A CRITICAL ETHNOGRAPHIC STUDY OF OVERDOSE
PREVENTION SITES AS A COMMUNITY-BASED RESPONSE TO
OVERDOSE DEATHS

by

Michelle Olding

B.A., McGill University, 2012
M.P.H., University of Toronto, 2014

A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

in

THE FACULTY OF GRADUATE AND POSTDOCTORAL STUDIES
(Interdisciplinary Studies)

THE UNIVERSITY OF BRITISH COLUMBIA

(Vancouver)

July 2022

© Michelle Olding, 2022
The following individuals certify that they have read, and recommend to the Faculty of Graduate and Postdoctoral Studies for acceptance, the dissertation entitled:

A CRITICAL ETHNOGRAPHIC STUDY OF OVERDOSE PREVENTION SITES AS A COMMUNITY-BASED RESPONSE TO OVERDOSE DEATHS

submitted by Michelle Olding in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Interdisciplinary Studies

Examining Committee:

Ryan McNeil, Associate Professor, School of Medicine, Yale University Co-supervisor

Jade Boyd, Assistant Professor, Department of Medicine, UBC Co-supervisor

Thomas Kerr, Professor, Department of Medicine, UBC Supervisory Committee Member

Vicky Bungay, Professor, School of Nursing, UBC University Examiner

Jennifer Baumbusch, Professor, School of Nursing, UBC University Examiner
ABSTRACT

Background: In response to an increasingly toxic illicit drug supply, drug user activists and allied organizations in British Columbia, Canada have rapidly implemented overdose prevention sites (OPS): sanctioned spaces where people can use drugs while monitored by responders trained to manage overdoses. While emerging research documents multiple health and social benefits of OPS, the distinct expertise, socio-spatial practices, and labour underpinning these interventions have not been studied in-depth. This dissertation uses community-based and critical ethnographic approaches to examine the implementation and operation of OPS in Vancouver as a community-based response to escalating overdose deaths.

Methods: Ethnographic fieldwork was conducted at four OPS between July 2018 and March 2020. Ethnographic fieldwork entailed observation of OPS activities, in-depth qualitative interviews with staff and service users, and site-specific focus groups with responders with lived experience. Rooted in critical research approaches, I analysed data to explore how OPS operated to mitigate overdose-related harms within the context of broader structural vulnerabilities such as poverty, criminalization, socio-spatial exclusion, and an increasingly unpredictable and toxic illicit drug supply.
**Findings:** Findings underscored how OPS extended forms of experiential and embodied expertise already existing among people who use drugs (PWUD), while also enabling comprehensive, specialized, and collective practices to emerge around overdose management. The overdose response function of sites had to be negotiated with other survival uses of the space by low-income services users who lacked access to safe, affordable housing and were regularly displaced from public space by urban governance techniques. Given their embeddedness within and deep knowledge of the communities they served, OPS workers were able to rapidly implement and adapt operational practices to address the broader social and health vulnerabilities of service users. However, the emotional burden and precarity of OPS labour intersected with other dimensions of structural vulnerability (e.g., poverty, criminalization) to place OPS workers with lived experience at heightened risk of burnout, with adverse impacts on service delivery.

**Conclusion:** This dissertation highlights the importance of overdose prevention services being designed by and leveraging the expertise of structurally vulnerable PWUD, while also indicating the need for policy changes to better support community-based overdose response.
LAY SUMMARY

This dissertation examines how overdose prevention sites (OPS) have been implemented and operated in Vancouver, Canada as a community-based response to the toxic drug supply and escalating overdose deaths. OPS are places where people can use illegal drugs while monitored by community responders trained to manage overdoses. I spent time in four OPS over a two-year period, observing how these sites operated and interviewing people about their experiences working at and using these sites. I found that the implementation of OPS strengthened community-based overdose response by enabling overdose-related care that was specialized, more comprehensive, and responsive to people’s broader survival needs. This research highlights multiple benefits of overdose-related interventions being designed and operated by people who use drugs (PWUD), but also the need for policy and organizational changes to better support PWUD’s work in overdose response.
PREFACE

This statement certifies that the work presented in this dissertation was conceived, conducted, and written by the Michelle Olding. All empirical research undertaken for the completion of this dissertation was approved by the University of British Columbia/Providence Health Care Research Ethics Board (H17-00557). The co-authors of the manuscripts that partially constitute this thesis include: Drs. Ryan McNeil, Jade Boyd, and Thomas Kerr. These individuals made contribution only as were commensurate with supervisory or collegial duties. The co-authors reviewed the dissertation and offered critical evaluations. However, Michelle Olding was solely responsible for overseeing and conducting data collection, analyses, preparing drafts of all manuscripts, submitting manuscripts for publication, and completing final revisions based on the comments of committee members, journal editors, and external peer reviewers.

A version of chapter 5 has been published in a peer-reviewed journal. Michelle Olding conducted all research and was solely responsible for drafting and revising the manuscript. The manuscript is published as:

https://doi.org/10.1016/j.socscimed.2020.113631
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>iii</td>
</tr>
<tr>
<td>LAY SUMMARY</td>
<td>v</td>
</tr>
<tr>
<td>PREFACE</td>
<td>vi</td>
</tr>
<tr>
<td>TABLE OF CONTENTS</td>
<td>vii</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>x</td>
</tr>
<tr>
<td>LIST OF ABBREVIATIONS</td>
<td>xi</td>
</tr>
<tr>
<td>GLOSSARY</td>
<td>xvii</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>xix</td>
</tr>
<tr>
<td>DEDICATION</td>
<td></td>
</tr>
<tr>
<td><strong>Chapter 1: INTRODUCTION</strong></td>
<td></td>
</tr>
<tr>
<td>1.1 Protohistories of Overdose Prevention Sites in Vancouver</td>
<td>3</td>
</tr>
<tr>
<td>1.1.1 Drug user organizing in Vancouver’s Downtown Eastside</td>
<td>5</td>
</tr>
<tr>
<td>1.1.2 Expansion of supportive housing</td>
<td>8</td>
</tr>
<tr>
<td>1.1.3 The legal challenges of Insite and resulting regulatory framework</td>
<td>12</td>
</tr>
<tr>
<td>1.1.4 Regulatory and program changes to facilitate community access to naloxone</td>
<td>15</td>
</tr>
<tr>
<td>1.2 The emergence of OPS during a public health emergency</td>
<td>16</td>
</tr>
<tr>
<td>1.3 Outstanding questions and study justification</td>
<td>18</td>
</tr>
<tr>
<td>1.4 Study objectives</td>
<td>22</td>
</tr>
<tr>
<td>1.5 Study approach</td>
<td>23</td>
</tr>
<tr>
<td>1.5.1 Locating myself in relation to the research and field sites</td>
<td>25</td>
</tr>
<tr>
<td>1.6 Organization of the dissertation</td>
<td>29</td>
</tr>
<tr>
<td><strong>Chapter 2: RESEARCH METHODS</strong></td>
<td>31</td>
</tr>
<tr>
<td>2.1 Introduction</td>
<td>31</td>
</tr>
<tr>
<td>2.2 Description of the field sites</td>
<td>31</td>
</tr>
<tr>
<td>2.3 Description of the study setting(s)</td>
<td>35</td>
</tr>
<tr>
<td>2.4 Ethnographic fieldwork and data collection</td>
<td>37</td>
</tr>
<tr>
<td>2.4.1 Observation</td>
<td>37</td>
</tr>
<tr>
<td>2.4.2 Semi-structured Interviews</td>
<td>41</td>
</tr>
<tr>
<td>2.4.3 Focus Groups</td>
<td>46</td>
</tr>
<tr>
<td>2.5 Ethical Considerations</td>
<td>48</td>
</tr>
<tr>
<td>2.6 Data analysis</td>
<td>50</td>
</tr>
<tr>
<td>2.7 Description of study sample</td>
<td>52</td>
</tr>
<tr>
<td><strong>Chapter 3: (RE)SITUATING EXPERTISE IN COMMUNITY-BASED OVERDOSE RESPONSE</strong></td>
<td>57</td>
</tr>
<tr>
<td>3.1 Introduction</td>
<td>59</td>
</tr>
<tr>
<td>3.1.1 Theorizing expertise in community-based overdose response</td>
<td>60</td>
</tr>
</tbody>
</table>
3.2 Expertise grounded in experiential knowledge..............................................68
3.3 The applications of embodied knowledge.....................................................70
3.4 OPS as places enabling specialized and comprehensive care.....................73
3.5 Overdose response expertise as collective performance.............................78
3.6 Discussion .......................................................................................................83
3.7 Conclusion .......................................................................................................86

Chapter 4: SITUATING OVERDOSE PREVENTION SITES WITHIN URBAN
GEOGRAPHIES OF SURVIVAL............................................................................88
4.1 Introduction .......................................................................................................88
  4.1.1 Geographies of marginalization and revanchist urban control...............88
  4.1.2 Situating OPS within geographies of survival.........................................90
  4.1.3 Outstanding questions and chapter objectives ......................................93
4.2 Accommodating multiple uses of OPS within geographies of survival.......96
4.3 Enacting spatial triage in Overdose Prevention Sites.................................100
  4.3.1 Controlling and expediting flow of service users.................................101
  4.3.2 Regulating drug selling under drug prohibition .................................106
  4.3.3 Managing the visibility of homelessness and drug use within revanchist
governances ........................................................................................................108
  4.3.4 Placing limits on social aspects of drug use ........................................111
4.4 Navigating harms and inequitable impacts of spatial triage......................113
4.5 Discussion .......................................................................................................117
4.6 Conclusion .......................................................................................................120

Chapter 5: TASK-SHIFTING AND THE PRODUCTION OF BURNOUT AMONG
OVERDOSE RESPONDERS WITH LIVED EXPERIENCE ..................................121
5.1 Introduction .......................................................................................................121
  5.1.1 Task shifting and ‘peer’ labour in overdose response .........................121
  5.1.2 Theoretical approaches to burnout .......................................................124
5.2 Job roles of OPS responders with lived experience ....................................127
5.3 Characterizing burnout in overdose prevention sites ..............................128
5.4 Drivers of burnout among overdose response workers with lived experience
....................................................................................................................130
  5.4.1 Economic insecurity and job precarity .................................................130
  5.4.2 Invisible and unpaid labour .................................................................134
  5.4.3 Challenges negotiating professional and personal boundaries .............136
  5.4.4 Lateral and gendered violence in the workplace ..................................138
5.5 Implications of burnout on service delivery ..............................................140
5.6 Discussion .......................................................................................................142
5.7 Conclusion .......................................................................................................146

Chapter 6: CONCLUSION ..................................................................................147
6.1 Summary of Findings .....................................................................................147
LIST OF TABLES

Table 1: Summary of characteristics of Overdose Prevention Sites observed ................... 32
Table 2: Characteristics of OPS service users interviewed for this study (n=23) ............... 53
Table 3: Characteristics of OPS workers interviewed for this study (n=14) ..................... 55
Table 4: Characteristics of OPS responders participating in focus groups (n=20) ............ 56
Table 5: Summary of programmatic recommendations for OPS operators ...................... 154
### LIST OF ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCCDC</td>
<td>British Columbia Centre for Disease Control</td>
</tr>
<tr>
<td>BCCSU</td>
<td>British Columbia Centre on Substance Use</td>
</tr>
<tr>
<td>CDSA</td>
<td>Controlled Drugs and Substances Act</td>
</tr>
<tr>
<td>COVID-19</td>
<td>Coronavirus disease of 2019</td>
</tr>
<tr>
<td>CRA</td>
<td>Community research assistant</td>
</tr>
<tr>
<td>DTES</td>
<td>Downtown Eastside</td>
</tr>
<tr>
<td>HCV</td>
<td>Hepatitis C</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
</tr>
<tr>
<td>OPA</td>
<td>Oropharyngeal Airway</td>
</tr>
<tr>
<td>OPS</td>
<td>Overdose Prevention Site</td>
</tr>
<tr>
<td>PHS</td>
<td>Portland Hotel Society</td>
</tr>
<tr>
<td>PWID</td>
<td>People who inject drugs</td>
</tr>
<tr>
<td>PWUD</td>
<td>People who use illicit drugs</td>
</tr>
<tr>
<td>SCS</td>
<td>Supervised Consumption Site</td>
</tr>
<tr>
<td>SRO</td>
<td>Single Room Occupancy</td>
</tr>
<tr>
<td>THN</td>
<td>Take Home Naloxone</td>
</tr>
<tr>
<td>VANDU</td>
<td>Vancouver Area Network of Drug Users</td>
</tr>
<tr>
<td>VCH</td>
<td>Vancouver Coastal Health</td>
</tr>
<tr>
<td>VPD</td>
<td>Vancouver Police Department</td>
</tr>
</tbody>
</table>
## GLOSSARY

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bag Mask Valve</td>
<td>Self-inflating and manual resuscitation device.</td>
</tr>
<tr>
<td>Binning</td>
<td>Collecting items (e.g., recyclables) to sell or exchange as an income generating strategy</td>
</tr>
<tr>
<td>Burnout</td>
<td>Negative psychological symptoms stemming from chronic workplace stressors, including overwhelming exhaustion, feelings of cynicism and depersonalization, and a sense of ineffectiveness or lack of accomplishment</td>
</tr>
<tr>
<td>Chill space</td>
<td>A designated area within an overdose prevention site for hanging out and monitoring after drug use</td>
</tr>
<tr>
<td>Community</td>
<td>A term used broadly to encompass a group of people who share social, political, economic, and/or geographic characteristics.</td>
</tr>
<tr>
<td>Community Research Assistant</td>
<td>Research assistant with lived expertise of drug use and a member of the community being studied.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>----------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>A synthetic opioid</td>
</tr>
<tr>
<td>Health Authority</td>
<td>The regional authority responsible for planning and delivering health care services within a geographic area of British Columbia.</td>
</tr>
<tr>
<td>Injection Room</td>
<td>Designated space in a supervised consumption site for people to inject drugs, typically containing booths or tables.</td>
</tr>
<tr>
<td>Jug / Jugging</td>
<td>To inject into one’s jugular/neck vein.</td>
</tr>
<tr>
<td>Mutual aid</td>
<td>Collective action to care for others, address survival needs, and work to change political conditions.</td>
</tr>
<tr>
<td>Narcan</td>
<td>Brand name for naloxone, the opioid antagonist administered to reverse an opioid-related overdose.</td>
</tr>
<tr>
<td>Overdose Prevention Site</td>
<td>A low-barrier supervised consumption site; in the Canadian context, operates outside of Federal regulations and is staffed primarily by people with lived experience of drug use and overdose.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Oximeter</td>
<td>A device for measuring the proportion of oxygenated hemoglobin in blood.</td>
</tr>
<tr>
<td>Panhandling</td>
<td>To ask strangers for money as an income generating strategy.</td>
</tr>
<tr>
<td>Peer</td>
<td>A term used to describe a person with current or past experience using illicit drug use. Typically used to refer to people who draw on this lived experience to inform their work in research, service, and policy settings.</td>
</tr>
<tr>
<td>Rescue breaths</td>
<td>Resuscitation technique in which you blow air into a person’s mouth to provide oxygen.</td>
</tr>
<tr>
<td>Revanchism</td>
<td>A political philosophy that seeks to retaliate or reclaim territory; used to describe urban policies that seek to “reclaim” space for wealthier and white residents, to the exclusion of others.</td>
</tr>
<tr>
<td>Rig</td>
<td>Needle used to inject drugs.</td>
</tr>
<tr>
<td>Sick / Dopesick</td>
<td>Refers to heroin/opiate withdrawal.</td>
</tr>
</tbody>
</table>
Socio-spatial

A term used in urban sociology to capture how the built environment and society interact to co-produce the urban environment.

Speed

Crystal meth.

Speedball

Mixture of cocaine and heroin.

Street Sweeps

Operations in which government agencies move and displace unhoused people living in public outdoor areas. Street sweeps frequently entail the confiscation and disposal of shelters and personal belongings of unhoused people.

Structurally Vulnerable

An individual or populations’ condition of being at heightened risk of negative health outcomes due to their position within overlapping power hierarchies and institutional arrangements.

Supervised Consumption Site

A federally-sanctioned site where people may use illicitly-obtained drugs under the monitoring of staff trained in harm reduction techniques and overdose management. SCS typically
provide sterile equipment and space (e.g., booths) for injection, and may offer ancillary health and social services.

<table>
<thead>
<tr>
<th>Supportive Housing</th>
<th>Structured form of low-income and subsidized housing that typically has support workers and ancillary services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Third Sector Actors</td>
<td>A term used to describe a range of organizations that are neither public or private (e.g., non-profits, community groups, co-operatives, social enterprises).</td>
</tr>
<tr>
<td>Triage</td>
<td>Refers to systems for prioritizing treatment of patients deemed to be in most urgent need of medical care, typically using assessments of illness severity and perceived likelihood of survival.</td>
</tr>
<tr>
<td>Vending</td>
<td>The informal selling of goods.</td>
</tr>
</tbody>
</table>
ACKNOWLEDGEMENTS

Thank you first of all to everyone who welcomed me into their Overdose Prevention Sites and shared their experiences through interviews, focus groups and informal chats. Witnessing the perseverance of frontline workers in the face of tremendous loss has been deeply humbling. I hope this dissertation treats your stories with the care and respect they deserve.

I would like to thank my supervisory committee members, Drs. Ryan McNeil, Jade Boyd, and Thomas Kerr. Your mentorship and scholarship have been critical to shaping this dissertation and my growth as a scholar. While completing this dissertation, I was a trainee at the BC Centre on Substance Use and completed a visiting fellowship at the University of California – San Francisco. Thank you to my mentors and peers in these spaces for providing a safe and supportive academic community. I would like to particularly thank Dr. Kelly Knight who has gone above and beyond to support my training as an ethnographer. Substantial portions of this dissertation were written in San Francisco, where I had the opportunity to work alongside some incredible harm reductionists. Thank you to Emily Valadoa, Porsha Dixson and all the SRO Overdose Prevention Specialists who profoundly shaped my thinking.

Completing a PhD is a time-consuming and expensive endeavour. It would not have been possible for me to carry out this project without the financial support I have received for salary and project expenses. Project funding through the US National
Institutes of Health (R01DA44181) ensured that I could provide stipends to all interview and focus group participants commensurate with community-established rates. I was able to work full-time on this project thanks to awards from the University of British Columbia and the Vanier Canada Graduate Scholarship. Many people supported me in securing this funding, by helping me navigate the various bureaucratic hurdles, providing guidance on grant-writing, and vouching for my research in letters of support. Thank you especially to Enid Ho, and Drs. Jeannie Shoveller, Janet Smylie, Kanna Hayashi, and Bohdan Nosyk.

I have been incredibly fortunate to be supported by my intelligent and compassionate family. Thank you to my mom, for nurturing critical thinking in all of her children and sparking a lifelong love of learning. Thank you to my dad for his support and pride in my academic work. And thank you to my twin sister Allysa, my fellow methodology queen, who happily stayed on the phone with me for hours to talk research design. My partner Virgil has been another unwavering source of support and encouragement over the past decade. The road to a doctorate has been paved by the many sacrifices he made along the way, including relocating for academic opportunities and picking up the slack at home when I was putting in long hours of fieldwork and writing.

Finally, I must acknowledge the tremendous contributions of the two community research assistants who worked alongside me on this project. This dissertation would have been something different (and not as good!) without their expertise and support.
DEDICATION

To all those we have lost to overdose and the war on drugs.

And for Sandra. You are deeply missed.
Chapter 1: INTRODUCTION

Canada is in the midst of a worsening drug overdose epidemic that has resulted in over 26,600 deaths between January 2016 and September 2021 (Special Advisory Committee on the Epidemic of Opioid Overdoses, 2022). Many of these deaths have occurred in the province of British Columbia (BC), where illicit opioid toxicity death rates have tripled since a public health emergency was declared in 2016 (British Columbia Coroners Report, 2022a). Overdose deaths here have been driven by an increasingly toxic and unpredictable illicit drug supply characterized by fluctuations in potency and adulterants with elevated overdose risk (British Columbia Coroners Service, 2022b). Recent drug checking data suggests that nearly all opioid samples submitted for testing in BC contain fentanyl and related analogues (e.g., carfentanil), and increasingly contain benzodiazepines or etizolam that can cause atypical and severe overdose (Ma et al., 2021; Vancouver Island Drug Checking Project, 2021).

The toxic illicit drug supply has amplified longstanding health inequities, with harms distributed along enduring fault lines of social and structural inequality (Dasgupta, 2018; van Draanen et al., 2020). Low-income and vulnerably-housed people have been disproportionately impacted, with approximately a third of overdoses occurring among people living in single room occupancy hotels (SROs), supportive
housing, motels, rooming houses or shelters (British Columbia Coroners Service, 2022b).\(^1\) Indigenous people are particularly over-represented among overdose deaths, with Indigenous men and women dying at rates respectively 4 to 9 times greater than other BC residents (First Nations Health Authority, 2021). These overdose vulnerabilities have roots in complex and ongoing legacies of structural racism, settler colonialism, and drug prohibition that differentially shape people’s drug use experiences, practices and access to health services and supports (Collins, Boyd, Cooper et al., 2019; Goldenberg et al., 2020; Lavalley et al., 2018). Notably, overdose deaths are occurring primarily among people using illicit drugs alone or in settings where bystanders do not have immediate access to the opioid antagonist medication naloxone (British Columbia Coroners Service, 2022a, b).

This dissertation examines how overdose prevention sites (OPS) have operated in Vancouver, Canada as a community-based response to mitigate the harms of the toxic drug supply and escalating overdose deaths. OPS are a low-barrier form of supervised consumption services (SCS) that provide a sanctioned and safer space for people to use illegal drugs and were originally scaled-up under a provincial emergency public health order. OPS are considered low-barrier for their minimal eligibility criteria and flexible

---

\(^1\) I use the term ‘vulnerably-housed’ to denote the situation of living in substandard housing, having frequent housing transitions, or being at risk of becoming unhoused (Hwang et al., 2011). I use the term ‘unhoused’ when referring specifically to the experience of living unsheltered or in emergency shelters. The term ‘homelessness’ is used in some cases to refer broadly to the situation of lacking stable, safe, permanent and appropriate housing, particularly when discussing the governance of homelessness as a social problem. (Gaetz et al., 2017).
rules, which enable them to accommodate a wider range of people and drug use practices than medically-supervised SCS. In Canada, OPS operate outside of federal regulations governing SCS and are staffed primarily by community members with lived experience of drug use who are trained in overdose response (Kennedy et al., 2019; Wallace et al., 2019). I use the term ‘overdose response’ to encompass immediate actions to prevent overdose death such as administration of naloxone and oxygen, but also other broader collective and socially-situated strategies for supporting people at risk of experiencing an overdose. As I will explore in this dissertation, these strategies are multiple, diverse, and draw upon distinct forms of expertise and labour that have been under-theorized in research on overdose response.

This introductory chapter sets the foundation for this dissertation by first briefly outlining the history of OPS in Vancouver, including the social movements and structural arrangements that made these interventions both necessary and possible as a community response to overdose deaths. I then synthesize existing research on OPS and present a justification for the present study. Finally, I outline the study approach, aims and organization of this dissertation.

1.1 Protohistories of Overdose Prevention Sites in Vancouver

In her historical study of naloxone and the politics of overdose, Nancy Campbell (2020) chronicles the multiple and intersecting ‘protohistories’ (the preceding and often unwritten histories of an event) that enabled overdose to become an object of political
concern: something “that public policy and ordinary people could aim to prevent” (p. 126). Drawing on evidence from several localities and temporal junctures, Campbell locates how HIV/AIDS activism, efforts to establish needle exchange, and other early forms of drug user organizing together shifted the direction of collective responses to drug use and overdose towards a harm reduction approach. These movements further transformed the very social infrastructure of activism, research, and public health practice by situating lay people—and people who use illicit drugs specifically—as empowered actors in overdose prevention and response.

Taking inspiration from Campbell’s approach, I foreground the present study by describing some of the protohistories that contributed to the emergence of OPS in Vancouver, Canada as a community-based response to overdose deaths. The protohistories of OPS considered here are: (1) drug user organizing in Vancouver’s Downtown Eastside; (2) the expansion of ‘supportive housing’ in Vancouver; (3) the legal battles of Insite and resulting regulatory framework governing supervised consumption services; and (4) recent regulatory and programmatic changes to facilitate rapid community distribution of naloxone. Together, these movements established a political environment, material conditions and infrastructure (both social and institutional) for OPS to be rapidly implemented as a response to illicit drug overdose deaths.
1.1.1 Drug user organizing in Vancouver’s Downtown Eastside

The unique history of drug user activism in Vancouver’s DTES created the social and structural conditions for OPS to be rapidly implemented as a response to increasing overdose deaths. The DTES is an approximately five by-ten-block neighbourhood east of the main financial district that is home to thousands of people who use illicit drugs (PWUD) (City of Vancouver, 2013). The neighbourhood is often characterized in mainstream media and policy discussions as a place of urban disorder and disease, a reputation that was solidified in the 1990s with the influx of people formerly institutionalized in the decommissioned Riverview Psychiatric Hospital and the explosive outbreak of dual HIV/AIDS and overdose epidemics (Liu & Blomley, 2012; Woolford, 2001). However, the DTES is also known for its strong tradition of grassroots activism and collective action around issues of housing, poverty, and social justice (Roe, 2009). In 1997, DTES residents and activists formed a drug user organization, known as the Vancouver Area Network of Drug Users (VANDU), to act on local public health emergencies and more broadly work towards drug user liberation from criminalization, stigma, poverty, and other systems of oppression (Boyd et al., 2009; Kerr, Small et al., 2006; Olding et al., 2017). VANDU grew from a small group of people meeting weekly in Oppenheimer park to one of the world’s largest and most influential drug user organizations, with a democratically-elected governing board and more than 1000 members (Boyd et al., 2009; Boyd & Boyd, 2013; Kerr, Small et al., 2006).
VANDU and allied drug user groups have been at the forefront of advancing innovative and low-barrier harm reduction approaches through direct action, education, and advocacy (Boyd et al., 2009; Kerr, Small et al., 2006; Small et al., 2012; Wood et al., 2003). VANDU’s unsanctioned nightly syringe program, which ran out of a tent from September 2001 to May 2002, is credited with advancing a low-barrier and needs-based approach to sterile syringe provision that was subsequently adopted as city policy (Wood et al., 2003). VANDU has initiated various programs that use peer support and witnessing to prevent overdose and other drug-related harms (e.g., HIV, HCV, and injection-related infections), including an Injection Support Team (from 2005 to 2009) in which volunteers trained in CPR, first aid and safer injection practices patrolled alleys in shifts, providing sterile injection supplies, collecting used syringes, and assisting people who could not self-inject (Small et al., 2012; Kerr, Small et al., 2006).

Notably, VANDU members have been involved in setting up multiple unsanctioned SCS since the 1990s. Local interest in supervised consumption sites grew during the 1990s in the wake of the provincial “Cain Report”, which recommended exploring SCS as an approach to addressing the HIV outbreak, and growing awareness of progressive drug policy in Western Europe (Kerr et al., 2017). In 1995, future VANDU co-founder, Ann Livingston, rented a storefront on Powell Street ostensibly as a drop-in centre for drug users but which also provided space for people to inject drugs (Boyd et al., 2009; Kerr et al., 2017). Known as the “Back Alley” and run by VANDU’s predecessor...
group, IV Feed, this site accommodated over 100 visitors a night until it was closed by police only a year later (Kerr et al., 2017). In April 2003, VANDU activists were among a coalition of activists, community members and health care professionals (known as the Coalition for Harm Reduction) to open an unsanctioned user-run SCS at 327 Carrall Street (Kerr et al., 2017). As with the OPS to be examined in this dissertation, ‘327 Carrall’ addressed an immediate need within the community while also making broader political statements. Through demonstrations, press releases, and direct actions at city council meetings (e.g., protests, disruptions), the Coalition for Harm Reduction framed their unsanctioned SCS as a protest against recent police crackdowns in the DTES. They exerted pressure on newly-elected Mayor Larry Campbell to open a sanctioned SCS as was called for in the city’s Four Pillar drug strategy and promised in his campaigning (Kerr et al., 2005; Kerr et al., 2017; Boyd et al., 2009).

Most recently, from 2010 to late 2013, VANDU ran an unsanctioned injection site out of a repurposed office room in its building where people could receive assistance injecting (McNeil, Small, Lampkin et al., 2014). VANDU further provided supervised smoking space for members in a ventilated bathroom, addressing a critical gap in existing harm reduction programming (McNeil et al., 2015). These services were ended abruptly in December 2013 when VANDU’s primary funder, Vancouver Coastal Health, issued a cease and desist letter against performing assisted and/or supervised injection onsite or through street outreach (McNeil, Small, Lampkin et al., 2014).
Drug user organizing in the DTES has accomplished a number of things that would subsequently enable OPS to be rapidly implemented and scaled-up as a community response to the overdose crisis. For one, drug user organizing in the DTES established a robust social infrastructure for community-led overdose response by organizing drug users around a philosophy of harm reduction and strengthening forms of mutual-aid that existed among PWUD (Boyd & Boyd, 2014). Secondly, the multiple unsanctioned SCS run by VANDU and other community activists helped evidence the feasibility and effectiveness of supervised injection sites run by and for drug users, while also drawing attention to the value of low-barrier approaches (e.g., allowing assisted injection) that would come to guide OPS practice (Kerr, 2006; Kerr et al., 2017). Thirdly, demonstrations and direct actions of drug users in the DTES demonstrated the power of civil disobedience in galvanizing government action, a tactic that would prove critical to securing provincial support and regulatory changes for OPS (Baker et al., 2020). Finally, and as discussed below, the founders and members of drug user activist groups such as VANDU would be pivotal to the establishment and ongoing operation of OPS, drawing on their expertise from decades of local organizing and direct service provision to marginalized drug users.

1.1.2 Expansion of supportive housing

A second and perhaps less obvious protohistory of OPS has been the advent of supportive housing as a local response to homelessness, and the related growth of the
non-profit sector as a provider of housing and health services for people experiencing housing vulnerability. A number of political, social, and economic forces coalesced during the 1980s and 90s to destabilise low-income housing in Vancouver’s inner city. Chief among these were the conversion of numerous SROs into tourist hotels leading up to Expo 86 (Hasson & Ley, 1997), commercial and residential gentrification facilitated by the sale of municipal land to condo developers (Olds, 2001), the Federal government’s termination of its active social housing programs, and destruction of low-income housing (Ley & Dobson, 2008). Recognizing the need to preserve existing affordable housing in the DTES, a number of third sector actors began to strategically take over private SROs and convert them into subsidized housing for people at risk of becoming unhoused (Roe, 2009). The Downtown Eastside Residents Association (DERA), a politically-influential neighbourhood group formed in the 1970s, secured grants from local and senior governments that enabled them to amass a portfolio of 640 new and renovated SRO units by 1992 (Hasson & Ley, 1994). While DERA disbanded in 2010, a number of non-profit organizations emerged during this era and adopted similar tactics of taking over private SROs. Unlike traditional property management companies, however, these non-profits specialized in providing supportive housing to different risk groups (e.g., youth, people living with HIV) through integrated health and social services (Roe, 2009).

Supportive housing expanded particularly in the years leading up to the 2010 Olympics, as the city faced wider pressures to “clean up” visible homelessness and drug
use (Roe, 2009). In 2007, the province purchased over a dozen SROs in Vancouver to be renovated and turned into supportive housing for people experiencing homelessness (Government of British Columbia, 2008). These purchases were accompanied by announcement of a partnership between the city, province, and federal governments to build 14 new supportive housing developments in downtown Vancouver (Vancouver City Council, 2007). This rapid transformation in governance of homelessness constituted what Fast and Cunningham (2018) describes as a “new regime of community care” as unhoused people have been increasingly moved into supportive housing buildings where they are at once residents and “clients” who are subject to surveillance and targeted for health-promoting services and interventions (Boyd, Cunningham et al., 2016). In conjunction with the activism of PWUD, these efforts to establish supportive housing ensured continuity of low-income housing in Vancouver’s DTES for structurally vulnerable PWUD and thus created a social context where rapid deployment of OPS was possible.

Supportive housing non-profits have made significant contributions to scaling-up harm reduction programs in Vancouver, and institutionalizing a harm reduction philosophy into housing environments (Pauly et. al, 2013). Supportive housing operators are themselves frequently advancing innovative harm reduction programming and sites for distribution of harm reduction supplies. One of the most influential non-profits, in this regard, is the Portland Hotel Society Community Service Society (PHS), a non-profit
which formed in the early 1990s with the mandate of providing housing for people deemed “hard-to-house” due to their drug use and/or mental health (National Collaborating Centre for Healthy Public Policy, 2011). PHS took over management of their first hotel in 1991 and have since expanded to manage 1500 supportive housing units in Vancouver and Victoria (Portland Hotel Society, 2021). Beyond building management, PHS collaborates with government partners to operate a continuum of innovative harm reduction programs that include a community managed alcohol program, a detox centre, a 24/7 needle depot, and a mobile needle exchange van (Portland Hotel Society, 2022).

Notably, in 2002, PHS discreetly built a supervised injection facility inside a boarded-up business on Hastings Street, referring to the project informally as the “Hair Salon” due to its individual booths, mirrors, and sinks (Small et al., 2005). PHS then publicly announced the site had been built, as part of a wider effort to pressure Vancouver Coastal Health Authority to co-sponsor an application to Health Canada for a Section 56 exemption under the Controlled Drugs and Substances Act (CDSA) which would allow the site to legally operate (Small et al., 2005; Kerr et al., 2005). This site, Insite, became the first legally sanctioned SCS in North America in September 2003 when it was granted a three-year exemption to be scientifically evaluated (Kerr et al., 2017).

The growth of the supportive housing sector has further shaped the harm reduction infrastructure in Vancouver by generating a more professionalized workforce
of harm reduction workers who provide psycho-social and practical support to residents experiencing housing vulnerability, poverty, and substance use challenges. This workforce includes PWUD, but often through a stratified employment structure in which PWUD are hired as ‘peers’ who work alongside or are supervised by predominantly non-peer support workers with professional backgrounds in social work, counselling, and nursing (Bardwell, Kerr et al., 2018; Olding et al., 2020). I will explore how these labour arrangements and power relations shape how overdose response work is organized, valued, and compensated by OPS operators.

1.1.3 The legal challenges of Insite and resulting regulatory framework

The opening of Insite represented a landmark achievement for harm reduction, the culmination of over a decade of grassroots organizing (Boyd, MacPherson & Osborn, 2006). However, it was swiftly followed by a major political backlash from the newly-elected Federal Conservative government and a lengthy legal battle to keep Insite open beyond the three-year pilot stage (Small et al., 2012). Despite mounting evidence supporting the public health benefits of Insite in reducing risk of overdose and infectious disease transmission (Kerr, Tyndall et al., 2006; Kerr et al., 2007; Wood et al., 2006), the Federal Minister of Health announced in September 2006 that the Federal government intended to only renew Insite’s Section 56 exemption for another 15 months (Boyd, 2013). Facing imminent closure, the PHS and two service users pre-emptively filed a civil claim
in the BC Supreme Court arguing that closing Insite was in violation of the Canadian Charter of Rights and Freedoms (Boyd, 2013).

The outcomes of this legal battle had mixed implications for the future of SCS in Canada. The case eventually moved up to the Supreme Court of Canada, where a nine-judge court unanimously ruled that the Minister of Health’s refusal to grant an exemption to Insite was arbitrary, grossly disproportionate, and contrary to the Charter (Canada v. PHS Community Services Society, 2011). The court ordered the Minister of Health to grant Insite an exemption under Section 56 of the CDSA and made some remarks about how future decisions regarding supervised consumption sites should be considered. In response, the Minister of Health renewed Insite’s exemption but moved to introduce a highly restrictive regulatory framework to govern future decisions. The Respect for Communities Act (Bill C-2, 2015) required potential SCS operators to meet twenty-six provisions to obtain a Section 56 exemption, including costly and time-consuming requirements to consult with local community groups and secure letters of support from various public health and public safety representatives. The passing of this legislation in June 2015 had a chilling effect on SCS scale-up in Canada, bottlenecking application processes and effectively stalling any new sites from being approved (Kerr et al., 2017).

In addition, the legal framework and professional regulations governing SCS placed constraints on operational policies and practices (Canadian HIV/AIDS Legal Network, 2007; Kerr et al., 2017). Although many PWUD require assistance injecting
(particularly women and people with disabilities) (Cheng et al., 2016; O’Connell et al., 2005; Small, Shoveller et al., 2011), SCS clients were not permitted to receive direct assistance from staff or other service users due to potential civil or criminal liability (Gagnon, 2017). Existing regulations did not allow for smoking of substances, despite longstanding high prevalence of smoking among PWUD and rapidly growing rates of overdose associated with inhaled substances (British Columbia Coroners Service Coroners, 2022a; Klar et al., 2016; Thinblin et al., 2004). Other studies suggested the clinical atmosphere of medically-supervised SCS may be a deterrent for some PWUD who have experienced discriminatory and stigmatizing treatment in traditional health care settings (Krüsi et al., 2009; Small, Ainsworth et al., 2011).

It became increasingly clear that SCS could not be scaled-up sufficiently or quickly enough to meet community needs under the existing regulatory and legal frameworks. Frontline experience and scientific research further indicated that the operational model of medically-supervised consumption sites would not work for many PWUD, and that complementary low-barrier models were urgently needed (Kerr et al., 2017; Small, 2011). As had been the case so many times before, it would fall upon the affected communities themselves to work outside of the law (and formal health care systems) to advance services that could help them survive the coming drug poisoning crisis.
1.1.4 Regulatory and program changes to facilitate community access to naloxone

Finally, the rapid implementation and expansion of OPS would not have been possible without a number of recent policy and regulatory changes related to naloxone, the opioid antagonist that reverses opioid-induced respiratory depression. While the BC Centre for Disease Control (BCCDC) has operated a Take Home Naloxone (THN) program since 2012, naloxone was initially only available by prescription to people who use opioids, and required them to first complete a training with a physician or nurse practitioner at one of 40 designated health units or community agencies (Banjo et al., 2014). Evaluations of the provincial THN program noted challenges in finding prescribers willing to participate in this program (Banjo et al., 2014), and difficulties recruiting long-term opioid users and other at-risk populations under this model (Young et al., 2019). In March 2016, Health Canada removed naloxone from the Prescription Drug List, enabling injectable forms of naloxone to be distributed without a prescription (Government of Canada, 2016). The College of Pharmacists of BC subsequently unscheduled naloxone in September 2016, allowing naloxone to be distributed to anyone at any site (College of Pharmacists of British Columbia, 2016). To meet growing demand for naloxone, the BCCDC added 341 new THN sites over a 12-month period and streamlined its ordering process (Young et al., 2019). These regulatory and programmatic changes enabled peer-run organizations to order and distribute naloxone without a health care professional onsite, as well as to flexibly adapt and innovate the trainings they provided to people
receiving naloxone for the first time (McKelvie, 2020; Young et al., 2019). These shifts led to a dramatic increase in naloxone distribution among lay people (Young et al., 2019), equipping PWUD and other grassroots activists with a crucial tool to manage overdoses in their communities.

1.2 The emergence of OPS during a public health emergency

In April 2016, the provincial health officer declared overdose deaths to be a public health emergency (Government of British Columbia, 2016). This declaration enabled the province to begin collecting real-time data about overdoses in the province, but did not immediately result in new policies or programs to address the epidemic. Activists, researchers, and service providers in affected communities called upon the newly-elected Liberal Federal government to declare a public health emergency and repeal Bill C-2 to expedite opening of new SCS (Nair & Hernandez, 2016). While the Minister of Health expressed an intention to remove barriers to SCS implementation, the federal government did not take immediate actions to repeal the Respect for Communities Act and declined to declare a public health emergency (Zimonjic, 2016). Overdose deaths in British Columbia surged to over 80 per month by late 2016 (British Columbia Coroners Service, 2022b), yet not a single new SCS had been approved to open.

In September 2016, DTES activists Ann Livingston, Sarah Blyth and Christ Ewart formed the Overdose Prevention Society and began setting up pop-up tents in alleyways stocked with supplies and naloxone (Lupick, 2016a; Woo, 2016). Funded through
crowdsourced donations and staffed entirely by community volunteers, the tents operated as unsanctioned supervised consumption sites where up to six people could inject at a time (Woo, 2016). The sites quickly became popular and were estimated to reverse over 200 overdoses in their first two months of operation (Lupick, 2016c). Founders invited journalists to visit these tents and gave interviews to large Canadian and international news outlets to draw attention to the overdose crisis and immediate need for more supervised consumption sites (Brend, 2016; Woo, 2016). In addition to these high-profile tents, members of VANDU’s outreach teams and PHS’s Spikes on Bike Programs were frequently reversing overdoses during their alley patrols, distributing naloxone, and training hundreds in overdose response (Leech-Crier, 2017; Lupick, 2016c, Dec 22). However, while these VANDU and PHS programs were permitted to provide overdose response, their service contracts did not permit them to directly supervise injections.

On December 8, 2016, the Health Minister of British Columbia issued a ministerial order directing health authorities to establish and fund overdose prevention sites for the purpose of monitoring and rapidly responding to overdoses (British Columbia Ministry of Health, 2016). VANDU’s OPS was operational within 24 hours of the ministerial order, set up similarly to the unsanctioned injection site that operated there previously. Within two weeks, approximately 20 OPS were operating in temporary sites or existing community service spaces in British Columbia, including five based in Vancouver.
At least 25 additional housing-based OPS were later opened in supportive housing buildings (Collins et al., 2020), alongside tenant-led overdose response programs in SRO hotels (Bardwell, Fleming et al., 2019; Nowell et al., 2020). By 2017, OPS had become a central feature of the overdose response in British Columbia with approximately 550,000 cumulative visits to OPS sites in this year alone (British Columbia Ministry of Mental Health and Addictions, 2020). In this year alone, SCS and OPS combined were estimated to have directly averted between 160 and 350 otherwise fatal overdose deaths (Irvine et al., 2019).

1.3 Outstanding questions and study justification

A small but rapidly growing body of research indicates wide-reaching health and social impacts of OPS (Boyd et al., 2018, 2020; Collins et al., 2020; Kennedy et al., 2022; Kolla et al., 2020; Pauly et al., 2020; Wallace et al., 2019; Olding et al., 2020). This research is situated within a broader body of epidemiological and social science research on ‘safer environment interventions’ that intervene upon the social, structural and environmental determinants of drug-related harms (McNeil & Small, 2014; Rhodes et al., 2006). Situated within this broader literature, OPS represent a low-barrier and historically-situated form of SCS that is distinguished from medically-supervised SCS by its unique legal status (provisionally sanctioned under public health emergency measures), staffing model (predominantly laypeople who use drugs), and adoption of flexible and low-barrier operating practices (e.g., permitting client-to-client injection assistance) (Pauly et al.,...
Recent studies indicate that implementation of OPS in BC has rapidly increased uptake of supervised injection services (Kennedy et al., 2022), improved access to a continuum of health and harm reduction services (Olding et al., 2020), and prevented numerous overdose deaths (Irvine et al., 2019; British Columbia Ministry of Mental Health and Addictions, 2020). To this day, an overdose death has never occurred at an OPS (British Columbia Centre on Disease Control, 2021).

This dissertation does not evaluate whether OPS mitigate overdose and drug-related harms, but rather addresses outstanding questions in the literature concerning how OPS have been implemented and operate in practice to mitigate harms of overdose. First, this dissertation addresses empirical and theoretical gaps concerning the roles and contributions of PWUD within overdose prevention and response. A growing evidence base indicates that direct involvement of PWUD in programs improves program accessibility (Broadhead et al., 1998; Leece et al., 2019), fosters trust and social connection (Olding et al., 2022; Mercer et al., 2021; Pauly et al., 2020), and facilitates feelings of comfort and safety among people disenfranchised from traditional health and social services (Bardwell, Anderson et al., 2018; Dechman et al., 2015; Kennedy et al., 2019; Mercer et al., 2021; Pauly et al., 2020; Wallace et al., 2018). Activists and public health scholars have increasingly drawn attention to the unique expertise that PWUD bring to drug policy and direct service provision based on their lived and living experiences.
Despite growing acknowledgement of lived expertise in policy documents and public health circles, little empirical research attempts to characterize this expertise within overdose response work or analyse how it may differ from the expertise of health care professionals (Faulkner-Gurstein, 2017; Kennedy et al., 2019; Kolla & Strike, 2019). In particular, there is a dearth of research that examines how responders with lived expertise draw on their distinct social positions, experiences, and relationships in practice to care for people experiencing overdoses (Kolla & Strike, 2019). Elucidating these underpinnings of expertise, I argue, is critical to understanding how OPS operate to prevent overdose deaths and provides insights into ways to leverage and strengthen forms of expertise that exist within communities of PWUD.

Secondly, this study seeks to extend research concerning how OPS operations have been shaped by social, structural, and other place-based processes that structure the everyday lives of PWUD in urban spaces. Previous research demonstrates how PWUD, particularly those who are racialized and low-income, are subject to forms of socio-spatial exclusion within cities that impact their access to and engagement with harm reduction services (Collins et al., 2018; Cooper et al., 2005; Greene et al., 2022; McNeil et al., 2016; Markwick et al., 2015; Rhodes et al., 2002). In Vancouver, intensive policing of street-based drug use, gentrification processes, lack of safe and affordable housing, and
punitive governance of homelessness (e.g., street sweeps, penalization of survival strategies) have been identified as inter-related processes that socio-spatially exclude PWUD from urban spaces and impede their access to overdose prevention services (Collins, Boyd, Mayer et al., 2019; Kerr, 2005; McNeil et al., 2021). Other research foregrounds the diverse meanings and functions of OPS within exclusionary and inequitable urban geographies, with accumulating research evidencing their function as a partial refuge from criminalization, violence, and stigmatizing treatment (Boyd et al., 2018; Collins et al., 2020; Foreman-Mackey et al., 2019; Kerman et al., 2020). However, it remains unclear how exclusionary geographies impact the day-to-day operation of OPS (e.g., their policies, practices, facility design) and how operators negotiate the tensions that arise between different and at times competing “uses” of the OPS by service users. This knowledge is essential to understanding the full impacts of exclusionary geographies on service provision, and how resulting inequities in service access can be mitigated.

Finally, this dissertation responds to a call for greater attention to the labour and psychosocial burden of overdose response work performed by community responders with lived experience (Kennedy et al., 2019; Greer et al., 2020; Shearer et al., 2019). Previous studies have found high levels of grief, trauma, and stress among workers at the frontlines of the overdose crisis (Kennedy et al., 2019; Kolla & Strike, 2019; Mamdani et al., 2021). Many of these studies emphasize the heightened stressors experienced by
overdose responders with lived experience, who are frequently experiencing, witnessing, and responding to overdoses in their work and personal lives (Kennedy et al., 2019; Kolla & Strike, 2019; Mamdani et al., 2021; Pauly et al., 2021). Recent studies suggest that the working conditions and labour experiences of overdose responders exacerbate these stressors as many PWUD are employed in precarious ‘peer’ roles often characterized by low wages, vague role definition, high job instability, limited benefits, and marginal power over working conditions (Bardwell, Anderson et al., 2018; Greer et al., 2020, 2021; Marshall et al., 2015; People with lived expertise of drug use national working group, 2021). Better characterizing the working conditions and labour experiences of OPS workers with lived experience can provide greater insight into policy shifts and organizational support that can mitigate burnout and in turn strengthen community-based overdose response.

1.4 Study objectives

This dissertation seeks to deepen understandings of how OPS have operated in Vancouver, BC as a community-based response to overdose deaths and the toxic illicit drug supply. I draw on nearly two years (July 2018 to March 2020) of ethnographic engagement with four OPS in Vancouver, where responders with lived experience of drug use work to prevent, identify and respond to overdose in their communities. This dissertation is formed of three sub-studies with the following aims:
1. To explore how expertise is assembled within OPS, with a focus on how expertise is developed and enacted by responders with lived experience of drug use (Chapter 3);

2. To investigate how OPS operators and staff manage the multiple “uses” of OPS by PWUD experiencing multiple intersecting survival threats, including the lack of safe and affordable housing, socio-spatial exclusion, and an increasingly toxic street-based drug supply (Chapter 4);

3. To examine the labour arrangements and working conditions of OPS responders with lived experience, and their implications on burnout and service delivery (Chapter 5).

1.5 Study approach

This work is grounded within a tradition of critical ethnography, a methodology which uses multiple methods (e.g., immersion in a field site, participant observation and in-depth interviewing) to examine power and the (re)production of structural inequities (Carspecken, 1996; Singer & Baer, 1995; Schepher-Hughes, 1990). Critical ethnography spans multiple and diverse disciplinary traditions (e.g., sociology, anthropology, urban geography, feminist studies), but has an overarching analytic approach of linking detailed descriptions of social practice in natural settings to critiques of broader social structures and power relations (Carspecken et al., 1996; Palmer & Caldas, 2015; Wacquant 2004). Critical ethnography differs from traditional ethnography in that it seeks to move
beyond description and interpretation to contribute towards social change (Madison, 2005; Bransford, 2006). I locate my work particularly within a body of critical drug research that examines how the harms or problems attributed to drug use (e.g., HIV, overdose, addiction, crime) and the various interventions deployed to address these problems (e.g., treatment, jail, harm reduction) are structured by broader socio-political arrangements, discourses, and power relations (Bourgois & Schonberg, 2009; Knight, 2015; Campbell & Herzberg, 2017; Watson et al., 2020).

Critical ethnography offers a particularly powerful tool for studying the delivery of public health and health care interventions to populations that experience multiple and intersecting forms of structural vulnerability (Snell-Rood et al., 2021). Structural vulnerability is a concept that is drawn upon in this dissertation to situate the positionality of PWUD who access and work at OPS. Structural vulnerability is a term used in health equity research to describe how social and structurally produced hierarchies of class, gender, and race (among others) pattern the health of populations by imposing physical and emotional suffering on specific populations and individuals (Quesada et al., 2011). Structural vulnerability focuses analytic attention to the broader structural forces that intervene upon both health status and health care delivery, including material conditions resulting from these arrangements (e.g., poverty, housing vulnerability) and complementary processes of depreciated subjectivity formation (Quesada et al., 2011; Snell-Rood et al., 2021). The structural vulnerability of PWUD
considered in this study context includes: being positioned low in social hierarchies of worthiness (e.g., as unworthy recipients of government support), being discursively aligned with a stigmatized and criminalized identity (e.g., as a ‘junkie’, ‘addict’, and ‘criminal’ that threatens urban order), and experiencing socio-spatial exclusion as a result (e.g., through street-based policing of drug use, lack of access to adequate housing, and municipal operations to remove PWUD from public space) (Collins, Boyd, Mayer et al., 2019; Fast et al., 2010; McNeil et al., 2015; Rhodes et al., 2012). This dissertation considers how PWUD’s experiences of structural vulnerability shapes the operation of OPS, including overdose response practices, facility design, operating practices and policies, and the organization of labour. In line with critically applied approaches (Schephers-Hughes, 1990), I aim to generate insights that can be used to strengthen community-based responses to the overdose epidemic.

1.5.1 Locating myself in relation to the research and field sites

A core epistemological assumption underpinning critical methodologies is that all knowledge production and claims are shaped by power relations, and that the social position, values, and assumptions of researchers shape every stage of the research process from choice of research questions to interpretation of results (Carspecken, 1996; Madison, 2005). In critical ethnographic work, the positionality of the ethnographer and their relationship to the field site is acknowledged to influence what they see, what is shared with them, and how they make sense of these experiences (Madison, 2005). While
details of my study sites, data collection methods and analytic strategies are detailed in
the next methodological chapter, I first situate myself in relation to this work and reflect
on how my particular positionality and experiences shaped my approach.

I started my PhD in September 2017 as a qualitative researcher with an interest in
harm reduction and some experience conducting community-based research regarding
HIV and the health of marginalized communities. My interdisciplinary training in
anthropology, public health, Indigenous studies, and gender studies framed my
approach to the work; I had an interest in exploring how the present overdose crisis was
linked to broader systems of power and structural inequality. I was keen to document the
innovative and community-based practices taking place within OPS, which were then in
their first year of operation. I had developed some professional relationships with local
drug user activists and non-profits in the year leading up to PhD through other research
collaborations (Olding et al., 2018), but otherwise had very little direct experience with
harm reduction and overdose prevention. My own drug use had never been criminalized,
stigmatized, or otherwise resulted in discriminatory treatment. I knew very little about
injection drug use, opioids, and overdose response, and often had to ask my collaborators
and research participants to explain basic terms and concepts. The learning curve was
humbling and sparked my interest in analyzing the processes and practices underpinning
expertise in community-based overdose response (See Chapter 3), as it quickly became
clear that OPS responders were drawing on a set of experiential, embodied and situated
knowledge that I did not possess and could not gain from a brief training in naloxone administration.

I was fortunate to enter the field under the mentorship of researchers who had decades long experience conducting community-based research in the DTES with drug user organizations and non-profits. My work was further embedded within a larger community-based project focused on responses to the overdose crisis, which facilitated identification of study sites and rapidly securing both Research Ethics Board (REB) and organizational approvals to carry out the proposed research. I was joined at early stages of my fieldwork by two knowledgeable and well-known community research assistants (CRAs) who had decades of experience in local harm reduction organizing. These CRAs contributed significantly to the direction of this dissertation by helping develop interview guides, introducing me to key people at OPS, vouching that I was not a cop or ‘poverty tourist’ when we walked through alleyways, composing, and sharing fieldnotes based on their own engagement with OPS, and co-leading some interviews with participants. Our neighbourhood walks together, and discussions about what we were witnessing regarding street policing and urban displacement techniques (e.g., street sweeps) helped expand the scope of this research to consider the role of OPS within the broader geography of socio-spatial exclusion and survival within the DTES (See Chapter 4).

Over the years, my relationship to the work shifted considerably. Many of the research collaborators, CRAs and research participants I met through fieldwork died
suddenly from overdose and other preventable illnesses. My initial optimism about the research weathered away as I attended more and more memorials, witnessed people reaching their breaking points with grief and exhaustion, and yet failed to see any bold policy changes to address the toxic drug supply driving overdose deaths. I grew angry and dissatisfied with being an observer and documentarian of the overdose crisis, and so became increasingly involved with local advocacy for harm reduction approaches, including taking a leadership position with the Vancouver branch of Canadian Students for Sensible Drug Policy (CCSDP). I pursued training in overdose response and learned a great deal from observing techniques in the OPS. I responded to a couple overdoses myself outside of OPS settings, experiences that sensitized me better to the emotional and psychological experience of overdose response. I found myself hypervigilant when outside my home, constantly scanning for prone bodies and anxious when I forgot my naloxone kit at home. The gravity of loss and suffering was difficult to process. Unlike my research participants, I was able to take breaks from my work and compartmentalize it away from my relatively safe and secure personal life. Recognizing this difference, and realizing that it was poorly acknowledged in the broader scientific literature, inspired my thinking for the chapter of this dissertation focused on the drivers of burnout among OPS responders with lived experience (See Chapter 5).

The COVID-19 pandemic brought an abrupt end to ethnographic fieldwork in March 2020, when the province imposed social distancing measures to prevent spread of
the novel coronavirus. I had, at this stage, completed interviews, focus groups, and observation at three of the four sites, and was one month into fieldwork at the final site: a small trailer located on the grounds of a hospital. In addition to cutting fieldwork shorter than planned, the pandemic disrupted plans to involve CRAs and research participants in the analysis and interpretation of findings. Sections of this dissertation (particularly Chapter 5, on worker burnout) have been adapted in light of thoughtful feedback from OPS operators and people with lived experience who reviewed drafts with compensation.

1.6 Organization of the dissertation

In this chapter, I have outlined the historical emergence of OPS as community-based interventions to prevent opioid-related overdose deaths in Vancouver, and presented the overarching research objectives, justification, and approach of this study. In Chapter 2, I outline the specific methods and analytic strategies employed for this study, as well as descriptions of the study sites and study sample. The subsequent three chapters present the substantive findings of this dissertation:

Chapter 3 examines how expertise in overdose response was assembled with OPS, with a focus on how OPS responders with lived experience gained and enacted expertise in overdose response. This chapter aims to deepen and re-situate theoretical understandings of expertise in overdose response, and in doing so, identify opportunities
to strengthen forms of expertise that exist within structurally vulnerable communities of PWUD.

Chapter 4 situates OPS within the everyday geographies of exclusion and survival of structurally vulnerable PWUD in Vancouver, including inter-related processes of housing insecurity, criminalization, gentrification, and revanchist urban governance techniques. This chapter examines the multiple survival uses of OPS within this context (beyond overdose prevention), and how OPS operators negotiated these at times competing uses of space through what I term ‘spatial triage’: a pragmatic set of rules, procedures, and spatial practices (e.g., facility design) that prioritized service delivery towards the most urgent threat of overdose fatality and in doing so constrained other uses of OPS within people’s geographies of survival.

Chapter 5 turns attention to the labour arrangements and working conditions of OPS workers with lived experience, exploring the experiences and drivers of burnout within this setting. This chapter considers ethical and pragmatic concerns regarding how overdose response tasks have been shifted to people with lived experience, and aims to identify strategies to prevent and mitigate burnout among structurally vulnerable overdose responders.

I conclude this dissertation in Chapter 6 by synthesizing key findings, study limitations, presenting policy and programmatic recommendations, and identifying future directions for research.
Chapter 2: RESEARCH METHODS

2.1 Introduction

In this chapter, I detail the research methods employed in this critical ethnography examining the operation of OPS as a community-based response to overdose deaths. I briefly describe the four study sites and provide some context on the broader study setting(s). I then present details of my fieldwork and specific data collection methods, including observation, in-depth interviews and focus groups. I outline some ethical considerations during fieldwork, including informed consent processes, compensation, and measures to ensure participant anonymity and confidentiality. I present my approach to data analysis, and conclude with a high-level description of the study sample.

2.2 Description of the field sites

Fieldwork is a foundational element of ethnography in which the researcher immerses themselves within a particular field site (location, environment, community) for an extended period of time (Emerson, 2001; Madison, 2005). The field sites for this study included four OPS located in Vancouver’s inner city. These four sites were among a total of six OPS operating in Vancouver at the start of this study. I purposefully selected multiple sites that varied with respect to type of operating organization, location,
capacity, design, staffing models, and services provided (Table 1). This heterogeneous sampling approach was critical to investigating some cross-cutting patterns and divergences in the implementation of OPS within this particular setting (Patton, 2002).

Field sites included: (1) An OPS located within the storefront of a drug user union that offered drop-in and community organizing space; (2) a storefront OPS operated by a supportive housing non-profit, co-located with injectable opioid agonist treatment and hydromorphone distribution programs; (3) an OPS established by local activists (later formed into a non-profit) that offers separate injection and smoking spaces and was located beside a community street market; and (4) an OPS trailer operated by a supportive housing non-profit and located on hospital grounds.

Table 1: Summary of characteristics of Overdose Prevention Sites observed

<table>
<thead>
<tr>
<th></th>
<th>OPS 1</th>
<th>OPS 2</th>
<th>OPS 3</th>
<th>OPS 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>Inside a drug user union in Downtown Eastside</td>
<td>Busiest intersection in Downtown Eastside</td>
<td>Adjacent a street market in the Downtown Eastside</td>
<td>On the grounds of a Downtown South hospital</td>
</tr>
<tr>
<td>Operating organization</td>
<td>Democratically-run drug user union</td>
<td>Supportive housing non-profit</td>
<td>Non-profit formed by activists</td>
<td>Supportive housing non-profit</td>
</tr>
<tr>
<td>Design</td>
<td>Small injection room in the back of the union</td>
<td>Storefront space with injection booths</td>
<td>Storefront space with injection booths</td>
<td>Trailer with injection booths</td>
</tr>
</tbody>
</table>

²This table presents approximations of service elements based on observations undertaken from July 2018 to March 2020. Given the rapidly changing context of the public health emergency, changes occurred frequently.
<table>
<thead>
<tr>
<th></th>
<th>OPS 1</th>
<th>OPS 2</th>
<th>OPS 3</th>
<th>OPS 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3 tables accommodating two people each</td>
<td>8 booths, accommodating two people each</td>
<td>12 booths, accommodating two people each</td>
<td>4 booths, accommodating two people each</td>
</tr>
<tr>
<td></td>
<td>Chill space in main foyer of union (couches)</td>
<td>Designated chill space within injection room</td>
<td>Designated chill space within injection room</td>
<td>Separate smoking tent</td>
</tr>
<tr>
<td></td>
<td>Unsanctioned smoking space in bathroom</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Max. Capacity</td>
<td>6</td>
<td>16</td>
<td>24</td>
<td>8</td>
</tr>
<tr>
<td>Modes of Consumption</td>
<td>Injection and Inhalation (in bathroom)</td>
<td>Injection only</td>
<td>Injection and Inhalation (in designated tent)</td>
<td>Injection only</td>
</tr>
<tr>
<td>Staffing</td>
<td>All staff are trained members of the drug user union</td>
<td>Unionized support workers (peer and non-peer) and casual peer workers</td>
<td>Casual workers (peer and non-peer)</td>
<td>Unionized support workers (peer and non-peer) and casual peer workers</td>
</tr>
<tr>
<td>Hours</td>
<td>10am to 10pm (Closed Thursdays)</td>
<td>1pm to 11pm</td>
<td>8am to 10:30pm</td>
<td>11am to 11pm</td>
</tr>
<tr>
<td>Services</td>
<td>• Monitoring and supervision</td>
<td>• Monitoring and supervision</td>
<td>• Monitoring and supervision</td>
<td>• Monitoring and supervision</td>
</tr>
<tr>
<td></td>
<td>• Naloxone administration</td>
<td>• Naloxone administration</td>
<td>• Naloxone administration</td>
<td>• Naloxone administration</td>
</tr>
<tr>
<td></td>
<td>• Oxygen administration</td>
<td>• Oxygen administration</td>
<td>• Oxygen administration</td>
<td>• Oxygen administration</td>
</tr>
<tr>
<td></td>
<td>• Harm reduction</td>
<td>• Harm reduction supplies and education</td>
<td>• Harm reduction</td>
<td>• Harm reduction</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OPS 1</td>
<td>OPS 2</td>
<td>OPS 3</td>
<td>OPS 4</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>supplies and education • Client-to-client injection assistance permitted • Support and advocacy programs</td>
<td>• Client-to-client injection assistance permitted • Hydromorphone program for enrolled patients • Spectrometer drug checking twice weekly • Co-located with an injectable opioid agonist treatment program (for enrolled patients) • Physician on site once weekly</td>
<td>supplies and education • Client-to-client injection assistance permitted • Spectrometer drug checking twice weekly</td>
<td>supplies and education • Client-to-client injection assistance permitted • Spectrometer drug checking once weekly</td>
<td></td>
</tr>
</tbody>
</table>

**Rules**

| • Have drugs ready when entering OPS • No selling or buying anything in OPS (drugs included) • No food or liquid • 15-minute time limit enforced • Respectful conduct | • No uncapped rigs • No passing of money • Must inject at assigned table • Only one person may inject at a time • 30-minute time limit enforced • Respectful conduct | • No buying or selling drugs • No uncapped rigs • No stated time limit, but generally 30 minutes • Respectful conduct | • No buying or selling drugs inside trailer • No soliciting • Only one person may inject at a time • No unpacking bags • No stated time limit, but generally 30 minutes • Respectful conduct |
2.3 Description of the study setting(s)

The OPS included in this study were located within two inner-city neighbourhoods with distinct social geographies: The Downtown Eastside (OPS 1, 2, 3) and Downtown South (OPS 4). As has been detailed in the introduction, The DTES is widely characterized in mainstream media as an impoverished and derelict neighbourhood located near the urban core of a city that is otherwise safe, desirable, and wealthy (Knight et al., 2017; Liu & Blomley, 2012; Woolford, 2001). The neighbourhood has a high concentration of low-income housing, with numerous services providing emergency shelter, food, healthcare, and harm reduction services (City of Vancouver, 2013). It is also a heavily policed neighbourhood, with place-based policing intensifying alongside commercial and resident gentrification (Collins, Boyd, Mayer et al., 2019). The DTES has a long-standing, well-established street-based drug market where a range of illicit drugs are available for purchase including opioids (e.g., heroin, fentanyl), crack cocaine, and methamphetamine (Small et al., 2013; Wood & Thomas, 2006). This drug use scene serves as the social and spatial hub for a number of street-based informal economies including drug selling, sex work and the vending/exchange of goods (Shannon et al., 2008; Small et al., 2013; Wittimer & Parizeau, 2016). The three DTES-based OPS included in this study are all situated within blocks of each other on Hastings Street, established within spaces that were already frequently used by PWUD in their daily lives.
Downtown South, in contrast, is the city’s highest-density residential and entertainment district known primarily for its restaurants, shopping outlets, bars, clubs and theatres (City of Vancouver, 2020; Fast & Cunningham, 2018). While Downtown South has a lower density of subsidized housing and social services compared to the DTES, it is where the majority of youth-oriented services and shelters are located (Fast & Cunningham, 2018). During the study period, OPS 4 was the only OPS in South Downtown and was uniquely located on the grounds of a large urban hospital. While this hospital was located outside of the main drug use scenes, this location addressed a need for safer spaces for PWUD to use drugs while hospitalized or after being discharged (McNeil, Small, Wood et al., 2014; Ti et al., 2015). During the study period, it was also the only OPS in Vancouver to be located outside of the DTES, although supervised consumption services were available through an HIV care organization adjacent to the hospital to people living with HIV who were registered clients.

While this research intensified my engagement with these neighbourhoods, I started fieldwork with a good familiarity of both neighbourhoods. I had worked at the Downtown South hospital for three years preceding this project, and was involved in a number of research projects in the DTES upon starting fieldwork. As a doctoral student, I was part of a community-based and qualitative research team based in the DTES. My experience navigating these neighbourhoods facilitated my rapid entry into the field sites
and sensitized me to the implications of certain dynamics (e.g., street-based policing, gentrification, by-law enforcement) when conducting fieldwork.

### 2.4 Ethnographic fieldwork and data collection

This dissertation draws on 20 months of ethnographic fieldwork spanning from July 2018 to March 2020. I conducted fieldwork in collaboration with two community research assistants (CRAs) who had strong ties to the DTES and personal experience with drug use and overdose response. Ethnographic fieldwork commenced at the drug user union where I had pre-existing relationships (OPS 1) and proceeded through two to five-month intensive periods at each subsequent study site (in order of study site numbers). While fieldwork across sites was staggered, I maintained contact with key informants throughout the study period and periodically returned to sites from earlier waves of research. This approach allowed me to rapidly immerse myself in each site, while also identifying converging and diverging trends across sites over time. I secured permissions from the site operators and managers prior to commencing fieldwork and informed staff and service users of my research role. Research activities at the drug user union were approved through a unanimous vote of the governing board.

#### 2.4.1 Observation

I employed participant observation as my primary method to produce rich and nuanced accounts of the everyday activities of OPS (Hammersly & Atkinson, 1983), with particular attention to labour arrangements and care practices around overdose. My
observer role aligned most closely with what Gold (1958) topologizes as ‘observer as participant.’ I did not have a participatory role at the OPS as a worker or service user and for the most part observed site activities unobtrusively in my role as a ‘researcher.’ However, I developed friendships and professional relationships over the course of my fieldwork that blurred this role and in some cases I was actively involved in the events I was observing. The CRAs who observed alongside me occupied a more participatory role during observation, as ‘insiders’ who were already deeply involved in local harm reduction practice, were well-known within the community, and who worked at or accessed some of the field sites in in their daily lives (e.g., as volunteers, workers, or service users).

In total, I conducted approximately 100 hours of observation over the 20-month study period. While the intensity of fieldwork varied over the study period (including a few months where I temporarily paused fieldwork to analyse data and write sections of this dissertation), I typically conducted observations one to two days a week during daytime operating hours. Observation sessions were initially coordinated around the availability of CRAs who worked part-time on Tuesdays and Wednesdays, but later expanded to include a more diverse range of days.

Ethnographic observations focused on overdose response procedures, socio-spatial features of the site (e.g., facility design, layout, rules/policies) and labour arrangements within OPS. Ethnographic visits lasted one to four hours and typically
included a neighborhood walk around the site to track other relevant dynamics, such as weather conditions, major community activities (e.g., community marches and protests), police presence, public drug use, drug market activity, and overdoses in public spaces. CRAs accompanied me on many site visits and walkarounds, and conducted some independent observations at sites they visited in their everyday lives. All team members carried naloxone and were trained to respond in the event of an overdose.

I observed primarily from the lobby and waiting areas of OPS, which offered ideal vantage points to unobtrusively view site activities and initiate informal conversations with service users and staff. I limited my observations within designated drug consumption spaces (i.e., injection tables and booths) given the potential for my presence as a researcher to pose discomfort to service users or otherwise interfere with overdose response procedures. During observation sessions in these spaces, I interacted primarily with staff, observing their job activities and engaging in unstructured conversations about their roles and responsibilities, site policies and procedures, and perspectives on socio-spatial features of the site such as built environment, physical layout, atmosphere, and flow of people. When overdoses occurred, I documented how team members worked together to manage these situations, including specific actions taken, decision making processes, and patterns of communication.

I composed detailed fieldnotes to build a “thick record” of my observations (Carspecken, 1995). Fieldnotes are the primary way that ethnographers document and
make sense of what they experience in the field (Emerson et al., 2011). In line with critical approaches, I understand my fieldnotes as inscriptions that are shaped by my own positionality and values (Caspecken, 1996; Madison, 2005; Emerson et al., 2011). To encourage reflexivity and enhance the credibility of findings, I adopted a collaborative approach to writing and interpreting fieldnotes with my team members (Bourgois & Shonberg, 2009). Following each observation session, the CRAs and I independently wrote fieldnotes that we then discussed together in a private space at our field office. These discussions helped me better contextualize the people, places and processes captured in fieldnotes. For the most part, we wrote fieldnotes immediately following observation sessions to elicit more detailed and specific descriptions (Emerson et al., 2011). In a few instances, CRAs observed relevant events at OPS during their non-work days (e.g., overdoses, police interactions) that they documented in fieldnotes and shared with me. These fieldnotes contained critical observations about dynamics in injection room spaces that helped address the limitations of my own limited engagement with these spaces. All fieldnotes were typed and stored on an encrypted work laptop, with pseudonyms assigned to disguise the identity of participants. In addition to generating a multi-vocal record of fieldwork, our combined fieldnotes were drawn upon to finalize interview guides and develop coding frameworks for analysis.
2.4.2 Semi-structured Interviews

Concurrent with ethnographic observation, I conducted semi-structured interviews with a total of thirty-six people who constitute the ‘workers’ and/or ‘service users’ of OPS. Semi-structured interviewing is a commonly-used qualitative method to learn about people’s lived experiences, beliefs, opinions and meaning making (Roulston & Haplin, 2022). Semi-structured interviews are typically guided by a flexible interview protocol that consists of topics, open-ended questions and probes designed to elicit detailed responses about the research subject (DeJonckheere & Vaughn, 2019). For this study, I used semi-structured interviews designed to explore the experiences, perceptions and opinions of participants concerning the implementation of OPS, with a particular focus on the expertise of workers, spatial practices, and labour arrangements. While ethnographic observation allowed me to generate a nuanced account of service features and everyday practices, semi-structured interview were necessary to gain a deeper understanding of how and why particular service elements came to be (e.g., job roles, overdose response procedures, rules, facility design), as well as the opinions of participants regarding “how things are done” at OPS (Yano, 2008) and how they could be done differently to better meet the needs of structurally vulnerable PWUD. This method allowed me to delve into more personal and sensitive topics (e.g., personal drug use, experiences of overdose) in a private space where participants had greater power to
leave the conversation if they became uncomfortable (compared, for example, to informal conversations during their shift or waiting to use the site).

Of the thirty-six interview participants, twenty-three were recruited as service users, and fourteen were recruited as OPS workers. One individual was interviewed twice, once as a service user and once as a worker. I used purposeful sampling to identify and recruit participants who could provide rich details about the day-to-day operation of OPS (Carspecken, 1996; Patton, 2015). Purposeful sampling is widely used in qualitative research to select “information-rich” cases that will “illuminate the inquiry question being investigated” (Patton, 2015, p. 265). Service users were purposively sampled to reflect a diverse range of socio-demographic characteristics including age, ethnicity, and gender. While I recruited service users who had varying levels of engagement with OPS, I prioritized interviewing people who frequently used OPS as they were better positioned to provide nuanced accounts of how the sites operated. OPS workers were purposively sampled to include individuals occupying a range of roles at the site including managers, supervisors, front desk attendants and other frontline responders. This sample was intentionally skewed towards workers who had longstanding involvement with the OPS, as these participants held valuable historical knowledge. All participants were recruited onsite, through either the direct invitation of research team members (myself or CRAs) or referral of OPS staff and other service users. Nearly all interviews were conducted the same day as recruitment, given significant
challenges coordinating scheduling with participants who may have no fixed address or phone number.

Interviews were conducted in a private onsite space, were audio-recorded, and ranged in length from 15 to 90 minutes (average 45 minutes). Workers had the option of completing interviews during their working hours (with permission from supervisors) or at another time of their convenience (typically immediately before their shift). As most service users were recruited from the waiting area of the OPS, I offered service users the option of completing their interview before or after using the site. This flexibility was important given that some participants were experiencing opioid withdrawal when recruited and would not be able to complete a lengthy interview without first “getting well” (alleviating symptoms of withdrawal by using opioids). Some participants expressed feeling calmer and more comfortable after using their drug of choice. While rare, interviews were ended if participants were unable to continue due to difficulties following questions or falling asleep.

Before each interview with service users, I collected socio-demographic data from participants using a structured form. I then conducted interviews using a semi-structured interview guide that had been developed in collaboration with CRAs. I began interviews by asking participants about their current living situation, followed by questions about their daily lives such as their typical drug use and how they made money. I then asked participants about their experience using OPS. I asked participants to describe a typical
visit to an OPS, their reasons for choosing to use at particular sites, their interactions with staff and other service users, and perspectives on specific operational features (e.g., rules, operating hours, site location, staffing, ancillary services). If participants disclosed experiencing an overdose themselves, I asked if they would be willing to share what they remembered happening. I asked participants if they had ever witnessed or responded to an overdose and, as comfortable, to share the story of what happened. To elicit rich details about how overdoses were managed in OPS and other non-OPS settings (e.g., alleyways, housing environments), I then followed up with probes about the circumstances surrounding the overdose (e.g., drugs used, location), as well as how the overdose was managed (e.g., who was involved, use of naloxone, calling 911, other support offered). If participants appeared to be emotionally distressed, I reminded them of the right to decline responding to any question and asked if they would like to pause or end the interview.

CRAs co-facilitated some interviews with service users, a decision that was made according to participants’ preferences and considerations of power dynamics within the interview process. One of the CRAs who was a white man reflected early on that his presence could make some women participants uncomfortable given pervasive experiences of gendered violence in the community. We decided that all interviews with women would be conducted by myself, with support from the other CRA who was an Indigenous woman. As a younger white woman with class privilege, I was often
perceived as a nurse or medical student despite my frequent attempts to emphasize my non-clinical research role. I noticed that, during interviews led only by myself, participants tended to emphasize the public health functions of OPS and their own engagement in “responsible” drug use practices (e.g., never using alone, testing their drugs). When co-facilitating an interview with one of the CRAs, in contrast, interviews tended to be more dialogic and generated richer data about the broader functions of OPS within people’s complex lives. CRAs sometimes choose to share aspects of their own experience (e.g., with criminalization, housing vulnerability, drug use) to build rapport, foster comfort for the participant, and enrichen the conversation (Harris, 2015).

Interviews with workers broadly explored participants’ experiences establishing and/or working at OPS. I typically began each interview by asking participants to describe how they came to work at the OPS. If participants had been involved in establishing the site, I asked them to share the story of how this OPS was established. Subsequent questions examined participants’ roles and practices at the site; their interactions with services users; and, their perspectives on features of the sites such as the organizational structure, overdose response procedures, atmosphere, built environment, division of labour, and rules/norms governing use of space. I conducted these interviews alone given that CRAs had personal or professional relationships with many of these participants that could present an ethical conflict. Interviews were generally conducted
onsite before or during the participant’s shift, with the exception of one interview that was held in a private space in my field office.

2.4.3 Focus Groups

To complement and triangulate data generated from observation and individual interviews, I facilitated three site-specific focus groups with a total of 20 OPS workers. Focus groups are widely used in health research to investigate group dynamics, attitudes, and norms on a specific topic (Green & Thorogood, 2004; Guest, Namey & Mitchell, 2012). The primary aim of focus groups in this dissertation was to create a space where responders with lived experience of drug use could share their perspectives on working conditions in OPS. This was identified as a priority by multiple participants during fieldwork who expressed they would benefit from discussing issues collectively outside of their work hours. A secondary aim was to observe interpersonal dynamics between workers when discussing working conditions, as this provided insights into whose perspectives and opinions were being prioritized or marginalized within the sites.

Focus group participants were recruited through the referral of the governing board of the drug user union and managers at the other two sites. With their assistance, I recruited a sample of participants at each site with a diverse range of roles and

---

3 A focus group was not possible at the fourth, hospital-based OPS due to the COVID-19 pandemic. I was unfortunately not able to conduct virtual focus groups due to technological barriers, including participants’ lack of access to video conferencing technology and reliable internet.
experiences at the sites. I purposefully oversampled women participants, ensuring they constituted at least half of the focus group participants to help mitigate gendered conversational inequalities (Cannon, Robinson & Smith-Lovin., 2019). Participants were informed that the focus group would be an opportunity to discuss their experiences working at OPS. All OPS staff were eligible to participate if they identified as a person with lived experience of drug use and did not currently hold a managerial role with hiring/firing power. I aimed for a sample of 6 to 8 participants for each focus group, overrecruiting up to 10 participants in anticipation of no shows (Tausch & Menold, 2016).

To minimize barriers to participation, I conducted focus groups onsite at OPS either in a separate private room (OPS 1) or in the injection room when the site was closed and otherwise empty (OPS 2 and 3). I began each session by introducing myself, the study purpose, and going through the informed consent process. I distributed brief socio-demographic surveys for participants to fill out before or after the session. I then invited participants to collectively discuss ground rules for the session to ensure principles of safety and respect guided our conversation (Green & Thorogood, 2004; Guest, Namey & Mitchell, 2012). Two main ground rules were established from these conversations: to avoid cross-talk and to not repeat what was said in the discussion.

As a warm up question, I invited each participant to briefly share their role and how they came to work at this site. I then posed questions to the group about their experiences working at the sites, including relationships with other staff and clients,
challenging and rewarding aspects of work, and experiences of burnout. These discussions generated valuable data about interpersonal dynamics within worksites, and enabled me to assess consensus and divergence around issues raised in the individual interviews concerning working conditions and burnout. All sessions were audio-recorded, with the permission of participants, and lasted between 40 and 90 minutes.

2.5 Ethical Considerations

All study activities were undertaken with approval of The Providence Health Care - University of British Columbia Research Ethics Board. As required under my research ethics approval, written informed consent was obtained from all interview and focus group participants. During the informed consent process, participants were informed of the study purpose, the types of questions that would be asked, the risks and benefits of participating, compensation, how their privacy would be maintained, and their right to decline or end the interview at any time. During focus groups, I emphasized that I could not guarantee complete confidentiality given the group format, and enjoined participants to exercise caution when sharing sensitive information with the group. I further requested that, if re-telling the experiences of others, to speak generally and avoid using names or other easily identifiable information. Verbal consent was obtained during observational work, using a short script introducing myself, the nature of the research, and asking consent to be present and take notes about our conversations.
All interview and focus group participants were compensated CAD $30 cash in recognition of their time and contributions. During the consent process, I emphasized that participants would be paid the full amount even if they declined to answer questions or decided to withdraw from the interview. Participants rarely declined to answer questions and no participants asked to withdraw from the interview.

While I have concealed the names of study sites for this dissertation, given that there are only four sites, I have taken additional measures to protect the anonymity of individual research participants. When presenting quotes or ethnographic excerpts in this dissertation, I omit information that could be used to identify participants such as their specific age and ethnicity. Focus group dialogue is presented without any identifying socio-demographic details. I generally do not link participants to particular sites unless it is required for analysis, such as to characterize a distinct dynamic at a particular site. Despite these efforts, some site managers and operators may still be identifiable given their unique roles at sites. I therefore informed this sub-group of participants during the informed consent process that anonymity could not be completely guaranteed and highlighted potential risks to their employment that could arise from disclosing information that breached organizational policies. All staff consented to participate despite these risks, and in some cases expressed an interest in being recognized in publications by their actual name. Out of caution and uncertainties
about how this research may be used in the future, I assigned pseudonyms for all participants.

2.6 Data analysis

Audio files of interviews and focus groups were professionally transcribed, with any potentially identifiable information removed from transcripts. Fieldnotes and transcripts were uploaded to the qualitative data analysis software NVivo 12 to facilitate data analysis. Throughout fieldwork, I drafted interview summaries to synthesize and identify the main stories emerging from data about people’s engagement with and work at OPS (Saldaña, 2013). I concurrently composed analytic memos to flag data limitations, recurring patterns, unusual cases, emergent topics for investigation, linkages to theory, and ideas for analytic codes (Carspecken, 1996). I coded data using a flexible approach that combined deductive and inductive approaches (Deterding & Waters, 2018). For the purposes of data reduction and retrieval, I first assigned large segments of data to index codes aligning with interview questions and a priori concepts (e.g., overdose response and experiences, perspectives on operating practices and design, role at the OPS). Interview transcripts and fieldnotes were simultaneously coded for respondent and site-level attributes to facilitate comparison of data across sub-groups (e.g., gender, ethnicity) and study sites (Deterding & Waters, 2018).

I then coded indexed segments of data line-by-line using analytic codes that aligned with concepts and themes tailored to each sub-chapter’s research question and
theoretical approach (Saldaña, 2013). For **Chapter 3**, I used analytic codes related to expertise within the context of OPS implementation and overdose response (e.g., experiential knowledge, embodied knowledge, legitimacy, overdose response procedures, other care practices, division of labour). For **Chapter 4**, I used analytic codes focused on socio-spatial practices within the OPS (e.g., spatial features of the OPS, managing perceptions of the site, moving people through space, triage practices, enforcing rules, drug selling onsite). For **Chapter 5**, I used analytic codes related to experiences and drivers of burnout conceptualized to be theoretically relevant (e.g., control over workplace, job insecurity and precarity, gendered drivers of burnout, hidden and unpaid labour, professional and personal boundaries).

Various dimensions of structural vulnerability (e.g., criminalization, housing vulnerability, stigma towards drug use, gendered violence, socio-spatial exclusion) were considered in all analyses for their potential to structure the operation of OPS, including the expertise, socio-spatial practices, and labour experiences of responders. I further drew on intersectionality theory to consider how these dynamics were shaped by the diverse social locations of OPS workers and service users within intersecting systems of oppression and inequity (Collins, 2000; Brady, 2018). For the purposes of this study, I focused particularly on structural vulnerabilities and inequities emerging from interlocking systems of gender, race, ethnicity, and social class.
To perform some member checking and strengthen the credibility of findings, I sought feedback from PWUD and other OPS workers through informal conversations during fieldwork, dissemination of research summaries, and structured reviews of the manuscript. Individuals who provided feedback on research summaries or sections of this dissertation were paid for their work at hourly consultation rates established by the CRISM People with Lived or Living Expertise (PWLE) of drug use national working group (People with lived expertise working group, 2021). The feedback received through these reviews helped clarify ambiguities and make sense of contradictory evidence.

2.7 Description of study sample

A total of fifty-five individuals participated in this study. This sample includes twenty-three people interviewed as service users, fourteen people interviewed as OPS workers, and twenty OPS workers who participated in focus groups. The total study sample size (n=55) has been adjusted to account for one individual who was interviewed as both a service user and worker, and who also participated in a focus group. The participant is referred to by the same pseudonym when quoting from their interviews. While we categorize participants as either ‘workers’ or ‘service users’ to signal how they were recruited for this study, there was considerable fluidity between these subjectivities. Many participants recruited as workers described accessing OPS for their own drug use, and some participants recruited as service users occasionally worked at OPS on a casual basis.
Among service users interviewed for this study, 13 (56.5%) were men and 10 (43.5%) were women (Table 2). Service users had a median age of 43, and identified predominantly as white (60.9%) or Indigenous (39.1%). Many participants (65.3%) reported being unhoused in the past year. Nearly all service users reported using multiple substances in the past 30 days, including heroin (73.9%), crystal methamphetamine (69.6%), fentanyl (43.5%), cocaine (30.4%), other opioids (13%) and crack cocaine (8.7%).

### Table 2: Characteristics of OPS service users interviewed for this study (n=23)

<table>
<thead>
<tr>
<th>Sample characteristics</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td>43</td>
</tr>
<tr>
<td>Range (IQR)</td>
<td>35-48</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Man</td>
<td>13 (56.5%)</td>
</tr>
<tr>
<td>Woman</td>
<td>10 (43.5%)</td>
</tr>
<tr>
<td><strong>Race or Ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>Indigenous</td>
<td>9 (39.1%)</td>
</tr>
<tr>
<td>White</td>
<td>14 (60.9%)</td>
</tr>
<tr>
<td><strong>Current housing status</strong></td>
<td></td>
</tr>
<tr>
<td>Apartment</td>
<td>2 (8.7%)</td>
</tr>
<tr>
<td>SRO Hotel (private)*</td>
<td>3 (13%)</td>
</tr>
<tr>
<td>SRO hotel (public)</td>
<td>6 (26.1%)</td>
</tr>
<tr>
<td>Shelter</td>
<td>2 (8.7%)</td>
</tr>
<tr>
<td>Friend's place</td>
<td>2 (8.7%)</td>
</tr>
<tr>
<td>Unsheltered/outside</td>
<td>8 (34.8%)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (4.3%)</td>
</tr>
<tr>
<td>Sample characteristics</td>
<td>n (%)</td>
</tr>
<tr>
<td>------------------------</td>
<td>-------</td>
</tr>
<tr>
<td><strong>Unhoused in past year</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>15 (65.2%)</td>
</tr>
<tr>
<td><strong>Sources of income (past 30 days)</strong></td>
<td></td>
</tr>
<tr>
<td>Part-time-employment</td>
<td>10 (43.5%)</td>
</tr>
<tr>
<td>Drug selling</td>
<td>15 (65.2%)</td>
</tr>
<tr>
<td>Sex work</td>
<td>2 (8.6%)</td>
</tr>
<tr>
<td>Recycling/vending/binning</td>
<td>16 (69.6%)</td>
</tr>
<tr>
<td>Panhandling</td>
<td>5 (21.7%)</td>
</tr>
<tr>
<td>Social assistance</td>
<td>20 (87.0%)</td>
</tr>
<tr>
<td>Research honorarium</td>
<td>20 (87.0%)</td>
</tr>
<tr>
<td>Other</td>
<td>10 (43.5%)</td>
</tr>
<tr>
<td><strong>Diagnoses</strong></td>
<td></td>
</tr>
<tr>
<td>COPD</td>
<td>2 (8.7%)</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>16 (69.6%)</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>10 (43.5%)</td>
</tr>
<tr>
<td>Diabetes</td>
<td>4 (17.4%)</td>
</tr>
<tr>
<td>Other Chronic Health</td>
<td>14 (60.9%)</td>
</tr>
<tr>
<td><strong>Substances used past 30 days</strong></td>
<td></td>
</tr>
<tr>
<td>Cocaine (powder)</td>
<td>7 (30.4%)</td>
</tr>
<tr>
<td>Crack Cocaine</td>
<td>2 (8.7%)</td>
</tr>
<tr>
<td>Crystal Methamphetamine</td>
<td>16 (69.6%)</td>
</tr>
<tr>
<td>Heroin</td>
<td>17 (73.9%)</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>10 (43.5%)</td>
</tr>
<tr>
<td>Other opioids</td>
<td>3 (13%)</td>
</tr>
<tr>
<td>Speedball</td>
<td>1 (4.3%)</td>
</tr>
<tr>
<td>Other</td>
<td>4 (17.4%)</td>
</tr>
<tr>
<td><strong>Drugs of choice</strong></td>
<td></td>
</tr>
<tr>
<td>Cocaine (powder)</td>
<td>3 (13.1%)</td>
</tr>
<tr>
<td>Heroin</td>
<td>5 (21.7%)</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>13 (56.5%)</td>
</tr>
<tr>
<td>Other opioids</td>
<td>5 (21.7%)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (4.3%)</td>
</tr>
</tbody>
</table>

*SRO = Single Room Occupancy hotel

**Participants selected up to two options
Among OPS workers interviewed for this study, 8 (57.1%) were men and 6 (42.9%) were women (Table 3). OPS workers had a median age of 48, with most identifying as white (71.4%) or Indigenous (21.4%). Participants included 3 site managers, 6 shift supervisors and 5 other frontline workers.

Table 3: Characteristics of OPS workers interviewed for this study (n=14)

<table>
<thead>
<tr>
<th>Sample Characteristics</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td>48</td>
</tr>
<tr>
<td>Range</td>
<td>30-62</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Man</td>
<td>8 (57.1%)</td>
</tr>
<tr>
<td>Woman</td>
<td>6 (42.9%)</td>
</tr>
<tr>
<td>Race or Ethnicity</td>
<td></td>
</tr>
<tr>
<td>Indigenous</td>
<td>3 (21.4%)</td>
</tr>
<tr>
<td>White</td>
<td>10 (71.4%)</td>
</tr>
<tr>
<td>Black</td>
<td>1 (7.1%)</td>
</tr>
<tr>
<td>Highest level of education</td>
<td></td>
</tr>
<tr>
<td>Some high school</td>
<td>4 (28.6%)</td>
</tr>
<tr>
<td>High school diploma</td>
<td>1 (7.1%)</td>
</tr>
<tr>
<td>Some college</td>
<td>5 (35.7%)</td>
</tr>
<tr>
<td>Bachelor’s Degree</td>
<td>3 (21.4%)</td>
</tr>
<tr>
<td>Trade/Technical training</td>
<td>1 (7.1%)</td>
</tr>
<tr>
<td>Role at site</td>
<td></td>
</tr>
<tr>
<td>Manager</td>
<td>3 (21.4%)</td>
</tr>
<tr>
<td>Shift supervisor</td>
<td>6 (42.9%)</td>
</tr>
<tr>
<td>Other frontline worker</td>
<td>5 (35.7%)</td>
</tr>
<tr>
<td>Lived experience of drug use</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>12 (85.7%)</td>
</tr>
<tr>
<td>No</td>
<td>2 (14.3%)</td>
</tr>
</tbody>
</table>
Focus group participants included a total of 20 OPS responders with lived experience of drug use, half of whom were men and half were women (inclusive of one trans woman) (Table 4). Focus group participants identified as white (60%) and Indigenous (45%). There were six participants from OPS 1, four participants from OPS 2 and ten participants from OPS 3.

Table 4: Characteristics of OPS responders participating in focus groups (n=20)

<table>
<thead>
<tr>
<th>Sample characteristics</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td>46</td>
</tr>
<tr>
<td>Range</td>
<td>37-60</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Man</td>
<td>10 (50%)</td>
</tr>
<tr>
<td>Woman</td>
<td>10 (50%)</td>
</tr>
<tr>
<td>Race or Ethnicity</td>
<td></td>
</tr>
<tr>
<td>Indigenous</td>
<td>9 (45%)</td>
</tr>
<tr>
<td>White</td>
<td>12 (60%)</td>
</tr>
<tr>
<td>Study Site</td>
<td></td>
</tr>
<tr>
<td>OPS 1</td>
<td>6 (30%)</td>
</tr>
<tr>
<td>OPS 2</td>
<td>4 (20%)</td>
</tr>
<tr>
<td>OPS 3</td>
<td>10 (50%)</td>
</tr>
</tbody>
</table>
It is around noon when a man runs into the site. Rather than checking in, as is customary, he attempts to slip behind the front desk and make a frantic dash for the injection room. Nick, who is staffing the desk, shouts out, “Woah buddy, slow down! You need to check in.”

“Narcan [naloxone]! We need Narcan!” the man replies. He tells us that a woman has overdosed outside and has been down for five minutes. Hearing this, Nick jogs toward the injection room while reassuring the man he’s on his way to help. The man paces around the lobby, eventually dashing back out the front door. Nearly everyone in the foyer is calm, continuing their conversations. A few people slip outside to see what’s happening. Meanwhile, Tara, the supervisor on shift at the injection room, bursts from the injection room, cursing. “She’s been down for five minutes? Holy fuck, shows how much people care!”

I follow Tara out front where we find a middle-aged woman lying flat on the sidewalk, unresponsive. Her chest is not rising, indicating that her breathing has slowed or stopped. Yet, her skin retains some colour and has not yet taken on the clammy, blueish hue of someone with overdose-related hypoxia. Tara kneels over the woman and begins delivering oxygen using a bag-valve-mask. She pinches and rubs the woman’s arms to try to rouse her. “Karen, sweetheart, you are outside of [the drug user union]. You are safe. I need you to take a big breath in. Come on, sweetheart.”

Nick arrives at Tara’s side and is on the phone with 9-1-1 as he quickly prepares and injects a dose of intramuscular naloxone into the woman’s thigh. A small crowd has now gathered. One woman cheers on: “Come on, get up, get up!”

After a few minutes of administering oxygen, Tara looks up and exclaims to the crowd, “She’s breathing!” Tara tells everyone that Karen has fluttered her eyes. As she continues to rub her arm, Tara encourages Karen to keep breathing. “Come on Karen. That’s a nice big breath! Now you got to stay with me. You need to stay with me, or we’re gonna have to Narcan you again.”

Nick is still on the phone with 9-1-1 as he prepares a second dose. Karen is taking shallow breaths on her own, but not moving or responding to Tara. Nick injects the second dose, just as we hear the sirens of an approaching fire truck. An
onlooker steps onto the street to wave over the firetruck, but a car pulls in at this moment and inconveniently parks in front of the site. As I am closest, I step over and curtly instruct the driver to move along.

Karen finally comes to, just as the firefighters walk over with an oxygen tank and first aid kit. Tara supports Karen’s shoulder as she slowly pulls herself into a sitting position. A few onlookers trickle away as sighs of relief ripple through the crowd. An ambulance arrives at the scene, and paramedics take control of the situation. Nick and Tara slip back into the site. It is now only a few of us watching, including the site manager, Magda.

Paramedics pull a stretcher out from the ambulance and attempt to guide Karen onto it. Karen is still in a daze and looks confused. I notice a man collecting Karen’s things from where they are scattered along the sidewalk. A pair of pink clogs are laid on the end of the stretcher. A blanket is also collected, and some white plastic bags. Magda and I notice another man eyeing a plastic bag that remains on the ground. We give each other a concerned look.

“Do you think that’s her bag?” I ask Magda.

“I think he’s just picking it up for her...” Magda replies “but let’s just watch...”

The man picks up the plastic bag and turns to walk toward a tent pitched outside of the shelter next door. Magda follows the man toward the tent. She asks for the bag and proceeds to ruffle through its content. After inspecting, she shrugs and returns the bag to the man. “It’s just filled with junk food,” she tells me. She explains that she also learned that Karen is living in the tent pitched outside the shelter, and that the man is her boyfriend.

Karen has been guided onto a stretcher, but is sitting upright and looking around. She slowly spins her leg to the side of the stretcher and starts easing herself off. She is looking around the street, searching for something.

“Are you coming with us?” the paramedic asks her.

Karen continues her search, not responding to the paramedic’s question. She is still disoriented, but increasingly mobile, shuffling to inspect items on the ground.

Again, the paramedic asks, “Are you coming with us to the hospital?” When Karen still does not respond, Magda approaches and has a hushed conversation with Karen before returning. Magda explains to me that Karen lost all of her money when she was overdosing. It’s the monthly social assistance disbursement day and if she cashed her whole cheque that would be hundreds of dollars. Karen’s not going to the hospital because her money is missing and she desperately needs to find it.

A paramedic, frustrated that Karen is refusing transport to hospital, glances at Magda and myself as she packs up to leave. “I guess some people just need to make the same mistake again and again,” she says, rolling her eyes. “Maybe I’ll see you later today.”
I return inside the site, where I debrief with Tara and Nick about the overdose. Tara and Nick tell me that they held Karen’s dope for her while she was under so that no one could steal it. I tell them that Karen’s money is missing. At this, Tara shakes her head and walks back outside to aid in the search.

3.1 Introduction

Karen’s overdose was one of at least 13,265 overdoses that occurred in British Columbia in 2018 (British Columbia Centre for Disease Control, 2022). The vignette above captures a situation now common in Vancouver’s DTES and other communities impacted by the increasing toxicity of street drugs. Tara and Nick, two skilled responders at a drug user-run OPS are called upon to manage an opioid-related overdose that could lead to brain injury or death. They act quickly and proficiently to reverse Karen’s overdose before emergency medical responders arrive on the scene.

What this vignette renders visible, and the focus of this chapter, is how expertise in overdose response enlists more than an individual’s technical knowledge and skills of administering first aid and naloxone. Beyond this, Tara and Nick work together to support Karen in other ways during her overdose: reassuring her of her safety and whereabouts, safeguarding her belongings, and communicating updates to concerned onlookers. They are aided by Karen’s companions and concerned onlookers who perform crowd control, shout words of encouragement and clear the path for emergency medical responders. Karen herself exercises agency over her care, rejecting post-overdose transport to hospital as she prioritizes finding her missing and possibly stolen money.
In this chapter, I draw on ethnographic fieldwork, interviews and focus groups to explore how expertise in overdose response was assembled within OPS, focusing specifically on how responders with lived experience of drug use developed and enacted expertise in overdose response.

3.1.1 Theorizing expertise in community-based overdose response

Opioid-related death and injuries can be prevented in real time through the rapid administration of naloxone by a bystander. The community-based provision of naloxone was first advanced in the 1990s through pilot Take Home Naloxone (‘THN’) programs that distributed naloxone to people who use opioids and trained them in overdose identification and managements (Bennett et al., 2011; Dettmer et al., 2001; Galea et al., 2006; Maxwell et al., 2006; Strang et al., 1996). Scientific evaluations of these programs indicate that providing naloxone to people who use opioids and those likely to be near during an overdose (e.g., family, friends, health care providers) is an effective strategy to reduce fatal overdoses (Bennett et al., 2011; Dettmer et al., 2001; Galea et al., 2006; Maxwell et al., 2006; Strang et al., 1996; Walley et al., 2013). THN programmes have since been expanded in North America, Europe, and Australia, in some cases accompanied by regulatory changes that improve access by allowing naloxone to be distributed through new settings (e.g., community agencies, shelters, syringe exchanges, pharmacies, emergency departments) and without a prescription (Canadian Pharmacists Association, 2017; Davis & Carr, 2015; McDonald & Strang, 2016).
By recruiting, training and equipping PWUD to reverse overdose with naloxone, THN programs position PWUD as valuable community responders whose social networks and relationships make them uniquely well-situated to prevent overdose deaths (Faulkner-Gurstein, 2017). Peer-to-peer administration of naloxone has further transformed the social meaning and possibilities of this technology, shifting it over the course of a few decades from a medication deployed dispassionately or even harmfully by medical professionals onto the bodies of PWUD to a tool of empowerment, solidarity and harm reduction wielded by PWUD themselves (Campbell, 2020; Farrugia et al., 2019; Wagner et al., 2014). A diverse range of overdose education and response programs have emerged as part of this shift, including naloxone training and distribution programs, street outreach, and safer environment interventions designed and/or implemented by PWUD (McAuley et al., 2015; McNeil & Small, 2014; Mercer et al., 2021).

While the benefits of PWUD involvement in overdose education and response programs are now well-established (Mercer et al., 2021; Marshall et al., 2015), the particular expertise and expert knowledge of PWUD in this work remains undertheorized. Existing research on PWUD-led overdose response has largely studied expertise by assessing individuals’ knowledge, skills, and competencies in carrying out recommended techniques for overdose response, such as calling 9-11, administering naloxone and performing basic first aid (Neale et al., 2018). This approach is evident in the earliest studies evaluating the feasibility and effectiveness of THN, which largely
employed quantitative surveys to assess how bystanders respond to overdoses (Baca & Grant, 2007; Best et al., 2002; Doe-Simkons et al., 2009; Gaston et al., 2009; Lagu et al., 2006; Tracy et al., 2005). These studies generated supportive but variable findings about PWUD’s practices around overdose, with PWUD reporting a high willingness to aid people experiencing overdoses (Baca & Grant, 2007; Lagu et al., 2006; Doe-Simkons et al., 2009), but also inconsistent access to naloxone (e.g., not carrying it) and reluctance to call 9-1-1 (Baca & Grant, 2007; Best et al., 2002; Lagu et al., 2005; Gaston et al., 2009; Tracy et al., 2005). Studies further found that PWUD who participated in overdose education and response training demonstrated improved confidence and knowledge of effective overdose response techniques, including greater uptake of and willingness to use naloxone for opioid overdoses (Ashrafioun et al., 2016; Bennett & Holloway, 2012; Galea et al., 2006; Green et al., 2008; Gaston et al., 2009; Piper et al., 2008; Strang et al., 2008, Tobin et al., 2009; Wagner et al., 2010). However, due to their quantitative design, these studies provided limited insight into how and why PWUD make decisions about overdose management in practice (Neale et al., 2018).

A growing body of research has since adopted qualitative and mixed-methods methods to better understand the circumstances surrounding overdoses and how they are managed in community settings (Chang et al., 2019; Dechman, 2015; Holloway et al., 2018; Farrugia et al., 2019; Farrugia et al., 2020; Faulkner-Gurstein, 2017; Kennedy, et al., 2019; Kolla & Strike, 2019; Lankenau et al., 2013; Lavalley et al., 2020; Neale et al., 2018;
Richert, 2015; Sherman et al., 2008). These studies problematize relationships between individual competency and outcomes by identifying barriers to effective overdose response, including the often-hidden nature of overdoses, structural barriers to naloxone access, impeding actions of other bystanders, concerns about post-overdose reactions, and fears of calling 911 due to the ongoing criminalization of drug use (Holloway, 2018; Kolla & Strike, 2019; Lankenau, 2014; Richert, 2015; Sherman, 2008). As such, this body of work moves beyond a focus on individual knowledge and skills to consider social and structural factors affecting overdose response. Drawing primarily on PWUD’s accounts of witnessed and experienced overdoses, multiple studies uncover how PWUD leverage their relationships and experiential knowledge to prevent overdose deaths and address other care gaps resulting from PWUD’s social marginalization, criminalization, and medical disenfranchisement (Dechman, 2015; Faulkner-Gurstein, 2017; Kennedy, et al., 2019; Kolla & Strike, 2019; Lavalley et al., 2020).

Recent studies of overdose education and prevention programs in the US (Faulkner-Gurstein, 2017), and Australia (Farrugia, 2019, 2020) offer particularly important insights into the expertise of PWUD in overdose response. Drawing on interviews and participant observation of overdose prevention training sessions in New York, Faulkner-Gurstein (2017) highlights how naloxone as a public health strategy depends on the experience and expertise of drug users. Specifically, this ethnographic research identifies how “peer” participants in naloxone training programs draw upon
their knowledge of the local drug supply, proficiency using needles (helpful for injectable formulations), and familiarity with social spaces of drug use to become technically proficient responders. In their qualitative interview study examining the use of take-home naloxone in Australia, Farrugia and colleagues (2019, 2020) further locate how the social relations and situated strategies of people who use opioids (e.g., titrating naloxone doses, communication during overdoses) affords multiple positive outcomes during overdose response including safety, comfort, alleviation of pain and reduced conflict.

While existing research provides strong evidence that PWUD have expertise that is critical to overdose response, very little research exists to characterize how PWUD come to develop this expertise outside of formal training sessions, and how they enact it in practice, in real world settings (Kolla & Strike, 2019). For one, most studies only consider PWUD’s skills and abilities at one or two points in time (e.g., before/after naloxone training), which are assessed primarily through the retroactive accounts of individuals who witnessed or experienced overdoses (Bennett & Holloway, 2012; Best et al., 2002; Green, Heimer & Grau, 2011; Lankeanau et al., 2013; Neale et al., 2018; Piper et al., 2008; Richert, 2015; Strang et al., 2008). While such accounts provide insight into how individuals responded to a past overdose, this approach overlooks considerations of temporality and place, including how expertise develops over time, in relationship to particular people and spaces, and operates in ‘real time’ during overdose events. Secondly, expertise is typically analysed with a narrow focus on technical aspects of
identifying and responding to overdoses (e.g., administering naloxone, rescue breaths), with relatively less attention to social and relational aspects of care that can improve responses such as shared decision-making, communication, and conflict resolution (Farrugia et al., 2020; Faulkner-Gurstein, 2017). As exemplified in Farrugia and colleagues’ research (2019, 2020), attention to these social and relational dimensions of care can reveal other important extra-overdose outcomes achieved by community overdose responders (e.g., protection from violence and theft). Finally, while existing research documents numerous challenges to effective overdose response (e.g., fear of criminalization and eviction when seeking medical help), there is little research examining how PWUD navigate these challenges in practice, including expert knowledge acquired outside of brief training sessions and the development of localized and collective strategies.

The gaps outlined above are a product of dominant scientific knowledge systems (Mazzocchi, 2006), in which researchers generally have not had access to or been embedded within the spaces where overdoses routinely occur. Ethnographic engagement with spaces and communities where overdoses routinely occur can provide greater insight into how communities of PWUD develop expertise in managing overdoses, and the localized care practices that emerge among people who experience broader forms of structural vulnerability such as poverty, housing insecurity, criminalization, and stigma (Bourgois & Schonberg, 2009; Boyd et al., 2018; Collins et al., 2020; Kolla & Strike, 2019).
Recent ethnographic research by Kolla & Strike (2019), for example, uncovers how PWUD employed to operate satellite overdose prevention and education programs in their homes encountered multiple contextual and structural challenges to carrying out recommended overdose prevention measures (e.g., never using alone, carrying naloxone, calling 911 during an overdose) including lack of access to supervised injection space, vulnerability to eviction and continued criminalization of drug use. This work draws attention to the value and need for further ethnographic research to elucidate the social contexts and structural arrangements that can promote effective overdose response.

OPS provide particularly rich sites for studying community expertise in overdose response given the high volume of visits and overdoses at these sites, and the exceptional track record of these sites in preventing overdose deaths. OPS sites in BC respond to approximately 300 to 400 overdose events each month, and have never reported a single overdose fatality (British Columbia Centre for Disease Control, 2022). OPS are also spaces where overdoses have become an object of expert labour performed by PWUD, and offer a semi-bounded space to observe the assemblage of expertise over time.

Informed by a sociological approach to expertise proposed by Eyal (2013), this chapter examines the social arrangements and practices through which expertise is assembled within OPS. This approach understands expertise as a practice—that is, the ability to perform a task proficiently—that emerges through the assemblage of particular actors, objects, techniques, devices, and institutional and spatial arrangements (Eyal
I am particularly interested in how OPS responders’ social position, relationships, and experiences within communities of structurally vulnerable PWUD informed their work and contributed to collective expertise around overdose management (Brady, 2018). To investigate this question, I first draw on concepts of experiential and embodied knowledge. The term ‘experiential knowledge’ refers broadly to knowledge gained from lived and living experiences of a phenomenon (Borkman, 1999; Caron-Flinterman et al., 2005), and has been widely deployed to conceptualize the primary sources of PWUD’s expertise in harm reduction practice (Chang, Behar & Coffin, 2019; Hughes et al., 2022; Jauffret-Rousteide, 2009; Southgate & Hopwood, 2001). Embodied knowledge describes a tacit and practical form of experiential knowledge (“knowing how”) that arises specifically from one’s everyday bodily practices (Oerther & Oerther, 2018). With respect to overdose response, embodied knowledge may encompass practical skills and competencies derived from the everyday bodily practices of drug use (e.g., confidence using syringes) and having personally experienced an overdose (Faulkner-Gurstein, 2017). I draw on these concepts to explore how PWUD develop and enact expertise over overdose response. I then consider how particular structural, social, and spatial arrangements of OPS leveraged and strengthened this expertise, resulting in specialized and comprehensive collective care practices around overdose management.
3.2 Expertise grounded in experiential knowledge

Ethnographic fieldwork in OPS settings indicated that experiential knowledge was foundational to OPS responders’ expertise in overdose response. Overdose responders emphasized that their confidence and proficiency in overdose response derived largely from habitual practice. Overdoses were a common event due to contamination of the drug supply with fentanyl and other adulterants, with local emergency health services recording a more than four-fold increase in overdose-related emergency calls between 2015 and 2019 (British Columbia Centre for Disease Control, 2022; British Columbia Emergency Health Services, 2021). Participants described having “lost count” of how many overdoses they had responded to, or provided estimates in the tens to hundreds. Knowledge about overdose presentation and response was therefore gained initially through informal practice in community settings.

OPS responders positioned their work at OPS as an extension and enhancement of skills they had already acquired from overdose response in other settings. Overdoses in public settings, for example, often attracted crowds of onlookers who had varying levels of experience managing overdoses. As one participant described in a focus group, more experienced responders would sometimes use public overdoses as an opportunity to train others in effective techniques:

And I can show the crowd because I don’t know how many times responding to an overdose has actually become a teaching experience. People are saying, “You’re killing him, sit him up, do this, do that”, and I say “Just shut up and fuckin’ watch and listen.” (Focus group participant)
As captured in the opening vignette of Karen’s overdose, public overdoses were also an event during which people honed skills for addressing a wider range of issues surrounding an overdose, including how to share tasks with other bystanders, de-escalate potential conflicts (e.g., accusations of theft), communicate effectively with emergency medical professionals, and anticipate other needs of the person experiencing an overdose. These skills were not easily learned through trainings, and often required responders to hold localized knowledge about issues that could arise during an overdose. As seen in Karen’s case, helping safeguard people’s belongings and ensuring people do not get robbed during an overdose was one such skill that was necessary within the context of poverty and housing vulnerability.

Having a pre-existing relationship or knowledge about the person overdosing could further enhance care, as this helped responders personalize and tailor their actions to the individual. To help orient and reassure people during an overdose, I witnessed that responders would use the individual’s names and provide context clues about where they were and what had happened. Knowing details about the individuals’ situation further helped responders anticipate people’s care needs, for example, by limiting physical touch for people with post-traumatic stress or coordinating care for pets for someone requiring transport to hospital. In this respect, experiential knowledge allowed for more individualized and flexible forms of care.
3.3 The applications of embodied knowledge

Participants were not only experienced in responding to overdoses, but typically had experienced overdoses themselves due to the toxic drug supply. Responders drew on this embodied knowledge—a distinct type of experiential knowledge acquired through the bodily experience of using drugs and overdosing—to proficiently identify and manage overdoses. Responders who used drugs, for example, expressed the belief that they could identify an overdose sooner than nurses and others who did not have this experience. As Mark, a responder at the drug user union, expressed:

We don’t have nurses here. We’re all peers. That’s the benefit of ours. You know, they thought it couldn’t be run by just peers. But we can identify an OD before [nurses], you know, because we’ve all been there and used, we’ve been active or we’re still active users. (Mark, 40s)

In one exceptional case, an OPS worker described how he drew on his own experience of using heroin to help him better differentiate between “nodding off,” a drowsy state experienced during an opioid high that may only require monitoring, and an actual overdose requiring immediate intervention:

In my first year [of working at an OPS], I was having a hell of a time understanding the nodding, and I was wrecking people’s high and I didn’t want to do that. I had a really close friend that uses heroin and I said, “I’m going to use heroin one night, and just one night.” I just wanted to see how it affects me. So, I got off work at four, I met up with my friend at six-thirty. We had four points of down [heroin] and a half-ball of side [crystal meth], and we went all through the West End on the alleys for 18 hours. My first shot was amazing. I thought, “Well, whoa.” And so, I was quite comical, because I said, “Now I understand why you guys don’t talk, because I’m having a hell of a time trying to figure out how to walk.” You know, like after that night, I went from, you know, just a worker to an actual peer, where I totally
got it and I totally stopped knocking them on the shoulder every time they nodded, because you can read the person, you know them. (Neil, 50s)

Embodied knowledge further shaped whether and how responders deployed naloxone alongside other interventions. Opioid-experienced participants recalled symptoms of precipitated withdrawal (e.g., anxiety, nausea, racing heart, tremors) after being over-administered naloxone (e.g., administered naloxone while responsive and breathing, administered multiple doses at once), as well as the disappointment of losing a pleasurable high. To minimize these undesirable effects, responders would often first attempt other techniques to prevent people from losing consciousness or otherwise rouse them when they were still breathing. As one participant explained:

I’ve been through probably between 50 and 100 kits [of naloxone]. Yeah. So, I try not to use it as much as possible. I mean I think people are too quick to use that first. I think they should use, for instance, cold water on the back of the neck is something that people should try first if they got it. So, but there’s other things too. Like I mean rubbing the chest, just getting the person up and moving or... I mean saying the word “Narcan” [naloxone]. Sometimes, sometimes you tell them, “look, I’m going to hit you with the Narcan, “they’ll kind of [acts out waking up]. (Max, late 40s)

Responders further drew on embodied knowledge to provide care that attended to people’s emotional needs during overdose and other adverse drug experiences. OPS workers often provided emotional support to clients experiencing a broad range of drug experiences beyond opioid overdose, such as ‘bad trips’ caused by ‘Trippy dope.’ Trippy dope was a term used to describe opioids (thought to be adulterated with synthetic cannabinoid) that produced a short-lived but distressing drug experience with psychedelic and dissociative components (Betsos et al., 2021). One OPS worker described
how he drew on his own experiences with trippy dope to guide service users through
what he characterized as a frightening, but ultimately not life-threatening experiences:

This girl started crying, and she says, “I just did the trippy dope,” and so one of our
workers goes, “I know who to go see.” So, she brings her right to me. And because
I’d been through it lots of times, I said, “Come sit down beside me.” I said, “I know
what you’re going through. It’s a really tough thing.” I said, “You know, it’s... it
feels horrible. You feel like you’re going to die. You know, you feel like the world’s
caving in on you. But just trust me when I say this: you’re going to be okay.” And
so, she sat there with me for a few minutes, and she was fine. (Michael, 40s)

Responders’ memories of overdosing informed their approach to post-overdose
care, as they were knowledgeable and empathic about post-overdose emotions and
reactions. Participants emphasized how post-overdose feelings could include
embarrassment, shame, anger, and disorientation. One participant described overdosing
at a medically-supervised consumption site and wanting to immediately leave due to
embarrassment of having urinated herself:

I don’t remember anything besides waking up and having the people there standing
over me going “Are you okay? Are you okay?” And the only thing I could think is
“oh my God. I peed myself.” Like I started crying because I peed myself. It wasn’t
because I OD’d. Like that didn’t even cross my mind. I was just more embarrassed.
And when the lady that seen that, she kind of was like “oh my God.” And she got
really worried for me and she said “Well, can you sit here for 45 minutes” and I was
like: “No. You got to be crazy if you think I’m going to sit here.” And she said, “well,
because you just died.” Like that didn’t even phase me. I was just more worried
about me. Very embarrassed. So, I wanted to leave and there wasn’t more concern
for like anything else happening. But there was so much fentanyl in there that I kept
nodding out after because the Narcan only has a 45-minute window or whatever
[...]there’s still a really like high risk of that OD’ing afterwards when the Narcan
wears off. So, it’s kind of like... it’s scary. It’s really scary. (Maggie, 40s)
As this quote captures, people were at high risk of overdosing again after a reversal given that naloxone typically wears off before the opioids themselves. However, the negative emotional experiences accompanying an overdose could lead people to flee the setting where they experienced an overdose, particularly when treated with judgement or stigma by onlookers. The embodied knowledge of responders was described as improving post-overdose monitoring as responders found it easy to react in a non-judgemental and empathetic manner that encouraged people to stay for post-overdose monitoring. As one site manager explained:

And drug users are more likely to stick around if they’re waking up to a drug user. And, you know, they just don’t look at each other with judgment, because they understand where they’re coming from. So, I think it’s impossible and... not impossible, but I think it’s like you cannot replace that knowledge with any training...you couldn’t replace these peers with doctors and nurses, and other people that were compassionate and have the same result, because they’re not... I don’t think that people would respond the same. (Lacey, 40s)

3.4 OPS as places enabling specialized and comprehensive care

OPS provided specialized spaces for overdose management, enabling more comprehensive forms of community care than what were possible in non-specialized and non-intervention spaces. Participants emphasized how even in their most rudimentary form (e.g., as ad hoc tents), OPS enabled responders to be in the “right place at the right time” to quickly identify and reverse an overdose. As one manager shared:

Overdose prevention sites are good. They’re like the first line of, you know, defence against overdoses for people. Like having, being in a place... like we just had an overdose where someone, you know, like literally his pulse I think was at like 30 or something like that, and it was like “whoa!” And it’s freaky, if he was alone
somewhere in his house, he would be dead right now. So, there’d just be no way he would live through that. So, it’s good he’s here …and if he was in the alley with that kind of a pulse, and no one saw him, he’d be dead by now, or his brain would be damaged. So, we avoid all kinds of stuff like that, just by being here and as soon as they overdose, we see them, and we deal with it immediately. (Lacey, 40s)

With provincial funding and in-kind support, however, OPS spaces were able to provide more robust and specialized care to people experiencing overdoses. OPS facilities were designed and adapted with overdose prevention in mind, including open-concept layouts for injection spaces that facilitated quick identification of overdoses and rapid response. At one site, new walls and doors were erected between the injection room and the lobby to more tightly control access to the space. It became standard practice at this OPS to clear sites and refuse access during overdoses that required additional emergency medical service intervention. As one worker explained, this practice temporarily disrupted access to the site for others, but was described as necessary to protect the privacy of service users and to keep pathways clear for paramedics entering with medical transport stretchers:

Well, one thing that we can do now is if we do have an overdose, we can shut that door off and lock it, and nobody’s getting in. Nobody can peek in and see what’s going on or what’s taking so long. And that way the person in the front, he could actually ask everyone to step outside and basically, we could just have the site, only the people out there, and nobody in the waiting room. So, we could do that. I think in the situations like that, it’ll be helpful. (Debra, 30s)

OPS became better equipped over time with tools to support overdose response beyond naloxone, including oropharyngeal airway devices (OPA) to keep airways open,
oxygen tanks and Bag Valve Masks (BVM), oximeters to monitor oxygen saturation, and automated external defibrillators. Starting in late 2018, drug-checking using Fourier-transform infrared spectroscopy and immunoassay was available on a rotating basis at OPS, allowing service users to test their substances for fentanyl and other adulterants that could contribute to overdose. As one worker shared, access to these tools enhanced the level of care that responders were able to provide at sites:

Well, I started out years ago, when I got my Narcan training through [a medically supervised injection site]. And then basically, I just got a refresher when I started here. Because it was basically everything I already knew, except they give me a few more tools now. Now I have a Bag Valve Masks, I have an OPA and I have oxygen, which really makes my job so much easier. (Michael, 40s)

Such space-contingent expertise in identifying and responding to overdoses occurring in an OPS was juxtaposed with overdoses in other common settings (e.g., housing, alleyways, public bathrooms), where response could be hindered by isolation of the person using drug, uncertainty about one’s whereabouts, and lack of access to tools to respond to an overdose. One participant who engaged in sex work shared a challenging circumstance where she struggled to reverse the overdose of a client at his home:

I had to bring him [my client] back [to life] and the problem was that where he lives, there’s a street there [points]. There’s a street there [points in another direction]. There’s a street there [points in another direction]. I had no idea which street we were on. I called the ambulance and I guessed. I said “But there’s three streets here. I’m not really quite sure”, and this is while he’s dead in his room. I had to run out and get the address for where he lives. Then I had to run back and fucking resuscitate him. I worked on him for 45 minutes doing chest compressions because
I didn’t have Narcan on me either. I was so dumb. Now I carry it all the time but I didn’t have it that day. (Alexa, 40s)

Participants described OPS as having other properties that positively impacted responders’ practice. Workers expressed pride in operating out of places that looked “legitimate,” as OPS increasingly had proper lighting and heating as well traditional service space features such as a check-in desk and stainless-steel surfaces. Legitimacy was not the same as expertise, but these markers of legitimacy gave workers greater confidence in their own expertise, and signaled such to service users. One manager described how moving from an alleyway tent into a permanent, indoor trailer space made workers feel like their work was more legitimate:

The energy that people seem to be deriving from that move [into the trailer] is pretty incredible. Like folks are so excited to be indoors in a space that’s warm, in a space that looks and feels a lot more – a lot more robust and a lot more kind of legitimate, I think. Like there’s – you know, I’ve had a couple members of our team talk to me about – kind of realizing now that they’re not in that tent anymore, how much operating either in a tent or in the basement of a mostly shutdown building or whatever, like really made them feel like their work was less legitimate, right? And now all of a sudden, they’re in this space with we’ve got really nice like stainless steel surfaces, and like have a place to put everything, and locked doors, and like heat and windows and, you know, and like they’re like, “I feel really good about the work that I get to do in this space. (Craig, 30s)

The implementation of OPS as specialized and community-run spaces afforded new possibilities for post-overdose care. All OPS had a designated chill space for post-overdose monitoring which provided service users an alternative to monitoring in hospital, where participants described being subjected to stigmatizing treatment. The paramedic’s response to Karen’s refusal of transport to hospital in the opening vignette
—rolled eyes and declaration that “some people need to just keep making the same mistake”—was just one of many stigmatizing encounters PWUD had with emergency medical professionals during overdoses. When asked why they refused post-overdose transport to hospital, many participants emphasized stigmatizing and discriminatory treatment:

Because I know that it is surely going to be a process of me being put on a gurney, sitting in the middle of the waiting room with ambulance attendants and a nurse sitting there, centering me out around the rest of the patients. Every time I will either close my eyes or even think of leaning back, they’ll start throwing out, you know, comments, nasty comments. They talk about personal business out loud in front of the other patients. It’s just all-round horseshit and they’ll keep you until… if they know you’re homeless, they’ll keep you until about 3:00 in the morning or so, and then kick you loose. Sometimes with no shoes. So yeah, I don’t bother with that. I don’t listen to them when they try to get me to go. (Max, 40s)

Having a dedicated space for overdose response created possibilities for care that went beyond immediate overdose reversal. Participants highlighted that by interacting with the same people over time in the same space they were able to open up conversations about other supports and services, conversations that were more difficult in public settings such as alleyways and parks:

And then when we do that [reverse an overdose], we also, you know, see if they need any other services. We can start to talk over time if they, you know, [say] “I’m tired of this shit. I want rehab.” And we’re here for them. Like, it’s impossible to access someone who’s lying in an alley, you know, to, [say] “Hey, do you want to go to rehab?” Like that doesn’t happen, right? So those scenarios were less likely to happen [in the alleys] (Lacey, 40s)
3.5 Overdose response expertise as collective performance

Observations of overdose management in OPS, considered alongside accounts of overdoses in other settings, revealed how proficient overdose response was often a collective performance involving communication and shared decision-making within a dynamic environment. Participants shared that managing an overdose on one’s own could sometimes be challenging given the emotions, urgency and multiple components involved. In one focus group, participants commiserated with each other about the challenges of managing an overdose in public settings and handling bystanders who attempted interventions that were not in line with best practice (e.g., trying to sit the person up when they were not breathing, providing compressions despite a pulse being detected). In this conversation, one participant sarcastically remarked: “I notice, listening to crowds, everyone becomes an expert.” This comment speaks to the potential challenges of managing overdoses collectively, as people can have competing approaches to overdose management that are difficult to navigate during a life-threatening and emotionally charged medical emergency. Responders described how their uncertainties about other people’s skills and motivations in non-OPS settings made them feel like they were managing overdoses alone, even when surrounded by others, and that bystanders could be “interfering” rather than helpful.

In contrast, overdose response at OPS was characterized as routine and mostly organized, which enabled people to proficiently carry out life-saving procedures. When
invited to describe an overdose recently observed at an OPS, one service user emphasized the calm and efficient manner of the response:

Well, the person just overdosed and, you know, everybody was pretty calm about it, right. And then people, they know their job and they just get to it and it’s taken care of, right. It happens so often it’s not even kind of shocking. You see it all the time, right? (Jordan, 30s)

OPS staff explained that this calm and efficient approach did not occur organically, but rather required considerable work to orchestrate as it would in other specialized settings with team-based care. Staff described the earliest days of OPS implementation as hectic and chaotic, as staff learned through trial-and-error how to handle challenging situations such as simultaneous overdoses and mental health crises. The increasingly contaminated drug supply was also resulting in atypical overdose presentations that were more difficult to identify and manage, such as fentanyl-induced muscle rigidity and prolonged sedation from benzodiazepines. Disagreements or miscommunications regarding how to handle these situations could impede overdose response and otherwise sow conflict between workers.

Over time, OPS enacted a number of practices and processes to routinize and optimize collective practices around overdose response. One of the earliest strategies was role delegation and specialization. I observed that overdoses in OPS were always managed collaboratively in pairs or as part of a larger team. To orchestrate and optimize this teamwork, OPS developed chains of command for overdose events and delegated responsibilities to team members before each shift. Overdose response teams included a
supervisor who typically oversaw the response by leading assessment and making decisions about care, administering naloxone, tracking time after dose administration, and coordinating with emergency medical responders. At least one other worker then supported the lead by opening and keeping airways open, placing an oximeter to monitor saturation, monitoring respirations, and ensuring a good seal on the face mask or BVM. Ideally a third worker would be available to physically administer oxygen as needed by performing rescue breaths or squeezing the BVM bag. One worker from the drug-user union described the chain of command and task delegation at his site:

So, when there’s an OD [overdose], the attendant, the guy back there, well it’s his room anyways. But especially when there’s an OD, it’s his room. He heads the OD, like he does like the major part. Like and all’s I do is work for him now. Like he’s supposed to yell, “OD!” and get the horn, and right away I’ll grab the naloxone and start it up, and help him, if the person’s still in the chair, getting him down onto the floor and on their backs and that, and just... and he’ll start, you know, monitoring the guy, see if he’s breathing, to see, you know, generally they go blue and white, pale, like right fast, eh? So, and then I’ll have the oxygen there for him. I’ll have everything ready and he’ll say, you know... you know, to inject him in a muscle. And the person will be hooked up to oxygen and then we’ll start with the air and the oxygen, and compressions if we need it, right? (Gordon, 50s)

Role delegation and specialization helped minimize ambiguities and conflicts about how to manage overdoses, and allowed team members to focus on tasks where they demonstrated particular proficiency. While disputes still arose occasionally regarding best practices for overdose management, particularly during moments of significant staff turnover, teams generally developed a shared understanding of how to manage overdoses and share responsibilities.
To further strengthen and organize overdose response, most OPS codified collective knowledge about overdose management into checklists, decision-making flow charts and standardized procedures that staff were trained to follow. These documents specified sequential steps and guidance about when and how to administer oxygen (using indications of saturation from oximeters or assessments of respiration); when to administer naloxone and how far to space out doses (0.4 mg naloxone every 3-5 minutes until oxygen saturation and respiration improves); and when to call 911 (when overdose is moderate to severe based on unresponsiveness and breathing). These procedures were again important for managing uncertainty during complex and unusual overdose presentations and to pre-empt potential disputes about care.

Beyond written and formal procedures, OPS workers established informal practices for managing situations that fell outside the traditional scope of emergency medical response. These informal practices built from the experiential knowledge of responders, as they reflected practices PWUD had developed to mitigate the broader social vulnerabilities of people experiencing overdose (e.g., to violence, theft, or criminalization). The opening vignette presents one such practice, in which Tara and Nick discreetly “hold” Karen’s drugs while she is unconscious to prevent potential theft. In situations where police may be present (e.g., outside of OPS or in other public settings), hiding drugs was also strategic to protect overdose victims from criminalization. While workers at OPS would not touch service user’s drugs out of policy (and to prevent
accusations of theft against themselves), they would generally keep an eye on their belongings during an overdose to prevent theft. In Karen’s case, bystanders further supported care of Karen by organizing her belongings for transport to hospital and interacting with emergency health care professionals on her behalf during a time where she was disoriented. While not outlined in any written procedural document, I observed that this collective performance of care was routinized over time at sites with clear benefits for service users in enhancing continuum of care.

Finally, OPS became sites for collective capacity building around overdose response through on-the-job mentorship and the creation of training programs tailored to the needs of community-based overdose responders. A ‘Street Degree in Overdose Prevention’ was established through the collaboration of OPS operators and the local health authority. Through this low-barrier training program, OPS workers and community members could drop in on bi-monthly sessions and work towards a ‘street degree’ in overdose management that was earned after completing ten modules. This provided a mechanism for OPS responders to continually expand their skills, as well as disseminate their own knowledge more broadly within the community. The modules were facilitated by OPS workers and covered collectively-identified domains of practice such as: overdose management (advanced management, train-the-trainer, collaborating with first responders), knowledge and skills specific to working in an OPS (safer injection practices, managing other medical emergencies, drug knowledge, local community
resources, drug checking, common OPS challenges and solutions), peer worker well-being and safety (managing extreme situations, leadership, preventing burnout) and stigma reduction (cultural safety, communication skills, peer facilitation). This training program was credited by participants as promoting greater acknowledgement and legitimization of the expertise of OPS peer staff. The opportunity to continually learn and share their own expertise was a source of confidence and pride for many responders. As expressed by one staff member, this confidence could translate into improved morale and performance at work:

Training is good. Just train and train. Train your people. Because I believe that when people are trained, or you do a lot of training they feel more confidence. And when people are feeling confident about what they’re doing, they’re going to do their job better. So, you know, we want to make people feel confident and good about what they’re doing. (Frank, 50s)

3.6 Discussion

This chapter examined how expertise in overdose response was assembled within OPS, with a focus on how expertise was developed and enacted by responders with lived experience of drug use and overdose. This work contributes new insights regarding expertise in community-based overdose response by illuminating how OPS sites leveraged the experiential and embodied knowledge of structurally vulnerable PWUD, while also establishing spaces and processes that afforded more specialized, comprehensive, and routinized overdose care.
This work deepens understandings of the role of experiential and embodied knowledge in expert practice. Research on expertise within health care provision (including management of overdoses) has largely privileged explicit knowledge that can be easily articulated, codified, and measured (e.g., self-reported knowledge and confidence about overdose response procedures) (Epstein, 1999; Smith et al., 2003; Neale et al., 2018; Strang et al., 2008). Yet a large body of sociological, anthropological, and nursing research documents how people acquire crucial knowledge, skills and competencies through their everyday lived experiences, habitual practice, and socialization (Blume, 2017; Castro et al., 2019; Epstein, 1999; Lisko & O’Dell, 2010; Smith et al., 2003). This work extends these insights to overdose response work, demonstrating how PWUD working in responder roles draw on their experiential and embodied knowledge to provide overdose care that is not only technically correct (i.e., administering naloxone and oxygen correctly), but also socially adept and responsive to the broader needs of structurally vulnerable PWUD. This analysis distinguishes embodied knowledge as a distinct type of experiential knowledge that responders with lived experience of drug use apply when managing overdoses: to identify overdoses, decide on intervention approaches, and provide empathic care (Oerther & Oerther, 2018). Through routinely responding to overdoses and in many cases drawing on their own experiences of overdosing, responders learned how to communicate effectively with bystanders and medical professionals, delegate tasks efficiently, and attend to diverse
social and psychological concerns of people experiencing overdose. These findings align with and build upon previous research identifying the social and relational practices of PWUD as critical to the positive public health and social outcomes attributed to community-based overdose education and prevention programs (Farrugia 2019, 2020; Faulkner-Gurstein, 2017, Kennedy et al., 2017).

This work further extends theorization of expertise in overdose response by illuminating some of the arrangements, conditions, and practices through which expertise in community-based overdose response is assembled (Eyal, 2013). In conceptualizing expertise as a practice that is assembled, this analysis foregrounds the distinct socio-spatial arrangements, devices, people, and processes that are brought together within OPS to afford multiple positive outcomes in overdose care (Farrugia, Fraser & Dwyer, 2018). Findings re-situate community expertise in overdose response as an adaptive response to the contaminated drug supply, in which the very survival of structurally vulnerable PWUD is contingent upon collective practices and skills of recognizing and responding to an overdose as these become more frequent and complex. In this setting, collective expertise around overdose management was strengthened through the grassroots establishment (and eventual government support) of OPS as specialized places where PWUD with varying drug use experiences and knowledge can gain expertise in various technical skills and social competencies enlisted in overdose management. Over time, OPS became sites of collective expertise around overdose
management as workers established shared understandings, procedures, and collaborative practices for managing overdoses.

Finally, this study generates pragmatic evidence about how expertise in community-based overdose response can be cultivated. The findings add to existing evidence supporting OPS and other place-based overdose prevention interventions as fostering environments that are conducive to overdose prevention and response (Collins et al., 2020; Foreman-Mackey et al., 2019; Kennedy et al., 2021; Kolla et al., 2020; McNeil et al., 2014; McNeil & Small, 2014; Olding et al., 2021; Pauly et al., 2020). This work further indicates the importance of staffing overdose response programs with responders who have pre-existing ties to the places and people they serve, and who hold experiential and embodied knowledge of drug use and overdose (Kennedy et al., 2019). Findings support a team-based approach to overdose management that can be enhanced through the development of formal and informal tools to support shared decision-making, communication, and collaboration during overdose events. Finally, this work highlights the benefits of expanding overdose response training, moving beyond a focus on technical aspects of naloxone administration to encompass other psycho-social and relational aspects of overdose prevention and harm reduction practice.

3.7 Conclusion

Based on ethnographic analysis of OPS, this chapter suggests a re-situated understanding of expertise in community-based overdose response as (1): grounded in
experiential and embodied forms of knowledge; (2) situated in place and the social, spatial and relational arrangements that facilitate specialization and comprehensive care; and (3): a collective performance that involves developing shared understandings of overdose management in a broader sense, including processes for managing uncertainty, delegating team responsibilities and sharing decision-making. Re-situating expertise in this manner allows for a deeper recognition of the individual knowledge, skills, and capacities of PWUD as responders, while also drawing attention to tangible ways to support and promote community expertise in overdose response.
Chapter 4: SITUATING OVERDOSE PREVENTION SITES WITHIN URBAN GEOGRAPHIES OF SURVIVAL

4.1 Introduction

The previous chapter explored how OPS built upon and strengthened unique forms of expertise in community-based overdose response. This chapter indicated additional functions of OPS for PWUD beyond overdose prevention, as findings illuminated how responders enacted forms of care that were responsive to people’s broader health and social vulnerabilities. In this chapter, I aim to better situate the diverse “uses” of OPS within the geographies of survival forged by structurally vulnerable PWUD, including how OPS accommodated and negotiated tensions between different uses of service space.

4.1.1 Geographies of marginalization and revanchist urban control

Political-economic restructuring over the past several decades has transformed cities, producing new geographies of marginalization (Brenner, Maruse & Mayer, 2012; Mitchell, 2011; Peck & Tickell, 2002; Wacquant, 2008). Intensified poverty and housing vulnerability have become defining features of North American cities, driven in large part by growing wealth inequality, retrenchment of social welfare, deregulation of wage labor, and expansion of the carceral system (Wacquant, 2008; Peck & Tickell, 2008). Patterns of uneven urban development have further relegated people experiencing extreme poverty and housing vulnerability to bounded places (e.g., “skid rows”,

88
“ghettos”) that are marked by stigma and discourses of vilification (Rhodes, 2012; Takahashi, 1997; Wacquant, 2007; Woolford, 2001).

In response, urban municipalities have mobilized a diverse range of urban control strategies to regulate urban poverty and homelessness. Critical urban scholars have foregrounded the revanchist nature of contemporary urban control strategies that seek to punish and “take back” the city from groups constructed as socially undesirable—often racialized, poor, and unhoused people (Mitchel, 2003; Mitchell, 2020; Smith, 1996; Wacquant, 2009). Urban control strategies implicated in revanchist politics include by-laws that prohibit sheltering, sleeping, and panhandling in public spaces (Blomley, 2007; Chesnay et al., 2013); court-ordered area restrictions that restrict people from entering areas of the city (McNeil et al., 2016; Moore, et al., 2011); urban surveillance tools such as CCTVs and community policing (Boyd, Fast et al., 2016; Doherty, Busch-Geertsema, & Karpuskiene, 2008; Raco, 2003); and hostile architecture intended to discourage sleeping and sheltering (Petty, 2016; Sylvestre, 2010). These strategies operate to exclude certain structurally vulnerable groups from desirable public places (“good neighbourhoods”), as well as to displace them from economically depressed areas targeted for gentrification (Amster, 2003; Harvey, 2003; Mitchell, 2020).

There are multiple adverse impacts of revanchist urban governance strategies on health equity (Chang et al., 2022; Darrah-Okike et al., 2017; Robinson, 2017; Qi et al., 2022). Several studies document how laws restricting the activities of unhoused people in public
space impede their ability to carry out even basic subsistence practices such as sleeping, sheltering, and eating (Darrah-Okike et al., 2017; McNeil, Cooper, Small et al., 2015; Robinson, 2017). Other studies demonstrate how municipal operations to spatially contain or displace unhoused people negatively impact this population’s health by dispossessing them of resources necessary for health (e.g., temporary shelters, medications, harm reduction supplies), disconnecting them from health-promoting supports and services, and pushing them into more isolated and hazardous places (Chang et al., 2022; Qi et al., 2022).

4.1.2 Situating OPS within geographies of survival

A related body of research highlights the manifold spaces and spatial relations that have emerged to help people survive exclusionary urban geographies (Cloke, May & Johnson, 2010; DeVerteuil, 2014; Dozier, 2019; Hennigan & Speer, 2019; Miewald & McCann, 2013; Mitchell & Heynen, 2009; Mitchell, 2011; Murphy, 2009). This body of scholarship draws attention to the precarious assemblage of services and community supports that people navigate to meet basic subsistence, shelter, and other material needs. These spaces and spatial arrangements constitute what Mitchel and Heynen (2009) term “geographies of survival,” structuring how marginalized people live within cities, and even whether they may live. Several ethnographies illuminate the complex geographies of survival of very poor and vulnerably housed people as they move through public space and institutional circuits of food programs, emergency shelters, supportive
housing, drop-in spaces, jail, and treatment programs (Fast, 2021; Fast & Cunningham, 2018; Knight, 2015; Lopez, 2020).

Recent critical urban scholarship draws attention to the particular significance of harm reduction programs within the geographies of survival forged by structurally vulnerable PWUD (Dozier, 2019; Lopez, 2020; McKelvie, 2020; McLean, 2012; McNeil, 2015). Harm reduction encompasses a diverse continuum of philosophies and practices, but is most commonly studied in relation to interventions such as syringe service programs, naloxone distribution programs, and supervised consumption sites (Hawk et al., 2017). These interventions can be understood as ‘safer environment interventions’ that reshape social, structural and physical environments in order to enable risk reduction (e.g., HIV, HCV, overdose mortality) and other positive outcomes (e.g., social connection, empowerment, quality of life) (McNeil & Small, 2014; Rhodes et al., 2006).

As such, harm reduction programs are places; places that are inhabited, remade, and used by structurally vulnerable PWUD to help them survive exclusionary urban geographies (Duff, 2007; McLean, 2012; McNeil & Small, 2014). As explored by McLean (2012) in an ethnographic study of a New York syringe exchange service, an intervention designed primarily as a public health tool can “become reimagined by its users as a general welfare center, occupying a paramount space in their personal geographies of survival” (p. 3). McLean’s study, and several others since (Boyd & Boyd, 2013; Gowan, Whetstone & Andic., 2012; Lopez, 2020; McKelvie, 2020), underscore the diverse uses of
harm reduction programs as places to obtain basic necessities, socialize, generate income, connect to other supports, and even establish collective political goals.

In Vancouver, OPS are places that have become particularly central to PWUD’s geographies of survival. Vancouver is widely reputed to be a compassionate city with a progressive approach to urban drug use and housing vulnerability (Longhurst & McCann, 2016), and yet, it is simultaneously a place where life itself is increasingly untenable for those pushed to the margins. The housing vulnerability of low-income residents has been exacerbated by growing wealth inequality and a speculative real estate boom that has rendered Vancouver one of the most unaffordable cities in the world (Collins et al., 2018; Fleming et al., 2019; Ley, 2015; McNeil et al., 2021; Yu et al., 2021). Poverty has become increasingly concentrated within the DTES in particular, an economically depressed neighbourhood that has long been a place for those “shunned by the mainstream” and displaced from or priced out of other neighbourhoods (Roe, 2009, p.1). Most Vancouver-based OPS have been established in the DTES, as this neighbourhood is home to a large and dynamic drug use scene and has been disproportionately impacted by the toxic drug supply. These OPS have become important sites within PWUD’s broader geographies as spaces where they can receive life-saving care during an overdose.

However, recent ethnographic and qualitative research suggests that OPS have important uses in promoting the survival of PWUD, beyond preventing overdose deaths.
The broader literature on supervised consumption sites evinces that these interventions mitigate the considerable risk of injury, arrest, stigmatizing treatment, and gendered violence that structurally vulnerable PWUD face when using drugs in public settings (Boyd et al., 2018; Fairbairn et al., 2008; Small, Moore, Shoveller, Wood, & Kerr, 2012; McNeil, Kerr, Lampkin et al., 2015; McNeil & Small, 2014; McNeil, Small, Lampkin et al., 2014; Rhodes et al., 2006). Research from Vancouver and other Canadian cities indicate that OPS, in particular, are used by marginalized PWUD as a place of sociality, solidarity and mutual support; a temporary shelter during inclement weather; a partial refuge from violence and criminalization; a gateway to other social supports and services; a place to generate income; and a place to engage in other everyday survival practices such as sourcing drugs, food and other material goods (Boyd et al., 2018; Boyd et al., 2020; Collins et al., 2020; Foreman-Mackey et al., 2019; Kerman et al., 2020).

4.1.3 Outstanding questions and chapter objectives

While it is well-established that OPS are used by PWUD to meet multiple survival needs, it remains unclear how service providers and service users negotiate these different uses in practice. The survival threats facing structurally vulnerable PWUD are complex and—as the previous chapter illustrates—OPS mitigate some of these threats by providing overdose-related care that is responsive to people’s broader needs. However, OPS are not adequately funded or mandated to operate as “general welfare centres,” and therefor face difficult decisions about how to deploy constrained resources such as space
and staff. Further research is needed to understand how operating organizations, staff and service users manage the tensions that can emerge when people attempt to use the space beyond its intended overdose response functions.

Moreover, there is a need to better situate how exclusionary geographies and revanchist governance strategies shape these tensions. In the Vancouver context, this includes consideration of local strategies to regulate the presence and survival practices of unhoused people. In the DTES, this entails intensive street-level policing and daily municipal operations to move people from places where they find shelter (known as ‘street sweeps’) (Bennett & Larkin, 2018; Mannoe, 2022; St. Denis, 2021). While subject to less street-level policing than the DTES, the Downtown South is another inner-city neighbourhood where the everyday activities of structurally vulnerable PWUD are tightly regulated by police, by-law officers and private security guards who control access to public and private spaces (Boyd, Fast & Small, 2015; Fast & Cunningham, 2018; Marwick et al., 2015). Previous research highlights the adverse impacts of these urban control practices on PWUD’s health and access to harm reduction services (Kerr, Small & Wood, 2005; Markwick et al., 2015; McNeil et al., 2015), including recent ethnographic research highlighting how place-based policing and gentrification processes impede PWUD’s access to OPS (Collins, Boyd, Mayer et al., 2019). While there is evidence to suggest that such urban control practices further impact how PWUD use harm reduction spaces (McLean, 2012; Lopez, 2020), this dynamic is not yet well understood in OPS.
settings. Further, little is known regarding how these dynamics frame PWUD’s uses of sites and tensions that surround these uses. This information is critical for understanding the full impacts of socio-spatial exclusion on PWUD’s engagement with OPS, and the role of these sites within their broader geographies of survival.

This chapter addresses these research gaps by exploring: (1) how OPS service space was organized and altered to accommodate the broader uses of OPS within PWUD’s geographies of survival; and (2) How OPS operators prioritized service delivery when facing tensions between these different uses; tensions that are structurally linked to revanchist geographies. In addressing the second question, I draw upon and theoretically extend the concept of ‘triage.’ In medicine, triage refers to systems for prioritizing treatment of patients deemed to be in most urgent need of medical care, typically using assessments of illness severity and perceived likelihood of survival (Iverson & Moskop, 2007). The concept of triage has since been taken up by social scientists to describe broader cultural and political processes through which certain individuals and groups of people are prioritized for care and treatment, while others are excluded (Anderson, 2015; Nguyen, 2010). Drawing on data from my ethnographic research, I detail how OPS operators enacted what I term ‘spatial triage’: a pragmatic set of rules, procedures, and spatial practices that oriented service space towards addressing the most urgent threat of overdose fatality and, in the process, constrained other uses of OPS within people’s geographies of survival. After detailing how spatial triage was
enacted within OPS, I conclude by reflecting upon the implications of spatial triage from an equity perspective.

4.2 Accommodating multiple uses of OPS within geographies of survival

While OPS were established primarily to prevent overdose deaths, ethnographic fieldwork indicated that these sites accommodated other important uses of the space within PWUD’s geographies of survival. OPS were central to people’s geographies of survival as they represented one of the few publicly-accessible spaces in Vancouver that welcomed vulnerably housed PWUD. Importantly, sites operated with low-barrier policies (e.g., allowing client-to-client injection assistance, splitting, and sharing of drugs, booth sharing, late night and weekend operating hours) that improved program accessibility and facilitated drug use practices more closely aligned with how drugs were used in non-intervention settings. Service users further emphasized that OPS were situated strategically in spaces they already frequented to source drugs, access cheap food, make money, find emergency shelter, and socialize. In the case of the drug user union, the OPS was set up within the repurposed office of a storefront that had been operating drop-in space for PWUD since the late 1990s. As a result, OPS were described as fitting well within the everyday spatial and survival practices of service users. As Darryl, a service user, described:

We come down here to score [buy drugs] and since we’re down here to score, instead of going all the way back home and using by myself or with my friend or
neighbours, it’s just a safe place to use, right? It’s not too far away either, right. We can grab something cheap to eat at a cheap restaurant or go to the 44 Club [a city run cafeteria] for a cheap meal sometimes, whatever. There’s a lot of resources down here. A lot of free food. And drugs. (Darryl, 50s)

As spaces that were run or staffed by community members with lived experience, OPS were places where people could receive support, information, and advice to help them survive experiences of poverty and housing vulnerability. Some staff described OPS as places where people new to the neighbourhood could receive practical information about how to avoid criminalization, access food and health programs, seek housing, and navigate an increasingly unpredictable drug supply. This was particularly the case at the two OPS started by community activists (OPS 1 and 3), as operators of these sites had decades long organizing experience around issues of criminalization, housing, and poverty. For some participants, OPS further offered an important space of social connection that improved their quality of life. One service user described how she frequently accessed one particular OPS to build friendships and avoid “a lonely life”:

Even though they do have someone watching, the person watching is usually one of... they’re just like us. We are all conversing together. It’s just like having tea. I don’t know. And it’s just a safety thing. They’re people like Clara [a shift supervisor]. And so, I’ve been trying to get to know her a little bit better. I respect her and I really like having conversations with her. She’s smart. I find that and she has great fashion sense and me and her have a lot of the same tastes so I kind of wanted to, you know, get to know her a little better. She’s a nice lady. I need friends. And at my age, I realize that now, and so I do make an effort. You know. I don’t want a lonely sad life. So, in order for that not to happen, I have to work at it. Everybody does. (Alexa, 40s)
Beyond this, OPS became important places for people to access employment and carry out other income-generating activities. OPS offered low-barrier employment opportunities for PWUD as the sites were staffed almost entirely by PWUD who worked on a casual basis and were paid in cash at the end of each shift. These jobs were described as some of the few formal job opportunities for PWUD who faced multiple barriers to alternate employment. OPS were used in other ways to generate income, such as a base for vending clothing, food, and other household goods. Notably, I observed managers at the OPS located next to a street market allowing people to sell goods (e.g., clothing, electronics, food) outside of the site and advocating on their behalf during interactions with city police or by-law officers.

With provincial and municipal support, nearly all of the OPS included in this study underwent major facility transformations, including moving from temporary set-ups (e.g., tents) into more permanent, purpose-built spaces with electricity, heat, running water, and designated spaces for service users to ‘chill’ after using the injection room.\(^4\) These facility transformations were characterized by participants as improving the “atmosphere” of sites and enabling people to use the sites to meet a broader set of survival needs. The availability of heating in fixed sites and trailers, for example, made

\(^4\) The drug user union did not undergo major facility changes over the study period. This site had offered drop-in space since the 1990s and offered unsanctioned supervised consumption space in a back office for off and on for over a decade. As such, the spatial arrangements of this site were already well established by the time the OPS was implemented and required less adjustments.
spaces a welcome reprieve from inclement weather, and sites became particularly busy during heavy rain when people risked injuries (e.g., trench foot) or losing personal belongings in wet conditions. Electricity in facilities meant service users could sometimes charge cell phones and other devices at OPS, a particularly important feature for people living unsheltered or in emergency shelters that were closed during the day. For these service users, who lacked a fixed address or regular internet access, fully charged cell phones were a critical resource that connected them to friends, family, support workers, and health care providers.

To varying extents, OPS were also able to offer temporary shelter for unhoused people. The drug user union offered the most robust and flexible space in this regard, including longstanding drop-in space with couches and tables, and access to bathrooms. Recognizing that many unhoused service users were unable or unwilling to use traditional shelters (for example, due to shelter policies prohibiting drug use or pets), the street market OPS temporarily turned their site into an emergency shelter at night with staff available to monitor drug consumption. The trailer OPS at the hospital, in contrast, only had enough space for two chairs near the entrance that people could use only if waiting to use the injection booths. During the day, when shelters were closed and campers were not permitted to stay in city parks, people would often congregate along Hastings Street where three of the four OPS were located. One service user shared how
the sidewalk outside of the drug user union OPS was an ideal place to locate her tent, given the protection offered by other campers and service users:

Like sometimes people get too rowdy in some places and you got to move [your tent] right away. Like I don’t know, like one day, like you know, some people just get too nosy and they go in your tent without asking, so you got to move. So that’s the only reason why I stay by that area [outside of the OPS]. Because people can look after your stuff there. (Darlene, 40s)

Together, these findings speak to the multiple roles and functions of OPS within structurally vulnerable PWUD’s geographies of survival, and provide evidence that OPS operators adapted services to better accommodate these uses through facility re-design and low-barrier policies.

4.3 Enacting spatial triage in Overdose Prevention Sites

Low-barrier approaches and facility adaptations were described as improving the accessibility of OPS, encouraging people to access OPS and stay longer when they did. Importantly, these arrangements opened up new possibilities of using the space beyond overdose prevention, including as a place to hang out, find shelter, socialize, and make money. However, I observed tensions arising between these multiple uses, tensions that were amplified by service user’s housing insecurity and socio-spatial exclusion from other public spaces. As indicated in the previous section, service users’ lack of access to secure housing and public space led them to use OPS in diverse ways to meet everyday survival needs. However, as I will detail in this section, these competing uses sometimes presented challenges to sites’ primary overdose prevention
function. Further, local forms of revanchist governance (e.g., criminalization of drug use, socio-spatial regulation of homelessness) exerted pressures on sites to further regulate the practices of service users in ways that constrained these very survival uses of sites. To manage these tensions, OPS increasingly enacted what can be understood as spatial triage – spatially regulating the practices of PWUD through rules, procedures and facility modifications that prioritized the most urgent and acute survival threat of overdose and thus constrained other functions of the sites within service users’ geographies of survival. My analysis highlights four primary functions of spatial triage observed within OPS: (1) controlling and expediting flow of service users; (2) spatially regulating drug selling under conditions of drug prohibition; (3) managing the visibility of homelessness and drug use within revanchist geographies; and (4) placing limits on social aspects of drug use.

4.3.1 Controlling and expediting flow of service users

As OPS became central to PWUD’s geographies of survival and people spent more time at OPS, increasing service volumes presented a new problem: growing wait times and a need to move people along efficiently to make space for others. As one worker explained:

I think our average [daily visits] are getting closer to 70, 75 people a day, so it’s like a bit more than doubled [from when we started]. And then, like I said, I think because the space is more comfortable, there’s a little bit more room, it’s a little bit warmer, all that stuff, like we’re kind of having to negotiate like a lot more, I guess, crowd control kind of dynamics, for a lack of a better term. (Craig, 30s)
Expediting service flow was a particularly crucial priority due to the increasingly toxic drug supply. Participants emphasized the heightened risk of fatal overdoses as wait times increased and people were unable or unwilling to wait for a table. I observed that, during particularly long wait times, people would sometimes choose to immediately use outside the OPS. As Damien, a service user, explained:

The biggest concern, I think, with most drug users is the amount of time it takes to get in [to the OPS], right? ‘Cause then a lot of people walk out frustrated ‘cause it takes 10 minutes to do a fix and then they’ll go walk outside and end up overdosing there because of the lines, right? (Damien, early 40s)

To ensure people had timely access to this life-saving service, OPS enacted multiple techniques of spatial triage to expedite the movement of service users through the OPS. The bluntest instruments were time limits for injection and smoking spaces, which ranged from 5 minutes (for smoking in a bathroom) to 30 minutes (for an injection booth). In nearly all interviews with staff and service users, enforcing time limits and moving people along from injection booths (and into designated ‘chill spaces’) was presented as one of the primary spatial triage strategies for managing OPS, yet also a common source of conflict. Time limits were challenging to enforce given that many service users were unhoused and the OPS was one of few places to find shelter during the day (where drug use was also permitted), when most shelters

---

5 While two of the sites did not formally indicate a time limit, I observed that during busy days workers at these sites encouraged people to move on from the booths and into the chill space after 15 to 30 minutes.
were closed. In this sense, injection booths represented a rare space over which they could claim ownership and exercise control over, even if only for 30 minutes. As one worker described:

\begin{quote}
The most challenging [part of my job]? Dealing with people, waiting times. [Laughs] And people at the booth, clients taking so long at a booth where like I’ve learned to understand, from my managers telling me, “They’ve got nothing,” and his motto, a good saying I learned from him was: “It’s the only 30 minutes of their life that they have control of.” Because they’re homeless, a lot of them. They’ve been told when or what they can and can’t do. They come in here, they’ve got no house or they’re at a shelter, they have to leave at a certain time, so they run around out on the streets because they can’t go in ’till in the afternoon. So, they have nothing to control in their lives. The only control they have is that half-hour that they say, “F you. I’m sitting here and using my 30 minutes.” (Mark, 40s)
\end{quote}

However, workers described time limits as more of a “guideline” than a “rule” and would generally provide leniency when people required more time due to difficulties finding a vein or challenges with fine motor skills required to prepare and inject drugs:

\begin{quote}
You’re supposed to only be in there 15 minutes but we don’t really kick you out in 15 minutes. But that’s more like a guideline, you know, that it shouldn’t be more than that, but there are people… we understand that some people it takes a lot longer. You know, we don’t kick them out because of that. (Sherry, 60s)
\end{quote}

While time limits represented the most direct tool to control service flow, building modifications were needed to reinforce rules and facilitate people to follow them. Towards this end, sites designated and alternate spaces for other survival activities. All sites offered a ‘chill space’ separate from the injection booths which service users were invited to use after they had finished their injection or surpassed the time limit. The chill space was always monitored by a staff member who kept an eye for potential overdoses
and enforced rules against drug use in the chill space. While most chill spaces were sparsely furnished with fold-out chairs, the drug user union had pre-existing couches where people could rest and sometimes sleep.

Beyond placing limits on when and how long people could use injection booths, OPS sought to expedite movement of people through the service space by more closely regulating how service users were able to use the space to meet broader survival needs. Specifically, sites enacted formal and informal rules that restricted survival practices such as eating, personal grooming, and vending. These rules were most closely enforced during busy days and at physically smaller sites in order to ensure booths could be turned around quickly for others waiting to use them. As one worker at the hospital-based trailer OPS explained:

People would set up shop in here. And same with even selling clothes and stuff. We’ve had to make some rules around that, that are like: no unpacking your bags, at all. Like we used to kind of let it slide before, when there weren’t as many people, and now we just don’t have the space for it, or the time. (Trina, 30s)

Other spatial techniques were subtle yet effective in expediting service flow, such as the decision to not provide mirrors at booths. Mirrors can be helpful for people when injecting to facilitate identification of veins, but were described as facilitating other practices (e.g., putting on makeup) that could lead people to stay at the booths longer. As one worker explained:

We don’t have mirrors. And our motto is, you know, once you’ve done your fix, you can do whatever you want and go sit in the chill area and relax. You don’t have to take the booth up, right? We try to get the people in and out, turnover. It’s not a
fast-enough turnover, so we try to keep them under so we eliminated the mirrors on the walls and now women aren’t doing their makeup, and a lot of people, they get high and then start picking their face, right, looking in the mirror. You’ll find that’s why a lot of people end up sitting at their booths. They get too comfortable and then we have had people waiting too long and then they get frustrated and go out and use not under, you know, supervision. (Mark, 40s)

Participants commonly remarked how the orientation of services toward expediting flow strained and complicated relationships between workers and service users. While staff overall reported positive relationships with service users, some noted that the were no longer able to provide the same individualized practical and social support to service users as they had during lower volume periods:

We used to just have more time, more one-on-one time with everybody who came in, and we could like focus more attention on each person, kind of. Because there were so few people that, yeah, you could do that. But now – now there’s a lot less time to do that and a lot more stuff going on, so you don’t have that focus our attention for like one-on-one as much. (Trina, 30s)

A more disciplinary or adversarial dynamic could arise as staff encountered pressures to enforce time limits and restrict the practices of service users, in some cases leading to verbal and physical attacks against staff. For those unhoused, and who were denied access to public space, spatial ownership over injection booths was particularly important. As a staff member described, workers therefore used gentle tactics to encourage these service users to move from injection booths, including assuring them that they could rest undisturbed in the chill space:

If you try and tell somebody, “Hey, it’s time to get up from the table; your time is up,” they’re going to tell you to fuck off. You know, so the thing is, is try to sound like somebody who knows where they’re coming from. Be understanding. You
know, so… and be less demanding. So, for myself, I’ll say to somebody like, “Hey, I see you’re done your shot there. I’m not bugging you to move right away, but I just want you to know that I’m going to come back in a couple minutes, and then hopefully by then I can clean the table.” And then what it does is it sits in the back of their mind that you are coming back, so they’re already starting to prepare mentally to, you know, get that move happening. And I also try to reassure them that, you know, if they move to the chill space, they can take a nap, they can shut their eyes, and people are going to be less likely to bother them. And if you stay at that table, they’re going to have one of the staff are going to be bugging them, or other clients that are waiting to come on to the floor and do an injection. [The clients are] going to be yelling and, you know, making things difficult or uncomfortable for them as well. So, I just try to point out the, you know, the good and the bad behind their choices, you know. (Michael, 40s)

4.3.2 Regulating drug selling under drug prohibition

Drug selling was another practice that was subject to spatial triage in OPS. All except one of the OPS (the hospital site) were situated within the large DTES-based drug use scene where most participants purchased their drugs. Proximity to drug selling was indeed necessary for OPS to becoming critical sites within people’s geographies of survival. Being located close to the hub of drug market activity and having drug sellers operate nearby to OPS meant people did not have to travel far to reach sites after sourcing their drugs. This spatial proximity made OPS a viable and logical place to use drugs more safely. It also ensured that OPS were more easily accessible to those PWUD who made money primarily through street-based drug sales and could not afford to stray too far or too long from the spaces where they operated. One service user, Darlene, explained how women working in street-based drug sales occupied a particularly marginal status and were at greater risk of losing territory or respect: “You’ve got their boss that’s hanging
over their head waiting for money, and they don’t want them to be gone for an hour, you know what I mean?”

While OPS were situated strategically within drug selling locations, drug selling could not legally occur within OPS at risk of them being shut down by local police or defunded by local health authorities. Workers further described rules around drug sales as necessary to prevent coercive sales tactics, aggressive debt collection, and territory disputes that could deter people from accessing the site. As required under their service contracts, OPS established rules early on prohibiting drug sales or the exchange of any money on site. To operationalize these rules and assert control over the site, OPS displaced any potential drug sales from the OPS itself. One worker explained how rigid rules prohibiting drug selling gave way over time to rules that spatially moved drug purchases outside:

At the beginning we were a bit more hardline with the rules, like, “Oh, no drug dealing,” you know? And like no drug dealing anywhere on this site. And we’ve obviously, you know, it was easy to be that way in the beginning, when no one was coming. [Laughs] But now it’s like – it’s like okay, yeah, well, we have to kind of – we have to accommodate some drug dealing outside. But there’s still no dealing inside the trailer. We’re like, “You know, you’ve got to go – just go outside for that.” So, it’s basically like right outside the doors that people can. (Trina, 30)

Most participants agreed with rules placed around money exchange and drug sales at OPS, and developed spatial strategies to adhere to these rules such as stepping outside to complete drug sales or delaying payment until after they finished using the site. As Michael, a worker, explained:
So even myself, like I use, you know, and people will give me the coke that I’m going to use, and then I say, “But I’m not going to hand you the money. I’ll hand you the money when you’re leaving, or if you want to just slip out for a second I’ll give it to you right now,” you know? (Michael, 40s)

While this spatial tactic of moving drug sales outside was generally accepted by service users, it constrained the function of OPS as a refuge from street-based policing and criminalization. Service users continued to be at risk of criminalization when procuring their drugs outside of or near OPS. Some service users were concerned that police might be monitoring the sites to identify drug users and subsequently target them for searches and questioning. One service user expressed concerns that police were using the OPS to arrest people on bench warrants and breaches of probation:

[The police] know this [OPS] is where everybody comes, in the neighbourhood. So, if someone’s got a warrant, they just sit out front and they wait for the person to show up and they arrest them. Um, they cherry pick drug dealers by just... ‘Cause these places, the addicts come to these places so obviously the dealers are gonna come to these places ‘cause their clientele are here. And I think it’s kind of inappropriate that they use these places as like, fishing in a barrel with a shotgun. [chuckles] It’s not fair. Especially the people who have warrants for bench warrants or breaches or shitty things like that. Like, little stupid things. They shouldn’t be allowed to sit out front of a safe injection site and wait to see that person show up for their morning shot [injection] and arrest them. (Sam, 40s)

4.3.3 Managing the visibility of homelessness and drug use within revanchist geographies

Participants’ narratives of their everyday lives highlighted how they were subject to displacement and socio-spatial exclusion within the city. This displacement and socio-spatial exclusion in turn structured how people used OPS, specifically as a tactic to temporarily find shelter or refuge from surveillance and displacement operations. For
unhoused participants, daily life was structured by municipally-sponsored ‘street sweeps’ and the cyclical displacement of people from tent encampments. In my fieldwork, I observed police and by-law officers routinely moving unhoused residents away from sidewalks, parks, and the sheltered storefronts of businesses and condos. Participants who had lived in the neighborhood for many years described how public space available for drug users and unhoused people had been condensed overtime into a two-block area around the intersection of Main and Hastings Streets:

It [The neighbourhood] has definitely cleaned up. What they did was… everything was spread out for blocks and blocks and they [the city] said years ago they were gonna clean it up, consolidate it to a block or two. Well, they did exactly that. That’s what they did. All the drug addicts and all the activity into one, like, core area, which is this block and the next block. (Suzie, 50s)

As a result of these revanchist urban control practices, there was very little space where unhoused and vulnerably housed PWUD were allowed to be and carry out basic subsistence practices. While OPS operators sought to preserve spaces within and around the site for survival practices such as sheltering and vending, these uses of space became increasingly fraught and contested over time for their potential to lead to longer wait times or otherwise impede with overdose response procedures (e.g., blocking entryways for emergency medical professionals).

OPS operators and staff also became ambivalently enlisted in managing the visibility of homelessness to ensure the service’s political acceptability within neighbourhoods that were wealthier (in the case of the DTS) or rapidly gentrifying (in the
case of the DTES). At one site, for example, workers expressed concerns about residents of a new low-barrier shelter using the sidewalk outside of the OPS during daytime hours when the shelter was closed. Staff described how public drug use and conflicts between shelter residents could bring unwanted attention from police. As one supervisor described, staff sought to manage the behaviour and practices of people sheltering outside due to fears that police or local health authorities would shut down the OPS:

This shelter here, it’s people that have been kicked out of all other shelters and they just can’t get along in the shelters so they put them here, so a last step. So, imagine that’s the type of people who were coming in all that winter, and it was just crazy. There were fights sometimes, you know. So, we [the supervisors] right away were right there, on top of it, breaking it up. And not in a threatening way. Like I always talk to people, like talk to them and explain what’s going on, what we’re doing and why they shouldn’t be doing it. They think that this is their place. And you know, if you’re going to be using in here, in the front there, you know, and people, you know, cops come in and see us. So, you know, you’re putting the place at risk of being shut down. And it’s your place. Why would you do that, right? (Gordon, 50s)

At the hospital-based OPS, challenges specifically arose around managing smoking and congregating of service users outside of the trailer. This site was located in the parking lot of a hospital with a no-smoking policy that extended to the interior and exterior of the trailer. This OPS was also located adjacent to a condo whose residents had issued complaints about the site being located across from them. One staff member explained how, as a result of these external pressures, the site needed to “curb” some of the smoking and congregating outside in order to ensure the site could continue to operate at this location:
This hospital is like a no smoking property, and it’s technically it’s not our job to enforce those rules, either, outside of our space. It’s like hospital Security’s jurisdiction. But, you know, it doesn’t – it doesn’t look good when there’s like a bunch of people smoking, like even cigarettes, buying like drugs and stuff like right out front. So yeah, we’ve had to kind of curb that a little bit. (Trina, 30s).

4.3.4 Placing limits on social aspects of drug use

Finally, I observed that OPS placed limits on social aspects of drug use when they were seen to be in tension with overdose detection and prevention. Most OPS, for example, instructed people to remain in their seats while using injection booths so that they could maintain site lines of all the tables. While this rule discouraged socializing in the injection rooms of OPS, it was perceived as necessary to identify overdoses and respond quickly. As one worker described:

[When the site gets really busy] the music gets louder, people get out of the chairs and move around, which they’re not permitted to do because it’s a tight space. And when people are moving around and whatever, I can’t have a clear line of sight to that last table. Buddy could be overdosing in the corner and I can’t even see him. (Suzie, 50s)

Adjustments were also made over time to rules regarding table sharing in OPS in order to prioritize overdose response. The accommodation of drug-using companions at single tables improved the accessibility of OPS for people who used in pairs (e.g., with a partner or friend), but this also effectively doubled the capacity of the sites and increased the likelihood of people overdosing simultaneously when sharing and using the same drugs. To mitigate the possibility of multiple people
overdosing simultaneously, two sites introduced a rule that people sharing tables must stagger their use. As one OPS worker explained:

At first, we were like, “Oh, yeah, no sharing a booth.” But then couples started coming in, and, you know, it started getting busier, so we started like letting it happen. But we, you know, we had to come up with some rules around it, which was: no using at the exact same time. Like you have to stagger it. Like one person uses – you can sit at the same booth, but one person uses and then you switch. That’s something that came up too, because what if they overdose at the same time, was our thinking. (Trina, 30s)

This same OPS reinforced rules around staggered drug use at injection tables by providing only one chair at each table. As described by one worker, this seating arrangement was intended to facilitate overdose response and workers were instructed to encourage people to use in the chair rather than standing or lying down:

So originally, they [management] wanted the person that was shooting up to be sitting in that chair so that if they overdose you can dump them down easy. There’s a technique to dump them so that you can start the procedure of, you know, getting them breathing again. But I don’t enforce them to sit in the chair. I don’t actually make them do that because a lot of people aren’t comfortable sitting. Some people like to stand. Some people like to sit on the floor. Some people get juggled [injected into the jugular vein], which typically they lay on the floor for that. So, there’s different positions that people can be in. They don’t all like to just sit in a chair. (Debra, 30s)

As this excerpt indicates, techniques of spatial triage were not totalizing, but rather contested and constantly re-negotiated by staff and service users. Service users found ways to circumnavigate rules and use the space in ways that better suited them (e.g., laying down beside table to be injected in the jugular). I observed that staff generally tolerated these practices as long as they did not impede overdose response.
or otherwise pose a risk to others. This flexibility was important given that service users might otherwise need to use drugs in unsupervised settings where they were at significant risk of fatal overdose due to the toxic drug supply.

4.4 Navigating harms and inequitable impacts of spatial triage

On its surface, spatial triage was a pragmatic form of spatial regulation seen as necessary to optimally operate OPS by limiting seemingly non-essential uses of space, rather than limiting who is allowed to use the space or receive care. In practice, however, spatial triage had unintended impacts that led to inequities in service access. Since PWUD's access to and use of public space within the city was inequitably distributed along axes of gender, race, and class, so too were the harms of spatial triage. I observed multiple instances of spatial triage unwittingly deterring unhoused service users from accessing these spaces through rules that restricted bringing larger and potentially obstructive personal belongings into the space. For example, the following excerpt from my fieldnotes described a man attempting to enter an OPS with a cart of personal possessions:

A man pops his head into the OPS and asks the front desk clerk if another man, who has been standing outside for a bit, can bring his cart in with him while he uses the injection room. The clerk shakes their head and says that no, he cannot bring his cart as they must keep the space clean and pathways clear in case there is an overdose. The man tries to advocate for the man and his cart, emphasizing to the staff that the other man is unhoused and doesn’t have someone to watch his stuff. The man with the cart overhears this all from his position in the alleyway and, looking demoralized, begins to walk away, dragging the cart behind him. (Fieldnotes from OPS 2, Fall 2018)
Spatial triage within the context of drug prohibition and revanchist management of homelessness meant that OPS operators encountered pressure to minimize the visibility of people sheltering and using drugs outside of the site. Internally, frontline workers and service users expressed concerns that crowding and camping outside would negatively affect the “atmosphere” of the site. However, external pressures from police and other residents figured largely into these concerns, and the impacts were inequitably distributed on the basis of race given the more intensive policing of Indigenous PWUD. OPS staff expressed concerns that Indigenous people were subject to heightened surveillance and stigmatizing treatment in the public space surrounding sites, including discriminatory and abusive treatment by police. These concerns were expressed in light of then-recently published data indicating that between 2008 and 2017, 15 percent of Vancouver Police Department “street checks” involved Indigenous people, who constituted only two percent of the population (Vancouver Police Department, 2021). In fieldnotes from November 2018, I document one such instance where an Indigenous man is stopped, ID’d (asked for identification) and searched by police directly outside of an OPS:

We [myself and a CRA] observe two police officers handcuffing an Indigenous man outside of the OPS. They ask the man for his ID and, when he responds that he has none, they tell him that he has a responsibility to carry ID on him at all times. They handcuff the man while one officer proceeds to rummage through his two backpacks, pulling everything out onto the police car. There is only clothing in his backpack, suggesting that the man is currently homeless. After a few minutes of searching, it seems the officers have not found what they are looking for. The clothing is now exposed on the car hood while the rain starts coming down,
drenching all of the man’s clothing. The police release the man from handcuffs and return his wallet, watching on as he struggles to jam everything back into his bags. (Fieldnotes from OPS 2, Fall 2018)

Attempts to limit sheltering within and outside of OPS disproportionately impacted Indigenous PWUD who were significantly more likely to be unsheltered and ‘sleeping rough’ (i.e., unsheltered in public settings). In our sample, Indigenous service users were twice as likely to be living unsheltered/outside compared to white service users, which aligns with trends observed in the 2020 homelessness counts for Metro Vancouver (British Columbia Non-Profit Housing Association, 2020).

Spatial triage was also gendered in that women’s use of space was more tightly regulated and subject to scrutiny. Women’s use of injection space was frequently characterized as more problematic than that of men, with emphasis put on activities associated with femininity such as using injection tables to put on make-up or re-arrange items in a purse. In one interview, a man who worked at multiple OPS described the challenges of limiting non-drug use activities at OPS, proceeding to identify women’s use of space as most impeding service flow:

This is a safe injection site, so really, this isn’t really helping in any way [with service users] opening up their box and bags. If you have an overdose, all these people’s stuff is in our way, and then it’s an issue to get them to clean up, and then, you know, gotta get them to go. And when it’s time for them to go, we can’t get them out because they’ve got their bags and they’re so stoned and they don’t… you know, and I’m not prejudiced, you know, biased, but females are the worst. [Laughs] Because once they open Pandora’s Box, it’s like oh, my God. [Laughs] Well, they take everything out of their bags, and they spread it all over. And yet you’re supposed to have this little spot and you’re supposed to be there for 15 minutes and
go. Well, but they aren’t there for 15 minutes. When they open their bag they’re there for three hours. (Neil, 50s)

While women were characterized as having more inappropriate uses of the space, women working at OPS shared that they found it most challenging enforcing time limits with men due to gendered power dynamics:

A lot of the male clients that come in [are challenging]. You know, ‘cause you have half-hour seatings. And when it’s raining like this you need to keep it turning, ‘cause it’s busy. ‘Cause people are running into places to get out of the rain. So yesterday was like a nightmare. A guy, half-hour seating, he was there for, like, two hours. He just wouldn’t leave. ‘Cause he’s a guy and we can’t make him because by law we cannot force him, we’re paid volunteers. It can be hard and ideally, we’ve got two women and a guy out there [working]. But quite often it doesn’t work out that way so there’s three girls and that’s where sometimes you run into problems when you see big strong-armed people just not listening. (Suzie, 50s)

Together, these examples speak to the unintended yet harmful impacts of spatial triage from an equity perspective: it disproportionately impacted and impeded the use of OPS by PWUD who experienced distinct and heightened forms of socio-spatial exclusion within the city. OPS managers, workers and service users were often aware of these dynamics and would bend rules and advocate for leniency to accommodate those most marginalized. I further observed OPS workers challenging and speaking out against socio-legal practices that harmed service users, including engagement in advocacy coalitions seeking to end municipal street sweeps and discriminatory police checks.

Nonetheless, negotiations around space within OPS were fraught and ethically complicated, and the outcomes of these negotiations at times constrained the broader uses of OPS within PWUD’s geographies of survival.
4.5 Discussion

This chapter situates OPS as spaces with important and diverse roles within the geographies of survival forged by PWUD. My analysis traces how low-barrier approaches and facility enhancements improved program accessibility and expanded how OPS could be used by PWUD, including as spaces for socializing, mutual-aid, sheltering, and income-generation. However, as service volumes increased and tensions over space heightened, OPS operators and frontline workers enacted spatial triage to manage these multiple and, at times, competing uses of space. Spatial triage worked to discourage and limit certain uses of the space in order to address what was perceived as the most urgent threat to survival: overdose fatality. Practices of spatial triage involved dynamic, pragmatic, and often contested rule-making about how people were allowed to use the space (e.g., time limits, restrictions on drug selling and vending), as well as internal procedures and facility modifications (e.g., new layouts, removal of mirrors). These practices, in turn, had some unintended and inequitable impacts on service access, given co-existing power relations and inequitable access to public space along axes of gender, class, and ethnicity.

The findings in this chapter contribute to existing literature in three ways. First, this research builds upon and extends work examining contemporary forms of triage that govern the delivery of care during mass casualty situations (e.g., warfare, epidemics) and/or under conditions of scarcity (Anderson, 2015; Iverson & Moskop, 2007; Nguyen,
This analysis illuminates how triage is acted out in a service space that faces complex challenges of prioritizing service delivery to PWUD experiencing multiple survival threats due to their socio-spatial marginalization. Findings indicate that triage was enacted primarily at a spatial level, by placing limits not on who could use these spaces, but rather how these spaces could be used. The concept of ‘spatial triage’ may prove useful for analysing how service space is organized to accommodate and prioritize different potential survival uses of these spaces by people who are socio-spatially excluded within urban spaces.

Second, these findings offer insights into how tensions between care and revanchism are negotiated within service spaces. An ongoing debate animating critical urban scholarship is the extent to which services for unhoused and low-income populations are implicated within revanchist politics (Clarke, Parsell, & Vorsina, 2020; DeVerteuil, 2014; Murphy, 2009; Proudfoot, 2017). Spatial triage was primarily necessary within OPS due to pervasive housing insecurity and revanchist urban governance practices (e.g., street sweeps, red zoning, police street checks, anti-camping bylaws) that limited PWUD’s access to and use of other spaces. These dynamics created pressures on OPS to accommodate “uses” beyond drug use (e.g., for sheltering and income generation), but also to organize space in ways that minimized visibility of drug use, homelessness, and other survival practices (e.g., vending, drug dealing). Spatial triage can be understood as a set of pragmatic strategies deployed by service operators to
negotiate these revanchist pressures with the primary objective of maintaining widely accessible, low-barrier and inclusive spaces for people to use drugs more safely. As such, this analysis suggests that spatial triage did not align neatly with revanchist or care logics, but rather operated as a mechanism for OPS operators to flexibly and dynamically manage the tensions that arise between them in practice.

Third and finally, this analysis indicates an ethical and pragmatic imperative to transform the structural conditions that make spatial triage necessary for service providers, while also working at a smaller scale to ensure that spatial triage can be accomplished in ways that are least harmful. At a structural level, external pressures for spatial triage could be minimized by increasing access to safe and affordable housing and addressing policy drivers of socio-spatial exclusion among PWUD, particularly bylaws and laws that criminalize subsistence practices of unhoused people (Doran, Fockele & Maguire, 2022; Fleming et al., 2019). Decriminalization and safe supply programs, currently being pursued at provincial and municipal levels, could reduce pressures on OPS to restrict drug selling onsite and instead enable sites to work more openly with PWUD to source safer drugs of known quality and potency (Bardwell, Boyd et al., 2019; Ivsins et al., 2020). At an operational level, OPS may mitigate harms of spatial triage by expanding approaches already being successfully implemented in some sites, such as: offering ‘chill spaces’ people can access when not injecting; providing secure spaces or lockers for people to store personal belongings; establishing designated smoking spaces;
offering continual training in gender-sensitive and anti-oppressive practice; and advocating locally for policies that protect the rights of low-income and unhoused people to public space. These service innovations will require additional funding and pragmatic supports to implement.

4.6 Conclusion

As is the tradition in harm reduction, OPS operators and frontline providers have demonstrated creativity and nimbleness in attending to the complex survival needs of PWUD experiencing poverty, housing vulnerability, and criminalization. This chapter illuminates how, given the complex survival threats facing those accessing OPS, spatial triage was enacted over time to pragmatically focus services on meeting what was perceived as the most immediate survival threat: the acute risk of overdose death due to the toxic illicit drug supply. Spatial triage occurred through rule-making and procedures governing use of space, as well as spatial arrangements within OPS (e.g., facility modifications and layout). Given the embeddedness of OPS workers within the communities they served, this spatial triage was arguably more flexible and attuned to diverse community needs than medically supervised injection sites where space is more tightly governed by regulatory frameworks and institutional logics of risk mitigation. Spatial triage nonetheless created unintended service barriers for some of those most marginalized within the city, including women, Indigenous, and unhoused PWUD.
Chapter 5: TASK-SHIFTING AND THE PRODUCTION OF BURNOUT AMONG OVERDOSE RESPONDERS WITH LIVED EXPERIENCE

5.1 Introduction

The emergence of OPS can be considered a form of task shifting in which structurally vulnerable PWUD have assumed an expanded role in overdose response to fill an urgent gap within the healthcare system. This chapter analyses how this task shifting has occurred, with a focus on the labour arrangements and working conditions of responders with lived experience. In doing so, this chapter identifies multiple drivers of burnout and details their adverse impacts on service delivery.

5.1.1 Task shifting and ‘peer’ labour in overdose response

Initially devised as an approach to delivering HIV care in lower-resourced settings, task shifting has since been promoted globally as a pragmatic strategy for reducing staffing shortages and care inequities in various domains (e.g., mental health, substance use, maternal and child health) by shifting healthcare tasks to less specialized health workers with shorter training periods and lower pay scales (European Commission, 2019; World Health Organization, 2008). While typically conceptualized as top-down restructuring in which governments delegate tasks to new groups of workers, task shifting can also occur from below when civic and other voluntary organizations mobilize to fill gaps within healthcare systems (Buchman et al., 2018). This has been the case with overdose response programs in North America, where activists have engaged
in grassroots organizing and civil disobedience to establish programs that train PWUD to identify and manage overdoses (Buchman et al., 2018; Davidson, Lopez, & Kral, 2018; McNeil, Small, Lampkin, Shannon, & Kerr, 2014; Sherman et al., 2008). These programs leverage experiential knowledge and networks of PWUD to bring life-saving care to drug-using populations that are stigmatized within healthcare systems, reaching people who might not otherwise receive medical attention during an overdose due to fears of criminalization or other punishments (e.g., losing custody of children or eligibility for public programs) (Buchman et al., 2018; Faulkner-Gurstein, 2017; Kennedy et al., 2019).

In Canada, peer overdose response roles grew significantly through the grassroots implementation of OPS staffed primarily by PWUD. Lacking public funding, these programs initially relied on volunteer staffing with some stipends available through crowdfunding (Wallace et al., 2019). Temporary sanctions and provincial funding for OPS subsequently created waged work as PWUD supervised injections, provided harm reduction education, and reversed overdoses using stimulation (e.g., conversation, physical touch), oxygen and naloxone (Buchman et al., 2018; Kennedy et al., 2019; Wallace et al., 2019).

Previous research documents numerous benefits of this task shifting, locating it within a social movement to involve PWUD meaningfully in the planning and delivery of programs that affect their lives (Kennedy et al., 2019; McNeil, Small, Lampkin et al., 2014; Sherman et al., 2008; Ti & Kerr, 2013). Beyond saving lives, overdose response
positions offer low-barrier employment opportunities for people excluded from formal labour markets due to drug use and other structural barriers (Bardwell, Anderson et al., 2018; Greer et al., 2018). However, the way in which this task shifting has been implemented raises ethical and pragmatic concerns that have received little scholarly attention (Buchman et al., 2018; Dechman, 2015; Kolla & Strike, 2019). It is important to contextualize that this task shifting has occurred on the heels of decades-long austerity budgeting and neoliberal restructuring of public programs that have weakened labour power, lowered wages and increased precarious forms of labour (Peters, 2012; Wacquant, 2009). In Canada and other wealthy democracies, governments increasingly contract out public services to non-profits through competitive bidding processes that mimic market competition and institutionalize imperatives to keep labour costs low (Evans, Richmond, & Shield, 2005). This contracting environment creates downward pressure on labour costs, which are typically more flexible than other service delivery costs (Peters, 2012). The short-term nature of funding contracts further favours casual and temporary roles, as operating organizations often only have funding certainty for six-to-twelve month terms (Evans et al., 2005).

Under these conditions, overdose response positions available to PWUD are frequently low-wage and casual (i.e., on-contract, temporary), lacking the benefits and responsibilities of protected full-time employment (Greer, Bungay, Pauly, & Buxton, 2020; Greer et al., 2018). Although casual positions are important low-barrier work
opportunities for some PWUD, the devaluation and casualization of overdose labour risks financial exploitation of PWUD in these roles who are likely to experience heightened economic insecurity and limited formal labour opportunities (Bardwell, Anderson et al., 2018; Greer et al., 2020; Greer et al., 2018; Richardson et al., 2015). The implications of these processes on working conditions and the delivery of overdose response programs are critical questions that have, with few exceptions, been overlooked in existing research (Buchman et al., 2018; Kennedy et al., 2019; Greer et al., 2020).

5.1.2 Theoretical approaches to burnout

One concern related to task shifting is burnout among healthcare workers, such as overdose responders, who encounter considerable work stress and hazards (Kennedy et al., 2019). In occupational health and psychology, ‘burnout’ refers to negative psychological symptoms stemming from chronic workplace stressors, including overwhelming exhaustion, feelings of cynicism and depersonalization, and a sense of ineffectiveness or lack of accomplishment (Maslach & Leiter, 2016). Burnout is recognized as a common occupational hazard for workers in people-oriented ‘caring’ professions (e.g., social work, nursing), particularly those whose work entails exposure to traumatic situations (Ben-Porat & Itzhaky, 2015; Jennings, 2003). Previous research finds burnout can impair workers’ mental health and job performance, resulting in lower quality of care and staffing shortages as workers resign or take leave due to work-related stress (Poghosyan, Clarke, Finlayson, & Aiken, 2011; Willard-Grace et al., 2019).
Dominant theories of burnout emphasize individual-level and—to a lesser extent—organizational determinants of burnout, often stopping short of implicating broader labour relations and social conditions (Leiter & Maslach, 2004; Maslach & Leiter, 2016). These models (e.g., the Jobs Demands Resources, Areas of Worklife, and Conservation of Resources models) build from a body of research focused predominantly on full-time and middle-class professionals in stable employment, with comparatively little attention to experiences of precariously employed and low-wage workers (Schaufeli, 2017). As public services are increasingly delivered on a contract basis that favours part-time, low wage and temporary employment (Peters, 2012), there is a need to analyse how these labour relations structure burnout processes and, in turn, the delivery of public programs. Further, burnout research can benefit from considering how other structural changes characteristic of neoliberal governance (e.g., disinvestment from welfare programs) interact with individual and organizational level dynamics to produce burnout.

PWUD’s burnout experiences differ from other frontline providers due to their social embeddedness within the communities they work and structurally-imposed vulnerabilities (Kolla & Strike, 2019). The concept ‘structural vulnerability’ captures how the marginal position of groups within social hierarchies renders them more vulnerable to negative health and social outcomes (Quesada, Hart, & Bourgois, 2012). Previous research documents how PWUD face intersecting forms of social and economic
marginalization under drug prohibition that heighten their risk of unemployment and financial instability (Bourgois, 2002; Richardson, Wood, & Kerr, 2013). In Vancouver, as elsewhere, soaring housing costs and insufficient social assistance rates have exacerbated these vulnerabilities. In 2018, the welfare income of a single person receiving disability assistance ($14,802 CAD) equalled less than one third of Vancouver’s poverty threshold using the Federally-adopted Market Basket Measure ($48,677) (Djidel et al., 2020). For PWUD with social assistance as their primary source of income, strict earning restrictions (approximately $12,000 annually) constrain labour opportunities to more precarious and informal work (Boyd et al., 2018). These structural arrangements may increase PWUD’s vulnerability to burnout in overdose response jobs, while also depriving them of critical material, social and, symbolic resources to mitigate negative consequences (Quesada et al., 2012). Structural vulnerabilities can in turn contribute to stressful workplaces as workers in positions of relative powerlessness direct frustrations at themselves and those with less power — a process referred to as lateral violence (Thobaben, 2007).

This chapter examines experiences and drivers of burnout among PWUD working in OPS in Vancouver, BC: an epicentre of Canada’s overdose crisis and home to a range of publicly-funded overdose response programs. My analysis investigates how burnout is produced among overdose response workers with lived/living experience of drug use, including the role of inequitable working conditions, economic insecurity, and other forms of social disadvantage. We further explore the implications of burnout on the
delivery of overdose response programs. The findings presented herein draw from ethnographic fieldnotes and excerpts from individual interviews and focus groups. When focus group excerpts include the voices of multiple participants, dialogue is presented in order, as it occurred organically during conversation.

5.2 Job roles of OPS responders with lived experience

Most participants worked part-time and on-call—sometimes picking up shifts at multiple OPS—and were generally paid in cash at the end of each shift (typically four hours long). Workers were often themselves OPS service users who were recruited into casual work through informal processes. Formal applications and interviews were required for some roles, particularly managerial and supervisory employment. PWUD performed critical jobs at OPS, including as front-desk attendants, shift supervisors, injection room attendants, and (less frequently) site managers. Training for these positions varied considerably across sites and roles, but occurred primarily through unstructured “on the job” learning. Notably, one site ran a training program that offered regular workshops to PWUD and other OPS workers on overdose management and related skills (e.g., managing extreme situations, safer injection practices, anti-stigma, and cultural safety).

In two of the four sites, PWUD in casual peer roles worked alongside unionized support workers employed by the non-profit organization operating the site. Despite performing similar work, wages for casual workers (predominantly PWUD) were
sometimes half that of unionized employees. During the study period, wages for non-union workers ranged from a low of $8.50 CAD/hour (reception position) to a high of $18.50 (shift supervisors). Most participants earned between $10 to $12/hr, which is less than the 2018 provincial minimum wage ($12.65/hr) and significantly less than the estimated ‘livable wage’ required to meet basic needs in Vancouver ($20.91/hr) (Ivanavoa & Saugstad, 2019).

5.3 Characterizing burnout in overdose prevention sites

Workers reported substantial psychological challenges related to their work, which they commonly labelled as “burnout.” Across all sites, participants described feeling exhausted from their work due to challenging working conditions and the demanding nature of overdose response: “it’s just a weariness that you can’t even explain to anyone who doesn’t do this job.” Witnessing and responding to overdoses was stressful and traumatic, and most participants had lost close friends or family members to overdose. Workers described feeling “numb” to death and avoiding “dealing with” grief in order to continue doing their job. As expressed by focus group participants:

R1: Like there’s a lot of “I’ll deal with this later. I will deal with this later” […] And later hasn’t come in three years.
R2: The countless times that you hear the name of somebody you’ve really come to care about and they’re gone. […]
R3: Like, you’ve normalized it in a sense that you can still function with it.
R2: We normalize it all just to be able to come to work every day.

Job-related stress also manifested as physical ailments. I observed that workplace tasks were sometimes physical, such as when workers moved boxes to restock supplies.
or repositioned someone to facilitate overdose response. Physical work tasks could exacerbate pre-existing injuries and chronic pain, which were common among participants. Participants also described hypervigilance that generated tension and pain in their bodies. One woman explained how she became aware of muscle tension after taking a seven month leave from overdose response work and receiving coverage for massage therapy through a different job:

I never realized how tight I actually was ‘till this woman went and like took out the knots. I cried. I screamed. [...] And she flat out said. She said “you hold all your stress in your muscles. That’s where your stress is. It’s just three years of stress is everywhere in your muscles.

Many participants coped with grief and stress by increasing drug use. While some found drug use helpful for alleviating suffering, others were distressed by escalating drug use. As one woman described:

In 2016 I ended up relapsing because I wasn’t able to process everything the way I should have, and I’m desensitized to, you know, death, and the overdoses. I’m not surprised when I hear someone overdosed, and I can’t feel sadness for it. So, because of those two things, and just continuing to work, work, work myself to the bone—[relapsing] was the easiest solution for me. (Dana, 50s)

As documented in fieldnotes and interviews, many workers left their role for periods of time or reduced their hours due to stress. Staff turnover was most common among casual staff, but also occurred among supervisors. Many supervisors interviewed or observed at early stages of fieldwork were no longer in this role a year later.

While workers expressed feeling “defeated” and “demoralized” by work, many felt obliged to keep working. As one participant expressed: “We’re broken people and
we just keep going.” The obligation to continue working was couched in terms of collective responsibility to prevent overdose deaths. When asked whether they ever needed to step back from their role due to burnout, workers in one focus group explained:

R1: There’s no option to step back because—
R2: Step back, people die.”

5.4 Drivers of burnout among overdose response workers with lived experience

5.4.1 Economic insecurity and job precarity

Participants’ accounts highlighted how economic insecurity and job precarity exacerbated work-related stress and contributed to burnout. Economic insecurity was structurally linked to stagnating social assistance rates, limited employment opportunities, and the cost of living in one of the world’s most unaffordable housing markets (Demographia, 2020). While many casual workers had social assistance as their primary source of income, recipients needed to supplement this income to meet survival needs. Overdose response work was described as one of the few formal labour opportunities available to PWUD, particularly those with little formal training and education. As Lou, in his 50s, said: “What else could I do at 59 years old after being a drug addict all my life?”

The provincial social assistance system maintained economic insecurity by failing to provide adequate income and clawing back employment income earned beyond exemption limits. OPS partly circumvented this issue by successfully advocating that
casual peer work be considered an exempted income not counting towards annual earning limits for assistance recipients. However, significant barriers remained for people wishing to transition into full-time and managerial positions. As full-time protected work was not considered exempted income, workers transitioning into more secure contract positions risked losing eligibility for critical supports, such as disability and income assistance, subsidized housing, and medication coverage. As one participant explained:

I’m in BC housing [subsidized housing] and when I was on straight assistance, I was paying $328 a month. Then I was working. All of a sudden, I’m paying $560 a month, which is like $240 increase. That’s quite substantial […] I was better off on welfare.

Stipends from casual work helped alleviate the economic strain of living off monthly social assistance payments, yet wages were often insufficient to achieve economic security. OPS managers interviewed for this study were supportive of increasing wages for casual positions, but were constrained by funding agreements with the local health authority. Some managers described low wages as a strategy to “spread out” work opportunities, given that interest for overdose response work outstripped what could be supported with funding. As casual positions were not considered protected employment, most PWUD working at OPS lacked benefits such as vacation, extended health coverage, and sick leave. This economic insecurity and lack of benefits prevented workers from taking time off or engaging in practices that might prevent burnout (e.g., counselling, vacation). As one participant explained:
I worked three years. I never got a vacation. I couldn’t afford one if I did. I can’t afford stress leave because our pay cheques aren’t enough that the 60% that [Employment Insurance] would give us is not enough to live on. And we just have to keep going and going.

As casual positions were not covered by provincial labour laws, most PWUD working at OPS also had no protections if they were injured at work or needed to take leave for health reasons. Some of the more experienced workers in casual roles felt they had to “pick up the slack” when unionized employees went on leave, fueling animosity and distrust among workers. Some participants shared stories of feeling punished for taking unpaid time off by being demoted or facing challenges securing shifts upon return.

Low wages were a source of symbolic injury for PWUD, who were aware they were paid less than other frontline providers not defined by their drug use, despite performing similar tasks. Participants felt their labour was devalued because they were labelled as “peers” and that pay inequities reflected ambivalence toward the lives of people who use drugs. As expressed by focus group participants:

R1: Just because we use drugs, I mean, they don’t think that we deserve to be making that [the same pay as other frontline providers].
R2: We don’t deserve it, and they don’t think that people deserve to live that are on drugs. They’re: “Well, let them die then. You know. I mean why should we waste our money on them.”

Other participants believed the devaluation of their labour was integral to government support for OPS: “Why do you think the government likes it so much? It’s cheap.”

The limited opportunities for advancement also contributed to burnout. Workers with lived experience described reaching a professional ceiling or cap, with few
opportunities to move into more desirable and better compensated positions. One participant explained:

I started this crisis back in August 2016 when these sites were opened. [...] I’m a supervisor. I actually had to quit for a while because of burnout, because I needed to get away and because there was no advancement opportunity, which was a big deal to me.

As this quote exemplifies, PWUD’s expertise from overdose response work did not always translate into better job prospects in their worksite (e.g., in managerial and training roles) or the broader labour market. The scarcity of advancement opportunities could make the job feel like a dead end, or, as one participant framed it: “there’s nothing at the end of this.” PWUD were keen to progress in their roles by taking on mentorship responsibilities. When asked what could be done to prevent burnout, one worker replied: “give the veteran peers the chance to mentor and don’t hold us back because of our roles.”

Interviews suggested lack of control over working conditions was a core component of burnout: “You don’t know what’s going to happen around the corner [...] you never know what’s next.” Feelings of burnout were pronounced at higher-volume sites, where working conditions were described as “unpredictable” and where staff sometimes responded to multiple overdoses simultaneously. Recounting their earliest shifts at a high-volume OPS, one worker noted: “we kept having overdose, overdose, overdose. Like sometimes seven overdoses to ten overdoses in a seven-and-a-half-hour shift. And I was like: I didn’t join up to be a paramedic!” Workers who expressed having greater autonomy in their role and control over the working environment (typically
supervisors) conveyed greater job satisfaction and resilience in the face of burnout. One woman preferred supervisory work, explaining: “I have more say in what they [other staff] are going to do and what they’re not going to do.”

Some workers believed unionizing or collectively organizing was required to secure better working conditions, wages, and job security. As one participant asserted: “it’s three years in and we’ve earned a union, a year of representation. We’ve earned benefits. We’ve earned job security, further education. We’ve earned people’s respect.”

5.4.2 Invisible and unpaid labour

Psychological models of burnout posit that burnout can emerge when workers are not rewarded appropriately, materially or symbolically, for dedication to work (Neckel, Schaffner, & Wagner, 2017). This featured as a prominent dynamic in participants’ accounts. PWUD employed at OPS performed a broader range of caring work than overdose prevention. One participant described her roles as such: “We’re mental health workers, we’re bartenders, we’re babysitters. We’re moms, dads, you know, foster [parents] to all of these people and shit.” As captured in this quote, one aspect of invisible labour was mental health support. Participants noted that many service users lived with mental health challenges that required additional training and sensitivity to accommodate. To do their job well, workers emphasized the importance of being able to distinguish when someone was experiencing a mental health crisis that could otherwise be overlooked as intoxication. As one participant explained:
A lot of people out here have the dual diagnosis, right, of mentally challenged as well as the drug addiction and the two are so close that it’s like ADHD and addiction. A lot of them are parallel, right. They look the same. And a couple of times I’ve found myself talking to somebody who was actually mentally hurt or broken and not in the drug stupor that I thought he was in, right.

Conflict resolution was another stressful form of hidden labour, as fieldnotes documented that workers with lived experience were frequently responsible for diffusing conflict within OPS. I observed that PWUD often took charge of conflict de-escalation given their prior relationships with service users. Similarly, participants described keeping an eye out to prevent theft or protect service users they considered vulnerable: “I’m supposed to keep it as safe as I can for everybody here, with violence, with theft, whatever I can do [...] [It is] a lot of very hard work and a lot of very unpaid work.” (Lou, 50s)

Relationship-building and social support featured prominently in participants’ work. I observed that workers with lived experience received requests for multiple types of support during their shift (clothing, cigarettes, a place to stay), which some considered a key part of their job. As one man shared:

If they need help we do housing, shelter, food. You know, if someone’s homeless then we try to get them into a shelter if they need help. Clothing, or refer them to anywhere if they need it. Detox, anything. We try to help them with everything. (Mark, 40s)

While workers took pride in providing social support, they could also feel overwhelmed by requests since OPS do not typically receive additional funds to support
this work. Some reported using their own money or resources to help service users. As one woman described:

I mean, I spent three years developing relationships which are deeper than that now. Like, I mean, I'll sit with them while they're dopesick and just cuddle for three hours until we come up with ten bucks together to get them well. Or I've given them the money to get them well or take them out for something to eat when they're hungry.

Fieldnotes documented frequent instances of people voluntarily working outside of their formal hours. One worker regularly arrived an hour before the site opened to “check in” with people waiting outside the OPS, and to help people manage appointments and navigate bureaucracies. While outreach was part of his job, this work often went unlogged and therefore unpaid.

5.4.3 Challenges negotiating professional and personal boundaries

The hidden work described by participants was linked to their social positions within drug-using networks and expectations around mutual support. For workers embedded in the communities they served, boundary setting was challenging and even undesirable despite being considered protective of burnout. The logic of task shifting overdose response to PWUD is predicated on the intersection of professional and personal, as workers with lived experience are expected to engage people within their social networks and bring expertise based on shared experience. The binary of professional and personal life did not exist for many PWUD, for whom overdose response work at OPS was an extension of the care work they already did within their
networks. As one participant explained: “you do this [overdose response] when you walk out the door. You do this at your home.”

Overlapping professional and personal lives contributed to burnout as participants felt they were never truly able to leave their role. For women working at OPS, gendered care expectations contributed to requests that went beyond their job responsibilities and sometimes placed them in unsafe situations. For example, one woman shared:

You know, guys seem to be a little aggressive or whatever [...] if they feel that they want something, you know? And women can be a little bit taken advantage of, right? That’s why a lot of these guys [coworkers], they go walking over or walking me to the bus stop so that if people are approaching me for things, right? And they are approaching me for lots, like money and cigarettes, and can they stay the night and stuff like that, and it’s hard to say no, you know? (Cathy, 40s)

I observed that workers were often responsible for enforcing OPS rules and regulations among friends and family, which could strain relationships. Tensions often arose when moving people along from tables after they finished injecting:

Like [friends] come in and, you know, they kind of take advantage sometimes, you know, want to stay late [...] and when other people are waiting it’s kind of hard to say, “Like I know you’re my buddy and everything, but you’ve got to get off the table.” (Cathy, 40s)

Participants voiced safety concerns stemming from rule enforcement that spilled into their life outside of work, as exemplified in this quote:

I’ll be great friends with somebody and then they’ll break a rule and I will have to enforce it and now I’m the enemy and it carries over. Like they don’t drop shit when they leave here like we do. They carry it over. I’ve been threatened to be stabbed by a client who was a really good friend.
Moreover, PWUD often did not have the same protections from threats as other healthcare professionals, such as the means to live anonymously in a “safer” neighbourhood.

5.4.4  *Lateral and gendered violence in the workplace*

Conflict and harassment were routine aspects of the job that contributed to burnout. Fieldnotes indicated that a recurrent source of interpersonal conflict was the use of OPS for non-drug-related activities such as grooming, phone charging, socializing and (where they existed) washroom use. OPS were refuges from inclement weather and important spaces for meeting other survival needs. However, this ancillary function of OPS was a source of conflict and even violence when it caused delays accessing injection booths, or when workers denied people access to sites for other purposes. In one focus group, for example, a worker described having a knife pulled on him while enforcing rules around time limits for using the bathroom.

Women working at the sites encountered misogyny and gendered harassment, including sexual remarks and instances of being followed after their shift. As one woman described: “Sometimes guys, especially if they’re doing crystal meth, they get all horny and weird […] there’s unwanted attention that happens.” Some women felt they lacked respect from coworkers and that their concerns were not taken seriously by management:

And I mean its peers not respecting us, males in particular. It’s a sausage party here. But it’s also from the management. Men complain, shit gets taken care of. Women
complain, we’ve got our period. We’re just having a bad hair day. Something, everything’s always minimized when it comes to women’s concerns.

Threats were sometimes minimized by women themselves, who conveyed that gendered harassment was to be expected, even from coworkers. In a focus group at one OPS, three women described how a male co-worker referred to them using a gendered derogatory term (‘cunt’) and issued what they perceived as empty death threats. The women nonetheless expressed understanding for the man’s behaviour, explaining “this isn’t normal work” and that they “had been called worse, by better.” One woman said she started using the word frequently at work to diminish its power to demean her and other women: “I used that word to such a point because I needed women to not flip out every time they heard it because if someone calls you a cunt, it wrecked your whole week.”

Other forms of lateral violence between coworkers were documented during fieldwork, including animosity towards workers who were considered less ‘worthy’ of their position—for example, due to perceived inappropriate drug use while working—and towards those who had access to benefits or opportunities not available to others. In one focus group, a participant expressed disdain for a co-worker she assumed received social assistance:

R1: You know what though? But some of us aren’t really here for the pay because I know I’m not really here for the pay ‘cause I come in here almost 24/7 just to make sure everything’s okay and…
R2: [Interrupting] It’s nice to not to have to worry about having your rent paid.
R1: Oh, trust me, I have to worry about having my rent paid, trust me. I don’t, I’m not
on welfare or nothing so that’s why I work at all these places but still… R2: Yeah, it’s like people … if I don’t work I don’t have anything.

As this excerpt illustrates, workers’ frustration at their economic insecurity was sometimes misdirected toward other PWUD working in the OPS, contributing to interpersonal tensions.

Despite interpersonal tensions, coworkers were viewed as an important resource for mutual support as they understood the unique challenges of the work: “And it does have to be a co-worker too because people in the street don’t understand what we’re doing, right. What our stressors are.” Some participants found that opportunities to socialize outside of work helped reduce stress and improve working conditions by strengthening relationships between staff:

Just getting to know different people on a different level has been really helpful and amazingly it’s like the other peers that—and the clients from time to time—keep me from burning out completely and keep it inspiring enough to stick around.

5.5 Implications of burnout on service delivery

While burnout exacted a physical and mental toll on workers, it also posed operational problems. Staff turnover and missed shifts presented multiple challenges. Fieldnotes documented frequent instances of OPS being unable to open on time as supervisors “fished” for people to fill shifts. To fill staffing shortages, workers would sometimes work back-to-back shifts that left them feeling exhausted and less able to cope with job demands:
Yeah [I’ve experienced burnout], when you’re doing say back-to-backs or you’ve done a shift and somebody stands you up so now you’re doing another shift and it’s just one of those days that there’s a lot of angry people out there and they just seem to be all coming through the front door.

I observed that staffing shortages occasionally resulted in less experienced people on the floor and communication breakdowns between team members who did not often work together. As one participant remarked: “you can tell when the crew is not tight, you know?” (Sara, 29)

Drug use to cope with stressors occasionally presented operational concerns. Workers were sometimes able to have what they called “maintenance shots” at work to avoid withdrawal and stay well during their shift. While perspectives on drug use at work were mixed, accommodation of drug use among workers was considered important for ensuring a low-barrier work environment. However, participants noted that stress and trauma could lead some workers to increase drug use in ways that made it difficult for them to perform their job: “I mean there’s people that like show up and they’re like good and then they just disappear halfway through the shift. Like an hour into their shift, they’re sitting on the table getting high.” Given uncertainties regarding the potency of unregulated opioids, opioid-using workers could become overly intoxicated when drugs were more potent than anticipated, inhibiting their ability to perform some tasks.

There was a perception that chronic burnout over the course of the overdose crisis had eroded a culture of mentorship and mutual support that existed among PWUD with
long-standing involvement in community organizing and advocacy. One woman described how a ‘team culture’ eroded over time as workers became burnt out:

When I first came into the work, I had a bunch of people willing to teach me, and so I was a sponge of information. And now because of the burnout, because of, you know, the experiences folks have had without maybe necessarily engaging in the supports they should have, or didn’t get the supports that they should have, you know, [they] come from this “out for yourselves” [culture], when it should be team building and more mentorship-based. (Dana, 50s)

5.6 Discussion

In summary, overdose responders experienced burnout that had adverse implications on their well-being and the delivery of OPS. In this setting, task shifting formally expanded peer workers’ scope of practice and skills to include activities PWUD are well-positioned to perform, including overdose management, conflict de-escalation, social support, and operations of OPS. However, PWUD employed in ‘peer’ roles do not always receive the pay and benefits that would support them to thrive in these roles. The economic insecurity experienced by PWUD and precarious nature of their work meant they had little power to refuse stressful work, and lacked resources to alleviate burnout such as paid time off and separation of their work and personal lives. The structural vulnerability of workers and service users could further contribute to burnout, as dissatisfaction regarding economic insecurity and social marginalization was sometimes directed laterally towards other PWUD.

The social position of workers with lived experience shaped burnout experiences as they encountered expectations for care work that extended beyond their formal
overdose response roles. Previous ethnographic research documents how marginalized
drug-using communities are held together by moral economies of sharing in which webs
of mutual obligation and reciprocity are essential to survival (Bourgois, 1998). This
analysis suggests a moral economy of sharing shaped burnout in multiple ways. Given
their social position, PWUD faced greater expectations for care work than coworkers who
were not defined by their drug use, and expressed challenges maintaining professional
and personal boundaries. In some cases, workers’ responsibilities (e.g., enforcing site
rules) conflicted with social obligations to friends and family members using the site,
resulting in interpersonal tensions and safety concerns.

As documented elsewhere, overdose response workers with lived experience
provide invaluable care and support to service users, and have saved many lives through
their work (Irvine et al., 2019; Kennedy et al., 2019). However, this research raises ethical
and pragmatic concerns regarding how task shifting has been implemented, specifically that
it may produce and reinforce labour inequities when the labour of PWUD is not
compensated and supported equitably. Activists and scholars have argued that, when
PWUD are not integrated equitably within healthcare workforces, task shifting may
worsen power imbalances and pay disparities between formal ‘non-peer’ workers and
casual ‘peer’ workers (Buchman et al., 2018). This research echoes these concerns and
contributes evidence that task shifting of overdose response tasks in this setting produced
‘peer’ jobs that are more precarious and lower paid than the work performed by formal
health care workers. While this task shifting has been primarily motivated by the movement to better involve PWUD in service delivery, it has also occurred alongside broader transformations to the labour market and welfare system, including the decline of full-time employment in favour of part-time and temporary work, diminishing power of collective labour organizations such as unions, housing insecurity, and stagnating social assistance rates (Klein, Ivanova, & Leyland, 2017; Peters, 2012). All these factors worsen the economic insecurity and job precarity of PWUD, who face substantial barriers to employment due to criminalization of substance use and the exclusion of drug-using populations from the labour market through techniques such as criminal records checks and drug testing (Bourgois, 2002; Boyd et al., 2018; Greer et al., 2018).

As PWUD assume a greater proportion of overdose-related work, governing bodies have a role to play in funding programs adequately to ensure equitable compensation and supports for these workers. This study was conducted in a higher-income jurisdiction that invests relatively considerable funding to enable PWUD involvement in overdose response. I anticipate that the pay and employment inequities PWUD in lower-resourced settings is even more pronounced, particularly where no systems exist to compensate those in ‘peer’ roles for their labour (Greer et al., 2018). Nonetheless, participants in this study conveyed that pay rates were insufficient for the scope of their work, and should be tied to at least a livable wage (Ivanova & Saugstad, 2019). Improving wages requires addressing structural issues with the social assistance
system which pose barriers to transitioning into formal, protected labour. This research further suggests that fostering opportunities for PWUD in decision-making roles could alleviate burnout by creating opportunities for advancement and increasing their control over working conditions (Marshall, Dechman, Minichiello, Alcock, & Harris, 2015). Unionization and collective organizing among workers could help advance labour rights and improve working conditions, as has been attempted in other settings (Bedard, 2014).

The findings urge a rethinking of dominant theories regarding burnout, demonstrating the value of applying a structural vulnerability lens to understand how burnout is produced and experienced by workers who occupy a marginal status within labour markets and society. Conceptual models of burnout processes have been largely based on cases of exhaustion among full-time employees in specialized ‘caring’ professions with stable employment and relatively high socio-economic status (Schaufeli, 2017). This study indicates these models are nonetheless useful for identifying organizational level contributors to burnout among low-wage and casual workers. As is posited in the Areas of Worklife model, many drivers of burnout identified in overdose responders’ accounts stemmed from stressors related to workload, control over work, perceived unfairness, and insufficient rewards for their work (Leiter & Maslach, 2004). However, this analysis documents how stressors in these domains were reinforced by inequities stemming from PWUD’s marginal status in society and the labour market, which shaped how labour was organized and compensated within OPS. Further,
workers’ social position within drug-using networks—and related expectations around care work—constructed unique social vulnerabilities to burnout not captured in dominant theories of burnout that instead emphasize organizational context and individual personality traits (Maslach & Leiter, 2016). My findings also draw into question the effects of labelling workers’ psycho-social suffering as ‘burnout’ given the potential of this concept to individualize and medicalize a phenomenon that, in this case, links closely to challenging working conditions, economic insecurity and precarious labour practices.

5.7 Conclusion

This chapter illuminates how the devaluing and casualization of overdose response labour engendered by task shifting, compounded by other dimensions of structural vulnerability, were central to the production and experience of burnout among overdose response workers with lived experience. Findings highlight concerns regarding how task shifting has been implemented within overdose response programs, including the adverse impacts of low wages and job precarity on workers’ well-being and delivery of programs. While recognizing that stressors associated with overdose response may only be eliminated by addressing root drivers of the overdose crisis, this research indicates burnout may nonetheless be alleviated by strengthening working conditions, compensation, and economic security for workers with lived experience.
Chapter 6: CONCLUSION

6.1 Summary of Findings

This dissertation employed critical ethnographic approaches to examine the implementation and operation of Overdose Prevention Sites in Vancouver, Canada as a community-based response to escalating overdose deaths and a toxic illicit drug supply. Chapter 3 examined how expertise in overdose response was assembled within OPS settings. This chapter identified that OPS responders’ expertise was grounded largely in experiential and embodied knowledge, as responders gained proficiency through habitual practice and drew on their own drug use and overdose experiences to provide overdose care that was technically proficient and attentive to the broader needs of structurally vulnerable PWUD. This analysis further demonstrated how the establishment of OPS strengthened existing forms of expertise by enabling more specialized, comprehensive, and routinized overdose care.

Building upon insights from chapter 3, Chapter 4 examined the role of OPS within the geographies of survival forged by structurally vulnerable PWUD in Vancouver. This chapter located how OPS had multiple survival “uses” for PWUD experiencing socio-spatial exclusion due to the lack of safe and affordable housing, revanchist urban control practices, and an increasingly toxic street-based drug supply. Beyond their primary function in overdose response, OPS offered a place for social connection and mutual-aid; a temporary shelter; a partial refuge from violence and multiple forms of criminalization;
and a place to make money and meet material needs. Findings indicate that while OPS accommodated multiple potential uses of space, processes of ‘spatial triage’ emerged over time as service uptake increased and sites encountered pressures to minimize visibility of drug use and homelessness. Spatial triage entailed the development of rules, procedures and facility modifications that constrained other survival uses of OPS (e.g., for sheltering, income generation, socializing) in order to prioritize prevention of fatal overdoses. While spatial triage offered a pragmatic way to prioritize service delivery to address the most acute survival threat facing PWUD, these practices had unintended and inequitable impacts on service access. This chapter identified how women, Indigenous and unhoused service users were disproportionately impacted by spatial triage given their distinct experiences of socio-spatial exclusion.

Chapter 5 examined the labour arrangements and working conditions of OPS responders with lived experience of drug use, and their implications on burnout and service delivery. This chapter situated the implementation of OPS as a form of task shifting in which structurally vulnerable PWUD, non-profits, and voluntary organizations mobilized to fill an urgent gap within the healthcare system. Ethnographic and interview data were analysed to explore how working conditions, labour arrangements, economic insecurity, and social disadvantage shaped burnout. Findings indicated that overdose response workers commonly experienced burnout, which they attributed to the precarious and demanding nature of their work. While casual positions
offered low-barrier employment, PWUD often lacked the wages and benefits enjoyed by other frontline workers, with limited supports and opportunities for advancement. Due to their social position within drug-using networks, PWUD’s work encompassed hidden care work that participants felt was constant and undervalued. The scarcity of permanent full-time positions, alongside barriers to transitioning into formal employment, prevented many PWUD from earning livable wages or taking time off to “recharge”. This chapter highlights how the devaluing and casualization of overdose response labour, compounded by other dimensions of structural vulnerability, are central to burnout among OPS workers with lived experience.

6.2 Unique contributions

This dissertation makes several unique contributions to the broader literature on community-based overdose response and prevention interventions. While these contributions are detailed in each chapter, three overarching contributions are particularly important to highlight.

First, this dissertation contributes to a rapidly growing body of work that uses ethnographic approaches to generate deeper insights into the social and structural contexts of drug use and overdose vulnerability (Bardwell et al., 2018, 2021; Bourgois & Schonberg, 2009; Collins et al., 2019, 2020; Knight, 2015; Kolla & Strike, 2019; Lopez, 2020; McNeil, Small, Lampkin et al., 2014; Maher, 2002; McNeil, Fleming, Collins et al., 2021; Small, Kerr, Charette et al., 2006; Small, Rhodes, Wood et al., 2007). My research
contributes most to ethnographic research examining how safer environment interventions such as OPS work to reduce overdose-related harms (Bardwell, Fleming et al., 2019; Boyd et al., 2018, 2020; Collins, Boyd, Mayer et al., 2019; Kennedy et al., 2019; Kerr, Small, Moore & Wood, 2007; McNeil & Small, 2014). Methodologically, this dissertation illustrates the insights to be gained from ethnographic engagement with spaces where overdoses routinely occur and are managed. By spending time within OPS and observing overdose responses in real time, I was able to characterize features of community-based overdose response that are situational, tacit, and therefore difficult to document using qualitative interviews alone. This dissertation further indicates benefits of following program implementation and operations over an extended period of time. Observing OPS activities over 20 months enabled me to analyse how these sites were adapted over time to address the complex needs of service users and mitigate harms of a rapidly changing illicit drug supply.

Second, this dissertation illuminates the broader functions of OPS amidst conditions of structural vulnerability and socio-spatial exclusion. Building upon qualitative research considering the diverse functions of overdose prevention interventions in mitigating structural vulnerability (Bardwell et al., 2021; Boyd et al., 2018; Collins et al., 2020; Foreman-Mackey et al., 2019; Kerman et al., 2020), this dissertation indicates broader benefits of OPS for service users who are often low-income, vulnerably housed, and subject to socio-spatial exclusion within urban cities. Findings underscore
how responders strived to provide what has been framed elsewhere as “structurally competent” care by recognizing and responding to the broader health and social vulnerabilities experienced by this population (Metzl & Hansen, 2014). In practice, this entailed accommodating other survival uses of OPS (e.g., sheltering, vending), minimizing the risk of violence and theft during overdose, as well as providing emotional and practical support to people accessing OPS.

Third and finally, this dissertation contributes further insight into the expertise and labour of PWUD in overdose response. Previous research evidences the important role of PWUD in enhancing the reach, acceptability and outcomes of overdose response programs (Bennett et al., 2011; Kennedy et al., 2019; Leece et al.; 2019; Owczarzak et al., 2020), while also indicating ancillary benefits of overdose education and training in boosting PWUD’s confidence and sense of empowerment (Marshall et al., 2017; Mitchell et al., 2017; Wagner et al., 2010; Wagner et al., 2014). This work builds upon recent work situating PWUD’s involvement in overdose response as expert labour that is both valuable and necessary within the context of drug prohibition and structurally-produced drug harms (Collins, McNeil, Czechaczak & Boyd, 2020; Greer et al., 2020; Kolla & Strike, 2019; Lavalley et al., 2021). This dissertation contributes to our understanding of PWUD’s labour in OPS contexts, highlighting how OPS were implemented and organized in ways that leveraged and strengthened the expert knowledge and practices of PWUD. In analysing PWUD involvement in OPS as labour, findings illuminate structural inequities
and precarious working conditions that must be addressed to support the crucial work of PWUD in OPS.

6.3 Limitations

This research has some methodological limitations that should be considered when interpreting findings. First, in order to mitigate potentially negative impacts of my presence on service delivery, I conducted minimal observations in injection rooms themselves and drew on interviews and fieldnotes from CRAs to characterize dynamics in these spaces. A more participatory mode of ethnographic engagement by myself (e.g., working at the site) could have enriched this work, but had to be balanced in this case with the need to maintain OPS as spaces run and staffed by people with lived expertise of drug use. Secondly, I conducted all fieldwork during daytime operations due to scheduling constraints. I believe that socio-spatial practices at night differed in meaningful ways, with gendered and racialized implications that I am unable to account for in this study. Thirdly, as participants were recruited directly from OPS, this study does not capture perspectives of workers who permanently left work due to burnout. Fourth and finally, focus groups with OPS responders included a mix of shift supervisors and casual workers. While these sessions generated important data about interpersonal dynamics and responders’ views on working conditions, the format may have discouraged more junior and casual workers from raising critical perspectives about their working conditions. Semi-structured interviews were therefore important to ensure that
more junior and precariously-employed staff could express their perspectives in a private and confidential setting.

The COVID-19 pandemic posed limitations on this research. Data collection at the hospital-based OPS (OPS 4) was cut short in March 2020 due to the pandemic, as social distancing measures halted in-person research. These circumstances limited ethnographic observation to a month and prevented me from conducting interviews or focus groups with service users at this site. While further observation and interviews at OPS 4 would have strengthened this study, the data I was able to collect supported trends observed in other sites.

6.4 Recommendations

As a critically applied ethnography, this dissertation aimed to generate evidence that can be used to strengthen community-based overdose response. The individual chapters identify multiple policies, operational practices and innovations in service delivery that can support this goal. Table 5 presents a summary of programmatic recommendations based on this research, which may be considered by operating organizations when implementing and operating an OPS. These recommendations are synthesized and discussed below.
Table 5: Summary of programmatic recommendations for OPS operators

<table>
<thead>
<tr>
<th>Domain</th>
<th>Recommendations</th>
</tr>
</thead>
</table>
| Planning and implementation   | • Involve local PWUD early on in planning, and compensate them for their contributions  
                                  • Locate OPS in spaces that are accessible and already frequently used by PWUD  
                                  • Build a coalition of supporters (e.g., organizations, community members, researchers, local government officials) that can be mobilized to act on broader community issues impacting the site (e.g., community opposition, policing, municipal displacement operations)  
                                  • Develop a governance structure that enables frontline workers and service users to participate meaningfully in operational decision-making |
| Built environment             | • Open-concept designs for injection room spaces may facilitate overdose response  
                                  • Physical separation of lobby and injection room may be preferred for privacy  
                                  • Site should ideally be well-lit and temperature-controlled  
                                  • Provide booths/tables that can accommodate two or more people  
                                  • Establish designated smoking space outdoors or in well-ventilated room  
                                  • Provide “chill space” for post-overdose monitoring and hanging out  
                                  • Provide temporary storage space for people to keep personal belongings  
                                  • Provide bathrooms and other amenities that address broader needs of people who rely on public space for survival (e.g., water, coffee, charging stations, couches for sleeping)  
                                  • Equip sites with tools to support overdose response, including oxygen saturation oximeters, oxygen tank, bag mask valves, and airway devices  
                                  • Offer community organizing space for PWUD and allied community groups |
| Staffing                      | • Prioritize staffing sites with community members with lived experience of illicit drug use, in both frontline and operational roles  
                                  • Hire staff with diverse life experiences and social locations  
                                  • Pay all staff a livable wage  
                                  • Offer a continuum of employment options for people with lived experience, spanning from casual stipend roles to permanent, full employment in leadership positions.  
                                  • Build in flexible benefits and sick leave options for casual staff (e.g., a lump sum payment in lieu of benefits, an allotment of paid sick days each month). |
<table>
<thead>
<tr>
<th>Domain</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain</td>
<td>• Tailor payment mechanisms to meet the current needs of workers (e.g., cash at each shift)</td>
</tr>
<tr>
<td></td>
<td>• Establish job titles that accurately reflect the jobs workers perform (e.g., support worker, front desk clerk, shift supervisor, harm reduction specialist, overdose responder)</td>
</tr>
<tr>
<td></td>
<td>• Create opportunities for teams to socialize and relax outside of work hours</td>
</tr>
<tr>
<td></td>
<td>• Develop continual, community-driven training opportunities (e.g., trauma-informed and anti-oppressive care)</td>
</tr>
<tr>
<td></td>
<td>• Provide additional supports to workers wishing to transition into more secure employment arrangements (e.g., assistance with setting up a bank account, financial management, navigating tax and public assistance implications)</td>
</tr>
<tr>
<td></td>
<td>• Adopt a harm reduction approach to drug use during work hours</td>
</tr>
<tr>
<td>Rules and</td>
<td>• Establish minimal and flexible rules that accommodate: booth sharing, peer-to-peer injection assistance, supervised jugging, as well as splitting and sharing of drugs</td>
</tr>
<tr>
<td>Procedures</td>
<td>• Operate with minimal eligibility requirements (e.g., service users agree to abide by a code of conducts for respectful behavior)</td>
</tr>
<tr>
<td></td>
<td>• Booth time limits may be necessary to ensure timely service access for all</td>
</tr>
<tr>
<td></td>
<td>• Develop protocols for issues that commonly arise in OPS, such as unusual overdoses, other medical emergencies, conflict de-escalation, and attending to overdoses outside OPS</td>
</tr>
<tr>
<td></td>
<td>• Clearly delegate tasks and chains of command at the beginning of every shift</td>
</tr>
<tr>
<td>Ancillary services</td>
<td>• Offer co-located and timely drug checking services</td>
</tr>
<tr>
<td></td>
<td>• Provide referrals, as requested, to housing, social, and health services</td>
</tr>
<tr>
<td></td>
<td>• Expand and evaluate co-located safe supply programs that provide pharmaceutical-grade alternatives to the toxic illicit drug supply</td>
</tr>
</tbody>
</table>
This dissertation indicates that community-based overdose response can be supported through establishment of specialized spaces for people to use drugs and receive comprehensive care during an overdose. Findings illustrate the distinct benefits of low-barrier and community-run OPS, demonstrating how these services complement and address limitations of medicalized models of SCS. However, findings also indicate a need for complementary regulatory, policy and operational changes to address the structural drivers of overdose vulnerability. Most OPS service users experienced housing vulnerability, poverty, criminalization, and socio-spatial exclusion that rendered them more vulnerable to the toxic drug supply and fatal overdose. This dissertation illuminates how these intersecting structural vulnerabilities also impacted people’s access to and use of OPS, leading people to use these sites tactfully to meet multiple survival needs (e.g., as temporary shelter, place to make money, refuge from criminalization). These dynamics posed significant operational challenges on OPS which lacked the power and resources (e.g., space, funding) to accommodate these uses alongside their primary work in overdose management. Ultimately, higher-level policy changes are needed to relieve these pressures on OPS and reduce the structural vulnerability of PWUD; policy changes that decriminalize drug use, establish pharmaceutical-grade alternatives to the toxic drug supply, improve income security, and ensure access to safe and affordable housing (Bonn, Tousenard et al., 2020; Fleming et al., 2019; van Draanen, 2020). At a more proximal level, findings indicate an urgent need for OPS service innovations to mitigate
harms of the toxic drug supply, such as integration of safe supply programs and expansion of safer smoking spaces (Bardwell et al., 2021; Bonn, Tousenard et al., 2020; McNeil et al., 2021, 2022; Olding et al., 2020; Wallace et al., 2019). Additional funding and resources will be needed to support these innovations and ensure OPS can continue to provide life-saving overdose care.

As OPS are pursued in new settings, it is critical that they are designed and implemented through meaningful involvement of structurally vulnerable PWUD, and draw upon the diverse knowledge, skills, and practices that PWUD bring to overdose response. This dissertation indicates the importance of flexible and low-barrier policies (e.g., allowing booth sharing, assisted injection, and splitting and sharing of drugs), identifying these as critical features of this model of supervised consumption. This research further demonstrates the benefits of continual learning opportunities and training that extend beyond technical skills of naloxone administration to encompass other social and relational aspects of overdose care (Farrugia et al., 2020; Kolla & Strike, 2019; Parkin et al., 2020). Findings suggest training should address workplace culture issues through trauma-informed and anti-oppression approaches that aim to counter forms of discrimination and lateral violence.

Finally, this study makes a number of recommendations to better support overdose responders’ work and well-being. Findings emphasize that overdose response is emotionally burdensome and challenging work that enlists many technical and social
skills. Efforts to support responders in performing this work must extend beyond individual-level therapeutic interventions (e.g., counselling) to also strengthen working conditions, pay, resources and other practical supports for responders. Findings support the benefits of offering a continuum of employment options for people with lived experience, spanning from casual stipend roles to permanent full employment in leadership positions. However, findings also indicate the need for better pay, supports, and benefits for people in casual “peer” roles; this can be advanced by granting casual staff sick days and leave, paying workers at a liveable wage, and tailoring the payment structure to meet the current needs of the worker (e.g., cash). Findings further indicate responders desired greater opportunities for advancement and leadership within organizations operating OPS. However, additional supports may be needed to help people transition into more permanent and secure employment such as assistance with financial management (e.g., setting up a bank account) and mitigating potential impacts on housing and social assistance income. Reforms to the social assistance system will likely be necessary to truly mitigate these impacts, such as implementing a basic income regime that guarantee all recipients receive a liveable income without conditions (Stahl & MacEachen, 2020). Finally, given the power and employment inequities observed between people in peer vs. non-peer roles, job titles should accurately reflect the work and specialized skills workers perform (e.g., support worker, front desk clerk, shift
supervisor, harm reduction specialist, overdose responder) and not define workers solely by their drug use.

### 6.5 Future Research

This dissertation has focused exclusively on the implementation of OPS in Vancouver, a city with a large urban drug scene that offers a robust continuum of harm reduction services. There is a need to understand how overdose prevention services are being implemented in other settings (e.g., suburban and rural areas) that lack the same social and institutional infrastructure for implementation (Bardwell & Lappalainen, 2021; Boeri & Lamonica, 2021). Illicit drug use in suburban and rural communities is typically more isolated or dispersed than large urban cities, suggesting a need to investigate different models of delivery in these settings such as mobile or virtual supervised consumption (Mema et al., 2019; Perri et al., 2021). Given that most overdose deaths are now occurring in non-traditional housing settings (e.g., supportive housing, SROs, motels, hotels, shelters), future projects should pilot and evaluate resident-driven and low-barrier models of supervised consumption in these environments (Bardwell et al., 2017; Collins et al., 2020; Kolla & Strike, 2019; Nowell et al., 2020). There is also an urgent need to expand and evaluate safer smoking spaces (Bardwell et al., 2011; Gehring et al., 2022), as options for supervised smoking remain very limited despite over half of overdose deaths in BC now being linked to inhaled substances (British Columbia Coroners, Service 2022b).
Findings from this study suggest that while OPS have strengthened community-based overdose response, additional measures are required to address the adulterated and unpredictable drug supply that is driving overdose rates. Towards this end, safe supply programs have been implemented in two Vancouver OPS to provide participants at high risk of fatal overdose with hydromorphone as a pharmaceutical-grade alternative to illicit opioids (Ivsins et al., 2020, 2021; Olding et al., 2020; Tyndall, 2020). With the arrival of the COVID-19 pandemic in March 2020, new guidelines were rapidly developed in BC to facilitate and provide clinical guidance on prescribing opioids, stimulants, and benzodiazepines as a strategy to mitigate risks of withdrawal, COVID-19 transmission, and exposure to the toxic drug supply (British Columbia Centre on Substance Use, 2020). Available research indicates promising potential of safe supply programs to prevent overdoses, as well as more broadly improve quality of life, decrease illicit drug use, and reduce engagement in criminalized forms of income generation (Ivsins et al., 2020, 2021; McNeil et al., 2022). However, access to safe supply remains very limited, in part because the prevailing clinical model is difficult for many PWUD to access due to low prescriber-uptake and pre-existing barriers to primary care (Bonn, Palavew, et al., 2020; Ivsins et al., 2020). Further research is needed to study the feasibility and implementation of alternative supply models that are lower-barrier and dispense drugs that match what PWUD are seeking in the illicit market (Bonn, Tousenard et al., 2020; Ivsins et al., 2020; McNeil et al., 2022).
This dissertation advances the concept of spatial triage to describe how OPS oriented services to prioritize overdose response, and in doing so restricted the other survival uses of OPS by structurally vulnerable PWUD. Future research is needed to understand how spatial triage may be occurring in other service settings and the upstream policy and systems arrangements that shape these processes. The concept may prove analytically useful for understanding dynamics in other programs that provide space and deliver services to people experiencing socio-spatial exclusion on the basis of their drug use, poverty, housing insecurity, and race. However, it is unclear the extent to which this phenomenon is distinct to OPS and other harm reduction services. It is particularly crucial that future studies analyse spatial triage in contexts where harm reduction programs such as OPS are being implemented alongside intensive and racially-targeted social-spatial regulation of drug use and homelessness.

Finally, the COVID-19 pandemic and related public health measures have exacerbated overdose vulnerability and impacted overdose prevention services in ways that are not yet fully understood (Aronowitz et al., 2021; Mackinnon, Socías & Bardwell, 2020; Olding et al., 2020). OPS have experienced operational disruptions and challenges during COVID-19 that contributed to a dramatic drop in service utilization during the initial months of the pandemic (British Columbia Centre for Disease Control, 2022). While service volumes have steadily increased and are approaching pre-pandemic levels (BC Centre for Disease Control, 2022), OPS have needed to adapt services in ways that have
not yet been characterized or analysed (Olding et al., 2020). Future research must consider the impacts of these changes on service delivery, as well as the impacts on responders working in “peer” roles who—as documented in this dissertation and other work (Greer et al., 2020)—experience heightened job and economic precarity (Olding et al., 2020a).

6.6 Conclusion

Collectively, the findings of this dissertation underscore how the implementation and operation of overdose prevention sites in Vancouver has strengthened community-based overdose response, resulting in more specialized, routinized, and comprehensive overdose response practices that are attentive to the broader structural vulnerabilities of PWUD. These findings contribute further evidence of the public health and social benefits of overdose-related interventions designed and run by members of the affected community. Specifically, the experiential and embodied knowledge of PWUD resulted in novel and innovative practices around overdose management. However, findings further indicate the need for complementary structural changes to intervene upon the structural drivers of overdose, as well as policy and organizational changes to improve working conditions and economic security of PWUD working in responder roles.
BIBLIOGRAPHY


Canada (Attorney General) v. PHS Community Services Society, SCC 44 33556 (Canada 2011).


Mazzocchi F. (2006). Western science and traditional knowledge. Despite their variations, different forms of knowledge can learn from each other. *EMBO reports, 7*(5), 463–466. https://doi.org/10.1038/sj.embor.7400693


Vancouver City Council. (2007, October 29). Memorandum of Understanding between BC Housing Management Commission (BC Housing) and the City of Vancouver (the city) regarding the development of city-owned sites for social and supportive housing. Retrieved from https://council.vancouver.ca/20071212/documents/sc1appendixA.pdf


