

**INDIVIDUAL AGENCY UNDER SYSTEMIC CONSTRAINTS: DYNAMICS OF  
HEALTH AND SOCIAL SERVICE ACCESS AMONG PEOPLE WHO USE DRUGS  
RECEIVING INCOME ASSISTANCE**

by

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Individual agency under systemic constraints: Dynamics of health and social service access among people who use drugs receiving income assistance

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## **Abstract**

Prior research shows that people who use drugs and receive income assistance experience unique difficulties accessing and engaging with health and social services, contributing to unmet population health needs. While these findings are important, a deeper understanding of the factors shaping barriers is necessary so that effective strategies to facilitate access can be implemented. Drawing on 121 interviews conducted in a Canadian inner-city, this study analyzes the health and social service experiences of people who use drugs and receive income assistance during the ongoing opioid overdose crisis. Through an application of Coleman's framework for linking macro social outcomes and micro-level behaviour, this research examines the institutional, operational and interactional dynamics impacting client experiences with service access. The findings show that institutional frameworks influence the decisions and actions of individuals when engaging with providers by structuring and constraining their available choices. Operational challenges and stigmatization during encounters with providers leads to disengagement, which limits the utilization and positive effects of services. Despite these obstacles, individuals exercise agency in navigating, adapting to and pushing back against these constraints in order to meet their service needs. Efforts to reform social policies and service delivery must be informed by a patient-focused perspective that considers the inter-related institutional, operational and interactional dimensions of this complex service landscape.

## **Lay Summary**

People who use drugs living in poverty often rely on a variety of health and social services in order to meet their needs. Although previous research has identified barriers that prevent service access among marginalized communities, limited work has explored the specific experiences of people who use drugs on income assistance. We draw on 75 interviews with people who use drugs receiving income assistance in Vancouver, Canada to explore experiences accessing health and social services. We found that individuals face systemic challenges in meeting their needs. The design of income assistance required participants to engage with doctors to prove eligibility, which created access barriers for some participants and subjected them to medical surveillance. Long wait times limited access to services— particularly supervised consumption sites. Stigma was common during interactions with providers and had negative health consequences. However, we also found that participants developed strategies to optimize service outcomes.

## **Preface**

This thesis draws on research conducted at the British Columbia Centre on Substance Use and the University of British Columbia by Dr. Lindsey Richardson, Principal Investigator of *The impact of Alternative Social Assistance disbursement on drug-related harm: a randomized controlled trial*, (TASA Study).

Ryan Jamula was responsible for conceptualizing the current study, analyzing data for the current study, and writing the manuscript.

The TASA Study obtained ethical approval from the Research Ethics Board at the University of British Columbia / Providence Health Care Research Institute, H14-02401.

TASA is a registered clinical trial at [ClinicalTrials.gov NCT-0245-7949](https://clinicaltrials.gov/ct2/show/study/NCT02457949).

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## List of Abbreviations

MMT            Methadone Maintenance Treatment

TASA:        The impact on Alternative Social Assistance Disbursement on drug-related harm  
(or “Cheque Day Study”)

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## **Chapter 1: Introduction**

In the context of a national opioid crisis coinciding with rising social inequality (Breau, 2015; MacDonald, 2018; Belzak & Halverson, 2018), people who use drugs receiving income assistance face significant challenges in meeting their health and material needs. Cash transfer income assistance supports are intended to protect against the harms of poverty. However, inadequate means-tested benefit levels keep many Canadians entrenched in poverty and experiencing material deprivation (Shahidi et al., 2019; Vozoris & Tarasuk, 2004). Food insecurity, housing precarity and poor health outcomes are common among income assistance recipients (Kerr et al., 2005; Gurstein & Vilches, 2010) — adversities which can be further exacerbated by criminalized substance use. Consequently, many people receiving assistance rely on an inadequate patchwork of social supports and services like food banks, shelters and meal programs to supplement their income and survive on government payments (Holmes et al., 2018; Tarasuk et al., 2014; Williamson et al., 2006). Concurrently, people who use drugs must also contend with a dangerous illicit drug supply that heightens risks for overdose and the need for medical and harm reduction services (Beletsky & Davis, 2017). During an epidemic which has disproportionately impacted structurally marginalized populations (van Draanen et al., 2020; Belzak & Halverson, 2018), understanding how individuals at the intersection of substance use and income assistance experience social and health-related services is crucial to develop more effective policy responses, social supports, and service provision.

Poverty in Canada is spatially concentrated, with many recipients of income assistance living in high-density urban spaces (Hajnal, 1995). These inner-city communities are often characterized by high rates of chronic and infectious diseases like hepatitis C and HIV, exposure

to violence, and high rates of illicit substance use (Wood et al. 2007; Shannon et al. 2005; Tyndall et al., 2006). Due to significant shelter costs and an insufficient supply of social housing, substandard shelter conditions may cause or worsen health conditions (Gurstein & Vilches, 2010). Given these barriers, structurally disadvantaged neighbourhoods are often portrayed through a deficit lens and stigmatized as being undesirable and dangerous (Ivsins et al., 2019; August, 2014). However, some scholars have challenged monolithic characterizations of inner-city neighborhoods by showing how locations commonly associated with marginalization can benefit residents through the formation of networks, social ties and close proximity to services (August, 2014; Ivsins et al., 2019). These services, which include traditional medical institutions like hospitals and clinics, as well as community-based programs such as drug treatment centres, harm reduction services, food banks, and shelters, are essential to the well-being of low-income individuals who use drugs. As health is deeply connected to place (Cummins et al., 2007), considering the environments where people live and interact with services is necessary to understand the dynamics of health and social service access.

While the social safety net is intended to protect against poverty-related harms, income assistance payments in Canada have long been identified as an inadequate policy response to alleviate economic marginalization (Shahidi et al., 2019; Lightman et al., 2009). Though making ends meet while receiving income assistance is challenging for most, people who use illicit drugs face the additional financial pressure of sustaining their substance use. Current income assistance rates are insufficient to support a living and regular drug consumption, thus people who use drugs often engage in prohibited income generating activities in order to supplement personal finances (Richardson et al., 2015; DeBeck et al., 2007). Activities such as binning, sex work, and drug dealing can generate greater earnings than social assistance; however, they also carry risk of

additional harms such as arrest, incarceration, violence, and the creation of additional barriers to accessing services or health treatments (Richardson et al., 2015; DeBeck et al., 2007). Evidence suggests that individuals may refrain from prohibited activities if the additional income generated was unnecessary to support substance use (DeBeck et al., 2007). Thus, the choice to engage in illicit income generation is often a decision made under financial duress, highlighting the inadequacy of income assistance in ameliorating economic marginalization.

In a system characterized by low benefit levels and strict eligibility criteria, individuals collecting income assistance must navigate bureaucratic application processes and ongoing medicalized surveillance (Kneebone & White, 2009; Pulkingham & Fuller, 2012). Individuals receiving assistance in British Columbia are classified into three categories based on their ability to work: employable, Persons with Persistent Multiple Barriers (PPMB), or Persons with Disability (PWD). Of relevance to the time frame of the current study, in 2015, total monthly support was \$610 for employable assistance, \$657.92 for PPMB, and \$906.42 for PWD. In 2017, rates were raised by \$100 in the lower employable and PPMB categories, and by \$227 for recipients receiving PWD. Despite these increases, rates remained well below the Canadian standard low income cut-off poverty measure which (as of 2017) was \$1750 per month for a single individual in a large city (Statistics Canada, 2021). Receiving disability assistance requires the completion of a “Persons with Disabilities Designation Application” involving medical (completed by a doctor or nurse practitioner) and assessor (completed by any prescribed professional, e.g., registered nurse, social worker, occupational therapist, etc. ) reports (Government of BC, 2021). Successful navigation and interaction with health professionals is not only necessary for medical care, but also to potentially access financial resources, an additional layer to patient-provider interactions unique to the circumstances of income assistance recipients.

The income assistance payment schedule also has important implications for the relationship between substance use and access to social and health-related services. Scholars have observed an increase in substance use and overdose rates following synchronized monthly government cheque payments (Rosen, 2011; Verheul et al., 1997; Richardson et al., 2021a). This ‘cheque day’ phenomenon affects a range of service providers each month: supervised drug consumption sites become overwhelmed with high demand, and paramedic services receive an increase in calls to overdose emergencies (Zlotorzynska et al., 2014; Richardson et al., 2016.) While services directly addressing the increase in drug consumption experience a surge in demand, community meal programs experience decreased demand leading them to close front line services to deal with other operational concerns such as staff meetings and trainings. The cheque day phenomenon illustrates how the institutional design of cheque disbursement impacts individual and community-level dynamics, which has operational consequences for service provision and individual access.

While demand for social and health-related services are high among marginalized populations, operational and interactional challenges may impede accessibility. Long wait times, hours of operation and transportation concerns have been identified as accessibility barriers among marginalized populations in urban Canadian contexts (Williamson et al., 2006; Socias et al., 2016; Small et al., 2011). Additionally, both substance use and poverty contribute to stigmatization during patient-provider interactions, which can negatively impact healthcare outcomes and impede service utilization (Neale et al., 2008; Van Boekel et al., 2013; Reutter et al., 2009). Stigma has been shown to contribute to poorer treatment in health care settings and challenges accessing pain medication (Neale et al., 2008; Van Boekel et al., 2013; Goodman et al., 2017). These operational and interactional challenges impede accessibility, leading to

inequities in care and service utilization. As unmet service needs are an indicator of material insecurity and structural deprivation, and have been associated with increased exposure to violence for people who use drugs (van Draanen et al., 2021), these barriers warrant further exploration. However, addressing interactional and operational challenges may require a systemic approach. As Friedman et al (2021) describe in their conceptualization of stigma as a “multilevel system,” challenges are often rooted in macro institutional and political forces, dynamics which are neglected by solely individual-level analyses. Individual and operational issues must be placed in context with the broader social structure, otherwise policy responses may neglect the root causes of the issues they intend to address.

Environmental factors, social policies and institutional structures undoubtedly impact the experiences individuals have with social and health-related services. However, acknowledging the role of agency is imperative as individuals are not passive recipients of their environment. As agentic actors, people navigate, adapt to and contest complex structures, institutional constraints, and social interactions (Rütten & Gelius, 2011; Abel & Frohlich, 2012). An analysis of social and health-related service experiences should not focus singularly on either structure or individual agency, but rather the relational dynamics of both. While individual choices are often constrained by social structures, individuals exercise agency in navigating and responding to these constraints. Abel & Frohlich (2012) argue that agency can be “structurally transformative,” providing the example of how the lobbying efforts of disadvantaged women achieved structural change. Thus, while systemic constraints shape the experiences of individuals, the exertion of individual agency in response to these constraints has the potential to effect the social structure.

While previous research has identified important challenges in accessing social and health-related services among marginalized populations, there are critical gaps. First, limited

research on service access has focused on the experiences of individuals who occupy the specific social location of being a person who uses illicit drugs and receives income assistance. This intersection imposes specific constraints, shaping the contexts and individual circumstances in which people engage with, experience, and perceive services. Thus, the aim of this study is not to simply identify and list existing challenges; rather, the objective is to detail the dynamics that both constrain and enable effective service experiences and patient-provider interactions.

Drawing on qualitative interviews conducted among people who use illicit drugs and also receive income assistance, this study explores the following research question: how do people who use drugs and receive income assistance experience social and health-related services in the city? Through an application of Coleman's analytic frame that links micro-level behaviour to macro-level social structures and population-level outcomes (i.e. Coleman's "boat"; Coleman, 1987), this study examines the institutional, operational and interactional factors that impact experiences with social and health-related services. The study considers how individual action, shaped by system-level contexts, shapes broader social outcomes. This study also draws on social theories of medicalization, stigma, and cultural health capital to comprehend the different processes occurring at and between macro and micro levels of analyses. An increased understanding of the relational linkages between macro and micro-level processes can inform social policy and service implementation by revealing structural problems and by understanding how individuals are both affected by and shape these structures through strategic and behavioural adaptations. In the midst of the ongoing opioid crisis, understanding how individuals experience social and health-related services is essential in order to address system-level gaps and improve population health and social welfare.

## Chapter 2: Literature Review

Despite Canada's universal publicly funded medical care system, socioeconomically marginalized people who use drugs experience high levels of unmet social and health-related service needs (Ross et al., 2015; Hyshka et al., 2017). Infectious and chronic disease are common co-morbidities of injection drug use, and management of health conditions are often complicated by the conditions of living in poverty (Shannon et al., 2005). For example, research has indicated that the material conditions and chaotic life circumstances of living in poverty contribute to suboptimal HIV treatment adherence (Kalichman & Kalichman, 2016). Given the serious burden of disease related to substance use disorder (Vigo et al., 2020), the degree of unmet health need is an alarming premise for the well-being of people who use drugs living in poverty. Failing to address these unmet health needs will exacerbate population health disparities and contribute to worsening conditions — outcomes which could be prevented through sufficient access to social and health services.

Research in urban settings has identified that Canadians living in poverty rely on a range of medical and community services to meet their health needs, but often experience access barriers (Williamson et al., 2006; Loignon et al., 2015). The intersection between poverty and substance use has been shown to compound these challenges. For instance, homeless people experience significant unmet needs for medical care, an issue which is exacerbated for people who additionally use illicit substances (Hwang et al. 2010; Palepu et al. 2013; Khandor et al., 2011). Barriers preventing access to care among people who use drugs include the burden of appointments, access to transportation, long wait times, and experiences or anticipation of poor treatment and stigmatizing interactions (Neale et al., 2008; Small et al., 2011; Ross et al., 2015;

Loignon et al., 2015; McNeil et al., 2014). For housing insecure individuals, the inability to provide a residential address can also hinder access to primary care (Ross et al., 2015).

Additionally, people may avoid services that are not covered by provincial health plans such as dentist and optometry due to financial constraints (Williamson et al., 2006). These barriers shed light on inequities in access to critical services, but should be considered in conversation with the specific structural context of the income assistance system.

The relationship between access to health services and marginalization becomes more nuanced when considering the role of institutional and social supports in mitigating health inequities. Importantly, recipients of income assistance in Canada have access to supplementary benefits including public coverage for dental, eye care, prescription medication and opioid agonist therapy. These institutional supports may intervene and complicate direct associations between marginalization and access to health services. For example, in a study among people who inject drugs in Vancouver, Jaffe et al (2021) found positive associations between receipt of income assistance and access to adequate dental care. However, negative associations remained between adequate dental care and indicators of structural marginalization, specifically street-based income generation and homelessness (Jaffe et al., 2021). Thus, through ancillary benefits, the income assistance system enables access to health services which recipients would otherwise likely be unable to afford. The provision of dental benefits is one mechanism through which institutional environments can positively influence the ability of individuals to engage with services.

## **2.1 Medicalized Social Policy and Physician Gatekeeping**

Medicalization (Conrad, 1992) is a useful lens to understand the institutional imbrication between the health and social welfare system, and its implication for engagement in health services for income assistance recipients. Researchers have argued that social policy trends represent a medicalization of government responses to poverty, as social support provision has become increasingly tied to recipient health status (Pulkingham and Fuller, 2012; Hansen et al., 2013; Holmqvist, 2009). Consequently, eligibility for social support is often dependent on physician diagnoses, and recipients are categorized based on whether they have health barriers preventing employment. This extends the role of the health professional beyond the provision of medical care and attributes the deservingness of financial assistance to the recipient's health status (Hansen et al., 2013; Holmqvist, 2009). In British Columbia, income assistance is categorized into three groups: Expected to Work (ETW) or basic assistance, Persons with Persistent and Multiple Barriers (PPMB), and Persons with Disability (PWD). Collecting the more generous rates of PPMB or PWD requires submitting medical documentation and ongoing assessments of eligibility completed by health professionals. By framing the issue at the individual level of health diagnosis, medicalization shifts focus away from identifying poverty as a social problem towards a view of personal deficit and subjects individuals to greater levels of scrutiny and surveillance (Waitzkin, 1989; Pulkingham and Fuller, 2012). In the context of people who use drugs collecting income assistance, physicians hold a gatekeeping position to legitimate the need for disability support payments through diagnosis. This medicalization of social assistance adds an additional layer to complex dynamics already at play in patient-provider interactions. Although the medicalization process can benefit individuals by providing access to treatment options and increased financial supports for those with diagnosed conditions,

medical labels may result in discrimination, stigmatization, and increased surveillance (Conrad, 1992; Brown, 1995; Campbell, 2012). Further, the medicalization of social supports risks excluding individuals who do not meet the established medical eligibility criteria (Pulkingham & Fuller, 2012). Placing medicalization in conversation with stigmatization and cultural health capital reveals further implications for people who use drugs receiving income assistance and the relationship between macro systems and individual behaviour.

## **2.2 A Stigmatized Intersection: Poverty and Drug use**

The structural position of people who use drugs receiving income assistance presents risks of experiencing multiple and intersecting forms of stigma, which can have repercussions related to accessing services. Research has identified that recipients of means-tested benefits are often blamed for their poverty, perceived as ‘lazy’, or seen as cheating the system for money (Stuber and Schlesinger, 2006; Reutter et al., 2009). Additionally, negative characterizations of people who use drugs impose dehumanizing labels like “addict” and “junkie” (Conner & Rosen, 2008). When individuals become attributed to stigmatizing labels in institutional settings, this may trigger the application of negative stereotypes by medical personnel, particularly towards those with marginalized social identities (Link & Phelan, 2001), with potentially significant impacts on their experience and quality of care.

Indeed, in a systematic review examining substance use stigma among health providers, Van Boekel et al (2013) find that healthcare professionals generally held negative attitudes towards patients who used drugs, including perceiving people who use drugs as emotionally challenging and fearing violent encounters. A California based study identified that health providers often viewed patients who use drugs as a waste of scarce time and resources (Chang et

al., 2016). However, it is important to note that attitudes may vary based on specialization, as some studies showed effective training may mitigate the perpetuation of stigma (Van Boekel et al., 2013).

In order to avoid discrimination, individuals may conceal their substance use from others, engaging in what Goffman (1959) described as “impression management.” Research has identified that people who use drugs report mistreatment and face difficulties accessing pain medication (Neale et al., 2008; Carusone et al., 2019). This can lead to delays in accessing care or leaving hospital against medical advice, allowing conditions or illness to remain untreated and potentially worsen (Anis et al., 2002; McNeil et al., 2014; Carusone et al., 2019). Patients who experience stigma discrimination are also less likely to complete treatment, seek care in the future, and be successful in recovery (Carusone et al., 2019; Lloyd, 2013). Given the prevalence of substance use stigma across society and within care-providing institutions, it is unsurprising that there are consequences for people who use illicit drugs in accessing health services. These material effects of stigma produce and exacerbate pre-existing health disadvantage and inequities in care.

Though often apparent during individual patient-provider interactions, it is important to situate stigma within the institutional and organizational contexts in which they emerge. In an Ontario study, Webster et al (2019) find that physicians are challenged by working with patients experiencing substance use disorder, poverty, and mental health issues. Providers may be expected to do work outside of the traditional medical domain, such as navigating patient access to other social supports, which is work that they have not necessarily been trained or given the resources to do effectively (Webster et al., 2019). In the context of the overdose crisis, prescribing pain medication is complicated by care standards that recommend the tapering of

opioids. Physicians may worry about losing their license for overprescribing opioids and are “hamstrung” by lack of supports and alternative treatments (Webster et al., 2019). Challenging work environments, lack of training, and inadequate organizational supports lead to frustrations and may contribute to provider burnout, while hindering the ability to provide effective and compassionate care (Van Boekel et al., 2013; Webster et al., 2019). Stigma in the medical system should not be solely attributed to an individual deficit of health professionals, but must be considered at the institutional level by acknowledging the overarching limitations that characterize the system and impact the structure of care.

Methadone maintenance treatment (MMT) provision provides an example of how institutionally embedded stigma becomes part of the structure of medical care for individuals with substance use disorder. In a review of four studies conducted in Ireland and Northern Ireland, Harris and McElrath (2012) characterize MMT as a form of institutional stigma and social control. Methadone provision often frames individuals as “addicts,” imposing moralizing views around drug abstinence. Patients are usually subjected to ongoing surveillance mechanisms such as supervised daily consumption and urine tests, with consequences for “unclean” samples such as withholding doses of methadone (Harris and McElrath, 2012). This treatment model encourages clients to be passive recipients to methadone maintenance therapy and subjects them to control mechanisms and surveillance, perpetuating the stigmatizing notion that people who use drugs are inherently deviant and require intensive and invasive monitoring.

### **2.3 Navigating Interactions: Cultural Health Capital**

In individual contexts shaped by medicalized identities and structural stigma, the theoretical concept of Cultural Health Capital (CHC) can help us understand how these macro-

level systems are embedded in micro-level patient provider interactions. An extension of Bourdieu's concept of cultural capital, Shim defines CHC as "a specialized form of cultural capital that can be leveraged in health care contexts to effectively engage with medical providers" (Bourdieu, 1986; Shim, 2010, pp.3). Further, Chang et al (2016) claim that CHC is a relational concept that "is valued and exchanged between providers and patients as they interact" (pp. 91). The components of CHC represent a toolkit of skills which help to optimize interactions with providers, examples which include knowledge of medical terms, self-discipline, awareness of interpersonal dynamics and the ability to communicate social privilege (Shim, 2010; Dubbin et al., 2013). Past research has identified that some doctors may give preferential treatment to patients who are able to display indicators of CHC, such as being able to communicate symptoms effectively or demonstrate health knowledge (Dubbin et al., 2013; Chang et al., 2016). Like other resources, health capital is unevenly distributed throughout the population, reflecting the structural disadvantages (i.e. racial, gender and class-based stratification) embedded in medical institutions (Shim, 2010). CHC has been applied to a diversity of health-related contexts and issues including: the healthcare experiences of disadvantaged women in India (Sudhinaraset et al., 2016); health management among prisoners (Novisky, 2018); and immigrant health in Norway (Næss, 2019). While Chang et al (2016) explore the dynamics of substance use stigma in patient-provider interactions, the application of CHC to the dynamics of substance use and marginalization has otherwise been quite limited. Given the ability of CHC to explicate how inequality and inequity emerge in healthcare settings, applying CHC to the context of people who use drugs receiving income assistance may offer important insights.

Cultural health capital provides a useful frame to understand how patients who use drugs navigate the dynamics of a stigmatized and criminalized health behaviour during interactions with providers. While substance use stigma can lead to the devaluation of people who use drugs in health settings, patients (and providers) may actively engage in mitigating these harms (Chang et al., 2016). Patients may utilize strategies such as limiting substance use disclosure, signalling health seeking behaviour, and communicating medical knowledge, to display “good patienthood” and reshape negative perceptions held by providers (Chang et al., 2016; Shim, 2010). Providers can also promote and cultivate CHC in patients by adopting a non-judgemental attitude towards substance use and learning about the structural contexts of their patients (Chang et al., 2016; Dubbin et al., 2013). This is an important finding because it adds nuance to the conversation suggesting that some people who use drugs are able to circumvent challenges related to stigma through their available CHC, while others may struggle. Due to the unequal distribution of capital, CHC signalling by patients who use drugs may intersect with macro-level inequalities like structural racism and socioeconomic marginalization (Shim, 2010). For instance, research has indicated that Indigenous patients who use drugs face both racism and substance use stigma during treatment in patient-provider interactions (Goodman et al., 2017). Although to my knowledge, the links between structural racism, substance use, and cultural health capital have not been explored as an explicit area of research, applying CHC to this context could help better understand how these macro level inequalities impact individual interactions.

Although most applications of the CHC framework have been confined to formal healthcare and clinical encounters, many marginalized communities face exclusion from formal health services and must deploy other resources to meet their health needs. This warrants an expansion of the scope of CHC’s application, to encompass the vast breadth of interactions

related to social and health-related service access which exist outside traditional medical institutions. Madden (2015) extends CHC beyond traditional settings to understand how marginalized communities navigate care in contexts of limited access by mobilizing “Navigational, social, familial and linguistic skills and knowledge... to access doctors and prescription drugs” (Madden, 2015, pp. 1). In their study of Mexican-American border communities in Texas, Madden (2015) finds that low-income, immigrant, and uninsured populations mobilize cultural resources outside of hospitals to get the care they need and argues that these competencies are also a form of CHC. For instance, unauthorized and uninsured immigrants use navigational skills to find assistance programs to access medication, challenging the assumption that marginalized populations hold little cultural health capital. Subsequent work draws attention to the ways community healthcare workers are also able to activate CHC in socially marginalized populations by working with patients to understand and address specific challenges and barriers, such as helping patients apply for financial assistance programs (Madden, 2018). This expanded scope of cultural health capital allows for a more comprehensive analysis of the dynamics of client interactions with service providers, both within and outside of formal medical institutions.

While prior American-based research has applied CHC in the context of substance use stigma in clinical encounters (Chang et al., 2016), less is known about interactions in other community based settings. To my knowledge, no prior study has explicitly applied cultural health capital to the experiences of socioeconomically marginalized people who use drugs accessing a broad scope of social and health-related services. Given the diversity of services structurally marginalized people who use drugs rely on in Canadian inner-cities, it is important to contemplate how CHC may also apply to services outside of clinical settings. Addressing this

research gap will help explicate the dynamics of these encounters and identify solutions that may mitigate barriers for people who use drugs receiving income assistance during their interactions with services.

#### **2.4 Macro-Micro Links: Applying “Coleman’s Boat”**

Exploring how individuals respond to constraints when engaging with services requires a coherent analytical frame that connects multiple levels of social analysis. James Coleman’s (1987) conceptual approach to theorizing considers how researchers can move from individual units of analysis to explain macro-level social outcomes. This model, commonly referred to as “Coleman’s Boat,” outlines a series of macro-micro-macro linkages which positions individual action as the foundation of social outcomes. The model begins by describing how the macro structure shapes the individual context. For the purposes of this study, the relevant macro context includes the structure and institutional design of the income assistance and health systems, and drug policy. These macro dynamics shape individual contexts, which influences the actions taken by individual actors. For example, decisions to use illicit drugs, access harm reduction services, or seek medical care are influenced by broader social policies and institutions. The third relationship moves back up to the macro-level, depicting how individual actions collectively shape social and health outcomes, such as the perpetuation of the overdose crisis. Thus, this study applies “Coleman’s Boat” to examine how individual experiences with services may explain broader macro-level social phenomena at the intersections of substance use, income assistance and health. By drawing connections across multiple levels of analyses, this approach has the potential to illuminate the processes which lead to complex social phenomena and identify future research and policy pathways forward.

## Chapter 3: Methods

This study explores how people who use drugs and receive income assistance experience health-related services, through an analysis of 121 in-depth interviews from 75 unique individuals. Data was collected between November 2015 and March 2018 for the qualitative component of the TASA (The impact of Alternative Social Assistance Disbursement on drug-related harm) “Cheque Day” study operated by the British Columbia Centre on Substance Use (Richardson et al. 2016). The research setting was an inner-city neighbourhood located in Vancouver, Canada, with a substantial population of people who use drugs receiving income assistance. As the first place in North America to open a supervised injection site, Vancouver has been at the forefront of the movement towards a harm reduction approach to addressing substance use related issues (Jozaghi & Andresen, 2013; Wood et al., 2007). Owing much to the efforts of community activists, British Columbia has taken a comparatively progressive approach to substance use service provision. However, the opioid crisis continues to disproportionately impact this region (Belzak & Halverson, 2018) and demand for health and social services remains high and ongoing among marginalized people who use drugs. Given this context, inner-city Vancouver is an ideal location to study health-related services among people who use drugs and also receive income assistance due to the spatially concentrated prevalence of substance use, poverty, and the range of services available. Understanding the dynamics and challenges related to service use in this context may also have important implications for other jurisdictions looking for guidance in responding to the opioid crisis.

### **3.1 The Cheque Day Study**

Synchronized, once monthly income assistance payments have been characterized by escalations in individual and community-level harms including increased drug consumption, barriers to accessing services, and overdose related morbidity and mortality (Rosen, 2011; Verheul et al., 1997; Riddell & Riddell, 2006; Richardson et al., 2021a). The TASA study is a mixed-methods experimental project involving a randomized controlled trial and a nested qualitative parallel process evaluation to test whether changing the timing and frequency of income assistance payments is effective in reducing this drug-related harm around government payment days.

Participants were eligible for the study if they regularly used illicit drugs, were currently receiving government income assistance, and reported increased substance use around government payments. Researchers recruited 194 participants, who were allocated across three study arms: a control group (regular payment day), a staggered intervention (monthly desynchronized payment schedule), and a split and staggered intervention (semi-monthly and desynchronized cheque schedule). Participants completed follow-up visits every two weeks for a six month period to assess intervention impacts. Recruitment to the parent study was conducted through community advertisements, outreach and chain referral sampling. Though random representative sampling was not possible due to the eligibility criteria and an absence of a sampling frame of people who use drugs, researchers aimed to recruit as diverse a sample as possible.

### **3.2 Qualitative Sub-Study**

The qualitative component of the study aimed to capture the experiences of participants transitioning to an alternative income assistance schedule and the effect this had on substance use

patterns, their financial stability and their broadly defined well-being. Using maximum variation sampling to ensure a range of experiences and perspectives, 75 participants were recruited to take part in the qualitative parallel study. Each participant completed between one and three interviews, for a total of 121 interviews. The interviews were conducted by the study research coordinator who used topic guides to explore various themes, including service use, which is the substantive focus of the current study. A portion of the participants (n=13) completed baseline, mid-point, and completion interviews. However, due to a high intervention withdrawal rate in the parent study, additional participants (n=62) were quota sampled into a qualitative feasibility sub-study at the point of withdrawal, stabilization on the intervention after 90 days, or completion of the intervention after 180 days. Interviews ranged from 15 to 90 minutes, were audio recorded, transcribed verbatim, and uploaded to Nvivo. Participants who completed shorter targeted interviews in the feasibility study were paid a \$15 honorarium for their time, while those who completed longer traditional interviews were paid \$30. Participants have been assigned pseudonyms to protect confidentiality.

### 3.3 Sample Description

Table 1 shows the demographics of the qualitative sample, which included 42 (56%) self-identified men and 33 (44%) self-identified women. Twenty-seven (36%) participants self-identified as Indigenous, 45 (60%) as white, and three (4%) as Asian. Fifteen participants (20%) were aged 20-39, 34 (45%) were ages 40-49, and 26 (35%) participants were over the age of 50.

**Table 1. Sample Demographics (n=75)**

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<b>Self-identified Gender</b>	
Women+	33 (44%)
Men^	42 (56%)
<b>Ethnicity</b>	

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Indigenous	27 (36%)
White	45 (60%)
Asian	3 (4%)
<b>Age</b>	
20-39	15 (20%)
40-49	34 (45%)
50+	26 (35%)

+ includes 2 trans women

^ includes 1 trans man

### 3.4 Data Analysis

In order to reduce the data into manageable amounts for analysis, research assistants indexed transcript excerpts into broad categories using the interview topic guides (Deterding and Waters, 2018). This process involved coding segments of the interview transcripts in Nvivo according to the themes relevant to the research question, allowing for a focused analysis within a large data set that covers many topics. In order to analyze social and health-related service experiences, segments that were coded under the initial broad category of “Service Utilization” were extracted. This narrowed the data set to include segments of interview data relevant to service use and excluded portions of the interviews related to other topics. A broad approach was used to encompass both formal medical services (i.e. hospitals, clinics, and pharmacies) and community-based social services that impact health and well-being (i.e. meal programs, food banks, drop-in centres, supervised injection facilities, and shelters).

The data within this category was coded line-by-line using a retroductive approach, an iterative process allowing for use of both deductive and inductive coding (Ragin, 1994). Inductive codes included dimensions of operational challenges (e.g., wait times, hours of operation, financial costs), while deductive codes included indicators of cultural health capital (Shim, 2010) (e.g., navigating bureaucracy, interactional style, following orders, stigmatizing treatment), and indicators of medicalization, such as participant descriptions of doctors as

gatekeepers (Conrad, 1992). This approach permitted a detailed exploration of how individual service experiences and perceptions are related to multiple levels of the social world– from the macro-level policy context, to meso-level operational barriers, and micro-level interactions and behaviour. To identify patterns in the data, outliers were analyzed and comparisons were made across participants, contrasting positive experiences against negative ones (Miles and Huberman, 1994). This comparison allowed for the identification of different factors which enable and constrain access to services and to acknowledge heterogeneity and nuance within the data.

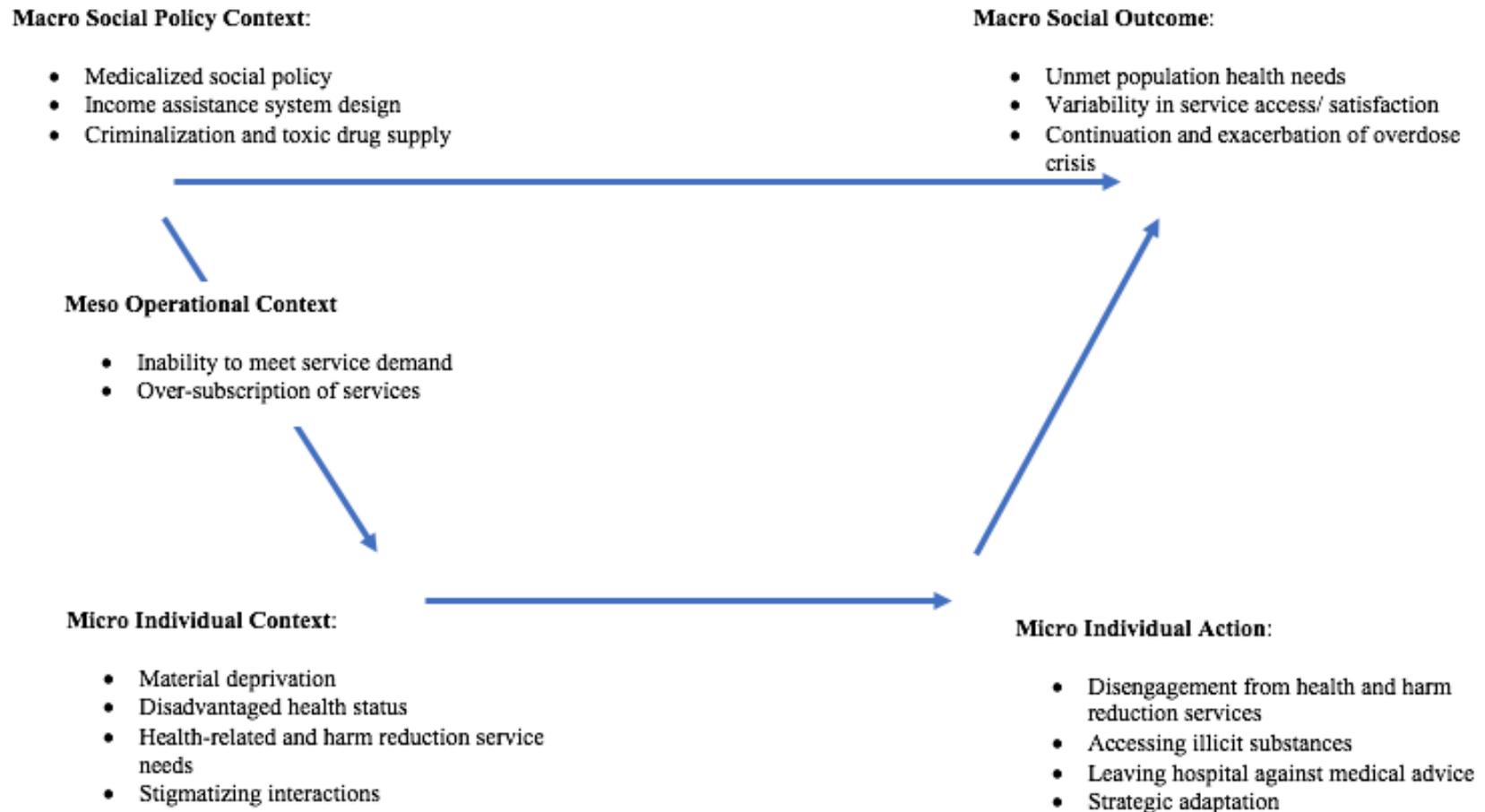
Tests of reliability and validity of the coding used the negotiated agreement method (Campbell et al., 2013). Testing for reliability assesses the stability, accuracy and reproducibility of codes between the researcher and an independent coder. The independent coder, who was trained on four major themes, coded a randomly selected subset of the data. Coding discrepancies were resolved through a process of negotiation. Table 2 details the major themes identified in the current study, along with stability scores.

**Table 2. Coding Reliability**

Code	Description	Stability Score
Operational barriers	Barriers to access occurring at the operational level (e.g. wait times, costs, hours of operation, regulations).	0.96
Disruptions to care or treatment	An interruption to an ongoing service or medication regimen (e.g. missed doctor's appointment, going off medication, leaving the hospital).	0.97
Mistreated or disrespected by staff	Description of mistreatment by service employees (either or perceived or explicit).	0.97
Doctor as gate-keeper	Instance where a physician prevents or enables access to a resource (e.g. other services, medication, income assistance).	0.98

The paper now turns to a discussion of the results. Figure 1 highlights the findings through a modified application of “Coleman’s Boat,” detailing a set of relationships between macro, meso and micro levels of analysis. For the purposes of this study the macro level refers to institutional structures such as government policy, the income assistance system, and the structure of the medical system. At the meso-level, the study explores the operational dynamics and barriers related to service providers. While the meso-level is not included in Coleman’s original frame, it effectively comprises operational barriers and facilitators that fall between the macro and micro dynamics. Lastly at the micro-level, this research considers individual behavior and interactions with service personnel and considers how these micro factors shape broader social outcomes.

Figure 1. Coleman’s Boat: Service Use Dynamics Among People Who Use Drugs Receiving Income Assistance



## Chapter 4: Results

Participants accessed a range of services including hospitals, pharmacies, drug treatment facilities, supervised injection facilities, meal programs, shelters, and drop-in centres. Table 3 presents the characteristics of participants who are quoted in this study (n=29), including their age, gender identity, self-identified ethnicity, type of income assistance they received, and whether they were enrolled in alcohol or drug treatment around the time of their interview. Several individuals (n=19) were accessing opioid agonist therapy or other alcohol and drug treatment. Of the quoted participants, 16 self-identified as a man and 13 self-identified as a woman; 17 self-identified as White, 10 as Indigenous and 2 as Asian. The majority of quoted participants (n=21) were receiving disability assistance, the highest level of income assistance available in British Columbia. Experiences were characterized by heterogeneity across participants and services. Despite experiencing institutional and structural constraints, participants engaged in processes of negotiation and adaptation to meet their needs. The results are organized into three broad themes related to the levels of analysis: institutional (macro), operational (meso), and individual (micro). While the implications of issues presented in the results often span over multiple levels of social analysis, findings were organized according to the most relevant level.

**Table 3. Characteristics of Participants Quoted (n= 29 of 75 participants)**

<b>Pseudonym</b>	<b>Gender Identity<sup>†</sup></b>	<b>Ethnicity</b>	<b>Age Group</b>	<b>Income assistance type</b>	<b>Addictions Treatment/OAT*</b>
Keith	Man	Indigenous	40-49	PPMB	No

Diana	Woman	Asian	40-49	PWD	Yes
Tom	Man	White	40-49	PWD	Yes
Samantha	Woman	White	50-59	PWD	Yes
Louis	Man	White	40-49	PWD	Yes
Randy	Man	White	40-49	PWD	No
Len	Man	Indigenous	40-49	Basic	No
Sandra	Woman	White	50-59	PWD	Yes
Phil	Man	White	30-39	PWD	No
Kasey	Woman	Indigenous	40-49	PWD	Yes
Owen	Man	White	50-59	PWD	Yes
Lucy	Woman	White	50-59	PWD	No
Ethan	Man	Indigenous	40-49	PPMB	Yes
Leah	Woman	White	40-49	PWD	Yes
Trevor	Man	White	50-59	PPMB	No
Jennifer	Woman	White	50-59	Basic	Yes
Alexis	Woman	Indigenous	50-59	PWD	Yes
Niall	Man	Asian	50-59	PWD	Yes
Miranda	Woman	Indigenous	50-59	PWD	No
Gareth	Man	White	30-39	Basic	Yes
Aaron	Man	Indigenous	40-49	PWD	No
Jamie	Man	White	50-59	PWD	Yes
Beth	Woman	White	40-49	PWD	Yes
Serena	Woman	Indigenous	20-29	PWD	Yes
Chris	Man	White	40-49	Basic	Yes
Sara	Woman	Indigenous	20-29	PWD	No
Ken	Man	Indigenous	40-49	PWD	No
Robert	Man	White	40-49	PPMB	Yes
Claire	Woman	White	50-59	PWD	Yes

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\* Refers to whether participant had received addiction treatment or opioid agonist therapy around the time of interview

† Includes 1 trans woman and 1 trans man

#### 4.1 The Macro-Level: Social Policy, Medicalization, and Institutional Gatekeeping

Participant experiences navigating income assistance application processes revealed the gatekeeping role of doctors within a medicalized institutional context. These narratives illustrated the ways macro-level policy design structured how individuals engaged with social and health services. In British Columbia, the application for disability assistance involves a

“Persons with disabilities designation,” requiring a doctor or nurse practitioner to complete a medical report in addition to an assessor report from a prescribed professional. Some participants described how doctors were effective in helping them navigate application processes and access financial support. Louis, a white man who applied for disability assistance three times, was deemed eligible after a medical diagnosis: “Every time I had to reapply... but the third time, that’s when I saw [the Doctor] and he did a full physical, and that’s when he diagnosed me with osteoarthritis in every joint in my body.” Louis’ diagnosis of a chronic illness legitimated his deservingness for disability assistance from the perspective of the income assistance system. Keith, an Indigenous man, also credited his doctor with helping him to become eligible for PPMB assistance: “[the doctor] took care of it basically, filled out the whole form, and I just had to take it to the office.” This helpfulness was also expressed by Samantha, a white woman receiving disability assistance, who credits her doctor with being able to access the special transportation subsidy, an additional annual payment from the provincial government for individuals unable to use public transit. Due to the medicalization of social assistance, engagement with and attaining approval from a health professional was necessary in order for participants to be deemed eligible for resources beyond the basic employable assistance amount. This system of medical gatekeeping implies that individuals must have access to and be equipped to navigate these interactions with physicians, and that health status is a primary measurement tool for assessing recipient deservingness.

For some participants, reliance on the medical system acted as an institutional barrier to financial supports. Gareth, a white man receiving basic assistance, was considering finding a psychiatrist to get a mental health diagnosis so that he could apply for disability assistance: “I was thinking of going to a psychiatrist...I was just thinking of that to get, apply for disability, get

a diagnosis or whatever, and paperwork filled out, and get a psychiatrist to do that.” Gareth placed emphasis on his desire for additional financial support in describing his motivation for finding a psychiatrist, rather than his psychiatric needs— a consequence of the institutional design which requires medical documentation to access disability assistance. Sara, an Indigenous woman receiving disability, had an overall positive impression of her doctor, but her application for disability assistance was initially denied because of an error made by her doctor: “He didn’t write the other one, the other disability that I have. He said he got distracted and just wanted to get it done quick.” These accounts highlight three important consequences related to the medicalized structure of income assistance. First, the gatekeeping position of health providers makes these interactions highly important, and the consequences can be serious if gatekeepers make errors or people cannot access these gatekeepers to begin with. Secondly, this system creates a financial incentive for seeking out medical care, potentially forcing some people into ongoing surveillance that they would otherwise prefer to avoid. Lastly, since medical diagnosis is used as a measure for recipient deservingness, individuals unable to obtain a diagnosis or who do not meet established medical criteria may be excluded from financial supports (Pulkingham & Fuller, 2012).

Physicians also occupied an institutional gatekeeping role related to participants’ access to medication, due to their authority over issuing prescriptions. However, this dynamic is not merely a result of individual physician attitudes but is also attributable to the institutional structure. As many study participants were on medication to manage chronic health conditions, including methadone maintenance treatment for opioid dependence, medication access was a prevalent theme across interviews. Doctors exerted their decision-making institutional position, sometimes in a way which constrained patient agency. Phil, a white man on disability, described

struggling to access medication due to the resistance of doctors to write certain prescriptions: “I haven’t been prescribed Dexedrine for like, oh God, 6-7 months because I don’t have a general practitioner yet...I finally found this one doctor who did fill my prescription, but he won’t refill it because it’s a narcotic. He doesn’t want to sign for it. I’m like what the fuck! Like I need my meds!” This account highlights the frustration of participants whose doctors restrict access to medication they feel is needed. However, it is important to place the prescribing practices of doctors in context with the broader social forces and institutional constraints. Len, an Indigenous man on basic assistance, also struggled to find a doctor who would prescribe medication: “I have a very, very hard time, like really, I have a hard time finding a doctor because it’s hard finding a doctor that will prescribe Dilaudid around here, because they’re sort of against it.” Len’s perception that doctors are against Dilaudid draws attention to an institutional dynamic in the field of medicine. Due to the ongoing overdose crisis, the co-management of chronic pain and opioid dependence has been increasingly identified in other contexts as a complex challenge for physicians due to intersecting pharmacological and social factors (Voon et al., 2015; Eyler, 2013; Webster et al., 2019). For instance, a review by Eyler (2013) found that MMT patients experience heightened pain sensitivity due to long-term opioid exposure while also exhibiting increased tolerance, therefore requiring larger doses of opioids for pain treatment. This dynamic is complicated by prescriber fears of drug seeking behavior by patients, concerns over disciplinary action for overprescribing, misunderstandings over clinical guidelines, and limited evidence for best treatment practice (Eyler, 2013; Webster et al., 2019). As the frontline gatekeeper to medication, doctors may face pressures to balance the pain needs of their patients with the regulations imposed by governing bodies, without being provided adequate supports.

Participant accounts of accessing medication also suggests a prescribing paradox: while some patients criticized doctors for their unwillingness to prescribe medication, others felt doctors prescribed medication unnecessarily. Leah, a white woman on disability described how she felt pressure to increase her methadone prescription, even though she wanted to wean off of it: “They want to keep upping my dose. They keep asking are you sure you don’t want to up your dose? I’m like no I don’t want anything higher, thank you, it’s enough.” A similar sentiment was described by Niall, an Asian man on disability assistance who described the experience of his partner who was on methadone treatment: “Her doctor keeps on putting her up. I almost got to threaten him to stop doing that. She’s not a heavy addict. What are you doing you bastard? Putting her on 10 mils of methadone. They just care about their money. They don’t care about people.” Aaron, an Indigenous man on disability assistance, also expressed distrust of the medical system in relation to prescribing practices: “You know how much medication out there is prescribed for nothing?... And now it’s been a month and a half? No seizures, my head’s clearing up, and, uh, actually a little bit more active. Because I think they’re trying to keep you under control.” Participant characterizations of physician prescribing practices as reckless revealed distrust and skepticism around the motivations of health professionals. While the emergent paradox indicates divergence across experiences accessing medication, the unifying theme throughout these accounts was that doctors were in the position to control how and when medications were prescribed. As a result of the institutionalized and inherently power-imbalanced structure of medical care, numerous patients felt silenced regarding their treatment preferences and decisions.

Even when individuals obtained a prescription, institutional gaps in public medication coverage represented another institutional barrier for some participants. Although individuals

receiving income assistance in British Columbia are eligible for prescription coverage through BC Pharmacare, participant experiences revealed gaps in this system leaving some participants struggling to pay for medication. Jamie, a white man, described being unable to afford prescriptions: “I’ve always got a number of prescriptions holding at the drug store that I just cannot afford to pick up. I’m supposed to have them, but I can’t afford it... So I mean there’s all kinds of things that come up and I just can’t afford to pick up prescriptions.” During the time of the interview Jamie was dealing with a nail fungus but was unable to afford filling a prescription for Lamisil. This medication requires application to a special authority grant for coverage, which is only accepted if the individual meets specific criteria. This process requires a prescriber to submit a request, detailing the medical justification as to why the patient needs the drug. Similarly, Len was unable to afford his prescription for Pariet, a medication to treat ulcers and expressed frustration towards the government. “I haven’t gotten that for a while now. My Pariet, 20mg of Pariet. It’s for my ulcers... Goddamn government. Yeah. I don’t get it. It’s expensive.” Len was in the process of returning signed paperwork to his doctor to get access to the medication, but in the meantime his ulcers were left untreated. The institutional design of British Columbia’s Pharmacare program left gaps in coverage for some individuals, while simultaneously increasing the administrative burden of health professionals.

These results show how macro-level systems shape individual contexts of service use engagement and individual action. By requiring medical reports by physicians to receive disability assistance, social policy pushes recipients to interact with doctors about their financial status. This gatekeeping role also extends to prescription medication access, where patients often feel their own concerns are ignored by physicians. Difficulties accessing prescriptions may also be exacerbated by constraints, pressures, and fear of sanctions placed by institutions upon

providers. Further, even patients who obtain prescriptions may face barriers as gaps in public coverage limit access to certain medications. While the provincial government relies on medical professionals to operate as gatekeepers, the system simultaneously imposes constraints on physician agency by limiting the medications that are covered and requiring additional paperwork for certain prescriptions. These individual accounts draw attention to broader structural issues and highlight the ways in which macro-level contexts shape clinical encounters. It is crucial to keep these institutional contexts in mind when considering how individuals engage with, experience, and respond to social and health services.

#### **4.2 The Meso-Level: Operational Dynamics**

While macro-level policies shape the social infrastructure individuals navigate, operational dynamics emerged as participants engaged with services. These operational and organizational processes related to service provision exist at a meso-level between the macro institutional and micro individual levels of analyses. Participants expressed the importance of accessing community services and how vital their operations were to individual and community well-being. Alexis, an Indigenous woman on disability relied on community services to meet her needs for food and clothing: “I love the resources down here. I take full advantage of them... nobody can say that they’re starving down here because the east end feeds you... everywhere you go you’re getting free stuff, free meals.” Owen, a white man on disability, spoke about the benefits of accessing healthy food at a non-profit grocery store: “yesterday I got a dozen eggs for next to nothing.” Two participants even attributed service operations with saving lives. Serena, an Indigenous woman on disability assistance, explained that at Insite, “they have actual people working there to save lives, like drug addicts or recovering addicts.” Prior to being

hospitalized for a kidney infection, Miranda (an Indigenous woman on disability assistance) was living in a tent and suffering deteriorating health status. She described how a shelter helped get her life back: “I was in the hospital a bit longer but then they released me to [a shelter]. So that’s what helped me kind of get back, get my life back... If it wasn’t for going to the shelter, I’d probably be dead.” Miranda’s statement is a powerful testament to the vital contribution made by community service providers, despite operating in difficult conditions.

Although social and health services were vital for well-being, participants recounted numerous operational barriers which limited utilization: struggles adhering to schedules, hours of operation, and long wait times were challenges which discouraged, delayed or disrupted access to critical social and health-related services among participants. Attending appointments at a specific time was a challenge for Ethan, an Indigenous man on PPMB, who described missing a doctor’s appointment. He talked about the difficulties of knowing what time it is while being homeless: “I just don’t necessarily always know what time it is and you know I don’t have a clock sitting there in front of me or a TV I can turn on.” Despite experiencing homelessness, Randy, a white man on disability, refused to stay in a shelter due to the requirement to leave by 6:30 in the morning: “What are you going to do at 6:30 in the morning? Nothing. It’s fucking bullshit.” Similarly, Phil, also a white man on disability, faced challenges trying to access meal services: “A lot of times I’ve missed supper by 10 minutes and if you do that you’re screwed. Like there’s no place in the city that’s got like a supper at like 2 in the morning...” While operation hours and appointment times are necessary for the organization of service provision, scheduling challenges imposed constraints when the timing of service provision did not align with client needs and personal schedules. For some participants, this coincided with pre-existing

disadvantage such as housing insecurity and presented challenges to accessing the very services intended to alleviate disadvantage.

Long lines and wait times represented another operational barrier which prevented and deterred participants from accessing services. Louis described trying to use a local meal program: “Sunday night I went to the food line...and the street line was all the way to the next block. There’s so many people... It’s insane. Everybody’s coming here.” Louis’ account highlights the depth of food insecurity in the area and the demand on community service providers to meet this need. Long wait times at the doctor’s office led Diana, an Asian woman collecting disability, to go off of methadone treatment when her prescription ran out: “I’ve got to go to the doctor’s and sit in the office for three hours... It bothers me and so I stop.” Thus, long wait times disrupted access to basic necessities like adequate nutrition and medication, which can have deleterious health consequences.

Numerous participants also described long lines at the supervised injection facility, Insite. This resulted in individuals using drugs alone at home or on the streets, which prior research has identified as significantly increasing risks of drug related harm and fatal overdose (Kerr et al., 2013; Jozaghi, 2013). Participants like Chris, a white man on basic assistance, described how long lines would deter service use and lead to higher risk consumption practices: “I really should use Insite but when I go there, there are 10 people in front of me and that’s probably like a half hour longer.” Chris was not alone in the dissonance between his knowledge about harm reduction and his drug use practices, largely attributable to capacity or resource constraints. Serena explained how she “would walk out because it would be so long of a line, you know, and go use outside” and suggested that “they should open more Insites” because “it’s really dangerous.” These wait times are a major impediment that denies people access to a life-saving

harm reduction service (Marshall et al., 2011). The oversubscription to Insite's services during the study period is linked to the hostile institutional and political context it has endured. The federal government attempted to shut down the supervised consumption facility, forcing a legal battle which resulted in a Supreme Court ruling in favour of Insite in 2011 (Small, 2012). Despite the favourable ruling, operating a government sanctioned supervised consumption facility required obtaining an exemption from federal drug laws, a bureaucratic legal process which can take up to over a year and thus prevented service expansion to other locations. However, in response to a rise in overdose deaths in 2016 activists in Vancouver defied federal drug laws and created unsanctioned pop-up overdose prevention sites. The provincial government subsequently changed its policy approach by adopting this model in late 2016 and opened 18 overdose prevention sites in a span of under two weeks (Lupick, 2016). This example shows how operational barriers are linked to both macro contexts and individual behaviour, and importantly, how individuals and service providers can shape macro-level policy contexts.

While operational challenges were not confined to one time period, the escalation in substance use associated with monthly synchronized income assistance payments compounded issues for service provision. Increased drug consumption following cheque day strains the ability of emergency medical and harm reduction services to keep pace with the demand (Krebs et al., 2016; Richardson et al., 2021a). Len, an Indigenous man on basic assistance found that during cheque day, Insite was "Very, very, busy. You have to wait sometimes, an hour, 45 minutes, just to get in there." While harm reduction services experience an increase in demand, some community services like meal programs close their frontline operations on cheque day because of decreased demand, allowing them to hold staff trainings and meetings. Lucy, a white woman on disability assistance explained that "A lot of places, they don't do anything on cheque day

because no one shows up.” However, some participants identified this as a challenge and source of frustration. Kasey, an Indigenous woman on disability, who relied on community-based services for food recounted struggling to find support on cheque day: “I was trying to get food or go to the Women’s Centre ...where else was shut down? Fuck. There was 3 places that were shut.” Ethan was also upset that services closed down, arguing “I don’t understand what fucking is the difference between welfare day and any other day... We still usually have a need for food that day.” While at the community-level there is not enough demand to justify these services remaining open, these narratives highlight the heterogeneity in population needs and the operational challenges of meeting them. Furthermore, the fluctuation in service demand related to cheque day, exemplifies how service operations are shaped and challenged by institutional design beyond the control of providers – in this case, the schedule of income assistance payments. Insite has since expanded their operation hours and is open 24/7 to meet demand during income assistance payment days, an example of how service providers can adapt to meet community needs.

The operational challenges which emerge at the service provision level do not exist in silos from the broader system. Rather, they are rooted in deeper social issues embedded within the institutional social policy context. Macro-level policy plays an influential role in shaping both the demand for services and the constraints under which they operate. The long lines at overburdened community meal programs are symptomatic of inadequate social assistance rates which keep recipients below the poverty line (Vozoris and Tarasuk, 2004). While programs like food banks provide emergency relief, they are inadequate solutions to addressing chronic poverty (Holmes et al., 2018). The lengthy wait times at supervised injection facilities are related to the ongoing criminalization of drugs which has contributed to the proliferation of a dangerous illicit

supply and delayed access to safe alternatives (Beletsky & Davis, 2017). Previous governments have actively fought against allowing supervised consumption facilities, placing roadblocks which have limited access to harm reduction, and tragically cost lives (Small, 2012). Thus, operational concerns and challenges must be placed within the context of institutional constraints. Investments in frontline service capacity may help mitigate operational barriers moving forward, yet these are only symptom treatments. Addressing the roots of these issues require much deeper upstream changes in the governance of social supports and harm reduction focused drug policy. Understanding operational challenges at this meso-level, helps to clarify the relationship between macro policies and individual experiences. Challenges felt by service providers are at least partially attributable to institutional constraints, which consequently influences the accessibility of services for individuals and their available choices.

### **4.3 The Micro-Level: Individual Patient-Provider Interactions**

While institutional and operational dynamics establish the context in which individuals engage with social and health-related services, care is experienced through individual interactions. Patient-provider interactions and engagement with services were not singularly positive or negative experiences. When individuals described positive experiences they often emphasized the importance of interpersonal connections with service providers. Being treated with kindness and being able to relate to staff were important dimensions. Tom, a white man on disability, described a very positive experience during a three month stay at a recovery program: “I got there, and I enjoyed it so much. All the staff were my age, and they all enjoyed the same music as I did, and I had a big boombox, and I bought some Joel Plaskett albums, and I played those full blast... the staff loved it.” Notably, Tom did not discuss his experience in terms of medical treatment, but rather about being a similar age to the staff and the agency afforded by

being able to play his own music. Claire, a white woman on disability, described how she could rely on being treated well at a clinic, which encouraged her to access their services: “I just go there and talk to somebody, and, you know, they’ll treat me the best way that I can be treated. They’re really good there now. They’re not, um, bad people like there used to be.” Being able to relate interpersonally to providers was also seen as a benefit for Jennifer, a white woman on basic assistance: “Actually at my doctor’s office there’s a lady there, she’s a new counsellor there, she looks like she’s been through the ringer a few times... I might give her a chance.” The importance of kindness, compassion, and relatability with staff are important aspects of interactions that should not be overlooked, especially in light of the levels of stigma encountered by people who use drugs during service interactions. These results suggest that positive interpersonal dynamics can improve experiences with health and social services and may increase service uptake.

Negative patient-provider interactions were often rooted in what were perceived as stigmatizing attitudes towards people who use drugs. These negative encounters resulted in three specific healthcare related consequences: patient distrust of providers, having health concerns dismissed, and inadequate pain management. Importantly, these narratives also revealed the agency of patients in finding ways to meet their needs when they felt abandoned by the health system, and how individuals used their cultural health capital (Shim, 2010) to strategically optimize their encounters in medical settings. Experiences were also characterized by heterogeneity across participants and providers, thus, broad generalizations should be avoided. Nonetheless, participant accounts show that individuals navigate interactions and exert agency despite the imposition of operational and institutional constraints.

Several participants attributed their negative experiences accessing health services as being directly linked to their social position, frequently describing being mistreated and neglected when seeking hospital care. One inner-city hospital was the site of numerous complaints. Beth, a white woman on disability, described being treated “like scum” and as if “they didn’t even care” after being hospitalized for a drug overdose. She was told by her doctor that this negative treatment was related to her frequent visits, attaining the label of a “frequent flyer” within the hospital. Similarly, Gareth, claimed that he did not “have a good name on their record” and that “they don’t like me I guess.” These labelling processes described by participants were the starting point for negative patient-provider interactions involving stigmatized health behavior (Link & Phelan, 2013). This is consistent with prior research which has shown that providers hold stigmatizing views of patients who use drugs, which shapes negative healthcare outcomes (Van Boekel et al., 2013; Chang et al., 2016).

Negative service interactions led to a distrust of medical professionals which impacted the willingness to seek care in the future. For example, Beth claimed she did not trust her psychiatrist because she felt talked down to: “I wouldn’t even talk to her about half the, like half the shit I tell you...I don’t trust her.” This lack of disclosure stemmed from frustrations of being paternalized: “you’re talking to me like I’m a little kid or something... you’ve got to have a rapport.” Other participants indicated a skepticism around doctors’ motivations. This sentiment was expressed by Louis who exclaimed, “You know, they do whatever they want those doctors.” These cases of distrust were rooted in negative experiences and skepticism over whether providers were acting in patients’ best interests.

Participants frequently perceived the dismissal of their health concerns during hospital interactions. This contributed to a pattern where participants demonstrated persistence by

travelling to multiple healthcare services to meet their care needs. Ethan described the hospital staff where he first arrived as “abusive and neglectful,” explaining that “they told me nothing’s wrong with me” and that he was accused of lying. He later went to a different hospital and was diagnosed with double pneumonia: “The next day I went up to [another hospital] and they’re asking me, ‘Do you want to be resuscitated if you die?’ ...I would have fucking died.” Gareth similarly had his concerns dismissed when he went to the hospital for an infection in his hand:

I was like I’ve got nowhere to stay and my finger is getting way worse, getting more infected out on the street, like I need to stay overnight here or something and get these antibiotics or something, like there is something wrong with me. He’s like no you’re fine, it’s good. He sent me home. Then I went to [another] hospital, and he looked at my finger for one second and he’s like you need an operation, you need to stay here. He’s like I know you’re a drug user. He’s like don’t do your drugs while you’re here. I’ll give you all the drugs you want. We have the best drugs here. I’ll make it comfortable for you. Just do this operation or you’re going to lose your finger. They were so much different to me there.

Gareth’s experience at two different hospitals demonstrates the variability in care across providers, as the staff at the second hospital he went to treated him with greater urgency and compassion. While he was labelled as a “drug user” in both settings, the consequences of this label emerged differently in these encounters. Ken, an Indigenous man on disability explained his struggle to get a proper health diagnosis and the time investment required: “I’ve been telling them for a year what’s wrong with me. I’ve gone to a bunch of hospitals and told them what is wrong with me... I finally got it taken care of yesterday.” In addition to eroding trust in medical institutions, this type of mistreatment allowed acute health conditions to progress untreated and forced individuals in dire need of healthcare to seek care elsewhere. However, these individual accounts also show that individuals are not passive recipients of healthcare, but are actively engaged in advocating for their needs, within a system that sometimes neglected their concerns.

Inadequate pain management by health providers was another barrier experienced during patient-provider interactions, which participants attributed to the stigmatization of substance use and their marginalized socioeconomic status. Len explained how his status as a homeless person who uses drugs resulted in worse care and neglectful prescribing practices: “They are cutting me off because they think I am a drug addict! ...Like, they seem to treat you differently if you’re homeless... you get treated different and I hate that. That’s one of the reasons I keep leaving that place.” Len goes on to describe how he ended up discharging himself early from hospital, but said that “they would have had a hard time getting rid of [him]” if he was given sufficient pain medication. The struggle to receive medication led Trevor, a white man on PPMB, to develop an oppositional attitude towards the entire medical system: “I’ve broken many bones over my life and they don’t even give me an aspirin down here. So, I just decided to screw the fucking medical system, I’ll just buy whatever I need.” This sentiment was also expressed by Gareth: “I get my own medication because I know how much of a struggle it is to get medication right now, so what’s the point. I can just go get my own.” Stigmatized care in the health system, coinciding with difficulties accessing pain medication, motivated participants to find illicit prescription opioids elsewhere and to disengage from medical services.

While some patients navigated stigma by leaving the hospital or disengaging with the medical system, others strategically engaged with their provider and employed their cultural health capital (Shim, 2010) to mitigate harmful stereotyping. Sandra, a white woman receiving disability, was keenly aware of the effects of drug stigma held by health providers. She chose her words carefully and strategically avoided asking for pain medication, even when she needed it. She described her encounter: “I mean if I had asked the doctor “by the way, could you give me some morphine or maybe some Demerol or maybe some ketamine...” or whatever, she would

have said, “Lady! You know, are you drug seeking?” Because that’s exactly what they think when you ask.” Sandra’s account highlights how participants were aware of substance use stigma and strategically adapted their behavior in order to improve the outcome of their health care interaction and avoid dehumanizing labels (Chang et al., 2016). This process also happened more subtly in other interactions. Leah, a white woman on disability assistance, described a positive relationship with her doctor: “I have a pretty good doctor...they know that I work too... I think that makes a little bit of a difference.” Leah’s employment status acted as a marker of social acceptability, potentially resulting in less stigmatizing treatment. Len, who had negative encounters with numerous physicians was struggling to get treatment for hepatitis C and described how he was “trying to get back on his [doctor’s] good side,” claiming “he’s the only who can cure me.” A similar deference to doctor’s orders was expressed by Robert, a white man receiving PPMB, who acknowledged that he may begrudgingly have to follow physician advice: “I guess I’m just gonna have to follow what my doctor or counsellor say which kind of sucks but they still say you’ve got to get rid of your friends, that’s it. Because I don’t get high no more by myself, but when I hang out with my friends that’s all they do.” These accounts show that participants were actively and strategically engaged in attempting to meet their physicians expectations in order to optimize the outcomes of their encounters. Participants adapted their individual behaviour as a tool of “impression management” (Goffman, 1959).

While patients strategically adapted their actions in order to optimize their interactions with providers, optimizing encounters was not singularly a unidirectional process. Some providers used their position and knowledge of the system to circumvent some of the institutional and operational barriers faced by patients. Samantha described how her doctor was able to get her access to the special transportation subsidy:

Like I still remember him sitting there. “I’m going to mark down,” Dr. [xx] says, “You hit people on the bus.” I go, “What?” [Laughs] He says, “I’m going to write this down.” If you say so. But that’s so that I can get the money like for transportation [Yeah], like I can’t be on the bus like without causing trouble.

Samantha’s doctor was willing to use his position and knowledge of the system to help her access additional resources, a finding consistent with research examining the role of health professionals in assisting patients to access resources (Madden, 2018). However, Samantha recognized this was not the norm, stating that it is “too bad more doctors weren’t like that.” Louis also received assistance from a health professional, describing himself and a friend as “preferred customers” at the pharmacy: “Yeah, what I do is I’ve got this deal with my pharmacist... he gives me a carry on Tuesday [Oh, that’s right] for Wednesday so I don’t fuck up.” This allowed him to avoid attending the pharmacy every day for his daily dose. These examples demonstrate how the actions of providers can help to mitigate and navigate challenging operational and institutional dynamics, positively influencing interaction outcomes for their clients.

#### **4.4 Results Summary**

Through an analysis of macro, meso and micro dynamics, the findings show how people who use drugs receiving income assistance experienced social and health service access in an urban Canadian setting. Due to a medicalized social policy structure, participants were forced to navigate the gatekeeping position of physicians in order to access financial resources from the income assistance system. This unique dynamic raised the consequences of encounters with physicians, by introducing a financial incentive for accessing healthcare and creating barriers for those unable to access physician care or obtain medical diagnosis. Though this system relies on doctors to assess the eligibility of income assistance recipients, their professional judgement was

also scrutinized by the province when prescribing medication. Some participants were denied coverage of certain medications or were forced to submit a special application to the provincial ministry, despite having a prescription from their physician. At the meso-level, operational barriers such as long lines, wait times and hours of operation hindered service utilization, particularly at Insite, which contributed to the uptake of higher risk drug injecting practices. These operational barriers were exacerbated following synchronized monthly cheque payments due to the cyclical escalations of drug use, which increase demand for harm reduction services. Operational dimensions were rooted in macro-level policy decisions (i.e. drug criminalization and inadequate assistance rates) and influenced individual action, highlighting the linkages between analytic spaces. At the micro-level, participants navigated challenging interactions with providers, and frequently confronted stigma, which contributed to inadequate pain management and the dismissal of patient health concerns. Participants responded to these challenges through exertion of individual agency in numerous ways. While some chose to disengage from services and sought out alternative ways to meet their needs, others strategically engaged and deployed their cultural health capital to optimize service encounters. Collectively, the results demonstrate how individual responses to institutional and operational constraints contributed to system level outcomes among the study population.

## Chapter 5: Discussion

Driven by a toxic illicit drug supply, the opioid crisis continues to devastate communities. This study explored the experiences of people who use drugs receiving income assistance in accessing health-related services in a Canadian inner-city. Using “Coleman’s Boat” (1987) as an analytical frame, our findings highlight the relationships between macro systems, individual action and social outcomes. The results show how institutional structures, operational barriers and interactional dynamics shape individual experiences accessing health-related services among people who use drugs who are collecting monthly income assistance payments. Understanding processes occurring at each level of analysis is necessary for the development of effective, evidence-based policy that addresses challenges related to the intersection of socioeconomic marginalization and substance use. Improving the responses of social and health-related services, particularly in the midst of an overdose crisis, is critically important to reduce morbidity and mortality and improve well-being.

At the macro-level, the results highlight consequential dimensions of the institutional imbrication between the medical and income assistance systems. The findings show how a medicalized income assistance system (Conrad 1992; Pulkingham and Fuller, 2012), which assesses and categorizes recipients on the basis of their health status, influences the dynamics of patient-provider interactions. Doctors play a gatekeeping role within this system, as they are responsible for determining the deservingness of disability assistance recipients through an assessment of their ability to work. Participants described how having a doctor support them through the application process was crucial. Income assistance recipients are required to navigate the medical system in order to apply for assistance beyond the basic employable amount, highlighting how social policy structures shape individual interactions with services.

Doctors also held an institutional gatekeeping position in relation to medication access. Participant accounts represented a paradox, where some individuals faced difficulties accessing medication, while others felt it was being over prescribed. Patients were frustrated with physicians who challenged their agency or would not prescribe medication. Further, while income assistance recipients receive prescription coverage by BC Pharmacare, some participants needed medication that was not covered or required a special application to the province. This medicalized social policy structure assigns physicians complex multidimensional role expectations in regards to their authority. In one sense, this system relies on doctors to be the gatekeepers to income assistance by using their medical judgement as eligibility criteria. However, the system also imposes surveillance over prescribing practices, by limiting the prescriptions covered under BC Pharmacare and requiring special application processes for certain medications. This finding reveals an underlying tension within the institutional role of physicians, putting them in a complicated position to meet their patient needs.

At the meso-level, analyses elucidate how barriers in accessing numerous services emerge at the operational level. Participants struggled with limited opening hours, long lines, and appointment times, which led to reduced service use among participants, particularly at meal programs and supervised consumption sites. When individuals are unable to access harm reduction services, they may engage in more dangerous drug injection practices, which increases the risks of harms and overdose (Kerr et al., 2013; Jozaghi, 2013). Further, the inability to access food programs may exacerbate material deprivation and lead to nutrition-related health consequences. Harm reduction services were particularly oversubscribed following monthly synchronized government cheque days due to the cyclical escalation in substance use coinciding with cash transfer payments. While participants also highlighted how vital these services are to

their individual and community well-being, operational barriers were related to broader meso-level dynamics that negatively impacted utilization of some services.

At the micro-level, the results show that individuals experience stigma during their interactions with services, which leads to patient distrust of medical professionals, the dismissal of health concerns, and inadequate pain management. These findings are consistent with other studies which show that medical professionals may hold negative perceptions of drug use leading to inequities in care among people who use drugs (Van Boekel et al., 2013; Chang et al., 2016). However, participants were actively engaged in shaping these encounters, demonstrating agency and strategically adapting to optimize their individual outcomes and meet their needs. Stigmatizing interactions and difficulties accessing prescription pain medication led some participants to disengage from health services, while other patients used their cultural health capital in clinical interactions, by changing their language and behavior to fit the role of a “good patient” (Shim, 2010). Participants also demonstrated agency through their persistence and self-advocacy for their health, going to multiple locations to seek care after experiencing mistreatment. Acknowledging the agency of participants in navigating these structures, despite systemic constraints, helps explicate larger social outcomes.

In placing macro, meso, and micro analytic frames in conversation with each other, our results identify relational dynamics between institutional structures and individual agency for socioeconomically marginalized people who use drugs. Participant accounts of accessing a supervised consumption site provides a concrete example of how these levels of analyses are intertwined. Substance use criminalization has contributed to a dangerous illicit drug supply and high levels of overdose (Beletsky & Davis, 2017). While a detailed analysis of drug criminalization is beyond the scope of this analysis, it is important to consider the operational

barriers of supervised consumption sites within this macro policy context. The long lines at supervised consumption sites are symptomatic of considerable need for harm reduction services. At the macro- level, a legal and regulatory framework which has simultaneously criminalized drug use and constrained access to harm reduction services shapes a high need for service demand. Further, the design of the income assistance system compounds operational challenges, due to the spike in substance use following synchronized payments. At the meso-level, service providers become oversubscribed and struggle to operate at a level that meets community demand. At the micro-level, individuals in need of these services find their own circumstances constrained by these macro and meso factors. For instance, numerous participants described how they decided to use drugs elsewhere when the supervised consumption site had long lines. These individual decisions to disengage from services and use drugs elsewhere, have implications for broader social outcomes, such as increases in fatal overdose rates and the perpetuation of the opioid crisis (Marshall et al., 2011). Thus, by situating patterns of individual action within macro and meso contexts we can understand the social processes that shape population outcomes.

## **5.1 Policy Implications**

The results have shown the inter-related dynamics of institutional, operational and individual levels of analysis. Researchers and policy-makers should consider the consequences of policy and programmatic development at each level of analysis. The model detailed in Figure 1 can serve as a tool to evaluate the effects of policies on individual, operational and broader social factors. Based on these findings, we make a series of recommendations in order to improve access to services and the health outcomes of people who use drugs receiving income assistance.

Redesigning aspects of the income assistance system could address both operational and institutional barriers experienced by participants. The depth of resource insufficiency and economic marginalization and subsequent reliance on underfunded social services is directly related to low income levels. Thus, ensuring adequate income assistance levels would improve the material conditions of recipients by reducing poverty. Studies have shown that increases to social assistance rates have been effective in reducing food insecurity (Li et al., 2016; Loopstra et al., 2015). Improving material security would likely decrease the heavy burden placed on community services like food banks, shelters and meal programs, reducing the operational challenges through a macro-level policy response. Increases to assistance levels may also reduce risks associated with illicit income generating activities used to supplement insufficient support payments, and therefore may further mitigate associated harms. Importantly, monthly income assistance rates in BC were increased by \$175 in April 2021, the largest ever permanent increase (CBC News, 2021). While this is a step towards relieving economic precarity, income assistance rates remain well below standard measures of poverty in Canada and continue to relegate recipients to poverty.

In addition to increasing assistance levels, revisiting the application processes and eligibility criteria could alter the dynamics of institutional gatekeeping. Ongoing debates surrounding a universal basic income are relevant to this discussion. Establishing a guaranteed standard of assistance for all citizens, may also work to de-medicalize the social assistance system, by removing the need to assess health status for the provision of income assistance. This may also remove the administrative and bureaucratic burden placed on both patients and providers. Prior research has also shown the potential for a universal basic income program to reduce stigma associated with means-tested supports (Stuber & Schlesinger, 2006; McDowell &

Ferdosi, 2020). However, it is important to consider unintended consequences of disentangling the medical and income assistance systems. For instance, ensuring recipients continue to have access to ancillary benefits is important to ensure any potential health improvements related to changes are realized and not counteracted by negative unintended consequences.

Policy-makers should explore changes to the synchronized schedule of income assistance disbursement. Desynchronized modified income assistance payment schedules have been shown to reduce escalations in substance use (Richardson et al., 2021b). Thus, alternative disbursement schedules should be considered in order to reduce the operational challenges faced by service providers related to the increased drug consumption attributed to synchronized cheque days. Modifying payment schedules would likely impact the constraints of service providers, by reducing the drastic fluctuations in service demand surrounding cheque day, while improving service utilization and reducing harm at the individual level.

Inadequate care during medical encounters was a significant problem for several study participants, who often linked mistreatment to perceptions of being stigmatized. This had serious consequences, leading to distrust of providers, dismissal of health concerns, and inadequate pain management. Tackling widespread stigma towards substance use and socioeconomic marginalization in medical and social service settings is a challenging, yet necessary task for policy-makers that requires a multi-pronged approach. While no single solution will eliminate stigma in healthcare, prior research has identified that training can mitigate harm (Van Boekel et al., 2013). Medical professionals should be educated on the effects of substance use and poverty-related stigma. Specific training on treating people who use drugs can improve the care that patients receive and reduce experiences of discrimination. However, in addition to training, increased investments in health are needed to ensure that facilities are properly resourced and

frontline healthcare staff have adequate support to provide high quality care, and prevent burnout among staff (Van Boekel et al., 2013). In addition to improving individual patient care, increased investments could reduce inefficiencies within the health system. The pattern of individuals presenting at multiple healthcare facilities due to negative interactions is not only harmful to patients seeking care, but also an inefficient use of healthcare resources. Travelling to multiple locations to find appropriate care and leaving conditions untreated causes greater and more costly health problems long term. Future research should consider how best to allocate investments and implement effective training.

The results also highlighted the need for expansion of harm reduction services, including access to a safer supply of drugs. Participants discussed difficulties with accessing supervised consumption facilities, while at the same time acknowledging the importance of using their services to reduce the risk of fatal overdose. Supervised consumption services are an effective harm reduction measure which saves lives (Marshall et al., 2011) and should be expanded in order to increase access and reduce accessibility barriers. However, these interventions do not address the underlying issue driving overdose rates: the toxic drug supply. The expansion of supervised consumption services should be paired with ongoing efforts to decriminalize substance use and provide a “safe supply” of opioids. In 2019, Health Canada approved multiple opioid safe supply pilot projects. Results from a study showed that a safe supply program in Vancouver reduced substance use and overdose risk, improved pain management, and resulted in improvements to health and economic well-being (Ivsins et al., 2020). The criminalization of drugs has been a failed policy which has exacerbated the overdose crisis (Beletsky & Davis, 2017). Expanding access to a safe supply of drugs, as part of a comprehensive approach to harm

reduction services, would address multiple challenges faced by people who use drugs receiving income assistance.

## **5.2 Limitations**

There are some limitations to this study. First, the generalizability of these findings may be limited. Due to the urban research context, some findings may be less relevant to other jurisdictions which have a different service landscape, including smaller cities and rural environments. Additionally, institutional contexts, including drug policy, differ across national and provincial jurisdictions. For instance, in places where supervised consumption sites remain legally prohibited the specific research findings related to operational barriers at Insite may be less applicable, and other dynamics not identified in this study may be more salient. Other findings of this study, such as the gaps in British Columbia's Pharmacare coverage are also specific to the province and may be less relevant in other contexts. However, consideration of similarities and differences across institutional and operational jurisdictions will help determine whether the application of findings in other settings is appropriate. Secondly, the findings may not be representative of the broader population of people who use drugs due to potential for selection bias in the parent study from which participants were recruited. Participants for the study had to be willing to change their income assistance schedule and attend regular follow-up meetings over a six-month period. Third, the data included interviews with individuals accessing services, but did not include the perspective of service providers or medical professionals. In order to more comprehensively understand service interactions, future research should consider the perspective of providers and the constraints they face. Drawing on the breadth of issues highlighted in this study, future research should also conduct more in-depth evaluation of

specific services in order to develop strategies to improve utilization and outcomes across their entire client population.

### **5.3 Conclusion**

Experiences with social and health-related services among people who use drugs collecting income assistance are complicated by a confluence of factors related to poverty, drug criminalization, substance use stigma, and social policy design. This study contributes to the literature by specifying how these dynamics play out in different analytic spaces, and how these different dimensions are interconnected. At the macro-level, a medicalized design of the income assistance system presents doctors a gatekeeping position between patients and their access to financial and medical resources. At the meso-level, accessibility barriers characterized by long lines, oversubscription, and hours of operation limit the impact and utilization of vital services. Third, at the micro-level, individuals often confront stigmatizing patient-provider interactions, as they exert agency to meet their needs in response to institutional and operational constraints. These actions taken by individuals, such as obtaining illicit substances as a response to difficulties accessing a prescription, collectively shape macro social and health outcomes such as the degree of unmet population health needs, variability in service access and satisfaction, and the perpetuation of the overdose crisis. In order to improve health outcomes and reduce harm at the societal level, we must look to these patterns amongst individual experiences which reveal the systemic flaws in public responses to social problems. Thus, to reduce the harms of the opioid crisis, researchers, public health experts and government officials should build solutions informed by and with the voices of those who access, engage with or could otherwise benefit from relevant social and health-related services.

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