CTS policy is composed of social claims that speak to larger beliefs about drug use and drug users and the policy emphasizes the spirit of self-regulation and personal responsibility to cease drug use. Participants demonstrated their apt recognition of neutralization in the CTS policy. I also flesh out the reasons for the persistence of harm reduction values by staff. Throughout my analysis I centre on participant's alternate visions of drug use than those in the CTS policy and their recognition of the social determinants of health.

### 4.3.2 "It's just a big sham": Political Expediency in Drug Policy

One of my first questions to participants was why they thought the change in policy had occurred. It was important to elicit their opinions on the government's motivation to shift SCS to CTS to better understand how frontline workers are responding to the policy change. Staff's

understanding of the motivation behind the policy change colours their behaviours in response to said policy. Participants mentioned two key considerations for how the CTS policy's conception and design acts as a PTP. Their first concern was around whose voice was counted in the PC Government's report on SCS. Subsequently, their second concern was that the policy was a political move to signal control over the overdose crisis to the PC Government's through mechanisms that were likely to be approved by voters.

The phrase "Nothing about us without us", which was originally popularised by disability advocate James Charlton (1998), conveys that no policy should be conceived and implemented without the meaningful input of the people the policy will impact. The phrase has been adopted within the drug policy advocacy community[10]. However, people who use drugs rarely get the opportunity to shape drug policy (Boyd et al., 2016), while frontline staff with lived or living experience of drug use are expected to provide care according to policy mandates. Historically, PWLLE have been routinely excluded from meaningful engagement and leadership positions in developing drug and health policy. When I asked Brad, a vocal member of a drug policy advocacy network and Harm Reduction Worker, if he had been contacted for consultation he responded, "No, and they didn't ask us any questions when they made these changes… so a lot of it just feels like this is an arbitrary decision." Participants described the development of the PC Government's review of SCS as delegitimizing, since as the expertise of frontline workers and PWLLE was excluded.

This exclusion was not due a lack of available stakeholders. Brad told me about the Opioid Advisory Committee, a multi-disciplinary team of doctors, nurses, harm reduction workers, chronic pain patients, and other stakeholders that was "doing some really cool work".

[10] This can be found boldly displayed on the Canadian Association of People Who Use Drug's mission webpage. https://www.capud.ca/mission

The group was formed by the preceding Liberal Government "to ensure that those closest to the crisis are providing critical insight about what is happening on the ground" (Government of Ontario, 2017). However, since Ford obtained power in 2018, the group has not been called upon to meet. Other participants shared Brad's view that the effective disbandment of the Opioid Advisory Committee was a deliberate act of exclusion rooted in the PC Government's ideological bias of the PC Government. Relatedly, Bacchi (2009) asks researchers to consider: who is best positioned to produce knowledge that counts as "truth", how do they secure positions of influence, and what do they do with that influence (p.283)? These questions are useful to probe how participants experience the political effects of knowledge production and in the following chapter, how they disrupt it.

In describing her understanding of the government's motivation for the policy change, Celia, a Social Seupport Worker who has worked at multiple SCS over her career, said, "I honestly think it's for public appeasal, I think that people can't cope with the idea of a space that is only there to allow individuals to consume substances because people generally in society don't view that as healthy coping, right?" Safe consumption sites exist in a contentious space within the public domain. Common beliefs about these sites include an increase in criminal activity and drug paraphernalia. While research indicates public perception is improving (Kolla et al. 2017), drug users and unhoused people remain subjected to strong "Not In My Backyard" (NIMBY) attitudes, particularly by groups that treat systematically produced inequalities as individual failures.

The CTS policy brings NIMBY concerns into focus in two of the key findings documented in the policy's Backgrounder. First, the policy states, "There are divided opinions on the community impacts of Supervised Consumption Services and Overdose Prevention Sites in

terms of crime increase, drug trafficking or public disorder (such as vandalism and discarded syringes) or their effects on the quality of life for local residents" (Government of Ontario, 2018c). The policy also states, “The current supervised consumption services and overdose prevention site models require changes to adapt their scope, especially to address public concerns that have been raised about them” (Governemnt of Ontario, 2018c). Community consultation is not a new requirement. All SCS in Canada are required to provide a report on community support or opposition for a medical or scientific exemption of section 56 in the Canadian Drugs and Substance Act. While the process of community consultation has been met with criticism by researchers and frontline staff, it is not within the scope of this thesis to critique the utility of the process because it is not a new requirement by the PC Government. [11]It is significant to note that research has well established that, across decades, SCS do not promote drug use and increase crime (Kennedy et al., 2017; Wood et al., 2008; Potier et al., 2014). Instead, I will argue that the emphasis on SCS to adapt their scope to quell concerns about crime, public disorder, and drug trafficking acts as a discursive signal to the public in an attempt to politically neutralize a population.

Participants viewed the policy as a politically expedient endeavour rather than a research-based and community driven approach to the overdose crisis. In fact, participants used terms such as “bullshit”, “sham”, and “rebrand” to describe the CTS policy. Frontline staff are acutely aware of the increased expectation for the site to assuage concerns about the quality of life for those who will not use an SCS. When I asked Brad why he thought the change in policy occurred, he responded,

> **Brad:** Because people don’t like to think of addicts using drugs, obviously. I think it sounds a lot more pretty and acceptable to the more conservative of voters, even liberals,

[11] The PC Government did impose increased measure for sites within a certain proximity of schools, parks, and childcare centers (Watson et al., 2020)

> really anybody that doesn't see drug users as fucking people, and they want more to a story. They want the recovering addict, or they want the fucking recovering person, you know what I mean? I think sometimes people just use drugs, and for whatever fucking reason they use drugs, that is their choice, and to help them come up with a decision is their fucking right and some people don't like that.

Brad's comment reveals how we pathologize those who do not fit the expectations of the self-disciplining neoliberal citizen choosing treatment over drugs. Once one is 'liberated' from their relationship with substances, the bodies considered 'recovered' are expected to "become part of this system, even if, more than the substance, it is the speed of the world that makes them ill" (Theodoropoulou, 2020). Since pursuing abstinence is a valuable and worthwhile endeavour for some, this approach effectively masks ideological content under the guise of health logics and science, making it uncontestable (Shore & Wright, 2015, p. 421). Even further, the policy masquerades as a well-intentioned device of medical care and an intervention into a well-established pathologized state of being. Harm reduction becomes susceptible to a risk-management ideology in a sociopolitical context that prioritizes productive bodies, resulting in the process of neutralization, a notable shift from the fulfilment of an individual's needs (Quirion, 2003). The insidiousness of the shift to treatment lies in the traditional function of SCS as places to support people wherever they are in their drug-using journey, aptly described in Brad's final comment.

When I asked Linda, a Harm Reduction Worker, her thoughts on why the policy change occurred, she swiftly and confidently replied, "politics". When I asked her to elaborate she said, "society doesn't want drug users in our population. I think there's this general understanding that society wants drug users to get treatment." Linda's terse comment reveals how an emphasis on abstinence-based treatment within SCS depoliticizes harm reduction. It also convenes harm reduction with institutionalised policies that follow the biomedical paradigm. Public

understandings of treatment as a cure for the health and social ills of drug use is often associated with drug free ideology.

The primary mechanism of neutralization deployed in the CTS policy is the promise of the ameliorating of public disorder and crime by rehabilitating those who use the sites. Since their inception, SCS have been primarily presented as medical interventions, in part because SCS do address certain healthcare concerns. However, it is a recognized rhetorical tactic that medical authority is borrowed to justify their existence to those who would otherwise find their activities problematic. Interestingly, the following chapter explores how participants recognize and employ this tactic for their own purposes. The CTS policy frames the site as a medical service in order to appeal to a voter base that is more likely to value a treatment-based approach. Ingrid was present during the community consultations and said, **"**we brought the community into the health centre, and the model that was being put forward was very much what would sell to the general public. You had a nurse, it looked very medical". Ingrid's comment highlights the intentional emphasis on the site's medical aspects, such as the newly required presence of a nurse on staff, to signal risk reduction to the greater population through the elimination of perceived harms. It is important to note that progressive practises of governance coexist along traditional forms of repression (Smith, 2012). Celia said,

> "I see a lot of kind of defence of these spaces to people who are maybe a bit naysayer like 'oh no, it's fine it's like a medical service, there's nurses there, there's EMTs there'.... So I think the treatment services push is just something that has really been put out there to appease the general public."

It is possible to use a public health crisis as a conduit to advance a political agenda. The functional aspect of improved health conveniently aligns with a reduction in drug use, as medical authority is used to justify changes in one's habits (Zola, 1972). The entangled nature of prohibition and health logics offer a politically ripe circumstance to frame abstaining from drug

use as a panacea for SCS guests and concerned residents. Thus, there is an assumption readily made that placing social problems within the realm of healthcare leads to the removal of moral and punitive consequences and relegates such problems to medical, and therefore objective, interventions (Zola, 1972). The results of entangled medical and criminal models of addiction in the policy is increased surveillance and the pathologization of SCS guests. This characterization lends itself to the justification for the need to neutralize a population from their potential harms to the broader community.

In the discursive analysis of the policy, I argued that the underlying assumption within CTS policy is that drug use is the central problem SCS should alleviate (Arlt, 2022). This assumption is not unique to the CTS policy. Within drug policy, there is a deeply entrenched belief that drug use is wrong because it results in social ills, criminal activity, and health problems (Duff, 2021). This view exists in contrast to social models of drug use that are characterised by a recognition of environmental factors that contribute to substance use disorders (Rhodes, 2002) and more progressive frameworks of understanding injecting drug use as normative and rational (Vitellone, 2017).

The frontline staff I interviewed, with or without lived experience of drug use, regularly de-pathologized drug use. Reasons for doing so included recognizing the inherent joys of drug use and the realities of drug use in contexts of extreme social disadvantage and political exclusion. In one account, a participant told me they would like to see a return of ordering "heroin from a Sears catalogue with a fancy syringe and going about life, injecting heroin when you feel like it". Similar to Celia's comment about "people not seeing using drugs as a healthy coping mechanism", these comments reflect a divide in the acceptance of drug use between frontline staff and the aims of elimination of drug use in the CTS policy. The negotiations of

drug use and characterisations of health and illness by frontline staff challenges the claim that drug use is the foremost concern for SCS guests. Another frontline worker, Jane, described drug use as a natural and expected response to trauma,

> "When I started working in this site and I heard these stories, 'oh my god my mother put me to work on the street at 12 years old and I had to eat pizza out of a garbage can last night for dinner', I never ask myself, 'why did this person get into drugs?' most of the time I'm thinking, 'why the fuck didn't they do them sooner, man?' This poor person, some of these people you have no idea the stories, the life some of these poor girls have had."

Jane's empathetic anecdote positions drug use as an inescapable fact rather than a moral issue (Smith 2012, p. 211). Further, her understanding of the drug use encounter led to an ontological reframing that punctuates dominant claims that treat drug use as a deviation from the "normalized health body" that policy is meant to correct (Duff, 2015, p. 20). Jane's alternate understanding of drug use incorporates broader sociopolitical circumstances, creating friction with the framing of drug-use within the CTS policy. This friction has implications for how care is practiced and embedded within certain social circumstances (Buch, 2015).

Keeping Jane's statement in mind, I note that frontline staff must provide care in the setting of harm-reduction-as-public-health-policy that 'avoids confronting the very things that produce the most harm for drug users: drug laws, dominant discourses of drug use and the stigmatisation of users' (Keane 2003, p. 231, cited in Smith, 2012). Participants' recognition of systemic inequities led to frustrations with the increased emphasis on abstinence-based treatment, as many participants feel that treatment will not alleviate the stressors of poverty and trauma. The recognition of using drugs for pleasure and to cope with enduring socio-economic circumstances are positioned by staff in direct conflict with the "drug-use as the problem; abstinence as the solution" model ingrained in the CTS policy. Drug policy attempts to shape drug using subjects and restrain or promote certain modes of care, influencing what is seen as

possible or not possible (Duff, 2021). When I asked Brad what he considered to be good harm reduction practice, he confidently stated,

> **Brad:** "I think having a good knowledge of the systems that create harm in people's lives is important. So having a good working knowledge of the drug war, and the ways that these like incarceratory models that we use to attack people's lives and do a bunch of damage, if the real harm that's, or the main harm that people face."

Brad's answer re-inserts structural factors into the equation of the service-provider-policy-interaction. Roe (2005, p. 244) articulates a historic tension between those who see the movement as a 'medical means of promoting health and mitigating harm', and a more activist faction that positions harm reduction as 'a platform for broader and more structural social change' (Smith 2012, p.211). Brad's reframing of what counts as harm transcends the problematization of drugs that the CTS policy is predicated upon and recentres social harms in his practice.

In sum, participants felt the CTS policy reflects conservative neoliberal beliefs about drug use; mainly as it did not address the structural causes of the overdose crisis, forcing staff to frequently confront the limitations of a treatment-oriented approach. Participants rejected how the policy regards drug use in relation to various health and social ills. Frontline staff were critical of the lack of representation of PWLLE in the conception of the policy and see the policy as a strategy to appease voters. Characterising the policy as politically expedient allowed for the ideological tone to come into focus more clearly and for participants to articulate instances of neutralization. An exploration of the political awareness that frontline staff possess enables an examination of PNP within the broader socio-political context.

## 4.4 Policy and Practice: Providing Harm Reduction in a Community Health Centre

According to the CTS policy, in order to receive government funding, each site has to be integrated with a CHC or demonstrate cross-organizational ties with supports, such as withdrawal management (Government of Ontario, 2018a). As indicated by the *News Release* that announced the policy in 2018, "The sites are not sufficient as standalone entities disconnected from other services; sites should support individuals to seek addictions treatment as well as other health and social services" (Government of Ontario, 2018b). It is important to note that InSite in Vancouver has offered co-located withdrawal management services since 2000 (Kerr et al., 2017) and SCS have been attached to CHC formally and informally in Toronto since 1999 (Kolla & Strike, 2021). Therefore, the integration of other health services is not an innovative addition to SCS.

Researchers have demonstrated the benefits of the integration or close proximity of SCS to other health and social services at the discretion of people who use drugs and other stakeholders (Kryszajtys et al., 2022). However, it must be recognized that each context is unique and implementation requires a balance between all stakeholders involved. Therefore, it is essential to consider the implementation contexts of SCS as built environments can have a variety of health impacts for service users (Bardwell et al., 2020, p. 102245). If stakeholders that miss the contextual understanding of SCS are there primary influence of planning sites there can be consequences for uptake for potential service users.

In essence, by requiring sites to demonstrate an increased entrenchment into formalized medical institutions, the result constrains the models of supervised consumption available to PWLLE. Some of the concerns staff that raised are not a result of the CTS policy directly but rather regulations from Health Canada. However, the discretionary funding stipulations, such as

the one mentioned above, and the requirement of further entrenchment into the medical institution, the CTS policy creates new forms of surveillance and control.

The CTS policy created a blanket standardisation of SCS models. Flexibility in service design between OPS and standalone SCS was born out of necessity, during the early years of the fentanyl crisis in 2016 (Kerr et al. 2017). Since then, flexible models of service have been imperative in meeting the needs of a diverse individuals. Participants explained that prior to the CTS policy, SCS had more freedom in developing organisational policy and protocols, greater choice in staffing, such as the decision to employ a nurse on site or not, and most significantly the ability to be provincially funded as an OPS. The degree of flexibility is not trivial, it establishes "meeting people where they are at" within healthcare institutions.

I suggest that since the CTS policy was, for all intents and purposes, a political reaction, the operational changes function as a signal to increase the institutions of law and order and medicine. In the following section, I trace how the concept of accountability was employed in the CTS policy, like other neoliberal policies (Shore and Wright 2015), to mobilise discourses of medicalization, surveillance, and what Stevenson (2014) calls "anonymous care" (p. 75). By referring to accountability, I characterise the expedient force of the CTS policy by "its ability to communicate a moral sense of obligation which political actors can act on, shape or change relationships" (Hoeyer et al., 2019, p. 465). In the following sections I describe participants' experiences of providing harm reduction centred care in a setting with increased accountability to the norms of public order and health. I also depict the challenges they face when the goals of treatment align with those of prohibition.

### 4.4.1 "Egg Shells" and "Red Tape": On Surveillance and Accountability

Frontline staff, especially those with lived experience of drug use, exist in a social and occupational marginalised role. The consequence of the CTS policy effectively doing away with the OPS model is that the three remaining OPS in Ontario are not provincially funded, forcing workers who seek job security to work for an agency with stricter rules. When Brad worked at an OPS that was funded by the previous Liberal Government, he noticed a stark change in procedure compared to working at a CTS site. When I asked Brad if the CTS policy change impacted his ability to provide the care he values, he replied,

> "I think it made it harder. Another change that happened is when we were an OPS, [removed because of identifying information] everything felt a little less corporate style management structure and with moving to a CTS it feels a little bit more like that, and that's just a little bit more impersonal with the way that management interacts with the rest for the employees. And it feels formalised in a way that is sometimes stifling, and I feel like is less responsive at getting employees needs met or addressing what is coming up or stuff, it also feels more punitive often, and so I miss when things could be kinda smaller and a little more collegial between the different…yeah"

Brad's recollection of more personal and compassionate communication amongst colleagues, many of whom are PWLLE, rests upon a desire to revert to the less hierarchical OPS style of management. I asked him to elaborate on how the change made the work environment more punitive, and his response elicited the very stressful position he has been put in as a site manager. He shared an example of one of his worries,

> **Brad:** If we don't follow procedure then we get written up and have our job in jeopardy rather than being seen as "oh like something bad happened to you, let's support you and let's see if there's training you need". Like if somebody gets a needle stick injury they get a note, a letter put in their file and we're told that if we get another, then that's a fireable offence… what really worries me, the real effect of that is at some point somebody is gonna get a needle stuck injury and not report it.

Brad's concern highlights the explicit shift from the recognizing that a staff member may need additional training and prefers to offer to provide it over to a rigid and unforgiving approach between coworkers. The values in harm reduction are embedded into the workplace

model and influence how coworkers interact with one another. The CHC integration changed the flow of work practices, creating an increased burden of consideration for frontline staff regarding their work practices. Similarly, Maya told me that being involved in an agency (CHC) forces her to make decisions that won't get her fired while she is helping guests.

> **Maya**: "There's a lot of like weird red tape around a lot of things and I think again a lot of the management in my program see it and don't agree with it but in order to stay open within a community health centre there's so much walking on eggshells and trying to keep everyone happy to keep the program open so it's really tough sometimes"

Maya's comment about "walking on eggshells" was a common concern amongst participants. The fear suggests that there is an alternative approach to care that exists on the other side of the rules and regulations she refers to as "red tape". As such, instances of providing harm reduction care exist in tension with the increased rule-based operations of a CTS. This shift changed the way that staff relate to one another. As Celia notes,

> "When that's a decision you can make as a worker and not in the back of your mind being fired or reprimanded or having the entire site shut down because there's this grey area and you've made a decision to try to, like, do something for like the best possible health outcome that's a much easier space to navigate than just having to be like 'no'."

From these conversations, it became clear that risk management logic extends beyond SCS guests to internal practises that influence the staff's priorities. The goals and aims of staff are distinguishable from the rigid procedures they are expected to follow, despite the loss of harm reduction informed care. Staff felt like they were "walking on eggshells" as to practice valuable care within the SCS. The challenges Maya, Brad, and Celia referenced here reflect on the nature of the systems they operate under and up against. Care is constrained through the threat of either an individual losing their job or the entire site being shut down. Accountability serves to establish responsibility (Hoeyer et al. 2019). Staff must regulate and manage

themselves accordingly, to avoid the punitive effects that create a level of personal responsibility rendering them accountable to their coworkers, SCS guests, and the community at large.

### 4.4.2 Spatial Reorganization: On Social Control and Accountability

The integration of SCS into CHC was meant to demonstrate a commitment to wrap around services, such as primary care, social services and access to treatment. I argue that the institutionalisation of all SCS was touted as comprehensive care but rather acts as PTP under the guise of accountability.

Staff spoke highly of the ability to refer their guests to a variety of services in house, noting the benefits of having closely linked services at their disposal. However, they also expressed concerns with CHC integration operating as a barrier because of the surrounding medical treatment options,

> **Joe:** "I know having been in this situation it can be very intimidating. First and foremost a lot of our services are in community health centres, hospitals, shelters, and these can be very intimidating places, these are places that are filled with a lot of stigma. I know one of our community health centres had a supervised injection site and when people are waiting to access the site they're standing beside the AA people, the NA people, their methadone doctor potentially, their addiction counsellor, it just doesn't set [people] up for success because you have so much judgement there, so much stigma perpetrated by just different community members coming in to get food or clothes and they don't understand the nature of problematic substance use and what not."
>
> **Stephanie:** So that makes me wonder, since putting safe injection facilities in community health centres, does that make it a little bit more difficult to access then because there are all these other services, is it like people are expected to go to these services first and if those people catch them at the safe injection facilities it causes a little bit of like those other services don't understand why they're still using the safe injection facility?
>
> **Joe:** Totally, my methadone doctor is 15 feet away.
>
> **Stephanie:** And it's like "hey what are you doing there?"
>
> **Joe**: Exactly, she's already giving me a urine analysis asking me about my usage and she punishes me if I use and that's just not something I can avoid…
>
> **Stephanie:** If you want to use the site?

**Joe:** Exactly.

Joe is a PWLLE and he has found this set up to not only be a barrier, but also a subtle form of coercion induced through shame. Joe raised concerns about the province's requirement that SCS-CHC integration situates a harm reduction service alongside people who perpetuate an abstinence model of addiction treatment because harm reduction philosophies are often held in tension with abstinence-based approaches. Joe's concern highlights the ideological conflict of a harm reduction service as it is now embedded in a facility alongside practitioners who may prioritize abstinence-oriented treatment. This scenario indicated to me that certain interventions regarding substance use are prioritized within the healthcare ecosystem and supervised consumption is lower on that proverbial list. For example, some PWLLE have termed the methadone treatment as “liquid handcuffs”, and previous literature has framed aspects of the methadone experience as a form of social control (Bourgeois, 2000; Smye et al., 2011). The physical renegotiation of space created by the CTS policy maintains the dominant narrative of a linear recovery.

Harm reduction becomes susceptible to a risk-management logic resulting in the process of neutralization, a notable shift from the fulfilment of an individual’s needs (Quirion, 2003). Neutralization in enacted as a PTP by the reorganisation of space, creating opportunities to police subjects as they are now under surveillance and accountable to other service providers who may “punish” them for their use of the site. Whether this by-product of the CHC integration was intentional or not, “moral sentiment and political efficacy are fragile in ways carefully revealed in the intimacies of care” (Livingston 2012, p.93). As such, within a CHC, political tensions between interventions are exacerbated for both staff and guests who actively use drugs.

### 4.4.3 Dissolving Forms of Community Care: On Deficits and Accountability

The PC Government claimed that the CTS policy focus on integration of SCS into CHC "would include an enhanced and necessary focus on connecting people who use drugs to primary care, treatment and rehabilitation, and other health and social services" (Government of Ontario, 2018b). Participants affirmed that the increase in funding allowed for guests' medical needs to be attended to more quickly than before the policy change. However, within the same conversations, many participants expressed frustration about the decrease in funding for resources they consider essential for meeting client's needs. For example, Leanne shared both perspectives. She said that, "I feel like there's more supports now because were in a bigger facility, and we might have had more funding…that has given me the opportunity to work on client's needs." Later in the interview, she expressed concerns around how funding was distributed, "I think that the way they tried to micromanage funding, it took away the ability for us to meet our clients' needs head on, like, funding for transportation, funding for snacks, things along those lines. It became really hard for us to be able to allot [funds] to different things to fit our clienteles needs". I decided to probe these ideas with Joe, as he was one of the final participants. Joe's response confirmed that certain assets are considered important to frontline staff but were not funded.

> **Stephanie:** When I talk to people they tell me they have more funding and now they have more resources to do the work.
>
> **Joe:** I don't know who they are, who they're talking about because everyone I talk to, it's definitely not like that around here, you know? The hardware, a lot of the extra stuff we have like food and stuff like that, clothes and stuff like that, it's completely gone. Stuff for people to do during their chill out times like the video game systems and television, so now people are using and they're bounced, there's nothing to keep them around anymore. Whereas before it was a cup of coffee, a small plate of food, a snack, a television program, a video game, it's enough to keep them in the site for a little while to watch them and make sure everything is okay."

The space that Joe is referring to is commonly called a “chill room”. Joe highlights the pragmatic role of these services in keeping guests safe and ensuring they are tended to after doing their shot. A chill room also offers time to chat with guests, providing an opportunity for staff to build trust with and get to know guests better. These spaces have been included in previous models of unsanctioned overdose prevention sites where they have been critical to ensure greater comfort and overdose prevention for guests (Kennedy et al. 2019). Conversely, within the CTS policy, funding was allocated to support the stipulation that each site would employ a full-time nurse, suggesting a fundamental reorientation of the sites. The change minimizes forms of community care and preferred medical resources. Participants expressed concern over the inclusion of a nurse in tandem with a reduction of the resources that experiential workers value. They were ultimately concerned that this change will create barriers to the aim of making guests feel more comfortable in the space. This barrier is particularly pronounced because nurses are required to witness injections. Many participants find the practice of witnessing to perpetuate stigmatising and intimidating interactions with healthcare providers, which prevent people from using the site. In response to the requirement of nurses to witness injections, Brad stated,

> “People are really sensitive to surveillance and it just feels like really horrible… Lots of people still feel shame about being witnessed… trying to take away that ‘we're watching you’ feeling helps a lot of people relax. It takes a lot of work to reassure people and build a trusting relationship where you’re not secretly judging them”.

Previous studies of SCS in Ontario have found that common reasons for using sites, beyond intended purposes of clean gear and supervised injection, included positive social interactions and connections with the community (Boucher et al. 2017, p. 6). Brad’s emphasis on building a trusting relationship with guests harkens back to the core principles of harm reduction.

As a highly contextual practice, PWLLE welcome injection witnessing and assistance, but only if requested and offered by those with an established and trusting relationship.

"Meeting people where they are at" extends beyond fostering interpersonal relationships and establishing SCS in locations with high incidents of overdoses. Participants pointed out that recreating the socioenvironmental circumstances where one would use drugs is intentional and drawn from lived expertise. As Brad explained in his response to moving into a CHC, "That's not the environment that people do drugs in… when they're using drugs in their community and homes they don't set it up so it looks like a hospital". Here, surveillance is operationalized through eschewing the distinct social and cultural norms that underline injection drug use outside of a SCS (Fischer et al, 2004). By focusing on guests' needs, harm reduction strategies help to reduce the social exclusion that traditionally threatens people who use drugs (Quirion 2003, p. 248). The physical environment and the vibe a place projects are significant factors in influencing whether guests feel comfortable and are willing to use sites. Experiential workers' knowledge has been essential to fostering comfortable and welcoming environments (Kennedy et al. 2019). Frontline staff felt that the conflicting nature of witnessing, when post-injection care is more appropriate, undermined their expertise, while creating a more challenging environment to provide care.

At one point in our conversation, Celia professed in frustration that she had submitted a request for funding to create a space that would provide the assets Joe mentioned because it would "really help people access our services, but we did not get the funding". With funding rejected by the PC Government, staff felt like they had to work harder to build relationships with guests so they felt comfortable enough to remain on site post-injection. The requirement for a nurse to witness injections is treated as an act of accountability on behalf of the SCS operations

and results in a justification for institutionalisation. Within public health, accountability comes to mediate relations of care and structure what is considered good care (Hoeyer et al. 2019). Through a restructuring of priorities for what is significant enough to merit funding, the CTS policy created a space for increased surveillance and undermined PWLLE knowledge and expertise.

### 4.4.4 Senseless Census: The Bureaucratization of Care

Celia told me that providing good harm reduction requires minimal barriers, "I think the biggest thing that we can do for folks is work on having as few barriers as possible to accessing care. Whether that's physical barriers coming into the space or social barriers." Celia has worked at multiple sites throughout the OPS to CTS transition. Prior to the CTS reform, she described the guest intake process as "very basic". The intake process is what happens when someone walks into the site to use the services. Celia recounted the questions as "only what we would need to best serve people". These questions consisted of their age, their gender, and the drug they were going to use. She was careful not to ask more, unless people were interested in chatting. In describing the intentions of this approach, Celia said, "Discussion came up organically, people's needs and wants came up on their terms when they wanted to discuss them instead of having this three-page long intake that we had to do every single time someone came in, when really they just need to use and get going with their day."

The long intake procedure Celia referring to reflects the introduction of increased reporting requirements. These requirements are a feature of the CTS policy, "Under the new model, each site would implement an ongoing monitoring and reporting plan, as well as adhere to a comprehensive enforcement and audit protocol. This would help review performance, provide measurable outcomes and ensure compliance" (New Release, 2018). Reporting

requirements define a population and, importantly are politically volatile. Data collection is not simply useful for the information it collects, but it also signals a particular future, one of order and neutralization.

In regard to SCS, it has been suggested that increased reporting requirements reflect changes in governments rather than scientific or organisational evidence (Daple and Gagnon, 2021). The introduction of these requirements is a strategy conservative governments use to force SCS to change their philosophy and service delivery (Daplé and Gagnon, 2021). Prior to conducting interviews, I saw some of the outrage about an increase in reporting from SCS staff on Twitter. As a result, one of the changes I probed about was the new reporting requirements (amongst other possible changes), when I asked the participants if there was anything different since the policy change. Numerous participants expressed frustration with increased paperwork.

Unfortunately, this trend poses unique problems in SCS. The increased bureaucracy mean harm reduction services shed some of their most traditionally meaningful elements. This section highlights the friction between the paperwork aspect of institutionalisation and harm reduction philosophy. To better understand the effects of increased reporting requirements on care, I have included this section because many participants voiced concerns about data collection. Further, Hoeyer and colleagues (2019), posit “one cannot understand the workings of accountability without engaging the practises through which they emerge and come to have effects” (p.461). Therefore, the data-collection procedure is a political act, shaping what the program aims to catalogue. I argue that increased reporting is a form of governance that dilutes harm reduction principles within the SCS through the various methods, which are outlined below

Participants identified that a key aim in their practice of harm reduction includes person-centred care which is achieved through building relationships. Joe shared, “...it [reporting and

monitoring procedures] takes up so much of my time that I could be using it in a lot better fashion. Every conversation keeps people safer and builds relationships…". Staff build relationships by fostering trust with SCS guests. A key mechanism to fostering trust includes avoiding asking intrusive questions that people would feel uncomfortable answering, and allowing those concerns to be voiced, as Celia said, "organically". Celia's experience in her site prior to the CTS change reflects the practice of "meeting people where they are at" by prioritising the exchange of information from a mutually beneficial standpoint. She describes the policy change,

> **Celia:** "...A lot of it came down to redundant paperwork or excessive paperwork that not only like, took attention away from folks who are accessing the space it's not just like 'oh no I have to fill out another form woe is me', that it is also time that I can't spend you know, working with the folks that are accessing services and having that face time and having those conversations that's more time with me and my head buried in a computer or on a clipboard when people might need attention. And again, too, just the sense of people walking on eggshells, kind of more from a staffing perspective"

The collection of data is celebrated as progress towards evidence-based healthcare policy. Yet, discussions with those tasked with data extraction reveals the everyday realities of data collection are complicated. Participants argue that adhering to the data collection mandates constrains their ability to practise a person-centred approach to care. Celia admits that fulfilling her administrative duties requires her to forgo opportunities to enact relationship building and puts her in a position of "walking on eggshells" to fulfill to organisational requirements. This finding is concerning because staff now have an increased pressure to keep guests around post-injection with a conversation, especially in light of the lack of resources available at sites, such as a chill room. The increase of data collection at the expense of human interaction reinforces the medicalization of care and actively diverts harm reduction practises. Celia's attention is diverted from the human context because she needs to adhere to a checklist within the computer.

Thus, interactions “become increasingly routinized and detached” from SCS guests' concerns and experiences related to their health (Saluk 2021, p.9). The imposition of increased reporting requirements engenders what Lisa Stevenson (2014) describes as “anonymous care”, where practises of care are rendered as “professional and not personal through bureaucracy as it is indifferent to the persons and the personal” (Stevenson 2014, p. 76). Participants expressed how “anonymous care” creates a particular dilemma that results in increased stress for frontline staff.

Another concern about all the paperwork is that it is an attempt to increase the validation of these services through the emphasis on what is deemed important to track within mainstream medical institution. These seemingly mundane tasks provide critical insight into operations of power and regimes (Shore and Wright 2015, p. 421). As Celia details below, this PTP has exerted influence and altered practices.

> **Stephanie**: Are there any other ways you feel these changes have impacted the type of care that you provide?
>
> **Celia**: I think it has made workers and agencies a bit more rigid in their service delivery just because I think it really kept people on their toes, the idea that some site aren’t being funded at all, that funding could be pulled if all of these policies and procedures aren’t being checked off, I think it made people scared, this like, very abrupt and unnecessary change in a funding model and so I think again agencies are afraid to stick their necks out and advocate for what people are needing in the community. I think workers are very careful to, you know, be checking all the boxes and really put unfortunately the policies and procedures sometimes above what people are needing, maybe that are coming through the door.
>
> **Stephanie:** Okay so my understanding is that checking the boxes equals funding?
>
> **Celia:** Exactly, that’s the thing, you gotta show numbers to get funding… Like we now have to show that were sending “x” number of people to treatment we have to show to like, mountains and mountains of paperwork that you know someone had an [injection] assistance from somebody else. All of this stuff is a detriment to people accessing services… Like when will keeping people alive be sufficient and like, not require all of this extra proof that they’re worthwhile spaces and they aren’t a cure all like they aren’t going to solve the overdose crisis but it might keep people alive long to survive the overdose crisis.”

Celia's remarks about the vast number of resources that she is required to adhere to, in the name of transparency, undermines professional autonomy. Requiring data on treatment referrals does not reflect the philosophy of SCS, and the resources that are diverted from care to fulfilling this need compromise the nature of SCS (Daple and Gagnon 2021). Lisa Stevenson examines this shift from *providing* care to *demonstrating* care through data collection over providing care in her account of suicide hotlines in the Arctic. Once care becomes reduced to a checklist of boxes, it morphs into anonymous care, which is "keeping people alive without caring for their quality of life" (Stevenson 2014, p. 85).

The motivation and substance of health information technology has implications for accountability and governance after data is collected. Echoing other participants, Ingrid mentioned, "data collection is becoming more cumbersome, and the manager having to spend a lot more time with reporting, it just takes away from their ability to do the work." Ingrid shared that she is exhausted, skeptical, and resentful,

> **Ingrid:** Like that takes so much time, like the managers having to do all the reporting, it takes way time from service delivery, what happens to all of that information? Like where does it go? What do they do with it? …and people aren't basing decisions off of that because if they were, because if bureaucrats were actually basing decisions off of that we would have expanded…if they actually cared about what we have to report. I just think it goes to someone's office and they just look at it and they do nothing with it and it just sits there with all of the other ones.

Previous accounts of data-tracking in healthcare indicate the tension between satisfying the bureaucratic indicators of success and what a frontline staff felt would benefit an individual (Hannsmanss, 2021). When Ingrid said collecting data "takes away from doing this work", one could argue data collection is the work, but her distinction suggests otherwise. There is a stark contrast between the excessive paperwork that satisfies the organisation over what staff *could* be

doing with their time, such as fostering trust and building relationships with SCS guests that they find personally and professionally meaningful. This diversion of priorities is a common feature of bureaucracy. Once a formal set of targets is established, reality becomes as it exists on paper, and human needs fall to a secondary consideration (Graeber, 2019, p. 47). Thus, institutionalisation prioritises the needs of the organisation over the needs of the individuals it serves.

This section identified the changes that staff faced in their work environment after the policy was implemented. In their daily practices, staff must contend with the broader social and political forces of neutralization through accountability practices that result in mechanisms of surveillance and social control. While these practices occur through spatial reorganization of sites and a shift in how staff relate to one another, a significant material manifestation of this practice is through increased reporting requirements. In all three cases, staff found it harder to provide care aligned with harm reduction values.

## 4.5 Conclusion

At the beginning of this thesis, I questioned the implications of integrating SCS into the broader healthcare ecosystem. I also asked if the CTS policy changed how staff practiced harm reduction. I found that the policy reform constrains experiential knowledge and imposes a particular reality on those who visit CTS. Staff found that the requirement for nurses to witness injections, the denial to fund meaningful resources, and the increase in data collection impinged upon the fundamental principles of harm reduction. Significantly, frontline staff felt excluded from the policy-making process. Exclusion can lead to refusal, and the patterns of alternative social relations constructed to deal with the exclusion become real cracks, powerful spaces of refusal-and-creation (Holloway 2010, p.25). The staff's positions about the limitations and

misguidance in the CTS policy serve as a powerful motivator for how to engage with the policy. The following chapter explores the generative opportunities seized by staff to provide more meaningful care.

# Chapter Five: Identifying Cracks— Policy Navigation Practice Cases

*"Canada is in the midst of a devastating opioid overdose crisis, an unprecedented health emergency. This is an emergency that has been caused and exacerbated by state bureaucracies, hierarchies, and policy and laws that criminalise drugs and the people who use them. The losses are staggering, and the grief is overwhelming. Yet bureaucratic red tape, the ongoing war on drugs and government inaction continues to fuel the fire. And we continue to lose more of our friends and family members. We are in a position where our only path to survival is to bypass state imposed red tape, rules and regulations. To help our friends, families and ourselves, it is our ethical responsibility to take things into our own hands. We must undermine the barriers enforced by bureaucratic hierarchies. We must take risks, and we must act.*" (Dodd & McClelland, 2017)

## 5.1 Introduction

As Dodd and McClelland (2017) clearly stated in their commentary five years ago, the overdose crisis was, and still is, a manufactured crisis that can only be surmounted if individuals take action to overcome state imposed barriers. This crisis is the result of social values that are imposed by state-authority. In this chapter, I outline how SCS frontline staff address the impacts of the ideological implications in the CTS policy in their daily practices of care through what I call Policy Navigation Practices (PNP). I define PNP as selective manoeuvres that staff use to mend the gap between ineffective and inaccurate policy procedures and the needs of guests within the SCS. Frontline staff work with what means they possess in their role to circumvent unsupportive policies with the aim of providing care. Initially, I anticipated frontline staff would use their creative discretion to enact PNP in clinical situations that necessitate an alternative direction. I was not sure what this would include exactly, only that it would be with the intent to enact harm reduction over policy directions that fundamentally contradict the principles of harm reduction. By going into data collection with an open mind I ended up applying and thus expanding the concept of PNP to include an instance of grassroots organizing that I came across in my data collection.

In the previous chapter I have demonstrated the ethos of harm reduction remains despite institutionalisation efforts. I now shift my inquiry to uncover the elusive and yet fundamental acts of harm reduction oriented care. To accomplish this, I examine the ways in which the CTS policy is enacted and resisted by frontline staff who accommodate and contest the policy. Specifically, I discuss four instances of PNP and how their application relates to core tenets of harm reduction and experiential worker expertise. Before I delve into each PNP, I set the stage for how I characterise experiential workers. Each of the following PNP offers insight into frontline staff's method of determining their position as a policy actor and adjusting their behaviour to alter the course and direction. I seek to answer, how is the CTS policy accommodated, refused, and disrupted?

## 5.2 Policy Actors as Experiential workers

Unintentionally, the overwhelming majority of participants in my study are staff with lived experience of drug use. Eight out of ten participants identified as PWLLE, and had worked in harm reduction for a period of time before becoming employed in a SCS. As explored in the previous chapter, the delineation between workers with lived experience and other staff contributes to a hierarchal structure that minimize their expertise (Greer et al. 2021). The significance of the presence of workers with lived experience of drug use cannot be overstated. Thus, exploring their unique experience within an SCS offers insights into how lived experience knowledge and practice is integrated into mainstream harm reduction services.

The importance of the strong presence of experiential worker in my study is that their unique identity and background shapes their engagement with SCS guests and policy governing drug use. When one comes from a place of lived experience of drug use, the training and

preparation one brings is personal and comes from a place of identity. The distinction here is that there is a strong socialization that shapes their engagement with their work; as opposed to a frontline staff member who may have training in social services or medical care, but not harm reduction and thus, may follow policy without the scrutiny lived experience affords. There is an added layer of complication as an experiential worker since "peer workers not only *work* in stressful environments but *live* the same realities too" (Mamdani et al., 2021, p. 2). As Maya explains,

> **Maya:** A lot of the people that I would have run into in outreach in [town] could have been people I was friends with, like any of the folks that come into the CTS could easily be people that I could have met at some meetings that I would go to. I'm not far removed from the folks who come access our services.

The SCS is not a self-contained place of work; it is porous connecting to other aspects of their lives. For experiential workers, personal lives and professional lives are intertwined and are difficult to separate from one another (Mandami, 2021). Workers with lived experience have described "fulfilment from their work that helps them make sense of their personal losses and hardships" (Pauly et al., 2021, p. 20). It is because of this source of purpose that their work has different stakes and thus a different relationship with governing policy.

In addition to their unique skills and expertise, experiential workers face unique barriers and challenges. An example of such is the lack of training for PWWLE. As Joe told me there is little training for peer roles,

> **Joe:** Most of the time the amount of training that I actually got either before this job or moving into the site was very, very scant. A couple [of] programs at a mental health association, you know? But yeah, basically [we're] on our own, there's no models for peers, really working in this community, so they just kind of threw us to our own devices basically."

Joe's comments highlight the unique role PWLLE face in healthcare settings. Experiential work makes up an umbrella of roles and responsibilities (Greer et al., 2021). As a result, experiential workers are hired for their experience in numerous areas and are expected to draw upon appropriate expertise without much guidance. The consequences of occupying such a nebulous position include a lack of role clarity and expectations. Despite trying hard to do good work while remaining flexible and responsive, the lack of clarity for organizations sets up for failures rather than success (Greer 2021, p. 9). Linda described a situation where she experienced the stark difference between harm reduction values and institutional expectations.

> **Linda:** It's very nebulous how my work sees relationships with guests, I've been accused of being unprofessional several times and it's hard to be an activist and it's hard to be a harm reduction worker. I'm constantly having to justify what it is I do and still justify being a professional at the same time, especially because I was hired based on lived experience as opposed to having a social work degree. I wish that, especially if I'm hired based on lived experience, that would be constantly upheld and just be like "yeah you were hired based on lived experience do your thing"

Linda's experience speaks to what it means for PWLLE to navigate overdose response and policy within a mainstream health institution. Certain ways of relating to one another that are acceptable within community become a liability within work environments; which effectively undermines the unique skills PWLLE bring to harm reduction efforts and hinders opportunities to provide community informed care. Thus, the evolution of PWLLE's involvement in harm reduction efforts from self-organizing to integration into mainstream health institutions results in operational consequences (Greer et al., 2021).

When harm reduction efforts emerge from external forces such as policy-making in established institutions, the efforts can create a moral subjectivity guided by neoliberal forms of governance (Duff, 2018). However, when harm reduction is practised by PWLLE, it is an expression of community care meant to keep each other alive and safe. Historically PWLLE

have had their agency stripped away, and have faced life-threatening discrimination at the hands of healthcare services (Boucher et al. 2017). There is a gulf between these two forms of harm reduction filtered through paradigmatic differences in existence, such as an emphasis on the "new public health perspective" reduction of disease transmission, and PWLLE emphasis on building community and autonomy (Boucher et al. 2017, p.3). Ontological formations are "defined through the ways in which basic categories of existence are lived spatially, temporally, corporeally, performatively and epistemologically" (James 2014, p.183). As such, "negotiating ontological difference is foundational to what it means to be human" (James 2014, p. 173). The persistence of knowledge and practises of care amongst PWLLE speaks to the appropriateness and effectiveness of the strategies they employ.

After Joe shared a few instances of guest's behaviour to which he turns a blind eye, I asked, "So, do you have more examples of the way you let things slide?" Joe responded, "Yeah it's tough because usually there's three of us in there, a nurse, a peer, and what they call a community worker and we've all got different ways of looking at things, it's usually the community workers and the peers that are a little more apt to let people slide." PWLLE efforts and roles are shaped and constrained by large institutions under the pretense of "peer engagement," which often does not extend to meaningful inclusion of PWLLE (Greer et al., 2021). There is often a difference between what is permitted in the site and what SCS guests need. Joe is motivated by his corporeal understanding of the needs of someone visiting a SCS. He continued from his comment above,

> "Because people need the medications they need to feel normal, 90% of the time I'm using is just to feel normal. Yeah, you gotta buy drugs. The government is not supplying them like the only thing that we're getting is dilaudids, there's people who are using fentanyl doing basically baby aspirin, they're gonna get what they need and I don't see that as criminal".

Participants ground their approach to care in the fundamental tenet of PNP not to recreate punitive structures but to enable behaviours that people find beneficial to the functioning of an SCS. In these instances of micro-policy implementation, there are two key considerations; the actors, and their methods. The actors are the frontline staff in SCS and the positionality they bring with them, while the methods include circumstances surrounding policy implementation or refusal. In the context of spatially defined harm reduction efforts in Ontario, an important consideration to understand the actors and their methods lies within the context of their personal philosophies (harm reduction) and the broader policy-implementation context (governmentality of neoliberal logics). My decision to ground participants' refusal of policy mandates in a strength-based approach rather than insubordination comes from honouring their understanding of providing good care.

Through an anthropological lens, I was able to "listen differently" (Stevenson, 2014) to how previous accounts of micro-level policy implementation have framed policy actors' behaviours and motivations. Stevenson claims that listening differently naturally silences certain voices in order to privilege others (Stevenson, 2014, p. 8). I do this to elevate instances that would be considered "disobedience" or "non-compliance" to the methodological interventions they are. The similarities in motivations demonstrate an intentional positionality shared among participants. An intentional positionality is the conscious and deliberate stance an individual takes that guides actions and behaviours. However, it is important to consider Joe's comment that not all staff share his views on drug use, or that they are able to act on them because of the position they assume at the site. The array of position is due to varying levels of political involvement or awareness amongst staff in addition to staff that are bound by college rules such

as nurses and social workers. Thus, PNP are not necessarily carried out in every circumstance that may call for their application.

Staff assess policy prescriptions for their utility in the circumstance presented and partially comply or selectively resist mandates to deliver more appropriate care. Further, an experiential worker's behaviour may be influenced by the power gradient within hierarchal institutions (Greer et al., 2021). As mentioned in the previous chapter, staff have to weigh the advantages and drawbacks of their decision at a moment's notice in order to keep their employment at the increasingly institutionalised site. Thus, it is important to consider the role of institutional goals that constrain and diminish PWLLE advocacy and shape their workplace experience (Greer et al., 2021). The following sections describe how experiential workers navigate the structural constraints.

## 5.3 "Grey Areas" and "Blanket Rules"

Several participants mentioned the concept of "grey areas" in describing how they are able to practice harm reduction informed care under the increased rules of the CTS policy. Within the context of this thesis a "grey area" represents an ill-defined situation. Grey areas explain why and how tactics and strategies are employed when other perhaps more sanctioned policy practices are rejected or seen as impractical (Dolson, 2015). The use of the metaphor of the "grey areas" indicates participants' ability to expand and capitalise on these moments; and are analogous to what Holloway (2012) describes as cracks, where "in each of these cases, the cracks, the spaces or moments in which we reject external authority and assert that 'here and now we rule', are outgrowths of more limited struggles coming up against the limits of the system" (p.23). As moments seized by staff that upon repetition, "grey areas" contribute to the widening of cracks. Acknowledging "grey areas" means working in a way that recognises

situational context and how each individual operates within these contexts and disregards "hard and fast" or "blanket rules" to provide higher-level forms of care. Exploiting "grey areas" allows for the inherently contradicting nature of frontline staff's jobs to be addressed. The contradiction lies in the fact that staff are expected to, and motivated to, provide lifesaving care while adhering to a set of organisational rules they find can act as a barrier to this expectation. Multiple staff have responded that the integration into CHCs created a struggle to strike a balance between providing care they value and abiding by organisational standards. They do this through timely recognition of "grey areas", between the rules and their own knowledge of effective strategies for the people they serve.

Maya was the first person I heard explicitly mention the metaphor and application of "grey areas".

> **Maya***:* "I think embracing the grey areas of things is super important in harm reduction, like especially in a working kinda capacity. A lot of the issues that we face are kinda around people not being able to grasp the "rules". Not like hard fast rules but more like guidelines and a lot have a lot to do with like the context with like whatever situation…so I think like in order to kinda say you're doing like providing harm reduction services it has to be like meeting people where they're at, I know that's the most like used statement ever but its super true."

For Maya, operationalizing "grey areas" refers to successfully capitalizing on contextual idiosyncrasies as essential to providing harm reduction informed care. She makes the point that the individuals she serves at a SCS would benefit from more flexible approaches to care. By doing so, Maya's draws a direct relationship between the concept of "grey areas" and harm reduction care. When she mentions "meeting people where they are at", she does so in contrast to applying blanket rules. Enacting harm reduction requires traversing the grey space to provide a shifting continuum of care on a moment's notice, regardless of what established protocols are expected to be followed.

> **Stephanie**: "I'm just wondering, kinda getting back to the elements of harm reduction practice, could you or would you mind giving me a story or an instance that illustrates how you apply those elements in your work at the SCS?
>
> **Maya:** "I mean I get in trouble a lot for like breaking rules and stuff…some people are like very stick to the rules and some people are not and I'm one of the not".

I thought it was peculiar that Maya responded to my question about practising harm reduction with a confession about breaking rules. When I probed her for an example, she responded with "there a bajillion", but wanted to start with an example she was not directly involved with. She recalled a time when her coworker dug out a baggie of drugs from a sharps container when their colleagues told the guest that there was nothing they could do, and was on the verge of calling security. The coworker found a solution that kept them safe from a needle poke, but ensured that the guest "wouldn't get his hand cut off if he was supposed to sell that."

> **Maya:** I'll give you an example I wasn't directly involved in just cause it's the first thing that's glaring in my brain 'cause it was really recent and it caused a kerfuffle. So a person dropped their drugs in the sharps bin by accident and it's one of those ones that isn't like an open faced one it's like you put it in the slot and the slot like slides and to closes back up so they're like relatively see-through though so anyway this person was like 'I'm not leaving like I need to get that like can you like unlock the bin like or I'm just gonna rip it off the wall cause it's like $180 I'm not just gonna leave that here. I'll get my hands cut off y'know?' So fair enough and I guess technically through Health Canada we can't get a policy that actually allows us to let people go back into the sharps bin because of a lot of different safety risks but there's like some grey where like if people choose to do that, we do also have tongs and gloves set aside for when we need to like idk shove the stuff down in the sharps bin and make more space or whatever so one of my coworkers was like super not into that and was like nope you need to leave you need to get out and was not listening to him or hearing him out whatsoever. And I was just like *nervous laugh* woah, so bottom line one of my coworkers swooped in and gets some gloves on and tongs and gets his shit to him and he leaves and no one gets hurt"

Maya and her coworkers are fully aware that disregarding the "no going into sharps bin" rule has merit; and they do not want to risk a needle stick incident. However, this situational context provided an opportunity for staff to repurpose the tongs and gloves that were set aside for making room in the sharps container. In fact, Maya referred to this act of "selective resistance"

as categorically harm reduction in nature, as entering a sharps bin with gloves and tongs is less likely to be as dangerous as the consequences the guest would face from whomever he owed the drugs.

When I asked Maya if the CTS policy impacts her ability to provide harm reduction services, she responded with “for sure” and that she was even jealous of the lack of “red tape” and “institutionalization” that OPS have in their ability to prioritize experiential workers in the decision making process and autonomy in creating site guidelines. In Maya’s opinion, these frivolous rules were a clear indication “that people who access the services aren’t being consulted”. Maya found that these rules deter people from coming and that it's reasonable for people to forget things, and people shouldn’t be punished for that. Maya emphasized that the practice is a “hush hush thing” that some staff do because other times guests will try to get the drugs out themselves, and that results in losing access to services for the day.

> **Maya:** “we have like a pause system it’s kinda like being altered at the moment and it’s like if there’s like violence inside the centre there’s like some ground rules that like can’t happen so like if someone breaks one of those rules they get like a pause in their services…when they’re paused or their services are paused, they’ll still like come by and ask for gear and stuff and some of my coworkers are like ‘nope you’re paused I can’t give you anything you need to go over to (section redacted due to identifying information about the site), y’know if someone’s made the walk over and is requesting sterile supplies then why would I says no to that? *laughs* like, regardless of what happens so I often break that rule as well”

Frontline workers like Maya recognize that blind adherence to overarching policy is not only ineffective in providing guest-centred care, but can actively hinder it. Through her creative discretion that is rooted in her lived experience, Maya is able to ensure a guest has continued access to care. One of the ways in which she manages this is through rejecting what she calls “blanket rules”. She emphasises the importance of individualised care, “you can’t just like apply the same blanket rules and I say rules again with air quotes *laughs*, to people and expect them

to all just follow that especially if you're trying to provide like consumption services". The "blanket rules" Maya refers to are a way of constructing responses to every person and situation indiscriminately. Brad refers to the ineffectiveness of this approach specifically in harm reduction work,

> **Brad:** "I think a lot of it comes down to the same themes of responsive care that really fits what the clients' needs are, and I feel like in too much of the institutionalised work that we do whether its healthcare or social work or whatever it's about creating systems that people are forced to navigate that don't work for them but demanding that they conform to the system rather than actually trying to build systems that are working in people's lives and are able to shift and move so they are working for people better."

As mentioned in earlier in this chapter, many frontline staff have an acute recognition of the political forces that contextualizes their work, but their decision to operate in contrast is not an act of resistance simply for the sake of resisting, they are motivated by their desire to recenter the needs of the people they serve. Brad's powerful comment echoes Celia's recognition that services must be flexible to the needs of the individual and he takes her point further to suggest systems can be created to perform this function.

Working in the grey does not simply apply to moments of tactical adherence, but also to conceptualising the CTS space itself. Natalie shares how she conceptualises her site and how it influences her practice,

> **Natalie:** "I see it as a place for people who use drugs and are marginalised to come out and seek support in various ways. I don't just see it as a place where people can come in and use their substance, I feel that it is just a welcoming- just non-judgment space that is necessary in their community. Like yeah, we function as a consumption and treatment service site but we also just offer support any way that we can. That is how our agency functions, we don't work on black and white, we like to work in the grey. Our main purpose is to be a safe place for people to use but we're really focussed on being an open space."

Often, navigating this space requires improvised thinking at a moment's notice. A participant's commitment to providing harm reduction informed care extends beyond the physical site itself. It is here, in the expansive space guided by a willingness to support in whatever way they can that enables the following example.

Enacting quality care cannot be bound to a physical location when one is embedded into the drug using community. Linda described a situation in which she was working and was approached to respond to an overdose in a nearby apartment – which is not allowed under her site's policy,

> **Stephanie**: "Can you tell me about a time you felt like you were improvising or thinking on your feet and it enabled you to supply good healthcare?"
>
> **Linda**: "I knew it was policy that we weren't to go off site but I went off site anyways and like I trusted her, I had known her for a very long time and I ran and I provided healthcare to the person who was overdosing in her apartment and I came back to site and no one was the wiser, but I knew it was against policy so I didn't say anything to anyone, but it was the rig- I believe it was the right thing to do … It only took less than 10 minutes, and I saved the person's life and I wasn't endangering anyone and the fact that she came to us and she trusted us, I hold that very, very, very, dearly and close to my heart… it was a split-second decision I had to make. Do I toe the line and go with policy? Or do I just run and do this thing? And I did."

Linda's account reveals the multiple options she weighed before she could make her choice. Particularly, a significant factor in her decision was shielding her guest from the harms of criminalization. The stakes of frontline worker's decisions are between life and death. Often, the modalities of action accomplished in CTS operate moment by moment with an emphasis on *who* the staff is working with and the situational context. Other times there is a coordinated effort to selectively adhere to or to refuse policy implementation. Thus, practising harm reduction necessitates the recognition and seizure of "grey areas".

Frontline workers found the increase in rules after the policy change to require additional attending to in order to do their work. Leanne shared "I knew that we were getting a harder time

with a lot more of the guidelines that need to be followed…. But we were really adaptable". Unlike arbitrary rules and principles, the use of "grey areas" fundamentally enacts care relationally. Examinations of such care practices counters discourses of passivity in doling out policy and demonstrates a commitment to solidarity with those in need (Buch, 2015). Official rules are used as guide posts and critically evaluated for their effectiveness in emerging situations. If said rules do not achieve an outcome in line with the philosophy of harm reduction, they can be forgone in favour of a circumstantially appropriate approach. The exploitation of these spaces involves an intentional method of weighing the advantages and disadvantages of the policy procedure to apply selective resistance and partial accommodation to navigate within the grey area. At a fundamental level, the values and the expectations that arose from the policy reform has put experiential workers in a position where they have to defy the rules even more so than previously. As Linda's case demonstrates, adhering to policy means potentially compromising the life of people who use drugs and the values of frontline workers who strive to provide meaningful care. Yet, to defy the rules often means SCS staff are vulnerable to losing their jobs.

## 5.4 Recasting the Concept of Treatment

Ontario's Ministry of Health and Long-Term care boasted that the CTS model would "offer a new focus on connecting people with treatment and rehabilitation services" (Government of Ontario, 2018b). The recurring references to rehabilitation and plans to "expand access to addiction treatment by creating more detox beds in high need communities" (Government of Ontario, 2018b), indicate the concept of treatment to be understood as that of pathways of abstinence (Arlt, 2022). In contrast, frontline staff offered multiple interpretations of the word "treatment" that both recognize as well as reject the form of treatment assumed in

the CTS policy, and appropriate the word to fit a broader scope of health and social services. The CTS policy attempts to enforce a static notion of treatment, while frontline staff's interpretation alters the instrumental function of the concept.

Through the explicit renaming of SCS to include the word "treatment" in the title, in combination with the increased expectation on treatment referrals, staff noticed an emphasis on abstinence-based treatment paths,

> **Brad:** "There's definitely like, an assumption that you're gonna send people to a lot of doctors like, detox and like, residential treatment like a lot of like, drug treatment stuff is built into that assumption. Like it's so rare that we send people to drug treatment and to be honest if people tell me they wanna change their drug use, drug treatment like residential drug treatment is definitely not what I've seen work the best of help people the most so if people wanna go there like I'm not gonna, like I will do whatever people ask me to do, want me to do, but if people are trying to talk about options, like I'll talk about that as an option but also be honest with them about like what some of the limitations of that are."

While the language used in the CTS policy suggests SCS as an instrument to the ultimate goal of treatment services; Brad problematizes an impetuous referral to treatment. Brad recognizes the merits of treatment, but he pauses to explore options he knows would be more beneficial given the guests situation. The following sections demonstrate how frontline staff resist or accommodate the discursive imposition of treatment in SCS.

### 5.4.1 Framing Safe Consumption Sites as a Conduit to Treatment

Given that treatment is framed as a priority in the CTS policy, it is difficult to escape when discussing the roles of SCS. Frontline staff employed creative ways to use the term to align with their goals. The most explicit instance I encountered of recasting treatment was by Joe. His understanding of harm reduction comes from his lived experience of surviving the war on drugs, something many of his friends did not. Joe did not get involved in harm reduction because he wanted to, but because he felt compelled.

**Stephanie:** I'm wondering, what was your personal goal when you started working at the safe consumption site?

**Joe:** Just to see some of my friends stop dying. I feel awful saying this but I feel like I survived a war or something… I was going through some old pictures the other day and everybody is dead except for me and this guy who's like hospice care right now. Like everybody's dead, like 10 years ago. I'm just sick and tired of being sick and tired. We've lost so much love and so much potential and these people deserve better, it just breaks my heart.

When I asked Joe what he thought the function of a SCS was, he immediately said as a landing point for treatment.

**Stephanie**: Okay, and I'm just wondering what do you see the role of a safe consumption site as?

**Joe:** I think first and foremost to get people into treatment, and I know myself speaking, first and foremost I need to be alive to access treatment and the amount of overdoses, the amount of disease transmissions, the engagement that supervised injections services I think meet all those criteria very well.

**Stephanie:** Okay, when you say treatment what do you mean by treatment?

**Joe**: I see supervised injection as a form of treatment, it's the first step to access treatment, you know? Like you gotta start somewhere you know? It's for me, anyway, a place to get the conversation started.

Shortly after this comment, when I asked why he thought the CTS change occurred, Joe sheepishly admitted that by positioning SCS as treatment he can garner more support behind the service, despite whether he characterises a SCS as treatment.

**Joe**: From what I understand the Ford government always wanted to be tied in [to] treatment per se anyway, maybe that's why I'm actually bringing it up, because any time you need to prove something to this awful government, it has to be in the treatment guise.

**Stephanie:** Yeah and how do you feel about that? How has that impacted your work?

**Joe:** Yeah, it impacted it a lot…Having been in the system for so long I am now able to move my arguments a little bit and call something as treatment or frame it more as treatment so it can get the back-up it needs but yeah it's been really tricky. I just think

> that people deserve dignity and health and they shouldn't have to be forced to stop using drugs if they don't want to.

Joe's adeptness to know how and when to get away with a politically expedient concept of treatment is a cunning tactic that momentarily reroutes an established intervention to further progress care for PWLLE. In this instance, it can be argued that what Joe is doing with the word treatment is in the same vein as what the PC Government has done to the concept of "harm reduction". The PC Government has endorsed harm reduction, but has failed to elaborate or affirm some of its most core characteristics, undermining the set of assumptions that prop up the term. The PC Government's reluctance may be rooted in an ideological disapproval of harm reduction, or unwillingness to fully commit to a politically contentious concept (Hyshka, et al. 2017). Joe's ability to seize an element of treatment in it's given form and alter the term, creates an opportunity for a synthesis of new elements (de Certeau, 1984). As Brad shares, the change in language reflects both the expansion of the term as well as what is counted as treatment,

> **Brad:** Not only was the policy change bringing in a bunch of language and expectations from the sites about being conduits to treatment services and also the idea that everyone who uses an SCS must require "treatment", but also what we define treatment as. When the conservative party talks about "treatment" it is very clear that they are talking about abstinence-based treatment. And also particular types of abstinence treatment with certain philosophies on substance use and people who use. By far the most helpful treatment service as well as the one that we have seen work the best has been safe supply. But the Conservatives do not fund or support safe supply.

Safe supply is an intervention of offering pharmaceutical grade alternatives to illicit drugs. The intervention picked up momentum in the beginning of the pandemic to support people who use drugs during a dual public health crisis by the means of self isolating and as a mode of social distancing (McNeil et al., 2022). Brad's comment on the provincial government not offering funding for safe supply refers to the five streams of harm reduction services in Ontario where each but two streams receive provincial funding: safe supply and injectable Opioid

Agonist Treatment (iOAT), which offer pharmaceutical grade opioids to drug users seeking to move away from the illicit supply (Government of Ontario, 2020). Participants felt this sent a pretty strong message to what type of treatment the provincial government values.

In this instance, “partial accommodation” and “selective resistance” occur through the struggle over an appropriation of the symbol of treatment. In the hands of frontline staff, treatment is not seen as static or fixed, but negotiated through practice. However, Ingrid warned that this tactic is not without consequences and can often be a slippery slope for coerced treatment. In her response to this key finding in the member-checking document, Ingrid shared,

> “My issue is that we always did referrals to treatment and that, yes, we do expand treatment to include broader health and social services. I think the example of positioning the SCS as a first step is actually dangerous given what’s happened in Alberta and what I assume could one day happen here where SCS have now been positioned as pathways to "recovery". Could see more coerced, forced treatment. So that is something I would consider as it's really a dangerous area to position.”

The opportune nature of tactics means that beyond being intrinsically temporary and fleeting, the seizure of the term “treatment” can transform from its original meaning while in the hands of the practitioner. However, the same can be said for when the product leaves the hands of said practitioner and travels across a political landscape. Ingrid mentions “what happened in Alberta” as an example of where the provincial government of Alberta created an internal review of SCS in the province and declared “overdose prevention services as a recovery-oriented system of care” (Government of Alberta, 2021). To avoid further entrenching SCS as pathways to abstinence, staff in Ontario must carefully and sparingly attend to when to frame SCS as treatment. The result is an ongoing consideration that reflects staff’s expertise in recognizing the appropriate situation to evoke this tactic.

### 5.4.2 An Expansive Concept of Treatment

Linda is an experiential worker who has worked at SCS before and after the CTS policy. She emphasises trust and relationship building in her practice. She finds working in an agency means she has to justify what she does at work, forcing her to temper her lived experience and activist side. Policy navigation practices exist on a shifting scale of accommodation and resistance. Reckoning when to comply, either functionally or ideologically is essential to workers' success in navigating the CTS policy. Linda shared an example of partial accommodation that afforded a guest an opportunity that otherwise would have not come about. Linda recounted an instance where her colleague was able to get one of the guests on a safe supply prescription because it was framed as treatment, and since the policy's focus is on treatment, she used the Ford's Government's commitment to leverage a prescription.

> **Linda:** I know that a really good friend of mine has been working super, super, super hard for a really long time to get funding for this so… it came through recently, probably because of the CTS she got the funding for it, but I don't officially know why it came through.
>
> **Stephanie:** Why do you say it's probably because of the CTS that she got funding for safe supply like, what about the CTS advances the probability of getting funding for safe supply?
>
> **Linda:** She was able to make the argument that the guests that or patients that were eligible for this program were not successful on methadone or suboxone and this would and they were overdosing on fentanyl and that they were known to our site and that we had nurses that are nurse practitioners on site that could prescribe safe supply and that it would be a treatment that would work for them and that they went to rehab, several rehabs and that they were unsuccessful and that they were treatment resistant, whatever that mean. So, it might just be an alternative treatment.
>
> **Stephanie**: Okay, and the sense that I'm getting is because they put treatment in the title now it holds some accountability for them to provide treatment, it's a bit of a leverage thing?
>
> **Linda:** Yeah.

In Linda's recollection she employs a tactic in the chance offerings of the moment, and "vigilantly make use of the cracks that particular conjunctions open in the surveillance of the proprietary powers" (De Certeau 1984, p. 37). Linda's tactic mirrors a situation where healthcare workers have been known to enact housing as treatment through "eligibilization" (Hanssmann et al. 2021). Through knowledge of available programs and systems, Hanssmann witnessed his participants navigating housing-related issues for their patients by widening the bounds of what counts as eligibility for housing programs. Similar to Linda's account, this was achieved through leveraging institutional goals, despite a difference in method, in their favour. Linda utilised a medical strategy as a "productive act of resistance", where one uses the medical system to counter other oppressive systems, to provide positive health effects (Kolla and Strike 2021 p.129). Within the context of the CTS policy and frontline staff, this creative response maintains proximity to the principles of harm reduction and drug use as lived by frontline staff.

### 5.4.3 (Re) Aligning Treatment with Harm Reduction

The final way I witnessed frontline staff rework the concept of treatment is through apprehending the static notion of treatment and enacting treatment as something else. Ingrid introduced me to an expansive concept of treatment. Consistent with its origins and principles, she describes harm reduction as going beyond reducing blood borne illness; it is an emancipatory ideology to change how we talk about people who use drugs and the services geared towards them.

> **Ingrid:** Harm reduction is about justice work, it's about liberation, it is an ideology of liberation and we should be working towards dismantling the drug war and all aspects of it. To me, that is what harm reduction is and it's also about support and you can have, like, therapeutic relationships and you can support people, mutually support people, yeah I mean like obviously it is about needle exchange, supervised consumption sites, safer supply some really basic things but it's also changing we see drug use and the way that we see people who use drugs and harm reduction has really changed that a lot especially when we talk about language and changing language and the way that we talk about

> people who use drugs and including people who use drugs in the creation of programs and services that are geared towards people.

For Ingrid the goals of harm reduction include reducing exposure to violence from the war on drugs aligning her practice with the original principles of harm reduction. Ingrid offers an inherently rehumanizing approach to care, specifically as she talks about the elevation of PWLLE experiential knowledge and meaningful inclusion in the policy making process.

When I asked Ingrid why she thought the policy changed she responded that the Ford Government wanted to make it seem like they were doing something different by focussing on treatment. She argued that the type of care one received in SCS *is* treatment, "if you think about treatment as a form of a therapeutic relationship". Ingrid reimagines the concept of treatment within the landscape of the CTS policy,

> **Ingrid:** That change in policy occurred because they wanted to rebrand the supervised injection sites, they didn't wanna admit that what we were doing was like good, they wanted to make it seem like it was like a focus on treatment, but, it is treatment, like what we're doing, like if you think about treatment in terms of a therapeutic relationship, what better place can— you can just like walk in the door and you can talk to a person, you can't do that- like when you're struggling you can't do that anywhere. There's nowhere you can just walk in, if you wanna go into addiction treatment you have to call, make an appointment, go to a focus appointment thing, like it's not easy.

"Selective resistance" creates alternative possibilities under the imposed but incomplete sociopolitical system. Ingrid's redefinition of treatment is not an innovative conception of treatment. Her "partial accommodation" of the treatment approach through an application of an alternative form of treatment creates an opportunity to provide a more meaningful form of care. She applies the medicalized language of care such as "treatment" as a sheath to provide a broader spectrum of services that are grounded in guests' needs. It is through her tactical borrowing of medical authority that she is able to maintain the legitimization of harm reduction-informed care in the environment of the CTS site.

# 5.5 Recasting Participation in Drug Policy

The previous sections demonstrated how frontline staff with lived experience draw upon their knowledge to selectively comply with and resist policy mandates. The exclusion of people with lived experience in the policy making process discussed in chapter four opens up critical questions about how knowledge is validated in health services. The next two sections demonstrate how participation is recast in the drug policy process by examining tactical measures to reinsert harm reduction values into policy implementation. The first is the practice of frontline staff privileging experiential worker knowledge, care and ways of being over the top-down approaches that originate in the medical institution.

### 5.5.1 Knowledge and Evidence: Privileging Lived Experience in Safe Consumption Sites

In response to the increased emphasis placed on medical authority, the practice of elevating experiential worker's knowledge was broadly shared amongst participants. As discussed in the previous chapter, frontline staff felt the requirements to have a nurse on site and integration into a CHC resulted in an environment that diminished their expertise and perpetuated the hierarchy of medical knowledge.

In this section I focus on how two Social Support Workers, Celia and Natalie, redistribute expertise and knowledge claims in the context of overdose prevention and guest care in SCS. The origins of elevating experiential knowledge originates from OPS models where constant feedback from guests is used to improve interventions (Watson et al. 2020, p. 102615). As such, I lead into this section with a comment from an experiential worker, Brad.

> **Brad:** I mean in my work at least what I've heard from the community that we serve, pretty consistently, is that they like having people who have lived experience, there tends to be some um, suspicion or hesitancy around the idea that people just pick this up in a book um, or like read a textbook and that they think they know my life… so having people with lived experience becomes important to people, and because that's the community I came from, that's what I grew up thinking too. And so it just always made

> sense to me, I remember being a peer worker and thinking why is my coordinator someone who's never done drugs before so I don't think that stuff are [the] things I needed to learn, I feel like that was in me already.

Brad's point emphasizes not only the importance of community but the knowledge fostered within communities that lends itself well to leadership. Indeed, early on in our interview, Celia shared, "People who are using drugs should be shaping those spaces and dictating what those services are. People who are using drugs are the people who know best what they need." She is a Social Support Worker who has worked at both an OPS and a SCS turned CTS. She does not show up in her role as having lived experience of drug use.[12] Early on in her career she struggled to understand why "all of these services seemed to be available and people were still struggling, and being non-compliant, and all these ugly words that people and systems use to describe people who aren't thriving to what seemed to be decent social services". It was only once she got involved in a harm reduction-based agency that her idea of how to relate to the people she worked with shifted,

> **Celia:** When I started working for an agency for an HIV service organisation that really promoted harm reduction, all of that seemed to click for me. All of the situations in which someone wasn't thriving it made sense to me that we weren't offering people what they needed, and we weren't listening to what that person was saying [about] what they needed for themselves and or their families."

Celia's experience highlights the value of building services with the leadership of those who would benefit from the services' existence. Yet, lived experience is not as valued as medical staff and knowledge, encouraging a hierarchy of interventions. Historically, "valuing academic knowledge over lived/ living experience can be linked to the capitalist economic system, which was instituted during the colonial era, expense of the poor and marginalized folks who were

[12] While Celia (and other Social Support Workers) may have lived experience of drug use, she is not permitted to show up at work with it to the same extent as peers due to college rules on disclosure that forbid her form speaking about experiences.

banned from academic spaces" (Mamdami et al 2021, pp. 8-9). Celia goes on to explain that this notion is deeply ingrained in the CTS policy,

> "I think that this policy change reinforced either the lack of need for people with lived experience or belittled their importance in the space by prioritising medicalized knowledge. I think it really served to reinforce that folks with lived experience are expendable and are not, shouldn't be, prioritised as staff in this space."

Despite this shift, Celia recounts, "The person with lived experienced, 100% all the time, knew what was going on in the space. They were the person who could answer questions about variances in drug use, how to best find a vein if someone was struggling, all those things." Celia's experience is in line with research that found that the representation of lived experience skills and expertise is underutilized in organizations (Greer et al., 2021).

Natalie also emphasises deferring to experiential workers. Natalie does not present in her role to the SCS with a lived experience hat on, but rather as a Social Support Worker. She is adamant that all work and policies pertaining to SCS should be led by people with lived experience and that working alongside peers has been a significant influence in her practice.

> **Natalie:** I don't believe that there should be any dismissal of peer-based knowledge. That is necessary when providing harm reduction-based work, because again, I will never know as well as someone who has lived experience, and I think that that is the key component of ensuring that a harm reduction program, policy, mandate or whatever is running well is if there is peer involved input.

Both Natalie and Celia's accounts emphasize what experiential workers "know", producing a performative constitution of "truth" that elevates multiple contextually approaches and privileging some knowledge over others (Lancaster, 2016). I asked Natalie how she applies this in her work,

> **Natalie:** We do use oxygen in our site before we use Narcan, so a lot of people will come in and we will say do not Narcan them unless necessary, so we have to be creative with that all the time, so again even though it is up to the nurse were pretty collaborative in nature in that a peer may have a technique… so just being creative in that sense, you know, like using ice packs, heat packs, talking to someone or like using like trap pinches

> instead of like jumping to Narcan because we know we have oxygen and that it's pretty dang effective and we like to lean on that more than jumping on Narcan which pushes them onto withdrawal which makes them feel shame and the guilt cycle a lot. You don't really want that unless the person is unconscious and can't consent to us doing that but if the person says again I don't wanna be Narcan'd we'll try our very best to work around it and work in the grey and try to appease them.

Natalie's approach to overdose response involves a variety of tactics that she learned from her coworkers with lived experience. Her decision to elevate their approaches redistributes expertise. It is through the recognition of the "grey", that the multiple can be seen and is seized.

Likewise, Brad, whose past experience of drug use guided him to his position as manager in a SCS, explained that he has had to train nurses to provide oxygen.

> **Brad:** "What I mean is that nurses do lots of jobs, but reviving people who are overdosing is usually not one of them, so lots of nurses don't come in with any of that experience, and even paramedics don't revive people, they stabilize people to transport to hospital. So this idea that nurses fix the safety issue because they're medical doesn't make sense because if you look into what they do. I mean even hospitals- like giving oxygen, I've had to train nurses on how to use oxygen because their only experience has been in a hospital where the oxygen just comes out of a tube in the wall. They're not using oxygen tanks so I just think it as— they put this as a "necessity" to open a site without thinking about whether that actually makes sense or not.

I want to note that people with lived experience have a considerable respect for nurses and their skills. Participants have witnessed nurses' affiliation with the medical institution propped up as a tool of legitimization for SCS. Brad shared that PWLLE are "way quicker to identify an overdose or a potential overdose than a nurse who spend their career in a hospital." Frontline staff's privileging of a certain type of knowing is directly related to a large scale reckoning of what constitutes "evidence" in the drug policy arena. Rhodes and Lancaster (2019) draw from Mol's (1999) work to consider evidence as not merely epistemology, but ontological because of how "evidence comes to be by attending to performance and practice of the ways interventions are implemented, improved and modified" (p. 112487). As such, participants are not describing an alternative approach to what we commonly consider to be evidence-based

policy. Rather, by considering evidence and knowledge as co-productive, Lancaster (2016) suggests the perspective that evidence does not sit objectively outside policy. The implications for the concept of evidence as applied to policy is the expansion of what counts as the production of evidence. By attending to how certain tactics undermine the hierarchy of knowledge, we witness how evidence is remade in practice. Evidence of efficacy of a policy, then, lays in the translation of an intervention into practice. I observe a larger scale intervention into the evidence making process in the final PNP.

## 5.6 Grassroots Policy Participation: Place and Intervention

My conception of PNP initially did not include grassroots policy participation, such as organisational advocacy prior or during the establishment of CTS sites. Initially, PNP only included tactics performed unspoken and in fleeting moments amongst frontline workers, their colleagues and guests that shaped clinical outcomes. Whereas I imagined strategies would be instances where staff had band together to change policy within sites after the CTS policy had been established. I did not intend to include grassroots policy initiatives.

My direction changed when I interviewed Natalie, a Social Support Worker at a social service site that was previously not a SCS, and came to fruition as a CTS. Natalie and the other staff were actively involved in the planning of the site. Would-be staff attended town hall meetings to influence the location of the site, and to dispel any misinformation the weary community may have had about the function of a SCS. de Certeau (1984) states that strategies are unspoken or spoken beliefs or practises that are shared amongst workers in a given space. Whereas I framed the previous three PNP as tactics, Natalie and her team's cohesive response acted as a strategy by successfully reappropriating the imposing system. Staff increased

autonomy over their clinics' practices through earlier intervention. Further, since a strong tenent of the CTS policy is meant to placate NIMBYism, the staff's strategic intervention in the community consultation phase of the policy implementation offers an expansive application of PNP at the organisational and municipal levels.

Community consultations were exceptionally emphasised in the CTS implementation policy. Through partial accommodation of this process, frontline staff sought to reinsert themselves into the community consult procedure in a meaningful way. As Natalie shares,

> **Natalie**: I think the very fact that many of us who were on staff were involved in the policy making process is something that has helped. I'm one of the very many people that are on our team that attended all of the town halls that actually gave input to the leaders in our communities to actually make decisions whether or not this site should exist. So just being actively involved, I think, in that process just like years ago has caused us to perhaps have a larger stake in our services regarding being provided and just feel more empowered to actually speak up because we've been there since day one, some of us.

Recognizing the discursive tenets of the CTS policy mobilised the staff at Natalie's site to intervene so they could have more autonomy over their clinical practices. The generative potential of the initial interventions at community meetings has implications for site operations and the nature of participation in drug policy. Unofficially, community consultation meetings are viewed as opportunities for the individuals to air their grievances about SCS, which then must be recorded and submitted as part of an application contributing to increased barriers for opening sites. Best practices for public health and public opinion can run in contrast to one another. Previous research has found that there is a gap in public perception in understanding that SCS can reduce versus increase drug-related harms (Kolla et al., 2017). Yet, the community consultation process bestows a procedural legitimacy upon public opinion that "produces particular forms of knowledge as truth" (Lancaster 2016, p. 148). By obeying the systems own

logic, frontline staff altered the preconceived intent of community consultations to establish a more value congruent site from its inception.

> **Stephanie**: So, you were able to maintain this kind of bottom up value system? Can you give an example or a story of how you were able to do it and how you were able to maintain that?
>
> **Natalie**: The year before, we were going to these town hall meetings and one of them was about figuring out where to put the site and a lot of people in the community didn't want the site to be in downtown just because they were trying to beautify downtown and gentrify it and blah blah blah, and we were met with a lot of community members who were opposed to opening the site where we are– and we're actually located centrally in downtown [city name and site location] so we are in like the perfect location but a lot of people wanted to push us out of the community. So a lot of the town hall meetings were uh, *pause for effect* very passionate conversations from both sides.
>
> Just constantly, and we went to one particular meeting just before the site before it was approved were tensions were so high and everybody, like everybody, on the side of wanting to open the site was very upset about where this was going because a lot of people in power were speaking out about how they didn't want this in downtown. A lot of people with money like condominium owners and people who had like, millions of dollars in tech start-ups and all of those people in power because they had money were like, very against it. So we came into that meeting believing that like we were like going to placed out in the boonies and left to do our work out there but [redacted due to identifying information] we came into it with guns a-blazing with like, all of our stories about overdoses we responded to, friends, family, random people we lost to addiction and an unsafe supply and the lack of safe places to go, and then we were just shocked by people in power were on the side of the policies actually being on our side and a little appalled that these community members that quote unquote care were like "not in my backyard" and luckily we haven't had a lot of community push back instead we've had a lot of support because our site has reduced ambulance calls, police calls, just, instances of quote and quote mischief in our community.

The origins of Natalie's site demonstrate the possibilities of what could be different if other voices and experiences are elevated. The influence of grassroots policy influence is not unique to this SCS, Ingrid believed that external pressure on politicians such as the demonstration of the 1275 crosses on the grounds of the Ontario legislature was essential in keeping sites across the province open. Frontline staff at Natalie's site proactively addressed the concerns mentioned by other participants about the exclusion in the policy-making process that enabled the schism from harm reduction ideology and the CTS policy. The result is a significant

influence on the PNP within the SCS. The relationship between knowledge and power is critical and intercepting as a key point in the knowledge generating process altered the operational nature of a site. Through their engagement, Natalie and her coworkers were able to recast the technical claims about drug-use and PWLLE and the role of SCS that influenced how the site is perceived moving forward.

Holloway (2010) argues achieving goals within a struggle is an interstitial process, not limited to a physical space, but accomplished through creating opportunity by skillfully identifying points of interventions. Through earlier intervention in the policy making process, one can operationally as well as discursively shift policy outcomes. At the other end of the spectrum, refusal also offers an alternate perspective, uplifting additional forms of knowledge. Recently, drug user activists refused to participate on a committee that would address health service options for PWLLE in Alberta (Dodd et al., 2022). Spearheaded both by PWLLE and healthcare professionals, the group published their concern for the individuals that were already invited to the committee. Their concerns included being invited as secondary guests and the selection of committee members that conveys an act of "political theatre" with an ideological conclusion already made. Their refusal to engage in the process is a strategic effort to not legitimize a deeply anti-harm reduction policy table.

## 5.7 Conclusion

Through expansive techniques of accommodation and refusal, frontline staff engaged in creative implementation of policy and procedures. Policy navigation practices attend to "the ability of social agents—individual or collective— to recruit, manage and incite social circumstances through particular practises and modes of thinking" (Kyriakides 2018, p.453). The

first PNP I discuss traces spaces of ideological contestation for practicing care within newly formed structures. The second PNP case demonstrates how the concept of treatment can be strategically appropriated to impose alternate social claims or manipulated to formulate new opportunities. The third case, is a broadly shared practice of privileging lived experience knowledge over top-down policy that speaks to the nature of evidence in drug policy. Finally, I describe one case of organisational PNP occurring as an act of solidarity among frontline staff from the initial conception of the site through to the running of the site. Initially, I did not include grassroots policy influence, such as organisational advocacy prior or during the establishment of CTS sites. My decision to include this as a PNP is twofold, first, it is relevant to understanding how individuals use tactics and strategies to influence established policy and second, doing so on a larger scale speaks to an expansive and contextual understanding of the role of PNP in the harm reduction community. The depth and extent of PNP are constricted by professional and personal location as well as circumstantial opportunity. Cracks are born out of necessity to reclaim place and tactics are born of the urgency for political alliance and connection (Kyriakides, 2018, p. 453). By operating in ways that are guided by experiential knowledge of harm reduction, rather than the ideological tenants of CTS policy reform, staff divert ill-conceived models of care for a more effective approach to care.

# 6. Chapter Six: Conclusion

## 6.1 Research Findings and Contributions

### *6.1.1 Summary of Findings*

In this research, I posit that frontline SCS staff have been engaging in creative application of policy procedures by means of tactics and strategies I termed policy navigation practices. Frontline staff are uniquely positioned to mitigate a deep mismatch between the social reality imposed by the 2018 CTS policy reform and their own harm reduction oriented world view. As I examine staff's daily work, tensions between policy and practice materialised. This thesis contributes to the exploration of the institutionalization of harm reduction by considering the role of frontline staff 's response to policy as a form of care.

Drawing on critical ethnographic inquiry I have demonstrated the importance of relationality in harm reduction informed care and how this tenent conflicts with multiple mandates within the CTS policy such as refusing funding for community resources, increased surveillance, and additional reporting procedures. I synthesized multiple social theory approaches such as the role of governance in the process of knowledge and evidence making, identifying ontological paradigms to contrast harm reduction practice and the CTS policy, and characterising participants' behaviours as "selective resistance" and "partial accommodation" (Dolson, 2015). These theoretical frameworks illustrate that despite the provincial implementation of a policy that is rooted in a neoliberal and medicalized understanding of how a person exists within the world, frontline staff engage in policy navigation practices to provide care that is rooted in principles of harm reduction. Thereby staff in SCS continue the legacy of PWLLE resisting oppressive structures to enact harm reduction oriented care.

The first argument of this thesis is that harm reduction is an ontological expression enacted amongst SCS staff. I demonstrate harm reduction practice as a way of operating in the world that is premised on the adage of "meeting people where they are at" as informed by lived experience of drug use. Through interviews, I elicit what harm reduction means to frontline staff in relation to the assumptions about the nature of drug use that comprise the CTS policy. I located staff's understanding of harm reduction as rooted in the knowledge of PWLLE as a powerful motivator for practices of care. I characterize SCS as a space where two conflicting claims about the nature of drugs and drug use exist in tension. I argued that frontline workers look not to overarching policy mandates to deliver care, but towards a shared world view steeped in the principles of harm reduction.

The second argument is that the CTS policy constrains practices of harm reduction through increased medicalization, resulting in challenges to providing care under neoliberal health policies. Using the guidance of the CMA framework I have demonstrated the association between overarching sociopolitical systems and their manifestations in everyday engagements between frontline staff and guests. In chapter four I showed that staff recognize the conflicting nature of harm reduction as they understand it and the expectations outlined in the CTS policy. I apply Foucauldian inspired concepts that characterise policy as a technology of power to highlight the tensions between harm reduction and the CTS policy. Staff's primary concerns with the policy change include the absence of meaningful engagement with PWLLE, resulting in the use of community consultations to politically neutralize a population by reshaping the SCS as a means for the medical eradication of substance use. I characterize SCS as interstitial spaces where ontological tensions between harm reduction and a characteristically neoliberal and medicalized approach to drug use emerge.

I investigate the concept of accountability practices that are informed by neoliberal values as a justification for the forms of governance that arise in the CTS policy; which participants indicated undermined their ability to provide harm reduction care. Distinct interventions within the policy include the spatial reorganization of SCS as the service is now integrated into CHC. This change resulted in less leadership from PWLLE, as well as increased bureaucratic and operational procedures, which increased forms of governance over care practices. Safe consumption sites' integration into CHC also resulted in a form of surveillance that shames individuals into a particular order of engaging in health services with an emphasis on abstinence-based services. Frontline staff also experienced difficulty acquiring funding for resources that guests would enjoy and would therefore engage more service users and keep guests under observation longer to ensure they will not overdose after the initial injection. Finally, frontline staff expressed a deep concern with the increase of data collection in their daily work. Participants felt it took away meaningful time to build connections with guests while simultaneously not offering any substantial use in return. It is clear that participants feel constrained by the institutional policies. I then move on to characterize how care persists in these spaces.

The third and final argument is that PNP are not merely disunited individual acts of resistance but a redistribution of power. I situate micro-policy implementation intersection of de Certeau's (1984) "tactics" and "strategies" and Holloway's (2012) concept of cracks. I suggest frontline staff enlist both tactics and strategies to impose on a dominant order specifically through Dolson's (2015) "partial accommodation" and "selective resistance". The range of PNP of care include outright refusal and leveraging evidence and institutional aims to achieve harm reduction-oriented goals. It is significant for our understanding of health policy implementation

that frontline staff clearly expressed that they do not look to overarching policy to inform their practices of care.

### *6.1.2 Contributions*

A critical ethnographic approach is well positioned to increase our understanding of the relationship between policy and frontline staff. I have described how the elements of critical ethnography frame my inquiry into the CTS policy and are suitable to address my research questions because the methodology attends to power imbalances and injustices. The CMA framework embeds frontline staff's experiences and behaviours within the larger sociopolitical landscape. By considering harm reduction as an ontological position, I was able to illuminate how the CTS policy conflicted with frontline staff's view of care and how they sought to mitigate these conflicts. Finally, a critical ethnographic lens reinserts an emphasis on human doing that cannot be examined through metrics or administrative data to capture how frontline staff enact care under the political ideology encapsulated in the CTS policy.

My exploration of the encounter between the political ideology in the CTS policy and frontline staff's harm reduction oriented care offers an entry point to understand locally situated dynamics between policy, practice, and social relationships in SCS. My decision to focus on frontline staff in SCS contributes to an understudied population whose work is a matter of life or death and whose relationships with guests are informed by a rich shared world view. Frontline staff have instrumental decision making space to navigate that directly impacts the type of care SCS guests receive. By investigating their relationship to policy and their worldviews, I offer insight on a crucial factor for how SCS operate. A focus on attitudes, values, and beliefs that inform care becomes more essential in policy and program planning and operations as harm reduction continues to become increasingly integrated into mainstream health services.

As the experiences of these frontline staff demonstrate, responses to the CTS reform continues the legacy of PWLLE enacting their own form of care. Safe consumption sites may currently be established throughout the healthcare landscape but this was not always the case. Historically, self-led overdose response efforts have always involved rule-breaking to bring health services in line with the values that compose harm reduction care (see, eg.,Dodd & McClelland, 2017; Kerr et al., 2017; Watson et al., 2020). My research demonstrates how said values persist within mainstream health institutions by situating staff's responses as politically motivated acts of care. Further, I have begun to investigate how this persistence is accomplished through tactics and strategies that are in direct response to systemic violence resulting from the war on drugs. Finally, this research has illustrated the network of relationships amongst SCS staff, guests, world views from lived experience, and within policy. I emphasized that the relationship between policy and care is in a state of flux. I have shown that enacting PNP requires considerable discretion in implementing harm reduction care in the setting of a CHC.

This thesis has demonstrated how the expansion of harm reduction into mainstream health services for PWLLE can lose sight of traditional harm reduction perspectives and supports. Previous studies of policy implementation suggest bringing in workers from a minority group will limit structural reproduction of ineffective policies (Lipsky, 1971). However, my thesis data demonstrated experiential workers in SCS felt ignored and dismissed which created a stressful work environment. These findings reiterate Mamdani and author's (2021) observations that experiential knowledge and expertise is diminished in settings that are produced within societal stigma against drug use. The demands expressed by participants builds upon past work describing the devaluation of PWLLE delivered labour (Olding et al., 2021). Additionally, for experiential frontline staff, there is an added complicated nature of providing harm reduction

care. Following Greer and colleagues (2021) findings concerning experiential workers in BC, I have demonstrated that by exclusion from the policy-making process frontline staff are constrained and enabled by organizational influences that impact staff's ability to perform community-appropriate forms of care. My research along with Greer et al., (2021) found these experiences not to be unique to any one organization but widespread across different sites.

Further, this research underscores Mamdani's and authors (2021) findings that the role of experiential workers is not utilized to its fullest value, creating a gap in care. The implication of inconsistent levels of training, vague job descriptions, and feeling slotted into mainstream health institutions as a second thought rather than building health services around PWLLE directives leads to an increasingly emotionally volatile environment to navigate. Research participants have asked for more flexibility in service provision. Specifically, there is a need to implement bottom-up models of communication that identify what the problems are, what the solutions should be, and that the necessary changes must be guided by those with lived experience of drug use. Top-down policies, like the CTS policy, expect individuals to enter a system and bear the burden of change in their daily tasks.

Moreover, this thesis highlights many concerns and areas for improvement for those who work in SCS. Frontline staff have indicated specific needs that are not being met. Primarily, staff indicate their work is most effective when policy conceptualization and implementation is led by PWLLE. One participant even specifies the reinstatement of the Opioid Advisory Committee. Participants have emphasized that their ability to provide meaningful care thrives when they are able to foster relationships with guests. Despite this clearly articulated need, staff find themselves preoccupied with increased bureaucratic procedures and punitive organizational protocols that compromise one's ability to build relationships with SCS guests. The constraints

on relationship-building do not only diminish the quality of care guests receive, but also position staff "above" guests, directly contradictory to the objectives of harm reduction which make it so successful. In addition, both experiential and non-experiential participants expressed concern with the increase in staffing hierarchy as a result of being further absorbed into the healthcare landscape.

Not least of all, this thesis offers useful insight into the endeavour of providing care under neoliberalism. Participants' experiences have spoken to the moral significance of providing care that resists external influences of self-governing rationalities. Staff actively recognized and questioned the expectation of being drug-free and opted for providing care without the aim of changing the recipient to align with neoliberal ideas about productive and meaningful citizenship. This goal was achieved when frontline staff conscientiously practice care that mends the gap between institutional standards and ineffective policy, even when doing so risks their jobs. These findings challenge scholarship such as SLB theory (Lipsky, 1971) that suggest frontline staff let individuals fall through the cracks when resources are scarce and instead draw upon a complex framework to improvise methods of care for SCS guests. The recognition of PNP contributed to a deeper understanding of de Certeau's (1984) "tactics" and "strategies" (p.xix) by demonstrating that those who are oppressed can identify spaces of weakness in the overarching system and impose their ways of being. Policy navigation practices are active acts of care and informed by an alternative understanding of relating to one another that emphasizes the power of "human doing" (de Cetreau 1985, p. xv) within incongruous and imposing social circumstances.

My analysis of harm reduction care in relation to drug policy contributes to the literature of care and policy in the field of anthropology. I consider responses to policy as a form of care

and I explore the motivations and methods behind how care is applied and what is considered good care. I build off of research that demonstrates care emerges through instances of state failure (Buch, 2015), which in turn reveals the moral and political nature of care-giving (Livingston, 2015). I also trace how care becomes obscured by dominant cultural ideas about how to measure care (Stevenson, 2014). Further, I identify the key mechanisms that lead to the lapse in adequate care. I have revealed how notions of health are politically situated, demonstrating how the roles of prohibition and the medicalization of social issues in shaping healthcare responses for PWLLE. I describe locally situated understandings of what constitutes "good care," and how care practices persist amongst sociopolitical forces that continually eradicate these practices. I have observed the persistence of emphasizing individuality and relationships over neoliberal practices and indicators of health as rooted in a deeply established understanding of an individual's relationship with drugs.

## 6.2 Limitations

The limitations of this thesis centre on the bias within the participant sample. The nature of the study, asking people to speak about a vocally contested policy change, meant that participants who answered the recruitment call, particularly the ones active on Twitter and through CAPUD, likely had shared critical ideas about the CTS policy. Both of these networks include people who occupy dual roles as SCS staff and politically engaged advocates for harm reduction and decriminalization. As advocates, they likely have a desire to speak on such topics and therefore a readiness to participate in research.

Further, a large number of respondents were experiential workers and not nurses or social workers. As experiential workers are consistently paid less than other professionals at SCS, the high number of PWLLE respondents could be due to the need for the honorarium. The

high number of participants with lived and living experience may have influenced the range and readiness to speak on instances of resistance to the CTS policy. With harm reduction's historical roots in disrupting ineffective top-down policies through practices grounded in the lived experience of drug use, it is likely the emphasis on engaging lived experience in the policy process, and the willingness to forgo policies that do not do so, is exceptionally emphasized by participants in this study.

Finally, while the recruitment criteria did not stipulate any particular region, the sample size includes three urban centers and no rural or northern Ontario sites, meaning the findings are not particularly relevant to sites planning or operating outside of urban centers. It is important to note these limitations, but their presence does not negate the quality of the data and the ability to answer the proposed research questions.

## 6.3 Future Research and Recommendations

### *6.3.1 Future Research*

This research focussed on how frontline worker's in SCS respond to dominant ideas about drug use and drug users as enforced through policy and what that means for the harm reduction community. Holloway (2010) claims that "the cracks are always questions, not answers" (p.8). What do the presence of these cracks speak to? And what does the exploitation of cracks indicate for health service workers? I am left wondering to what extent PNP influence the landscape of possibility in frontline workers' daily encounters with guests and larger structural transformation? As well as, what is the toll on experiential workers to occupy the role as an experiential worker as well as an enforcer of bureaucratic protocol? Researchers have begun to

address this concern (Greer et al., 2021), however ethnography would be uniquely positioned to reveal the intricacies of the challenges faced by experiential workers.

Further, both “selective resistance” and “partial accommodation” are individual practises rooted in experiential knowledge and we understand that PNP are interventions that can be categorized as evidence to be used in drug policy. How do we scale up these findings to an organizational and policy level? Accountability is a strong justification for many of the CTS policy’s requirements. Moving forward, I would like to clarify to whom are we to be accountable? These questions would benefit from future inquiries into examining the role of leadership staff, such as directors of SCS and CHC, in navigating policy changes.

The recent movement to prescribe a safer supply of opioids and the emergence of compassion clubs (Felicella, 2021) necessitates an exploration of the medical integration of harm reduction efforts of SCS to curb overdose deaths. Additionally, concerns about the growing medicalization of psychedelics points to a future need to examine the intersection of drug use and institutionalization (Hesse, 2021). It would be fruitful to continue to examine the resourceful ways workers negotiate their worldview and how they overcome state-imposed beliefs about drugs and drug use. I urge researchers to investigate: what happens when those given the task of enacting certain social claims about the world choose to do otherwise? And what are the implications of these choices on broader understandings of health and health services?

### *6.3.2 Recommendations*

Identifying and critiquing the sociopolitical forces that constrain and enable care is a necessary task in progressing health services. Through analyzing the challenges faced by frontline staff in SCS, solutions have begun to emerge. The following recommendations are

derived from those with lived experience of drug use and hinge on strengthened relationships amongst PWLLE and government and within organizations.

- Committing to permanent provincially funded low-threshold services such as OPS
- Expanding a variety of service models, including flexible models of staffing
- A review of necessary data collection procedures localized to the needs of each individual site
- Reinstate a provincial multi-disciplined Opioid Advisory Committee
- Increasing space for leadership from PWLLE, including and beyond managerial roles, within sites
- Developing rules collaboratively and with flexibility as to not reproduce punitive structures within SCS
- Providing clear expectations to experiential workers that values and emphisizes their unique skillset
- Offering education and training to incoming staff who do not have lived experience of drug use about harm reduction philosophy in addition to interventions such as overdose prevention and reversal

Until we treat prohibition informed policy and harm reduction as more than difference of opinions, but rather as two conflicting expressions of how humans are to occupy social spaces, we will continue to only marginally improve drug policy and health services.

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# Appendix A- International Harm Reduction Association

International Harm Reduction Association (2010). What is harm reduction? A position statement from the International Harm Reduction Association. [Retrieved from London, United Kingdom : https://www.hri.global/what-is-harm-reduction].

The Harm Reduction Coalition is an internationally recognized policy advocacy organization that lists the core principles of harm reduction as following:

1. Accepts, for better and or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
2. Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.
3. Establishes quality of individual and community life and well-being–not necessarily cessation of all drug use–as the criteria for successful interventions and policies.
4. Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.
5. Ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.

6. Affirms drugs users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use.

7. Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.

8. Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.

# Appendix B- Twitter Recruitment Script

Participants will be recruited via two sampling techniques. The first is convenience-sampling where I will gather respondents from my research-related Twitter account. A possible script for my tweet will read:

"I will be conducting my fieldwork for my master's thesis in summer 2020 and I am looking to interview SCS workers in Ontario about their views and experiences on the 2018 CTS reform, if you are interested in partaking in a 1-hour interview please email me at arlts@uvic.ca"

A follow up tweet in the thread will read:

"I would appreciate if my followers could retweet this to spread the word"

# Appendix C- Interview Protocol

## Session Structure

### Introduction of the researcher

I am a second year masters' student in the University of Victoria's Social Dimensions of Health Program. My interest in this topic stems from my experiences in drug policy activism and my interest in community- versus state-led health policy making.

### Explain objective

This study is concerned with how broader discourses of drug-use and harm reduction shape policy implementation, and the response to this implementation. There has not been an inquiry to the on the ground experiences of this policy reform. I want to know if this policy has affected how your practice harm reduction, and how workers such as yourself view and navigate the CTS policy reform in your daily routine at work.

### Obtain consent

I will be recording and transcribing this interview as well as taking notes to use as part of my master's thesis. I will offer the participant the approved consent form.

## Interview Topics

| Domains | Conversational Points |
|---|---|
| **Harm Reduction Beliefs** | • Influences on personal beliefs about harm reduction<br>• Experiences working or practicing harm reduction |
| **CTS Policy Reform** | • Position on CTS reform<br>• Influence on daily practices<br>• Formal procedures that accompanied the change<br>• Whose voices were included in the change |
| **Policy Navigation Practices** | • How staff ensure client care<br>• Specific actions taken to accomplish harm reduction goals |

# Interview Questions

## Introductory Questions

1. Can you tell me a little bit about yourself?
2. What does a day at work look like?
3. What was your goal when you started working at the SCS?

## Questions About Harm Reduction

1. Can you list what harm reduction means to you?
2. What do you see as the role of a SCS?
3. When do you feel like you are providing the best care for visitors?

## Questions About CTS Reform

1. There have been recent policy changes... has this impacted how you provide harm reduction services?
2. Why do you think this change in policy occurred?
3. Were there changes in procedure such as new training or reports or presentations?
4. What has it been like working under this change?

## Questions About Policy Navigation Practices

1. What do you do that is helpful for your visitors, but not required?
2. Are there things you change so that the visitors get optimal service?
3. Do you feel like the ways you resist this policy changes anything?
4. If there is one thing you wish you could change about clinic protocols—what would it be?

# Appendix D- Email Script to Participants

Hello [name],

You are receiving this email because in 2020 you participated in the Practices of Care study examining how the 2018 Consumption Treatment Service (CTS) transition influenced your daily work as a frontline staff in Safe Consumption Sites (SCS) in Ontario. I want to express my sincerest gratitude for your participation and I hope despite navigating two public health crises, you have been able to stay well.

At the end of your interview I asked if you would like to review the key findings and provide some feedback. I am reaching out because you replied that you would be interested in doing so. I have included the findings below, along with three questions and space for additional comments. I want to note that you may decline to respond to these questions. If you would like to response I would appreciate your response by Wednesday February 2, 2022, but if you plan to respond and need more time, please let me know. Please respond even if you do not currently work in an SCS. If you do not respond by Wednesday, February 2, 2022 it will be implied you do not want to further participate. I want to repeat that no names or specific city your work is in will be used in the final document.

If you have any questions or concerns, or would like a list of supports do not hesitate to contact me.

Thank you for your time,

Stephanie Arlt

**Feedback Document**

**Introduction**

In this study, Consumption Treatment Services (CTS) have been analyzed as a intervention that is not in line with harm reduction philosophy and traditions. To better understand how this impacts harm reduction care, I interviewed ten frontline workers in CTS across Ontario. I summarize my findings below in two sections. The first section summarizes participants' positions on why the policy was implemented and how they experienced the changes in their daily work. The second section outlines how participants have adapted their practices to better serve Supervised Consumption Site (SCS) guests.

**Participant Feedback**

The goal of this exercise is to for you to consider whether I have correctly understood your intended response about your experience as a frontline worker under the CTS policy change. I

want to note that not everyone will have the exact same experiences so the aim is to respond to my interpretation keeping in mind the many different people in different sites.

While you read my findings, please consider the following questions and statement:

1) Do you think the above interpretation reflects one or more of your experiences working at a CTS? If yes, please elaborate. If no, how so?

2) Is there anything you would want to rephrase, such as policy navigation definitions or the summary of concerns about the CTS policy?

3) Can you think of any other examples of policy navigation practices you would like to share?

Please feel free add any further comments (no minimum or maximum word count required- whatever you feel satisfies any additional thoughts you have)

## Key Findings- Frontline Staff's Positions and Concerns about the CTS Policy

### Harm Reduction Knowledge

Frontline staff were intimately familiar with the tradition of harm reduction. Many drew from their lived experience as a person who uses/d drugs. Participants mentioned the phrase "meeting people where they are at" on multiple occasions to describe their approach to working with SCS guests. This position influenced how SCS staff thought about drug use and treatment; and framed their healthcare behaviours. Staff felt drug use was warranted either because of the joys of an altered state of conscious or to cope with trauma and poverty.

### Positions on the CTS Policy

No participant expressed indifference to the policy change. Most knew the policy change by name, and a few recognized that it was coming from the Progressive Conservative Government (under Premier Doug Ford). The policy's alignment with Conservative ideology heavily influenced participants' perspectives on the policy. Most participants thought that changing the name to "Consumption Treatment Services" was a political move, simply a rebrand; and that treatment is not the primary function of a SCS. The focus on treatment was viewed as a compromise between Ford Conservative voters and harm reduction advocates; because of Doug Ford's campaign comments about wanting to shut down all the sites. Participant's also felt the content of the policy was misaligned with what services guests needed from an SCS with specific concerns discussed further in detail in the following section. Finally, participants expressed frustration with the process the Progressive Conservative Government used in designing the policy. These concerns included the lack of meaningful inclusion with people who use drugs and those who work in SCS and the disregard for scientific evidence.

### Changes in Their Work World

Participants had diverse experiences with being integrated into a Community Health Center (CHC). In some cases it was helpful to be able to refer guests to other health and social service in house. Other times, the requirements that all SCS had to be integrated into CHC sometimes acted as a barrier to care because it limited the opportunity for a variety of supervised injection models. Some changes felt disconnected from the realities of drug use such as the requirements of injection surveillance and the rejection of funding for recourses such as "chill rooms" to keep people around after their shot. The staff that voiced these concerns felt this undermined peer expertise and are in opposition to harm reduction tradition. Many participants felt that the increase in reporting requirements took meaningful time away from establishing relationships with SCS guests. Participants who had worked in OPS and SCS prior to the CTS policy felt the change came with more rules and regulations, which made it more difficult to make choices they felt would best benefit their guest in fear of being punished or even losing their job. Many participants used the term "walking on eggshells" to describe this feeling. Overall frontline staff were committed to providing a harm reduction form of care in as many circumstances as they could despite increased constrains.

## Key Findings- Policy Navigation Practices

When I went into this study, I made the assumption that the CTS policy would force staff to alter how they engage with SCS guests because of the policy's emphasis on treatment. However, it became clear that this was only one aspects of the CTS policy. From my interviews with ten CTS worker's in Ontario, I have noticed four ways that frontline staff have been able to mend the gap between overarching policies and the needs of guests within their clinic. All but the fourth are in clinical practices. I included the fourth because it influences clinical practice.

1. **Exploiting Grey Areas**

   Definition: Recognizing and acting on nuanced areas within rules to better attend to guests needs, often against organizational standards, but more in line with harm reduction philosophy.

   Examples: Leaving the site to attend to an overdose call when the organization's policy and procedures prohibit frontline staff leaving the grounds during their shift; handing out supplies to guests who have been "paused" form receiving services for behavioural violations; findings ways to give back drugs left behind without touching them as to avoid "trafficking".

2. **Reworking the Concept of Treatment**

   Definition: Expanding the criteria of treatment to include a broader form of social and health services than originally implied in the CTS policy.

Examples: Positioning SCS as the first step to treatment despite beliefs that using a SCS doesn't necessary require treatment to follow; leveraging the change in name to expand access to more than abstinence-based treatments.

3. **Privileging Lived Experience Knowledge**

Definition: Non-experiential workers deferring to experiential expertise over medical approaches.

Example: Addressing an overdose with icepacks and oxygen over Narcan to avoid withdrawal; working collaboratively to come to decisions in spite of imposed medical hierarchies.

4. **Grassroots Organizing**

Definition: Organizational-level intervention in the policy making process to persuade public opinion; and to bring organization policy and procedures more in line with harm reduction philosophies as opposed to individual clinic-based interventions.

Examples: Attending community consultation meetings to inform those against a SCS in their neighbourhood about the benefits of the site; participating in advocacy demonstrations to put pressure on the provincial government to keep sites open.