“IT’S POWERFUL TO GATHER”: A COMMUNITY-DRIVEN STUDY OF DRUG USERS’ AND ILLICIT DRINKERS’ PRIORITIES FOR HARM REDUCTION AND HEALTH PROMOTION IN BRITISH COLUMBIA, CANADA

by

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Abstract

It is essential that the autonomy and dignity of people who use illicit substances be respected by meaningfully involving them in research into their needs and priorities. This dissertation reports on two projects in which substance users were involved in planning and conducting qualitative research in British Columbia, Canada. In the first phase of the research, a province-wide series of 17 workshops, facilitated by drug users, was held to identify health and harm reduction priorities for this population. I found that drug users in British Columbia identified clear priorities to improve their well-being: improving interactions with health professionals, promoting access to a range of housing options, improving treatment by police, ensuring harm reduction best practices are followed everywhere, improving social assistance, supporting drug users' organizations, and engaging new and existing allies. These were based on the values of collectivity, activity, freedom from surveillance, and accountability. An unexpected finding of this research was identifying a need and opportunity for drug users to collaborate with illicit drinkers (defined as people who consume non-beverage alcohol (e.g. mouthwash) and people who consume beverage alcohol in highly criminalized ways (e.g. homeless drinkers)) based on their shared priorities, values, and polysubstance use. In response to this conclusion, the second phase of this research involved a series of 14 town hall meetings with illicit drinkers in Vancouver’s Downtown Eastside to research their perceptions of the harms they face from illicit drinking, the strategies they currently use to reduce these harms, and their ideas for additional harm reduction initiatives. These meetings were planned and facilitated with a steering committee of drug users and illicit drinkers. I found that the harms illicit drinkers experience and some of the strategies they suggest (particularly safe spaces and managed alcohol programs) can usefully be interpreted as examples of structural, everyday, and symbolic violence. This work has led to several positive outcomes for drug users and illicit drinkers, including deeper involvement of substance users in planning provincial harm reduction services and the formation of an activist group for illicit drinkers.
Preface

The research questions in this dissertation were suggested by the Vancouver Area Network of Drug Users and the BC-Yukon Association of Drug War Survivors and refined by me. I developed the methods used for data collection and analysis in consultation with these organizations and my supervisor, Jane Buxton.

Members of the Vancouver Area Network of Drug Users and the BC-Yukon Association of Drug War Survivors and staff members of the Vancouver Area Network of Drug Users facilitated workshops in the provincial drug users needs assessment and contributed to data analysis through group discussion of the workshop results. I documented the workshops using fieldnotes and conducted the software-based data analysis of these. The specific methods employed in this phase of my research are described in Chapter 3.

Nicole Latham, Hugh Lampkin, Lorna Bird, Rob Morgan, Marilyn Sheppard, Earl Greyeyes, and Henry Williams facilitated in the meeting series with illicit drinkers. I produced fieldnotes of these meetings. I also facilitated a series of focus groups on illicit drinking which were transcribed by a professional transcriptionist. The facilitators mentioned above contributed to data analysis through ongoing discussion, and I conducted the software-based data analysis of the fieldnotes and transcripts. The Eastside Illicit Drinker’s Group for Education approved sharing these results. The specific methods employed in this phase of my research are described in Chapter 7.

This research has not been previously published. Ethics approval was granted by the UBC Behavioural Research Ethics Board, certificates H10-01257 (“Health and Harm Reduction outside the Greater Vancouver Area”) and H11-01101 (“Participatory Research with Illicit Drinkers to Investigate Alcohol Harm Reduction Programming Options”).
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To Trudy and Betty
1. Introduction

Drug users' organizations have been established to promote the health and human rights of people who use illicit substances. They are both user-centred (that is, "the experiences, rights, needs, and aspirations of illicit drug users are respected and are the basis for developing both principles and practice") and user-led ("people identifying as current illicit drug users are the custodians of Drug User Organisations and are empowered to participate in and control decision-making within those organisations ") (Madden n.d.). Most organizations emphasize broad political and social change with the goals of full inclusion of drug users in society and establishment of their right to use currently illicit substances (Curtis 2004; Jauffret-Roustide 2009). In this, they are different from organizations that exist to provide services to drug users without challenging the social structures in which service delivery is embedded. A threat to their activism faced by many drug users' organizations is pressure from government and other funders to become more involved in service delivery; this is seen by many as a method of co-opting drug users' organizations away from their radical potential (Madden n.d.; Wodak 1993; Crofts and Herkt 1995; Friedman 1998; Henman et al. 1998; Mold and

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1 This background deliberately sets the stage for my collaborative research with drug users' organizations by focusing on the strengths and successes of the movement, rather than the traditional deficit-oriented list of health problems experienced by drug users. For discussion of the health and social problems associated with drug use, please see Stein 1999; Gordon and Lowy 2005; Degenhardt and Hall 2012; Nutt et al. 2007.

2 Following convention at the Vancouver Area Network of Drug Users and the BC-Yukon Association of Drug War Survivors (partnering organizations for this research), the term "drug user" will be used in this paper rather than "person who uses illicit drugs." This is meant to reflect the language used in our partner organizations, not to deny the personhood of people who use illicit substances. I celebrate the fact that our participants are also family members, friends, workers, volunteers, and community members, in addition to drug users. Additionally, I call attention to Jauffret Roustide's use of the term, in contrast with the pejorative "drug addict," as "a responsible, self-reliant citizen able to adopt preventive behaviors" (Jauffret-Roustide 2009).

3 Many organizations exist to promote the safe and responsible use of marijuana and psychedelics, and to advocate for their legalization where currently illegal. I respect the work of, but exclude from this discussion, those organizations that primarily promote such substances for recreational, medicinal, or spiritual purposes. Instead, what we call "drug users' organizations" are those that work with people who use substances, such as heroin, crack cocaine, and crystal methamphetamine, that are tied to political, social, and economic marginalization.
Drug users' organizations can also be contrasted with therapeutic or self-help groups such as Narcotics Anonymous, as the latter emphasizes an illness-based model of drug use that can conflict with the political goals of drug users' organizations (Trautmann 1995; Jauffret-Roustide 2009). As well, drug users' organizations should be distinguished from "micro-social responses," such as shifts to healthier behaviours within friendship or using networks, as these may be promoted by drug users' organizations but may also occur outside of them (Friedman et al. 2007).

The structure of drug users' organizations may be either democratic (involving leadership selected by members) or oligarchical (leadership self-selected or selected by non-drug users). Democratic organizations may promote ease of involvement, improve legitimacy of campaigns to promote healthy behaviours, and encourage many different types of users to become involved (thereby challenging tokenism and the categorization of drug users into "good"/"bad" or "responsible"/"irresponsible"). Oligarchical organizations, however, may have an advantage in service delivery and may be more acceptable to funding bodies (Friedman 1996). Beyond this membership base, non-drug user allies (that is, people who are not drug users but support their political objectives) who defer to drug user leadership are essential to the success of drug users' organizations, as they are less likely to face negative consequences for their support of drug users' rights (Friedman et al. 1987; Osborn and Small 2006). Such support may extend as far as helping establish drug users' organizations (Friedman et al. 1992; Jose et al. 1996; Henman et al. 1998), although organizations established by researchers or service providers may face difficulties earning the trust of drug users (Friedman et al. 1992; Henman et al. 1998).

The first drug users' organizations formed in response to the HIV/AIDS epidemic and the War on Drugs, with inspiration from movements for gay men's health and patients' rights (Madden n.d.; Crofts and Herkt 1995; Hulse 1997; Henman et al. 1998; Wodak 1993; Curtis 2004; Mold and Berridge 2008; Jauffret-Roustide 2009). Given their early focus on HIV, membership in many organizations was reserved for drug injectors, although more recently there has been greater inclusion of people who use illicit substances by inhalation and other routes (Henman et al. 1998; Kerr et al. 2006). Alcohol use and people who primarily use
alcohol have not generally been an area of focus of drug users' organizations.

Little historical documentation exists of the work of drug users' organizations, particularly when compared to activities undertaken by government and academia, and therefore their contributions are often unacknowledged and undervalued (Hunt et al. 1999; Hulse 1997; Crofts and Herkt 1995; Friedman et al. 2007). Despite this obstacle, evidence exists of many instances in which drug users' organizations successfully undertook activities to advocate for or to serve drug users' needs directly.

Drug users' organizations are frequently invited to advise government agencies responsible for health on drug users' needs and on the acceptability and feasibility of interventions, particularly on matters related to prevention of blood-borne infections, harm reduction efforts, and substance abuse treatment programs (Hulse 1997; Crofts and Herkt 1995; Kerr et al. 2006, 2001; Curtis 2004; Jauffret-Roustide 2009; Henman et al. 1998; Crawford 2010; Wodak 1993; Bennett, Jacques and Wright 2011). Some engage in educational efforts aimed at challenging stigma among health and legal professionals, researchers, the media, and the general public (Kerr et al. 2006; Crawford 2010). Through political activities such as demonstrations, lobbying, and media outreach, drug users' organizations have endeavoured to humanize drug users, advocate for improved services, and promote less punitive legal responses to drug use (Friedman 1996; Jauffret-Roustide 2009; Henman et al. 1998; Osborn and Small 2006; Kerr et al. 2006; Boyd, MacPherson and Osborn 2009; Friedman et al. 2007; Curtis 2004; Crofts and Herkt 1995; Gowan, Whetstone and Andic 2012).

Most drug users' organizations provide some services to local drug users, particularly harm reduction services or activities to reduce the spread of infectious diseases (Friedman 1996). These services frequently include peer-run distribution and recovery of syringes and other harm reduction supplies (often delivered with a mobile outreach component) (Kerr, Oleson and Wood 2004; Kerr et al. 2006, 2001; Hayashi et al. 2010; Curtis 2004; Southwell 2010; Crofts and Herkt 1995; Friedman et al. 2007; Henman et al. 1998; Crawford 2010; Gowan, Whetstone and Andic 2012) and peer education and support programs (Wodak 1993; Crofts and Herkt 1995; Friedman 1996; Kerr et al. 2001; Curtis 2004; Kerr et al. 2006; Friedman et al. 2007; Jauffret-Roustide 2009; Gowan, Whetstone and Andic 2012). Other activities may include programs to promote behaviour change (such as safer injection practices) (Friedman
et al. 1992; Friedman 1996; Hunt et al. 1999; Kerr et al. 2006; Friedman et al. 2007) or to carry out consumer advocacy work (such as disseminating warnings about tainted drugs)(Friedman 1996; Southwell 2010). Services to connect drug users with each other have included conferences (Crawford 2010) and magazines and newsletters (Crofts and Herkt 1995; Henman et al. 1998; Jauffret-Roustide 2009). Less formally, drug user organizations may provide an opportunity for drug users to develop self esteem through involvement in programs that help others (Friedman 1996; Henman et al. 1998; Kerr et al. 2006; Osborn and Small 2006; Boyd, MacPherson and Osborn 2009).

These activities are carried out despite significant challenges faced by drug users' organizations, including the drug war and police/state repression (Curtis 2004; Jose et al. 1996; Friedman et al. 1987; Moore and Wenger 1995; Allman et al. 2006; Henman et al. 1998) and the need of drug users living in poverty to prioritize survival activities (Moore and Wenger 1995; Allman et al. 2006; Friedman et al. 2007; Jauffret-Roustide 2009). When drug users' organizations are successful, co-optation by government and other interests becomes a threat (Madden n.d.; Curtis 2004), and lack of support from other agencies serving drug users (whether due to distrust in users' abilities or competition for funding) may be an additional problem (Friedman et al. 1987). Internalized oppression⁴ may discourage drug users from taking part in activities if they believe they are not deserving of better treatment or that their actions will not be effective (Moore and Wenger 1995) and stigma may discourage them from "outing" themselves through participation (Jauffret-Roustide 2009; Crofts and Herkt 1995). Finally, drug use and addiction itself may interfere with an individual's ongoing participation in an organization, although appropriate supports may mitigate some of the difficulties they encounter (Crofts and Herkt 1995; Bennett, Jacques and Wright 2011; Friedman et al. 1987; Wodak 1993). It should be noted that many of these challenges are the same as those faced by other oppressed groups that are organizing to promote their rights (Crofts and Herkt 1995).

British Columbia is home to one of the world's longest-running and most successful drug users' organizations, the Vancouver Area Network of Drug Users (VANDU). VANDU's elected board of directors, drawn from and responsible to the organizations' 2000 members,

⁴By internalized oppression, I mean negative self-perception and a sense of deservedness of negative experiences that is often the consequence of being a member of an oppressed group.
oversees a wide variety of projects focused on political activism, harm reduction, and peer education. Several other drug users' organizations exist in the province, of which the most established are the Society of Living Illicit Drug Users (SOLID) in Victoria and the Rural Empowered Drug Users' Network (REDUN) in Nelson and Grand Forks. In 2009, VANDU hosted drug users from around the province at the Pacific Summit for Drug User Health, which led to the establishment of the BC-Yukon Association of Drug War Survivors (BCYADWS), a provincial organization run for and by drug users. As, Drug users' perspectives in BC drug policy have primarily been represented by those from Vancouver, due in part to the success of VANDU. As a result, a key goal of BCYADWS is to better identify and represent the needs of drug users living in other communities, both large and small.

The genesis of the program of research in this thesis was the desire by BCYADWS to undertake a community-based needs assessment in order to determine the health and harm reduction priorities of drug users in BC. A key goal of the research was to facilitate ownership and participation by drug users throughout the process, in keeping with the principles of drug users' organizations articulated above (Chapters 3 to 6). Results from the needs assessment study led directly to a second research project, conducted in partnership with VANDU, exploring health and harm reduction for people who drink non-beverage alcohol\(^5\) (Chapters 7 to 8).

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\(^5\) The terms “non-beverage alcohol” and “illicit drinking” are both used in this document. Non-beverage alcohol refers to alcohol that is not intended for human consumption, such as mouthwash and hand sanitizer. Illicit drinking refers to the consumption of non-beverage alcohol and the consumption of beverage alcohol in highly criminalized ways (e.g. homeless drinkers). More information on these terms can be found in Chapters 6 and 7. Non-beverage alcohol can include liquids containing ethanol and also bittering agents to make it unpalatable, liquids containing ethanol and also other additives that are not meant to be consumed, or liquids containing other types of alcohol, most commonly isopropanol. Very few estimates exist of the prevalence of non-beverage alcohol use. A review of studies from the 1950s to 1980s found lifetime use among hospitalized alcoholics from 6-20%, with rates at the upper end of that range for “Skid Row alcoholics (sic)” (Egbert et al 1985). A more recent case report suggests that the introduction of alcohol-based hand sanitizers to hospitals may have led to an increase in consumption of that particular product (Archer et al 2007). Beverage alcohol is associated with a myriad of physical and social harms, particularly liver disease, heart disease, unintentional and intentional injury, and poor psychological health. (Room et al 2011; World Health Organization 2014). Isopropanol effects the body similarly
The specific research questions guiding the provincial community-based needs assessment were as follows:

1. What are British Columbian drug users' priorities to promote health in their communities?
2. How can drug users work to meet these priorities?
3. How are drug users’ priorities shaped by the social, economic, and historical contexts of their everyday lives?

The questions guiding the health and harm reduction study for people who drink non-beverage alcohol were:

1. What and how is non-beverage alcohol being consumed in Vancouver's Downtown Eastside?
2. What harms do illicit drinkers perceive are associated with non-beverage alcohol?
3. What steps are illicit drinkers already taking to reduce these harms and what other actions do they believe would be helpful?
4. How does the social and economic marginalization of illicit drinkers influence their perceptions of harms and harm reduction?

Chapter 2 of this dissertation presents the theoretical frameworks and the methodologies drawn upon in my research. Chapter 3 describes the specific research methods used in the provincial needs assessment, then Chapters 4 through 6 presents the results of that phase of the research. Chapter 7 introduces the research methods used to investigate health and harm reduction for people who use non-beverage alcohol, and Chapter 8 presents the findings of that phase of the research. Finally, Chapter 9 addresses the strengths and limitations of my

To ethanol but causes a more marked gastritis; the effects of various additives are poorly studied (Egbert el al 1985). Alcohol maintenance programs (in which non-beverage alcohol drinkers are given small amounts of beverage alcohol throughout the day to replace their consumption of non-beverage alcohol) have been piloted to reduce harms from non-beverage alcohol use; these show promising results in stabilizing drinkers’ lives (Podymow 2006; Kidd, Kirkpatrick and George 2011; Stockwell et al 2013; Evans 2015). For more on these programs, see Chapter 8.
research, suggests avenues for further research, and describes actions that have been taken as a result of my findings.\(^6\)

\(^6\) The somewhat unconventional structure of this dissertation is a reflection of the community-driven process used in my dissertation. The second phase of the research (reported in Chapters 7 and 8) stemmed directly from the results of the first phase (reported in Chapters 3 through 6). I have therefore chosen to discuss theory and methodology first, but to present the specific methods in separate sections to better reflect the iterative nature of the research.
2. Theory and methodology

In this chapter, I describe how critical theory has influenced my study design, data collection and analysis, and interpretation. I then elaborate on several key concepts within critical theory that are of particular importance to my work. I also outline the methodological traditions (ethnography and community-based research) upon which I have drawn in conducting my research, and describe my own background in order to contextualize my research choices.

2.1 Critical theory

The research in this dissertation was shaped by the framework of critical theory. Critical theory as a paradigm is concerned with identifying and challenging instances of inequity and situating these instances within social, political, economic, and historical contexts. It stands in contrast to the post-positivism of much of public health research and practice; in other words, critical theorists reject the idea that reality is both external to the mind of the knower and (indirectly) accessible through objective observation. At the same time, they do not hold that reality is entirely socially constructed and that truth can only exist in a way that is subjective and local. Instead, critical theorists hold that social, political, economic, and historical forces (which are virtually “real” even if they have no existence outside human minds) shape human experiences of the world and the observations they can have of it (Lincoln and Guba 2000; Willis 2007). The “contexts” in which an individual acts are not deterministic, however, as one’s perceptions and experiences will in turn influence their understanding of and response to external forces.

The knowledge produced in critical research is not generalizable in the post-positivist sense, but is expected to uncover local instances of the broader power imbalances inherent in our late capitalist and imperialist political system (Willis 2007). An important influence of postmodernist and constructivist thought has led critical theorists to interrogate "grand narratives" of oppression based primarily on class and to instead focus on multiple and intersecting forms of domination and oppression, including but not limited to those based on gender, sexuality, race, and class (Collins 1998; Kincheloe and McLaren 2002).

Critical researchers are called to be passionate witnesses rather than dispassionate observers.
In Haraway's words, as witnesses they are called to "make a difference in the world, to cast [their] lot for some ways of life and not others (Haraway 1997)." This is because research is seen as a fundamentally political act (Cannella and Lincoln 2004). The process by which certain individuals become researchers and others subjects, the selection of an area for inquiry, the framing of the question, the choice of methods, the analysis and interpretation of results: all of these are shaped by power structures. What separates critical theorists, then, from their post-positivist peers is not that they undertake research shaped by a given ideology. Instead, it is that those ideological influences are made explicit. In this, they draw from a tradition of reflexivity in feminist scholarship (Reinharz and Davidman 1992) to acknowledge that researchers are situated in certain social, economic, and political positions that necessarily shape their construction of the research product.

The researcher’s role as a witness allows him or her to engage with (often obscured) political, social, and economic forces and to draw connections between them in such a way that hidden opportunities for liberatory practice become clear. A tension, then, in critical research is between the goal of emancipation for the subjects of research and the researcher’s role as privileged holder of the knowledge that guides the way. The drive to uncover “false consciousness” has the potential to reify the subject as the ignorant Other to the enlightened academic. Cannella and Lincoln (Cannella and Lincoln 2004) advocate resisting this possibility with “reflexivity and humility.” Others advocate participatory methodologies, with participants rather than subjects involved in a process of co-learning with the researcher (Cook 2005).

Because ideology is, in critical research, explicitly influential in shaping the area of inquiry and the creation of the product, the post-positivist criteria of judging research by its reliability (that is, the extent to which subsequent investigations would reach the same conclusions) and validity (that is, the extent to which the investigations measure that which they purport to measure) are not particularly helpful guideposts in evaluating the quality of products of this paradigm. Instead, Lather suggests four criteria for validity in critical

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7 By which, following Hall (1996), I mean "The mental frameworks—the languages, the concepts, categories, imagery of thought, and the systems of representation—which different classes and social groups deploy in order to make sense of, define, figure out and render intelligible the way society works."
research: (1) triangulation of methods, (2) construct validity, (3) face validity, and (4) catalytic validity. Triangulation of methods involves collecting various types of data, using various methods, and based on various theories, in order to seek "counterpatterns as well as convergences" (Lather 1986). To achieve construct validity, a researcher must keep analysis grounded in the lived experiences of participants and not be overly deterministic in the application of theory; a commitment to reflexivity is an important part of this process. Face validity is encouraged by member-checking to explore participants' own understanding of research findings. Finally, catalytic validity is measured by the extent to which the research leads to emancipatory action on a societal, local, or personal level (including challenging false consciousness in participants (Guba and Lincoln 2005)) (Lather 1986).

Public health is both a process (“collective action for sustained population-wide health improvement” (Beaglehole et al. 2004)) and an academic and professional discipline. Although the discipline of public health has its origins in part in struggles for social justice and health equity (Susser and Susser 1996; Rosen 1993), its primary methodology, epidemiology, has a strong tradition of post-positivism and a focus on individual-level analysis (Baum 1995; Szklo and Nieto 2004; Pearce 1996). In recent years, however, researchers have called for a shift to stronger social analyses: first "political economy" and "social epidemiology", then later "ecosocial" approaches that attempt to better integrate structural and individual-level analyses (Krieger 1994; Blankenship, Bray and Merson 2000; Krieger 2001; Syme 2005; Breilh 2008). With these more critical analyses, epidemiological methods have, to use another of Haraway's metaphors, elements of the cyborg; born of "technoscience," they have the potential to be "exceedingly unfaithful to their origins" (Haraway 1991). Moreover, as will be discussed in greater detail below, the increasing use of qualitative methods within public health provides an additional avenue for situating individual attributes and experiences in context (Dunn and Janes 1986; Carey 1993; Baum 1995; Lambert and McKevitt 2002).

Public health studies of illicit drug use and its antecedents and consequences have followed the shift to ecosocial research approaches, manifested as a call for new focus on structures and institutions that affect drug users' lives and the ways in which drug users' relate to and resist these structures (Des Jarlais 2000; Rhodes 2009; Singer 2006a). Rhodes' "risk environment" framework has been Particularly influential in calling attention to the ways in
which social conditions become embodied in individual drug users' health (Rhodes et al. 2012). Criticisms of this approach caution, however, against overly deterministic "passive understandings of context" (Duff 2007) and emphasize the agency of individuals in responding to the political, economic, and social structures around them (Duff 2007; Bourgois and Schonberg 2009; Valentine and Fraser 2008). Calls for critical use of ethnography to deepen understandings of context assert that such methods complement epidemiological insights into drug users' health (Bourgois 2002; Singer 2006a; Maher 2002).

2.2 Key concepts

Several key concepts within the paradigm of critical theory are important to this thesis. **Structural violence** is a cause of suffering that is unnatural and caused by forces external to the individual. The term refers to "historically given (and often economically driven) processes and forces that conspire to constrain individual agency" (Farmer 1996b) and lead to an unequal and unjust distribution of suffering. An analysis of the "structures" of structural violence must be geographically broad (that is, noting the interconnectedness of individual instances of violence with occurrences and trends elsewhere), historically deep (situating violence within histories of dominance and resistance), and engaged with the intersections of oppression along axes of gender, ethnicity, and class (Farmer 1996a). While this analysis should not be read as deterministic, it does emphasize that "risk" of suffering is distributed along lines of power in society (Farmer 1996b). A related term, **structural vulnerability**, emphasizes the agency of individuals even as their lives are constrained by powerful external forces (Rhodes et al. 2012).

Structural violence is a process; **social suffering** is the result when this violence becomes embodied and experienced in ways shaped by social forces (Kleinman, Das and Lock 1997). This suffering is often hidden from view by the marginalization of those experiencing suffering (Farmer 1996a). The techniques of **symbolic violence** exaggerate individual agency in order to obscure the real structures causing harm, which makes sufferers into scapegoats and causes them to internalize a belief in their own complicity (Farmer 1996b; Bourdieu 1998). The term **everyday violence** refers to the "routinization of daily mortifications and little abominations" (Schepet-Hughes 1992) visited on marginalized individuals, which spills over into overt violence against the rest of the population periodically. Everyday violence is
internalized and reproduced by those who are the targets, such that they become perpetrators as well as victims (Schepers-Hughes 1992; Bourgois and Schonberg 2009).

Structural and everyday violence are important concepts to my research in two ways. The first is that drug users, and particularly those who are further marginalized along other axes of oppression, are subject to it in many facets of their lives (Rhodes et al. 2005; Bourgois and Schonberg 2009; Rhodes et al. 2012). The second way is that drug use itself can be seen as a means by which people cope with their negative experiences of structural violence, particularly experiences of colonialism and the disconnection from community fostered by capitalism, as argued convincingly by Alexander (Alexander 2008).

People who experience structural and everyday violence may express their agency through various forms of resistance. Solorzano and Delgado Bernal (2001), in their work on Chicana and Chicano students opposing discriminatory school structures, distinguish four types of opposition. (1) Reactionary behaviour is when a person is disruptive of oppressive institutions but without an awareness of the oppression they face. (2) Self-defeating resistance describes opposition in which oppressive institutions are critiqued, but the individual involved does not have social justice as a goal; dropping out of school in the face of discrimination is an example of this type of resistance. (3) Conformist resistance occurs when a person desires social justice but has limited awareness of how structural factors are preventing it from being realized; they attempt to succeed within oppressive institutions and may blame themselves for the roadblocks they face. (4) Finally, transformational resistance involves both critique of oppressive institutions and a desire for social justice. Transformational resistance exists on a spectrum, from subtle challenges to overt and disruptive action against the status quo.

Another key concept, harm reduction, features prominently in my research. Harm Reduction International (formerly the International Harm Reduction Association) defines harm reduction as "policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption" (International Harm Reduction Association 2010). This is distinct from use reduction, as encouraged through measures to decrease supply and/or demand, which is the primary response to illicit drug use under the legal
framework of prohibition (Marlatt 1996).

Although some authors, noting the origins of harm reduction in civil disobedience and drug user activism, have emphasized the liberatory potential of harm reduction (Marlatt 1996), others challenge its fit within the critical paradigm. Specifically, these authors point out the role that harm reduction plays in disciplining and controlling drug users, potentially thereby contributing to the maintenance of prohibition and other marginalizing and oppressive policies (Miller 2001; Roe 2005; Fischer et al. 2004; Smith 2011a). Several authors complicate this debate by adding the caveat that situating drug users as self-controlled citizens who are responsible for their own health (by, for example, using clean injecting equipment) and the health of their communities (by, for example, returning all used injection equipment to be safely disposed of) can lead to their experiencing some of the privileges enjoyed by non-drug users. For this reason, even though a harm reduction approach may make demands of drug users that are difficult to fulfill within the structural constraints they face, harm reduction may be valued by drug users precisely for its disciplinary role (Moore and Fraser 2006; Gowan, Whetstone and Andic 2012). A potential avenue for better integrating harm reduction within the critical paradigm is proposed by Pauly (2008a), who suggests that applying a social justice framework could help reconceptualize the harms of drug use to include poverty, violence, and other effects of political and economic disenfranchisement.

2.3 Ethnography

The research in this dissertation was conducted using critical ethnographic methods within a public health tradition. Ethnography is "a family of methods involving direct and sustained social contact with agents, and of richly writing up the encounter, respecting, recording, representing at least partly on its own terms, the irreducibility of human experience. Ethnography is the disciplined witness-cum-recording of human events" (Willis and Trondman 2000, emphasis original). Interviews, focus groups, collection of documents (including photographs), and participant observation are all commonly used as sources of data in ethnographic research. The researcher iteratively and inductively produces an analysis of these texts by examining them systematically for themes and exceptions (O'Reilly 2005).

Ethnography’s roots are in anthropology, a field where the study of other cultures was often
an extension of the imperialist gaze, and the desired objectivist stance served to essentialize members of a culture rather than recognize the multiple and shifting nature of identities (Jordan and Yeomans 1995; Brown 2004). Over time, however, some ethnographers have moved towards "a more modest notion of speaking from a historically and culturally situated viewpoint" (Foley and Valenzuela 2005), with the result that the value can be recognized in the intuitive and subjective knowledge of both researcher and subject (Brown and Dobrin 2004). A related development among ethnographers is the increasing tendency, in the wake of political changes in the 1960s, to engage with inequalities of social status, race, and gender and the structures that produce and sustain these inequalities (Foley and Valenzuela 2005). The resulting methodology is often called "critical ethnography" and has come to include a wide variety of qualitative techniques conducted through a critical lens (Carspecken 2001).

Within the discipline of public health, ethnography is valued for its ability to generate local and practical knowledge (while still, as critically engaged work, remaining reflective of the broader social and political contexts). Ethnography and related anthropological methods can be used to generate hypotheses, explore local knowledge of public health problems, deepen understanding of results obtained with other methods, design interventions, conduct evaluations, critique policy and practice, and engender action (Braithwaite, Bianchi and Taylor 1994; Hahn and Inhorn 2009; Rhodes et al. 2012; Mykhalovskiy and McCoy 2002). As well, the rich tradition of theory within anthropology can complement the usual emphasis on methodology within public health (Lambert and McKevitt 2002; Hahn and Inhorn 2009). Bourgois, arguing for a critical meeting of anthropology and epidemiology, suggests that mutual distrust and siloing may hinder cross-disciplinary collaboration. If this wariness can be overcome, however, collaboration can help to temper the post-positivist excesses of epidemiology while retaining its earnest practicality, and can keep ethnography grounded in the real lives and struggles of its subjects (Bourgois 2002).

Ethnography has been particularly influential in researching HIV/AIDS risk among injection drug users. For example, researchers employing this methodology have presented important insights surrounding the influence of policing on injection practices (Rhodes et al. 2012; Small et al. 2006), drug users' economic strategies and their influence on paraphernalia sharing (Bourgois 1998; Bourgois and Schonberg 2009), the process of peer-based outreach (Dhand 2006), and the impact of needle distribution programs (Singer 2006a; Grund, Kaplan
and Adriaans 1991). The nuanced understandings of HIV risk thus developed can then be used to tailor intervention efforts to suit the realities of drug users' lives. More broadly, ethnography is useful to explore areas that have often been neglected by other disciplines that research drug use: drug users' experiences and subcultures, the positive or coping aspects of drug use, and the political economy of drug use and its suppression (Neale, Allen and Coombes 2005; Singer 2012).

2.4 Community-based research

Another methodological tradition that informed this work is that of community-based research. Community-based research is conducted in conjunction with representatives of the community that is the subject of the research. It is both an ethical imperative and of practical benefit. Ethically, it encourages ownership and control of the research process by communities who, in many cases, have been relatively excluded from research about them. Practically speaking, well-conducted community-based research improves the "rigor, relevance, and reach" (Balazs and Morello-Frosch 2013) of research in the study design, data collection, analysis, and knowledge to action phases through increased community trust/participation and the use of the diverse skills, knowledge, and talents of community members (Israel et al. 1998; Leung, Yen and Minkler 2004; Minkler 2005).

An influential review of community-based research in public health describes eight key features of this approach: (1) communities are seen as based on socially constructed identities; (2) community-based research builds on community strengths and resources; (3) collaboration between academia and community is encouraged in all phases of the research;  

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8 MacQueen et al. conducted a qualitative research project that investigated the definition of community for various groups involved with public health community-based research. Their analysis defines community as "a group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings" (MacQueen et al. 2001). While I use this as a working definition, I agree with Singer's assertion that the utility of the word community lies somewhat in its imprecision. Singer's work also unpacks the commonly used phrase "drug user community" and concludes that its use has both benefits and drawbacks: benefits, because it challenges the notion that drug users are simply a threat to the communities around them and celebrates their community-building actions, and drawbacks, in that it homogenizes drug users and minimizes the structural barriers to creating a sense of community in their lives (Singer 2006b).
(4) there is an emphasis on building knowledge in order to take action; (5) empowerment and co-learning are goals; (6) an iterative approach is used to generate research questions; (7) community-based research uses an ecosocial approach with attention to community resilience; and (8) findings are shared with all partners (Israel et al. 1998). Community involvement in decision-making has been described as occurring on a "ladder," with lack of involvement at the bottom and control by subjects at the top (Arnstein 1969; Hart 1992). A more nuanced approach is suggested by Green and colleagues, whose "checklist" for classifying participatory research in health promotion encourages researchers to explore the ways in which community members are involved or excluded from full participation in the entire research process, from question design to action based on research findings (Green n.d.).

Drug users and some researchers have called for a greater emphasis on community-based research in researching issues related to drug users' health (Coupland and Maher 2005; Jurgens 2008; Salmon, Browne and Pederson 2010). Some of the difficulties in following through on these suggestions are common to research involving marginalized communities; others are relatively unique. Communities often value more practically-oriented research than do academics and grow impatient with the slow timelines of university research, and research that is not translated into action that can mean that academics benefit more than the community. Tokenism can result from researchers selecting only specific community members to take part; partnering with existing organizations that represent the community may help mitigate this problem. Negotiating clear expectations about how results will be released (especially those that are potentially unflattering) is essential to avoid conflict as the project progresses. Most importantly, power differentials between researchers and community members create perilous situations that must be addressed through reflexivity and humility (Minkler 2005; Wallerstein and Duran 2006). Drug users, like other oppressed groups struggling to meet their basic needs in the face of considerable opposition, need

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9 It is because of this idea that a research project can deeply engage the community on some levels and be researcher-directed on others that I prefer the term "community-based research" to "community-based participatory research."

10 Interestingly, the National Institute on Drug Abuse, a major research funding body in the United States, lists "developing a collaborative research process" as among their five research priorities, yet lists service providers, service funding agencies, and academics researching other health issues as their only potentially collaborators (Compton et al. 2005).
support (including, frequently, financial support) in order to fully participate in research (Salmon, Browne and Pederson 2010). The regime of prohibition creates barriers as many individuals are disinclined to self-identify as users of illicit drugs when such use is highly criminalized. With a view to minimizing these challenges, VANDU created a manifesto for researchers\textsuperscript{11} working with drug users that suggests best practices, including supporting partner organizations (not just individual drug users), negotiating what and how results will be disseminated, and participating as an ally in drug users' political struggles (Vancouver Area Network of Drug Users 2010).

2.5 Reflexivity

Reflexivity is the process of situating oneself within social, economic, and political contexts in order to clarify to the research audience how these factors shaped the research product. Within a critical approach, it is particularly salient, as the researcher's ideology, positionality, and disciplinary background are considered factors to be made explicit, rather than minimized (Carspecken 2001; Foley 2002). Although important to all types of research, it is a key concern when fieldwork is involved, as characteristics and attitudes of the researcher will influence how and what information is shared by participants (Hahn and Inhorn 2009).

Brown cautions, however, against responding to critiques of the objective, postpositivist observer by foregrounding the researcher at the expense of the participants (Brown 2004).

With this imperative in mind, my academic background includes undergraduate studies in community development and graduate education in public health and medicine. My qualitative research training and experience therefore emphasized the pragmatic approach often taken in public health.

As a white, middle class woman I experience the unearned benefits of my privileged place in society. I became politicized as part of the grassroots anti-globalization movement during the lead up to the 2002 G8 conference in Calgary, Alberta. Since then, I have been involved in various ways in the global struggle for social and economic justice. After working in Addiction Services at the Vancouver Coastal Health Authority, I became an ally of drug user activists, although I am not myself a user of illicit substances.

\textsuperscript{11} This document was created in 2010, after the first research project of this dissertation, but before the second project was conducted.
My background influenced my program of research in several key ways. That I was approached by the BCYADWS at all was due to their view that I was someone knowledgeable about drug users’ struggles and activism with access to the status and resources conveyed by academia. The information shared with me by participants reflects, I suspect, their assessments of what I would understand about their lives and what I would like to hear about their ideas on health and substance use. The emphases I suggested in data collection reflected my own understanding of how poverty and criminalization constrain drug users' lives but do not preclude their agency. And my approach to data analysis was shaped by these same views and also my interest in producing actionable recommendations for health service providers. (Both data collection and analysis are further described in Chapters 3 and 7.) At all times, however, I endeavoured to be open to new insights from participants and collaborators, even when these challenged my previously held beliefs.
3. Specific methods I: drug users’ needs assessment

Data collection and analysis for this thesis was an iterative process that took place in two phases. The first was the provincial drug users' needs assessment (described in this chapter), and the second involved working with people who use non-beverage alcohol in Vancouver's Downtown Eastside (described in Chapter 7, Specific Methods II). This chapter will describe the impetus for the research, data collection and analysis, and participant characteristics.

The idea for a participatory needs assessment of BC drug users was first suggested in a BCYADWS board of directors meeting. Its goals were to identify strategic priorities for BCAYDWS and to inform provincial programs that support marginalized drug users, with a particular emphasis on drug users' needs and priorities outside the Greater Vancouver Area.

The specific questions guiding this research were:

1. What are British Columbian drug users' priorities to promote health in their communities?
2. How can drug users work to meet these priorities?
3. How are drug users’ priorities shaped by the social, economic, and historical contexts of their everyday lives?

These questions and the planned research were intended to foreground drug users' perspectives to counteract the ways they are often marginalized in research about them; to facilitate interpretation of study results in the context of the prohibition of drugs and the social, political, and economic marginalization of drug users; and to encourage an analysis of the ways the oppression of drug users overlaps and intersects with that of other groups.

The BCYADWS board decided to include an academic research component to this project because they hoped it would contribute to a high quality product, allow them to access academic resources to support the project, and lend legitimacy to their findings. I was approached to participate because of my past involvement as an ally of VANDU and my participation (as a facilitator) at the conference that launched the BCYADWS. With my involvement and the support of my supervisor, the project became a partnership between BCYADWS, the BC Centre for Disease Control (BCCDC), and VANDU (providing organizational capacity and facilitation expertise).
I held two-hour workshops in 17 British Columbia communities over a three-month period (Figure 3.1.). These workshops were advertised by poster and word of mouth to current and former users of illicit drugs in each community. This was accomplished primarily by harm reduction service providers and public health nurses who were contacted in advance by VANDU staff members. In four communities, workshops were held in partnership with local drug users' organizations. Communities were chosen by the paid VANDU staff person (a non-drug user) acting as project coordinator based on local contacts and VANDU staff and board appraisals of the extent of local drug scenes (with communities seen as having larger street-based drug scenes sought out even in the absence of local contacts).

Figure 3.1. The communities visited during the provincial needs assessment.

Each workshop was facilitated by one paid staff person and two or three drug user volunteers who received small stipends ($20/day) to honour their time. The drug user facilitators were board or general members of BCYADWS or board members of the Vancouver Area Network.
of Drug Users. All VANDU facilitators (of which there was at least one per workshop) had extensive training and experience facilitating meetings. The coordinator and VANDU facilitators jointly developed the meeting agenda (with my input) and agreed on facilitation techniques during a series of brainstorming meetings held prior to departure for the first community. The agenda, including questions to be addressed in the workshops, was then written up by the coordinator and distributed to the facilitators. The coordinator and VANDU facilitators oriented the BCYADWS facilitators to their roles in informal meetings before each workshop; these meetings also provided an opportunity for the project coordinator and VANDU facilitators to clarify their roles for the day. Debriefing and feedback about facilitation techniques (including from my perspective as a researcher) occurred after each workshop.

The workshops were organized around the question, "What do you need to live healthy lives as drug users in your community?" In the first half of the meeting, participants brainstormed answers to this question; in the second half, the facilitators helped to prioritize and strategize about how to meet these needs. Each meeting opened with an introduction from the facilitators to themselves and their organizations. The facilitators then used flip chart paper to record participants' responses to both open-ended (e.g. "How is access to health and harm reduction services in your community?"”) and close-ended questions (e.g. "How many people in this room have had harm reduction supplies confiscated by police?"). Close-ended questions were primarily asked in follow up to issues raised by participants in the workshop or to gather information to provide context to issues mentioned in previous workshops. The questions emphasized both strengths within communities and areas for improvement. There was considerable variation in the questions asked and the format of the discussion based on responses from participants. The opening half of the workshop generally concluded with a breakout exercise in which pairs or small groups of participants decided on their highest priority for change (either from the preceding discussion, or something that had not been mentioned yet) and then shared it with the larger group (see Appendix A, provincial needs assessment agenda, for the general format and questions used in these workshops).

I took detailed notes on a laptop computer at each of these workshops. Based on the previous experience of team members in facilitation and research with drug users, it was felt that, given the marginalized nature of participants and our lack of time to gain trust, audio
recordings would not be acceptable to participants. Ethnography has a long and proud tradition of the use of fieldnotes (Sanjek 1990b, 1990a), defined as "a discrete textual corpus produced by fieldwork and constituting a raw, or partially cooked, descriptive database for later generalization, synthesis, and theoretical elaboration" (Clifford 1990). Much of social science research, however, is now done using audio or video recordings, which have the advantage of capturing a more complete account of a participant's words and cadence than is captured in fieldnotes. Even transcripts of recordings, however, are selective and subjective, in that decisions must be made about what will be transcribed (words, other noises, pauses, etc) and how (with editing for clarity, with offensive terms intact, etc.) (Poland 1995; Hammersley 2010). The subjectivity and social construction of fieldnotes, therefore, is not unique to this method of recording occurrences in the field. Moreover, fieldnotes have certain advantages over recordings: they encourage ongoing reflection (Lederman 1990) and allow for data collection with participants who would not permit recordings. Good quality fieldnotes capture detail; include initial analytic thoughts; and reflexively attend to the author's stance, emotions, and decisions about how action, dialogue, and other observations are (re)produced in the text (Emerson, Fretz and Shaw 2001). Beach (2005) suggests that, while all fieldnotes are a product of the researcher's attention and embodied experience in the field, those that emphasize transcription of participants' speech relatively privilege their voices and their choices of what to share with the researcher; accordingly, my fieldnotes emphasize dialogue and discussion. The initial notes were edited and extended following the workshops. I made additional, but less formal, notes on my discussions with the workshop facilitators before and after the workshops.

Maher, whose ethnographic work with injection drug users has been influential in advocating for a harm reduction approach, argues that it is necessary to embrace a politically and personally engaged role in the field in order to better understand the context of drug users' lives (Maher 2002; Fry, Treloar and Maher 2005). Lending practical support to partner organizations builds trust (thus facilitating access), deepens understanding, and fulfills an ethical duty. In addition to my role as researcher, I drove the team between research sites (over 2000 km), helped shop for and prepare food, assisted in workshop set-up and other administrative tasks, and shared a room (or tent or trailer) with one of the facilitators. My non-research assistance helped stretch the project budget to allow us to visit more
communities, which improved my reputation as a trustworthy researcher and I believe led people to share more sensitive information with me than they might have otherwise. It was also an expression of my belief in the value of BCAYDWS and VANDU's work and my commitment to seeing it carried out.

Immediately before each workshop, I obtained written and oral consent from potential participants. In order to reduce financial coercion, attendees were told they were welcome to participate, and receive the $5 stipend offered to all participants, regardless of whether they consented to take part in the research; the statements of those who did not provide consent were not recorded. Stipends were offered to offset the opportunity costs of participating (people in some instances missed food line-ups or income-generating opportunities to attend) and to honour participants' knowledge and time (Fry and Dwyer 2001; Salmon, Browne and Pederson 2010; Bell and Salmon 2011, 2012). Participants were offered the opportunity to withdraw specific statements or to clarify what they had meant by visiting me after the workshop. This happened on a few occasions, mostly by participants who wished to provide additional information that they had not conveyed during the workshop. Fieldnotes did not identify individual participants, and it was therefore not possible for participants to completely withdraw after participating if they did not remember the statements they made during the workshop. I obtained written consent from the facilitators to take notes on our discussions. As many of our discussions were quite informal, however (occurring, for example, while in transit between communities), I verbally renewed consent when discussions included sensitive topics such as past experiences of trauma. Approval for the study was granted by the University of British Columbia Behavioural Research Ethics Board (certificate H10-01257). Ethics approval from the health authorities was not required.

Data analysis took place in two stages. The facilitators and I had extensive daily debriefings to reflect on what was discussed at the workshops, which, while not a formal academic analytic process, helped develop ideas which influenced facilitation and questioning at subsequent workshops and which were refined during more traditional analysis using NVivo 7 (Reyes Cruz 2008). These discussions included specific reference to contextual factors (i.e. political, economic, and social marginalization of drug users) that influenced the responses participants gave. The software-based analysis, which I conducted, involved double coding all workshop notes to identify beliefs expressed by participants and the values that underlie
these beliefs, an approach adapted from Saldaña (2009) and Gable and Wolf (1993). This technique was chosen to facilitate a thematic analysis useful to BCYADWS priority-setting and a concurrent more theoretical exploration of how the priorities expressed might relate to drug users' positions in society and the ways in which they attempt to resist marginalization. As an example, participant comments regarding negative experiences of surveillance in a health care setting were coded as "improving health care" as a priority for change and also coded as "freedom from surveillance" as a value underlying this priority. The initial codes were modified and categorized as analysis progressed in order to develop broader themes (Altheide 1987). The analytic process attempted to strike a balance between understanding participants' own views (or, more accurately, the version shared with us) and contextualizing their reports within broader social, political, and economic structures and trends (Lather 1986; Carspecken 2001). Specifically, I drew on critical theory to better understand how participants' experiences echoed and intersected with the patterns of oppression of other marginalized groups. As well, my use of theory influenced my understanding of how drug users' marginalization constrained their responses to emphasize immediate needs rather than large scale change. I attended to contrasting opinions and areas of disagreement between participants in order to better understand both common and uncommon viewpoints. In general, however, I do not report quantitative information regarding themes, because the questions posed to respondents varied somewhat between workshops and responses are therefore not directly comparable. Where terms such as "most" or "a few" are used, it should be noted that these refer to the sample only, and should not be generalized beyond it (Neale 2014).

From the data originally coded as "beliefs" were developed seven themes reflecting participants expressed priority areas for change. These are presented in Chapter 4. From the data coded as "values," four key themes were identified that reflected the ideals expressed by participants. These are described in Chapter 5. The themes (priorities and values) were presented to the board of BCYADWS, the staff of VANDU, and BCAYDWS members attending an annual general meeting for member checking. They agreed with the overall themes and made a number of suggestions for refinements, particularly around language, that were incorporated into the final analysis.

Three hundred and two participants attended the workshops, with mean of 18 participants
(range 6 to 42) per meeting. The facilitators strongly felt that it would interfere with the atmosphere of the meeting to collect demographic information about participants. Instead, general information about the composition of the meetings was shared from BCYADWS membership sign-up forms distributed and collected during the workshops. Unfortunately, many of these forms were destroyed in a flood at the VANDU office. The information from the four communities visited on Vancouver Island had been entered into a computer before the flood, and is summarized below. In my opinion, the demographics of participants in the other communities visited were similar, with two notable exceptions: a greater proportion of participants were Aboriginal (First Nations, Inuit, or Metis) in the five northern communities visited, and a greater proportion of participants used prescription medication (vs heroin or crack cocaine) in the five communities visited in the interior region of the province and more used alcohol in the northern communities.

In the communities where data is available, approximately one-third (22/69) of participants identified as women and two-thirds (47/69) identified as men. Approximately one-third identified themselves as Aboriginal (23/66 responding to this question). Half (32/64 responding to this question) identified a single substance of choice, while the other half described polysubstance use. Two-thirds used crack and/or powder cocaine (45/64), a quarter used heroin (18/64), and smaller proportions used prescription drugs (12/64, primarily morphine), marijuana (9/64), alcohol (3/64), and crystal meth (4/64). Three participants noted they were currently not using illicit drugs. Approximately a quarter of participants were receiving methadone maintenance therapy (17/66 responding). Of participants responding to a question about routes of administration of drugs, most reported smoking (49/59 responding), less than half reported injecting (24/59), and approximately a quarter used drugs intranasally (snorting) (14/59). Two participants specifically mentioned oral use of pharmaceutical medication in addition to other routes of administration. Participants reported using illicit drugs for a mean of 21 years (range 3-41 years).
4. Participant priorities: seven areas for action

In this chapter and the next, I present the results of the provincial drug users’ needs assessment and discuss the relationships of these results to my theoretical framework and the academic literature. The results section of this chapter (section 4.1) describes workshop participants' priorities for change to improve drug user health, based on the workshop themes coded as “beliefs” as described in Chapter 3. The discussion section (4.2) compares and contrasts these priorities to what others have suggested are important factors to improve drug users' health.

4.1. Results

Workshop discussions led to the development of seven priorities for change that were shared by participants across the province: improving interactions with health professionals, promoting access to a range of housing options, improving treatment by police, ensuring harm reduction best practices are followed everywhere, improving social assistance, supporting drug users' organizations, and engaging new and existing allies. These are summarized in Table 4.1 at the end of this chapter.

4.1.1. Improve interactions with health professionals

Health care provision, and its perceived inadequacy for people who use illicit drugs, was raised by participants as an issue of vital importance. Chief among the problems participants reported experiencing was discrimination by health care providers. They described this discrimination as taking the form of being treated disrespectfully, receiving less comprehensive care than non-users, waiting longer for care, and potentially being denied the treatment they believed was necessary. The provision of health care is a site where oppression and control are enacted for many marginalized groups, with the result that access and quality of care are often compromised. One participant, summarizing his experiences with his local hospital, said, “The hospital won’t let you in if you’re a drug addict. They put you to the back of the list. You have to be dying to get in” (Community A).12

Nurses, pharmacists, and medical office assistants were mentioned as members of the health

12 Each community was assigned a letter for confidentiality. The individual speakers in each quotation are not identified.
care team that were perceived as discriminatory by participants, but the most vitriolic condemnation was of physicians. One participant described visiting her family doctor with her young daughter:

I find the doctors are pretty bad. They knew me as a drug user before [she is now a non-user] and they took one look at me, and they told me I was jumping to conclusions, there was nothing wrong with my daughter. But her eardrum busted that night! They just wanted me in and out. They should have taken more than five minutes to look at me and her (B).

This mother’s experience was that her legitimate concerns about her daughter were dismissed by a doctor and that this dismissal was at least in part due to the doctor knowing of her history of drug use.

In some communities, participants reported that being Aboriginal was often enough to cause health care workers to assume they were drug seeking and treat them accordingly. One said, “The doctors here judge Natives. They’re fricking ignorant. They think everyone’s trying to get pills. You break your finger and all they’ll give you is extra strength Tylenol” (B). Such racism was encountered in communities across the province, but was particularly pronounced in the Northern Health Region, where a larger proportion of the population is Aboriginal. This is a clear example of how axes of oppression (against Aboriginals and drug users) intersect to produce compounded impairments in access to health services. Interestingly, Aboriginal-specific health services were seen as not just an exception to the usual racism for Aboriginal patients, but also a place where white drug users could receive non-judgmental care. As one participant explained, “[Aboriginal-focused primary care clinic] is very open. They won’t look down on you. They’re developed from an Aboriginal point of view, [but] they’ll treat you white or Aboriginal or whatever” (C).

Despite these exceptions, the general experience of drug users with the health care system was described as beset by discrimination and judgmental attitudes. As a result, participants told us that many drug users have difficulty obtaining health care. A variety of reasons were suggested for this situation. A common complaint was that participants had been “red-flagged,” that is, marked (in electronic or paper records or possibly just in the minds of staff) as a drug user and therefore, at best, denied painkillers and other controlled substances or, at worst, banned from the premises altogether. Others were afraid to access health care for fear
their issues (particularly abscesses) would mark them as drug users and therefore lead to substandard care in the future. Many participants felt that their doctors did not listen to them, and as a result prescribed inappropriate or unwanted treatments (interestingly, none suggested that this was a failure to explain why certain treatments were offered – for example, antidepressants given when sleeping pills were requested – but rather a failure to provide what patients already knew that they needed).

But the most important barrier to accessing health care, as described by participants, was simply that the experience is so consistently negative that most would prefer to avoid it unless absolutely necessary. “[I] don’t want to access health care because of it” (D), one participant said. A more specific example was given by a mother, who explained that her daughter “has juvenile rheumatoid arthritis and her family doctor won’t have a thing to do about it because she’s an addict.” In consequence, she continued, her daughter had come home from an appointment in tears and refused to return to the physician for care. Several participants in different communities compared the quality of care they received to that given to animals – one adding that his opinion seemed to count for as much to his doctor as a sheep’s would to a veterinarian. With participants feeling that “we get treated like shit before we get treated properly” (D), it is no wonder that many delay seeking care until, in many cases, their condition is much more serious and difficult to treat than it would be with prompt care.

Drug user-specific issues in accessing health care are compounded by a problem faced by patients across the province: a lack of physicians in rural areas (Snadden and Bates, 2005). Describing her small city, one participant said, “To see a walk-in doctor is near impossible and to get a family doctor, forget about it” (E). In smaller communities, this creates particular difficulties for those who might have had negative experiences with one of the few doctors in town. It is also particularly problematic for those who need specialized services such as methadone. “We have to go an hour away through the mountains to get methadone” (F), explained a participant, while others described traveling to Vancouver for hepatitis or HIV services.

Medical areas of particular concern that participants highlighted to us were pain management, methadone maintenance, confidentiality, and preventing and treating bacterial
infections. Regarding pain management, participants reported encountering difficulties obtaining medication after an injury. This was particularly distressing for patients on methadone, several of whom reported being told that their maintenance dose of methadone should be sufficient to control pain from injuries. In the longer term, patients with chronic conditions (including several with cancer) described supplementing what they considered insufficient doses with medication bought on the street:

I’ve been on the same prescription for a year and a half, so I asked at the pharmacy why I’m always getting the shakes, and the pharmacist said I’m just used to my dose so I’m not even getting anything for pain. I have to buy on the street three days a week and you can imagine what that costs (G).

In this participant’s community, and in many other areas of the province, heroin is generally unavailable and pharmaceutical drugs such as morphine are the most commonly consumed opiates. As a result, drug users are particularly dependent on their physicians and, combined with the desperation of opiate addiction, this sets the stage for conflict. Several participants told us that their physicians attributed limiting or reducing doses to potential or actual audits by the BC College of Physicians and Surgeons, the licensing body for physicians in the province. The College has the power to revoke the ability to practice medicine of those found contravening its policies on opiate prescription, which permit opiates for pain relief but not as a maintenance therapy for opiate addiction. Physicians may therefore have limited prescriptions to participants based on their assessment of potential professional consequences, or used this as an excuse to avoid arguments with patients to whom they are denying medication.

A variety of issues relating to methadone maintenance were reported by participants around the province. For some, methadone was prescribed too easily: it was offered for stimulant addiction or when the physician wanted to cease prescription of pain medication. For others, it was too difficult to obtain: there might not be a qualified physician in their community and high costs were associated with travel. Travel to pharmacies was also a problem, especially for those on observed dosing who lived in areas without public transportation. In a couple of communities, certain recovery homes required a methadone prescription for all residents. And urine testing was generally felt to be invasive and unwarranted, especially when physicians required methadone patients to undergo regular tests for stimulants (which were
seen as unrelated to methadone dosing). Despite these many problems, a number of participants were enthusiastic about methadone and the role it had played in stabilizing their lives, and several of them described being prescribed it respectfully and appropriately.

Participants reported what they considered breaches in confidentiality occurring between physicians and police and between physicians and other health care providers. An exchange between several participants and the facilitators illustrates this concern:

Participant 1: My doctor actually passed on to the next doctor that took over from him that I was a drug addict and not to take me on.

Participant 2: What happened to the law of confidentiality between a doctor and patient? You should be able to sue his ass off.

Facilitator 1: You need money to do that, and some doctors think if you’re harming yourself you can break confidentiality. They need some education.…

Facilitator 2: They use the word consultation between doctors, but it’s just passing gossip (H).

This conversation reveals a common concern of participants: that one health care provider would share a patient’s drug use history with another without the patient’s permission. Especially in small towns, such behaviour could limit a patient’s options for receiving care, and this state of affairs was seen to create an additional disincentive to informing health care providers about illicit substance use.

A final area of specific concern about health care was dissatisfaction with the treatment of bacterial infections. Participants told us of friends who had died from endocarditis or other bacterial infections, but many were hesitant to seek treatment out of fear they would be assumed to be drug users (for having infections seen as drug use-related) and subsequently face judgement and discrimination from health care providers. As one participant said, access to treatment for such things was sufficient in his community, but “[you] have to put up with attitude from the medical people” (I).

Workshop participants consistently suggested that improvements in health care services for people who use drugs could be achieved through education of service providers. This was in keeping with a general emphasis on the value of knowledge and education, expressed, for example, by participants explaining they attended the workshop to “gain some knowledge” (J) or “educate myself” (K). That participants foregrounded education over structural factors
(such as differential access by class and ethnicity to the health care professions) is of interest because it shows respondents believed their problems in health care access were enacted primarily at the individual level. This can be read as demonstrating a need for popular education of drug users on the contextual factors affecting their lives, and simultaneously as an example of optimism that positive change can be achieved. The following conversation shows a belief in the value of education and training in combating discrimination:

Facilitator: What would be a good strategy to take on the discrimination in clinics?

Participant 1: Bring my bow and arrow? [laughter]

Participant 2: Get sensitivity training for the medical community. They have it for different religions, for different cultures, different colours. Why don’t they have it for different people?

Participant 3: Education for the doctors (G).

Another participant echoed this sentiment, and further explained that the type of learning that is necessary cannot be achieved in traditional academic settings: “It has to be through education. Everything they know is in school and they don’t learn from us” (K). As evidence that better treatment is possible, participants cited examples of rare respectful service providers, many of whom worked for Aboriginal-specific health care organizations or were street outreach nurses.

4.1.2. Promote access to a range of housing options

Housing, and a lack of access to affordable, dignified housing, was raised as an issue for drug users in every community we visited. This is unsurprising, as lack of a national social housing strategy for Canada has meant access to housing is primarily though the free market, which leaves those who are economically or otherwise vulnerable with impaired access to appropriate shelter (Hulchanski et al. 2009). In many communities, the focus was on access to shelters and the manner in which people were treated at those shelters. In particular, participants mentioned limited shelter hours and restrictions on using substances or carrying drug paraphernalia in shelters. An urgent concern in several communities was the practice of banning individuals from the (often only) shelter for a period of several days after an episode of intoxication. Especially in the winter, this leaves shelter users in a particularly vulnerable position, and participants reported sleeping outdoors or in ATM vestibules in response. One
participant contrasted the approach taken in his town with that of a neighbouring community:

I went to [nearby larger community] last night. I went to [women’s shelter]. They ask if you have anything on you, [and] you give it to them and they put it in a sealed bag and you just ask for it back and go outside and do your thing, but here they’ll kick you out. People are out on the street in the alleys, sitting outside freezing to death (L).

This concern is in keeping with a harm reduction approach for shelters and other emergency housing services.

In communities where participants discussed long-term housing solutions, many described desiring homes with fewer restrictions. Regarding supportive housing, participants frequently called for housing in which substance use would be permitted and harm reduction encouraged, which, as the following statement shows, is a practice they felt would improve the safety of residents:

In one of the transition houses, one of the workers went through a girl’s bag and took the pipe and kicked her out even though she wasn’t using inside, and that was, like, her safety pipe, so now she’ll have to go use somebody else’s (L).

This participant’s story demonstrates that restrictions in supportive housing can be problematic for residents and even endanger them. Other restrictions that participants found troublesome were surveillance when entering or leaving a building, restrictions on guests, and room and bag searches. Similar concerns were expressed about market housing, where participants described themselves as subject to arbitrary whims of landlords and as facing acute discrimination.

A minority of participants, however, wished for more rules and restrictions in supportive housing. These individuals tended to be newly abstinent and described needing an environment free from triggers in order to avoid relapsing. One participant explained:

[We need] stronger reigns on supportive housing so people can’t use in there. Not a step up and then there’s using so you can’t step any further up (J).

Substance use by neighbours was the most frequently mentioned trigger, but a few also mentioned their difficulties in living near drug dealers or former sex work clients.

The smaller communities we visited had an extremely limited range of shelters and/or
supportive housing options. The result of this was that most communities had shelters or housing that prohibited substance use, a few had shelters or housing that allowed it, and only a very few had both types. Overall, participants felt that drug users’ lives would be improved by offering a greater variety of housing options to suit people’s varied life circumstances.

4.1.3. Improve treatment by police

The production of laws and the enforcement of them through policing are not value-free — instead they are shaped by dominant ideologies and serve to reproduce the power of ruling groups. Reflecting this, some participants and especially the facilitators emphasized that, in the long term, in order for drug users to live healthier lives, the laws criminalizing drug use and drug users need to change. One participant explained that the law enforcement approach to drug use is wrong-headed by saying, “They think that if they lock you up, that’ll solve the problem, but it won’t” (F). Another put it more bluntly: “There’s obviously a problem, and it’s the laws” (M).

In the short term, participants expressed a desire for an end to police harassment and violence and for police to take a stronger interest in protecting drug users. Participants described many incidents of what they considered harassment by police. A common theme in these was questioning and searching of property by police when the person in question had done nothing to invite such scrutiny. This was considered especially egregious when clean harm reduction supplies were seized in these encounters. One participant said, “I get pissed when cops take my rigs. They do it just to be assholes” (M).

Violence by police and correction service officers was also a frequent complaint, one which many participants felt was ignored by the media and other police officers when experienced by drug users. “Police brutality,” another participant said, is “way bigger than police harassment. If you’re a well known drug user, nobody takes you seriously” (N). Many other participants echoed this sentiment, describing police denying needed medical treatment or taking their jackets and turning on the air conditioning, mid-winter, in the sobering unit.

Participants, however, wanted more than just an end to police harassment and violence: they wanted police to be actively working for them when they themselves were victims of crime. As it stands, they felt that, “If they know it’s drug related [i.e. a dispute between drug users] they don’t do anything” (E). Drug users are frequently in vulnerable positions in society and...
in need of protection from those who would hurt or exploit them. Participants wanted protection of their rights to be to be equal to that of other citizens, but felt that the police were not meeting this ideal. This is in keeping with a critical view of police, which draws attention to how policing and the criminal justice system are performed foremost to protect the interests of dominant groups.

A few participants did note that certain police officers were not a problem for their community, and in fact could even be supportive. Although contingent on “how you interact with them” (E), a few police were described as looking out for drug users and even being “friendly” (E), showing that respectful relationships between police and drug users are possible.

4.1.4. Improve social assistance

The existance of social assistance reflects a theoretical belief that society has a duty to care for all its members, but the implementation of these programs has been scaled back in recent years so that the reality is that assistance is difficult to access and of inadequate amount in most cases. People who find it difficult to obtain employment, including drug users, are therefore doubly vulnerable. Participants in communities large and small generally agreed that the amount available from social assistance did not meet their needs, with the result that most rely on charity to make ends meet. Rent for market housing, for example, was described as significantly in excess of the social assistance housing allotment, meaning that recipients frequently spend their remaining funds on shelter rather than food in order to make up the difference. One participant noted the potential, in larger communities, of receiving enough help to meet the most basic of needs, but noted, “There’s enough to keep people going but not enough to get them up” (K). In what seems something of an understatement, one participant said, “It’s unfortunate that we have to live on so little [that] we have to depend on food being given out” (L).

The social assistance system is expected to provide additional funds for individuals needing health care goods or services outside the provincial health care plan, such as dental care and mobility aids. Participants spoke often of the inadequacy of this coverage. Most of the cost of methadone, for example, is covered for individuals on social assistance, but a portion is deducted from the monthly allowance and no support is given for those who must travel long
distances in rural areas to access a prescribing physician. Many participants had experience with knee or back braces, crutches, or similar items being denied them by social assistance workers. And dental care was described as wholly inadequate, available “only if you’re in major pain and it’s an emergency” (P) because “as soon as they figure out you’re on assistance, they don’t want to see you” (E).

Beyond the problems with the amount of support available, participants described feeling “shunned” (L) by Ministry of Economic and Social Development workers and receiving service from them that interfered with their abilities to improve their health and wellbeing. That social assistance was offered in a way participants found demeaning is in keeping with Western society's emphasis on economic productivity as a source of moral value, enforced through social sanctions such as stigmatization of the poor and institutional sanctions such as complex social assistance bureaucracies. One explained how this inadequate service was enacted: “Over at this office over here, I went in with my intent to rent [a form that allows a person on assistance to access funds for a damage deposit] and they said three to five days to get the paperwork. The place probably will be gone by then! The phone’s ringing off the hook over there with people who want to rent the room” (E). Others described being able to access the services they needed, such as crisis grants or clothing allowances, only by being aware of the rules and willing to stand up to social assistance workers who were denying them available benefits.

4.1.5. Support drug users' organizations

Workshop participants who had experience with drug users' organizations (in the communities where other drug user groups were present; some members of VANDU were also encountered in other communities) were overwhelmingly supportive of drug user organizations, and expressed pride in their organizations' achievements as well as their personal achievements. Of those who had not participated in drug users' organizations, most were intrigued, and many expressed admiration for the facilitators and the achievements of VANDU. Of particular interest was disclosure by several of the facilitators that they were active drug users, which was received with surprise and enthusiasm by participants. The ability to envision positive identities for drug users is lacking in a society that primarily medicalizes and criminalizes drug use, and the opportunity to do so at the workshops was
clearly welcomed.

Current and former drug users have a lot to offer the community, according to workshop participants. They described having hard won knowledge and experiences, a desire to "give back" to their communities, and an interest in taking a leadership role on issues that affect them. Drug user organizations were seen as one way to harness this expertise and interest, although participants also spoke in positive terms about volunteering with health authorities and other services organizations and about informally supporting one another.

As an additional benefit of drug users' organizations, participants spoke of how experience of connecting openly with other drug users can be emotionally uplifting; as one participant said, "It's powerful to gather. I've never heard the words 'drug war survivors' before – I'm walking out of here today taller than when I walked in" (P). As another said, despite the challenges drug users' organizations face in small communities, they may be especially important as a "home base" (D) in communities where a lack of anonymity can lead to increased surveillance and discrimination.

Several participants suggested, however, that drug user-led organizations will have difficulty functioning without support. In particular, they saw a need for financial support (principally envisioned as coming from government sources) and the support of non-drug user allies in the community. This may be difficult to achieve given the growing emphasis on fiscal restraint and quantifiable outcomes in Canadian health care provider organizations.

4.1.6. Ensure harm reduction best practices are followed everywhere

A critical reading of harm reduction, as described in Chapter 2, emphasizes this approach's potential for both liberation and control of drug users. Workshop participants, however, emphasized only its positive aspects. With very few exceptions, they described harm reduction services as a necessary and effective method for encouraging drug users to take care of their own health. Harm reduction was described as a matter of life or death, with frequent references to its role in preventing blood-borne infections. Participants described harm reduction services as supporting them to live healthy lives without placing conditions on them. One explained, "The needle exchange was probably a major factor in a lot of people's lives, mine included. I couldn't have worked without it" (H).
Participants also expressed pride at the ways in which they had been involved in delivering harm reduction services, either formally or informally. Describing her reasons for attending the workshop, a participant said, "I'm here because I've been involved in other communities with drug use and making the streets safer and better" by distributing crack paraphernalia at a time when people were contracting serious infections (P). Others mentioned their involvement in distributing or collecting syringes and sharing harm reduction information with their peers.

A small number of participants disagreed with the philosophy of harm reduction. These fell into two groups: some felt harm reduction was not applicable to their lives (although, when questioned by the facilitators, most admitted to using harm reduction services at some point in the past), and a few felt that harm reduction was "enabling" and that "maybe if they [drug users] get sick enough, they'll get off [drugs]" (J). More commonly expressed, however, was the belief that the abstinence-based approach does not work for many people and leaves them isolated and ashamed after a relapse. A participant said, "NA [Narcotics Anonymous] doesn't work for everyone. They call it relapse and you're out, even if you use a couple times per year and keep your life together" (K).

Despite the general support for harm reduction, however, many participants had concerns that the availability or quality of harm reduction services was lacking in their communities. Harm reduction policies in British Columbia (for example, a policy to distribute syringes as needed rather than only exchange with clients on a one-new-to-one-used basis) are set by a central agency for the province as a whole. Implementation of these policies, however, is carried out by regional health authorities and/or non-profit agencies subcontracted to deliver services; the actual services delivered, therefore, are influenced by the priorities and values of the agencies involved and their employees, which may conflict with the philosophy of harm reduction. Moreover, all services are carried out in an atmosphere of fiscal restraint and accountability, which may make full implementation of harm reduction services (and services for any marginalized group) a low priority. One participant explained:

You give back your rigs and you get another one, but they don't give you enough. They only give five needles and they're closed weekends. A regular user uses more than five in a weekend. I ended up sharing with someone else because they were dull (B).
In addition to limitations on syringe distribution, as this participant described, other concerns that were raised included lack of confidentiality in services and insufficient collection of used syringes (such as drop boxes and collection at needle distribution services). Limited hours during which harm reduction supplies could be accessed was an issue in many communities. In response to a facilitator's question about how people access supplies after needle distribution in one community closes each evening at six o'clock, the following exchange occurred:

Participant 1: Try to buy them off of people. I've paid $20.
Participant 2: Or go to the pharmacy. [But] they didn't want to give it to me. They asked if I was diabetic. They judge you (M).

This experience, and the importance that participants placed on having more comprehensive access to harm reduction services, was echoed in most of the workshops.

Great emphasis was also placed on expanding the services available to people who smoke crack cocaine or use other non-injection drugs. Access to crack pipes, screens, mouthpieces, and harm reduction education was far from uniform in the communities we visited and even within communities fluctuated depending on funds available to harm reduction organizations. Pipes were particularly difficult for participants to access and considered an urgent need in order to reduce infection risk from sharing and to prevent people from using broken pipes.

Participants in most communities also expressed a strong interest in safe consumption facilities. Many were familiar with Vancouver's supervised injection facility (Insite) and expressed a desire to see a similar service offered in their own communities. In addition to supervised injection for heroin or prescription opiate users, a supervised inhalation site was suggested in several communities as a way to meet the needs of people who use crack cocaine. Such facilities would be a safe place where "you won't get kicked in the ass or judged" (P). Beyond a single participant who noted that such facilities would not be necessary if adequate housing were available, no critiques of supervised consumption facilities were offered; instead, similar to the attitude taken to harm reduction services in general, participants expressed a desire to see expansion of services to match the desirable programs available in other communities.
4.1.7. Engage with new and existing allies

Stigma (negative judgements towards people on the basis of their drug use) and discrimination (negative actions that flow from stigma) from the general public were described as ubiquitous and an important barrier to drug users' health. Workshop participants believed that they were judged first and foremost by the substances they choose to use, rather than by any other characteristics they possessed or actions they took. "It's so easy for people to put a label on drug users" (I), explained one participant. Labelling people as drug users was seen as part of the process of excluding them from the rest of society. Once excluded, participants' experience was that the public would prefer that drug use and drug users in their community be hidden from view. This was summarized by a participant who said, "The attitude around here that I've seen is not to help people, it's to keep it quiet" (P). A strong sense of the injustice of stigma and discrimination was communicated by participants; as one said, "I don't want people to judge me on who I am, I want them to judge me on what I do" (K).

The stigma and discrimination experienced by drug users is not uniform. Participants reported that it occurs along axes of domination, so that more privileged drug users are able to escape the full effects, while others are targeted to a greater extent. Targeting was seen as occurring based on a large degree on appearance, so that people of particular physical characteristics – including ex-users and Aboriginal people – are often labelled drug users and subject to the stigma and discrimination that entails.

Participants reported harmful practical and psychological effects of their experience of stigma and discrimination. They perceived being unfairly excluded from accessing housing, accessing loans, employment, and other opportunities on the basis of being labelled as drug users. One used the word "shunned" (L) to powerfully describe the emotional experience of being rejected based on his drug use. Another used an evocative rhetorical device to describe the rejection she feels: "If you approach people for help in this town, they'll turn their backs on you" (P). Both practical and emotional effects were seen as contributing to the poor health of drug users.

Many participants were optimistic, however, that the perpetrators of stigma and
discrimination could become allies\textsuperscript{13} of drug users. Their hostility, to these participants, was based on ignorance, and could therefore potentially be ameliorated by outreach and education. "Users are part of the community. There's psychological separation but no real separation" (K), one explained. "I think there are people in this town that would help," said another, going on to explain that the barrier to their help was that these individuals did not know about the issues facing drug users (P). Using the media to humanize and normalize drug users was proposed as a promising strategy – "To print it and read it means it's going on" (D) – but several participants urged caution in this approach based on past negative portrayals of drug users in the media. Others hoped that drug users in their community could take actions of which the public would approve, such as collecting discarded syringes, in order to improve their public image. Suggested messaging for any public education and outreach included the ubiquity of drug use (including by people who would not normally be thought of as drug users) and the dire negative health consequences of the drug war. Succinctly describing drug users' own role in challenging public ignorance, one participant said, "If we don't speak up, no one's going to listen to us" (E).

Workshop participants also raised the issue of working with existing allies, who were described primarily as supportive service providers. Allies were seen as useful because of their perceived power and respectability, because they often have skills that drug users might not possess, and because of their ability to sustain group momentum by using their organizational skills (for example, by coordinating meetings or obtaining funding). In many cases, however, participants could name specific potential allies but were not certain how they could best support drug users and user-run organizations. The full potential of drug users' existing allies, then, remains to be harnessed but is a promising target of future efforts.

\textbf{4.2. Discussion}

This participatory needs assessment, conducted as a partnership between two drug users’ organizations and a government health agency, researched the priorities of drug users for improving their health and investigated the manner in which they would prefer to see changes carried out. We found that the study participants had clear and consistent ideas for

\textsuperscript{13} Workshop facilitators define allies as non-drug users who are willing to support drug users to achieve their goals and respect them as the experts on their own lives.
systemic and institutional changes. These ideas (improving interactions with health professionals, promoting access to a range of housing options, improving treatment by police, ensuring harm reduction best practices are followed everywhere, improving social assistance, supporting drug users' organizations, and engaging with new and existing allies) can be seen as examples of how structural violence and resistance manifest in drug users' lives.

Health care, housing, policing, and social assistance are sites in which structural violence is enacted against drug users. In each case, government services (or, as is frequently the case, contracted agencies and non-profit organizations), while nominally providing necessary assistance, are also places of discipline, shame, and exclusion. The effects of this treatment are not just psychological, but become embodied: the body is literally changed (made ill, hungry, and/or hurt) through constrained access to resources and encouragement to enact detrimental behaviours (Krieger 2005; Farmer 2004).

Participants described both physical and emotional harm being perpetrated through health care institutions, as enacted specifically by health care workers. Others have similarly found that relationships between health care workers and drug users are characterized by mistrust, resulting in less care-seeking and lower quality therapeutic relationships (Brener et al. 2010; Simmonds and Coomber 2009; Siegal et al. 2006; Livingston et al. 2012; Lloyd 2013; Neale, Sheard and Tompkins 2007; Neale, Tompkins and Sheard 2008; Merrill et al. 2002). Low-barrier services for drug users have been suggested as helpful in fostering positive relationships (Islam, Day and Conigrave 2010; Smith 2011b).

Participants' descriptions of their desire for safe and dignified housing stand in sharp contrast with their current experience of shelters, inadequate market housing, limited social housing, and rough sleeping. As with health care, housing is a domain in which drug users' opportunities to maintain their health are dramatically constrained by ideologies that value self-reliance and market- or charity-based provision of services. An extensive body of literature suggests that housed drug users engage in fewer HIV risk behaviours and are less likely to contract the disease than those who are homeless (Corneil et al. 2006; Aidala et al. 2005; Shannon et al. 2006; Elifson, Sterk and Theall 2007). More broadly, housed current or former substance users also have fewer emergency department and jail visits, better mental
and physical health, and better overall quality of life (Kushel et al. 2003; Larimer et al. 2009; Morales-Manrique et al. 2011; Galea and Vlahov 2002; Shannon et al. 2006). Despite the need, since the 1980s the Canadian government has withdrawn from a role in ensuring affordable housing for citizens in favour of a neo-liberal free-market approach, leading to an increase in homelessness (Hulchanski et al. 2009). Our participants emphasized that they saw a dire need for social housing, with an emphasis on a range of types of housing. This echoes others’ findings that shelters are sites of both refuge and risk (Briggs et al. 2009; Wadd et al. 2006; Evans 2011) and that among supportive housing both abstinence-based and low-barrier facilities have shown benefit (Tsemberis, Gulcur and Nakae 2004; Milby et al. 2005; Padgett et al. 2011; Collins et al. 2012).

Participants' perception of the police as perpetrators of symbolic and everyday violence rather than as a source of protection is a clear example of how the marginalization of drug users is enacted. Others have also identified aspects of policing as detrimental to drug users' health. In particular, intensive policing of drug markets encourages riskier drug use behaviours, interferes with the use of harm reduction and health services (Cooper et al. 2005; Small et al. 2006; Aitken et al. 2002; Smith 2011b; Kerr, Small and Wood 2005), and is associated with higher rates of HIV among injection drug users (Friedman et al. 2006). Incarceration is associated with increased morbidity from infectious and non-infectious diseases (Burris et al. 2004; Galea and Vlahov 2002) and negative relationships between police and drug users may contribute to internalized stigma and interfere with recovery (Lloyd 2013). While drug users in one study hoped that increased policing in their neighbourhood would lead to improved safety for themselves and their children (Cooper et al. 2005), participants in another reported that they would not seek police assistance due to a perception that the police would not protect them (Smith 2011b). At the same time, police enforcement of drug laws has not been found to have a substantial effect on the availability, cost, or frequency of use of illicit drugs (Kerr, Small and Wood 2005; Friedman et al. 2006).

The negative health impacts of drug use are felt disproportionately by drug users of low socioeconomic status (Galea and Vlahov 2002). Not surprisingly, then, our workshop participants identified reforming social assistance (both the services offered and the manner in which they are delivered) as a priority for drug users in BC. In keeping with the "involution of the state" (Bourdieu 1998), in which social services are reduced as part of a
package of neoliberal reforms, the focus of government effort in recent years has been on preventing drug users and others seen as "undeserving" of state support from accessing the social safety net (Petersen and Lupton 1996). The denial of even this most basic level of care and the subsequent consignment of many drug users to abject poverty is a clear example of how structural violence harms drug users' health. Given this focus on excluding drug users from social assistance, it is not surprising that very little research has been conducted into their experience of accessing it. Among the limited number of studies that have been conducted, researchers found that drug users report experiencing social assistance as demeaning and bureaucratic (Ashery et al. 1995) and that personal or family members' substance use can interfere with meeting program administrative demands (Mulia and Schmidt 2003). Challenging commonly-held stereotypes of drug users, a American study found that after controlling for other factors, substance-dependent individuals were equally likely to leave for work (and no less likely than non-dependent to return to welfare) but more likely to leave for administrative reasons (including non-compliance and jail) and changes in family composition; the authors attribute this to their lower social capital and to the disciplinary role of welfare (Schmidt et al. 2002).

In describing their priorities for improving drug users' health, participants identified problems as occurring both at the level of individual interaction (e.g. drug user and police officer, drug user and social assistance worker) and at the structural level (e.g. drug users and criminalization, drug users and government policies). This provides an interesting extension of Rhodes et al.'s "structural vulnerability" framework (Rhodes et al. 2012). While Rhodes et al. emphasize the agency of individuals despite structural constraints, our participants drew attention to the agency of those who are perpetuating structural violence even as they themselves are constrained by institutional and societal factors.

Health care workers, for instance, often find their ability to deliver high quality care to drug users is constrained by societal and institutional emphasis on the neoliberal value of "personal responsibility" and by limitations on the resources and time available for care (Merrill et al. 2002; Pauly 2008b; Bell and Salmon 2009). As an example, most jurisdictions have strict limits on the range and amount of opiates that can be prescribed, constraining physicians' ability to provide opiate maintenance therapy. Our participants, and some other researchers (Simmonds and Coomber 2009; Lloyd 2013), suggest education of health care
workers as a mechanism to improve therapeutic relationships. While such programs have been shown to be of some benefit (Silins et al. 2007; Livingston et al. 2012), and are based on a hopeful view of current problems as based in knowledge deficits, action against structural constraints and the criminalization of drug use is also important to improving drug users' health care experiences. Health care workers themselves have a key role to play in challenging these constraints. Although health care workers serving drug users may themselves be marginalized within their organizations through "stigma by association" (Phillips et al. 2012), by virtue of their experience and socioeconomic status they are positioned to act as advocates and activsts for their clients (Lovi and Barr 2009; Friedman et al. 2001). More broadly, many health care workers are well-positioned to push for social justice in the provision of health care generally and for an equitable distribution of other resources that affect health.

As with health care workers, certain police officers can and do resist becoming complicit in the mistreatment of drug users. Law Enforcement Against Prohibition, for example, is an organization of current and former criminal justice professionals who advocate for legalization and regulation of currently illegal substances (Law Enforcement Against Prohibition 2011). In addition to the acts of resistance (such as selective enforcement of rules) undertaken by individual housing workers, those involved in housing policy can resist political and institutional constrains in order to advocate for better quality and quantity of housing (Krieger and Higgins 2002). And it has been suggested that an alliance between those receiving and those distributing social assistance can be fostered through an analysis of the ways in which neoliberal reforms have made social assistance workers' jobs more difficult and less fulfilling (Morgen and Maskovsky 2003).

Bourdieu used the phrase "the left hand of the state" (Bourdieu 1998) to describe people who work in government-supported social service fields, including health, education, and social assistance. They are contrasted with the right hand of the state, which is made up of the ruling elites and policy-makers. He calls on the left hand to recognize their role in either perpetuating or resisting neoliberal reforms and the imposition of structural and symbolic violence, an analysis that has many commonalities with our participants' calls for change in health care, policing, housing, and social assistance at both the individual and institutional level. While public acts of transformational resistance such as media engagement or political
organizing obviously meet this appeal, our participants also draw attention to the ways in which small acts of resistance to complicity in structural violence – such as respectful engagement with people who use illicit drugs – can be experienced as health-promoting and life-affirming.

The remaining three priorities suggested by participants – promotion of user-run organizations, implementation of best practices in harm reduction, and the recruitment of new allies – also celebrate the potential of transformational resistance to structural violence. In these areas, participants saw opportunities to build on past victories for drug users and to take further action to improve the health of their communities.

Drug users' organizations, for example, were seen as a way to gain influence over organizations nominally "serving" drug users. Such organizations, by providing a common goal around which to organize and a cooperative structure in which to do it, also offer an opportunity to counter the everyday violence in which drug users are pitted against one another in the struggle for scarce resources. They have been advocated for as a vehicle for empowerment and health promotion for drug users (Curtis 2004; Friedman et al. 1987; Hayashi et al. 2010; Henman et al. 1998; Jauffret-Roustide 2009; Jose et al. 1996; Kerr et al. 2001; Kerr, Oleson and Wood 2004; Kerr et al. 2006; Mold and Berridge 2008; Trautmann 1995; Wodak 1993) (for more on the history and potential of drug users' organizations, please see Chapter 1). While supporting drug users in their organizational goals, however, it is important that the notion of a drug user "community" be critically explored. Although there are shared norms and expressions of caring among groups of drug users, there is also violence and exploitation (Singer 2006b). Other significant challenges, including lack of financial resources, exist to the implementation of these organizations (see Chapter 1). As participants expressed, however, there is a also a great deal of potential for drug users' knowledge and experience to be harnessed in a way that allows them to connect with each other and make meaningful contributions to their communities.

Some researchers have criticized the field of harm reduction for being a site of surveillance and control of drug users (Miller 2001; Roe 2005), for not promoting a rights-based approach to drug use (Ezard 2001; Hathaway 2001), for reducing the harms of criminalization (and thus being a "band-aid" solution only that in practice supports prohibition (Rolles 2010)), or
for minimizing the benefits (including pleasure) of drug use (Hathaway 2001; Tupper 2008; Moore 2008). Our participants' primary critique of harm reduction services, however, was that there are not enough of them. We worked with facilitators who themselves believe in the value of harm reduction and recruited participants through organizations that provided harm reduction services as part of their mandates, and this no doubt influenced the range of responses offered. Participants challenged facilitators on other subjects, however (for example, by calling attention to their lack of experience with rural issues) and criticized other aspects of the services offered by hosting agencies (for example, housing policies when meetings were associated with shelters). In line with the postmodern critique of harm reduction, it is possible that drug users have internalized the pressure to act as self-governing subjects who must regulate themselves to reduce risk, and therefore need harm reduction services to fulfill their duties as citizens (Miller 2001; Roe 2005). Such conformity to the neo-liberal subject's duties may interfere with the development of a politicized awareness of structural barriers to drug users' health, but may also allow access to the (self)-respect and recognition bestowed upon self-governing citizens (Moore and Fraser 2006; Keane 2003). A final insight into participants' support of harm reduction is offered by Lee, whose qualitative research found that drug users reported that interactions with harm reduction services made them feel valued and deserving of care (Lee and Zerai 2010).

Participants found the practice of harm reduction, however, somewhat beset by problems of quantity and quality. A small body of academic research mirrors their concerns. For example, following an evaluation of British Columbia harm reduction service provision, provincial best practice guidelines were developed and disseminated to improve the quality of services offered (Buxton et al. 2008; Chandler 2008; Harvard, Hill and Buxton 2008). An Ontario, Canada, evaluation of similar guidelines found an overall improvement in practice, but that opportunities for quality improvement remained due to financial impediments and opposition from senior decision-makers (Strike et al. 2011). Research in other jurisdictions has found deviation from best practice in the form of insufficient syringe quantities distributed, limited services for crack users, and missed opportunities for providing preventive health services (Heinzerling et al. 2006; Bluthenthal et al. 2007; Smith 2011b). Given participants' overall support of the harm reduction approach despite their experience that certain facets could be improved, and their desire to be more involved in directing the services offered to them (see
Chapter 5), there is great potential to further involve drug users in designing best practices and evaluating their implementation.

Our results are congruent with others who have found that stigma against drug users from the general public is widespread and experienced through discrimination, which is associated with reduced mental and physical health (Young et al. 2005; Ahern, Stuber and Galea 2007). Internalization of this stigma is common and leads to feelings of low self-worth and to discrimination among drug users (e.g. housed against homeless) (Simmonds and Coomber 2009; Ahern, Stuber and Galea 2007). Successes have been reported from challenging this stigma in the media and at an individual level through activism, education, and fostering positive contact experiences between drug users and non-drug users (Lloyd 2013). Despite the ubiquity of negative experiences of stigma and discrimination, participants communicated a sense of optimism for the increasing inclusion and support of drug users.

In this chapter, I have described workshop participants' priorities to improve drug users' health – improving interactions with health professionals, promoting access to a range of housing options, improving treatment by police, ensuring harm reduction best practices are followed everywhere, improving social assistance, supporting drug users' organizations, and engaging with new and existing allies – and situated these priorities in the experience of and resistance to structural violence. In the next chapter, I will discuss the values underlying these priorities and compare and contrast them with dominant Western ideologies.

Table 4.1. Participant priorities to promote drug users' health.

<table>
<thead>
<tr>
<th>Priority</th>
<th>Key findings</th>
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<tbody>
<tr>
<td>Improve interactions with health professionals (Section 4.1.1)</td>
<td>• Participants reported significant experiences of discrimination from health care providers, and this acted as a barrier to seeking care</td>
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<td></td>
<td>• Pain management and methadone maintenance were areas of particular concern</td>
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<td></td>
<td>• Concerns around confidentiality were common</td>
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<tr>
<td></td>
<td>• Participants were hopeful that education of health care providers could lead to improvement</td>
</tr>
<tr>
<td>Priority</td>
<td>Key findings</td>
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| Promote access to a range of housing options (Section 4.1.2)           | • Participants expressed a desire for more low-barrier housing  
• When housing with a harm reduction approach is not present in a community, drug users' safety is compromised  
• A subset of participants requested supportive housing with a abstinence focus, as they found a harm reduction approach incompatible with recovery |
| Improve treatment by police (Section 4.1.3)                           | • The long term goal expressed by participants was decriminalization of drugs and drug users  
• In the short term, participants wanted an end to police harassment and violence against drug users  
• Police were not seen as protecting drug users from becoming the victims of crime |
| Improve social assistance (Section 4.1.4)                             | • Funds provided do not meet needs  
• Dental care is an area of particular concern  
• Drug users feel discrimination and judgement from Ministry workers |
| Support drug users' organizations (Section 4.1.5)                     | • Drug users' organizations offer an opportunity to "give back" to the community and connect with people in similar circumstances  
• Support (financial and logistical) is necessary for their functioning |
| Ensure harm reduction best practices are followed everywhere (Section 4.1.6) | • Participants were enthusiastic about the potential of harm reduction services to save lives  
• They expressed concerns that best practices in harm reduction are not followed in all communities  
• There is a need for additional services for people who use crack and for additional supervised consumption sites |
| Engage with new and existing allies (Section 4.1.7)                   | • Participants reported frequent experiences of stigma and discrimination, but hoped that perpetrators could become allies through media outreach and education  
• There are opportunities for drug users and their organizations to better work with supportive service providers |
5. Participant values: collective action and accountability

In this chapter, I present another set of themes from the provincial needs assessment, specifically the values expressed by participants that underlie their priorities for improving drug user health (in section 5.1. Results). I then relate these findings to others' work on dominant values in Western society and patterns of resistance to them (in section 5.2. Discussion). Finally, I suggest how knowledge of drug users' values can improve health service delivery (also in section 5.2. Discussion).

5.1. Results

Underlying the seven priorities for action were shared values of collectivity, activity, freedom from surveillance, and accountability. These are summarized in Table 5.1 at the end of this chapter.

5.1.1. Collectivity

Despite poverty, addiction, and other life circumstances that serve to keep drug users isolated from one another, workshop participants described a powerful desire to connect with and take care of others. That the BCYADWS potentially offered this opportunity was one of the primary factors motivating attendance at the meetings, and, as the following statement shows, a benefit many received for participating:

I never thought that my use of cocaine would get my in anywhere. It’s powerful to gather… I’ve never heard the word drug war survivors – I’m walking out of here today taller than when I walked in (P).

The speaker contrasts the isolation of her drug use with the “powerful” experience of connecting to those who have shared similar experiences. Importantly, this sense of connection could be carried outside of the meeting, as the name of the organization itself suggested ongoing membership in a larger group.

The workshops were also seen by several attendees as a way to connect with family members who were also drug users. It is not surprising that substance use is often multigenerational: the factors that predispose to drug use (such as poverty, trauma, and exclusion) are experienced intergenerationally as well. In three communities, parents and children spoke of the group as an experience that would be good for their families. As one mother said, in
response to a question about her interest in participating, “I’m here, my daughter’s here. I’m hoping to bring my family together” (C). This suggests not only that family connection is an important value, even among those with multiple generations affected by drug use, but also that these connections can be strengthened by meeting and connecting with a larger group that experiences similar issues.

Several workshop participants emphasized that the type of connection they sought involved unconditional support. One described the need for “somebody to knock on the door, no matter what you look like or how you’re smelling, to show that they care about you” (J). Such unconditional support was sometimes contrasted with that provided by Narcotics Anonymous or other twelve step programs, in which the connection to the group was severed if a person relapsed. Drug user organizing was, in this case, seen as an alternative support system in which connections could be maintained despite a person’s sobriety (or lack thereof).

Entwined with valuing social connection is a sense that everyone bears some responsibility towards others. One participant described her motivation for attending the meeting as being to gain information to help herself and others: “[I’m] looking for ways to keep myself safe and help others to keep themselves safe. If I can help anybody out anywhere, I’ll do that” (C). As an example of the ways drug users look out for one another, a participant described an incident in which she resisted pressure to share used injecting equipment: “Just last week, I noticed somebody where I live said, do you have a point [syringe]? I said all I have is my used ones, and she said, I’ll bleach it and use it. And I said no, you can’t do that.” (C). She is aware that bleach is inferior to new, sterilized syringes when it comes to preventing transmission of blood-borne infections and reducing damage to veins, and is therefore willing to risk her neighbour’s displeasure in order to protect her from a potential health threat.

While valuing responsibility for others’ welfare, workshop participants were aware of the many barriers to their achieving this ideal. As one put it, despite their ideals, "Drug users fight against each other" (N). Particularly highlighted were the ways in which drug users are pitted against each other in order to obtain drugs or other resources, such as being encouraged to report on one another’s substance use and other illegal activities to medical professionals or police:
To get Valium or any benzo [benzodiazepine], you pretty much have to go through mental health and see a shrink and play ball and wait six weeks. They try to keep a pretty tight lid on that, like all doctors, that’s part of the reality of getting drugs. There’s so much ass kissing, and they play us off each other. They’ll try to get someone to rat out everyone else in town, and they’ll do it, to try to gain their favour (Q).

This speaker displays anger at a system that encourages drug users to act against one another, but he also acknowledges the reality that many of them will in order to protect their relationship with the physician who controls access to certain pharmaceuticals. While participants valued connection and collective responsibility, they also valued survival, and in their experience a sad fact of life for very marginalized drug users is that these orientations are often incompatible.

5.1.2. Activity

Workshop participants told us that the circumstances of their lives and the manner in which they are treated pushes them towards a degree of passivity in their dealings with others. This is exemplified in the following exchange between a participant and one of the facilitators:

Facilitator: A lot of us have been abused for so long—
Participant: [finishing facilitator’s sentence] You end up accepting it (E).

The “it” that users may stop trying to challenge is near-constant stigmatization, discrimination, and exclusion from spaces open to non-drug users. Remaining motivated to resist this state of affairs is particularly difficult for isolated individuals, but even groups may find it difficult to overcome years of experience as patients and clients of health and social services. Passivity may also be adopted as a strategy to avoid punishment and present oneself as a model client, or result from lack of opportunities to develop capacity to act for oneself (see Browne 2007 for a discussion of this among First Nations women receiving nursing care). The outcome, in this case, is a desire for an “advocate” (G) to represent the needs and desires of the group to those in power. For example, in one workshop, when questioned about who they could influence to make changes on the major issues affecting drug users in their community (poor quality pain management and discrimination by doctors), a participant suggested, “[Name] does advocacy behind the white building... She’ll talk to people and if it’s suitable for her… she’ll do her best to [help], if they need a crisis grant, and sometimes
she gives out food.” (G). While this advocate appears to have the best interests of the community at heart, the fact that the group in question brought up her name and those of many other community advocates, at the expense of developing ideas of ways they themselves could bring about change, and that similar exchanges occurred in several other communities, suggests that drug users may internalize years of passive dependence on services and thereby depend on others even in situations where they could effect change.

Despite being subject to discrimination and service provision that encourages passivity, workshop participants consistently expressed the desire to have those in power hear what they have to say and to take action together on those issues that affect them. “People got to stick together to get things done!” (H) summarized one participant.

The idea that action is more effective when conducted by a group was encapsulated by one of the facilitators, who said, “There are allies, they’ll listen to us, but we have to get together and speak. We can write letters, we can go to these meetings. When we stand alone we’re screwed, but together we have a voice” (Q). Facilitators often used the word "allies," which can be contrasted with the desire of some participants for “advocates;” "ally" speaks to a relationship with non-users that is characterized by support but not loss of autonomy.

Workshop participants developed many creative strategies for acting as a group to challenge conditions in their communities. For example, in a rural community where many drug users had experienced discrimination from their doctors, the group developed a plan to meet as a group with the physicians in question:

Participant 1: “Can we have a meeting?”
Participant 2: “I don’t think they’ll come.”
Participant 3: “Swarm them, or hold a sit in!”
Participant 4: “Everyone book an appointment with their doctor, and then we’ll all go to that appointment with them. Then you’ve got their time” (F).

This exchange shows confidence that by acting together, drug users will be able to accomplish more than they would alone. Other participants raised the point that group action provides a measure of safety to those who are vulnerable alone. This was expressed by a participant speaking about bringing community issues to a police board meeting: “You got to do it as a group. If it’s just me does that they’d take me around back and beat me up” (Q).
This is a particularly important point for drug users who are members of groups that have historically been victimized by policing, medical and other institutions, such as Aboriginal people and those with disabilities.

In the eyes of facilitators, group action by drug users had already achieved many positive changes for their communities. One explained:

> There are user groups all over the world, and even an international organization. People who use drugs are the people who’ve made all the changes. If it wasn’t for their initiatives we’d still be sharpening needles with matchbooks (Q).

This statement shows that the speaker saw a benefit for all from drug users working together to speak out for their communities. On a more personal level, two other facilitators believed that group action by drug users had paved the way for them to be able to contribute their skills and talents to society:

> Facilitator 1: [Facilitator 2] and I are daily users—
> Facilitator 2: But we get things done. Because of all the things people have done before us, we can use and get things done, because we have such a big group and so much momentum (Q).

Workshop participants responded enthusiastically to these facilitators’ descriptions of their activism and expressed excitement about the idea that people could achieve so much while still continuing to consume drugs on a daily basis. This is unsurprising, given that these two individuals so well embody the values described in this section: although active drug users, they are able to work collectively and take action on the issues that affect those around them.

5.1.3. Freedom from surveillance

In addition to collectivity and activity, a desire for freedom from surveillance was a theme among workshop participants’ comments that underlies the seven priorities described in Chapter 4.

Workshop participants saw themselves as subject to scrutiny in almost every area of their lives. In navigating the health care system, in interactions with police and private security, in dealing with the bureaucracies of social assistance and child welfare — all of these institutions are believed to be paying close attention to users’ appearance, words, and actions.
One participant encapsulated this belief by saying of the police, “They spend so much money just watching us” (M).

In particular, workshop participants stressed, surveillance is experienced in accessing health care. Urine testing, for stimulants in particular, was seen by users as an unreasonable invasion of their privacy. One participant told us, “I’m prescribed Percocets for pain. A couple of months ago he [the doctor] piss tests me and it’s got speed in it; now he’s threatening to cut me off my pain meds.” Another replied to him, “They have to rationalize cutting you off, so they test you and test you until they find something” (F). Such surveillance went above and beyond what is necessary to maintain health; as one (non-using) facilitator put it, to much agreement from participants, “If I had cancer and was on pain medication they wouldn’t pee test me” (Q). Red flagging, described by participants as the process of having a health care worker put a note on a user’s file to advise other health professionals of his or her drug use, was mentioned often as a way in which the initial scrutiny users might face could have long-ranging consequences. The desire to avoid red flagging coloured almost all health care interactions and in many cases prevented users from sharing important health information with their providers.

Similarly, pharmacies were described as sites of intense surveillance. One participant with an opiate prescription described how pharmacy workers watched her closely both as she consumed her medication and in her journey to and from the pharmacy counter: “At Pharmasave, they used to take your cap apart and put the beads in a cup and watch you drink it. That’s how much they don’t trust us. They make you walk up and down a certain aisle because they think drug addicts are shoplifters. Pharmasave is the worst” (Q). Similar interactions were reported in other towns, where use of methadone was described as marking a person for careful observation for the entire duration of his or her time in a store. These experiences of surveillance should be interpreted with an understanding of how pharmacies operate as both health care facilities and capitalist enterprises, in which drug users are doubly oppressed as consumers of stigmatized medications (such as methadone) and economically marginal citizens.

Shelter workers and landlords, too, were described as closely observing the actions of drug users in their residences. Participants at one workshop, for example, described shelter
workers conducting bag checks in response to finding syringes in the facility's sharps containers (which, given it was purportedly a drug-free facility, were supposed to be solely for used razor blades). A similar anecdote was described in a different community: “In one of the transition houses one of the workers went through a girls bag and took the pipe and kicked her out even though she wasn’t using inside, and that was like her safety pipe, so now she’ll have to go use somebody else’s” (L). In both of these cases, the end result of this surveillance is the discouragement of users from carrying equipment that allows them to maintain some control over their own health. Additional issues mentioned in supportive housing in other communities were the use of cameras, sign-in systems for guests, guest identification requirements, and maximum visit lengths for guests. Notably, not all participants were opposed to such measures. A minority wished for stronger surveillance in order to prevent abuses of one resident by another, and to protect fledgling recovery by preventing visible drug use, which could be triggering for former users.

The surveillance they experience, participants noted, was based on their being visibly identified as drug users, not on the actual fact of their use. Non-users, therefore, might also find themselves subject to intensified observation if they could be mistaken for users. For example, one participant said, “I’ve been stigmatized with my disability since I was fourteen. Because my eye wandered and I talk slow, people always thought I was on drugs. I go to an interview and they ask what drug I’m on” (L). Similar experiences were described by others in courts and medical clinics, where the appearance of using (whether one was a drug user or, in fact, a drinker, former user, or even simply an Aboriginal person) was enough to invite enhanced scrutiny of a person’s actions.

Conversely, those who used drugs but did not have the stereotypical appearance of drug users could avoid such surveillance. As one participant asked, describing her interactions with the Ministry of Child and Family Development as someone they know to be a drug user, “I go to see my kid with his foster parents, and they’ve got a fridge full of cooler, and I can’t even have a drink?” (L) In this remark, she questions why similar behaviours are accepted for certain individuals, yet observed and used as a basis for judging fitness to raise a child in her case. Several participants noted that the ability to avoid being marked by drug use was associated with having funds and resources. As one participant put in, police and welfare workers could easily “buy their stuff in another town” (L). The injustice of the double
standard was highlighted by one participant who described the transitory nature of the visible drug use, saying, “That person might look really terrible today, covered in scabs, but give them a few days and some food and you might not even recognize them” (K).

Surveillance did not always originate from non-users, according to participants: even other drug users can be part of the system. Several participants described how “addicts are pitted against addicts” (D) by being encouraged to report on other users for money from tip lines or to curry favour with health care providers. This can lead to a state of distrust and isolation between users.

Drug user organizations, however, were contrasted with the surveillance experienced elsewhere. As one facilitator said, describing how his organization distributes crack pipes, “We give them out and don’t ask who they’re for.” This was mentioned in contrast to the system in a small town, in which, “You’re only allowed one a day, and you can’t get one for someone else even if they’re too ashamed [and] they don’t want anyone to know that they’re using” (B). In fact, one organization described successfully taking action to eliminate a surveillance activity in their community: the homeless shelter’s policy of publicly posting users’ names in order to ensure they were not permitted into the shelter. Through letter writing, they were able to get this policy reversed, an act that they felt was one of the most important achievements of their group.

Beyond feeling that they are under near-constant observation, participants chafed against the perceived judgment flowing from surveillance and the consequential implementation of what were felt to be unreasonable restrictions on users’ actions. For example, a woman described interacting with private security on public streets: “[You’re] told to move along as soon as you tie your shoes. [They’re] laughing at you and making comments: ‘I wonder how many people she’s sucked off today’” (E). This illustrates the negative consequences she experiences from surveillance, as she is both restricted in her use of public space and subject to judgment and demeaning comments from those hired to watch her.

In response to the surveillance they face, participants described a paradoxical desire for privacy and a desire to “not have to hide” (A). On one hand, participants expressed a desire that others not know their “business,” that is, whether or not they use illicit drugs. This was particularly true with regard to medical care, where participants felt strongly that information
should not be shared with other health and social service providers. On the other hand, participants described experiencing emotional strain from constantly concealing their drug use, and expressed relief that such concealment was not necessary in drug user activist groups. As one facilitator expressed, “We can be honest with each other. We don’t have to pretend we don’t use” (F). This allows for emotional support which many participants felt was denied elsewhere in their lives.

5.1.4. Accountability

As a contrast to the unidirectional surveillance participants experienced, mutual accountability was presented as the ideal state of affairs. That is, users accepted that oversight, when desired and accompanied by good intentions, might be able to help them to achieve sobriety, good health, or other positive outcomes. Monitoring and discussion of opiate use while on methadone, for example, was seen as in place to help users find a dose that would work best for them and to prevent overdoses, and was therefore generally accepted. (This is in contrast with monitoring of stimulant use, which, as mentioned above, was seen as an unwarranted intrusion in the privacy and autonomy of people receiving methadone.)

As a corollary to users being held accountable for their behaviour, however, participants expressed a strong desire to hold institutions and individuals accountable for the services they deliver. As one participant put it, “Anybody should have a voice in things that have to do with their lives” (K). In most cases, however, this voice is lacking. “There’s no accountability in the services” (P), said another participant, in reference to her experience living in supportive housing that she found rife with violence and discrimination. Many services were described as “dictatorships,” a reference to the lack of control participants felt they had over how services meant to help them were delivered. As an example of a hypothetical alternative to this state of affairs, participants in one community suggested that, if problems were encountered with medical care, there would ideally be a committee composed of medical and social service professionals to whom one could appeal one’s case. Modeled on restorative justice tribunals, this committee would allow drug users to hold doctors accountable for inadequate care, while still acknowledging the reality that certain decisions about medication and other therapies will likely remain out of the hands of addicts.
Actions by drug user groups were one way that such accountability of services could be achieved. One facilitator exhorted, to much applause, “Nothing big or fancy, let them know that you deserve respect. Keep going back and let them know you won’t take any shit” (I). A participant in another community echoed this advice, saying, “If you’re being shit on, document it. If there’s five people it’s harder to ignore. If your rights are being discriminated against, document it: we do have rights” (H).

5.2. Discussion

Among my research findings were the shared values of collective action and accountability that underlay participants' priorities for change. Understanding these values and their relationships to dominant societal values can help drug users' organizations, service agencies, government, and others better meet the needs of people who use illicit drugs.

Important ideologies of Western society include neoliberal economics, individualism, and self-monitoring. In a neoliberal economic climate, people are valued for their roles as consumers, and few constraints are placed on capitalist enterprises. The related ideology of individualism emphasizes autonomy and responsibility for oneself and active participation in one's community, while downplaying interconnectedness and responsibility for society as a whole (Rose 1996; Clarke 2004). A particularly important aspect of individualism with respect to health is that of self-monitoring and self-surveillance. Health is constructed as a personal responsibility which individuals must maintain through control of themselves and their actions, regardless of the constraints they might face. This ensures their continued value as economically productive members of society, thereby reinforcing neoliberal ideology. It is supported by health care systems that emphasize measurement and quantification of health data, allowing "rational" comparisons to be made between individuals in ways that minimize contextual differences. Measurement and quantification also help support identification of groups that are "at-risk," a process that contains disorder and establishes enhanced expectations for self-control by specific populations (Petersen and Lupton 1996). Flowing from the intensification of these ideologies, Canada, similar to other countries, has seen a recent shift away from state health and social service provision to a model of privatized services, contracted non-profit organizations, and individual self-responsibility (Evans, Richmond and Shields 2005; MacDonald 2011; Mcbride and McNutt 2007).
People who do not conform to the expectations of dominant Western ideologies face different forms of monitoring and discipline than do those who conform. In particular, they are exposed to heightened medicalization and policing. Medicalization casts difference as a health concern, leading to the logical conclusion that intervention is necessary to restore health. Under policing systems, differences are cast as criminal, and therefore subject to regulation and punishment by the state (Petersen and Lupton 1996). While these systems are sometimes described as distinct (as in the contrast between medical and criminal approaches to addiction), Brook and Stringer (Brook and Stringer 2005) argue that both approaches to drug use create "arena[s] of domination" in which drug users are characterized as needing outside forces to control their actions. Furthermore, in both regimes drug users are made dependent on non-drug users (whether health professionals, researchers, or criminal justice workers) who are cast as having a deeper and more complete knowledge of their drug use than do the drug users themselves.

Importantly, control of non-conformers is achieved only partly by violence and other forms of direct coercion. Much of the time, a process of observation, comparison to the mainstream, and public shaming are used to convince the individuals in question to submit voluntarily to practices that will restore order (Lupton 1997). Drug users, for example, are discouraged from injecting in public or semi-private (e.g. public washrooms) spaces partly because public use makes them visible, and thus subject to the stigmatizing gaze of non-drug users (Rhodes et al. 2007). Such structural and symbolic violence does not preclude the use of coercion, the threat and reality of which are used more commonly than many more conforming individuals would realize (Lupton 1997). For people who use illicit drugs, this direct coercion takes the form of the threat and reality of police violence, homelessness, and drug withdrawal, among other mechanisms.

And yet, "Neoliberal hegemony may not be as totalizing or as triumphant as its proponents claim it to be" (Morgen and Maskovsky 2003). The same is true for other dominant Western ideologies: transformational resistance does occur to the expectations and constraints

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14 By non-conformers I mean "those who are unable or unwilling to enterprise their lives or manage their own risk" (Rose 1996).
15 That is, resistance that includes a critique of oppression and a goal of social justice (Solorzano and Delgado Bernal 2001). See Chapter 2 for more on this term.
placed upon people. One means by which transformational resistance is enacted is through the deployment of what Wieloch (2002) calls "oppositional capital;" that is, the creation of a positive identity for a marginalized group that is in opposition to (and a rebellion against) the dominant culture and its expectations. He argues that oppositional capital is created in four ways: (1) distinction, in which the group is cast as separate from the mainstream; (2) antagonism, in which their difference is expressed as opposition to some element of dominant society; (3) political activism, which requires that the group identity be purposeful (i.e. aimed at changing some practices or systems); and (4) popular culture esthetics, in which the group draws upon common symbols of the dominant culture (including symbols of rebellion as "cool" or otherwise valuable) to add status to their created identity.

Resistance and conformity are not the only possible responses to dominant ideologies, however. Moore argues for a space between resistance and what he calls "incorporation." He uses the term "strategic accommodation" to describe the ways in which drug users present themselves as conforming with expectations in order to cultivate relationships with non-drug users and enhance access to services. As an example, he cites drug users' practice of claiming to service providers that used injecting equipment is always disposed of safely, which helps support a positive view of the drug users by the people providing harm reduction supplies (Moore 2009). This differs from what Solorzano and Delgado Bernal (2001) call “conformist resistance” because it is a strategic adoption of conformity, not based on the assumption that drug users have an obligation to conform in order to receive appropriate treatment.

Workshop participants' discussions reflected their experiences of dominant ideologies and the deployment of oppositional capital to resist them. As a population that does not fit well with the Western ideal of the economically productive, health-monitoring, individually responsible citizen, drug user workshop participants described themselves as subject to surveillance and control beyond that faced by the mainstream community. This was vividly illustrated by participants who recounted their experiences of accessing daily witnessed dosing of methadone in pharmacies. Witnessed dosing is an area of enhanced surveillance on its own, and participants described the added monitoring of pharmacy staff who saw them as a risk for shoplifting. These areas for surveillance fit clearly within the constructs of medicalization and policing of people who do not fully conform to dominant ideologies (Bourgois 2000). A key point made by participants was the surveillance they experience is
not necessarily based on their drug use, but on their appearance as drug users; those people who used drugs who were able to avoid being visibly identified as such, perhaps because economic advantage allowed them to hide their use, did not face the same experiences as those who had a stereotypical appearance of drug users.

Perhaps surprisingly given popular perceptions of drug users, participants did not desire total freedom from surveillance. Instead, they advocated for a system of mutual accountability, in which helpful oversight of their actions is balanced by drug users' own ability to observe and influence institutions that affect them. An interesting example of the contrast between beneficial and oppressive surveillance was provided in discussions of illicit drug monitoring when using methadone; monitoring for additional opiate use was seen in theory as a matter of safety that allowed for proper titration of dose, while monitoring for crack cocaine use was seen as an unreasonable invasion of privacy. Participants' reactions to surveillance echoed the results of Evans (2012), who found that residents of a managed alcohol program (a harm reduction initiative in which participants are given small amounts of beverage alcohol in a supervised fashion to reduce public drinking and consumption of non-beverage alcohol) characterized the supervision they experienced in both positive and negative ways: negative, because the managed alcohol program led to feelings of restriction and dependency; and positive, because they saw oversight of their actions as necessary to their continued well-being and self-control. These findings also align with the work of Gomart (2002) and Harris and Rhodes (2013), who argue that the "generous constraints" of methadone maintenance can facilitate drug users to care for themselves and their communities. Drug users' calls for better accountability of services were well promoted in the document "Nothing About Us Without Us" by the Canadian HIV/AIDS Legal Network (Jurgens 2008), and are supported by other authors (Friedman 1998; Kerr, Oleson and Wood 2004; Osborn and Small 2006).

Participants' descriptions of being encouraged to be passive and kept isolated are also in keeping with the enhanced control experienced by non-conforming members of society. In expressing their desire for advocates to speak on their behalf, we can see echoes of the role of the expert in medical and policing approaches to illicit drug use. The question can be raised, however, whether the desire for collective activity fully represents transformational resistance to dominant ideologies. Others have argued that encouraging active care of the self by drug users both plays in to neoliberal notions of personal responsibility and allows drug
users to claim some of the rights of the neoliberal subject, and therefore provides benefits even as it involves incorporation of dominant ideologies (Moore and Fraser 2006; Gowan, Whetstone and Andic 2012). The results of my research complicate this argument by contrasting activity in isolation with that undertaken collectively – and suggest that, by caring for the self through caring for others, drug users may access some of the benefits of neoliberal citizenship without fully embracing the role of "entrepreneurial citizen."

Drug user activism was positioned by participants and facilitators as a form of oppositional capital that supported ideologies of resistance, specifically collective action and accountability. The use of popular culture esthetics, one of Wieloch's (2002) mechanisms for promoting oppositional capital, was not significantly displayed in the workshops. His other mechanisms were apparent, however, and serve to highlight how oppositional capital is developed in the service of transformational resistance to dominant ideologies.

Participants described themselves as a distinct group in their emphasis on their collective identity as drug users, which they saw as giving them different experiences and insights from non-drug users (as also discussed in Chapter 4). Antagonism, or characterizing their group in opposition to mainstream society, was seen in participants' contrasting of the surveillance and control they experienced compared to non-drug users (or people who did not appear to be drug users). It was also seen in participants' comments about their deeper knowledge of their needs compared to that possessed by service providers. But the described opposition was not complete: as mentioned in Chapter 4, emphasis was placed on the common humanity of all people and the ways in which magnification of apparent differences prevents understanding of drug users' needs by the general public. Participants also contrasted their value of collectivity, particularly supporting one another unconditionally, with the individualism of mainstream society (although they acknowledged the difficulty of fully achieving this in their lives on the margins). The creation of oppositional capital through political activism is demonstrated through the value participants placed on activity over passivity. In this way, group identity is tied to the orientation of drug user activism as standing for change, rather than simply being individuals held together by a common identity.

Understanding drug users' values and how they relate to dominant ideologies is of more than academic interest. Incorporating collective action and accountability into programs that work
with and for drug users can help create institutions that meet their needs and in which they feel comfortable. Suggestions that flow from the identified values include: supporting drug users to come together and share their experiences and knowledge; promoting opportunities for drug users to be actively involved in their communities through service delivery and self-advocacy; discovering what accountability means to drug users in the context of institutions with which they interact, including discussion of when monitoring is valued and when it is seen as intrusive; putting in place mechanisms for institutions to be more accountable to drug user clients; and supporting drug users to be actively involved in holding institutions accountable.

One specific suggestion which arises from all of these values is to better incorporate drug user representatives in planning and evaluating services for their communities. The use of "representatives" is key: creating systems in which given drug users can canvas and represent the views of their communities, rather than selecting token drug users for committees, best meets the identified emphasis on collectivity. Providing practical support is also a necessary component of working with drug user representatives. Given the significant barriers drug users face to full involvement in meetings (unstable housing and poor sleep, hunger, differences in communication styles, withdrawal symptoms, etc.), it is essential that institutions that wish to employ their expertise work to minimize the obstacles to their effective participation. In this way, knowledge of the values presented here can best be translated into meaningful action.

In this and the previous chapter, I have presented priorities and values of drug users who participated in our series of workshops. Specifically, participants described an orientation to collectivity and action, valued freedom from surveillance, and desired a system of mutual accountability with the institutions and individuals in their lives. In the following chapter, I will show how some of these values and priorities are shared by another group of substance users attending the workshops – illicit drinkers – and describe some of the barriers that have kept them from collaborating with drug user organizations despite their commonalities.
<table>
<thead>
<tr>
<th>Value</th>
<th>Key Findings</th>
</tr>
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<tbody>
<tr>
<td>Collectivity (Section 5.1.1)</td>
<td>• Participants desired connection to others that is independent of whether a person uses illicit substances</td>
</tr>
<tr>
<td></td>
<td>• This connection was seen as entailing responsibility for the welfare of others</td>
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<td></td>
<td>• Participants recognized structural barriers to achieving the desired sense of connection with one another</td>
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<tr>
<td>Activity (Section 5.1.2)</td>
<td>• Passivity is encouraged by many of the institutions with which participants interact</td>
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<td></td>
<td>• Participants internalized this by expressing desire for &quot;advocates&quot; to act on their behalf</td>
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<tr>
<td></td>
<td>• Facilitators' suggestions of how participants could act for themselves were met with great enthusiasm</td>
</tr>
<tr>
<td>Freedom from surveillance (Section 5.1.3)</td>
<td>• Surveillance is ubiquitous in participants' lives and associated with perceived negative judgement of drug users' lives</td>
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<td></td>
<td>• Surveillance was seen as particularly intense in medical settings</td>
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<td></td>
<td>• The experience of surveillance was seen as dependent on appearance, so that those who use illicit drugs but do not have a stereotypical appearance may avoid it</td>
</tr>
<tr>
<td></td>
<td>• Participants described paradoxical desires for privacy and for &quot;not having to hide&quot;</td>
</tr>
<tr>
<td>Accountability (Section 5.1.4)</td>
<td>• As a contrast with surveillance, participants described an ideal situation in which they would be both held accountable for their actions and able to hold institutions accountable to them</td>
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</table>
6. Points of alliance and barriers to collaboration between drug users and illicit drinkers

Alcohol was not a planned focus of the provincial needs assessment, but arose as an issue of importance as the research progressed. While most workshop participants identified as current or former users of illicit drugs, a small proportion identified their substance of choice as alcohol. They described using alcohol in particularly marginalized and criminalized ways, including public drinking and use of non-beverage alcohol (such as mouthwash, hand sanitizer, rubbing alcohol, or hairspray). Some also described concomitant use of illicit drugs. Following the suggestion of one of the facilitators, we used the terms "illicit drinking" and "illicit drinkers" to distinguish this type of alcohol use from more socially sanctioned forms of alcohol consumption. The term was chosen to echo the phase "illicit drugs," which includes legal substances consumed in non-sanctioned ways (e.g. pharmaceutical opiate use without a prescription). Although illicit drinkers have not traditionally been involved in activism with drug users, their comments at the workshops pointed to three potential points of alliance between the two groups: (1) shared priorities, (2) shared values, and (3) polysubstance use. In this chapter, I present these points of alliance and discuss factors that may interfere with involvement of illicit drinkers in drug users' organizations. These are summarized in Table 6.1 at the end of this chapter.

6.1 Results

6.1.1 Shared priorities

Not all of the priorities that were identified for drug users were shared by the illicit drinkers that attended the workshops. Supporting drug user-run organizations, not surprisingly, was not raised as a priority by these participants, nor was developing alliances or improving social assistance. The other four priorities, however, were repeatedly mentioned by those who identified as illicit drinkers; that is, they expressed a desire to see improved relationships with health professionals, a greater range of housing options, better treatment from police, and implementation of harm reduction services.
Drug user workshop participants described interactions with health professionals that are marred by discrimination and surveillance. The illicit drinkers echoed these concerns: they expressed a belief that physicians and nurses arrive to patient encounters with pre-formed opinions about the needs and motivations of marginalized clients, and therefore are not in a position to provide responsive care. One participant described his experience of being unfairly judged at a hospital:

Like everyone says, it's hit and miss here. Certain clinics will treat you with respect, [but] the hospital triages you first. I went there for an abscess. I wasn't using drugs then, only drinking. They made me wait eight hours. They singled me out, they thought I was a drug user and they were all talking. It's a human rights violation (C).

Other illicit drinkers described similar concerns, and, like the drug user participants, placed a high priority on the development of systems to ensure health care could be obtained without judgement or loss of confidentiality.

In addition to their concerns about health services, drug user and illicit drinker participants expressed dissatisfaction with the housing options available to them, primarily centred on the need to provide shelter to those who are actively using substances. The following exchange demonstrates the constrained choices faced by drinkers in a town with a single shelter:

Participant 1: A lot of people want to talk about health, but if you're homeless–
Participant 2: They told me I had to sleep outside because I was drinking.
Participant 3: If you quit the drunkenness, you'll get a place to sleep overnight!
Participant 4: You end up sleeping in the bank, in the ATM area (O).

Similar to the views expressed by drug users, these drinkers find the restrictions placed on them prevent them from meeting a basic need, a situation which could be ameliorated by providing low barrier shelters that allowed for active substance use among that segment of the population unable or not wanting to restrain from it.

In describing the pathways to improved relationships with police, drug user participants mentioned the necessity of decriminalization of drug use and of reformed police conduct in regards to harassment, violence, and protection of drug users. Illicit drinker attendees pointed
out that although their substance of choice is legal, they too suffer from the consequences of improper treatment by police. For example, one group of friends explained their frequent interactions with police in their small town:

Participant 1: The cops always harass you, pull up on you, ask you what you're up to, even if you're just sitting there.
Participant 2: Even look through your backpacks.
Participant 3: And we don't have nothing, just a couple empties (N).

While these participants expressed their frustration with what they perceived as being inappropriate targets of police scrutiny, others mentioned lack of attention to health needs or even outright violence while in custody as examples of the unacceptable treatment they receive from police. As well, illicit drinkers brought up what they saw as a lack of action by the police in protecting them when they are the victims of crime. In one small, industrially-based town, several workshop participants described how they felt the police had been derelict in their duties:

Participant 1: There's this one gang that goes around town beating up homeless people, and the cops do nothing.
Participant 2: I got shot with a pellet gun by them and the cops didn't help.
Participant 1: We tell them what kind of cars they drive and still they don't help us (O).

The description of this incident echoes the sentiment of drug user participants that police are uninterested in protecting the rights and safety of people who use illicit substances. This is in keeping with a view of the criminal justice system as functioning in large part to protect the interests of those in power, a group from which illicit drinkers are clearly excluded.

Finally, drug user workshop participants expressed the belief that harm reduction services do improve their health and well-being, but that these services would be more effective if expanded and always offered in accordance with proven best practices. Illicit drinker participants, too, seemed convinced of the value of harm reduction. Their comments, reflecting the current scarcity of alcohol harm reduction services, emphasized the potential benefits of adapting programs for drug users to meet the needs of those who drink alcohol. For example, after describing the utility of supervised injection spaces, one illicit drinker asked, "What about for people who are alcoholics? They should have a little community or
building for people who drink outside so they can be safe inside” (C). Other participants described the need for education on reducing harms from non-beverage alcohol (similar to the educational programs offered to injection drug users) and preventing transmission of infections among people sharing the same bottle (inspired by the distribution of mouthpieces for crack pipes). Despite the various critiques of harm reduction (see Chapter 2 for a discussion), this policy has led to improvements in the quality of life and self-perception of drug users, and therefore it is understandable that illicit drinkers see benefits to extending the scope of harm reduction services.

6.1.2 Shared values

In addition to the shared priorities described above, both drug user and illicit drinker workshop participants strongly expressed their desire to see the existing system of surveillance and judgement from those in authority replaced by one of mutual accountability. Drug user and illicit drinker participants were positioned similarly in their positions relative to institutions of surveillance (e.g. policing, medical, and social assistance), although the difference between illegal and legal substances does necessarily affect the types and sites of surveillance to which they are subjected. Dissatisfaction with ubiquitous surveillance is clear in this young person's description of an encounter that occurred while she was walking home from classes:

The cops came up to me and said what was I doing outside walking at ten at night? I said, ‘Walking home.’ They said, ‘You been drinking?’ I said, ‘None of your business!’ They just want to take you in. I’m not allowed to walk down the street? (O)

An additional example of surveillance given by participants in multiple communities involved staff and customers at liquor stores. The comments included one participant describing the owner of the community’s only liquor store as being “like a king,” explaining that “he watches everyone outside” (O).

Similar to drug users, illicit drinker participants particularly chafed against the judgement that surveillance of their activities entailed. One woman explained that she drank non-beverage alcohol and said, to an enthusiastic response from the other participants, "There's folks out there that do drink alcohol, hairspray. You should not judge other people, that's their right, it's up to the people, what they drink out there" (C). Another participant described
obtaining food at one of the few places available in his community: “When you go to the soup line, if you’re drunk, they kick you out. You just want to eat and they make you eat outside. We’re not dogs!” (N) His last sentence implies that, more than the surveillance for intoxication or the restriction on where he can eat, he reacted negatively to the implied judgment that he is not fit to eat inside.

In contrast to unidirectional surveillance and judgement, some illicit drinkers echoed the comments of drug user participants by voicing their desire for greater say in the institutions that shape their lives. A service organization in one community, for example, feeds people "a bowl of soup and moldy bread" and "you get kicked out for a week for being intoxicated." Participants wondered, "How do they get funding for that?" (O) This reflects their belief that the organization is not, in their opinion, meeting the mandate for which it receives funds, and shows that drug user activist groups could potentially ally with illicit drinkers to push institutions to be more accountable to the people they serve.

6.1.3 Polysubstance use

Until this point, drug users and illicit drinkers have been referred to as if they are separate and distinct categories. The reality of substance use, however, is more complicated than that, and speaks to another potential point of alliance: use of drugs and alcohol by the same individuals.

A variety of patterns of polysubstance use were identified in the workshops. Some participants described being omnivorous in their consumption of psychoactive substances. As one said, "I’m a crackhead, alcoholic, pothead; five months clean, but I smoke lots of pot to keep away from it. I’m trying to stay away from the booze, too, but I had some last night" (L). Others explained how alcohol had been a gateway drug to other substances: "It was in past years definitely opiates, but alcohol was the catalyst to all of it. I’d get totally run down on alcohol and flip flop back and forth for many years" (Q). Still others described a trajectory in the other direction; as one said, "I was addicted to cocaine... My drug of choice now is alcohol. When I do have money, that's my downfall" (G).

Clearly, "illicit drinkers" and "drug users" as categories are neither exclusive nor stable. This reflects the created and fluid nature of the boundary between legal and (currently) illegal psychoactive substances. When combined with the common priorities and values described
by participants, this polysubstance use provides further rationale for including illicit drinkers in drug user organizing.

6.2 Additional findings

As the issue of illicit drinking was raised in workshops, it became a topic of discussion with the workshop facilitators at the daily debriefing sessions, in the evenings, and while in transit between communities. The following section is based on conversations with the workshop facilitators about the emerging findings on illicit drinkers and about potential barriers to including illicit drinkers in drug user organizing. Our daily discussions provided an important, albeit informal, part of the analysis of the workshop data.

One reason offered by facilitators for the exclusion of illicit drinkers from drug user organizing is the difficulty of working with illicit drinkers, a reason which loses some credibility in organizations that regularly and successfully work with users of a range of depressants, hallucinogens, and stimulants. Further discussion with the workshop facilitators yielded four potential reasons for this exclusion: racism, horizontal violence, extreme marginalization of illicit drinkers, and knowledge gaps around alcohol harm reduction.

6.2.1 Racism

In our needs assessment, illicit drinking was most strongly raised as an issue for further exploration at workshops held in northern communities. This corresponds to provincial data showing that the highest per capita rates of alcohol consumption in BC occur in the northern and interior regions and the northern part of Vancouver Island (Centre for Addictions Research of BC 2011) and that alcohol abuse rates are higher among homeless people in Prince George than they are in Victoria or Vancouver (Krausz et al. 2013). The proportion of attendees identifying as Aboriginal also rose as we travelled north, until Aboriginal attendees outnumbered non-Aboriginal by a factor of two to one or more. Such a trend follows local demographics, as the northern regions of BC have proportionally more Aboriginal residents.

In Canada and in many other colonial states, indigenous peoples face high proportions of substance use in general and alcoholism (and alcohol-related harms) in particular, although they also have higher proportions of non-drinkers (Thatcher 2004; Castor et al. 2006; Wilson et al. 2010; First Nations Information Governance Centre 2012). The burden of substance use
and mental health disorders in Aboriginal communities is directly tied to the ongoing experience of colonialism, economic and political marginalization, and the legacy of residential schools (Kirmayer, Brass and Tait 2000; Alexander 2008).

Aboriginal people's use of alcohol is framed differently in public discourses than non-Aboriginals'. They are portrayed as having a genetic predisposition to the abuse of alcohol and in lacking control around its use, and therefore in need of external controls to be placed on them. These discourses serve the purposes of dominant groups by facilitating non-Aboriginal control of Aboriginal people and resources and the apprehension of Aboriginal children (Thatcher 2004; de Leeuw, Greenwood and Cameron 2010; Salmon 2011; D'Abbs 2012). By creating the sense that Aboriginal alcohol use is a "special case," they may also hamper efforts to create links between drug users' organizations and illicit drinkers.

One of the facilitators (Lorna Bird) is the past president of the Western Aboriginal Harm Reduction Society (WAHRS), the world's first Aboriginal-specific harm reduction organization. She explained that WAHRS encourages participation from illicit drinkers, in contrast to the policy of most user-run harm reduction organizations, due to the large impact of alcohol on Aboriginal communities and its intimate ties to histories of colonization, forced assimilation, and residential school systems. This suggests both that involvement of illicit drinkers in drug users' organizations is possible, and that an acknowledgement of Aboriginal-specific substance use issues may facilitate greater participation of illicit drinkers.

6.2.2 Horizontal violence

Horizontal violence is an idea whose origins lie in critical theory. It refers to oppressive acts committed by individuals or groups that are themselves marginalized and oppressed. When they are prevented from taking action against their oppressors, they may instead internalize the worldview of their oppressors and strike out against members of communities that are similarly lacking in power (Fanon 1965; Freire 1970; Bourgois and Scheper-Hughes 2004).

Horizontal violence has been described in the relationships between members of specific subgroups of drug users. Simmonds (Simmonds and Coomber 2009) found that certain drug users characterize members of other subpopulations (for example, the non-homeless towards homeless, or steroid users towards other drug users) as irresponsible in order to "displace acknowledgement" of their own risky behaviours and to minimize their own difference and
stigmatization. Additionally, Radcliffe and Stevens described how certain drug users receiving addiction treatment (such as women and cannabis users) used the pejorative label "junkie" to distance themselves from the stigma (and self-stigma) of using drug treatment services (Radcliffe and Stevens 2008).

Workshop facilitators suggested horizontal violence as a potential factor that keeps drug users and illicit drinkers from working effectively together. They suggested that drug users can judge and even strike out at particularly marginalized people who drink alcohol when they are themselves experiencing discrimination and oppression. In addition, reflecting on their own perceptions of the inherent difficulty of working with drinkers, several facilitators concluded that many of their negative stereotypes of drinkers were based on a need to feel superior in their own choice of illicit substances. Challenging horizontal violence through consciousness-raising was seen, therefore, as a potential route to closer alliances in the future.

6.2.3 Extreme marginalization of illicit drinkers and the need for consciousness-raising

In Vancouver and in many other major cities around the world, leaders in the drug user communities and their allies have worked to politicize people who use illicit substances. This means awakening drug users to their own power to bring about lasting change and shifting focus from immediate needs (for example, daily food provision) to the institutions and political, economic, and social structures that influence how immediate needs are met (Kerr et al. 2001; Jauffret-Roustide 2009; Gowan, Whetstone and Andic 2012). It is necessary because the marginalization of illicit drug users creates a barrier to their engagement in self-advocacy. In the early days of VANDU, inspired by theories of popular education and liberation theology, community organizers encouraged drug users to recognize their power to effect change; as one founder put it, "The biggest obstacle to making the situation better was the marginalization of drug users, and the distance that addicts are from society. So the first thing we got involved in was the demarginalization of drug users" (Kerr et al. 2001).

One of the facilitators strongly believed that the majority of the illicit drinkers we encountered were so extremely marginalized that a process of consciousness-raising would be necessary in order for them to take part in drug users' organizations. Consciousness-raising is a term from the women's movement that refers to a group process of sharing
experiences and learning about how they are tied to systemic problems of power and oppression (Kravetz 1978; Sowards and Renegar 2004). A similar concept within critical theory is conscientization, "the process in which men [sic], not as recipients, but as knowing subjects, achieve a deepening awareness both of the socio-cultural reality which shapes their lives and of their capacity to transform that reality" (Freire 1970a). The facilitator contrasted the situation of illicit drinker participants with those of Vancouver drug users now, who she felt had a consciousness of the links between the personal injustices they face and broader societal trends. This explained, according to her, the focus by illicit drinkers on small, immediate goals (such as longer shelter hours rather than expanded access to affordable supportive housing) and the lack of emphasis placed by drinkers on collective action as a strategy to achieve change. A process of engaging with illicit drinkers and developing their sense of their own political power could, then, promote full participation of illicit drinkers in user-run organizations.

6.2.4 Knowledge gaps

The majority of our workshop facilitators were experienced activists and leaders in the drug user community. As such, they felt very confident in their knowledge of harm reduction strategies for a variety of substances and routes of administration (injection, inhalation, etc). This confidence did not, however, extend to their knowledge of harm reduction strategies for alcohol, and particularly non-beverage alcohol. In particular, they felt that without a better understanding of the effects of non-beverage alcohol on the body, they could not advise drinkers on steps they could take to maintain their health. They believed this barrier could easily be overcome, however, through consultation with scientific experts and collaboration with experienced illicit drinkers.

6.3 Discussion

A unique contribution of this thesis was identifying the opportunity to involve illicit drinkers in drug users' organizations based on shared priorities, shared values, and the realities of polysubstance use. Given the potential of this alliance, it was initially surprising that inclusion of illicit drinkers in drug user activism is not more widespread16. Discussion with the

16 There are undoubtedly exceptions to this generalization, of course. In fact, VANDU
workshop facilitators suggested racism, horizontal violence, extreme marginalization of illicit drinkers, and knowledge gaps about non-beverage alcohol as potential barriers to collaboration.

Identifying these barriers is an important step in working to surmount them. Knowledge gaps around non-beverage alcohol can be addressed with research and education, but the others are entrenched forms of oppression that must be actively challenged to be overcome. Although difficult, the points of alliance identified between drug users and illicit drinkers suggest that addressing these barriers would be worthwhile for all involved – potentially furthering drug user activism through new allies, empowering drug users by placing them in a leadership role, and extending the gains drug users have made for themselves to another group of substance users.

For these reasons, the board of directors of VANDU decided to reach out to illicit drinkers in Vancouver’s Downtown Eastside and learn more about the harms they experience in their lives and their ideas for ways to mitigate those harms. Drug users with an interest in the topic would lead the project in its first stages, with leadership passing to illicit drinkers as the project progressed. A research component, in partnership with the BC Centre for Disease Control, would facilitate exploring these questions in depth and communicating them to individuals and institutions with the power to implement positive changes for illicit drinkers. In the next chapter (Chapter 7), I describe the methods of research with illicit drinkers, and in Chapter 8 I describe and interpret the results.

conducted a brief project in which people could exchange rice wine (non-beverage alcohol) for beverage alcohol (Boyd, MacPherson and Osborn 2009).
Table 6.1. Points of alliance between drug users and illicit drinkers and barriers to collaboration.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Key findings</th>
</tr>
</thead>
</table>
| Points of alliance (Section 6.1) | • *Shared priorities* – Illicit drinker participants also expressed desire for improved relationships with health professionals, a greater range of housing options, better treatment from police, and implementation of harm reduction services  
• *Shared values* – Illicit drinker participants wanted a system of mutual accountability instead of surveillance  
• *Polysubstance use* – Many participants consumed both illicit drugs and alcohol |
| Barriers to collaboration (Section 6.2) | • *Racism* – Societal narratives of alcohol use as a unique problem among Aboriginal people inhibits alliances between drug users and illicit drinkers  
• *Horizontal violence* – Drug users may participate in discrimination towards illicit drinkers as a reaction to the marginalization they themselves face  
• *Extreme marginalization of illicit drinkers* – Drug users in BC are increasingly aware of their political agency; a process of consciousness-raising for illicit drinkers may be necessary for full collaboration  
• *Knowledge gaps* – Drug user activists have little knowledge of harm reduction strategies for non-beverage alcohol, but they are confident that these could be developed |
7. Specific methods II: meeting series with illicit drinkers

The conclusion from the provincial drug users’ needs assessment was that drug users and illicit drinkers share priorities and values (as described in Chapter 6), and may therefore mutually benefit from working more closely together. This provided an impetus for VANDU and the BCCDC to conduct a follow-up research project driven by the following questions:

1. What and how is non-beverage alcohol being consumed in Vancouver's Downtown Eastside?

2. What harms do illicit drinkers perceive are associated with non-beverage alcohol?

3. What steps are illicit drinkers already taking to reduce these harms and what other actions do they believe would be helpful?

4. How does the social and economic marginalization of illicit drinkers influence their perceptions of harms and harm reduction?

This was accomplished through a series of "town hall" meetings held with illicit drinkers in Vancouver's Downtown Eastside. These were large meetings (up to 30 participants) in which facilitators who were themselves substance users worked with a non-substance user staff member to guide discussion on illicit drinking, harms from alcohol, and harm reduction. The phrase “town hall” meeting was chosen to highlight some key features of the meetings: their size, the desirability of audience participation, and the planned discussion of topics of community importance.

Vancouver's Downtown Eastside was the site of this research. The Downtown Eastside is an intensively researched neighbourhood in urban Vancouver that is notable for its history of political activism, concentration of single-room occupancy hotel rooms and social service organizations, and current struggles with gentrification (Linden et al. 2012; Masuda and Crabtree 2010). It is also the location of Insite, North America's first sanctioned supervised injection site, which serves the neighbourhood's approximately 5000 injection drug users (Schechter and O Shaughnessy 2000 cited in Buxton et al. 2007; Wood et al. 2006). The study site worked well for this research project because of the concentration of illicit drinkers in the neighbourhood and because of the physical proximity and organizational linkages.
between VANDU and First United Church, a religious organization that offered low-barrier shelter beds and other services at the time of this research and was well-attended by illicit drinkers in the Downtown Eastside.

The first step in the town hall meeting series was convening a "steering committee" of VANDU members who had an interest in outreach to illicit drinkers, with the plan of expanding the steering committee to include illicit drinkers once the town hall meetings had begun. The steering committee's function was to provide input on project logistics, develop meeting agendas, and act as facilitators in conjunction with the program coordinator at the town hall meetings. The addition of new members was by group consensus, with attention to representation of women and Aboriginal people. A paid program coordinator (the same person as had acted as coordinator of the provincial needs assessment) and I were also present at all steering committee meetings, although we were not considered members of the steering committee.

The steering committee and the program coordinator felt that the town hall meetings should follow a style similar to other regular meetings held at VANDU in order to make the process run more smoothly. This meant one-hour meetings held weekly at the same time and location, with a break for the week after social assistance cheques were distributed (as experience has shown that people receiving social assistance have other priorities at this time). Compensation of $3 per meeting per participant was given to offset the opportunity costs of participating in the meetings. Steering committee members conducted outreach for the meetings by flyer and by word of mouth.

The decision was made at the first steering committee meeting to restrict participation to people who identified as consuming non-beverage alcohol. This is a narrower definition of illicit drinking than had been developed during the provincial needs assessment (see Chapter 6 for more), as it excludes people who consume beverage alcohol in highly criminalized ways (e.g. homeless drinkers). It was felt by the VANDU steering committee members to be necessary, however, to promote the participation of the most marginalized group of drinkers, and discourage domination of the meetings by people who primarily used illicit drugs and only occasionally used alcohol. The phrase "non-beverage alcohol" was felt to be too technical, however, and "alcohol that is not bought at a liquor store" was used in its place.
Decisions about participation were primarily left to self-identification, although on occasion members of the steering committee or the program coordinator challenged a person who they knew from other programs at VANDU and suspected to use primarily illicit drugs. They convinced such individuals to leave through a process of inducing guilt about the necessity of these meetings for illicit drinkers.

The general format of the town hall meetings was as follows. Sign-up took place an hour before the meeting was to begin; participants were invited to put their name on a sign-up list maintained by a member of the steering committee, then were free to leave until the meeting began. This was a system in place at many VANDU meetings to prevent lineups from disrupting other functions of the organization. I spoke with each participant after sign-up to obtain or renew consent to take notes during the meeting and to give them a copy of an information sheet about the research process. Participants who declined to participate in the research were excluded from note-taking but not from the meeting. To begin the meetings, steering committee members acting as facilitators presented an agenda written on flip chart paper and solicited any additional items from the audience. Often agenda items included a question to stimulate discussion (see Appendix B, illicit alcohol meeting agendas). As discussion progressed, a facilitator would keep brief notes on the flip chart of participants' responses. Another facilitator would select participants to speak with attention to the order in which hands were raised while encouraging participation from quieter members. Each meeting concluded with a moment of silence for illicit drinkers and drug users who had passed away or were still suffering, as is tradition at VANDU.

The ethics approval and consent process for these meetings differed somewhat from a standard approach. The UBC Behavioural Research Ethics Board gave approval to create a memorandum of understanding (MOU) with the steering committee instead of traditional consent forms (certificate H11-01101). This was inspired by the work of Khobzi and Flicker (2010), who recommend formally articulating roles and responsibilities for members of a community-based research partnership as a way to define the expectations of all involved. Khanlou (2005) suggests in particular that a MOU can be helpful in ensuring ethical practice and informed consent when some individuals inhabit a space between researcher and traditional participant, as did the steering committee members in this case. A question guide covering topics that would normally be addressed in a consent form (purpose of the research,
benefits, risks, anonymity, and so on; see Appendix D for the question guide and completed MOU) was discussed with the steering committee members. An agreement was then produced based on their responses and was signed by committee members and by me. Included in this agreement was a process for approval of the study results by the steering committee before they could be released publicly. The consent process for participants in the town hall meetings followed a more standard approach, in which I spoke to each participant at their first meeting, reviewed a written consent form with them, and obtained written consent to take notes. I verbally renewed this consent with each participant at subsequent meetings. Participation in the meetings (and receipt of an honourarium) was not contingent on participating in the research; if someone declined to participate in the research component, I did not take notes on their contributions to the meeting.

In addition to the steering committee and town hall meetings, four semi-structured focus groups were held with the intention of adding depth to the data already collected. One focus group each was held for women, youth (ages 19-29), and Aboriginal people, plus one open to any illicit drinkers. After providing a working definition of illicit drinking and a brief introduction to the research project to date, I asked a series of questions (see Appendix C for question guide) that were intended to elicit feedback and elaboration on the information gathered in the town hall and steering committee meetings. Participants received honouraria of $20. The focus groups were digitally recorded.

Field notes, much of which were verbatim, were produced by me for 14 town hall meetings and seven steering committee meetings, and transcripts were produced by a professional transcriptionist from recordings for the four focus groups. In total, the fieldnotes and transcripts reflected approximately 25 hours of discussion. I analyzed these documents in NVivo 8 using techniques drawn from interpretive description (Thorne 2008). I began the process by coding participants comments as they answered the research questions on a practical level. For example, harms described by participants from illicit drinking were noted and categorized as harms to physical health, to mental health, and so on. As this round of coding progressed, and in an ongoing fashion, I added an additional layer of coding that addressed the relationship between participant responses and their broader context. For example, I attended carefully to the potential increase in surveillance implied by participants’ suggestions for harm reduction services. In this round of coding, I was influenced by insights
from critical theory about the vulnerability of illicit drinkers and their constrained opportunities for resistance, and also by the substance user values (collectivity, activity, freedom from surveillance, and mutual accountability) described in Chapters 5 and 6. I then categorized and modified my initial codes on an ongoing basis to develop larger themes.

I presented the initial results to the steering committee and at an open meeting (the group continued to meet after the research was concluded – see Chapter 9 for details). Their feedback was incorporated into the results presented below. In accordance with my ethics process, the steering committee and larger group were also formally asked for approval to release the results, which they granted.

Specific demographic information was not collected at these meetings, as it was felt by the leadership of VANDU during the research design phase that this would hinder participation and engender mistrust of the research project. From my own observations of participants and from their comments in the meetings, however, I believe I am able to report on general characteristics well enough to provide context to interpret their statements. The meetings were overwhelmingly attended by men, with only a few women at each (including a single woman who identified as transgendered). The predominant ethnicities were white and Aboriginal. Most participants appeared to be between their thirties and fifties, although a few men in their twenties were very active in group discussions. Participants were housed in single room occupancy hotels, supportive social housing, homeless shelters (primarily the low barrier shelter at First United Church), and slept outside on the street. Most received social assistance through welfare or disability payments. Sixty individuals participated in the town hall meetings; most of these attended multiple meetings. The majority of meetings had 30 participants, and the smallest had 11 participants. Initially, the steering committee had three members, with an additional four added as the project progressed. Twenty-five people participated in the focus groups (five focus groups of five participants each).
8. Illicit drinkers’ perceptions of harm and harm reduction

In this chapter, I present the results of the meeting series with illicit drinkers. Specifically, I discuss participants’ descriptions of the types of non-beverage alcohol they consume, their views on the harms of illicit drinking, the strategies they currently use to reduce these harms, and their suggestions for additional harm reduction initiatives, with an emphasis on managed alcohol programs. These key findings are summarized in Table 8.1 at the end of this chapter. I then argue that the harms identified by participants and their current harm reduction strategies reflect their position as marginalized and poor substance users rather than being specific to illicit drinking. I make the case that their suggestions for future harm reduction initiatives be viewed in part as a response to symbolic violence that do not necessarily challenge larger power structures, and conclude by discussing the potential role of peer-based programs in illicit drinking harm reduction.

8.1 Results

8.1.1 Types of non-beverage alcohol consumed

At the early town hall meetings, the facilitators devoted much of the time available to learning what types of alcohol people were consuming and their reasons for doing so. The most common alcoholic substances consumed by participants were mouthwash and rubbing alcohol, with more than half of participants identifying as using these substances. “Pure alcohol,” described as a commercially made product available for purchase on the street from select individuals, was also consumed by more than half of participants. Less commonly used substances identified at the meetings (consumed by approximately one third of participants) were hand sanitizer, rice wine, and ginseng extract. The least common substances, identified by one quarter or fewer participants, were vanilla extract, hairspray, aftershave, and Lysol.17

Because injection of alcohol had been described during the provincial drug users’ needs

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17 Approximate fractions, rather than absolute numbers, are given for these substances to convey the lack of precision represented by these numbers, which were obtained by show of hands in a town hall meeting. It should be noted that for the less common substances, I noticed a pattern of one or two individuals raising their hands, then others following, indicating that there may be stigma against certain substances that affects participants’ responses.
assessment, we were particularly interested to learn if participants in the town hall meetings had consumed alcohol in this fashion. The steering committee decided to inquire about how people use alcohol to avoid planting a suggestion if it was not already within participants’ experiences. At the town hall meeting where this was raised, six participants told us that they had injected alcohol. Reasons given included becoming intoxicated or (in one case) as a substitute for water in which to dissolve illicit drugs for injection. Injection appeared to take place in the context of experimentation more than as a regular occurrence; several participants described it as a negative experience that they would not repeat.

In addition to non-beverage alcohol, participants at several meetings described other intoxicating liquids that they consumed. These were antifreeze (ethylene glycol), shoe polish (called “squeeze”), and cough syrup containing dextromethorphan. While no participants identified themselves as using antifreeze, and few consumed shoe polish or cough syrup, they are mentioned here as the confusion between non-beverage alcohol and other intoxicating liquids is of potential interest.

8.1.2 Reasons for drinking non-beverage alcohol

Participants described affordability and accessibility as the two main reasons for consuming non-beverage alcohol. Regarding affordability, one participant stated, "When I have money I drink beer. When I'm broke," he drinks "rubby [rubbing alcohol] and vanilla [extract]” (Town hall meeting, July 11). At another meeting, a different participant told us that he drinks hand sanitizer because, “That’s the best, according to me. That’s the cheapest thing I can have. The beer is expensive to me. I can’t afford it” (Town hall meeting, October 24). Most participants in these meetings received welfare or disability payments as their major source of income, leaving them far below the poverty line, making affordability a key issue. The relative affordability of non-beverage alcohol is further supported by participants’ descriptions of monthly patterns of alcohol use, which consist for many of drinking beverage alcohol in the days following receipt of social assistance cheques and non-beverage alcohol for the remainder of the month.

It should be noted that non-beverage alcohol is not necessarily more affordable than beverage alcohol when purchased from a retail outlet. We were told that non-beverage alcohol is, however, easier to steal or otherwise obtain for free. Theft from pharmacies and corner stores
was seen as easier (and with fewer consequences) than was theft from liquor stores. Certain types of non-beverage alcohol, too, are available outside of retail locations. Specifically, several participants mentioned accessing hand sanitizer at hospitals or using the alcohol swabs given out as part of harm reduction kits. In one of the focus groups, participants described "boosting" from pharmacies when they did not have funds to purchase beverage alcohol, and added:

Participant 1: You forgot one, construction sites. [laughter]
Me: Why construction sites?
Participant 1: ‘Cause they’ve got the washrooms with the hand sanitizer.
Participant 2: They got Purell [hand sanitizer].
Participant 1: You just give it a little tap and the thing opens up, boom, you got a bag of gel (General focus group).

Participants emphasized that theft of non-beverage alcohol was a last resort and much more likely if they were in withdrawal; although they considered it an option when regular alcohol was not affordable, it was described as involving risk and/or inconvenience (e.g. travel) that they would prefer not to encounter.

Beyond affordability, accessibility of non-beverage alcohol was a theme raised by participants. At one meeting, more than half the group said they had been refused service at a liquor store, and several others mentioned being turned away from bars and pubs as well. As one participant described, “They wouldn't serve my friend regular alcohol at the bar because he smelled like Listerine” (Town hall meeting, July 11). While acknowledging that many participants had also been blocked from purchasing non-beverage alcohol (“They won't serve you. You got too fresh of breath” (Town hall meeting, July 11)), participants described how it was generally more accessible than beverage alcohol as it could be purchased from corner stores or people who “bootleg” (Town hall meeting, July 11). Of note, most participants were "marked" as poor and a significant fraction were visibly Aboriginal; the influence of these factors on clerks’ perception of their deservedness and level of intoxication undoubtedly influenced the service they received in relation to alcohol.

Non-beverage alcohol was also described as more accessible than beverage alcohol for geographic reasons. This subject was raised at one of the town hall meetings:
Another participant says that, since the liquor stores stopped carrying the “cheap sherry,” the only place you can get it is 41st and Cambie [the flagship government liquor store, approximately 30 minutes away by public transit], and “Who the hell wants to travel all the way down there?” The result, he says, is that now they have to drink other stuff. Much of the audience agrees with this, saying, “Yeah, yeah,” and nodding (Town hall meeting, July 18).

In addition to geographic restrictions on availability, at certain periods of the day, particularly in the early mornings, non-beverage alcohol was considered more accessible than alcohol purchased from a liquor store. Moreover, the presence of individuals selling non-beverage alcohol on the street extended the hours in which these substances were available even further.

Despite its relative affordability and accessibility, only some individuals consume non-beverage alcohol. Participants described how initiation into its use was a necessary factor in their drinking choices. Homelessness was suggested as an important contributor, as described in the following exchange:

“Homelessness,” someone in the group calls out.

Another participant adds to that. “A lot of people come through and they’re homeless and they have nowhere to go and they’re going through tough times,” he says, the words spilling out one over the other. “Somebody gives me a free drink to go, one, like, basically Listerine or sanitizer,” that’s what people give you. “You see it happening at the church, in the parks.” He says that that’s where it [drinking non-beverage alcohol] starts. “Not everybody’s homeless,” he says, but it starts there. “You’re exposed. I thought the liquor would keep me warm, and when I didn’t have any more money, what would I turn to? Sanitizer, Listerine” (Town hall meeting, October 10).

This conversation shows how homelessness can contribute to the initiation into non-beverage alcohol use. Vancouver’s city council has undertaken a multi-year campaign to end street homelessness, but has so far been unsuccessful, due in large part to gentrification of the Downtown Eastside and the ensuing loss of relatively affordable housing stock (Cooper 2015), and many of our participants reported sleeping outdoors or in shelters. Other participants mentioned how friends who provided them with non-beverage alcohol were important to their initiation; in these retellings, drinking non-beverage alcohol was seen as a social practice that participants had not necessarily considered before it was offered to them.
An important caveat to the themes of affordability and accessibility is that participants frequently described how non-beverage alcohol is neither affordable nor accessible except in contrast with beverage alcohol. Regarding cost, many participants expressed outrage that prices for non-beverage alcohol were higher in their neighbourhood than in surrounding areas, as the following exchange suggests:

Nicole [program coordinator] tells the audience about how we went to [a nearby pharmacy] to look at the price of alcohol, and then about the cost in my neighbourhood (on sale for $2.69 vs. $6.99 at the local pharmacy). “Ridiculous,” someone says.

“It’s almost like they’re bootlegging it,” Lorna says. “They’re making a mint,” one of the participants agrees. “Everybody’s making a mint,” someone else says, adding that if you go to Superstore [suburban grocery store] it’s only $2 for a bottle for the same stuff they sell here for $7 (Town hall meeting, July 18).

Regarding the overall accessibility of non-beverage alcohol, little consensus existed among participants. Some left the Downtown Eastside daily to make their purchases; of these, some said this was to take advantage of lower prices elsewhere or to experience reduced stigma (because store owners would not assume it was for consumption), while others had been denied service at stores in the Downtown Eastside. Other participants reported the opposite: that they were unable to purchase alcohol outside the Downtown Eastside because they would be denied service, while certain store owners in the Downtown Eastside would provide them with non-beverage alcohol.

Overall, participants reported consuming a variety of types of non-beverage alcohol, with mouthwash and rubbing alcohol the most common. These substances were chosen for being more affordable and accessible than alcohol purchased at a liquor store or bar, but that did not mean they are considered particularly affordable or accessible by participants; in fact, high prices and difficulties in purchasing non-beverage alcohol were frequently reported.

8.1.3 Harms from illicit drinking

We spent a significant amount of time in the meetings with illicit drinkers discussing their perceptions of harms experienced from the substances they consume. While health professionals and others might assess the harms of illicit drinking differently, it is important that perspectives of illicit drinkers are captured in order to take action that meets their
priorities. Participants’ descriptions of the harms they experienced can be summarized into seven categories: (1) accidents, (2) violence, theft, and being taken advantage of, (3) harms to physical health, (4) harms to mental health, (5) withdrawal, (6) reduced access to services, and (7) interactions with police.

Accidents were seen as a significant risk of illicit drinking. These ranged from “bruises and bumps” (Town hall meeting, Sept 12) to “bleeding to death” (Town hall meeting, July 25), with falling and cuts most frequently mentioned as potential injuries. Alcohol negatively effects cerebellar control of balance and coordination; living in poorly maintained housing, having limited access to appropriate cooking facilities, and having poor access to adequate eye care and eyewear (Abdullah 2014) also contributes to the likelihood of illicit drinkers having accidents. Choking on one’s own vomit was also raised as a concern. The following story is representative of participants’ concerns:

A slim middle-aged Aboriginal man sitting quietly near me raises his hand and says that he knew somebody that was drinking Listerine and tried to cook and ended up cutting his finger trying to open a can. He says that he (the speaker) had to call an ambulance. [The implication is that if the person had been drinking alone it would have been much worse.] The guy sitting beside him says that he was the friend who cut himself, and confirms that it was a bad cut (Town hall meeting, July 25).

In this exchange, the harm of the accident was mitigated by the presence of a friend who was able to provide assistance. In a section below on harm reduction strategies practiced by illicit drinkers, I will further discuss the described benefits and drawbacks of drinking alone in order to reduce harms of illicit drinking.

A set of related harms of illicit drinking that was frequently mentioned included experiencing violence, being a victim of theft, or having someone take advantage of an intoxicated drinker. Violence was first discussed as follows:

Hugh [facilitator] asks if people find themselves on the receiving end of a lot of violence. [This wasn’t on the list of questions, as far as I know, but got a lot of response.]

“Yes, absolutely,” is the first answer.

Someone else says, “You have to defend yourself all the time.”

“Every day,” echoes a third participant (Town hall meeting, July 18).
Facilitators further questioned participants about the reasons why illicit drinkers experience violence. Theft was strongly endorsed as a reason, with theft of alcohol from people drinking alone as a particular risk. Violence from police and sexual assault were also mentioned as ways in which violence is experienced. In the women's focus group, one participant described the pervasive risk of sexual assault women illicit drinkers face, "When you’re by yourself and you get totally hammered, things happen to you. Like, for instance, I guess one day I was passed out beside the church and two guys were trying to feel me up while I was passed out" (Women's focus group). Participants in this group emphasized that they felt vulnerable to sexual assault and in other physical altercations based on their relative size and strength, and therefore depended on others to defend them when necessary.

A related harm mentioned by participants is that, when intoxicated and especially when desperate for money, they are vulnerable to exploitation. As examples, participants described incidents in which they had been offered cash after being hit by a car in exchange for not filing insurance or police reports; being given inert substances instead of drugs by dealers; and paying excessive prices for alcohol (including purchasing on credit, with payment due on the day social assistance cheques are distributed). Another way in which people take advantage of illicit drinkers is mentioned in the exchange below:

Someone else says that just like people “sell their stuff” to get more cocaine, he sells his stuff to get more alcohol.

“And when you do sell your stuff, you get ripped off,” another participant continues.

A third participant agrees, saying that people “take advantage of you,” figuring that the person is so drunk that he or she won’t know what is going on (Town hall meeting, July 18).

While violence, theft, and being taken advantage of were well known to illicit drinkers, the physical or medical harms of non-beverage alcohol generated more questions than answers.

There was lay understanding of the effects of alcohol on the liver in particular (one participant told me that a group like this is important for drinkers like him, but also to help people like his brother. He explained that his brother’s stomach “is already getting big from his liver giving out” (Town hall meeting, Sept 19)). Participants had many questions, however, about how non-beverage alcohol affects other internal organs and may contribute to
Damage to mental health was also raised as a harm of illicit drinking. This was presented more as a risk of the lifestyle associated with consuming alcohol than something inherent to the substance itself. In particular, participants mentioned drinking alone in one’s room (a strategy for avoiding theft, police attention, and sharing alcohol) as a contributing factor to depression. One also mentioned witnessing traumatic events (“Seeing a lot of traumatizing stuff” (Town hall meeting, July 25)) as damaging to mental health. The worst possible outcome of the negative effects on mental health was suicide, which participants saw as a particular risk for illicit drinkers.

Withdrawal and delirium tremens (“the DTs”) were seen as risks specific to alcohol. Several participants reported experiencing seizures, and many more had witnessed them in others. Less major symptoms, such as shaking, were also commonly reported, with mornings described as the worst time of day because of the overnight abstinence. Participants described withdrawal in very serious terms and had a variety of strategies for coping with it (see section 8.1.4 on current harm reduction strategies below).

Participants also mentioned impaired access to health services as an additional harm of illicit drinking. This occurred when people were intoxicated and subsequently not served by medical professionals. As one participant described it:

“You have to be sober, at least half-ass sober” to see a doctor. If not, they kick you out and say go back tomorrow, but often after that experience when you sober up you don’t want to go back (Town hall meeting, Aug 29).

In follow up to this statement, one of the facilitators asked who in the audience had had similar experiences. Over half of the participants answered in the affirmative. Access to medical services is already difficult for this population due to past experiences of stigma, difficulties navigating the bureaucracies of medical care (such as scheduling appointments, providing identification, etc.), and class and cultural differences with health care providers; adding the barrier of being denied service while intoxicated, especially to the subset of participants who are intoxicated most days, contributes to an inadequate standard of medical care.

Finally, negative interactions with police were mentioned as a significant harm of illicit
drinking. Participants described how police target known illicit drinkers to pour out their alcohol, give tickets for being drunk in public, and take them to the "drunk tank" (Steering committee meeting, October 10). They felt this targeting exceeded that faced by other substance users and that mistreatment (e.g. theft and violence) is common while in custody. Illicit drinkers' interactions with police often occur in the context of homelessness or residing in dwellings with restrictions on visitors; in these circumstances, public intoxication and subsequent criminalization are more likely. The substantial history of police mistreatment and targeting of Aboriginal people should also be acknowledged when discussing illicit drinkers' experiences of criminalization, as Aboriginal people made up a significant fraction of meeting participants and their experiences of criminalization as illicit drinkers are coloured by their frequent criminalization based on indigeneity.

Participants identified a range of harms from illicit drinking, but did not see all of these harms as inevitable. The next section describes strategies that participants described using to reduce harm in their lives.

8.1.4 Harm reduction strategies currently in use

Drinking in groups and drinking alone. Much discussion ensued at the town hall meetings on the relative safety of drinking alone versus drinking in groups. Drinking alone was described as feasible only if a person had a private room somewhere (i.e. was not homeless), as drinking alone in public invites violence and theft:

“You get the shit pounded out of you,” a participant says. There are noises of agreement. A person drinking alone will get “jacked up” because “you can’t just sit down here with a case of beer,” someone else says. He explains that people want it and will take it away. There’s a lot of agreement with this (Town hall meeting, July 25).

While drinking alone in public carries one set of risks, drinking alone in one’s room was seen as risking accidents, depression, and choking on vomit, as described in the section above. Drinking in a group was not seen as perfectly safe, however: participants mentioned that group members who become overintoxicated or pass out are at risk of theft and sexual assault. As well, due to restrictions on the types of indoor drinking spaces available to participants, drinking in a group almost always occurs outside, raising the risk of police attention.
A show of hands at one meeting revealed that slightly more participants preferred to drink in a group. Given that certain harms are minimized and others are maximized by drinking with others, how do participants navigate this decision? A key factor in decision-making seemed to be participants’ desire and need to share alcohol and funds to obtain alcohol. That is, most groups of drinkers in which our participants spent time had a usual practice of sharing alcohol among group members. This was seen as a harm reduction practice (see section on “Ensuring one has enough alcohol” below), but one that leaves an individual with little control over the pace of alcohol consumption. Some participants, therefore, while acknowledging the potential harms of drinking alone, still preferred this strategy if they had the funds and private space available to do so.

Ensuring one has enough alcohol. Closely related to the strategies of drinking in groups or alone were the techniques participants used to ensure they had sufficient alcohol to achieve a desired level of intoxication and/or avoid withdrawal symptoms. The first of these involved sharing one’s own alcohol with others, particularly those in withdrawal, which increases the likelihood alcohol would be available to the person offering should they ever need it. This was described at an town hall meeting: “‘Even if it’s somebody that you don’t know,’ if they have ‘the shakes,’ you should ‘share!’ The person suggesting this says that ‘what goes around, comes around’” (Town hall meeting, August 15).

Secondly, several participants advocated keeping money or alcohol in reserve so that some would be available when needed. And finally, participants described using “chip-ins” (Town hall meeting, August 15), meaning pooling money to purchase a bottle of alcohol, so that alcohol could be purchased even when an individual did not have sufficient funds by him- or herself. This most commonly took place in the context of drinking in a group and has important implications for controlling the pace of alcohol consumption (see below).

Limiting the amount or pace of alcohol consumption. Participants were well aware that the amount of alcohol they consumed had negative effects on them. A commonly suggested strategy, therefore, was to reduce harm by reducing the amount of alcohol consumed. This sometimes entails planning ahead, by not purchasing large amounts of alcohol or by drinking with someone who drinks less (and therefore using them to pace oneself); alternatively, participants mentioned enforcing this on others when drinking in a group by cutting a person
off or having a shared bottle bypass them. Taking days off from drinking was also mentioned as a strategy to reduce harm, although one that risks withdrawal symptoms if a person does not have strategies in place to deal with that (see section on pharmaceuticals below).

Participants described mixing drinks as an additional strategy to limit alcohol consumption. Water was the usual substance used to dilute alcohol so it could be consumed more slowly, although juice was also mentioned in favourable terms. The goal of this strategy is to reduce the number of episodes of over- and under-intoxication, the former of which carries risk of victimization and interactions with police, while the latter carries risk of withdrawal.

**Food and water.** Drinking adequate amounts of water, especially “before you pass out” (Town hall meeting, August 29) was suggested at a number of meetings as an important harm reduction strategy, albeit one hindered by the lack of freely accessible water in the Downtown Eastside. Participants suggested that this helps drinkers feel better by “cut[ting] down on your shakiness” (Town hall meeting, August 29) the following day.

Participants’ suggestions around food were more complex. There was widespread recognition of the need to eat a healthy diet or to “eat once or twice a day at least” (Town hall meeting, August 15). Food also seemed to be a way that participants expressed caring for other drinkers; much of the conversation was structured around providing food for others or encouraging others to eat rather than obtaining food for oneself. Despite the emphasis placed on eating, many participants admitted they do not consume food while drinking because it means they will require more alcohol to reach a given level of intoxication.

**Looking after other illicit drinkers.** Participants repeatedly emphasized that many of the harms of illicit drinking could be reduced by taking care of one another. In addition to the ways of demonstrating care already described (e.g. sharing alcohol, offering food), some participants described strategies implemented specifically to keep others safe. This first of these involved taking people who are particularly intoxicated to an environment where they could be looked after. A primary place suggested for this purpose was First United Church, the low barrier shelter where many illicit drinkers live. As one participant said, “‘If someone’s too drunk,’ walk them over to First United so they can ‘pass out on a bench’” (August 15, 2011). Other specific strategies for reducing harms to others included asking after people who had not been seen recently and placing people in safe positions (on their
sides, not in wheelchairs) to sleep. These suggestions reflect the limited supports available to illicit drinkers; expressions of care are severely constrained in the context of their economic and social marginalization.

**Pharmaceutical management of withdrawal symptoms.** An interesting harm reduction strategy was the use of pharmaceutical drugs, by prescription or otherwise, to manage withdrawal symptoms. Most participants were familiar with the use of medication to manage withdrawal, having been offered it in detox or while incarcerated. A small minority had extended their use to non-institutional situations, either by obtaining a prescription from a physician in the community or by buying pharmaceuticals on the street. While benzodiazepines were the most commonly cited medication for this purpose (and the type of medication suggested by medical experts (Amato et al. 2011)), atypical antipsychotics were also mentioned.

Participants readily offered the view that the harm reduction strategies they currently practiced were inadequate to support their health and well-being. They suggested a variety of additional strategies that could be implemented to supplement their current efforts.

### 8.1.5 Proposed harm reduction strategies

**Safe space.** Participants were well aware of Vancouver’s supervised injection site (Insite) and frequently suggested it as a model for how harms such as violence, theft, and accidents could be reduced for illicit drinkers. As one put it, “‘What about, see, if we have safe injection sites down over there, why can’t we have our own’ place to drink?” (Town hall meeting, Sept 12). Of note, this suggestion involves a space where participants could bring their own alcohol, rather than having alcohol provided, similar to how injections at Insite involve the user’s own supply of drugs. The presence of non-intoxicated personnel and potentially trained illicit drinkers as well was seen as a way of avoiding some of the physical and emotional harms that occur when drinking out of doors especially. Importantly, a supervised space for drinking was also highlighted as a way to avoid the attention of police and reduce the frequency of involuntary visits an illicit drinker might make to the police sobering centre. In keeping with this, it was felt to be necessary that police support the safe space and leave users of it alone both while inside and while entering or exiting. For example, at one of the town hall meetings, a participant says that, “there needs to be a zone around the place where
cops won’t come get you, similar to the way the cops leave people alone who are coming and
going from Insite” (Town hall meeting, Sept 12). A related issue raised at multiple meetings
was the need for supervised transportation home from such a space (thus helping to reduce
accidents and encounters with police) and securing housing for those who would otherwise
be consigned to the street after the facility closed.

Managed alcohol programs. Many harms from illicit drinking, such as those acquired in
accruing it or those due to drinking non-beverage alcohol specifically, are not reduced by
simply providing a supervised space to drink. Some participants therefore suggested that free
alcohol should be provided in conjunction with a supervised space. Methadone maintenance,
in which methadone is provided to reduce cravings to those addicted to opiates, was well-
known to participants and provided an important model as they envisioned how managed
alcohol programs might be implemented. Initially, the discussion in the town hall meetings
centered on the provision of non-beverage alcohol:

“Free Listerine,” someone says.

“How do you not get pneumonia?” [Responding to earlier speaker that had
been interrupted] Nicole [program coordinator, acting as facilitator] asks.
The first suggestion offered is that people should stay out of
the rain. Nicole
writes “protection from exposure.”

She then turns to the earlier speaker and says, “I heard you say free
Listerine.” There is a ton of laughter at this. Nicole waits for a beat, then
addresses the group as a whole. “This is a drinkers’ group” and “some of the
main issues that have come up are about alcohol availability,” so it’s not a
stupid statement. She says that she is going to write it down, and does
(Town hall meeting, August 22).

Further discussion, however, helped clarify that all participants would prefer beverage
alcohol if enough were available to permit a desired level of intoxication; the suggestions of
non-beverage alcohol provision were related to participants’ experiences of finding beverage
alcohol unaffordable in the quantities needed compared to non-beverage alcohol.

The goal of managed alcohol programs, according to participants, is to provide enough
alcohol for people to avoid withdrawal, to function in their daily lives, and to be intoxicated
enough to prevent them from drinking additional non-beverage alcohol. The following
suggestion illustrates this:
The young guy suggests that they could have a logo that would provide some clarification about the purpose of the facility. “‘Here to get fixed and not shit-faced,’” he suggests that it could say. Nicole writes this down and people clap (Town hall meeting, Sept 22).

Participants cautioned, however, that maintenance levels of alcohol for them would likely be higher than some might expect. Responding to a description of an informal managed alcohol program at a supportive housing facility in the Downtown Eastside that gave a resident a 375ml bottle (a "mickey") per day, the following exchange occurred:

Nicole then says, “I’m very much hearing that a mickey a day is not enough.”

“Just hand out shots to the people who’s there,” someone says. If a mickey is not enough, he suggests handing out “shooters, maybe a double, triple, single.”

Someone else chimes in, “A shot doesn’t go anywhere. If you hand out shots it’s got to be three ounces.” He explains that that way people can sit around and add water to it if they want. “I don’t know about you guys,” he concludes, addressing the other participants, “but I get a bit of a buzz off that” (Town hall meeting meeting, Sept 19).

For a managed alcohol program to meet its goals, the amount of alcohol offered would have to be enough to discourage clients from consuming additional non-beverage alcohol. Participants in this meeting series expressed concern that non-drinkers would underestimate their needs, and pointed out the need for alcohol dosing to be tailored to individual tolerances.

An area of debate among participants was whether managed alcohol programs should ideally involve consumption of alcohol on-site or whether it should be provided to users to the service to take elsewhere. This discussion was informed by participants' knowledge of methadone services (in which people receive daily doses that they consume in a witnessed fashion at a pharmacy, or may receive "carries," i.e. several doses that they can take with them) and Vancouver's heroin maintenance trial (in which people are given doses of heroin that must be consumed on-site at the trial facility). A benefit participants saw to consuming alcohol on site echoed their calls for a "safe space" for alcohol consumption: that is, consuming alcohol at a managed alcohol program would reduce exposure to accidents, theft, violence, and other forms of victimization that occur when drinking in public spaces. Key for
many participants was that consuming alcohol on site would also reduce interactions with police, although some remained concerned that police would observe a managed alcohol program with an eye to targeting illicit drinkers as they came or left the space.

A drawback to requiring that alcohol be consumed on site was that this was seen as restricting a person's freedom and interfering with a person's daily activities. "People deserve to have lives," as one participant put it (Town hall meeting, Sept 19). Many other services accessed by participants provide little flexibility in how interactions with clients take place (for example, requiring that people sit in a waiting room for extended periods to access a first-come, first-served type program), meaning a managed alcohol program with on-site consumption would potentially interfere with client accessing other services. As well, some participants were concerned that requiring alcohol be consumed at the facility would limit the program's reach and exclude some particularly marginalized illicit drinkers, particularly those who are accustomed to drinking in local parks. Encouraging people using the facility to leave after consuming their alcohol and to come back throughout the day as necessary was seen as a compromise position that would balance needs for safety and freedom.

Much discussion from participants centered on the need to have connections between managed alcohol programs and other supportive services, such as housing, counselling, and detoxification. They stressed that managed alcohol programs by themselves would not be that helpful to a person who remained homeless and in need of medical care. They also desired immediate access to detox services so that people could begin the process of safely withdrawing from alcohol whenever they were ready. These preferences were often expressed as a need to "link" to other services; a context of insufficient services to meet demand (e.g. waits of several days for detox services, lack of supportive housing options) suggests, however, that more than linkages between a managed alcohol program and other services will be necessary to meet illicit drinkers' needs.

A repeated suggestion from participants was that managed alcohol programs be offered in a non-residential format. At the time of the meeting series, the only managed alcohol program available in Vancouver was offered through a supportive housing facility to residents only. An alternative was desired by some participants for several reasons. First, living in permanent supportive housing was not seen as feasible or desirable by all participants. Some
felt that the rules and restrictions these facilities imposed (including splitting up partners and friends) made this type of housing undesirable. Others expressed concern that they could not meet the expectations of the facility over time and would lose their housing, and the managed alcohol program access along with it.

A second reason for suggesting non-residential managed alcohol programs was that they were seen as largely restricting a person's activities to a single building. Below, one participant who is new to Vancouver described a program in his home province:

[He tells the facilitator] that there is a place in Alberta that has been doing a program like that successfully for years, but that it's a pilot project. He describes its system by saying you have to live there to receive alcohol and says, "You get all the booze you want but you're not leaving" (Town hall meeting, July 11).

Especially for participants who were used to drinking in groups, the restriction of locations for drinking and of people to drink with (i.e. only others in the housing facility) was seen as a significant drawback to residential managed alcohol programs.

Third, non-residential managed alcohol programs were of interest to participants because they thought it the system most likely to lead to a non-clinical atmosphere. While accepting that some clinical oversight of a program might be necessary and desirable (particularly nursing services, although some participants did suggest a doctor's approval might be required to participate in a managed alcohol program), participants discussed how a "drinkers' lounge" might be structured to make it a welcoming, friendly place. Ideas included having inviting places to sit and socialize, showing movies, and having a quiet space to which clients could remove themselves if necessary (rather than being asked to leave the facility if they were engaging in conflict with other clients).

Finally, participants suggested a non-residential managed alcohol program was desirable because it seemed the most likely route to a peer-run facility: that is, controlled in a meaningful way by illicit drinkers themselves.

Peer-based services. Participants strongly expressed the belief that control by illicit drinkers over a managed alcohol program was both possible and desirable. Having a peer-based element was seen as making the service more accessible, as the following comment illustrates:
“Me, myself, if I was going to a drinkers’ lounge, I’d like to see someone that I kind of knew serving peanut butter and jelly sandwiches.” He elaborates that there could be health workers behind this person, but that he needs to see some people that he knows (Town hall meeting, Sept 12).

This participant indicates that having illicit drinkers working in the managed alcohol program would make him more inclined to access the service. Beyond simply having illicit drinkers as staff members, however, participants expressed a desire to have illicit drinker control over the manner in which services are offered. This was seen as a way to keep the services relevant to their needs and reaching the people who need them most. Through a process of brainstorming potential problems at a managed alcohol program and role-playing scenarios based around those problems, the group came to envision a service with a membership list in which membership was dependent on other illicit drinkers deciding that a person should receive services (in contrast to a program where health care or social service providers make the decision). Participants also suggested that having illicit drinkers set rules and policies for the service (such as how alcohol would be served or what to do if someone was over-intoxicated) would lead to a service that better meets their needs and a greater likelihood that clients would follow the rules. Of note, participants suggested a great many potential rules for a managed alcohol program, including details such as membership cards, systems for distributing drinks, and plans for expelling people who fight or are otherwise unruly.

Some participants did express doubt that illicit drinkers could achieve this vision of peer-based services. In particular, they questioned whether fights would be a problem. Others countered by challenging the implied idea that illicit drinkers have no self-regulation and providing examples of ways in which illicit drinkers manage their and each other’s behaviour. In the following example, several participants discuss a potential strategy for managing difficult behaviour at a managed alcohol program and connect it to how illicit drinkers manage their actions in less regulated situations:

“Have a separate cool-down room,” another participant offers. That way, if people don’t want to leave they could come and apologize later.

“Drinkers have their own code of conduct, too,” someone else confirms.

“Definitely a code of conduct.”

“In their own parties.” There are a lot of different people talking now, but they’re building on one another, not speaking over each other (Town hall
This discussion shows enthusiasm for the idea that illicit drinkers could manage their own and each other's behaviour in the context of a peer-based managed alcohol program. It aligns well with the value of collectivity, as identified in Chapter 5, and the priority of supporting peer-based programming identified in Chapter 4.

**Education.** An additional harm reduction strategy suggested by participants was education. Three types of educational activities were proposed: (1) by illicit drinkers, for illicit drinkers; (2) by experts, for illicit drinkers; and (3) by illicit drinkers, for service providers. For the first type, long-term illicit drinkers were seen as a source of valuable information about how to reduce harms from drinking. Specific strategies that were mentioned included recipes for mixing alcohol (to promote a steady state of intoxication, rather than over-intoxication and withdrawal) and teaching placement of drinkers on their side if pass out to reduce the risk of choking. Education by experts was requested for topics about which participants felt they lacked knowledge, such as the specific effects of non-beverage alcohol on the body. Finally, participants suggested that education of service providers, specifically health care providers, about the needs of illicit drinkers and the barriers they face in obtaining health care could improve the quality of services offered to illicit drinkers.

Participants in the illicit drinker meeting series identified a range of harms and strategies they used to reduce these harms. They also suggested several promising ideas for future alcohol harm reduction initiatives, including non-residential managed alcohol programs. During member checking, however, they cautioned that harm reduction should not be the only focus of efforts to work with illicit drinkers to improve their health and well-being. On-demand detoxification (currently most illicit drinkers face a several day wait for inpatient detox) and low-barrier supportive housing were also mentioned as key areas in which urgent improvements are needed to support illicit drinkers.

### 8.2 Discussion

In this section, I will compare the findings from the meeting series with illicit drinkers with results reported elsewhere in the academic literature. I will then argue that the harms and harm reduction strategies suggested by participants should be interpreted as examples of
structural and everyday violence against substance users rather than being specific to illicit drinking. I further make the point that some of the strategies proposed by participants should be viewed as responses to symbolic violence that do not necessarily address the roots of the violence illicit drinkers face, and conclude the chapter by suggesting that peer-based programs may help avoid some negative effects of the other proposed harm reduction strategies.

The term "harm reduction" as it pertains to alcohol is used in a few different ways in the academic literature. It can refer to a reduction in harm without necessarily any reduction in use, or to controlled drinking (set in contrast to abstinence-based programs) (Heather 2006). My use of the term here should be taken to mean strategies that reduce the harms of drinking alcohol without necessarily reducing alcohol consumption at the individual or population level. Globally, a number of alcohol harm reduction strategies have been studied and found effective: programs to improve safety and reduce violence at bars (Ritter and Cameron 2006; Stockwell 2006; Herring et al. 2010), drinking and driving reduction through random blood alcohol concentration measurement and legal sanctions (Ritter and Cameron 2006; Stockwell 2006; Herring et al. 2010), thiamine supplementation (to prevent Wernicke's encephalopathy) (Stockwell 2006), and prescription of naltrexone to encourage moderate drinking (which works through an effect on the endogenous opiates produced in response to drinking) (Marlatt and Witkiewitz 2002). Most relevant to the population of illicit drinkers attending our meetings is a "housing first" model to reduce homelessness (in which potential clients are provided with supportive housing before any attempt is made to reduce substance use or improve mental health, in contrast to an approach where housing is contingent on abstinence or moderate substance use and specific behaviours). In addition to its other benefits, a housing first strategy has been shown to reduce the cost of health and police services for homeless alcohol users. It also leads to a reduction in alcohol use, although this is not a requirement of participation (Larimer et al. 2009). An additional alcohol harm reduction strategy described in the literature that is relevant to participants in the illicit drinkers' meeting series is the use of "sobering stations" in which overly intoxicated people are provided with care but not taken into police custody. Unfortunately, this strategy has been attempted and described, but not evaluated (Herring et al. 2010). A study of naltrexone to reduce cravings is currently in progress (Collins et al. 2014). Finally, managed alcohol
programs, in which beverage alcohol is provided to chronic alcoholics, have recently been piloted and evaluated in several Canadian cities. One evaluation showed a reduction in alcohol use, emergency department visits, and encounters with police for program participants (Podymow et al. 2006). Early results from the Vancouver managed alcohol program pilot show improvements in mental health and reductions in seizure frequency and non-beverage alcohol use, but a possible decline in liver function tests and self-rated physical health for some participants (Stockwell et al. 2013). A longitudinal case study of a single managed alcohol program participant provides some insight into how these programs might achieve their results: by providing stability, the participant was able to invest in positive identity formation and search for more meaning in life (Kidd, Kirkpatrick and George 2011). Similarly, a case series by Evans et al (2015) argued that managed alcohol programs do more than reduce the risks participants face, but also act as “enabling places” that enhance well-being and facilitate recovery through a sense of togetherness, greater awareness of the consequences of alcohol use, and the promotion of self-management. A recent Cochrane review concluded there is not enough evidence to draw conclusions about the efficacy of managed alcohol programs (Muckle et al. 2012), but an ongoing national evaluation of Canadian managed alcohol programs will provide additional information in the next several years.

It is notable that many of the alcohol harm reduction strategies described in the literature do not apply to the poor and marginalized illicit drinkers who participated in this research. They do not, for example, generally have access to vehicles or even have sufficient funds to drink in bars. While they would likely benefit from thiamine supplementation, brain damage was not raised as a harm that participants identified from illicit drinking and medication to moderate drinking (as opposed to ease withdrawal) was not raised as a current or desired strategy. The reduction of homelessness through a housing first model, however, fits well with the harms described by participants, as many of them (violence, theft, etc) are caused or compounded by lack of safe housing with space for socializing. And managed alcohol programs were raised by participants as a desirable harm reduction strategy, although they contrasted their desire for a non-residential managed alcohol program with the residential facilities described in the literature.

Applying a more theoretical approach to the illicit drinkers' group results, I argue that the
harms that participants identified and the strategies they use to reduce them can usefully be interpreted using two key concepts from critical theory, structural and everyday violence. Structural violence, meaning suffering caused by forces external to the individual and distributed along lines of power, is of relevance here because the harms identified by participants and the strategies they currently use to reduce those harms are more closely linked to how illicit drinkers are positioned as poor and marginalized substance users than they are related to the specific substances ingested. The difficulties accessing health services that illicit drinkers described, for example, mirror the barriers to accessing health care described by drug users in the provincial needs assessment (Chapter 4). Harms of illicit drinking such as violence, theft, and being taken advantage of are also not specific to people who use alcohol; instead, they flow from lack of access to safe and dignified housing, negative relationships with police, and lack of economic opportunities. The political and economic climate that interferes with illicit drinkers' access to housing, protection, and health care also denies these needs to (poor and marginalized) people who use illicit drugs, and it is therefore not surprising that many of the harms described by illicit drinker participants relate only loosely to the specific substance in question. That structural violence dictates the majority of the harms illicit drinkers face can be seen even more clearly when comparing participants' experiences of consuming non-beverage alcohol with wealthy and powerful people who consumed it, such as Betty Ford and Kitty Dukakis; while these women certainly experienced harm from their drinking, it was manifested very differently than for illicit drinkers in Vancouver's Downtown Eastside.

The harm reduction strategies illicit drinkers employ are also reflective of their economic and social positioning. Pooling resources and sharing alcohol as strategies to avoid withdrawal are responses to the extreme economic marginalization illicit drinkers face; Bourgois and Schonberg (2009) describe similar strategies occurring among homeless drug users in California. Drinking in groups for protection is also a strategy that reflects the structural violence in place against illicit drinkers as it highlights the lack of other options they have to ensure their safety. And while the use of benzodiazapines to avoid withdrawal symptoms is relatively specific to alcohol harm reduction, that participants reported purchasing them on the street is indicative of the barriers they face in accessing appropriate medical care. A corollary of this strategy also exists among drug users; opiate users on occasion turn to
methadone acquired by means other than a physician’s prescription when they lack access to adequate methadone maintenance through formal medical channels (Harris and Rhodes 2013).

The harms and strategies illicit drinkers identified may also be interpreted using the concept of everyday violence, by which I mean the ongoing indignities and "little abominations" (Scheper-Hughes 1992) that illicit drinkers face, and which they may internalize and reproduce on one another. Reproduced everyday violence is especially important in the interpretation of participants' insights about the threats of violence and theft they face and the strategy of drinking in groups to avoid this harm: this helps us to understand how illicit drinkers can depend on groups for protection from outsiders and yet face victimization from within the group. Furthermore, sexualized violence among illicit drinkers can be viewed as an example of everyday violence that occurs along lines of gender. Meeting participants identified looking after other illicit drinkers as a strategy currently used to reduce harms, but it is clear from their other statements that internalized and reproduced everyday violence interferes with their ability to achieve this ideal. Here, too, we can see commonalities with the circumstances of drug users, who are also pitted against one another through their marginalization despite their desire for connection and mutual support (see section 5.1.1) (Bourgois and Schonberg 2009).

During member checking, however, participants cautioned that although the types of harms faced by illicit drinkers hold much in common with those encountered by other substance users, the degree of those harms is often intensified for illicit drinkers, who are generally even more economically and socially marginalized than people who primarily use illicit drugs. The visibility of illicit drinking was also perceived to be higher, primarily because of the characteristic breath odor occurring with alcohol use. And there are clearly some substance-specific harms and strategies suggested by participants: the dangers of withdrawal and the pharmaceutical strategies to manage it are unique to alcohol, and, while accidents occur in the context of substandard living conditions, their likelihood is increased by alcohol's effects on the cerebellum. Overall, it is important to balance identifying struggles common to many substance users and highlighting the unique harms faced by illicit drinkers.

When analyzing the proposed harm reduction measures identified by participants, it is useful
to employ the concept of symbolic violence, that is, the exaggeration of individual agency that casts victims as scapegoats and obscures the real perpetrators of structural violence (Farmer 1996b; Bourdieu 1998). Symbolic violence leads victims to internalize a belief in their own complicity and may therefore result in them not challenging, and even supporting, instances in which they are oppressed. Under a neoliberal ideology as it relates to public health, illicit drinkers, inasmuch as they are seen as not engaging in the self-care and self control demanded of neoliberal subjects, are cast as responsible for and deserving of the harms they experience. The role of structural factors (e.g. economic vulnerability and colonialism) is correspondingly minimized. The neoliberal approach to those who do not engage in called-for levels of self control is to impose external surveillance and control (Petersen and Lupton 1996); this can be contrasted with the desire for mutual accountability described by drug users and illicit drinkers (see Chapters 5 and 6).

Despite describing harms from illicit drinking that arise from structural violence against poor substance users, participants in this meeting series did not on the whole suggest measures that would challenge systemic oppression. Instead, they called for several potential harm reduction initiatives that would increase the external control they would experience. Safe spaces (places where illicit drinkers could gather and drink their own alcohol in a supervised fashion) and managed alcohol programs (programs where beverage alcohol is provided to illicit drinkers) both potentially minimize harms but also subject illicit drinkers to more intensive monitoring of their drinking and behaviour. This is particularly true of the versions of these programs suggested by participants, in which membership rules, rules about distribution of alcohol, and behaviour rules all featured prominently in discussions. These proposals can be usefully interpreted as a response to symbolic violence: illicit drinkers internalize the message that they are "out of control" and therefore propose strategies that give power to others instead of directly challenging the structural and everyday violence they face. Evans (2012) describes how residents of a managed alcohol program in Ontario, Canada, adopted an "ethics of responsibility" in response to program constraints; the increased governance of homeless drinkers both imposed (geographic and other) restrictions on them and gave them access to a new narrative of self-control, albeit one which they viewed with some ambivalence.

The suggestions offered by participants can also be viewed as simply what is realistic in this
political climate. That harm reduction initiatives are suggested instead of addressing structural inequalities raises the question of whether harm reduction contributes to the maintenance of a system of surveillance and discipline of substance users, in place of truly transformative social change (Miller 2001; Roe 2005; Fischer et al. 2004; Smith 2011a).

Pauly suggests expanding our ideas of the harms addressed by harm reduction to include "poverty, violence, and other effects of political and economic disenfranchisement" (Pauly 2008a). This approach fits well with my analysis that the harms experienced by illicit drinkers have much in common with those experienced by poor and marginalized users of illicit drugs, because political and social disenfranchisement is how many of the harms they experience are enacted. Participants' calls for peer-based programs provide a promising strategy for addressing immediate harms (such as violence and theft) while also countering marginalization and exclusion and promoting mutual accountability and substance user control of services. These programs should also support illicit drinkers to recognize and challenge their roles in reproducing the violence perpetuated on them. Applied thoughtfully, peer-based programs could therefore play a role in challenging structural, symbolic, and everyday violence against illicit drinkers.

Table 8.1. Types of non-beverage alcohol consumed, identified harms of illicit drinking, and current and proposed harm reduction strategies.

<table>
<thead>
<tr>
<th>Key findings</th>
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</thead>
<tbody>
<tr>
<td>Types of non-beverage alcohol consumed and reasons for use (Sections 8.1.1 and 8.1.2)</td>
<td>• Mouthwash and rubbing alcohol most common types of non-beverage alcohol consumed</td>
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<tr>
<td></td>
<td>• Affordability and accessibility spur use, although non-beverage alcohol is accessible and affordable only in comparison to beverage alcohol</td>
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</tbody>
</table>
### Key findings

| Harms from illicit drinking (Section 8.1.3) | • *Accidents* – from “bruises and bumps” to “bleeding to death”; participants were particularly concerned about choking  
• *Violence, theft, and being taken advantage of* – these dangers are exacerbated by drinking outside  
• *Harms to physical health* – Participants recognized negative effects of illicit drinking on the liver, but had many questions about other physical effects  
• *Harms to mental health* – Particularly depression, isolation, and trauma; illicit drinkers were seen at particular risk of suicide  
• *Withdrawal* – Seizures, delirium tremens, and shakiness were all mentioned as specific harms participants faced from alcohol withdrawal  
• *Reduced access to services* – Participants reported being turned away from health care services when intoxicated  
• *Interactions with police* – Drinkers are criminalized by having alcohol poured out, being given tickets, and being taken into police custody |
|----------------------------------------|--------------------------------------------------------------------------------------------------|
| Current harm reduction strategies (Section 8.1.4) | • *Drinking in groups vs. drinking alone* – This is a balancing act between the risks of being alone and the risks of groups; those without secure housing are more likely to choose groups  
• *Ensuring one has enough alcohol* – Sharing with others and pooling money are common strategies to ensure access to alcohol, especially in case of withdrawal  
• *Limiting the amount or pace of alcohol consumption* – Strategies illicit drinkers use to reduce the amount they drink include purchasing smaller volumes, drinking with friends who drink less, and mixing alcohol with non-alcoholic beverages  
• *Food and water* – Ideally, illicit drinkers would consume enough of both, but they admitted limiting food in particular in order to increase intoxication  
• *Looking after other illicit drinkers* – Particularly taking overly intoxicated people somewhere safe  
• *Pharmaceutical management of withdrawal symptoms* – Some participants mentioned using physician-prescribed or street-purchased pharmaceuticals when experiencing withdrawal |
## Key findings

<table>
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<tr>
<th>Proposed harm reduction strategies (Section 8.1.5)</th>
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<tbody>
<tr>
<td>• <strong>Safe space</strong> – A place where illicit drinkers would be protected from victimization and criminalization</td>
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<tr>
<td>• <strong>Managed alcohol program</strong> – Specifically a non-residential managed alcohol program with strong connections to other services such as detox and housing</td>
<td></td>
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<tr>
<td>• <strong>Peer-based services</strong> – Programs, particularly managed alcohol programs, in which illicit drinker decision makers were seen as more likely to meet illicit drinkers’ needs</td>
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<tr>
<td>• <strong>Education</strong> – Of illicit drinkers by illicit drinkers, of health professionals by illicit drinkers, and of illicit drinkers by topic experts (e.g. toxicologists)</td>
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9. Conclusion

In this program of research, I have worked with drug users and illicit drinkers to investigate their health and harm reduction needs and to situate the results within an analysis of the political, economic, and social structures that influence these needs. In this chapter, I will discuss the unique contributions of this research to the academic literature and address its limitations. I will also describe the strengths of my research by revisiting the validity criteria introduced in Chapter 2, detail actions that have been taken as result of my findings, make suggestions for practice, and suggest directions for future research in this area.

9.1 Unique contribution

My research provides unique methodological and substantive contributions to the academic literature. Methodologically, it is distinct in the use of substance users as facilitators in a qualitative needs assessment; I hope that my success with this technique will inspire further work of this type. As well, the use of a memorandum of understanding in place of a traditional consent form is a step forward in fostering ethical research practice with substance users. Substantively, research about Canadian substance users' needs and priorities has to date focused on urban areas, and the collection of data from smaller communities in British Columbia therefore can provide important information for planning services. My analysis of the values underlying the priorities of the provincial needs assessment can be used to tailor and market services to appeal to substance users and provides context to mine and others' analyses of their needs and priorities. My most important contribution, however, is my identification of the opportunity to engage illicit drinkers using approaches pioneered by drug users. To my knowledge, this is the only peer-based research that has been conducted with illicit drinkers, and the results of this work fill an important gap about a highly marginalized and underserved group.

9.2 Limitations

Several limitations to this research should be noted. Specific demographic information about participants is generally not available. Some of this was by design for practical reasons: partnering organizations felt that formal collection of this data would be unacceptable to participants (especially illicit drinkers) and would hinder their full participation.
Unfortunately, a flood at the VANDU office destroyed what demographic information was available for most of the provincial drug user needs assessment. The purpose of demographic information in this research, however, is to provide context to participants’ comments (e.g. knowing a significant fraction of participants are Aboriginal suggests that attention must be paid to the history of indigenous substance use, colonialism, and criminalization of indigenous peoples), instead of being to prove generalizability. Moreover, the purpose of critical ethnographic research is to uncover knowledge in local contexts; my results are generalizable only inasmuch as they uncover specific instances of more general power imbalances and oppression (Jordan and Yeomans 1995; Willis 2007). With this in mind, an exact count of demographic variables is less important than an overall sense of the composition of the meetings.

Some might see the use of peer and staff member facilitators as a weakness of this research. It is true that they approached meetings differently from how many academics would. Specifically, they actively worked to promote a sense of empowerment of participants rather than simply collecting information and also occasionally asked more closed-ended questions than I would have liked. This no doubt shaped the research results differently from if I had facilitated the meetings, however, I believe it also contributed to an atmosphere of trust and a depth of information beyond what I would have obtained.

Aside from the four focus groups conducted with illicit drinkers, most of the data collection in this research took place in groups of up to (and occasionally beyond) 30 participants. This differs from the format most commonly seen in academia, of groups of 6-10 individuals (often grouped by gender, age, or ethnicity), which is itself a legacy of market research techniques (Morgan 1996). Departing from tradition is not itself a limitation, when done with intention: the intention here was to support the participation of many people, including more marginalized individuals who might not participate if there was more competition for spaces. There were drawbacks to the large group format, however.

Large groups have been suggested to be most appropriate for topics about which participants do not feel strongly and are therefore each likely to have fewer comments (Morgan 1996). Given that the workshops and town hall meetings concerned topics that were in some cases literally matters of life or death, that is unlikely to be the level of interest our participants
held. Often a smaller number of participants conducted much of the discussion, while others took more of a watchful role. The facilitators felt that people who did not speak often still benefited from hearing what others shared, but this is still not ideal for the purposes of data collection. Larger groups might also hinder expression of unpopular or sensitive ideas, despite a request from facilitators that any information shared at the meetings be treated as confidential. Perhaps related to group size, the most vocal participants were often men; I did attempt to ameliorate this in the illicit drinkers’ meeting series by conducting a women's-only focus group. Overall, the larger meetings came with drawbacks but also had significant strengths. Where smaller meetings did occur (in smaller communities in the provincial drug users’ needs assessment and the illicit drinkers' steering committee), these provided an opportunity for the facilitators to probe more intensively on participants' responses than could be achieved in the larger groups.

The workshops of the provincial drug users’ needs assessment were only two hours in duration. Ideally, a longer meeting or repeated meetings might have encouraged a greater depth of discussion. I attempted to remedy this somewhat with the illicit drinkers’ meeting series, in which participants were encouraged to attend multiple meetings (and some attended all or almost all). Even in the one-off workshops, however, a surprising depth and breadth of topics was covered, and facilitators were able to tailor questions to explore topics in more depth that were of interest from previous meetings.

Finally, the participants in this research were not a random sample of substance users. The networks used to recruit, particularly those of facilitators and social service organizations, influenced who attended. People who depend on social service agencies for survival often become entangled in organizational politics, and therefore previous experiences with an agency affect whether a person will attend an event with which they are affiliated. We did our best to make the workshops and meetings as low barrier as possible and therefore open to a broad range of participants (including those often excluded from research), however, by providing honouraria to support participation, not requiring sign-up or consent in advance, and holding meetings in locations accessible and familiar to substance users.

9.3 Strengths and actions taken

Despite these limitations, this program of research also has significant strengths. These can
be highlighted by revisiting the validity criteria introduced in Section 2.1: (1) triangulation of methods, (2) construct validity, (3) face validity, and (4) catalytic validity (Lather 1986). Triangulation was achieved by collecting data in a variety of settings (workshops, town hall meetings, steering committee meetings, and focus groups) and from different groups of participants (drug users, illicit drinkers, and facilitators (some of whom were substance users and some of whom were non-using paid staff)). The similarities and differences in the themes identified between drug user and illicit drinkers, in particular, contributed in a major way to a key message of this research, that the harms faced and potential strategies proposed by illicit drinkers are related more closely to their positioning as marginalized substance users than they are specific to non-beverage alcohol. Construct validity, which requires foregrounding the lived experiences of participants even while applying theory, was a particular strength of the peer-based facilitation approach. This allowed me to step back from my own interests as a researcher and follow the leadership of substance users. The identification of illicit drinking as a priority during the provincial drug user needs assessment is a strong example of this in action, as it surprised me when raised by participants yet fit well within my theoretical constructs. Face validity was supported by member-checking with both drug users and illicit drinkers; their enthusiasm for the research results contributes to my belief that this construct was well achieved.

Finally, catalytic validity is assessed by the extent to which the research promotes action. This is a particular strength of my program of research. After presentation of the results of the provincial drug users' needs assessment to policy makers at regional health authorities, several actions were taken at the local and provincial level. Harm reduction services program implementation was reviewed by health authorities to better support the use of evidence-based practice. Funding was made available to support drug users' peer-based initiatives in each health authority, and representatives of the BCYADWS were invited to participate in provincial harm reduction planning on an ongoing basis. Substance user participation in planning provincial harm reduction services has proved so successful that a funded study is underway to develop best practice recommendations that can be used by other agencies.

Since the research on illicit drinking in the Downtown Eastside was conducted, illicit drinkers have continued to meet on a weekly basis at VANDU. Now called EIDGE (Eastside Illicit Drinkers' Group for Education), the group has been active in education, activism, and
EIDGE also runs an informal beverage alcohol buying program (in which inexpensive beverage alcohol is purchased in volume and sold at cost to those who would otherwise drink non-beverage alcohol) and collaborates with a new "drinkers' lounge" hosted by another local non-profit. They have also been actively looking for funding to open a non-residential managed alcohol program.

9.4 Recommendations for practice

The research in this dissertation suggests a number of recommendations for changes in practice by those working with drug users and illicit drinkers. While most applicable to the local contexts in which the research was conducted, those working in other jurisdictions may also find elements of these recommendations valuable.

The seven priorities suggested from the provincial drug users’ needs assessment – improve interactions with health professionals, promote access to a range of housing options, improve treatment by police, ensure harm reduction best practices are followed everywhere, improve social assistance, support drug users’ organizations, and engage new and existing allies – require large scale changes. While keeping the broader goals in mind, it is useful to develop focused and more immediately implementable suggestions. The values underlying these priorities suggest a number of achievable initiatives to promote collective action and accountability.

Organizations and institutions serving drug users can support the value of collective action by providing practical and financial support to drug users' organizations. Among their many benefits, these organizations can facilitate drug users to support one another and learn from each other; enable them to take action to promote their and their community members’ health and well-being; encourage the formation of new alliances by projecting a positive image of
drug users; and provide a resource to those wishing to consult about issues of importance to drug users. Drug users’ organizations and the types of supports they need will take different forms depending on the community, the size of the drug user population, and the availability of partnering agencies; key features for all, however, would include drug user leadership with a supporting role played by allies.

The value of accountability can be served by involving drug users in providing feedback to those institutions identified as problematic in the provincial needs assessment priorities: organizations providing health care, housing, policing, social assistance, and harm reduction services. To be successful, drug users must have real power to make changes in these institutions; in exchange, the institutions in question will be able to provide services that more directly meet their clients’ needs. Drug users’ organizations can help to avoid tokenism in feedback by supporting the selection of representatives and facilitating broad consultation, as long as this type of contribution is supported practically and financially. It is essential that any institutions involving drug users in providing feedback attend adequately to the many barriers they face to participating, by (for example) providing stipends, attempting to limit the use of jargon and other practices that make outsiders feel unwelcome, and scheduling meetings for places and times that are convenient to drug user participants. The guidelines for best practices in drug user involvement that are in development by the BC Harm Reduction Strategies and Services Committee (see section 9.3 above) may be useful to other institutions and agencies desiring deeper consultation with the drug users who use their services.

In health care, drug users’ health can be promoted by building on and expanding services that participants identified as working for them, such as street outreach nursing teams and Aboriginal-specific health services. Drug users and their organizations should be involved in designing and delivering education to health care workers in order to combat discrimination. Efforts should also be made to support the leadership of health care providers who promote social justice for drug users, potentially through connecting them in a community of practice and offering educational opportunities. Similarly, education for police officers and support for change from within police organizations can be promoted while keeping in mind the need for legalization and regulation of currently illicit substances. The number of supportive housing facilities should be increased, with particular attention to ensuring a variety of low-
barrier and recovery options to support clients with different needs. As described above, a review of harm reduction service delivery was conducted in British Columbia to promote it being conducted in accordance with best practices; a longer term goal to support this priority involves creating educational and evaluatory systems to ensure services keep with changes in policy and best practice.

The research with illicit drinkers identified a number of strengths, such as an ethos of caring and the knowledge of experienced drinkers, which should be built on in any programs meant to support this community. This principle can inform the creation of several types of educational programs: for illicit drinkers, by experts; for service providers, by illicit drinkers; and for illicit drinkers, by illicit drinkers. Additionally, the principle of building on strengths is important to piloting and evaluating a peer-based non-residential managed alcohol program, as suggested by participants. Illicit drinkers should be meaningfully involved in planning, operating, and evaluating this program.

9.5 Future research

Several avenues of further research are suggested by my work. On a practical level, piloting and evaluating a non-residential managed alcohol program would build on the findings of the illicit drinkers meeting series. Quantitative research on illicit drinkers' numbers and drinking habits would provide important data for planning services. More theoretically, my research points to a need for further investigation of substance users' support for and critiques of harm reduction services, particularly how these services align with the values of freedom from surveillance and collective action. Finally, additional research with illicit drinkers that uses gender-based and indigenous theoretical frameworks would complement my work by deepening our understanding of how the harms illicit drinkers face intersect with oppression based on gender and indigeneity.

My research aimed to use community-based methods to investigate the promotion of health and harm reduction among people who use illicit drugs and non-beverage alcohol. I found that drug users in British Columbia identified clear priorities to improve their well-being: improving interactions with health professionals, promoting access to a range of housing options, improving treatment by police, ensuring harm reduction best practices are followed everywhere, improving social assistance, supporting drug users' organizations, and engaging
new and existing allies. These were based on the values of collectivity, activity, freedom from surveillance, and accountability. I also identified a need and opportunity for drug users to collaborate with illicit drinkers based on shared priorities, values, and polysubstance use. From there, I investigated illicit drinkers' perceptions of harms and harm reduction related to non-beverage alcohol, and found the harms they experience, and some of the strategies they suggest (particularly safe spaces and managed alcohol programs) can usefully be interpreted as examples of structural, everyday, and symbolic violence. This work has led to several positive outcomes for drug users and illicit drinkers, including the formation of an activist group for illicit drinkers. It is my hope that it will also provide information to service providers and policy makers working to meet these communities' needs and support additional research to improve the lives of drug users and illicit drinkers.
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Appendix A – Drug users' provincial needs assessment agenda

1. Introductions
2. BCYADWS History and Description
3. Community Needs Assessment – Health Services
   - What do you need to be healthy in your community?
   - How is access to health and harm reduction services in your community?
   - What are the barriers to access?
   - What is working well and could be built on?
   - What isn’t working and needs to change?
4. Community Organizing
   - How can you respond to your identified community needs and struggles?
   - What action and strategies can you take in your community?
   - What does drug user organizing look like in your community?
5. Moment of Silence
## Appendix B – Agenda for illicit drinkers' meeting series

<table>
<thead>
<tr>
<th>Date</th>
<th>Meeting type and number</th>
<th>Potential discussion topics</th>
</tr>
</thead>
</table>
| Month 1  | 3 steering committee meetings | • Discuss defining illicit drinking and group membership  

  • Recruit and orientate drinkers to SC  

  • Plan for initial meetings  

  • Practice facilitation skills and roles |
| Month 2  | 3 large group meetings | • What are people consuming and how/where are they consuming it?  

  • What are the harms people are experiencing?  

  • What strategies are people already using to reduce these harms? |
| Month 3  | 3 large group meetings  

  1 steering committee meeting | • History of alcohol harm reduction in Downtown Eastside and elsewhere (rice wine, managed alcohol, etc)  

  • What does harm reduction mean to this group? |
| Month 4  | 3 large group meetings | • What are the barriers to alcohol harm reduction?  

  • What else is needed to live healthy lives as illicit drinkers? |
| Month 5  | 2 large group meetings  

  1 steering committee meeting | • What are the group’s priorities for alcohol harm reduction?  

  • Who needs to hear about these priorities and how should they be told? |
| Month 8  | Focus groups | • Further investigation of study questions, particularly as they relate to certain populations (e.g. women, youth, Aboriginals). |
Appendix C – Illicit alcohol focus group question guide

1. What are you consuming on a typical day (illicit alcohol, licit alcohol, and illicit drugs)?

2. How and where are you consuming alcohol?
   a. With others or alone?
   b. In public or inside somewhere?
   c. Any differences in these patterns when drinking licit versus illicit alcohol?

3. Where are you buying alcohol?
   a. Barriers to accessing it?
   b. Sources of money for buying it?
   c. Pooling money?

4. Why are you buying illicit alcohol?

5. What are the harms people experience from alcohol?
   a. Health effects
   b. Withdrawal symptoms
   c. Violence and victimization
   d. Shame and stigma
   e. Other

6. Are there any harms specifically from illicit alcohol?

7. What strategies are you already using to reduce these harms?
   a. Health effects
   b. Withdrawal symptoms
   c. Violence and victimization
   d. Shame and stigma
   e. Other

8. What else could be done to reduce these harms?

9. [Certain focus groups only] Are there any harms that are specific to [women, Aboriginal people, youth]? Are there any strategies for reducing the harms from alcohol that would work best for this [women, Aboriginal people, youth]?

10. What are the barriers to reducing harms from alcohol?

11. The illicit alcohol users' group at VANDU has talked a lot about the possibility of an alcohol maintenance program. This is a program where people are given regular alcohol so that they don’t have to drink illicit alcohol.
   a. Do you think a program like this would reduce harms from consuming alcohol? Why or why not?
   b. Would you use such a program? Why or why not?
   c. What would you want such a program to look like?
Appendix D – Illicit drinkers meeting series: steering committee

Memorandum of Understanding

[NB: the questions are the ones I brought to the steering committee and the bullet point underneath each summarize their responses]

What is the purpose of this project?
• to learn about what drinkers need
• to educate each other
• to develop leadership among drinkers
• to make drinkers realize that they’re not alone

What do each of us want to get out of this project?
• to learn new things
• to reduce discrimination against drinkers
• to have a group that drinkers can belong to
• to use what we learn to push for changes for drinkers (e.g. harm reduction)

What do we think are the risks of this project and what will we do about them?
• people being angry with facilitators (e.g. because they don't let nondrinkers in)
• research could be used in ways we don't like
• maybe nothing will change
• these risks are worth taking; we will stand together/back each other up to avoid the first and we will do activism to avoid the last two happening

How should we decide what gets written about the project? What if we disagree about the findings?
• Alexis will bring findings to steering committee
• they will help present to the whole group
• if Alexis and the rest of the steering committee disagree, we will ask the whole group to decide what to do

How should members of the steering committee be described in (a) notes, (b) presentations, (c) papers, and (d) community reports?
• everyone is proud to be identified by name
• in academic papers, Alexis might use first names or false names

You can contact Alexis Crabtree at [phone number] with questions about the project. You can also contact her supervisor, Dr. Jane Buxton, at [phone number].

You may want to know more about your rights in a research project. You can find out more by calling the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598. You can also contact this number if you have any concerns about your treatment in this research project.
Principal Investigator:
Dr. Jane Buxton
Physician Epidemiologist, BC Centre for Disease Control
Associate Professor, School of Population & Public Health, University of British Columbia
Vancouver, BC Canada
Telephone: [phone number]
Email: [email address]

By signing below, I indicate that I understand and agree with what is written above.

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